

## **Retiree Health Plan Advisory Board Meeting Agenda**

**Date:** Thursday August 5, 2021  
**Time:** 9:00am – 3:00pm [OnlinePublicNotices](#)  
**Location:** Juneau State Office Building 10th Floor Conference Room  
Anchorage Atwood Building, 19th floor, Suite 1970, Conference Room  
**Teleconference:** (855-244-8681 ID#: 177 409 5591 Password: 7378 8288  
[Click Here to Join the Meeting](#)  
**Committee Members:** Judy Salo (chair), Lorne Bretz, Joelle Hall, Dallas Hargrave, Paula Harrison, Cammy Taylor, and G. Nanette Thompson

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- 9:00 am**      **Call to Order – Judy Salo, Board Chair**
- Roll Call and Introductions
  - Approval of Agenda
  - Approve Previous Meeting Minutes
  - Ethics Disclosure and Public Comment Script
- 9:15 am**      **Public Comment**
- 9:30 am**      **Department & Division Update**
- Regulatory Updates
  - COVID Update
- 10:00 am**      **Modernization Initiatives**
- Specialty Medication Prior Authorization
- 10:30 am**      **Break**
- 10:45 am**      **Modernization Initiatives Continued**
- 12:00 pm**      **Lunch**
- 1:00 pm**      **Public Comment**
- 1:30 pm**      **Modernization Initiatives Continued**
- Preventive Care
- 2:15 pm**      **2022 DVA and LTC Rates**
- Board recommendation vote
- 2:45 pm**      **Final Thoughts**
- Next Meeting: November 4, 2021
- 3:00 pm**      **Adjourn**

## Table of Contents

Description	# of Pages	Page Number
Agenda	1	01-01
RHPAB Meeting Minutes	13	03-15
Optum Specialty Strategy Presentation	20	16-35
Specialty Pharmacy Drug List	8	36-43
Specialty Prior Authorization Presentation	10	44-53
Specialty Prior Authorization Proposal	9	54-62
Preventive Care Segal Memo	4	63-66
Preventive Care Buck Analysis	3	
Preventive Care Plan Booklet Language	6	67-72
Preventive Care USPSTF Recommendations	8	73-80
Preventive Care ACIP Vaccine Schedule Children	8	81-88
Preventive Care ACIP Vaccine Schedule Adults	6	89-94
Preventive Care Executive Summary	1	95-95
Preventive Care Proposal	17	96-112
AlaskaCare 2022 Premium Rate Development Presentation	15	113-127
Public Comment Timeline	1	128-128

## 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

#### Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members</i>		
Cammy Taylor	Committee Chair	Present
Joelle Hall	Committee Member	Absent
Nanette (Nan) Thompson	Committee Member	Present
Judy Salo	Board Chair	Present
<i>State of Alaska, Department of Administration Staff</i>		
Emily Ricci	Chief Health Policy 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	
<i>Others Present + Members of the Public</i>		
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)	
Andrew Robison	Aetna (medical third-party administrator)	
Miranda Roberts	Aetna (medical third-party administrator)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
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)	
Dorne Hawxhurst	Public Member	
Chris Pace	Public Member	
Barbara Potter	Public Member	
Sharon Hoffbeck	Retired Public Employees of Alaska (RPEA)	
Sadhna Paralkar	Segal Consulting	
Richard Ward	Segal Consulting (contracted actuarial)	

## 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 would review Aetna's proposed structure for preventive care benefits, as well as a proposal regarding pharmacy benefits. 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 is appropriate. 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 the 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 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 grandfathered, and 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: coverage of USPSTF services that are

considered evidence based, some standard vaccines, and preventive care for children. 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 decision may include 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 what has the strongest evidence base. She also reiterated why the retiree plan is grandfathered (noted above).

Lydia 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 aged 40 and older), so Aetna has chosen to cover this more broadly.

- Emily asked why this is controversial?
  - Lydia 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?
  - Lydia 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?
  - Lydia 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.
  - Lydia confirmed that this is not a USPSTF recommendation, but Aetna does cover this.
  - Emily also noted the difference between preventive (screening) and diagnostic care.
  - Lydia 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.

Lydia 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—Lydia noted that many states still require coverage of the PSA, and the 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?
  - Lydia 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.
  - Lydia 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?
  - Lydia 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?
  - Lydia 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. 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.
  - Lydia 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.
  - Lydia 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 a 24% increase in one year.<sup>1</sup> This is also a larger rate 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 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 different 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

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<sup>1</sup> Emily clarified that the slide on page 34 has a typo, should read 24.1%, not 34.1%.

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 determining 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 Optum'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 using external recommendations or guidelines?
      - Jocelyn responded that 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. 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, which has been discussed in the past. 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. 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. There were some issues in this process, but overall, they were able to address issues for each member.
- 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 [rhpab@alaska.gov](mailto:rhpab@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.

# Retiree Plan Specialty Prior Authorization Opportunity





# Addressing rising costs and improving outcomes

## RISING PRESCRIPTION COSTS



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

**AFFORDABILITY**

## ADVERSE DRUG EVENTS



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

**SAFETY**

## SPECIALTY DRUG INCREASE



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

**ACCESS**

# Specialty medications dominate spend

## COST

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

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

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

## COMPLEXITY

### Specialty patients

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

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

# Retiree Plan Specialty Drug Costs Per Rx

Specialty medications for chronic conditions

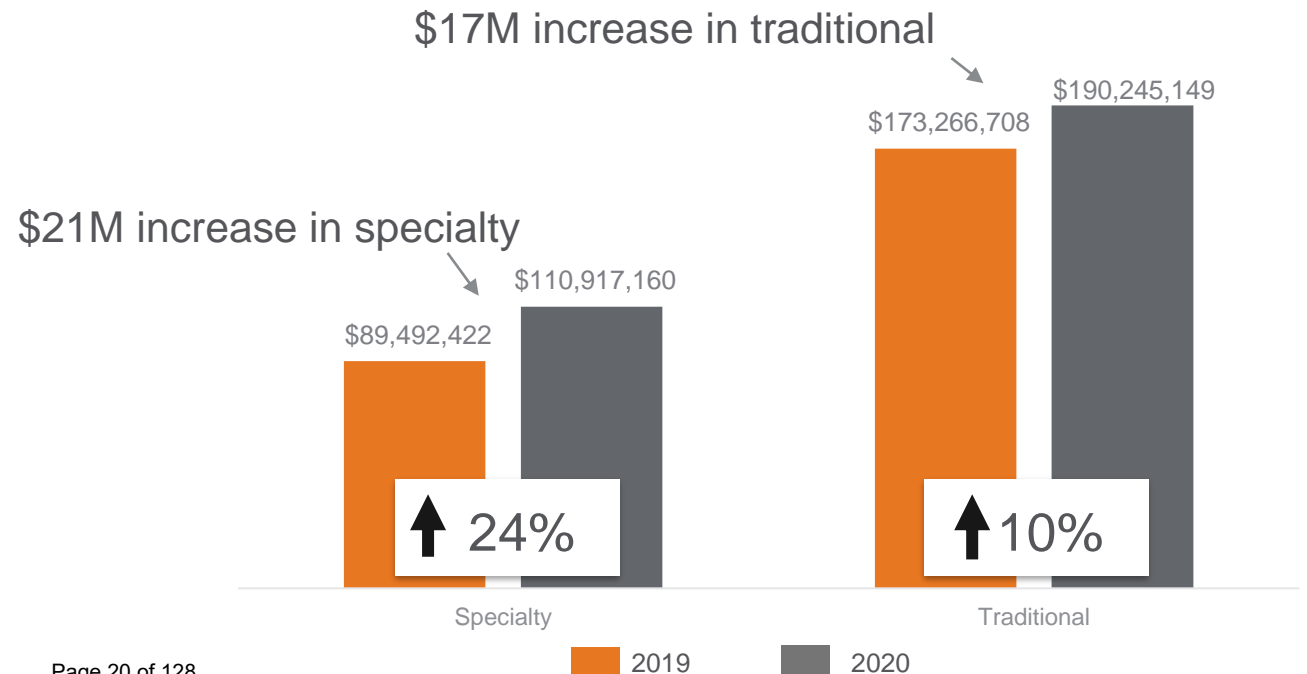
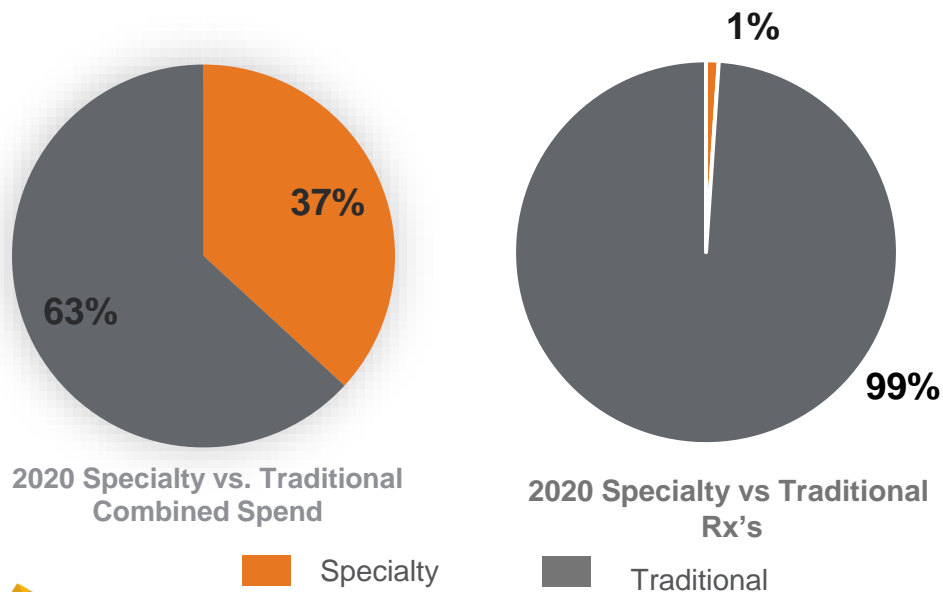
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Specialty Drug	Average Cost Per 30 Day Supply <u>Per Utilizer</u>	Average Cost Annually <u>Per Utilizer</u>	Total Number of Utilizers in 2020
Humira Pen	\$9,570	\$114,841	166
Xeljanz XR	\$9,476	\$113,715	74
Enbrel Sureclick	\$10,017	\$120,213	59
Jakafi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

# Retiree Specialty Medication Increases

2019 to 2020

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



# What is prior authorization?

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



## THE RIGHT DRUG AT THE RIGHT TIME

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



## SAFETY

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



## RETIREE EXPERIENCE

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

# How does OptumRx develop prior authorization?

OptumRx National Pharmacy & Therapeutics Committee

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

## Multi Specialty



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

## Nationally Represented



- Northeast
- Southeast
- Midwest
- West
- Southwest

## Responsibilities



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

## Determinations



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

# Retiree Plan – Specialty Prior Authorization Savings Opportunity

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

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

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



# Retiree Plan

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

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



# Prior Authorization Savings

## What's considered in the savings calculation?

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



## Example: Actiq®



**COVERED**  
for cancer pain

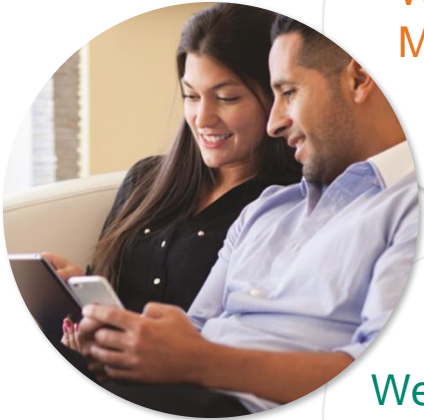
FDA-approved for treating cancer-related pain in members already taking opioid medication around-the-clock



**NOT COVERED**  
for migraines

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

# Enhance the member and provider experience with sophisticated digital tools



We support  
Members by:

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

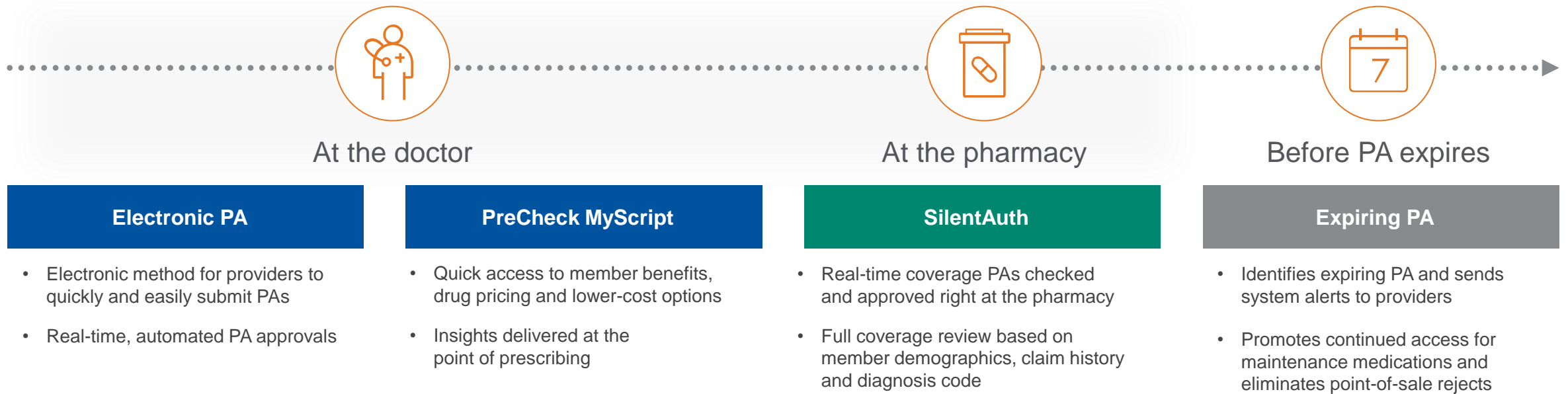
We support  
Physicians by:

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

# Prescriber experience and tools

Faster prescribing, better communication, continued access

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



# Member experience

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

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



Member discusses the medication subject to prior authorization with their prescriber



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



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



## Coverage Determinations

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

## Expiring Prior Authorizations

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

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



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



# Retiree Journey: Barbara's story

## Prior authorization promotes safe and effective medication use



Barbara, age 61 diagnosed with multiple sclerosis



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



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

1

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

2

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

3

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

4

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

5

Barbara's physician is notified of the PA approval.

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

Barbara receives PA approval notification via letter from OptumRx.

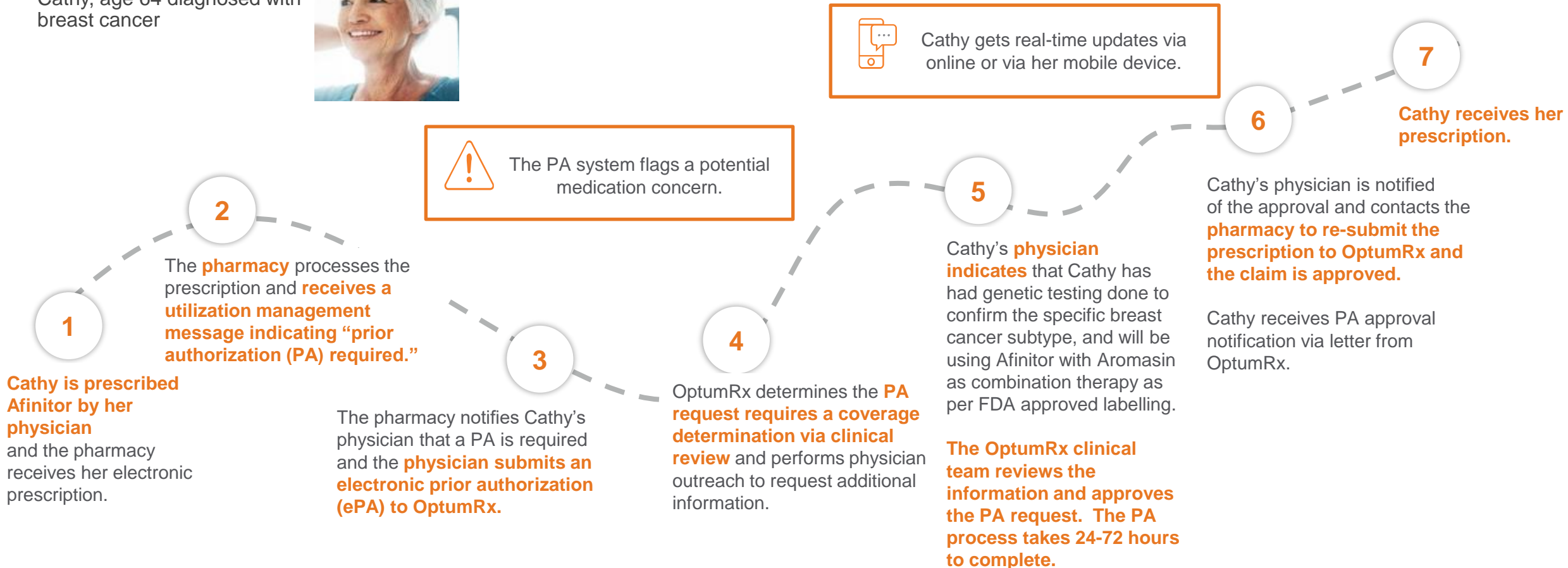
6

Barbara receives her prescription.

