

Retiree Health Plan Advisory Board Meeting Agenda

Date: Thursday, February 10, 2022
Time: 9:00am – 11:30am [OnlinePublicNotices](#)
Location: Video-Teleconference: [Join meeting](#)
Anchorage – Atwood Building, Commissioners conference room.
Teleconference: (650) 479-3207 Access Code: 246 897 14045
Password: RHPAB0222 (74722022 from phones)
Board Members: Judy Salo (chair), Lorne Bretz, Dallas Hargrave, Paula Harrison, Cammy Taylor, and Nan Thompson

- 9:00 am** **Call to Order – Judy Salo, Board Chair**
- Roll Call and Introductions
 - Approval of Agenda
 - Approve Previous Meeting Minutes (November)
 - Ethics Disclosure and Public Comment Script
- 9:15 am** **Public Comment**
- 9:30 am** **Department & Division Update**
- Legal/Regulatory Update (AAG Hofmeister)
 - IRMAA update and DVA Open Enrollment (DRB)
 - New DRB Website (DRB)
 - Preventive Care Update (Aetna)
 - Prior Authorization for Specialty Medications Update (OptumRx)
 - COVID Update – OTC Test Kits (OptumRx/DRB)
- 10:30 am** **Gene-Based, Cellular, and Other Innovative Therapies (GCIT) Network**
- Review initial draft proposal
- 11:30 am** **Adjourn**

Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Thursday, November 4, 2021 9:00 a.m. to 12:00 p.m.

Location: WebEx (virtual) only

Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB) Members</i>		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Lorne Bretz	Member	Present
Dallas Hargrave	Member	Present
Paula Harrison	Member	Present
Nan Thompson	Member	Present
<i>State of Alaska, Department of Administration Staff</i>		
Ajay Desai	Division Director, Retirement + Benefits	
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Erika Burkhouse	Assistant Vendor Manager, Retirement + Benefits	
Chris Murray	Member Liaison, Retirement + Benefits	
Christina Vasquez	Appeals Specialist, Retirement + Benefits	
<i>Others Present + Members of the Public</i>		
Ben Hofmeister	Assistant Attorney General, Alaska Department of Law	
Kimberly Krebs	Aetna (medical third-party administrator)	
Andrew Robison	Aetna (medical third-party administrator)	
Nicole Brown	OptumRx (pharmacy third party administrator)	
Sara Guidry	OptumRx (pharmacy third party administrator)	
Richard Ward	Segal Consulting (contracted actuarial)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Brian Rankin	Lewis and Ellis (contracted actuarial, Long-Term Care)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Bryn Goldbeck	Aetna (medical third-party administrator)	
Miranda Roberts	Aetna (medical third-party administrator)	
Randall Burns	Retired Public Employees of Alaska (RPEA)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Delisa Culpepper	Retired Public Employees of Alaska (RPEA)	

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, and the retiree health trust
- 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 Judy Salo called the meeting to order at 9:00 a.m. A quorum was present.

Approval of Meeting Agenda

Materials: Agenda packet for 11/4/21 RHPAB Meeting

- **Motion** by Cammy Taylor to approve the agenda as presented. **Second** by Nan Thompson.
 - **Discussion:** None.
 - **Result:** No objection to approval of agenda as presented. Agenda is approved.

Approval of Previous Meeting Minutes

- **Motion** by Cammy Taylor to approve the September 9, 2021 meeting as presented. **Second** by Lorne Bretz.
 - **Discussion:** None.
 - **Result:** No objection to approval of minutes as presented. Minutes approved.

Ethics Disclosure

Chair Salo requested that Board members state any ethics disclosures in the meeting and reminded members of the disclosure form available from staff, to keep any necessary disclosures on file.

- No disclosures were stated by members.

Item 2. Public Comment

Before beginning public comment, the Board established who was present on the phone or online, and who intended to provide public comments. Individuals were asked to state their full name for the record, and that if there are several people wishing to provide comment, comments will be limited to 3 minutes per person, at the discretion of the chair. Chair Salo also reminded Board members and members of the public of the following:

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

Members of the public who provide comments are also encouraged to submit their comments in writing to the Retiree Health Plan Advisory Board: rhpab@alaska.gov.

Public Comments

- No one in the meeting wished to provide public comment.

Item 3. Department of Administration + Division of Retirement & Benefits Updates

Chair Salo asked Emily Ricci to share updates.

Legal + Regulatory Updates

Emily Ricci asked Ben Hofmeister, Department of Law, to give an update:

Ben shared that there are not many updates on the cases of interest to this group

- *Freda Miller* case: This case is currently with the Alaska Supreme Court, and will have oral arguments on Tuesday, November 9. He noted that the proceedings can be watched online, live or recording.
- *Metcalfe vs State*: This case is in the trial court, from 2012-2013. The court made a decision finding that the creation of the Defined Contribution Plan in 2005 was an unconstitutional diminishment; this was sent back to the trial court, no update currently.
- *RPEA vs State*: This is about 2014-2016 amendments to the retiree plan. The case is currently in discovery, the exchange of information and answering questions. There are some motions that could dismiss this case, but this is still being determined. There is also a delay in trials generally, because of COVID's impacts on the court schedule, so this may take place in January 2022, but still uncertain.
- *RPEA vs. Tshibaka*: This case is also currently in litigation, regarding dental benefits. The Supreme Court arguments were made in April and can also be reviewed online.

EGWP Out-of-Area Enrollment Update

Emily shared that they are working on the EGWP out-of-area project, and asked Andrea to share:

Andrea shared an update: Because EGWP is a Medicare Part D plan, the State is required to provide several updates in writing as mandated by CMS. Participants need to submit a physical address because they need to live within the Medicare service area to be eligible (U.S. states and territories). If someone does not respond to these letters, they are considered "out of area" because they did not verify address. This has been an issue for people living in very rural areas without traditional street addresses, such as those who use a P.O. Box or there are not formal addresses. There was an issue this past year, over 500 members were disenrolled from EGWP because people were moved to the Standard plan (not the Opt-out plan, which has different cost-sharing for pharmacy benefits, usually with more out of pocket costs to the member). The fact that this group was not enrolled in EGWP means losing approximately \$500,000 in federal EGWP subsidies. To address this, the Division has been conducting outreach to these members to re-enroll them manually into the plan, and why it's important to have a physical address documented. Those who did not respond to the information have now been moved to the Opt-out plan if they were eligible for Medicare. For anyone who actually does live out of area, and therefore cannot access the EGWP plan, they were moved to the Standard plan, the existing plan for members who are not Medicare eligible.

