Retiree Health Plan Advisory Board
Meeting Agenda

Date:	Tuesday, September 27, 2022
Time:	9:00am – 03:00pm OnlinePublicNotices
Location:	JNU 6th Floor DRB Conference Room | ANC Atwood 19th Floor Conference Room Join meeting
Teleconference:	(650) 479-3207 Access Code: 2451 767 8627 Password: 96847485
Board Members:	Judy Salo (chair), Lorne Bretz, Dallas Hargrave, Michael Humphrey, Paula Harrison, Cammy Taylor, and G. Nanette Thompson

9:00 am **Call to Order – Judy Salo, Board Chair**

- Roll Call and Introductions
  - New Board Member: Michael Humphrey (RPEA Seat)
- Approval of Agenda
- Approve Previous Meeting Minutes
- Ethics Disclosure and Public Comment Script

9:15 am **Public Comment**

9:30 am **Department & Division Update**

- Legal Update
- Health Fairs
- DVA Open Enrollment
- Plan Booklet Updates for 2023
- Inflation Reduction Act and Impact on Medicare Part D
- EGWP Opt-Out Plan Update

10:00 am **GCIT - Final Proposal and Recommendation Vote**

- Proposal Review
- Recommendation Vote

10:50 am **Break**

11:00 am **Remove Precertification Penalty – Final Proposal and Recommendation Vote**

- Proposal Review
- Recommendation Vote

12:00 pm **Lunch**

1:00 pm **Member Support: Orphan Drug Program**

- Sara Guidry, PharmD, CSP, AAHIVP
  Senior Clinical Consultant, OptumRx

1:30 pm Premium Rates for Plan Year 2023

2:00 pm Subcommittee Reports
- RHPAB Bylaws

2:45 pm Public Comment

3:00 pm Wrap up/Adjourn
- Next Meeting: November 3, 2022

Retiree Health Plan Advisory Board

Quarterly Board Meeting Minutes

Date: Thursday, May 5, 2022 9:00 a.m. to 4:00 p.m.
Location: Atwood Building, Anchorage; HSS Building, Juneau; WebEx (virtual)

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Lorne Bretz	Member	Present
Dallas Hargrave	Member	Present
Paula Harrison	Member	Absent
Nan Thompson	Member	Present
State of Alaska, Department of Administration Staff		
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	
Michael Gamble	Economist, Retirement + Benefits	
Chris Murray	Member Liaison, Retirement + Benefits	
Christina Fantasia	Appeals Specialist, Retirement + Benefits	
Elizabeth Hawkins	Appeals Specialist, Retirement + Benefits	
Kathy O'Leary	Administrative Support, Retirement + Benefits	
Others Present + Members of the Public		
Hali Duran	Aetna (medical third-party administrator)	
Kimberly Krebs	Aetna (medical third-party administrator)	
Laura Price	Aetna (medical third-party administrator)	
Sara Guidry	OptumRx (pharmacy third party administrator)	
Sherry Johnston	OptumRx (pharmacy third party administrator)	
Nafesa Walters-Smith	OptumRx (pharmacy third party administrator)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Stephanie Messier	Segal Consulting (contracted actuarial)	
Quentin Gunn	Segal Consulting (contracted actuarial)	
Richard Ward	Segal Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Brad Owens	Public Member	
Stephanie Rhoades	Retired Public Employees of Alaska (RPEA)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Delisa Culpepper	Public Member	
(Call-in user)		

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 9:02 a.m. A quorum was present.