# Retiree Journey: Cathy's story

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

Cathy, age 64 diagnosed with breast cancer



# Specialty Management Savings Opportunity Summary

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

# Appendix





# Top 5 Specialty Class Prior Authorization Opportunities

## Medication list

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

# Non-EGWP (Under 65) Retiree Plan

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

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

# EGWP (Over 65) Retiree Plan

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

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

## 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 <sup>PA</sup>

## Anemia

Aranesp <sup>PA</sup>

Epogen <sup>PA</sup>

Mircera <sup>PA</sup>

Procrit <sup>PA</sup>

Reblozyl <sup>PA</sup>

Retacrit <sup>PA</sup>

## Antibacterials

Arikayce <sup>PA</sup>

## Anticoagulation

Arixtra

Fragmin

Lovenox

## Anticovulsants

Diacomit <sup>PA</sup>

Epidiolex <sup>PA</sup>

Fintepla <sup>PA</sup>

## Anti-gout agent

Krystexxa <sup>PA</sup>

## Antihyperlipidemic

Evkeeza

Juxtapid <sup>PA</sup>

## Anti-infective

Daraprim <sup>PA</sup>

Prevymis

## Asthma

Cinqair <sup>PA</sup>

Fasenra <sup>PA</sup>

Nucala <sup>PA</sup>

Xolair <sup>PA</sup>

## Cardiovascular

Northera <sup>PA</sup>

Vyndamax <sup>PA</sup>

Vyndaqel <sup>PA</sup>

## Central nervous system agents

Austedo <sup>PA</sup>

Brineura <sup>PA</sup>

Enspryng <sup>PA</sup>

Firdapse <sup>PA</sup>

Hetlioz <sup>PA</sup>

Ingrezza <sup>PA</sup>

Radicava <sup>PA</sup>

Ruzurgi <sup>PA</sup>

Sabril <sup>PA</sup>

Tiglutik <sup>PA</sup>

Uplizna <sup>PA</sup>

Xenazine <sup>PA</sup>

## Chemotherapy protectant

Elitek

## Cystic fibrosis

Bethkis

Cayston <sup>PA</sup>

Kalydeco <sup>PA</sup>

Kitabis pak

Orkambi <sup>PA</sup>

Pulmozyme <sup>PA</sup>

Symdeko <sup>PA</sup>

Tobi

Tobi Podhalr

Tobramycin

Trikafta <sup>PA</sup>

## Dermatologic

Scenesse <sup>PA</sup>

## Diagnostic

Acthrel

## Duchenne muscular dystrophy

Amondys 45

Emflaza <sup>PA</sup>

## Endocrine

Bynfezia Pen <sup>PA</sup>

Chenodal <sup>PA</sup>

Crysvita <sup>PA</sup>

Cuprimine <sup>PA</sup>

Cystadane

Depen Titra

Egrifta <sup>PA</sup>

Firmagon <sup>PA</sup>

Imcivree

Isturisa <sup>PA</sup>

Jynarque

Korlym <sup>PA</sup>

Kuvan <sup>PA</sup>

Lupaneta <sup>PA</sup>

Lupron Depot <sup>PA</sup>

Makena <sup>PA</sup>

Myalept <sup>PA</sup>

Mycapssa <sup>PA</sup>

Natpara <sup>PA</sup>

Nityr <sup>PA</sup>

Parsabiv

Procysbi <sup>PA</sup>

Samsca

Sandostatin <sup>PA</sup>

Signifor <sup>PA</sup>

Somatuline <sup>PA</sup>

Somavert <sup>PA</sup>

Supprelin LA <sup>PA</sup>

Syprine <sup>PA</sup>

Tepezza <sup>PA</sup>

Thiola

Thyrogen <sup>PA</sup>

Triptodur <sup>PA</sup>

Xuriden <sup>PA</sup>

## Enzyme therapy

Aldurazyme <sup>PA</sup>

Aralast NP <sup>PA</sup>

Buphenyl

Carbaglu

Cerdelga <sup>PA</sup>

Cerezyme <sup>PA</sup>

Cholbam <sup>PA</sup>

Cystagon

Elaprase <sup>PA</sup>

Elelyso <sup>PA</sup>

Fabrazyme <sup>PA</sup>

Galafold <sup>PA</sup>

Givlaari <sup>PA</sup>

Glassia <sup>PA</sup>

Kanuma <sup>PA</sup>

Lumizyme <sup>PA</sup>

Mepsevii <sup>PA</sup>

Naglazyme <sup>PA</sup>

Onpattro <sup>PA</sup>

Orfadin <sup>PA</sup>

Palynziq <sup>PA</sup>

Prolastin-C <sup>PA</sup>

Revcovi <sup>PA</sup>

# Specialty pharmacy drug list

Strensiq<sup>PA</sup>  
 Sucraid  
 Tegsedi<sup>PA</sup>  
 Vimizim<sup>PA</sup>  
 Vpriv<sup>PA</sup>  
 Zavesca<sup>PA</sup>  
 Zemaira<sup>PA</sup>

## Gastrointestinal agents

Gattex<sup>PA</sup>  
 Ocaliva<sup>PA</sup>  
 Xermelo<sup>PA</sup>

## Gene therapy

Zolgensma<sup>PA</sup>

## Growth hormone deficiency

Genotropin<sup>PA</sup>  
 Humatrope<sup>PA</sup>  
 Increlex<sup>PA</sup>  
 Norditropin<sup>PA</sup>  
 Nutropin AQ<sup>PA</sup>  
 Omnitrope<sup>PA</sup>  
 Saizen<sup>PA</sup>  
 Serostim<sup>PA</sup>  
 Zomacton<sup>PA</sup>  
 Zorbtive<sup>PA</sup>

## Hematological agents

Adakveo<sup>PA</sup>  
 Cablivi<sup>PA</sup>  
 Doptelet<sup>PA</sup>  
 Fibryga  
 Mozobil<sup>PA</sup>  
 Mulpleta<sup>PA</sup>  
 Nplate<sup>PA</sup>  
 Oxbryta<sup>PA</sup>

Panhematin  
 Promacta<sup>PA</sup>  
 Riastap  
 Soliris<sup>PA</sup>  
 Tavalisse<sup>PA</sup>  
 Thrombat III  
 Ultomiris<sup>PA</sup>

## 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  
 Epiriv HBV  
 Hepsera  
 Vemlidy

## Hepatitis C

Eplclusa<sup>PA</sup>  
 Harvoni<sup>PA</sup>  
 Ledip-Sofosb<sup>PA</sup>  
 Mavyret<sup>PA</sup>  
 Pegasys<sup>PA</sup>  
 Peg-Intron<sup>PA</sup>  
 Ribavirin  
 Sofos/Velpat<sup>PA</sup>  
 Sovaldi<sup>PA</sup>  
 Technivie  
 Viekira<sup>PA</sup>  
 Vosevi<sup>PA</sup>  
 Zepatier<sup>PA</sup>

## Hereditary angioedema

Berinert<sup>PA</sup>  
 Cinryze<sup>PA</sup>  
 Firazyr<sup>PA</sup>  
 Haegarda<sup>PA</sup>  
 Kalbitor<sup>PA</sup>  
 Orladeyo

Ruconest<sup>PA</sup>  
 Takhzyro<sup>PA</sup>

## Immune globulin

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

## Immunological agents

Actimmune<sup>PA</sup>  
 Arcalyst<sup>PA</sup>  
 Benlysta<sup>PA</sup>  
 Gamifant<sup>PA</sup>  
 Illaris<sup>PA</sup>  
 Lemtrada<sup>PA</sup>  
 Lupkynis

Palforzia <sup>PA</sup>

### Infertility

Cetrotide <sup>PA</sup>  
Follistim AQ <sup>PA</sup>  
Ganirelix <sup>PA</sup>  
Gonal-F <sup>PA</sup>  
HCG <sup>PA</sup>  
Menopur <sup>PA</sup>  
Novarel <sup>PA</sup>  
Ovidrel  
Pregnyl <sup>PA</sup>

### Inflammatory conditions

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

Taltz <sup>PA</sup>  
Tremfya <sup>PA</sup>  
Xeljanz <sup>PA</sup>

### Metabolic agents

Nulibry

### Metabolic bone disease

Reclast

### Mood disorder

Spavato <sup>PA</sup>  
Zulresso <sup>PA</sup>

### Multiple sclerosis

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

### Musculoskeletal agents

Botox Cosmet <sup>PA</sup>  
Evrysti <sup>PA</sup>

Exondys 51 <sup>PA</sup>  
Spinraza <sup>PA</sup>  
Viltepso  
Vyondys 53  
Xiaflex <sup>PA</sup>

### Narcolepsy

Wakix <sup>PA</sup>  
Xyrem <sup>PA</sup>  
Xywav <sup>PA</sup>

### Neurological agents

Botox <sup>PA</sup>  
Dysport <sup>PA</sup>  
Myobloc <sup>PA</sup>  
Xeomin <sup>PA</sup>

### Neutropenia

Fulphila <sup>PA</sup>  
Granix <sup>PA</sup>  
Leukine <sup>PA</sup>  
Neulasta <sup>PA</sup>  
Neupogen <sup>PA</sup>  
Nivestym <sup>PA</sup>  
Nyvepria  
Udenyca <sup>PA</sup>  
Zarxio <sup>PA</sup>  
Ziextenzo <sup>PA</sup>

### Oncology - injectable

Abecma  
Abraxane  
Adcetris <sup>PA</sup>  
Adriamycin  
Adrucil  
Alferon N  
Alimta  
Aliqopa <sup>PA</sup>

Alkeran  
Arranon  
Arzerra <sup>PA</sup>  
Asparlas  
Avastin <sup>PA</sup>  
Bavencio <sup>PA</sup>  
Beleodaq <sup>PA</sup>  
Belrapzo <sup>PA</sup>  
Bendamustine <sup>PA</sup>  
BendeKa <sup>PA</sup>  
Besponsa <sup>PA</sup>  
Bicnu  
Blenrep <sup>PA</sup>  
Bleomycin  
Blinicyto <sup>PA</sup>  
Bortezomib <sup>PA</sup>  
Busulfex  
Breyanzi  
Campath  
Camptosar  
Carboplatin  
Cisplatin Injectable  
Cladribine  
Clolar  
Cosela  
Cosmegen  
Cyclophosphamide  
Cyramza <sup>PA</sup>  
Cytarabine  
Dacogen <sup>PA</sup>  
Danyelza  
Darzalex <sup>PA</sup>  
Daunorubicin  
Docetaxel  
Doxil  
Doxorubicin  
Eligard <sup>PA</sup>  
Ellence  
Elzonris <sup>PA</sup>



# Specialty pharmacy drug list

Empliciti <sup>PA</sup>	Libtayo <sup>PA</sup>	Tecentriq <sup>PA</sup>	Balversa <sup>PA</sup>
Enhertu <sup>PA</sup>	Lumoxiti <sup>PA</sup>	Temodar <sup>PA</sup>	Bosulif <sup>PA</sup>
Erbix <sup>PA</sup>	Lupron Depot <sup>PA</sup>	Tepadina	Braftovi <sup>PA</sup>
Erwinaze	Margenza	Thiotepa	Brukina <sup>PA</sup>
Etopophos	Marqibo	Tice BCG	Cabometyx <sup>PA</sup>
Etoposide Injectable	Mesnex	Torisel	Calquence <sup>PA</sup>
Evomela	Mitomycin Injectable	Totect	Caprelsa <sup>PA</sup>
Faslodex	Monjuvi <sup>PA</sup>	Trazimera <sup>PA</sup>	Cometriq <sup>PA</sup>
Fensolvi <sup>PA</sup>	Mvasi <sup>PA</sup>	Treanda	Copiktra <sup>PA</sup>
Fludarabine	Mylotarg <sup>PA</sup>	Trelstar mix <sup>PA</sup>	Cotellic <sup>PA</sup>
Fluorouracil Injectable	Navelbine	Trisenox	Daurismo <sup>PA</sup>
Foloty <sup>PA</sup>	Nipent	Trodely <sup>PA</sup>	Erivedge <sup>PA</sup>
Fusilev	Ogivri <sup>PA</sup>	Truxima <sup>PA</sup>	Erleada <sup>PA</sup>
Gazyva <sup>PA</sup>	Oncaspar	Unituxin <sup>PA</sup>	Etoposide Capsule
Halaven <sup>PA</sup>	Onivyde	Valstar	Farydak <sup>PA</sup>
Herceptin <sup>PA</sup>	Ontruzant <sup>PA</sup>	Vantas <sup>PA</sup>	Fotivda
Herzuma <sup>PA</sup>	Opdivo <sup>PA</sup>	Vectibix	Gavreto <sup>PA</sup>
Hycamtin	Padcev <sup>PA</sup>	Velcade <sup>PA</sup>	Gilotrif <sup>PA</sup>
Idamycin PFS	Pamidronate	Vidaza	Gleevec <sup>PA</sup>
Ifex	Paraplatin	Vinblastine Injectable	Gleostine
Ifosfamide	Pepaxto	Vyxeos <sup>PA</sup>	Hycamtin
Imfinzi <sup>PA</sup>	Perjeta <sup>PA</sup>	Xgeva <sup>PA</sup>	Ibrance <sup>PA</sup>
Imlygic	Phesgo <sup>PA</sup>	Yervoy <sup>PA</sup>	Iclusig <sup>PA</sup>
Infugem	Photofrin	Yescarta <sup>PA</sup>	Idhifa <sup>PA</sup>
Intron A <sup>PA</sup>	Polivy <sup>PA</sup>	Yondelis	Imbruvica <sup>PA</sup>
Istodax OVR <sup>PA</sup>	Portrazza <sup>PA</sup>	Zaltrap <sup>PA</sup>	Inlyta <sup>PA</sup>
Ixempra kit	Poteligeo <sup>PA</sup>	Zanosar	Inqovi <sup>PA</sup>
Jelmyto	Proleukin	Zepzelca <sup>PA</sup>	Inrebic <sup>PA</sup>
Jevtana <sup>PA</sup>	Provenge <sup>PA</sup>	Zevalin	Iressa <sup>PA</sup>
Kadcyla <sup>PA</sup>	Riabni	Zinecard	Jakafi <sup>PA</sup>
Kanjinti <sup>PA</sup>	Rituxan <sup>PA</sup>	Zirabev <sup>PA</sup>	Kisqali <sup>PA</sup>
Kepivance	Romidepsin <sup>PA</sup>	Zoladex	Koselugo <sup>PA</sup>
Keytruda <sup>PA</sup>	Ruxience <sup>PA</sup>		Lenvima <sup>PA</sup>
Khapzory <sup>PA</sup>	Sarclisa <sup>PA</sup>	<b>Oncology - oral</b>	Lonsurf <sup>PA</sup>
Kymriah <sup>PA</sup>	Sylatron <sup>PA</sup>	Afinitor <sup>PA</sup>	Lorbrena <sup>PA</sup>
Kyprolis <sup>PA</sup>	Sylvant <sup>PA</sup>	Alecensa <sup>PA</sup>	Lynparza <sup>PA</sup>
Lartruvo <sup>PA</sup>	Synribo <sup>PA</sup>	Alkeran	Matulane
Leuprolide Injectable <sup>PA</sup>	Taxotere	Alunbrig <sup>PA</sup>	Mekinist <sup>PA</sup>
Levoleucovor	Tecartus <sup>PA</sup>	Ayvakit <sup>PA</sup>	Mektovi <sup>PA</sup>

Mesnex  
Nerlynx <sup>PA</sup>  
Nexavar <sup>PA</sup>  
Nilandron  
Ninlaro <sup>PA</sup>  
Nubeqa <sup>PA</sup>  
Odomzo <sup>PA</sup>  
Onureg <sup>PA</sup>  
Orgovyx  
Pemazyre <sup>PA</sup>  
Piqray <sup>PA</sup>  
Pomalyst <sup>PA</sup>  
Purixan  
Qinlock <sup>PA</sup>  
Retevmo <sup>PA</sup>  
Revlimid <sup>PA</sup>  
Rozlytrek <sup>PA</sup>  
Rubraca <sup>PA</sup>  
Rydapt <sup>PA</sup>  
Sprycel <sup>PA</sup>  
Stivarga <sup>PA</sup>  
Sutent <sup>PA</sup>  
Tabloid  
Tabrecta <sup>PA</sup>  
Tafinlar <sup>PA</sup>  
Tagrisso <sup>PA</sup>  
Talzenna <sup>PA</sup>  
Tarceva <sup>PA</sup>  
Targretin <sup>PA</sup>  
Tasigna <sup>PA</sup>  
Tazverik <sup>PA</sup>  
Temodar <sup>PA</sup>  
Tepmetko  
Thalomid <sup>PA</sup>  
Tibsovo <sup>PA</sup>  
Tukysa <sup>PA</sup>  
Turalio <sup>PA</sup>  
Tykerb <sup>PA</sup>  
Ukoniq  
Venclexta <sup>PA</sup>

Verzenio <sup>PA</sup>  
Vitrakvi <sup>PA</sup>  
Vizimpro <sup>PA</sup>  
Votrient <sup>PA</sup>  
Xalkori <sup>PA</sup>  
Xeloda <sup>PA</sup>  
Xospata <sup>PA</sup>  
Xpovio <sup>PA</sup>  
Xtandi <sup>PA</sup>  
Yonsa <sup>PA</sup>  
Zejula <sup>PA</sup>  
Zelboraf <sup>PA</sup>  
Zolinza <sup>PA</sup>  
Zydelig <sup>PA</sup>  
Zykadia <sup>PA</sup>  
Zytiga <sup>PA</sup>

### **Oncology - topical**

Targretin Gel <sup>PA</sup>  
Valchlor <sup>PA</sup>

### **Ophthalmic agents**

Beovu <sup>PA</sup>  
Bevacizumab  
Cystadrops <sup>PA</sup>  
Cystaran <sup>PA</sup>  
Dextenza  
Eylea <sup>PA</sup>  
Iluvien  
Jetrea  
Keveyis <sup>PA</sup>  
Lucentis <sup>PA</sup>  
Luxtorna <sup>PA</sup>  
Macugen <sup>PA</sup>  
Oxervate <sup>PA</sup>  
Ozurdex  
Retisert  
Visudyne  
Yutiq

### **Opioid antagonists**

Sublocade

### **Osteoarthritis**

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

### **Osteoporosis**

Evenity <sup>PA</sup>  
Forteo <sup>PA</sup>  
Prolia <sup>PA</sup>  
Teriparatide <sup>PA</sup>  
Tymlos <sup>PA</sup>

### **Pain management**

Prialt

### **Parkinson's disease**

Apokyn <sup>PA</sup>  
Inbrija <sup>PA</sup>  
Kynmobi <sup>PA</sup>

### **Pulmonary fibrosis**

Esbriet <sup>PA</sup>

Ofev <sup>PA</sup>

### **Pulmonary hypertension**

Adcirca <sup>PA</sup>  
Adempas <sup>PA</sup>  
Flolan <sup>PA</sup>  
Letairis <sup>PA</sup>  
Opsumit <sup>PA</sup>  
Orenitram <sup>PA</sup>  
Remodulin <sup>PA</sup>  
Revatio <sup>PA</sup>  
Tracleer <sup>PA</sup>  
Tyvaso <sup>PA</sup>  
Uptravi <sup>PA</sup>  
Veletri <sup>PA</sup>  
Ventavis <sup>PA</sup>

### **RSV**

Synagis <sup>PA</sup>

### **Substance abuse treatment**

Vivitrol

### **Transplant**

Astagraf XL  
Atgam  
Cellcept  
Cellcept IV  
Envarsus XR  
Myfortic  
Neoral  
Nulojix <sup>PA</sup>  
Prograf  
Rapamune  
Sandimmune  
Zortress <sup>PA</sup>

## About OptumRx

OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. Our high-quality, integrated services deliver optimal member outcomes, superior savings and outstanding customer service. We are an Optum® company — a leading provider of integrated health services. Learn more at [optum.com](https://www.optum.com).

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To fill a prescription for a specialty medication on this list, please call **1-855-427-4682** or visit [specialty.optumrx.com](https://specialty.optumrx.com)

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This specialty pharmacy drug list may not be a complete list of all specialty medications; this list can change at any time without notice.

Non-specialty alternatives may be a recommended first-line therapy to treat your condition. Please consult your doctor.