Of the 500 who are impacted by this, about 113 provided information and were re-enrolled in the EGWP plan. Those who did not respond, about 400, were moved to the Opt-out plan. There is a distinction between not being eligible to be in the EGWP plan (being out of area or not eligible for Medicare) and people who are eligible but have chosen not to be enrolled for any reason.

Emily added that staff will continue to contact and work with members to resolve this: some may be deceased, but the Division hasn't been notified, or they may be slow to respond to communications. In the meantime, they have addressed the issue for now, but continue to work through the list.

- Judy Salo complimented staff for the efforts to help people get appropriately enrolled. How are staff determining whether people may be deceased?
 - Andrea shared staff have access to some public records, through Lexis Nexis and other systems. They can access mailing lists as well, but they cannot manually change the retiree's address because it may have implications for COLA (Cost of Living Adjustment) and other reasons, so they do not make changes on their own without the member's consent to have it changed.
- Cammy Taylor asked if staff have access to other computer systems?
 - Andrea confirmed staff do not have access to other agency systems, such as the PFD list or vital records. The Pension side may have more access.
 - Emily confirmed this is a privacy issue, as a health plan they have limited access and are careful about sharing access (in either direction) because they have protected health information. Some Division staff may have access to certain systems, they were reviewing records as best they could and coordinated with other agencies, but they have less access than the pension system.
- Paula Harrison asked if a person is currently employed and has employee insurance, and their spouse is retired and eligible for state benefits, as well as the person potentially having AlaskaCare retiree benefits. If the spouse does not choose to enroll in the EGWP, how does this work as far as coordination of benefits?
 - Emily confirmed coordination of benefits can be complicated, especially for people who are employed and also are eligible for Medicare as well as accessing retiree benefits. She will follow up in writing to address this question, as it is complicated, and they have done a great deal of research about this and how it works.

Planned Updates for 2022

Emily asked Andrea to present on 2022 updates:

Medical Plan: Aetna ID Card Updates

Andrea described changes to the design of the Aetna plan ID cards:

The AlaskaCare logo has been updated to display Employee and Retiree more prominently on the card, so it is easier to tell which is which, especially if they have both employee and retiree coverage in their household. They have tried to make the font larger and easier to read but have not been successful so far. They will not do a mass re-issue of the plan cards but will be mailing these out to new retirees and on replacement cards going forward.

Emily added that the template is limited in terms of changes, but they hope this will be helpful.

Policy Updates: Preventive Care + Prior Authorization for Specialty Medications

Materials: Infographic on page 15 in 11/4/21 agenda packet

These two policy changes have been made to the medical and pharmacy plans, respectively, and go into effect January 1, 2022. Staff thanked the Board for their support on these changes!

Andrea shared that staff are working closely with Aetna to get the new plan changes in place, they are currently testing these changes in the claims system. OptumRx has also been updating their systems and are testing on the pharmacy side. Both groups of customer service teams have been trained on the plan changes, as well as the Division's internal customer service team.

The November and December e-newsletters for retirees will focus on these benefits, explaining the changes and what new benefits are in place for preventive care; there will also be 3 Tele Town Halls (November 18, December 16, and January 20, 2022).

- Judy commented that members must be very excited about these new benefits!
 - Andrea confirmed yes, many people have been calling and asking how to access these benefits. Customer service staff have reported several members asking about this.
- Judy asked for confirmation, what vaccinations are covered?
 - Emily noted that there is a long list, and it depends on what vaccinations are medically appropriate for which populations or situations. This includes flu shots, pneumonia, shingles, and others. These will be covered at the pharmacy and the provider's office.
 - Judy commented being able to access vaccinations at the doctor's office is a big change!
 - Emily agreed, and noted the Division is working to notify doctors' offices of this change as of January 1.
 - Judy noted that it can be confusing, she's aware that her doctor's office will offer some vaccines and not others because of coverage.
 - Emily noted the plan itself will cover these vaccines in all appropriate settings, but that the providers may still not offer them, so some may still need to be accessed through a pharmacy.
She also noted that staff are reviewing programs such as the Alaska Vaccine Assessment Program, which employees already participate in as part of the plan, but that retirees historically have not been eligible for. Now that these benefits are covered, staff are identifying other coverage and decisions can be re-evaluated, like offering programs to retirees as well if they are eligible.
- Judy asked if this impacts provider contracts and participating in programs nationally? Do they need to update contracts?
 - Emily noted that the national network mostly covers these things in other plans other than AlaskaCare. They are also working on this, but it may be different for Alaska providers since this coverage is new. She also explained that the network is national, but Aetna offers different types of plans—some are fully insured commercial plans, others are like the AlaskaCare plans where Aetna acts only as the Third-Party Administrator. It depends on coverage in each plan, but billing staff need to be aware of how these plans are different or may have unique coverage not available in the standard commercial plans.
- Judy followed up: for the member, the card documents that the plan is AlaskaCare, versus a card of a fully insured Aetna plan that is different. She noted it is important that people do not get the wrong information from a provider, so provider education is important.
 - Emily gave an example of a provider who said they were in-network with Aetna, but they were not; a member had to pay additional cost for a surgical procedure they had. Emily also has had personal experience, when asking "Are you in network?" a provider responded, "We bill Aetna" (not the same thing). Other providers may not be aware, such as the doctor or administrative staff, which networks they are part of. She encouraged calling Aetna to verify that the provider is in network, as well as talking to the provider directly.

Emily asked Sara Guidry to give an update on the specialty medications prior authorization:

Sara shared that OptumRx has uploaded information on all the specific medications that are subject to this new policy, as well as what criteria are used to make these determinations. They have also been training their customer service team to be aware of these changes. OptumRx has also prepared and will be sending a letter shortly to potentially affected members: these were planned for November 1, but will be mailed on Friday, November 5. She apologized for the delay, as they were aiming for 60 days' notice. OptumRx will also offer one additional "transitional fill" before getting the prior authorization in place if needed, if they need to finalize the paperwork or if there are delays getting information from their provider.