Approval of Meeting Agenda

Materials: Minutes beginning page 2 in agenda packet for 5/5/22 RHPAB Meeting

- **Motion** by Cammy Taylor to approve the agenda as presented. **Second** by Lorne Bretz.
  - **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 minutes of the February 10, 2022 regular Board meeting. **Second** by Lorne Bretz.
  - **Corrections**: In description of settlement, need to change "arbitration" to "mediation."
  - **Result**: No objection to approval of minutes as corrected. Minutes approved.
- **Motion** by Cammy Taylor to approve minutes of the March 25, 2022 special Board meeting. **Second** by Nan Thompson.
  - **Discussion**: None.
  - **Result**: No objection to approval of minutes as presented. Minutes approved.
- **Motion** by Cammy Taylor to approve minutes of the April 11, 2022 Modernization Subcommittee meeting. **Second** by Nan Thompson.
  - **Corrections**: On page 26 toward the bottom, Cammy's question about pre-certification items: "reduced" should be changed to "increased."
  - **Result**: No objection to approval of minutes as corrected. Minutes approved.
- **Motion** by Cammy Taylor to approve minutes of the April 20, 2022 Regulations Subcommittee meeting. **Second** by Nan Thompson.
  - **Corrections**: There are instances where it identifies the committee as Modernization, but should be Regulations: pages 29, 33, 34 in multiple lines.
  - **Result**: No objection to approval of minutes as corrected. 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 at this time.

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

Chair Salo asked Emily Ricci to share updates.

Legal + Regulatory Updates

Emily Ricci gave a brief update:

Staff have been working over the last 6 weeks on implementing the terms of the settlement agreement that came out of mediation with RPEA. Thanks to RHPAB members for making time for board and committee meetings in March and April. There is a draft plan amendment out for public comment, with the period closing May 20: the intent is to implement the plan amendments changes by June 1, unless they need to extend further after reviewing public comment.

Staff are also working with the Regulations subcommittee to draft a regulation outlining the process for seeking public comment and implementing plan changes. The next action for this committee will be in June, when they have draft regulations to share.

Preventive Care Birthday Cards

Materials: Aetna "Happy Birthday" starting page 39 in agenda packet for 5/5/22 RHPAB Meeting

The Division is implementing communications to let retirees know about preventive services available through the plan. One of these is a birthday card campaign to educate members about their preventive benefits, to be sent to employees, retirees and their dependents (spouses). The card will list their standard preventive services (exams, annual screenings, etc.) and have a check list of which benefits they have or haven't received. The campaign will begin in July of this year and continue through the year cycle until everyone has received one.

Aetna utilized a similar campaign with Bank of America employees and saw a 26% increase; UPS with 14%; and other clients with similar increases in utilization of preventive services. Retirees will begin receiving these cards in July, so the Board is aware if they get questions from members.

- Cammy Taylor asked as a follow-up from yesterday's vendor meeting: there is some confusion among members about what is preventive care, versus diagnostic care. There are some services that are considered follow-ups for existing conditions, such as annual blood tests. Would these not be considered preventive? And how can we educate members about asking questions, clarifying with their providers about how services are covered?

- Emily Ricci responded this could be accomplished through education at Town Halls, e-newsletters, talking to providers and encouraging members to call Aetna. It is difficult to broadly speak about this coverage since it depends on the situation and someone's prior diagnoses. She also noted this is standard care in most insurance plans, so providers and others are familiar with this policy.
- Cammy followed up to note it is true providers will understand this policy, it will be important to educate retirees about the fact their diagnostic services will not be covered as preventive.
- Judy Salo suggested including a disclaimer or description about the fact diagnostic services would not be considered preventive.
- Cammy suggested simple language such as "Talk to your doctor about preventive and diagnostic services."
- Emily noted there is limited opportunity to customize the card, but they can address this question in other communications channels.
- Teri Rasmussen shared in the monthly retiree e-newsletter, starting in January, they are including a highlight of preventive benefits in each issue. The January had an overview, and specific benefits are being highlighted in each issue through June.
  Past e-newsletter issues can be found here: https://drb.alaska.gov/news/#retiree
  Sign up for e-newsletters: https://public.govdelivery.com/accounts/AKDOA/subscriber/new
- Judy shared she has heard from many people they appreciate having these preventive benefits added, members are satisfied.

Andrea shared another communications campaign, specifically about diabetes, which is a large and common condition among the retiree group. The dental plan has been updated to include a program, for people with a diagnosis of diabetes, two additional cleanings and periodontal visits. There will be a communications campaign starting in June for members who have been diagnosed with diabetes, to inform them of this program and encourage them to participate.