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# Specialty Prior Authorization

July 28, 2021



# 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.

# 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.



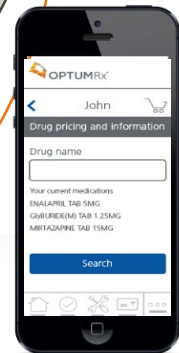
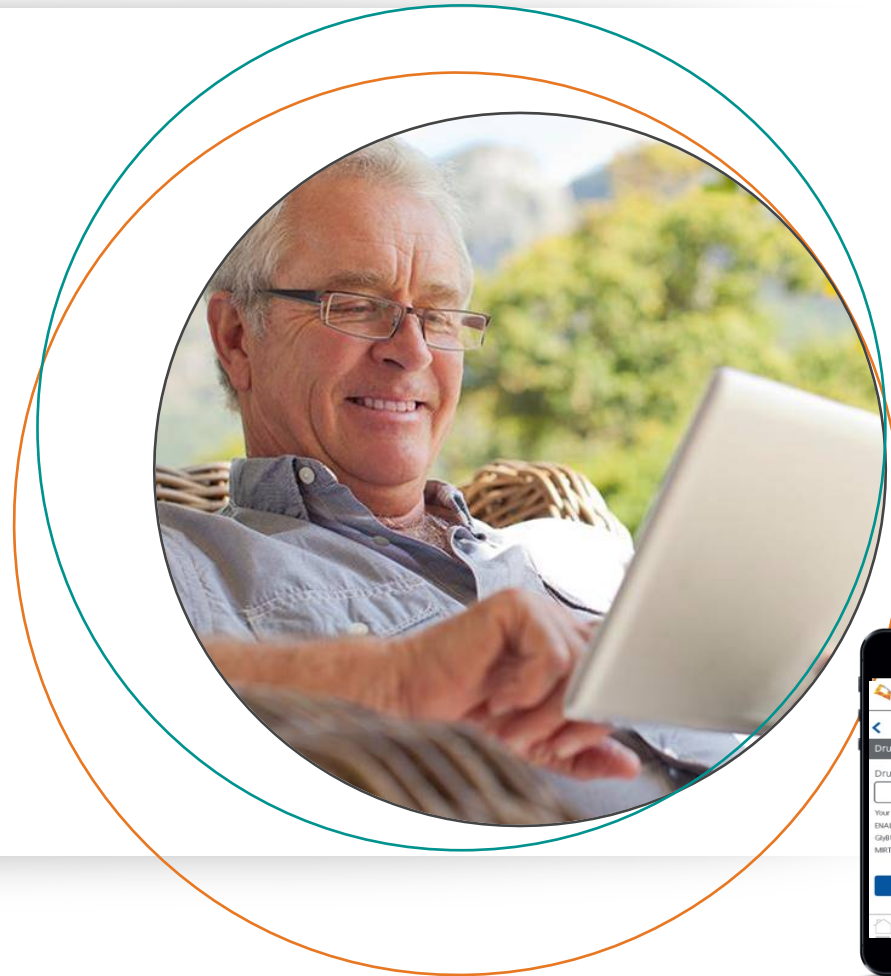
## STANDARD PLAN MANAGEMENT

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.

# 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](http://www.optumrx.com) or by calling OptumRx Customer Service.



# Visibility to your Prior Authorization

## Conveniently monitor PAs

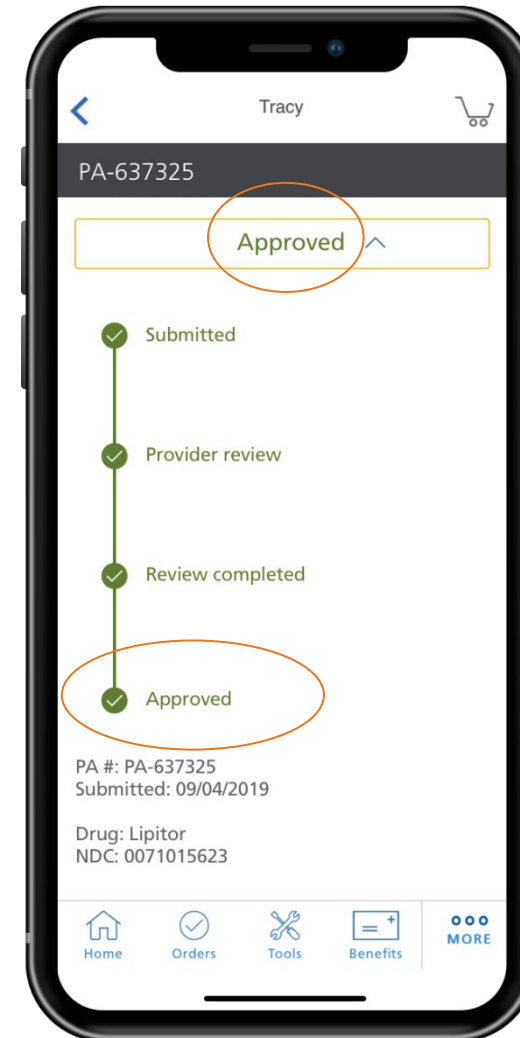
Track a PA status at anytime

## 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<sup>®</sup>

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

# Prior Authorization Criteria: Xyrem

Product Name: <u>Xyrem</u>	
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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Symptoms of cataplexy are present</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Symptoms of excessive daytime sleepiness (e.g., irrepensible need to sleep or daytime lapses into sleep) are present</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Prescribed by or in consultation with one of the following:</p> <ul style="list-style-type: none"> <li>• Neurologist</li> <li>• Psychiatrist</li> <li>• Sleep Medicine Specialist</li> </ul>	

**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
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of moderately to severely active RA</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Prescribed by or in consultation with a rheumatologist</p> <p style="text-align: center;"><b>AND</b></p> <p>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]</p>	

## 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
<p><b>Approval Criteria</b></p> <p><b>1</b> - Diagnosis of moderately to severely active Crohn's disease [7, 8, B]</p> <p style="text-align: center;"><b>AND</b></p> <p><b>2</b> - Trial and failure, contraindication, or intolerance to one of the following conventional therapies: [7]</p> <ul style="list-style-type: none"> <li>• 6-mercaptopurine (Purinethol)</li> <li>• azathioprine (Imuran)</li> <li>• corticosteroids (e.g., prednisone, methylprednisolone)</li> <li>• methotrexate (Rheumatrex, Trexall)</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3</b> - Prescribed by or in consultation with a gastroenterologist</p>	

## References:

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Proposal Title	Specialty Medication Prior Authorizations (R020)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1 <sup>st</sup> , 2022
Reviewed By	Retiree Health Plan Advisory Board
Review Date	August 5, 2021

### Contents

1) BACKGROUND..... 2

2) OBJECTIVES ..... 4

3) SUMMARY OF PROPOSED CHANGE ..... 4

4) IMPACTS..... 7

    Actuarial Impact | Pending ..... 7

    Financial Impact | Annual Cost Savings: Pending ..... 7

    Member Impact | Low ..... 7

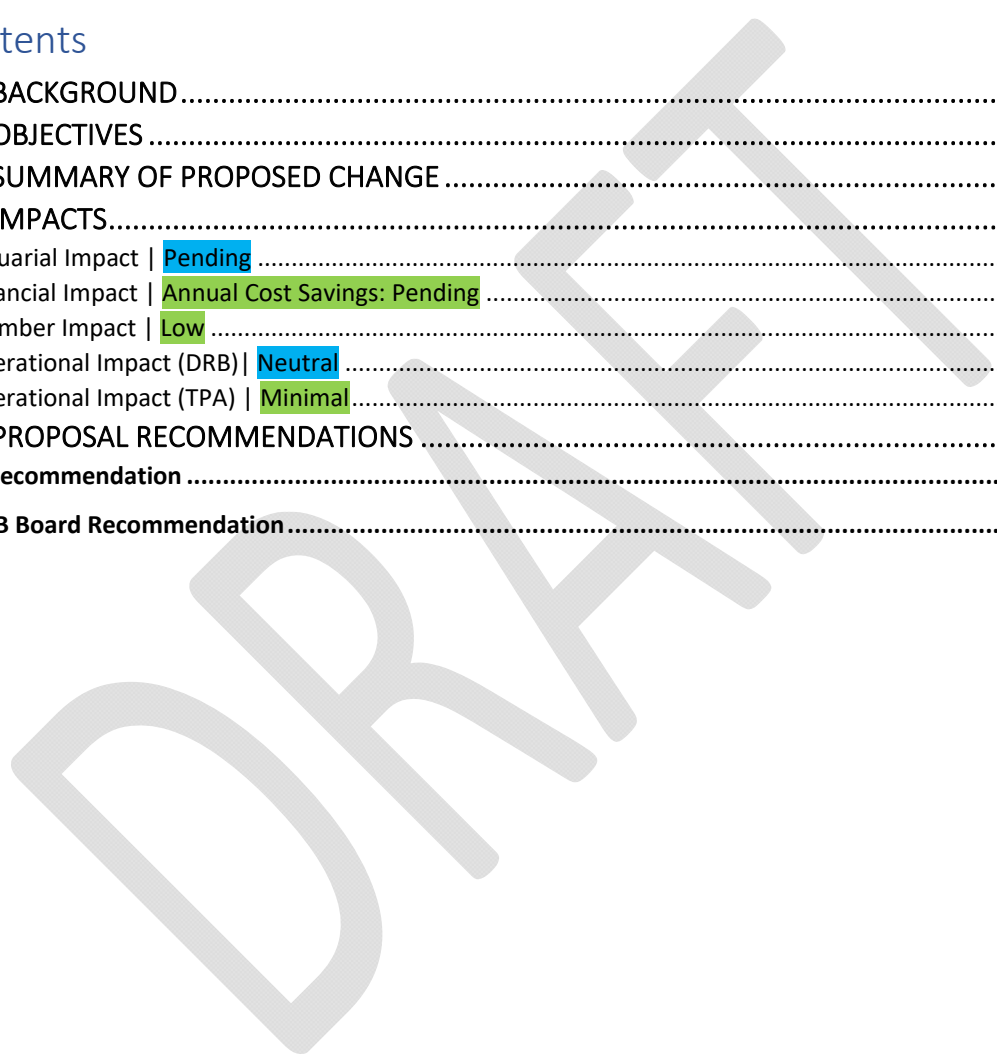
    Operational Impact (DRB) | Neutral ..... 8

    Operational Impact (TPA) | Minimal ..... 8

5) PROPOSAL RECOMMENDATIONS ..... 8

    DRB Recommendation ..... 8

    RHPAB Board Recommendation ..... 8



## 1) Background

### *Specialty Medications*

Specialty medications are typically highly complex, high-cost, or high-touch drugs that often require very specialized storage protocols or must be administered in a very specific manner. Specialty drugs:<sup>1,2</sup>

- May be prescribed for a person with a complex or chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure, is progressive, and/or is debilitating or fatal if left untreated or under-treated;
- Treat rare or orphan disease<sup>3</sup> indications;
- Require additional patient education, adherence, and support beyond traditional dispensing activities;
- Are oral, injectable, inhalable, or infusible drugs;
- Have a high monthly cost (e.g., more than \$1,000 for a 30-day supply)<sup>4</sup>
- Have unique storage or shipment requirements, such a refrigeration; and
- Are not typically stocked at a majority of retail pharmacies.

Many specialty medications are prescribed to treat chronic conditions, meaning that utilizers are likely to use that medication for a long time.

### *Specialty Medications as a Cost Driver*

Specialty medications are one of the largest rising cost drivers in pharmaceutical spend. In the United States in 2008, specialty medications accounted for just over 20% of pharmaceutical spend; by 2023, that percentage is expected to climb to over 50%.<sup>5</sup>

In the AlaskaCare Defined Benefit Retiree Health Plan (Plan), specialty medication use has grown along with its percentage of overall cost. In 2014, specialty medications accounted for 0.7% of total prescriptions and 19% of total Plan pharmacy cost (or \$33.5M out of \$176.7M).<sup>6</sup> In 2020, specialty costs for less than 1% of prescriptions (associated with 3.7% of utilizer) made up 37%, or \$110 million of the total Plan prescription drug spend. The Plan's costs for specialty medications increased \$21 million from 2019 to 2020 (24%), due to increased prescriptions and utilization of higher cost medications.<sup>7</sup>

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<sup>1</sup> Pharmaceutical Care Management Association. "What is a Specialty Drug?" <https://www.pcmnet.org/pcma-cardstack/what-is-a-specialty-drug/>

<sup>2</sup> See Attachment B: Characteristics of specialty medications, OptumRx Specialty Pharmacy Drug List, July 1, 2021, page 2.

<sup>3</sup> Affecting fewer than 200,000 people

<sup>4</sup> Medicare defines drugs with a 30-day equivalent negotiated price of \$670 or more as a specialty drug.

[https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2021%20mtm%20and%20specialty%20thresholds%20final%20part%20d%20bidding%2005.22.2020\\_8.pdf](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2021%20mtm%20and%20specialty%20thresholds%20final%20part%20d%20bidding%2005.22.2020_8.pdf)

<sup>5</sup> The Global Use of Medicine in 2019 and Outlook to 2023: Forecasts and Areas to Watch. IQVIA Institute.

[https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/the-global-use-of-medicine-in-2019-and-outlook-to-2023.pdf?\\_=1626801058214](https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/the-global-use-of-medicine-in-2019-and-outlook-to-2023.pdf?_=1626801058214)

<sup>6</sup> 2014 4<sup>th</sup> Quarter AlaskaCare Retiree Health Plan Report, pages 32-33.

<sup>7</sup> See Attachment A: OptumRx Presentation, *Retiree Plan Specialty Prior Authorization Opportunity*. June 18, 2021, page 5.

*Specialty Medication Spend in the AlaskaCare Retiree Plan*

Though specialty drug claims account for less than 1% of all AlaskaCare retiree Plan pharmacy claims in 2020, the \$110 million in Plan costs associated with those prescriptions totaled 37% of the total pharmacy spend. In 2020:<sup>8</sup>

- 60,677 AlaskaCare retiree Plan members filled prescriptions through the Plan’s prescription drug benefit.
- 2,272 individuals (3.7% of all utilizers) filled 10,923 prescriptions for specialty medications.
- Those specialty prescriptions represent less than 1% of the overall 1,380,472 total prescriptions filled by all utilizers.

These medications can have high costs per utilizer, as evidenced by table 1 below.

*Table 1. AlaskaCare Top 5 Specialty Medications for Chronic Conditions, 2020<sup>9</sup>*

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

*AlaskaCare Retiree Plan Coverage Provisions*

The Plan provides coverage for outpatient prescription drugs for the treatment of an illness, disease, or injury if dispensed upon prescription of a provider acting within the scope of their license.<sup>10</sup> *Section 4.5 Medical Necessity* under the Prescription Drugs section of the Plan states:

“To be covered under the plan prescription drugs must be medically necessary and clinically appropriate. This provision does not require the use of generic drugs.

The plan will cover some drugs only if prescribed for certain uses, or durations. Certain medications have specific dispensing limitation for quantity, age, gender and maximum dose. Determination of medical necessity will be based on recommendations by the federal Food and Drug Administration (FDA), combined with the pharmacy benefit managers standard coverage policies designed to ensure the medication prescribed is safe and effective. For this reason, some prescription medications may be subject to prior authorization to determine that the requested prescription drug is medically necessary.

<sup>8</sup> Ibid, page 8.

<sup>9</sup> Ibid, page 4.

<sup>10</sup> AlaskaCare Retiree Insurance Information Booklet, January 2021. *Section 4. Prescription Drugs.*

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



## DRAFT

The prior authorization ensures you are getting the most appropriate care and will occur in the best setting. This helps produce improved health outcomes and lower health care costs by reducing duplication, waste, and unnecessary treatments.”<sup>11</sup>

Prior authorization for prescription drugs is a pharmacy management process that reviews certain medications against clinical, evidence-based standards including those established by the FDA to promote safe and effective use of those medications. Similar to how most medical plans (including the AlaskaCare Defined Benefit Retiree Health Plan) require precertification for certain intensive, complex, and high-cost medical services, prior authorization is a common tool used by pharmacy plans to review dispensation of many different types of medications, including specialty medications.

The Division of Retirement and Benefits (Division) contracts with a Pharmacy Benefit Manager (PBM) – currently OptumRx – to process AlaskaCare prescription drug claims in accordance with the Plan and to apply any appropriate pharmacy management processes.

The prior authorization pharmacy management process is a critical tool for evaluating if the person utilizing a specialty medication meets the medical necessity guidelines outlined by the Plan and established by the FDA and other entities. Without the prior authorization process, the PBM does not have an alternative means to receive and review the information necessary to ensure the patient receiving the medication meets these criteria, including basic diagnostic information.

Currently the Plan does not have this prior authorization process in place for specialty medications. As the use of, and indications for, specialty medications increase, the need for the prior authorization process is becoming acute.

## 2) Objectives

- a) Promote safe and effective use of medications in accordance with evidence-based clinical standards.
- b) Employ prudent pharmacy management strategies to curtail unnecessary or unsafe utilization of high-cost medications.

## 3) Summary of Proposed Change

Prior authorization requires prescribers to provide patient-specific medication treatment information for review prior to approval and dispensing to the patient. This review ensures that a prescription drug is medically necessary, appropriately prescribed, meets FDA and other clinical guidelines for the condition being treated, and is therefore eligible for coverage by the Plan. By following clinical standards with use of evidence-based guideline criteria, the prior authorization process promotes safe and effective use of these medications.

The Division proposes implementing prior authorization requirements for specialty medications. To do so, the Plan would adopt OptumRx’s specialty prior authorization program. Under the proposed program,

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<sup>11</sup> AlaskaCare Retiree Insurance Information Booklet, January 2021. *Section 4.5 Medical Necessity.*

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

## DRAFT

before the Plan would provide coverage for certain specialty medications, OptumRx must receive and approve a prior authorization for the medication.

### *Prior Authorization Process*

Providers may submit prior authorization requests electronically, over the phone, or by mail. The prior authorization process is designed with expediency in mind.

Real Time: When appropriate, electronically submitted prior authorizations may be approved in real time through an automated system. Many providers (both in and out of network) have access to OptumRx's PreCheck MyScript tool, an integrated add-on to commonly used Electronic Medical Record (EMR) systems that provides real-time, patient specific drug cost and coverage details. Use of PreCheck MyScript can help ensure that prior authorizations are submitted and approved before the member initiates a prescription fill.

72 Hours: OptumRx processes and provides notice of prior authorization determinations within 72 hours. Initial determination notices may be provided verbally to expedite processing of the prescription, and a written follow-up notice will be mailed within three calendar days. Members can also monitor the status of a prior authorization request on the OptumRx secure portal or mobile app.

24 Hours: Expedited requests are processed, and determination notice is provided within 24 hours.

Because health plans commonly include prior authorization requirements for specialty medications, most clinicians are familiar with the process and are prepared to submit a prior authorization request before the member fills the prescription.

If a required prior authorization is not submitted prior to the member attempting to fill the prescription, when the pharmacy processes the prescription, they will receive a message at the point-of-sale indicating that prior authorization is required. The pharmacy typically notifies the prescribing physician, who is then responsible for submitting the prior authorization request and any associated required additional information.

Once the prior authorization has been submitted, OptumRx will review the prescription against clinical criteria specific to the drug and to the member's condition to ensure safe and effective use of the medication. Members will have the ability to access the clinical criteria specific to their specialty medication the OptumRx online member portal, or by calling OptumRx customer service.

- If the prior authorization request meets the clinical criteria, it will be approved, and the prescription may be filled.
- If more information is needed, OptumRx will reach out to the prescribing provider.
- If the information provided does not meet clinical criteria, coverage for the prescription will be denied, and information regarding the specific clinical criteria that was not met will be provided to the member.
  - The member may appeal this decision through the AlaskaCare appeals process, or they may work with their prescriber to obtain a different prescription.
  - The member's prescriber may provide additional clinical information to OptumRx to support use of the medication by the member, or they may request a peer-to-peer discussion with an OptumRx clinical pharmacist to discuss the member's individual condition and circumstances.

## DRAFT

Prior authorization approvals are typically valid for 3-36 months, depending on the medication. OptumRx identifies approved prior authorizations for prescriptions expiring within 30 days and will proactively reach out to the prescriber to request any information needed to extend the prior authorization.

If members are unsure if their current medication or any new prescriptions require a prior authorization, they may call OptumRx, consult the Plan's formulary<sup>12</sup> (list of prescribed medications), or review the current OptumRx Specialty Pharmacy Drug List (see attachment B) to determine if their drug is subject to prior authorization.