Andrea concluded that staff and the OptumRx team are ready for this policy to take place January 1.

- Nan Thompson asked whether providers, such as prescribers of specialty medications, pharmacies, are also being notified?
 - Andrea asked Sara if there will be a "fax blast" notification?
Sara stated OptumRx did not schedule this but can also do this outreach. She noted it may not be the most effective to notify providers, and they are primarily urging members to reach out to their providers.
- Cammy noted that during the discussion and approval of this policy, they discussed specifically notifying providers in advance to ensure that they aware of the change and have the opportunity to get this implemented. In Anchorage in particular, specialty providers and others are very short staffed, including issues like long hold times on the phone to call their office. Cammy urged OptumRx to take more proactive steps to the providers so they are aware of this change and can act, particularly Alaska-based providers for who this may be a new policy.
 - Sara responded notifying providers is not part of their normal process for these changes, they are primarily focusing on members.
 - Randall Burns (public member) commented that often pharmacies have been responsible for notifying providers, and providers ask pharmacies to contact them first, for example if someone's prescription will run out soon. He encouraged pharmacies to be proactive and contact doctors' offices on behalf of patients.
 - Cammy commented as an example, Alaska Heart Institute and Alaska Regional Senior Clinic tell patients to have their pharmacist contact their provider. She suggested a proactive general blast to pharmacies is the best course of action, so that they can follow up with providers.
 - Sara responded OptumRx can notify pharmacies, via a fax blast, which will make them aware of this policy change, and that they will start to see these as of January 1. Some pharmacists may contact physicians for patients during a transaction at point of sale, which will alert the physician that they need to complete this paperwork, and which may include an office visit for lab work or other information to document. Once the prior authorization is in place in the system, when it needs to be renewed, the system will automatically outreach to let the provider know the prior authorization needs to be renewed. Until it is in the system, however, it is more difficult to conduct outreach.
 - Cammy Taylor followed up: her understanding of the transition process was that the 3,500 impacted members would be proactively notified, as well as providers, and the Division and OptumRx will help them through that. What is the process?

- Sara confirmed the plan has been to notify impacted members, which requires members to contact their providers to complete the necessary process. Members can also ask OptumRx to initiate the process on their behalf, which they can do if requested. Typically, physician offices will process a batch of these prior authorization requests at the end of the day. It is best for the member to follow up with their physician to complete this process, especially if there is a follow-up visit request.
 - Judy asked if the letters being sent to members with current specialty prescriptions state that people can contact Optum to walk through the prior authorization process?
 - Sara confirmed the letter does not include that detailed wording but does have OptumRx's phone number and encourages members to call with questions.
 - Nan commented that the Board's intent when supporting this policy change was to ensure it was a smooth transition. She reiterated the request to ensure pharmacies and providers are aware of that change.
 - Emily agreed and noted that it's also challenging to find the appropriate timing: notifying people far in advance means they forget about it and set it aside. She also hears the concerns about letting people know in advance, especially as the end of the calendar year is often busy for providers. She noted that the January transitional fill will also help cover members while the paperwork is being filed.
- Judy commented that having additional resources for members at the call center, at the Division and OptumRx, would be helpful, to avoid long hold times. Also emphasizing that Chris Murray the member liaison is available to help members would also be helpful.
- Cammy commented it is encouraging to hear about the outreach efforts and reiterated that it is important to help members who are using these medications to have a smooth implementation.
 - Emily agreed, staff will share the letter template and will update talking points about provisions like the January transitional fill. She also noted that transitions and implementation always have wrinkles, so they are trying to plan ahead as best as possible, communication and reminders like this are important. She also noted that some members will inevitably wait until late January and utilize the transitional fill before taking action, but she hopes few people will do that!

Medicare Part D IRMAA Update

Andrea briefly shared that like prior years, members who are considered high income and are subject to an IRMAA surcharge on their Medicare premiums will be notified soon (mid-November) about the amount of this surcharge for 2022. They are required to pay this surcharge, but AlaskaCare will cover the costs of this surcharge for the EGWP pharmacy plan. Members need to submit paperwork annually, as this will also change year to year based on income 2 years prior (for 2022, it will be 2020 income). Once they submit that paperwork, retirees can submit paperwork to the Division to set up a reimbursement. The Division does not pay proactively, but starting in January, they can submit for either monthly reimbursement, or they can submit one time for reimbursement as a lump sum (for 2021, at the end of the year). If someone is already enrolled, they may not be subject to this surcharge for 2022, but it will depend on the determination. If they are still enrolled and still subject to the surcharge, they need to submit paperwork every year, but they can stay automatically in the electronic funds transfer (ETF) system with OptumBank. They just need to submit the letter they receive from Social Security when it

arrives. Members have 1 year to submit reimbursement—so they will have until the end of 2022 to submit for 2021 reimbursement.

DVA Plan 2022 Open Enrollment Update

Andrea provided an update: open enrollment for the Dental, Vision and Audio (DVA) plan for retirees continues through Wednesday, November 24, a 6-week period like previous years. The purpose is for retirees to confirm, update or change their election for choice of dental plan, part of the DVA plan overall. The customer service team has not reported significant issues or trends, so things are going smoothly. Mostly, members have been asking if they need to do anything if they want to stay in the same plan? They do not, their current election will roll over.

Current enrollment choices: 53.5% chose the Standard plan, 20.8% chose the Legacy plan, and 25.7% chose “Keep my current election.”

- Judy asked what the difference is between those who chose a plan, versus those who chose “keep my current election”?
 - Andrea explained the system just shows which choice they made, which was one of those 3 options. She will have updated numbers with total enrollment in the 2 plans, including those who opted to keep their election but are reported out separately in the report they have now. Once enrollment is closed later this month, she will provide an updated tally of selections.
 - Emily noted they encourage actively making a choice and checking every year, even if it’s the same choice. This way, people are informed about their benefits, including premium costs, and are actively making the choice.

New Division (DRB) Website

Emily provided an update: Division staff have been working to redesign and streamline the Division website and have spent the last year planning these changes. They are aiming to update and launch the site in first quarter 2022 and will be communicating about this to members.

The Board took a break at 10:22 a.m., and returned to the meeting at 10:35 a.m.