### *Development of Prior Authorization Clinical Criteria*

Every PBM has a process for reviewing and aggregating clinical guidelines to establish the clinical criteria used to evaluate prior authorization requests. This proposal contemplates the use of OptumRx's clinical criteria, however if the plan transitions to a different PBM in the future, that PBM's clinical criteria would be used to evaluate any prior authorizations in effect at that time.

At OptumRx, prior authorization criteria are reviewed and approved by the OptumRx Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is an independent, multi-specialty and nationally represented group of physicians and pharmacists. The P&T Committee evaluates medications based on scientific evidence to find their place in therapy. Quarterly meetings are held to evaluate, review and make clinical recommendations. Industry, clinical and company standards govern the P&T Committee's review, consideration and recommendation processes. The committee considers:

- U.S. Food and Drug Administration (FDA) approved indications
- Manufacturer's package labeling instructions
- Well-accepted and/or published clinical recommendations (ex: American Hospital Formulary Service Drug Information; DRUGDEX; National Comprehensive Cancer Network Drugs and Biologics Compendium; Clinical Pharmacology; major peer reviewed medical journals such as the American Journal of Medicine)

Based on this information, the P&T Committee evaluates whether a drug has unique therapeutic benefit, comparable safety and efficacy, or whether risk of harm outweighs the benefits. The P&T Committee complies with national quality standards including those provided by the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC®). After thorough clinical review of prior authorization guidelines is complete, the P&T Committee approves the utilization management criteria.

Actuarial Impact | Pending  
Financial Impact | Annual Cost Savings: Pending  
Member Impact | Low  
Operational Impact (DRB) | Neutral  
Operational Impact (TPA) | Minimal

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<sup>12</sup> AlaskaCare formularies are available online: <http://doa.alaska.gov/drb/alaskacare/optumrx.html>

## 4) Impacts

### Actuarial Impact | Pending

Analysis of any actuarial impact associated with implementing prior authorizations for specialty medications is under review and development.

### Financial Impact | Annual Cost Savings: Pending

#### Cost Saving Potential

Prior authorization is a core component of prudent pharmacy plan management. Medications requiring prior authorization typically have limited FDA-approved uses, are used for conditions that require special diagnostic confirmation, or have a high potential to be prescribed for off-label uses where appropriateness and efficacy are not well established. If left unmanaged without requiring prior authorization, these medications can significantly increase plan costs.

Prior authorizations review medications to ensure safe and effective use. Though cost of the drug is not one of the criteria used to review use of a medication during the prior authorization process, implementation of the prior authorization program is anticipated to bring annual incidental savings to the plan. Plan savings associated with prior authorizations typically fall into three general categories:<sup>13</sup>

1. **Drug Not Approved:** Some prior authorization requests are not approved because the drug is not appropriate for the member's condition, or because it has been prescribed in a manner contrary to evidence-based guidelines. For example, Xyrem is an orphan drug that is FDA approved to treat narcolepsy but is not covered for chronic fatigue syndrome or fibromyalgia. A prior authorization review would ensure that it has been prescribed to treat an appropriate condition. If an alternative prescription is not written, the cost of the drug is considered savings to the Plan.
2. **Alternative Drug Prescribed:** Some prior authorization requests result in the prescribing physician writing a prescription for an alternative medication. In this instance, the difference between the cost of the original medication and the cost of the alternative medication is considered savings to the Plan.
3. **Prescription Abandoned:** Some prior authorization requests are abandoned (additional requested information is not provided) by the provider or by the member. In this instance, the cost of the drug associated with the abandoned prior authorization is considered savings to the plan.

#### Annual & Long-Term Cost Impact

The anticipated financial impact to the plan associated with implementing prior authorizations is under review and further development.

### Member Impact | Low

Implementation of prior authorizations for specialty medications will impact a small portion of Plan members. As previously discussed, out of 60,677 members who filled prescription medications in 2020, only 3.7%, or 2,272 individuals filled prescriptions for specialty medications that would be subject to prior authorization.

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<sup>13</sup> OptumRx Presentation, Retiree Plan Specialty Prior Authorization Opportunity. June 18, 2021.

# DRAFT

Utilizers of specialty medications (or their providers) will be required to seek prior authorization. Members may contact OptumRx, review individualized information about their prescriptions on the OptumRx.com member portal, or consult the current OptumRx Specialty Pharmacy Drug List (see attachment B) to determine if any of their current medications are specialty medications that are subject to prior authorization. Medications on the list that require a prior authorization are indicated with a “PA” designation after the drug name.

Members who are currently utilizing specialty medications will be notified 60 days in advance of prior authorizations going into effect that a medication they are using will be subject to prior authorization. These members will be advised to speak with their provider, so that the provider is aware of the need to submit a prior authorization. Their provider will then initiate the prior authorization through the process described above in section 3.

Members who receive a new prescription for a specialty medication after prior authorizations are implemented will need to work with their prescriber to obtain the relevant prior authorization.

Because most health plans include a requirement for prior authorization for specialty medications, most providers are familiar with the process and are prepared to submit the necessary request and documentation before the member attempts to fill their prescription. In most cases, prior authorization is a process that occurs between the provider and OptumRx, and the member should not have to be heavily involved in the process.

There is no change to coverage for prescription medications that are prescribed under the terms outlined in the Plan booklet. The plan will continue to cover medically necessary and clinically appropriate prescription drugs.

## Operational Impact (DRB) | Neutral

To implement this change, the Division will need work with OptumRx to ensure that the prior authorization process is correctly implemented, including auditing and verifying the set-up, creating and executing a member and provider communication campaign, and preparing both the Division and OptumRx’s member services centers to assist members with questions related to prior authorizations.

## Operational Impact (TPA) | Minimal

Prior authorizations for specialty medications are a common plan feature and are included in nearly all commercial and self-insured plans administered by OptumRx. OptumRx has a robust prior authorization department that is already prepared to process any requests, and their member services staff are well versed in the program.

## 5) Proposal Recommendations

### DRB Recommendation

Insert the Division recommendation here when final.

### RHPAB Board Recommendation

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

Description	Date
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**DRAFT**

Reviewed by Modernization Subcommittee	06/18/2021, 07/28/2021
Reviewed by RHPAB	08/05/2021

**Documents attached include:**

<b>Attachment</b>	<b><u>Document Name</u></b>
<b>A</b>	OptumRx Presentation, <i>Retiree Plan Specialty Prior Authorization Opportunity</i> , June 18, 2021.
<b>B</b>	OptumRx Specialty Pharmacy Drug List, July 1, 2021
<b>C</b>	OptumRx Presentation, <i>Specialty Prior Authorization</i> , July 28, 2021.

DRAFT



Richard Ward, FSA, FCA, MAAA  
West Region Market Director, Public Sector  
T 956.818.6714  
M 619.710.9952  
RWard@Segalco.com

500 North Brand Boulevard  
Suite 1400  
Glendale, CA 91203-3338  
segalco.com

## Memorandum

**To:** Ajay Desai, Director, Division of Retirement and Benefits  
**From:** Richard Ward, FSA, FCA, MAAA  
**Date:** April 19, 2021  
**Re:** Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan (*Updated*)

The AlaskaCare Retiree Plan currently provides coverage for some select preventive benefits. Currently, the Plan provides coverage for the following routine lab tests:

- One pap smear per year for all women age 18 or older. Charges for a limited office visit to collect the pap smear are also covered.
- Prostate specific antigen (PSA) tests as follows:
  - One annual screening PSA test for men between ages 35 and 50 with a personal or family history of prostate cancer, and
  - One annual screening PSA test for men 50 years and older
- Mammograms as follows:
  - One baseline mammogram between age 35 and 40
  - One mammogram every two years between ages 40 and 50, and
  - One annual mammogram at age 50 years and above, and for those with a personal or family history of breast cancer.

Coverage is provided in the same manner that other medical treatments and services are covered. The Plan applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered.

Below is a table outlining the current benefits offered under the Plan:

<b>Deductibles</b>		
Annual individual / family unit deductible	\$150 / up to 3x per family	
<b>Coinsurance</b>		
Most medical expenses	80%	
Most medical expenses after out-of-pocket limit is satisfied	100%	
Second surgical opinions, Preoperative testing, Outpatient testing/surgery	100%	
• No deductible applies		
<b>Out-of-Pocket Limit</b>		
Annual individual out-of-pocket limit	\$800	
• Applies after the deductible is satisfied		
• Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit		
<b>Benefit Maximums</b>		
Individual lifetime maximum	\$2,000,000	
• Prescription drug expenses do not apply against the lifetime maximum		
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	\$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	\$25,430	
<b>Prescription Drugs</b>		Up to 90 Day or 100 Unit Supply
		Generic
Network pharmacy copayment	\$4	\$8
Mail order copayment	\$0	\$0

A change to the benefits under consideration would align the scope of benefits with those required of non-Grandfathered plans under the Affordable Care Act (ACA). Note that retiree plans, such as the AlaskaCare Retiree Plan, are not subject to the same provisions under the ACA that apply to the AlaskaCare Employee Plan. The changes to preventive benefits have been analyzed in the following two ways:

- A. Option A: In-Network: 80% coinsurance/deductible applies/out-of-pocket limit applies; Out-of-Network: 60% coinsurance/deductible applies/out-of-pocket limit does not apply.
- B. Option B: In-Network: 100% coinsurance/deductible does not apply; Out-of-Network: 80% coinsurance/deductible applies/out-of-pocket limit does not apply.



## Actuarial Value

Our updated analysis utilizes claims data and the Optum Comprehensive Benefit Pricing Model<sup>1</sup>, along with previously completed work using the Apex Actuarial Rate Modeling System<sup>2</sup>.

The impact of expanding the scope of covered services to align the scope of benefits with those required of non-Grandfathered plans under the ACA while being subject to deductibles, coinsurance and other plan provisions (Option A) would increase the actuarial value by 0.45%<sup>3</sup>.

The impact of expanding the scope of covered services to align the scope of benefits with those required of non-Grandfathered plans under the ACA at no member cost, 100% plan paid, for network provided services (Option B), would be an increase of 0.50% in actuarial value.<sup>4</sup>

The updated analysis reflects additional anticipated utilization resulting from the expanded benefits. For Medicare members, many of these services, including colonoscopies, are currently covered at 100% by Medicare. For these members, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible.

## Financial Impact

Based on the most recent retiree medical and pharmacy claims projection of \$633,000,000 for 2021 (dated August 28, 2020), and trended forward at 6% to \$670,000,000 for 2022, this equates to approximately \$3,000,000 (Option A) to \$3,350,000 (Option B) in additional annual costs to the Plan depending on the cost sharing provisions.

## Additional Notes

The data used for this analysis was reviewed, but not audited, and found to be sufficient and credible.

The above projection is an estimate of future cost and is based on information available to Segal at the time the projection was made. Segal has not audited the information provided. A projection is not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, change in demographics, overall inflation rates and claims volatility. Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled, or terminated employees during a period other than that which is

<sup>1</sup> The Optum Comprehensive Benefit Pricing Model provides comprehensive plan design and rate modeling capabilities, and is widely utilized throughout the industry by insurance carriers and consulting actuaries. Segal held an annual license to utilize this model at the time the analysis was conducted.

<sup>2</sup> The Apex Actuarial Rate Modeling System provides comprehensive plan design and rate modeling capabilities, and is widely utilized throughout the industry by insurance carriers and consulting actuaries. Segal held an annual license to utilize this model at the time the analysis was conducted.

<sup>3</sup> The previous analysis did not review the actuarial value change for a plan benefit that was subject to deductibles, coinsurance and other plan provisions.

<sup>4</sup> The previous analysis included in the July 25, 2018 Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan memo provide an actuarial value change of 0.75%.

referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

The Coronavirus (COVID-19) pandemic is rapidly evolving and will likely impact the 2021 US economy and health plan claims projections for most Health Plan Sponsors. As a result, projections could be significantly altered by emerging events. At this point, it is unclear what the impact will be for Health Plan Sponsors. Segal continues to develop and review plan cost adjustment factors and reports to apply to both short-term and long-term financial projections. Additionally, the potential for federal or state fiscal relief is also not contemplated in these budget projections.

cc: Emily Ricci, Division of Retirement and Benefits  
Betsy Wood, Division of Retirement and Benefits  
Andrea Mueca, Division of Retirement and Benefits  
Noel Cruse, Segal  
Eric Miller, Segal  
Quentin Gunn, Segal

## Preventive care and wellness

This section describes the **eligible health services** and supplies available under your plan when you are well.

### Important notes:

1. You will see references to the following recommendations and guidelines in this section:
  - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
  - United States Preventive Services Task Force
  - Health Resources and Services Administration
  - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.
3. Gender-specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.
4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your Aetna member website at [www.aetna.com](http://www.aetna.com) or calling the number on your ID card. This information can

also be found at the [www.HealthCare.gov](http://www.HealthCare.gov) website.

## Routine physical exams

**Eligible health services** include office visits to your **physician, PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** or other **health professional** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk human papillomavirus (HPV) DNA testing for women age 30 and older
- Radiological services, lab and other tests given in connection with the exam.
- For covered children, from birth to age 2:
  - An initial hospital checkup
  - Periodic well child exams
  - Consultation between the **health professional** and a parent

## Newborn hearing screening exam

**Eligible health services** include:

- Screening test for hearing loss prior to the date the child is 30 days old and
- Diagnostic hearing evaluation if the initial screening test shows the child may have a hearing impairment.

## Preventive care immunizations

**Eligible health services** include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

## Well woman preventive visits

**Eligible health services** include your routine:

- Well woman preventive exam office visit to your **physician, PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

## Preventive screening and counseling services

**Eligible health services** include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

- **Obesity and/or healthy diet counseling**

**Eligible health services** include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**

**Eligible health services** include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

- **Use of tobacco products**

**Eligible health services** include the following screening and counseling services to help you to stop the use of tobacco products:

- Preventive counseling visits
- Treatment visits
- Class visits;
- Tobacco cessation prescription and over-the-counter drugs
  - **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Tobacco product means a substance containing tobacco or nicotine such as:

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**

**Eligible health services** include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**

**Eligible health services** include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

## Routine cancer screenings

**Eligible health services** include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
- Found in the American Cancer Society guidelines for colorectal cancer screening

**Eligible health services** include:

- A mammogram for women:
  - With a history of breast cancer
  - Who have a parent or sibling with a history of breast cancer
  - Who have received a referral from a **physician**
- Additional cancer screenings at frequencies that may not be included in the guidelines referenced above. See your schedule of benefits for details.

## Prenatal care

**Eligible health services** include your routine prenatal physical exams, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You can get this care at your **physician's, PCP's, OB's, GYN's, or OB/GYN's** office.

### **Important note:**

You should review the benefit under *Eligible health services under your plan- Maternity and related newborn care* and the *Exceptions* sections of this booklet-certificate for more information on coverage for pregnancy expenses under this plan.

## Comprehensive lactation support and counseling services

**Eligible health services** include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

## Breast feeding durable medical equipment

**EXAMPLE PLAN LANGUAGE – NOT PROPOSED FOR INCLUSION IN THE ALASKACARE RETIREE HEALTH PLAN**

**Eligible health services** include renting or buying **durable medical equipment** you need to pump and store breast milk as follows:

**Breast pump**

**Eligible health services** include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**.
- The buying of:
  - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every three years, or
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

**Breast pump supplies and accessories**

**Eligible health services** include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

**Family planning services – female contraceptives**

**Eligible health services** include family planning services such as:

**Counseling services**

**Eligible health services** include counseling services provided by a **physician**, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

**Devices**

**Eligible health services** include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a **physician** during an office visit.

**Voluntary sterilization**

**Eligible health services** include charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

**Important note:**

EXAMPLE PLAN LANGUAGE – NOT PROPOSED FOR INCLUSION IN THE ALASKACARE RETIREE HEALTH PLAN

See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs*
- *Treatment of basic infertility*

EXAMPLE



Topic	Description	Grade	Release Date of Current Recommendation
Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked	The USPSTF recommends 1-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years who have ever smoked.	B	December 2019 *
Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening: adults aged 40 to 70 years who are overweight or obese	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B	October 2015 *
Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication: adults aged 50 to 59 years with a 10% or greater 10-year cvd risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	B	April 2016 *
Asymptomatic Bacteriuria in Adults: Screening: pregnant persons	The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.	B	September 2019 *
BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation	The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.	B	August 2019 *
Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer aged 35 years or older	The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.	B	September 2019 *

Breast Cancer: Screening: women aged 50 to 74 years	The USPSTF recommends biennial screening mammography for women aged 50 to 74 years. †	B	January 2016 *
Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.	B	October 2016 *
Cervical Cancer: Screening: women aged 21 to 65 years	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). See the Clinical Considerations section for the relative benefits and harms of alternative screening strategies for women 21 years or older.	A	August 2018 *
Colorectal Cancer: Screening: adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. The risks and benefits of different screening methods vary. See the Clinical Considerations section and the Table for details about screening strategies.	A	June 2016 *
Dental Caries in Children from Birth Through Age 5 Years: Screening: children from birth through age 5 years	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.	B	May 2014 *
Dental Caries in Children from Birth Through Age 5 Years: Screening: children from birth through age 5 years	The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	B	May 2014 *
Depression in Adults: Screening: general adult population, including pregnant and postpartum women	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	January 2016 *
Depression in Children and Adolescents: Screening: adolescents aged 12 to 18 years	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	February 2016 *

Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.	B	April 2018 *
Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of pregnancy	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	January 2017 *
Gestational Diabetes Mellitus, Screening: asymptomatic pregnant women, after 24 weeks of gestation	The USPSTF recommends screening for gestational diabetes mellitus (GDM) in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Chlamydia and Gonorrhea: Screening: sexually active women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years and younger and in older women who are at increased risk for infection.	B	September 2014 *
Chlamydia and Gonorrhea: Screening: sexually active women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection.	B	September 2014 *
Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions: adults with cardiovascular disease risk factors	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.	B	November 2020 *
Screening for Hepatitis B Virus Infection in Adolescents and Adults: adolescents and adults at increased risk for infection	The USPSTF recommends screening for hepatitis B virus (HBV) infection in adolescents and adults at increased risk for infection. See the Practice Considerations section for a description of adolescents and adults at increased risk for infection.	B	December 2020 *
Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women	The USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit	A	July 2019 *

Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years	The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.	B	March 2020 *
Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened. See the Clinical Considerations section for more information about assessment of risk, screening intervals, and rescreening in pregnancy.	A	June 2019 *
Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons	The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.	A	June 2019 *
Screening for Hypertension in Adults: adults 18 years or older without known hypertension	The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A	April 2021 *
Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services. See the Clinical Considerations section for more information on effective ongoing support services for IPV and for information on IPV in men.	B	October 2018 *
Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection	The USPSTF recommends screening for latent tuberculosis infection (LTBI) in populations at increased risk.	B	September 2016 *
Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia: Preventive Medication : pregnant women who are at high risk for preeclampsia	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	B	September 2014

Lung Cancer: Screening: adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	March 2021 *
Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.	B	June 2017 *
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.	A	January 2019 *
Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. See the Clinical Considerations section for information on risk assessment.	B	June 2018 *
Osteoporosis to Prevent Fractures: Screening: women 65 years and older	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.	B	June 2018 *
Perinatal Depression: Preventive Interventions: pregnant and postpartum persons	The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.	B	February 2019
Preeclampsia: Screening: pregnant woman	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.	B	April 2017 *
Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis: persons at high risk of hiv acquisition	The USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. See the Clinical Considerations section for information about identification of persons at high risk and selection of effective antiretroviral therapy.	A	June 2019

Prevention and Cessation of Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco	The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.	B	April 2020 *
Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women	The USPSTF recommends repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh(D)-negative.	B	February 2004 *
Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit	The USPSTF strongly recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004 *
Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults at increased risk	The USPSTF recommends behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs). See the Practice Considerations section for more information on populations at increased risk for acquiring STIs.	B	August 2020 *
Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.	B	March 2018 *
Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years with no history of cvd, 1 or more cvd risk factors, and a calculated 10-year cvd event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (ie, symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults aged 40 to 75 years. See the "Clinical Considerations" section for more information on lipids screening and the assessment of cardiovascular risk.	B	November 2016 *

Syphilis Infection in Nonpregnant Adults and Adolescents: Screening : asymptomatic, nonpregnant adults and adolescents who are at increased risk for syphilis infection	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.	A	June 2016 *
Syphilis Infection in Pregnant Women: Screening: pregnant women	The USPSTF recommends early screening for syphilis infection in all pregnant women.	A	September 2018 *
Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and US Food and Drug Administration (FDA)-- approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.	A	January 2021 *
Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons: pregnant persons	The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.	A	January 2021 *
Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.	B	November 2018 *
Unhealthy Drug Use: Screening: adults age 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)	B	June 2020
Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years	The USPSTF recommends vision screening at least once in all children aged 3 to 5 years to detect amblyopia or its risk factors.	B	September 2017 *

Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.	B	September 2018 *
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Pages: 1

†The Department of Health and Human Services, under the standards set out in revised Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2016 recommendation on breast cancer screening, go to <http://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening1>.

\*Previous recommendation was an “A” or “B.”



# Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED STATES  
2021

## Vaccines in the Child and Adolescent Immunization Schedule\*

Vaccines	Abbreviations	Trade names
Diphtheria, tetanus, and acellular pertussis vaccine	<b>DTaP</b>	Daptacel® Infanrix®
Diphtheria, tetanus vaccine	<b>DT</b>	No trade name
<i>Haemophilus influenzae</i> type b vaccine	<b>Hib (PRP-T)</b> <b>Hib (PRP-OMP)</b>	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	<b>HepA</b>	Havrix® Vaqta®
Hepatitis B vaccine	<b>HepB</b>	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	<b>HPV</b>	Gardasil 9®
Influenza vaccine (inactivated)	<b>IIV</b>	Multiple
Influenza vaccine (live, attenuated)	<b>LAIV4</b>	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	<b>MMR</b>	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	<b>MenACWY-D</b> <b>MenACWY-CRM</b> <b>MenACWY-TT</b>	Menactra® Menveo® MenQuadfi®
Meningococcal serogroup B vaccine	<b>MenB-4C</b> <b>MenB-FHbp</b>	Bexsero® Trumenba®
Pneumococcal 13-valent conjugate vaccine	<b>PCV13</b>	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	<b>PPSV23</b>	Pneumovax 23®
Poliovirus vaccine (inactivated)	<b>IPV</b>	IPOL®
Rotavirus vaccine	<b>RV1</b> <b>RV5</b>	Rotarix® RotaTeq®
Tetanus, diphtheria, and acellular pertussis vaccine	<b>Tdap</b>	Adacel® Boostrix®
Tetanus and diphtheria vaccine	<b>Td</b>	Tenivac® Tdvax™
Varicella vaccine	<b>VAR</b>	Varivax®
<b>Combination vaccines (use combination vaccines instead of separate injections when appropriate)</b>		
DTaP, hepatitis B, and inactivated poliovirus vaccine	<b>DTaP-HepB-IPV</b>	Pediarix®
DTaP, inactivated poliovirus, and <i>Haemophilus influenzae</i> type b vaccine	<b>DTaP-IPV/Hib</b>	Pentacel®
DTaP and inactivated poliovirus vaccine	<b>DTaP-IPV</b>	Kinrix® Quadracel®
DTaP, inactivated poliovirus, <i>Haemophilus influenzae</i> type b, and hepatitis B vaccine	<b>DTaP-IPV-Hib-HepB</b>	Vaxelis®
Measles, mumps, rubella, and varicella vaccine	<b>MMRV</b>	ProQuad®

\*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

## How to use the child/adolescent immunization schedule

- 1** Determine recommended vaccine by age (**Table 1**)
- 2** Determine recommended interval for catch-up vaccination (**Table 2**)
- 3** Assess need for additional recommended vaccines by medical condition and other indications (**Table 3**)
- 4** Review vaccine types, frequencies, intervals, and considerations for special situations (**Notes**)

Recommended by the Advisory Committee on Immunization Practices ([www.cdc.gov/vaccines/acip](http://www.cdc.gov/vaccines/acip)) and approved by the Centers for Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov)), American Academy of Pediatrics ([www.aap.org](http://www.aap.org)), American Academy of Family Physicians ([www.aafp.org](http://www.aafp.org)), American College of Obstetricians and Gynecologists ([www.acog.org](http://www.acog.org)), American College of Nurse-Midwives ([www.midwife.org](http://www.midwife.org)), American Academy of Physician Assistants ([www.aapa.org](http://www.aapa.org)), and National Association of Pediatric Nurse Practitioners ([www.napnap.org](http://www.napnap.org)).

## Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or 800-822-7967



Download the CDC Vaccine Schedules App for providers at [www.cdc.gov/vaccines/schedules/hcp/schedule-app.html](http://www.cdc.gov/vaccines/schedules/hcp/schedule-app.html).

## Helpful information

- Complete ACIP recommendations: [www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html)
- *General Best Practice Guidelines for Immunization*: [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html)
- Outbreak information (including case identification and outbreak response), see Manual for the Surveillance of Vaccine-Preventable Diseases: [www.cdc.gov/vaccines/pubs/surv-manual](http://www.cdc.gov/vaccines/pubs/surv-manual)
- ACIP Shared Clinical Decision-Making Recommendations [www.cdc.gov/vaccines/acip/acip-scdm-faqs.html](http://www.cdc.gov/vaccines/acip/acip-scdm-faqs.html)



**U.S. Department of Health and Human Services**  
Centers for Disease Control and Prevention

**Table 1**

**Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021**

**These recommendations must be read with the notes that follow.** For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2). School entry and adolescent vaccine age groups are shaded in gray.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs	
Hepatitis B (HepB)	1 <sup>st</sup> dose	←--- 2 <sup>nd</sup> dose ---→		←----- 3 <sup>rd</sup> dose -----→														
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	See Notes													
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose	←----- 4 <sup>th</sup> dose -----→				5 <sup>th</sup> dose								
Haemophilus influenzae type b (Hib)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	See Notes	← 3 <sup>rd</sup> or 4 <sup>th</sup> dose, See Notes →												
Pneumococcal conjugate (PCV13)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose	←----- 4 <sup>th</sup> dose -----→												
Inactivated poliovirus (IPV <18 yrs)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	←----- 3 <sup>rd</sup> dose -----→						4 <sup>th</sup> dose							
Influenza (IIV)											Annual vaccination 1 or 2 doses			Annual vaccination 1 dose only				
<b>or</b>											Annual vaccination 1 or 2 doses			Annual vaccination 1 dose only				
Influenza (LAIV4)											Annual vaccination 1 or 2 doses			Annual vaccination 1 dose only				
Measles, mumps, rubella (MMR)					See Notes	←----- 1 <sup>st</sup> dose -----→				2 <sup>nd</sup> dose								
Varicella (VAR)						←----- 1 <sup>st</sup> dose -----→				2 <sup>nd</sup> dose								
Hepatitis A (HepA)					See Notes	2-dose series, See Notes												
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)																		Tdap
Human papillomavirus (HPV)														*	See Notes			
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)			See Notes												1 <sup>st</sup> dose		2 <sup>nd</sup> dose	
Meningococcal B															See Notes			
Pneumococcal polysaccharide (PPSV23)												See Notes						

  Range of recommended ages for all children
   Range of recommended ages for catch-up immunization
   Range of recommended ages for certain high-risk groups
   Recommended based on shared clinical decision-making or \*can be used in this age group
   No recommendation/not applicable

# Table 2

## Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 month Behind, United States, 2021

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the notes that follow.**

Children age 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B	Birth	<b>4 weeks</b>	<b>8 weeks and at least 16 weeks after first dose.</b> Minimum age for the final dose is 24 weeks.		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	<b>4 weeks</b>	<b>4 weeks</b> Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis	6 weeks	<b>4 weeks</b>	<b>4 weeks</b>	<b>6 months</b>	<b>6 months</b>
<i>Haemophilus influenzae</i> type b	6 weeks	<b>No further doses needed</b> if first dose was administered at age 15 months or older. <b>4 weeks</b> if first dose was administered before the 1 <sup>st</sup> birthday. <b>8 weeks (as final dose)</b> if first dose was administered at age 12 through 14 months.	<b>No further doses needed</b> if previous dose was administered at age 15 months or older. <b>4 weeks</b> if current age is younger than 12 months <b>and</b> first dose was administered at younger than age 7 months <b>and</b> at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. <b>8 weeks and age 12 through 59 months (as final dose)</b> if current age is younger than 12 months <b>and</b> first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months <b>and</b> first dose was administered before the 1 <sup>st</sup> birthday <b>and</b> second dose was administered at younger than 15 months; OR if both doses were PRP-OMP (PedvaxHIB, Comvax) <b>and</b> were administered before the 1 <sup>st</sup> birthday.	<b>8 weeks (as final dose)</b> This dose only necessary for children age 12 through 59 months who received 3 doses before the 1 <sup>st</sup> birthday.	
Pneumococcal conjugate	6 weeks	<b>No further doses needed</b> for healthy children if first dose was administered at age 24 months or older. <b>4 weeks</b> if first dose was administered before the 1 <sup>st</sup> birthday. <b>8 weeks (as final dose for healthy children)</b> if first dose was administered at the 1 <sup>st</sup> birthday or after.	<b>No further doses needed</b> for healthy children if previous dose was administered at age 24 months or older. <b>4 weeks</b> if current age is younger than 12 months and previous dose was administered at <7 months old. <b>8 weeks (as final dose for healthy children)</b> if previous dose was administered between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was administered before age 12 months.	<b>8 weeks (as final dose)</b> This dose only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	<b>4 weeks</b>	<b>4 weeks</b> if current age is <4 years. <b>6 months (as final dose)</b> if current age is 4 years or older.	<b>6 months</b> (minimum age 4 years for final dose).	
Measles, mumps, rubella	12 months	<b>4 weeks</b>			
Varicella	12 months	<b>3 months</b>			
Hepatitis A	12 months	<b>6 months</b>			
Meningococcal ACWY	2 months MenACWY-CRM 9 months MenACWY-D 2 years MenACWY-TT	<b>8 weeks</b>	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	<b>8 weeks</b>			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	<b>4 weeks</b>	<b>4 weeks</b> if first dose of DTaP/DT was administered before the 1 <sup>st</sup> birthday. <b>6 months (as final dose)</b> if first dose of DTaP/DT or Tdap/Td was administered at or after the 1 <sup>st</sup> birthday.	<b>6 months</b> if first dose of DTaP/DT was administered before the 1 <sup>st</sup> birthday.	
Human papillomavirus	9 years	<b>Routine dosing intervals are recommended.</b>			
Hepatitis A	N/A	<b>6 months</b>			
Hepatitis B	N/A	<b>4 weeks</b>	<b>8 weeks and at least 16 weeks after first dose.</b>		
Inactivated poliovirus	N/A	<b>4 weeks</b>	<b>6 months</b> A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	<b>4 weeks</b>			
Varicella	N/A	<b>3 months</b> if younger than age 13 years. <b>4 weeks</b> if age 13 years or older.			

**Table 3**

**Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2021**

Always use this table in conjunction with Table 1 and the notes that follow.

VACCINE	INDICATION									
	Pregnancy	Immunocompromised status (excluding HIV infection)	HIV infection CD4+ count <sup>1</sup>		Kidney failure, end-stage renal disease, or on hemodialysis	Heart disease or chronic lung disease	CSF leak or cochlear implant	Asplenia or persistent complement deficiencies	Chronic liver disease	Diabetes
			<15% and total CD4 cell count of <200/mm <sup>3</sup>	≥15% and total CD4 cell count of ≥200/mm <sup>3</sup>						
Hepatitis B	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Rotavirus	Grey	Orange (SCID <sup>2</sup> )	Orange	Orange	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Diphtheria, tetanus, and acellular pertussis (DTaP)	Grey	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
<i>Haemophilus influenzae</i> type b	Grey	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots
Pneumococcal conjugate	Grey	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots
Inactivated poliovirus	Orange	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Influenza (IIV)	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Influenza (LAIV4)	Red	Red	Red	Red	Orange (Asthma, wheezing: 2–4yrs <sup>3</sup> )	Red	Red	Red	Orange	Orange
Measles, mumps, rubella	Red (*)	Red	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Varicella	Red (*)	Red	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Hepatitis A	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Tetanus, diphtheria, and acellular pertussis (Tdap)	Yellow with dots	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Human papillomavirus	Red (*)	Yellow with dots	Yellow with dots	Yellow with dots	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Meningococcal ACWY	Yellow	Yellow	Yellow with dots	Yellow with dots	Yellow	Yellow	Yellow	Yellow with dots	Yellow	Yellow
Meningococcal B	Orange	Purple	Purple	Purple	Purple	Purple	Purple	Yellow with dots	Purple	Purple
Pneumococcal polysaccharide	Purple	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots

Yellow Vaccination according to the routine schedule recommended
 Purple Recommended for persons with an additional risk factor for which the vaccine would be indicated
 Yellow with dots Vaccination is recommended, and additional doses may be necessary based on medical condition. See Notes.
 Red Not recommended/contraindicated—vaccine should not be administered.
 Orange Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction
 Grey No recommendation/not applicable

\*Vaccinate after pregnancy.

1 For additional information regarding HIV laboratory parameters and use of live vaccines, see the *General Best Practice Guidelines for Immunization*, "Altered Immunocompetence," at [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html) and Table 4-1 (footnote D) at [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html).

2 Severe Combined Immunodeficiency

3 LAIV4 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2021.

### Additional information

#### COVID-19 Vaccination

ACIP recommends use of COVID-19 vaccines within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. Interim ACIP recommendations for the use of COVID-19 vaccines can be found at [www.cdc.gov/vaccines/hcp/acip-recs/](http://www.cdc.gov/vaccines/hcp/acip-recs/).

- Consult relevant ACIP statements for detailed recommendations at [www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html).
- For information on contraindications and precautions for the use of a vaccine, consult the *General Best Practice Guidelines for Immunization* at [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html) and relevant ACIP statements at [www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html).
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of  $\geq 4$  months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as “through.”
- Vaccine doses administered  $\leq 4$  days before the minimum age or interval are considered valid. Doses of any vaccine administered  $\geq 5$  days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html).
- Information on travel vaccination requirements and recommendations is available at [www.cdc.gov/travel/](http://www.cdc.gov/travel/).
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html), and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases*. 31<sup>st</sup> ed. Itasca, IL: American Academy of Pediatrics; 2018:67–111).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see [www.hrsa.gov/vaccinecompensation/index.html](http://www.hrsa.gov/vaccinecompensation/index.html).

### Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadacel])

#### Routine vaccination

- 5-dose series at 2, 4, 6, 15–18 months, 4–6 years
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4<sup>th</sup> dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

#### Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

#### Special situations

- Wound management in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see [www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm](http://www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm).

### Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

#### Routine vaccination

- **ActHIB, Hiberix, or Pentacel:** 4-dose series at 2, 4, 6, 12–15 months
- **PedvaxHIB:** 3-dose series at 2, 4, 12–15 months

#### Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) 8 weeks after dose 2.
- **2 doses of PedvaxHIB before age 12 months:** Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.
- **Previously unvaccinated children age 60 months or older who are not considered high risk:** Do not require catch-up vaccination
- For other catch-up guidance, see Table 2.

### Special situations

#### • Chemotherapy or radiation treatment:

##### 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

*Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.*

#### • Hematopoietic stem cell transplant (HSCT):

- 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history

#### • Anatomic or functional asplenia (including sickle cell disease):

##### 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

*Unvaccinated\* persons age 5 years or older*

- 1 dose

#### • Elective splenectomy:

*Unvaccinated\* persons age 15 months or older*

- 1 dose (preferably at least 14 days before procedure)

#### • HIV infection:

##### 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

*Unvaccinated\* persons age 5–18 years*

- 1 dose

#### • Immunoglobulin deficiency, early component complement deficiency:

##### 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

\*Unvaccinated = Less than routine series (through age 14 months) OR no doses (age 15 months or older)

**Hepatitis A vaccination**

(minimum age: 12 months for routine vaccination)

**Routine vaccination**

- 2-dose series (minimum interval: 6 months) beginning at age 12 months

**Catch-up vaccination**

- Unvaccinated persons through age 18 years should complete a 2-dose series (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix**<sup>®</sup>, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

**International travel**

- Persons traveling to or working in countries with high or intermediate endemic hepatitis A ([www.cdc.gov/travel/](http://www.cdc.gov/travel/)):
  - **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2 doses, separated by at least 6 months, between age 12–23 months.
  - **Unvaccinated age 12 months or older:** Administer dose 1 as soon as travel is considered.

**Hepatitis B vaccination**

(minimum age: birth)

**Birth dose (monovalent HepB vaccine only)**

- **Mother is HBsAg-negative:** 1 dose within 24 hours of birth for all medically stable infants  $\geq 2,000$  grams. Infants  $< 2,000$  grams: Administer 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still  $< 2,000$  grams).
- **Mother is HBsAg-positive:**
  - Administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** (in separate limbs) within 12 hours of birth, regardless of birth weight. For infants  $< 2,000$  grams, administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Administer **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants  $< 2,000$  grams, administer **HBIG** in addition to HepB vaccine (in separate limbs) within 12 hours of birth. Administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, administer **HBIG** to infants  $\geq 2,000$  grams as soon as possible, but no later than 7 days of age.

**Routine series**

- 3-dose series at 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Table 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.

- **Minimum age** for the final (3<sup>rd</sup> or 4<sup>th</sup>) dose: 24 weeks
- **Minimum intervals:** dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks (when 4 doses are administered, substitute “dose 4” for “dose 3” in these calculations)

**Catch-up vaccination**

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents age 18 years or older may receive a 2-dose series of HepB (**Heplisav-B**<sup>®</sup>) at least 4 weeks apart.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).
- For other catch-up guidance, see Table 2.

**Special situations**

- Revaccination is not generally recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Revaccination** may be recommended for certain populations, including:
  - **Infants born to HBsAg-positive mothers**
  - **Hemodialysis patients**
  - **Other immunocompromised persons**
- For detailed revaccination recommendations, see [www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html](http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html).

**Human papillomavirus vaccination**

(minimum age: 9 years)

**Routine and catch-up vaccination**

- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9–14 years at initial vaccination:** 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted.
- No additional dose recommended after completing series with recommended dosing intervals using any HPV vaccine.