Plan Booklet Draft Changes

Materials: Plan booklet changes beginning page 16 in 11/4/21 agenda packet

Teri Rasmussen provided an update:

These two policy changes have been made to the medical and pharmacy plans, respectively, and are in the draft changes of the plan. The public comment period is Wednesday, October 13 through Friday, November 19. She shared that to date there have not been comments received on the plan booklet itself, but some on the policies.

The planned changes have been posted on the website, have been shared in the e-newsletter, and mentioned in the last Town Hall.

There are 9 places in the booklet with language changes: 6 detailing preventive care coverage, and 3 other changes. There is color coding for the changes: new language is in green, changed language in yellow, and removed language in red. There are 2 columns, showing the 2022 changes and comparing with the 2021 (current) language.

Teri walked through changes starting on page 16:

- Section 1.1 Medical Benefits, adding language about preventive care coverage
- Section 3.2 Precertification, about network provisions
- Section 3.3.11, renamed to Preventive Care and Screening Services (replaces old section)
- Section 3.3.1.8, Travel (small clarification)
- Section 3.3.20, Medical Standard of Care change
- Section 3.3.25, COVID Vaccine Coverage, following ending of the federal emergency
- Section 4.4 Covered Vaccines (all other vaccines)
- Section 5.1 Medical Exclusions (routine physicals now covered)
- Section 7.6 Changing DVA Coverage (clarifies coverage options)

Questions and comments from the Board:

- Cammy asked about Section 3.3.11: “test and lab services are covered as preventive when the person has the screening done within age/gender guidelines for USPSTF, and if the results are normal.” She asked whether other tests would be treated differently, if something is found, using the example of colonoscopy?
 - Emily offered an example: if someone gets a routine mammogram, and the result is not normal, this still may be considered preventive.
 - Andrew Robison (Aetna) shared that lab services are generally handled differently than colonoscopies, since the insurer does not see the result of the lab. The tests depend on the billing codes used: if the biller uses the preventive code or diagnostic code, that’s how the insurer sees it. They do not see the test results. It will depend on how the provider does the billing.
- Judy asked what the implication is for the member? Is it a difference in co-pay?
 - Emily responded yes; the cost sharing would be different. She noted that the Division gets periodic questions about this, but it often depends on how the provider coded and billed the service, so this is rare. Billing staff are generally knowledgeable about maximizing usage of preventive coverage, so this would be relatively rare.
 - Andrew added that most services like mammograms are considered preventive by default, unless they are coded otherwise, or if someone does not meet the age and gender guidelines for the codes.
- Cammy suggested that removing the phrase “if the results are normal” to avoid confusion.
 - Steve Ramos recommended changing the wording on this point but clarifies that this is referring to the fact that once someone has an abnormal result, their subsequent tests are not considered a “screening” immediately after, because there is other diagnostic, or treatment avenues pursued. It simply means that they would need to meet other criteria before it would be considered a preventive screening.
- Cammy noted that the point re: Travel (Section 3.1.1.8) the wording is different to what is posted online.
 - Teri will follow up to clarify this.
- Judy asked what happens following the ending of the public comment period? When will the new plan booklet be available to all members?

- Teri responded public comment ends Friday, November 19, and the plan booklet will go into effect and definitely be available as of January 1, 2022. She anticipates having the plan booklet being available and posted online in December prior to the effective date.
- Cammy asked if the Division also publishes hard copies of the plan booklet. She thanked staff for making the plan booklet available, and searchable in electronic form.
 - Teri confirmed that the plan booklet can be requested in hard copy from the Division and is also available online.

Teri provided the e-mail address for sending comments: doa.drb.alaskacare.retiree.plan@alaska.gov.

COVID-19 Update

Materials: Presentation about healthcare utilization beginning page 30 in 11/4/21 agenda packet

Emily invited Kimberly Krebs with Aetna to present:

There was a measurable drop in utilization in 2020 due to COVID disruptions, but in 2021 utilization is bouncing back to normal, with people seeking care that they may have delayed. There is also a sustained increase in telemedicine services, as many people took advantage of this resource. They anticipate this dropping off slightly, but still staying higher than pre-pandemic levels as people get comfortable with this service. She also noted that overall, more people are utilizing one or more benefits.

In 2020, about 2.5% of total costs were related to COVID claimants—this may mean services not related to COVID but related to a person who had a COVID diagnosis or episode. There were 21,905 viral tests ran through the plan, with about 1,713 antibody tests. They do not know the actual test results, but they can see that the person received additional care or services as a result, so it is a partial proxy. They have also seen an increase in inpatient care due to COVID, as people have more serious cases and need a higher level of care. They are also seeing higher outpatient care, as people avoid hospital services to avoid COVID exposure and seeking services elsewhere.

- Judy asked if there is a rough estimate of the dollar amount of the plan?
 - Kimberly noted the costs are in the slide, but that they are not added up on the slide—they are showing 2.5% of all claimants.
- Judy asked for a summary of current (2021) trend?
 - Kimberly noted in Alaska there is a 5.3% increase in utilization this year, with an overall nationwide increase of about 7% on average. This may look inflated, since it is 5.3% over the prior period, but 2020 was very low, so a larger percent increase would be expected even if the number is flat or lower compared to 2019.

Item 4. Long Term Care Valuation + Premiums

Materials: Presentation about Long Term Care Valuation beginning page 32 in 11/4/21 agenda packet

Judy invited Richard Ward to present. Richard also noted that Segal is seeing a trend of about 5.1% change in utilization across the plans they work with.

The Long-Term Care plan was established in 1987, first as a single plan (the bronze plan today). This is a voluntary plan, fully funded by participants' premiums, and self-insured; its assets are managed in a trust to cover the expenses, so it is the same as other health and pension plans, except it is funded by premiums instead of State resources. There are about 29,000 participants, and about 12,000 claims

annually, from about 500 claimants. (Most people do not use this annually, just when circumstances require). The plan is well funded, with premiums that have not changed since it began. This is very unusual for Long Term Care plans, which are difficult to plan for and which often do require premium increases due to the costs, since most people pay into it for several years and do not need to access it until later in life. There is a bi-annual actuarial valuation for this plan; the next is as of June 30, 2021, followed by a review of premiums and a recommendation whether to make any changes to the premiums. To date, Segal and Lewis & Ellis (actuaries) have not recommended premium changes based on the status and performance of the plan funds.