**Special situations**

- **Immunocompromising conditions, including HIV infection:** 3-dose series as above
- **History of sexual abuse or assault:** Start at age 9 years.
- **Pregnancy:** HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

**Influenza vaccination**

(minimum age: 6 months [IIV], 2 years [LAIV4], 18 years [recombinant influenza vaccine, RIV4])

**Routine vaccination**

- Use any influenza vaccine appropriate for age and health status annually:
  - 2 doses, separated by at least 4 weeks, for **children age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2020, or whose influenza vaccination history is unknown (administer dose 2 even if the child turns 9 between receipt of dose 1 and dose 2)
  - 1 dose for **children age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2020
  - 1 dose for **all persons age 9 years or older**
- For the 2021–22 season, see the 2021–22 ACIP influenza vaccine recommendations.

**Special situations**

- **Egg allergy, hives only:** Any influenza vaccine appropriate for age and health status annually
- **Egg allergy with symptoms other than hives** (e.g., angioedema, respiratory distress, need for emergency medical services or epinephrine): Any influenza vaccine appropriate for age and health status annually. If using an influenza vaccine other than Flublok or Flucelvax, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- Severe allergic reactions to vaccines can occur even in the absence of a history of previous allergic reaction. All vaccination providers should be familiar with the office emergency plan and certified in cardiopulmonary resuscitation.
- A previous severe allergic reaction to influenza vaccine is a contraindication to future receipt of any influenza vaccine.
- **LAIV4 should not be used** in persons with the following conditions or situations:
  - History of severe allergic reaction to a previous dose of any influenza vaccine or to any vaccine component (excluding egg, see details above)
  - Receiving aspirin or salicylate-containing medications
  - Age 2–4 years with history of asthma or wheezing
  - Immunocompromised due to any cause (including medications and HIV infection)
  - Anatomic or functional asplenia
  - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
  - Pregnancy
  - Cochlear implant
  - Cerebrospinal fluid-oro-pharyngeal communication
  - Children less than age 2 years
  - Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days

## Measles, mumps, and rubella vaccination (minimum age: 12 months for routine vaccination)

### Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 4 weeks after dose 1.

### Catch-up vaccination

- Unvaccinated children and adolescents: 2-dose series at least 4 weeks apart
- The maximum age for use of MMRV is 12 years.

### Special situations

#### International travel

- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.
- **Unvaccinated children age 12 months or older:** 2-dose series at least 4 weeks apart before departure

## Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 9 months [MenACWY-D, Menactra], 2 years [MenACWY-TT, MenQuadfi])

### Routine vaccination

- 2-dose series at 11–12 years, 16 years

### Catch-up vaccination

- Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- Age 16–18 years: 1 dose

### Special situations

**Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:**

- **Menveo**
  - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
  - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **Menactra**
  - **Persistent complement component deficiency or complement inhibitor use:**
    - Age 9–23 months: 2-dose series at least 12 weeks apart
    - Age 24 months or older: 2-dose series at least 8 weeks apart
  - **Anatomic or functional asplenia, sickle cell disease, or HIV infection:**
    - Age 9–23 months: Not recommended
    - Age 24 months or older: 2-dose series at least 8 weeks apart
    - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.

#### • MenQuadfi

- Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

**Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj ([www.cdc.gov/travel/](http://www.cdc.gov/travel/)):**

- Children less than age 24 months:
  - **Menveo (age 2–23 months)**
    - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
    - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
    - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - **Menactra (age 9–23 months)**
    - 2-dose series (dose 2 at least 12 weeks after dose 1; dose 2 may be administered as early as 8 weeks after dose 1 in travelers)
- Children age 2 years or older: 1 dose Menveo, Menactra, or MenQuadfi

**First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:**

- 1 dose **Menveo, Menactra, or MenQuadfi**
- Adolescent vaccination of children who received MenACWY prior to age 10 years:**
- **Children for whom boosters are recommended** because of an ongoing increased risk of meningococcal disease (e.g., those with complement deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.
  - **Children for whom boosters are not recommended** (e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

**Note:** **Menactra** should be administered either before or at the same time as DTaP. For MenACWY **booster dose recommendations** for groups listed under “Special situations” and in an outbreak setting and additional meningococcal vaccination information, see [www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm](http://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm).

## Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba])

### Shared clinical decision-making

- **Adolescents not at increased risk** age 16–23 years (preferred age 16–18 years) based on shared clinical decision-making:
  - **Bexsero:** 2-dose series at least 1 month apart
  - **Trumenba:** 2-dose series at least 6 months apart; if dose 2 is administered earlier than 6 months, administer a 3<sup>rd</sup> dose at least 4 months after dose 2.

### Special situations

**Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:**

- **Bexsero:** 2-dose series at least 1 month apart
  - **Trumenba:** 3-dose series at 0, 1–2, 6 months
- Bexsero** and **Trumenba** are not interchangeable; the same product should be used for all doses in a series. For MenB **booster dose recommendations** for groups listed under “Special situations” and in an outbreak setting and additional meningococcal vaccination information, see [www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm](http://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm).

## Pneumococcal vaccination

(minimum age: 6 weeks [PCV13], 2 years [PPSV23])

### Routine vaccination with PCV13

- 4-dose series at 2, 4, 6, 12–15 months

### Catch-up vaccination with PCV13

- 1 dose for healthy children age 24–59 months with any incomplete\* PCV13 series
- For other catch-up guidance, see Table 2.

### Special situations

**Underlying conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during same visit.**

**Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral corticosteroids); diabetes mellitus:**

#### Age 2–5 years

- Any incomplete\* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

#### Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

**Cerebrospinal fluid leak, cochlear implant:**

#### Age 2–5 years

- Any incomplete\* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

#### Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 1 dose PPSV23 at least 8 weeks later
- Any PCV13 but no PPSV23: 1 dose PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent dose of PPSV23

**Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:**

#### Age 2–5 years

- Any incomplete\* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2<sup>nd</sup> dose of PPSV23 5 years later

#### Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- Any PCV13 but no PPSV23: 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after the most recent dose of PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2<sup>nd</sup> dose of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

#### Chronic liver disease, alcoholism:

##### Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

\**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series. See Tables 8, 9, and 11 in the ACIP pneumococcal vaccine recommendations ([www.cdc.gov/mmwr/pdf/rr/rr5911.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf)) for complete schedule details.

### Poliovirus vaccination (minimum age: 6 weeks)

#### Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

#### Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- IPV is not routinely recommended for U.S. residents age 18 years or older.

**Series containing oral polio vaccine (OPV)**, either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See [www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s\\_%20cid=mm6601a6\\_w](http://www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_%20cid=mm6601a6_w).
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
  - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
  - Doses of OPV administered on or after April 1, 2016, should not be counted.
  - For guidance to assess doses documented as “OPV,” see [www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s\\_%20cid=mm6606a7\\_w](http://www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_%20cid=mm6606a7_w).
- For other catch-up guidance, see Table 2.

### Rotavirus vaccination (minimum age: 6 weeks)

#### Routine vaccination

- **Rotarix:** 2-dose series at 2 and 4 months
- **RotaTeq:** 3-dose series at 2, 4, and 6 months
- If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

#### Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Table 2.

### Tetanus, diphtheria, and pertussis (Tdap) vaccination

(minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

#### Routine vaccination

- **Adolescents age 11–12 years:** 1 dose Tdap
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

#### Catch-up vaccination

- **Adolescents age 13–18 years who have not received Tdap:** 1 dose Tdap, then Td or Tdap booster every 10 years
- **Persons age 7–18 years not fully vaccinated\* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at age 7–10 years:**
  - **Children age 7–9 years** who receive Tdap should receive the routine Tdap dose at age 11–12 years.
  - **Children age 10 years** who receive Tdap do not need the routine Tdap dose at age 11–12 years.
- **DTaP inadvertently administered on or after age 7 years:**
  - **Children age 7–9 years:** DTaP may count as part of catch-up series. Administer routine Tdap dose at age 11–12 years.
  - **Children age 10–18 years:** Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.

#### Special situations

- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
- For detailed information, see [www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm](http://www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm).

\**Fully vaccinated* = 5 valid doses of DTaP OR 4 valid doses of DTaP if dose 4 was administered at age 4 years or older

### Varicella vaccination (minimum age: 12 months)

#### Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 3 months after dose 1 (a dose administered after a 4-week interval may be counted).

#### Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at [www.cdc.gov/mmwr/pdf/rr/rr5604.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf)) have a 2-dose series:
  - **Age 7–12 years:** routine interval: 3 months (a dose administered after a 4-week interval may be counted)
  - **Age 13 years and older:** routine interval: 4–8 weeks (minimum interval: 4 weeks)
  - The maximum age for use of MMRV is 12 years.



# Recommended Adult Immunization Schedule for ages 19 years or older

UNITED STATES  
**2021**

## How to use the adult immunization schedule

- 1** Determine recommended vaccinations by age (**Table 1**)
- 2** Assess need for additional recommended vaccinations by medical condition and other indications (**Table 2**)
- 3** Review vaccine types, frequencies, and intervals and considerations for special situations (**Notes**)

Recommended by the Advisory Committee on Immunization Practices ([www.cdc.gov/vaccines/acip](http://www.cdc.gov/vaccines/acip)) and approved by the Centers for Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov)), American College of Physicians ([www.acponline.org](http://www.acponline.org)), American Academy of Family Physicians ([www.aafp.org](http://www.aafp.org)), American College of Obstetricians and Gynecologists ([www.acog.org](http://www.acog.org)), American College of Nurse-Midwives ([www.midwife.org](http://www.midwife.org)), and American Academy of Physician Assistants ([www.aapa.org](http://www.aapa.org)).

## Vaccines in the Adult Immunization Schedule\*

Vaccines	Abbreviations	Trade names
<i>Haemophilus influenzae</i> type b vaccine	Hib	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix®
Hepatitis B vaccine	HepB	Engerix-B® Recombivax HB® Hepelisav-B®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)	IIV	Many brands
Influenza vaccine (live, attenuated)	LAIV4	FluMist® Quadrivalent
Influenza vaccine (recombinant)	RIV4	Flublok® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM MenACWY-TT	Menactra® Menveo® MenQuadfi®
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero® Trumenba®
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax 23®
Tetanus and diphtheria toxoids	Td	Tenivac® Tdvax™
Tetanus and diphtheria toxoids and acellular pertussis vaccine	Tdap	Adacel® Boostrix®
Varicella vaccine	VAR	Varivax®
Zoster vaccine, recombinant	RZV	Shingrix

\*Administer recommended vaccines if vaccination history is incomplete or unknown. Do not restart or add doses to vaccine series if there are extended intervals between doses. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

## Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to the local or state health department
- Clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System at [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or 800-822-7967

## Injury claims

All vaccines included in the adult immunization schedule except pneumococcal 23-valent polysaccharide (PPSV23) and zoster (RZV) vaccines are covered by the Vaccine Injury Compensation Program. Information on how to file a vaccine injury claim is available at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation).

## Questions or comments

Contact [www.cdc.gov/cdc-info](http://www.cdc.gov/cdc-info) or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.



Download the CDC Vaccine Schedules app for providers at [www.cdc.gov/vaccines/schedules/hcp/schedule-app.html](http://www.cdc.gov/vaccines/schedules/hcp/schedule-app.html).

## Helpful information

- Complete ACIP recommendations: [www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html)
- *General Best Practice Guidelines for Immunization* (including contraindications and precautions): [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html)
- Vaccine information statements: [www.cdc.gov/vaccines/hcp/vis/index.html](http://www.cdc.gov/vaccines/hcp/vis/index.html)
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): [www.cdc.gov/vaccines/pubs/surv-manual](http://www.cdc.gov/vaccines/pubs/surv-manual)
- Travel vaccine recommendations: [www.cdc.gov/travel](http://www.cdc.gov/travel)
- Recommended Child and Adolescent Immunization Schedule, United States, 2021: [www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html](http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html)
- ACIP Shared Clinical Decision-Making Recommendations [www.cdc.gov/vaccines/acip/acip-scdm-faqs.html](http://www.cdc.gov/vaccines/acip/acip-scdm-faqs.html)



**U.S. Department of  
Health and Human Services**  
Centers for Disease  
Control and Prevention

**Table 1** Recommended Adult Immunization Schedule by Age Group, United States, 2021

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
<b>Influenza inactivated (IIV) or Influenza recombinant (RIV4)</b> <i>or</i>	1 dose annually			
<b>Influenza live, attenuated (LAIV4)</b>				
<b>Tetanus, diphtheria, pertussis (Tdap or Td)</b>	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (see notes)			
	1 dose Tdap, then Td or Tdap booster every 10 years			
<b>Measles, mumps, rubella (MMR)</b>	1 or 2 doses depending on indication (if born in 1957 or later)			
<b>Varicella (VAR)</b>	2 doses (if born in 1980 or later)		2 doses	
<b>Zoster recombinant (RZV)</b>			2 doses	
<b>Human papillomavirus (HPV)</b>	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
<b>Pneumococcal conjugate (PCV13)</b>	1 dose			1 dose
<b>Pneumococcal polysaccharide (PPSV23)</b>	1 or 2 doses depending on indication			1 dose
<b>Hepatitis A (HepA)</b>	2 or 3 doses depending on vaccine			
<b>Hepatitis B (HepB)</b>	2 or 3 doses depending on vaccine			
<b>Meningococcal A, C, W, Y (MenACWY)</b>	1 or 2 doses depending on indication, see notes for booster recommendations			
<b>Meningococcal B (MenB)</b>	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations			
	19 through 23 years			
<b>Haemophilus influenzae type b (Hib)</b>	1 or 3 doses depending on indication			

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or other indication

Recommended vaccination based on shared clinical decision-making

No recommendation/ Not applicable

**Table 2** Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2021

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 count		Asplenia, complement deficiencies	End-stage renal disease; or on hemodialysis	Heart or lung disease, alcoholism <sup>1</sup>	Chronic liver disease	Diabetes	Health care personnel <sup>2</sup>	Men who have sex with men
			<200 mm <sup>3</sup>	≥200 mm <sup>3</sup>							
IIV or RIV4 <b>or</b>	1 dose annually										
LAIV4	Not Recommended					Precaution			1 dose annually <b>or</b>		
Tdap or Td	1 dose Tdap each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years									
MMR	Not Recommended*	Not Recommended	1 or 2 doses depending on indication								
VAR	Not Recommended*	Not Recommended		2 doses							
RZV				2 doses at age ≥50 years							
HPV	Not Recommended*	3 doses through age 26 years		2 or 3 doses through age 26 years depending on age at initial vaccination or condition							
PCV13		1 dose									
PPSV23		1, 2, or 3 doses depending on age and indication									
HepA				2 or 3 doses depending on vaccine							
HepB				2, 3, or 4 doses depending on vaccine or condition				<60 years			
								≥60 years			
MenACWY	1 or 2 doses depending on indication, see notes for booster recommendations										
MenB	Precaution	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations									
Hib		3 doses HSCT <sup>3</sup> recipients only		1 dose							

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection
 
 Recommended vaccination for adults with an additional risk factor or another indication
 

 Precaution—vaccination might be indicated if benefit of protection outweighs risk of adverse reaction
 

 Recommended vaccination based on shared clinical decision-making
 

 Not recommended/contraindicated—vaccine should not be administered.
 

 No recommendation/Not applicable

\*Vaccinate after pregnancy.

1. Precaution for LAIV4 does not apply to alcoholism. 2. See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. 3. Hematopoietic stem cell transplant.

For vaccine recommendations for persons 18 years of age or younger, see the Recommended Child/Adolescent Immunization Schedule.

### Additional Information

#### COVID-19 Vaccination

ACIP recommends use of COVID-19 vaccines within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. Interim ACIP recommendations for the use of COVID-19 vaccines can be found at [www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html](http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html)

### Haemophilus influenzae type b vaccination

#### Special situations

- **Anatomical or functional asplenia (including sickle cell disease):** 1 dose if previously did not receive Hib; if elective splenectomy, 1 dose, preferably at least 14 days before splenectomy
- **Hematopoietic stem cell transplant (HSCT):** 3-dose series 4 weeks apart starting 6–12 months after successful transplant, regardless of Hib vaccination history

### Hepatitis A vaccination

#### Routine vaccination

- **Not at risk but want protection from hepatitis A** (identification of risk factor not required): 2-dose series HepA (Havrix 6–12 months apart or Vaqta 6–18 months apart [minimum interval: 6 months]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])

#### Special situations

- **At risk for hepatitis A virus infection:** 2-dose series HepA or 3-dose series HepA-HepB as above
  - **Chronic liver disease** (e.g., persons with hepatitis B, hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice the upper limit of normal)
  - **HIV infection**
  - **Men who have sex with men**
  - **Injection or noninjection drug use**

- **Persons experiencing homelessness**
- **Work with hepatitis A virus** in research laboratory or with nonhuman primates with hepatitis A virus infection
- **Travel in countries with high or intermediate endemic hepatitis A** (HepA-HepB [Twinrix] may be administered on an accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months)
- **Close, personal contact with international adoptee** (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A (administer dose 1 as soon as adoption is planned, at least 2 weeks before adoptee's arrival)
- **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy
- **Settings for exposure, including** health care settings targeting services to injection or noninjection drug users or group homes and nonresidential day care facilities for developmentally disabled persons (individual risk factor screening not required)

### Hepatitis B vaccination

#### Routine vaccination

- **Not at risk but want protection from hepatitis B** (identification of risk factor not required): 2- or 3-dose series (2-dose series Heplisav-B at least 4 weeks apart [2-dose series HepB only applies when 2 doses of Heplisav-B are used at least 4 weeks apart] or 3-dose series Engerix-B or Recombivax HB at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])

#### Special situations

- **At risk for hepatitis B virus infection:** 2-dose (Heplisav-B) or 3-dose (Engerix-B, Recombivax HB) series or 3-dose series HepA-HepB (Twinrix) as above
  - **Chronic liver disease** (e.g., persons with hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice upper limit of normal)
  - **HIV infection**
  - **Sexual exposure risk** (e.g., sex partners of hepatitis B surface antigen [HBsAg]-positive persons; sexually active persons not in mutually monogamous relationships; persons seeking evaluation or treatment for a sexually transmitted infection; men who have sex with men)

- **Current or recent injection drug use**
- **Percutaneous or mucosal risk for exposure to blood** (e.g., household contacts of HBsAg-positive persons; residents and staff of facilities for developmentally disabled persons; health care and public safety personnel with reasonably anticipated risk for exposure to blood or blood-contaminated body fluids; hemodialysis, peritoneal dialysis, home dialysis, and predialysis patients; persons with diabetes mellitus age younger than 60 years, shared clinical decision-making for persons age 60 years or older)
- **Incarcerated persons**
- **Travel in countries with high or intermediate endemic hepatitis B**
- **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy (Heplisav-B not currently recommended due to lack of safety data in pregnant women)

### Human papillomavirus vaccination

#### Routine vaccination

- **HPV vaccination recommended for all persons through age 26 years:** 2- or 3-dose series depending on age at initial vaccination or condition:
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
  - **Age 9–14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 additional dose
  - **Age 9–14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination series complete, no additional dose needed
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted
- **No additional dose recommended after completing series with recommended dosing intervals using any HPV vaccine**

#### Shared clinical decision-making

- **Some adults age 27–45 years:** Based on shared clinical decision-making, 2- or 3-dose series as above

#### Special situations

- **Age ranges recommended above for routine and catch-up vaccination or shared clinical decision-making also apply in special situations**

- **Immunocompromising conditions, including HIV infection:** 3-dose series as above, regardless of age at initial vaccination
- **Pregnancy:** HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