The slide on page 34 illustrates details about the four plan levels, from Bronze to Platinum. Slide 35 outlines the valuation methodology: like pension plans, this valuation looks long term, with projected future expenses and income, and uses a 5% discount rate to assume net present value. There are also assumptions about utilization, mortality and morbidity (how many people will need these services and at what cost, for what length of time). Slide 36 illustrates the results of the valuation: overall, both benefits (how much the plan will collect) and expenses (how much will be paid out) are going up, but the plan is anticipated to have over \$700 million in assets. The plan is expected to “pay down” significantly but has more than enough assets to cover expected expenses. Most of this gain is due to investment performance, where the fund is outperforming the net present value calculation of 5%. Slide 37 illustrates how this has changed over time: between 2019 and 2021, there was a very significant increase in the margin (assets minus liabilities) due to that investment performance. Some years there was lower performance, closer to only 100% funded. Now is it over 150% funded, just in 2021. Slide 38 illustrates the investment performance over the last 10 years. Pages 41-43 list premiums by plan.

- Cammy asked whether the plan valuation accounts for the age of participants?
 - Richard responded for each individual, there is a projection (based on probabilities) about whether they will pay premiums or lapse; whether they will survive to a certain age; and whether they will have a claim in the coming year. There are assumptions about whether people will or will not use the services, and at what age and therefore what intensity (magnitude of costs and use of services). An older person is more likely to need more services, and a higher cost claim.
- Cammy asked whether there are changes in assumptions about long term care services, are more people using services for a longer period of time?
 - Richard responded yes, it is based on plan performance and industry experience of claims, so it can change over time.
 - Brian Rankin responded Alaska is a relatively small market, so the data of the Alaska plan alone is not large enough to draw conclusions on. Most are based on industry averages. They have seen a general increase in length and cost of claims, but that most claimants do recover in a short period of time during recovery. But more people are staying longer in nursing homes or assisted living, including for several years.
- Judy asked if the Division collects data on how many people are in claim status, and how long they live or remain utilizing benefits?
 - Brian confirmed they do track this information. The most common outcome or “recovery” from long term care is that people pass away, but sometimes people do recover and exit long term care back to independent living. This is built into the model in terms of assumptions, including probability of a return to long term care in future.

- Nan asked about the margin between expected funding and expenditures, and future trend: given the difference now, would it be possible to consider lowering premiums in future?
 - Richard responded since the additional assets are driven by investment gains, not premiums, he recommends caution about considering reducing premiums. It is possible, but not likely, that these gains will be lost, given that it depends on investment performance. If gains were due to increased premiums collected, this may be a reason to reduce; for investment gains, the recommendation is not to assume these last.
 - Emily stated she also wonders if it would be better to reduce premiums given that they have been the same for a long time, but also the Division supports and understands the need for long-term stability. They would prefer to be more conservative in ensuring they have assets available, versus having to enact a spike in premiums a decade from now to respond to a significant loss or lack of assets to cover expenditures.
- Judy commented what she understands from long term care in some other states is, the plans are often not available, not adequately funded, and generally not in a good position for members to be able to access long term. She noted that Alaska's plan is a positive contrast. Is this indeed the national trend, that these plans are less available?
 - Brian responded there are fewer insurance companies offering LTC plans; others are facing rate increases and other difficulties. It is a good sign this plan is showing good returns, that is what is driving the positive margin. Alaska's plan should feel good about the current position, and there are no anticipated issues with the current performance.
- Judy commented when reviewing this plan, it is very accessible to members, and how they can get quickly approved to be on claim status when needed. Not just about how the plan is doing, but how it is serving the members who need it. And despite doing a good job, she also appreciates the people who help claimants navigate the system, because it is confusing and difficult. She noted that Board members get questions from members about plan stability, how the benefits will be accessible to their families, etc. These are all difficult questions to answer, because LTC plans are changing quickly, expensive for most people to access, and will continue to be an issue generally as more people age and need LTC services.
 - Brian commented he does not have direct experience with using or accessing the plans, since actuaries do not deal with the operational details, but it is good that the plan has easily defined benefits and forms, and just a few well-defined options.
- Judy commented that it would be good for the Division to provide information in the future about those operational questions, how members can access and utilize benefits.
 - Emily agreed this is a good idea and noted that their prior Tele Town Hall on Long Term Care was very popular; they have discussed running that topic again in a future update, and including it in the list of 2022 topics, as well as any other ways they can provide information about the program to members.
- Cammy asked for clarification: "There are no issues yet with this plan." What issues should the Division and the Board keep watch for, that would need addressing?
 - Richard noted that is general caution about the unpredictability of the future and long-term impacts. When actuaries review programs and project future trends, there is always an implied "for now". There isn't anticipated hardship based on the current data for this plan, just unknowns. The plan position could change for the worse in future.
 - Brian added there are no current known issues; this has been a well-run program.

Item 5. Medical Plan: Gene Therapy Network

Materials: Presentation about Gene Therapy beginning page 59 in 11/4/21 agenda packet

Chair Salo invited Aetna staff to present.

Emily shared that staff, and their vendors have about these technologies, medical gene therapy and other new treatments, in prior sessions. We've seen these types of treatments used for other members; the cost was over \$2 million. It brings tremendous opportunities, but also tremendous costs. It's going to be challenging for health plans to figure this out, and this is new technology, so all health administrators are still learning how to manage those costs and when these treatments are most appropriate and effective. Aetna has reported that in other plans they manage, there may be claims, especially if they occur out of network, for between \$6 and \$13 million.

There are no controls in the plan for services that are out of network but billed for these extremely expensive specialty treatments. This is a significant risk and area of financial vulnerability, for the plan as well as for members, especially if the plan only covers a limited portion of the cost. She noted that this can also make an individual easily hit the lifetime maximum of coverage with a single course of treatment. One-way other plans have managed these costs is through Gene Therapy Networks: the Division intends to implement this policy in the employee plan beginning January 1, 2022; the plan will only cover gene therapy when received through this network. The Division has not determined whether this is feasible or recommended for the retiree plan at this point, but this was the decision for the employee plan. Staff asked Aetna to provide a presentation today to introduce the concept as needing future discussion, but more detailed discussion will happen in a future meeting.