## Influenza vaccination

### Routine vaccination

- **Persons age 6 months or older:** 1 dose any influenza vaccine appropriate for age and health status annually
- For additional guidance, see [www.cdc.gov/flu/professionals/index.htm](http://www.cdc.gov/flu/professionals/index.htm)

### Special situations

- **Egg allergy, hives only:** 1 dose any influenza vaccine appropriate for age and health status annually
- **Egg allergy—any symptom other than hives** (e.g., angioedema, respiratory distress): 1 dose any influenza vaccine appropriate for age and health status annually. If using an influenza vaccine other than RIV4 or cclIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- Severe allergic reactions to any vaccine can occur even in the absence of a history of previous allergic reaction. Therefore, all vaccine providers should be familiar with the office emergency plan and certified in cardiopulmonary resuscitation.
- A previous severe allergic reaction to any influenza vaccine is a contraindication to future receipt of the vaccine.
- **LAIV4 should not be used** in persons with the following conditions or situations:
  - History of severe allergic reaction to any vaccine component (excluding egg) or to a previous dose of any influenza vaccine
  - Immunocompromised due to any cause (including medications and HIV infection)
  - Anatomic or functional asplenia
  - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
  - Pregnancy
  - Cranial CSF/oropharyngeal communications
  - Cochlear implant

- Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days
- Adults 50 years or older
- **History of Guillain-Barré syndrome within 6 weeks after previous dose of influenza vaccine:** Generally, should not be vaccinated unless vaccination benefits outweigh risks for those at higher risk for severe complications from influenza

## Measles, mumps, and rubella vaccination

### Routine vaccination

- **No evidence of immunity to measles, mumps, or rubella:** 1 dose
  - **Evidence of immunity:** Born before 1957 (health care personnel, see below), documentation of receipt of MMR vaccine, laboratory evidence of immunity or disease (diagnosis of disease without laboratory confirmation is not evidence of immunity)

### Special situations

- **Pregnancy with no evidence of immunity to rubella:** MMR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose
- **Nonpregnant women of childbearing age with no evidence of immunity to rubella:** 1 dose
- **HIV infection with CD4 count  $\geq 200$  cells/mm<sup>3</sup> for at least 6 months and no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart; MMR contraindicated for HIV infection with CD4 count  $< 200$  cells/mm<sup>3</sup>
- **Severe immunocompromising conditions:** MMR contraindicated
- **Students in postsecondary educational institutions, international travelers, and household or close, personal contacts of immunocompromised persons with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart if previously did not receive any doses of MMR or 1 dose if previously received 1 dose MMR
- **Health care personnel:**
  - **Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart for measles or mumps or at least 1 dose for rubella

- **Born before 1957 with no evidence of immunity to measles, mumps, or rubella:** Consider 2-dose series at least 4 weeks apart for measles or mumps or 1 dose for rubella

## Meningococcal vaccination

### Special situations for MenACWY

- **Anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:** 2-dose series MenACWY-D (Menactra, Menveo or MenQuadfi) at least 8 weeks apart and revaccinate every 5 years if risk remains
- **Travel in countries with hyperendemic or epidemic meningococcal disease, microbiologists routinely exposed to *Neisseria meningitidis*:** 1 dose MenACWY (Menactra, Menveo or MenQuadfi) and revaccinate every 5 years if risk remains
- **First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) and military recruits:** 1 dose MenACWY (Menactra, Menveo or MenQuadfi)
- For MenACWY **booster dose recommendations** for groups listed under “Special situations” and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see [www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm](http://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm)

### Shared clinical decision-making for MenB

- **Adolescents and young adults age 16–23 years (age 16–18 years preferred) not at increased risk for meningococcal disease:** Based on shared clinical decision-making, 2-dose series MenB-4C (Bexsero) at least 1 month apart or 2-dose series MenB-FHbp (Trumenba) at 0, 6 months (if dose 2 was administered less than 6 months after dose 1, administer dose 3 at least 4 months after dose 2); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series)

### Special situations for MenB

- **Anatomical or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use, microbiologists routinely exposed to *Neisseria meningitidis*:** 2-dose primary series MenB-4C (Bexsero) at least one month apart or

- MenB-4C (Bexsero) at least 1 month apart or 3-dose primary series MenB-FHbp (Trumenba) at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series); 1 dose MenB booster 1 year after primary series and revaccinate every 2–3 years if risk remains
- **Pregnancy:** Delay MenB until after pregnancy unless at increased risk and vaccination benefits outweigh potential risks
- For MenB **booster dose recommendations** for groups listed under “Special situations” and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see [www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm](http://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm)

## Pneumococcal vaccination

### Routine vaccination

- **Age 65 years or older** (immunocompetent—see [www.cdc.gov/mmwr/volumes/68/wr/mm6846a5.htm?s\\_cid=mm6846a5\\_w](http://www.cdc.gov/mmwr/volumes/68/wr/mm6846a5.htm?s_cid=mm6846a5_w)): 1 dose PPSV23
  - If PPSV23 was administered prior to age 65 years, administer 1 dose PPSV23 at least 5 years after previous dose

### Shared clinical decision-making

- **Age 65 years or older** (immunocompetent): 1 dose PCV13 based on **shared clinical decision-making** if previously not administered.
  - PCV13 and PPSV23 should not be administered during the same visit
  - If both PCV13 and PPSV23 are to be administered, PCV13 should be administered first
  - PCV13 and PPSV23 should be administered at least 1 year apart

### Special situations

- **Age 19–64 years with chronic medical conditions (chronic heart [excluding hypertension], lung, or liver disease, diabetes), alcoholism, or cigarette smoking:** 1 dose PPSV23

- **Age 19 years or older with immunocompromising conditions (congenital or acquired immunodeficiency [including B- and T-lymphocyte deficiency, complement deficiencies, phagocytic disorders, HIV infection], chronic renal failure, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, iatrogenic immunosuppression [e.g., drug or radiation therapy], solid organ transplant, multiple myeloma) or anatomical or functional asplenia (including sickle cell disease and other hemoglobinopathies):** 1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later, then another dose PPSV23 at least 5 years after previous PPSV23; at age 65 years or older, administer 1 dose PPSV23 at least 5 years after most recent PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older)
- **Age 19 years or older with cerebrospinal fluid leak or cochlear implant:** 1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later; at age 65 years or older, administer another dose PPSV23 at least 5 years after PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older)

## Tetanus, diphtheria, and pertussis vaccination

### Routine vaccination

- **Previously did not receive Tdap at or after age 11 years:** 1 dose Tdap, then Td or Tdap every 10 years

### Special situations

- **Previously did not receive primary vaccination series for tetanus, diphtheria, or pertussis:** At least 1 dose Tdap followed by 1 dose Td or Tdap at least 4 weeks after Tdap and another dose Td or Tdap 6–12 months after last Td or Tdap (Tdap can be substituted for any Td dose, but preferred as first dose), Td or Tdap every 10 years thereafter
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- **Wound management:** Persons with 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant woman, use Tdap. For detailed information, see [www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm](http://www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm)

## Varicella vaccination

### Routine vaccination

- **No evidence of immunity to varicella:** 2-dose series 4–8 weeks apart if previously did not receive varicella-containing vaccine (VAR or MMRV [measles-mumps-rubella-varicella vaccine] for children); if previously received 1 dose varicella-containing vaccine, 1 dose at least 4 weeks after first dose
  - Evidence of immunity: U.S.-born before 1980 (except for pregnant women and health care personnel [see below]), documentation of 2 doses varicella-containing vaccine at least 4 weeks apart, diagnosis or verification of history of varicella or herpes zoster by a health care provider, laboratory evidence of immunity or disease

### Special situations

- **Pregnancy with no evidence of immunity to varicella:** VAR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose if previously received 1 dose varicella-containing vaccine or dose 1 of 2-dose series (dose 2: 4–8 weeks later) if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **Health care personnel with no evidence of immunity to varicella:** 1 dose if previously received 1 dose varicella-containing vaccine; 2-dose series 4–8 weeks apart if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **HIV infection with CD4 count  $\geq 200$  cells/mm<sup>3</sup> with no evidence of immunity:** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 count  $< 200$  cells/mm<sup>3</sup>
- **Severe immunocompromising conditions:** VAR contraindicated


## Zoster vaccination

### Routine vaccination

- **Age 50 years or older:** 2-dose series RZV (Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon), regardless of previous herpes zoster or history of zoster vaccine live (ZVL, Zostavax) vaccination (administer RZV at least 2 months after ZVL)

### Special situations

- **Pregnancy:** Consider delaying RZV until after pregnancy if RZV is otherwise indicated.
- **Severe immunocompromising conditions (including HIV infection with CD4 count  $< 200$  cells/mm<sup>3</sup>):** Recommended use of RZV under review

Proposal Title	<b>Expanded Preventive Coverage (R007)</b>	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 <sup>st</sup> , 2022	
Reviewed By	Retiree Health Plan Advisory Board	
Review Date	August 5, 2021	

**1) Background**

The AlaskaCare Defined Benefit Retiree Health Plan (Plan) provides benefits necessary for the diagnosis and treatment of an injury or disease, but outside of a few specific services (mammograms, Prostate-Specific Antigen testing, and Pap smears), the Plan does not provide coverage for preventive care. The Plan is exempt from federal requirements mandating coverage for most preventive services.

Most active employee plans include coverage for preventive services, as does Medicare (which becomes primary for members at age 65). When retirees and their dependents enter the Plan, they are often surprised and frustrated by the absence of coverage for most preventive services. The lack of Plan coverage for most preventive benefits may result in members without other coverage foregoing recommended age-specific vaccinations, screenings, and other preventive services.

**2) Objectives**

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

**3) Summary of Proposed Change**

The Division of Retirement and Benefits proposes adding the full suite of evidence-based preventive services in alignment with the Affordable Care Act (ACA) and the AlaskaCare Third Party Administrator’s (TPA) clinical coverage standards. 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.

Preventive care would be covered with the following cost sharing provisions:

<b>In-Network</b>	<b>Out-of-Network*</b>
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.*

Covered preventive services include, but are not limited to, mammograms, Pap smears, prostate cancer screenings, vaccinations, wellness visits, colorectal cancer screenings, and lung cancer screenings. The specific services covered by the Plan will change over time as the recommendations are updated to reflect the most current research and evidence.

**4) Actuarial and Financial Impacts of Proposed Change**

The proposed change would increase the actuarial value of the plan by 0.50%. The annual anticipated fiscal impact of this change is estimated to be approximately \$3,350,000 in additional claims costs.

Proposal Title	Expanded Preventive Coverage (R007)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1 <sup>st</sup> , 2022
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## Contents

1) SUMMARY OF CURRENT STATE.....	2
2) OBJECTIVES.....	2
3) SUMMARY OF PROPOSED CHANGE.....	3
4) ANALYSIS.....	12
5) IMPACTS.....	13
Actuarial Impact   Increase 0.50%.....	13
Financial Impact   Annual Cost Increase \$3.35m.....	13
Member Impact   Enhancement.....	15
Operational Impact (DRB)   Neutral.....	15
Operational Impact (TPA)   Minimal.....	16
6) CONSIDERATIONS.....	16
Clinical Considerations.....	16
Provider Considerations.....	16
7) PROPOSAL RECOMMENDATIONS.....	17
DRB Recommendation.....	17
RHPAB Board Recommendation.....	17



## 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. <sup>1</sup> 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). <sup>2</sup>

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 primary 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<sup>3</sup>, members covered by Medicare have coverage for many of these services.

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

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

## 2) Objectives

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

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<sup>1</sup> AlaskaCare Retiree Insurance Information Booklet, January 2021, Sec. 3.3.1(d) *Medically Necessary Services and Supplies*; and Sec. 5.1, *Limitations and Exclusions*.

<sup>2</sup> AlaskaCare Retiree Insurance Information Booklet, January 2021, Sec. 3.3.11(a)-(d), *Radiation, X-rays, and Laboratory Tests*.

<sup>3</sup> Details regarding Medicare coverage and cost-sharing for preventive and screening services can be found here: <https://www.medicare.gov/coverage/preventive-screening-services>.

- 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.<sup>4</sup> 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),<sup>5</sup>
2. standard vaccines recommended by the Advisory Committee on Immunization Practices (ACIP),<sup>6</sup>
3. preventive care for children recommended under the *Bright Futures* guidelines, developed by the American Academy of Pediatrics,<sup>7</sup>
4. women-specific preventive care as outlined by the USPSTF, the Health Resources & Services Guidelines (HRSA) and other evidence-based guidelines.<sup>8</sup>

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

In alignment with the Plan booklet, *Section 3.3.1 Medically Necessary Services and Supplies*,<sup>9</sup> 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.<sup>10</sup> 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.

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<sup>4</sup> <https://www.healthcare.gov/coverage/preventive-care-benefits/>

<sup>5</sup> <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

<sup>6</sup> <https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>

<sup>7</sup> <https://brightfutures.aap.org/Pages/default.aspx>

<sup>8</sup> <https://www.healthcare.gov/preventive-care-women/>

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

<sup>10</sup> Aetna’s clinical policy bulletins are available online: <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#>

## DRAFT

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.<sup>11</sup>

For preventive care received from out-of-network providers, members would first have to meet the \$150 deductible, and then the plan would pay 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<sup>12</sup>) 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
<b>Current</b>	Limited coverage for specific preventive services	\$150	80%	\$800; applies after the deductible is satisfied
<b>Proposed In Network</b>	Coverage for preventive services in alignment with the ACA	N/A; deductible doesn't apply	100%	N/A; in-network preventive services covered at 100%
<b>Proposed Out-of-Network</b>	Coverage for preventive services in alignment with the ACA	\$150	80%	No out-of-pocket maximum for preventive services

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

<sup>12</sup> For out-of-network providers, the recognized charge for medical services and supplies are the lesser of a) what the provider bills or submits for that service or supply; or b) the 90<sup>th</sup> percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies. See Retiree Insurance Information Booklet, section 3.1.4 *Recognized Charge*.

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

*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*.<sup>13</sup> In accordance with state statute, when a member reaches age 65, their AlaskaCare retiree plan benefits become supplemental to Medicare.

*Coverage Provisions*

Table 2 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 <sup>14</sup>	Medicare Coverage <sup>15</sup>	Aetna Policy <sup>16,17</sup>
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.	<b>HRSA:</b> Annual screening for average-risk women 40 and older. <sup>18</sup>	One baseline between age 35-39. Screening mammograms once every 12 months age 40 or older. Diagnostic mammograms more frequently than once a year, if medically necessary.	Screening for women 40 years of age and older, once annually. <sup>19</sup>  <i>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).</i>

<sup>13</sup> <http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2021.pdf>

<sup>14</sup> These represent ACA-specified guidelines from the USPSTF, ACIP, and other relevant sources and are subject to change as those guidelines are updated.

<sup>15</sup> Unless otherwise noted, Medicare coverage in this table aligns with coverage descriptions provided at [www.Medicare.gov](http://www.Medicare.gov), accessed May 4, 2021.

<sup>16</sup> 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.

<sup>17</sup> 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).

<sup>18</sup> Health Resources & Services Administration. Women’s Preventive Services Initiative. <https://www.hrsa.gov/womens-guidelines-2019>

<sup>19</sup> Aetna Clinical Policy Bulletin 0584, [https://www.aetna.com/cpb/medical/data/500\\_599/0584.html](https://www.aetna.com/cpb/medical/data/500_599/0584.html)

Service	Current Plan Coverage	ACA-Specified Guidelines <sup>14</sup>	Medicare Coverage <sup>15</sup>	Aetna Policy <sup>16,17</sup>
Pap Smear	One per year for women 18 years of age and older. Also includes limited office visit to collect the pap smear.	<p>HRSA/USPSTF Grade A: One every 3 years for women aged 21 to 65 for cervical cytology alone.<sup>20</sup></p> <p>One every 5 years for women aged 30 to 65 for HPV testing alone, or when cervical cytology is combined with HPV testing.<sup>21</sup></p>	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.	<p>For women 21 years of age and older, once annually.</p> <p>HPV screening for women 30 years of age or older, once annually.<sup>22</sup></p>
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.	<p>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.</p> <p>USPSTF Grade D: Routine PSA screening for men age 70 and older is not recommended.<sup>23</sup></p>	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).	<p>For men 40 years of age and older, once annually.</p> <p>Prostate cancer screening via digital rectal exam is considered preventive for males 40 years of age and older, once annually.<sup>24</sup></p>

<sup>20</sup> Health Resources & Services Administration. Women’s Preventive Services Initiative. <https://www.hrsa.gov/womens-guidelines-2019>

<sup>21</sup> USPSTF, Cervical Cancer: Screening. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening>

<sup>22</sup> Aetna Clinical Policy Bulletin 0443, [https://www.aetna.com/cpb/medical/data/400\\_499/0443.html](https://www.aetna.com/cpb/medical/data/400_499/0443.html)

<sup>23</sup> <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1>

<sup>24</sup> Aetna Clinical Policy Bulletin 0521, [https://www.aetna.com/cpb/medical/data/500\\_599/0521.html](https://www.aetna.com/cpb/medical/data/500_599/0521.html).

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

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

<sup>26</sup> How to pay for Vaccines: Medicare <https://www.cdc.gov/vaccines/adults/pay-for-vaccines.html>

<sup>27</sup> Preventive Care Benefits for Adults. HealthCare.gov. <https://www.healthcare.gov/preventive-care-adults/>

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

<sup>28</sup> Preventive Care Benefits for Women. HealthCare.gov. <https://www.healthcare.gov/preventive-care-women/>

<sup>29</sup> 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>

<sup>30</sup> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-papPelvic-Examinations.pdf>

<sup>31</sup> <https://www.healthcare.gov/preventive-care-children/>

Service	Current Plan Coverage	ACA-Specified Guidelines <sup>14</sup>	Medicare Coverage <sup>15</sup>	Aetna Policy <sup>16,17</sup>
Colorectal Cancer Screening	Not Covered	<p><b>USPSTF Grade A:</b> Colorectal cancer screening recommended for all adults age 50-75. Frequency varies by type of screening.</p> <p><b>USPSTF Grade B:</b> Colorectal cancer screening recommended for all adults age 45-49. Frequency varies by type of screening.</p> <p><b>USPSTF Grade C:</b> Clinicians should selectively offer colorectal cancer screening for adults age 76-85, as appropriate based on an individual's specific circumstances.<sup>32</sup></p>	Screening colonoscopies covered once every 24 months if at high risk; or once every 120 months, or 48 months after a previous flexible sigmoidoscopy.	<p>Covered for adults 45 years of age and older. Frequency depends on colorectal cancer screening type.<sup>33</sup></p> <ul style="list-style-type: none"> <li>• Annual immunohistochemical or guaiac-based FOBT; or</li> <li>• Colonoscopy (every 10 years for persons at average risk); or</li> <li>• CT Colonography (virtual colonoscopy) (every 5 years); or</li> <li>• Double contrast barium enema (DCBE) (every 5 years for persons at average risk); or</li> <li>• Sigmoidoscopy (every 5 years for persons at average risk)</li> <li>• Sigmoidoscopy (every five years) with annual immunohistochemical or guaiac-based fecal occult blood testing (FOBT); or</li> <li>• Stool DNA (FIT-DNA, Cologuard) (every 3 years).</li> </ul>

<sup>32</sup> USPSTF, Colorectal Cancer: Screening: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening>

<sup>33</sup> Aetna Clinical Policy Bulletin 0516, [https://www.aetna.com/cpb/medical/data/500\\_599/0516.html](https://www.aetna.com/cpb/medical/data/500_599/0516.html)



Service	Current Plan Coverage	ACA-Specified Guidelines <sup>14</sup>	Medicare Coverage <sup>15</sup>	Aetna Policy <sup>16,17</sup>
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. <sup>34</sup>

*\*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.

<sup>34</sup> Aetna Clinical Policy Bulletin 0380, [http://www.aetna.com/cpb/medical/data/300\\_399/0380.html](http://www.aetna.com/cpb/medical/data/300_399/0380.html)

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*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.<sup>35</sup>

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

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<sup>35</sup> Baseline results could refer to either well or ill results.  
 2\_R007\_ExpandedPreventiveCoverage\_Proposal\_for20210805.docx

## 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.<sup>36</sup>

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

Currently, data regarding retiree member's use of preventive visits outside of those currently covered by the plan (e.g. mammograms or PSA testing) is limited as retirees may be receiving these services and paying for them out of pocket. O65 members are likely receiving more preventive visits due to Medicare's coverage, but those visits are typically not captured in AlaskaCare's claims data. However, when 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.

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<sup>36</sup> Colorectal (Colon) Cancer. US Centers for Disease Control and Prevention.

[https://www.cdc.gov/cancer/colorectal/basic\\_info/screening/index.htm](https://www.cdc.gov/cancer/colorectal/basic_info/screening/index.htm)

<sup>37</sup> Healthy People 2030. US DHSS. <https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care>

<sup>38</sup> Promoting Preventive Services for Adults 50-64: Community and Clinical Partnerships. CDC, AARP, AMA, <https://www.cdc.gov/aging/pdf/promoting-preventive-services.pdf>

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

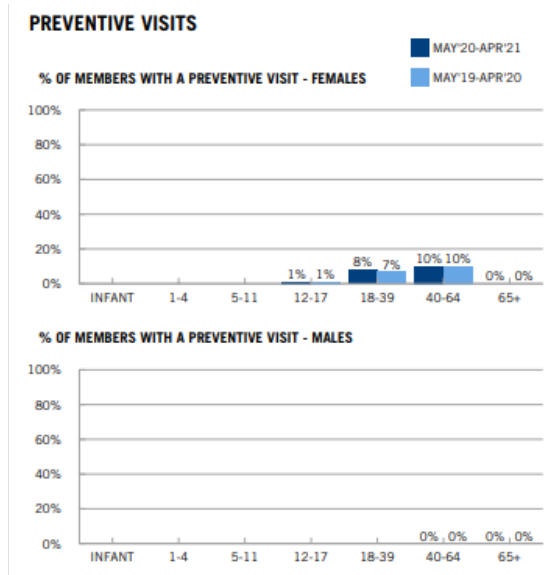
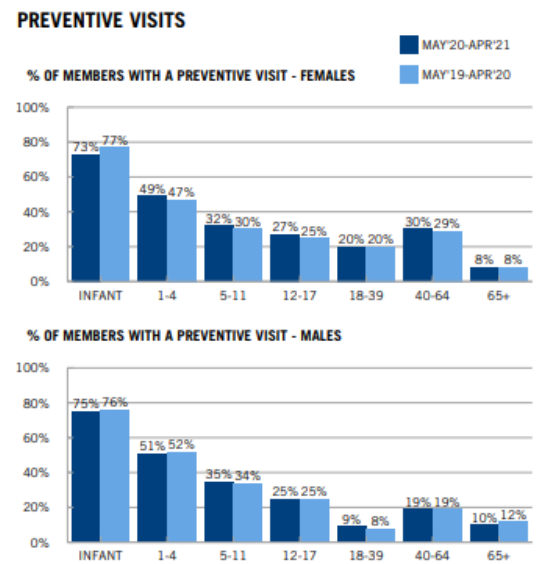


Figure 2. AlaskaCare Active Employee Plan Preventive Visit Claims



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
<b>Current</b>	N/A
<b>Proposed Expanded Preventive Care Coverage</b>	0.50% increase <sup>39</sup>
<u>In-Network:</u>	<u>Out-of-Network</u>
-100% coinsurance	-80% coinsurance
-deductible does not apply	-deductible applies
-out-of-pocket limit N/A	-out-of-pocket limit N/A

### 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 Wood Johnson Foundation in their 2009 study.<sup>40</sup> They found high-risk groups often stay away from

<sup>39</sup> Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan (Updated), Segal Consulting memo dated April 19, 2021.

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

## DRAFT

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

“It is unlikely that substantial cost savings can be achieved by increasing the level of investment in clinical preventive care measures. On the other hand, research suggests that many preventive measures deliver substantial health benefits given their costs.

Moreover, while the achievement of cost savings is beneficial, it is important to keep in mind that the goal of prevention, like that of other health initiatives, is to improve health. Even those interventions that cost more than they save can still be desirable. Because health care resources are finite, however, it is useful to identify those interventions that deliver the greatest health benefits relative to their incremental costs.”<sup>42</sup>

### 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.<sup>43</sup>

Medicare covers many preventive and screening services at 100%. For Medicare-eligible members, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. The analysis 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)<sup>44</sup> and to the Additional State Contributions (ASC)<sup>45</sup> 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.<sup>46</sup>

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<sup>41</sup> Benson WF and Aldrich N, CDC Focuses on Need for Older Adults to Receive Clinical Preventive Services, Critical Issue Brief, Centers for Disease Control and Prevention, 2012, <http://www.chronicdisease.org/nacdd-initiatives/healthy-aging/meeting-records>.

<sup>42</sup> Ibid.

<sup>43</sup> Ibid.

<sup>44</sup> AAL: The excess of the present value of a pension fund’s total liability for future benefits and fund expenses over the present value of future normal costs for those benefits.

<sup>45</sup> Employer contributions to retirement payments were capped in FY08. Since then, the state makes additional assistance contributions to help cover the accrued unfunded liability associated with participating employers.

<sup>46</sup> *Impact of Potential Change in Preventive Care Benefits for Alaska Care Retiree Health Plan*, Buck Consulting, May 7, 2021.

## DRAFT

The ASC provides payment assistance to participating employers' Actuarially Determined Contribution (ADC). The ADC is determined by adding the "Normal Cost"<sup>47</sup> 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<sup>48</sup> 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 that the long-term funded status of the trusts is subject to change in response to market volatility and many other factors.

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

### Member Impact | Enhancement

Neutral / Enhancement / Diminishment

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

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

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

### Operational Impact (DRB) | Neutral

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

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

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

<sup>49</sup> *Impact of Potential Change in Preventive Care Benefits for AlaskaCare Retiree Health Plan*, Buck Consulting, May 7, 2021.

## DRAFT

**\*\*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 a "yes/no" indicator switch in a TPA's claims adjudication system. The change would simplify the administration of the AlaskaCare retiree health plan, which currently requires customization to provide the limited preventive services covered by the plan today.

Similarly, it is industry standard to have a separate network/out-of-network coinsurance for preventive services and therefore will not require any customization. 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.

# DRAFT

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.  <i>If use of out-of-network provider is pre-certified, in-network cost sharing provisions apply.</i>

### 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, 08/05/2021

### Documents attached include:

Attachment	Document Name
A	<i>Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan (Updated)</i> , Segal Consulting memo dated April 19, 2021
B	<i>Impact of Potential Change in Preventive Care Benefits for AlaskaCare Retiree Health Plan</i> , 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





# AlaskaCare 2022 Premium Rate Development

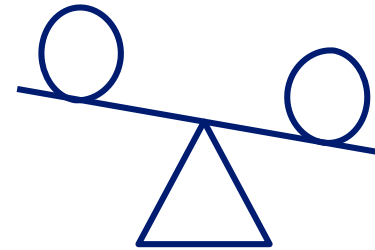
Medical and Pharmacy  
Dental, Vision, Audio  
Long-Term Care

**Retiree Health Plan Advisory Board**

August 5, 2021 / Richard Ward, FSA, FCA, MAAA

# Premium Rate Development

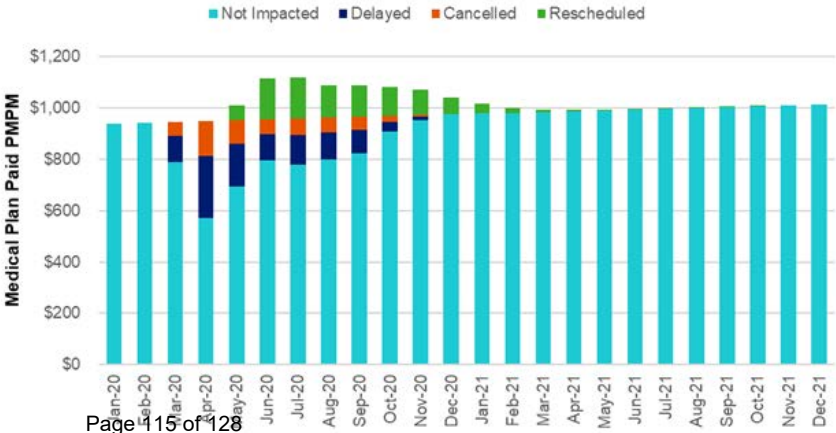
- At its most basic level, premium rates are developed to cover claims costs as well as administrative and operational expenses
- In many plans, this is considered over a multi-year period and balances other considerations, such as:
  - Annual premium rate stability/volatility
  - Premium rate competitiveness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



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

# COVID-19

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



# Premium Rate Development – Med/Rx

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

**Retiree Health liability is well funded, supported by \$13.6B in assets**

# Medical and Pharmacy Projection

- Segal projects the following financial results for Calendar Year (CY) 2022:

	2022
Total Projected Claims	\$616,898,158
Administration and Operational Expenses	\$32,193,816
Rx Rebates	(\$59,200,000)
EGWP/RDS Subsidy	(\$64,253,000)
Total Projected Cost	\$525,638,974
2021 Premium Based Revenue*	\$569,459,136
\$\$ Funding Overage/(Gap)	\$43,820,162
% Funding Overage/(Gap)	8.3%
Est. IBNR Liability As Of Dec 31, 2022	\$48,334,000

\* Medical/Rx revenue is based on all participants at the Retiree composite rate (as counts by Tier II/Tier III rate tiers were not available) x 12. A small number of retirees that pay premiums pay these rates and the revenue figure provided is illustrative of the annual revenue that would result from all retirees paying the current rates. State and Employer contributions are payroll based.

- Experience continues to be favorable for the Medical/Rx plan with a \$43.8M projected overage.
- 2022 premium rates for Medical and Prescription Drugs are sufficient at current levels. Results reflect a dampening of medical trend mostly due to the growth in the number of Medicare primary participants outpacing the number of non-Medicare participants coming on the plan. A Medicare primary participant costs about 50% less than a non-Medicare primary participant.
- Rates were decreased 5% for CY2021 due to the growth in Medicare membership continuing to reduce aggregate per capita costs.
- Ongoing growth in Medicare membership continuing to reduce aggregate per capita costs.
- Modest increase projected for EGWP subsidies.

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

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

# CY2022 Medical and Pharmacy Funding Rates

- There was a 5% decrease in contributions effective CY2021 due to the growth in Medicare membership continuing to reduce aggregate per capita costs.
- Segal is not recommending any changes to the CY2022 contributions.

Baseline	2021	2022	\$\$ Change	% Change
Medical - Composite	\$1,046.00	\$1,046.00	\$0.00	0.0%
Medical - Tier II/III Retiree Only	\$704.00	\$704.00	\$0.00	0.0%
Medical - Tier II/III Retiree & Spouse	\$1,408.00	\$1,408.00	\$0.00	0.0%
Medical - Tier II/III Retiree & Child	\$995.00	\$995.00	\$0.00	0.0%
Medical - Tier II/III Retiree & Family	\$1,699.00	\$1,699.00	\$0.00	0.0%
<b>Baseline Annual</b>	<b>\$569,459,136</b>	<b>\$569,459,136</b>	<b>\$0</b>	<b>0.0%</b>

# Medical and Pharmacy

- Actual Medical/Rx plan experience for FY19 – FY21:

	Period 1	Period 2	Period 3	P1=> P2	P2=> P3
	Jul '18-Jun '19	Jul '19-Jun '20	Jul '20-Jun '21		
<b>Members &lt;65 PMPM</b>	<b>\$1,113.62</b>	<b>\$1,075.40</b>	<b>\$1,137.45</b>	<b>-3%</b>	<b>6%</b>
<b>Members 65+ PMPM</b>	<b>\$512.82</b>	<b>\$476.20</b>	<b>\$473.63</b>	<b>-7%</b>	<b>-1%</b>
<b>Composite PMPM</b>	<b>\$681.23</b>	<b>\$629.99</b>	<b>\$629.20</b>	<b>-8%</b>	<b>0%</b>
<b>Total Medical/Rx Claims</b>	<b>\$595,672,310</b>	<b>\$559,657,200</b>	<b>\$566,362,891</b>	<b>-6%</b>	<b>1%</b>

Note: Subscribers plan is used to determine dependent's age for determine of over/ under age 65 status.

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

# Premium Rate Development - DVA

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

**DVA Plan is very well reserved, and the final rate determination balances lower premiums in the near-term, long-term solvency issues and large premium increases when “excess” reserves are exhausted**



# Executive Summary

- Segal projects the following financial results for Calendar Year (CY) 2022:

	2022
Total Projected Claims	\$48,347,456
Administration and Operational Expenses	\$2,325,126
<b>Total Projected Cost</b>	<b>\$50,672,582</b>
Premium Based Revenue	\$48,492,828
\$\$ Funding Overage/(Gap)	<b>(\$2,179,754)</b>
% Funding Overage/(Gap)	<b>(4.3%)</b>
Est. IBNR Liability As Of Dec 31, 2022	\$3,803,000

- If there are no changes to the current funding levels, there is a projected gap of approximately \$2.2M between cost and revenue.
  - The DVA assets are expected to continue to be above the target funding range of 150%-250% of IBNR, even with no funding increase.
- Included is an illustrative series of future increases, beginning in 2023, to manage the spend down of assets and minimize future increases.

The projections in this report are estimates of future costs and are based on information available to Segal at the time the projections were made. Segal has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, trend rates, and claims volatility. The accuracy and reliability of projections decrease as the projection period increases.

Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

The Coronavirus (COVID-19) pandemic continues to evolve and will likely impact the 2020-2021 US economy and health plan claim projections for most Health Plan Sponsors. As a result, projections could be significantly altered by emerging events. At this point, the full impact on Health Plan claim costs are uncertain. Unless specifically noted, Page 12 of 128 does not include any adjustments such as changes in eligibility, income, increases in healthcare costs or decreased investment returns. Additionally, the potential for federal or state fiscal relief is also not contemplated in these budget projections. Given the high level of uncertainty and fluidity of the current events, some plans may seek periodic updated estimates throughout the year to closely monitor health plan budget projections this year. Additional projections may be out of scope.

# CY2022 Dental, Vision, and Audio Funding Rates

- The Standard plan rates have remained level since CY2017.
- Segal is not recommending a rate increase for CY2022.

Standard Plan Rates	2021	2022	\$\$ Change
Retiree	\$66.00	\$66.00	\$0
Retiree & Spouse	\$131.00	\$131.00	\$0
Retiree & Child	\$119.00	\$119.00	\$0
Retiree & Family	\$187.00	\$187.00	\$0
Legacy Plan Rates			
Retiree	\$73.00	\$73.00	\$0
Retiree & Spouse	\$145.00	\$145.00	\$0
Retiree & Child	\$132.00	\$132.00	\$0
Retiree & Family	\$207.00	\$207.00	\$0

# Projected DVA Revenues, Expenses, Net Assets (\$millions)

## 0% Increase for CY2022 and Moderate Subsequent Increases



Illustrative Future Rate Increases						
CY2022	CY2023	CY2024	CY2025	CY2026	CY2027	CY2028
0.0%	5.0%	5.0%	5.0%	4.5%	4.5%	4.5%

# Premium Rate Development - LTC

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

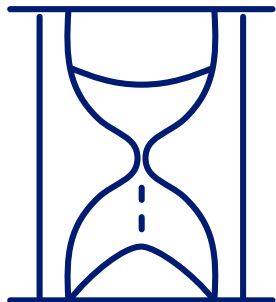
1. Project forward all anticipated benefits (and expenses), accounting for assumed mortality, morbidity, lapses, etc
2. Project forward all anticipated premium revenue (at current rates), accounting for assumed mortality, morbidity, lapses, etc
3. Add net difference between projected benefits and premiums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

**Segal recommends maintaining current premium rates through the next actuarial valuation. The 2021 valuation has identified investment gains having resulted in an improved net present value funded position. However, care should be exercised before modifying premiums rates based on short term gains (or losses).**

# LTC Valuation Results (June 30, 2021)

Component	June 30, 2019	June 30, 2021
1. PV of Future Benefits	\$740,263	\$779,931
2. PV of Future Expenses	\$7,108	\$8,503
3. PV of Future Premiums (PVFP)	\$315,648	\$336,381
4. Valuation Liabilities (=3 – 1- 2)	(\$431,723)	(\$452,053)
5. Valuation Assets	\$526,287	\$696,258
6. Valuation Margin (= 5 + 4)	\$94,564	\$244,205
7. Margin as a % of PVFP (= 6/3)	30.0%	72.6%
8. Funded Status (= 5/4)	121.9%	154.0%

\* All numbers in \$1,000s



# Historical LTC Funded Status

Valuation Date	Margin
June 30, 2009	\$3,298
May 31, 2012	\$30,280
June 30, 2015	\$27,244
June 30, 2017	\$7,372
June 30, 2019	\$94,564
June 30, 2021	244,205

\* All numbers in \$1,000s



# Questions?



DRAFT

## AlaskaCare Defined Benefit Retiree Health Plan Modernization Proposals Public Comment Period

The Division of Retirement and Benefits will hold a public comment period to provide an opportunity for member feedback on the following AlaskaCare Defined Benefit Retiree Health Plan modernization proposals proposed for implementation January 1, 2022:

1. Addition of coverage for preventive care
2. Prior authorization for specialty medications

The public comment period will open on August 11, 2021 and close on August 27, 2021. Public comments can be submitted by mail, email, or via the On-Line Public Notices page.

- There will be a Retiree Townhall meeting on Thursday August 19, 2021.
- The Division proposes holding a RHPAB meeting for the advisory vote on the proposals on Sept 7<sup>th</sup>, 8<sup>th</sup>, or 9<sup>th</sup>.

### **Sample Notice**

**Public Comment Period - AlaskaCare Defined Benefit Retiree Health Plan Modernization Proposals: Adding Preventive Care and Prior Authorization for Specialty Medications**

**Opens August 11 and closes August 27, 2021.**

The Department of Administration, Division of Retirement and Benefits, proposes to adopt the following changes to the AlaskaCare Defined Benefit Retiree Health Plan, effective January 1, 2022:

1. Addition of coverage for preventive care
2. Prior authorization for specialty medications

You may comment on the proposed updates by submitting written comments via email to [doa.drb.alaskacare.retiree.plan@alaska.gov](mailto:doa.drb.alaskacare.retiree.plan@alaska.gov) or via mail to:

- State of Alaska Department of Administration  
Division of Retirement and Benefits  
PO Box 110203  
Juneau AK 99811-0203

Comments may also be submitted through the Alaska Online Public Notice System.

A copy of the proposed updates will be available on the Division of Retirement and Benefits [webpage](#). **Public comments will be accepted through 4:30 p.m. AKDT on August 27, 2021.**