Emily invited Kimberly with Aetna to present:

Kim shared that Aetna has developed a network of providers to provide these services. Currently, the SOA plan does cover these therapies, based on the place and type of service. The new standard, if the plan accepts, such as what is proposed for the employee plan, is that the plan will not cover treatments from out-of-network facilities. Instead, a facility or provider needs to be in-network in order to qualify as a covered service under the plan.

Slide 3 provides more details about this policy. Aetna's negotiated terms with providers in network is, they cannot charge above the actual cost of the medication (no profit margin or overhead). The plan covers a specific network of providers who have been vetted and are considered best-in-class in terms of quality and efficacy. The plan also covers coordination and support, including lodging and travel costs, for patients using these treatment services at the covered and approved facilities.

Slide 8 covers a situation where a plan member still seeks treatment at an out of network facility: if that occurs, and the cost is incurred, Aetna will work with the facility to negotiate an appropriate rate. Slide 9 illustrates an example claim moving through the process: first, there is a dedicated gene therapy network team to do pre-certification review for the individual member's treatment; assuming that it is approved, and the facility is in network, the authorization is put into the system. There is a quick turnaround for approvals, typically about 5 days. The team would notify Aetna of the approval, and Aetna notifies the Division that it is approved. The therapy takes place. Following completion of the treatment, the claim is submitted by the provider, and continues through normal claim processing.

Slide 10 illustrates 3 medications that are covered in the network currently.

- Judy commented she is interested to learn more, but this is a new topic. What sources for more specific information would the team recommend to understand gene therapy generally?
 - Bryn recommended Google searches, or referring to the FDA’s website, which has a lot of information about these new therapies. Drug manufacturers also publish information about their own products.
 - Emily suggested Aetna could provide an educational overview of gene therapy at a future Board meeting, in context of discussing potential solutions for the retiree plan.
 - Judy and Nan agreed this would be useful.
- Nan noted that there are (likely) no in-state providers in Alaska for this service. Where would an Alaska-based person need to go to get treatment?
 - Kim responded there is one approved facility in Washington state, with 2 others pending approval. There is also an Alaska-based facility waiting for approval.
 - Emily pointed out this may depend on the treatment as well, correct?
 - Kim confirmed yes, it depends on the medication. For Luxturna, a person needs to travel to Oregon (closest to Alaska). The (pending) Alaska-based provider would be offering both Zolgensma and Spinraza if their application is approved.
- Judy asked where gene therapy is making the most impact, best clinical outcomes?
 - Emily noted one of the open questions is whether these treatments are curative long term, as they have not been around long enough to know, the answer isn’t known yet.
- Judy commented that this may mean medical necessity is subjective.
 - Emily noted they can discuss this further, when presenting about the treatments.
- Cammy noted she would like to understand if and how Medicare covers these services.
 - Emily responded there are complications with rebates and Section 340B pricing; this is something the Division is tracking, but that it is detailed and may not be relevant to cover in the next meeting, where the discussion will stay high-level. Division staff are monitoring this and will determine how rebates would be impacted.

Item 6. 2022 Planning Session: Modernization Initiatives

Materials: Modernization Topics + Status beginning page 61 in 11/4/21 agenda packet

Chair Salo invited Division staff to speak.

Emily shared that there was limited time left in the meeting, but she briefly shared that the modernization topics document included in the packet needs to be reviewed and updated, in consultation with the Board. She recommends that the Board look at the list in its next meeting (February) and discuss the Board’s priorities, as well as those from the Division’s perspective. She asks Board members to review this list carefully, identify items that members would de-prioritize or remove, which are important to keep, and what other ideas or priorities might be missing. Staff will send an email to the Board asking for this feedback and will update the list. Staff will also take into consideration feedback from stakeholder groups and other comments received in the meantime.

Item 7. Closing Thoughts + Meeting Adjournment

2022 Board Meetings

Materials: Proposed 2022 meeting schedule on page 63 in 11/4/21 agenda packet

The board's meetings are scheduled as follows for 2022. For regular meetings, quarterly vendor meetings are held the day before (typically Wednesdays).

- Thursday, February 10, 2022 (regular quarterly meeting)
- Thursday, May 5, 2022 (regular quarterly meeting)
- Thursday, August 3, 2022 (regular quarterly meeting)
- Thursday, November 2, 2022 (regular quarterly meeting)
- Modernization Committee is active, but meetings are not scheduled on a standing basis.

The meetings in the right and left columns are the same, just organized in different ways.

- Nan, Cammy and Judy confirmed the Advisory Board Meeting dates worked for them.
- Dallas noted that he was fine with the February dates. The August dates are often a problem for him, but the Board should not schedule around his availability.

Closing Thoughts

Chair Salo invited Board members to make closing remarks:

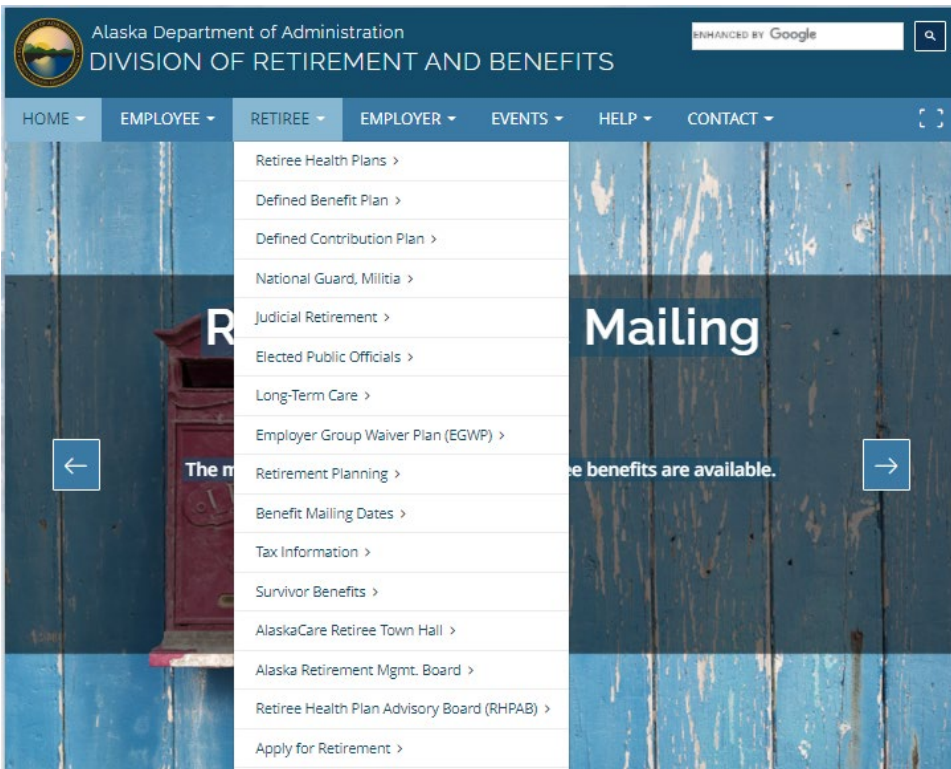
- Emily shared in the September meeting, we went through a lot of information very quickly; she wanted to again thank Betsy for a great job presenting she went above and beyond with the preventative care proposal. Emily should have shared these thanks in the September meeting, but is doing so now, thanks Betsy!
- Judy had shared some of the information about new preventative care coverage with a group of retired educators, and they all clapped. People were very pleased. Thanks to the Division for implementing this new policy!
- Paula asked who among Division staff would follow up with a response to her earlier question?
 - Emily responded she will be point of contact, she will hear from Emily, Betsy or Steve.

Motion by Judy Salo to adjourn the meeting. **Second** by Cammy Taylor.

Result: No objection to adjournment. The meeting was adjourned at 12:00 p.m.

The next Retiree Health Plan Advisory Board meeting will be Thursday, February 10, 2022.

Check RHPAB's web page closer to the meeting to confirm the schedule, location and to download materials for upcoming meetings. <http://doa.alaska.gov/drb/alaskacare/retiree/advisory.html>.



Streamlined Design

Easier Navigation

All Things Retiree in One Place

Focused Content

Same Information, Easier to Find

COMING SOON

New Retirement and Benefits and AlaskaCare webpage

We are getting a fresh new website design! The Division of Retirement and Benefits is updating the look and feel of our webpages, including the AlaskaCare webpage. The new webpages are designed so you can get online and quickly find what you need. They contain the same helpful information organized in a way that is easier to locate. All retiree information from the Division is located in a single menu, allowing you to quickly go straight to what you need.

Join us this Spring for a tour of the new AlaskaCare retiree webpage.

Stay tuned for more information.

The new webpages will launch in Spring 2022.

RETIREE HEALTH PLANS



Learn more about the different employee health plan benefits, coverages and monthly premiums.

Effective as of January 1, 2022

1. AlaskaCare Medical Plan Benefits

2. AlaskaCare Dental-Vision-Audio (DVA) Plan Benefits

3. AlaskaCare Pharmacy Plan Benefits

4. AlaskaCare Long Term Care (LTC) Plan Benefits

5. Medicare

6. Retiree Health Plan Advisory Board

7. Retiree Town Hall Events

8. Network Providers

9. AlaskaCare Additional Resources

10. News and Updates

11. AlaskaCare Health Plans

12. Retiree FAQs

13. Retiree DB Health Insurance Information Booklets

14. Retiree DCR Health Insurance Information Booklets

Proposal Title	GCIT Network Benefits - DRAFT
Health Plan Affected	AlaskaCare Retiree Health Plan
Proposed Effective Date	January 1, 2023
Reviewed By	Retiree Health Plan Advisory Board
Review Date	February 10, 2022

Contents

1) BACKGROUND	1
2) GOALS AND OBJECTIVES.....	2
3) SUMMARY OF PROPOSED CHANGES.....	2
4) IMPACTS.....	3
Member Impact Minimal.....	3
Financial Impact to AlaskaCare Cost Savings.....	4
Operational Impact (DRB) Minimal.....	4
Operational Impact (TPA) Minimal.....	5
5) CONSIDERATIONS	5
Clinical and Provider Considerations.....	5
6) PROPOSAL RECOMMENDATIONS	5
DRB Recommendation.....	5
RHPAB Board Recommendation.....	5

1) Background

Gene-Based, Cellular, and Other Innovative Therapies

Gene-based, Cellular, and other Innovative Therapies (GCIT) are a relatively new and rapidly advancing area of medical treatment that work by replacing or repairing defective genetic material within a cell.

GCIT services include:

- Cellular immunotherapy
- Genetically modified viral therapy
- Cell and tissue therapy, and more

GCIT products are U.S. Food and Drug Administration (FDA) approved therapies that are intended to treat or cure previously untreatable or difficult to treat conditions such as hemophilia, spinal muscular atrophy, and retinal disease. However, GCIT therapies are typically extremely expensive ranging in cost from \$600,000 to \$2.5 million. Because many of these therapies are new to market, many traditional cost

controls and network agreements do not apply, leaving the plan and members with little financial protection and oversight.

Current AlaskaCare Coverage

Currently, the Plan covers GCIT services under the medical plan from both network and non-network providers and facilities. However, because these therapies are so new, charges for these services are not contemplated by many standard network agreements, meaning Aetna and most network providers have not previously established an agreed-upon price.

The Plan also provides coverage for GCIT services as appropriate through the pharmacy plan (depending on the specific drug or treatment's administration requirements). Some GCIT services may be eligible for coverage under either the pharmacy or medical plan, while others may only be eligible for coverage under one or the other.

The AlaskaCare Plan currently includes an individual lifetime medical benefit maximum of \$2 million. Prescription drug expenses do not apply to the lifetime maximum.¹ As a result, GCIT services that are paid through the medical benefit may move retiree plan members closer to meeting their lifetime maximum. While the AlaskaCare Plan has not experienced prices of this magnitude, Aetna has reported other plans have seen charges nearing \$12 million for one course of treatment.

AlaskaCare Gene Therapy Experience

Though conditions treated by GCIT services are usually very rare, the AlaskaCare Employee Plan and the AlaskaCare Retiree Plan have already experienced claims for some of these novel therapies. For example, in early 2020 the Employee Plan paid approximately \$2.1 million for a member's Zolgensma treatment regimen. In 2021 a retiree plan member began a Spinraza treatment regimen (covered through the member's medical benefit): four initial doses administered in close succession and maintenance doses recommended every four months thereafter. Each Spinraza treatment carries a cost of approximately \$128,000. Both are gene therapy treatments indicated for spinal muscular atrophy, a hereditary condition that most often affects babies and children and causes muscles to become weak and waste away.

2) Goals and Objectives

Implementing the Aetna GCIT network and associated patient support program is intended to:

1. Ensure members maintain access to necessary treatments
2. Provide members with appropriate logistical and clinical support
3. Reduce member and plan risk and add cost controls for emerging high-cost treatments.

3) Summary of Proposed Changes

The proposed change ensures these therapies are covered through network GCIT-designated providers who have been manufacturer-approved to administer the drugs and who have agreed to contractual pricing terms for the therapies.

¹ 2022 AlaskaCare Retiree Insurance Information Booklet, *Section 1.1 Medical Benefits*, and *Section 3.1.5 Lifetime Maximum*. <https://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2022.pdf>

Under the proposed program, the Plan would only provide medical plan coverage for GCIT services received from a GCIT-designated provider or facility. No medical plan benefit would be provided for GCIT services received from an out-of-network provider. In addition to plan coverage for the GCIT therapy and associated medical charges, covered services would also include travel and lodging expenses (lodging: \$50 per night per person) up to \$10,000 per course of treatment for the member and a companion if the care must be administered away from the patient's home. Under the current plan benefits only limited travel costs would be reimbursable.

This proposal does not contemplate changes to coverage for GCIT services through the pharmacy plan. If GCIT services are covered through the pharmacy plan, the additional travel and lodging expense coverage would not apply.

Members receiving GCIT services from a network medical provider would have access to care coordination and support from a dedicated clinical team with specific GCIT experience. The care coordination team will help AlaskaCare members with the pre-certification process, ensure the member seeking treatment finds the most appropriate facility and provider, work directly with hospitals on claims, and provide answers to any questions that arise.

Use of the GCIT-designated network is expected to save the plan an average of 17% below the listed Average Wholesale Price (AWP) for applicable drugs and may include drug rebates in eligible circumstances. The plan will have additional cost protection due to Aetna and the GCIT providers having an agreed upon contractual price for services. The GCIT network program would initially apply to three products, though more products will likely be added to the program as it matures, and as new drugs come onto the market. Initial products include:

Zolgensma

- Approved by the FDA for children less than two years old with spinal muscular atrophy
- AWP: \$2.5 million
- Average savings: \$425,000

Luxturna

- Approved by the FDA to treat children and adult patients with an inherited form of vision loss that may result in blindness
- AWP: \$1.02 million
- Average savings: \$170,000

Spinraza

- Approved by the FDA for children less with spinal muscular atrophy
- AWP: \$612,000
- Average savings: \$100,000

4) Impacts

Member Impact | Minimal

The Retiree Plan has experienced fewer than five claims for some of these novel therapies. Current utilizers would not be adversely impacted by the addition of the GCIT network program.

Any new utilizers would be connected with the care coordination and member support aspects of the program (described above) when the precertification request for their medication is submitted to Aetna.

Future utilizing members would have dedicated support from the GCIT Network program team at Aetna to help with identifying the most appropriate provider and facility, coordinating claims, and obtaining approval for payment of associated travel and lodging claims.

Currently there are no facilities or providers in Alaska participating in Aetna's GCIT network, meaning it is likely members will travel to receive care.² The GCIT network covers travel costs beyond those typically available in the plan which results in better support for members.

However, some members may wish to seek care in state if possible. Aetna has already demonstrated success in negotiating single case agreements for GCIT services to be administered by an Alaska provider at an Alaska facility on an individual basis. Whenever possible and appropriate, Aetna will continue to pursue negotiation of single case agreements in Alaska.

While members will not experience a change to their out-of-pocket costs for GCIT services obtained through the medical plan, the reduction in the total cost of the services will result in the member using less of their lifetime medical benefit maximum.

Financial Impact to AlaskaCare | Cost Savings

There is no additional administrative cost to the plan associated with implementation of the GCIT network program.

Due to the rare nature of the conditions treated by GCIT therapies, it is difficult to estimate how much future utilization (if any) should be expected. However, should any claims be incurred for impacted medications, the plan would be protected from artificially inflated prices and would realize cost savings through the discounted rates available through the program.

Operational Impact (DRB) | Minimal

The Division anticipates minimal operational impacts associated with implementation and member communication as follows:

- Staff will need to review and distribute communications to educate and increase awareness of the GCIT Network program.
- Staff will need to update the Plan Booklet to ensure the benefit is appropriately described.
- Staff will need to coordinate and oversee implementation of the changes with Aetna.

After implementation, the ongoing operational impacts are anticipated to be minimal, and will include reporting, program monitoring, and updates to the booklet language and communication materials as appropriate.

² See attached "Aetna Institutes™ Gene Based, Cellular and Other Innovative Therapy (GCIT™) Designated Centers" for current list of providers.

Operational Impact (TPA) | Minimal

The initial impact to the Third-Party Administrator (TPA), Aetna, is anticipated to be minimal, primarily because Aetna already offers this program for their fully-insured book of business and for other self-insured customers who elect to participate:

- Aetna will update, code, and test their system to ensure that the changes associated with the program have been properly loaded.
- Aetna will ensure that their concierge staff are aware of the change and can properly communicate about and articulate specifics of the programs to members.
- Aetna will ensure internal channels are in place to connect any utilizing members with the appropriate care team as needed.
- Aetna will produce reporting on the utilization, impacts, and any savings associated with the program.

After implementation, the ongoing operational impacts are anticipated to be minimal and will include maintenance of the network and regular updates to the list of drugs included in the program.

5) Considerations

Clinical and Provider Considerations

Ensures patients receive GCIT benefit in facilities committed to cost and quality management. A dedicated clinical team guides the members through precertification to aftercare.

6) Proposal Recommendations

DRB Recommendation

The Division of Retirement and Benefits recommends implementation of this proposal, effective January 1, 2023.

RHPAB Board Recommendation

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

Description	Date
Reviewed by Modernization Subcommittee	
Reviewed by RHPAB	11/01/2021, 02/10/2022