New Division of Retirement and Benefits Website Overview

Teri Rasmussen shared the new website: https://drb.alaska.gov/

She noted the redesign applied across the entire Division, but they worked specifically to make their website easier to access for members. The website was designed to make it easy to find information with as few clicks as possible and focused on the member's user experience. It prioritizes the most common information, and groups information by member type, instead of the sections within the Division: for example, the Retiree tab at the top has all retiree-focused content, including AlaskaCare, pension, long-term care and other benefits.

The Retiree AlaskaCare plan (website: https://drb.alaska.gov/retiree/healthplans.html) page has a list of topics, but also has a tab on the right-hand side that provides an outline of all the links (e.g. FAQs, Resources, Booklets, etc.)

There is also a question mark button on the bottom left: if any page has this question mark, clicking the question mark will bring up an FAQ page with links to the most common questions. The lists are primarily alphabetized, to make it easy to locate the information you are looking for. The goal is to have all the information, as much as possible, in one menu. The page has all the content in one long page, with hyperlinks that "jump" to section headers in the table of contents at the top.

There is also a new News and Updates page, which has all the current news information: there are separate pages for Retirees and Employees. There is additional functionality, including links to e-newsletters; notices, such as plan amendments; highlighted information (also sent by e-mail). The RHPAB page also has information about upcoming and past meetings, with all the links and materials included for the Board meetings. The News page can pull up all news, all retiree-focused news, or specific to AlaskaCare or other specific benefits.

There is also a Help menu, a Contact page to reach the Division, as well as a Glossary of Terms page. There is a link to a Forms and Documents library to find specific documents, as well as a search function.

Additionally, on the front page as well as the right-hand slider menu, there are icons for all of their vendor partners: Aetna, OptumRx, etc. This connects directly to their websites, specifically to Member Services, to make it easier to access benefits from the TPA.

- Judy thanked Teri for the brief walk-through of the website. She commented they often refer to people to the website for information, this is extremely helpful for members! She noted they hear about people being confused about benefits, whether they qualify for Medicare or not, how would someone easily find that information specifically broken out by which group they belong to?
    - Teri shared there is a Medicare page, including who qualifies, information about the plans (Part A, Part B, etc.) they can enroll in, and a link to the Medicare office directly.
    - There is a contact drop-down menu as well, with numbers for the Division's service center, hours of operation, and how to contact in writing or in person, as well as other vendors.
- Lorne asked to view the IRMAA reimbursement page (Medicare Part D surcharge for retirees with high income).
    - Teri navigated to the page: it is highlighted as one of the frequently-accessed pages, and has information about what it is, how to apply for reimbursement, and FAQ.
- Nan Thompson thanked the Division for their work, she appreciates all the work put into this!

- Judy suggested there could be a standing agenda item in quarterly meetings to identify any comments, concerns or suggested changes to the website.

Emily noted the Division's communications team deserves a great deal of credit for the new website, they have worked for years to make this happen.

Teri encouraged feedback from Board members and retirees, the website is dynamic and can be changed, updated or improved if there are any issues people encounter. Please share comments and feedback at any time!

Benefit Clarification: Maintenance Care for Musculoskeletal Disorders

Materials: Benefit Clarification description starting page 37 in agenda packet for 5/5/22 RHPAB Meeting

Emily provided an overview of the benefit clarification, one part of the settlement agreement:

This benefit clarification identifies more specifically what musculoskeletal care services can be covered. If someone is accessing these services, such as chiropractic or medical massage, after 20 visits per year the administrator will ask for documentation from the provider that the person is having significant improvement. After 25 visits, if there is a 26th visit and there is not paperwork demonstrating that they are making improvement, payment may be withheld. If the visits are determined to be maintenance care, however, the retiree will be eligible to have an additional 10 visits covered as maintenance care. This has been an area of significant confusion, and request for coverage for maintenance care, while the plan has covered these services only for rehabilitative care.

- Judy asked whether the Division met with providers to discuss this coverage?
    - Emily responded rehabilitative care has issues with code modifiers in billing and met regularly with Alaska chiropractic providers about this and several other issues. Staff learned more about their services, providers were able to discuss what is available through Aetna, and they identified the issue of duplicate claims being submitted.
      They also clarified that these benefits are annual but also defined by episode of care: the benefit resets with the calendar year. But multiple visits, with an interval in between, may be considered two episodes of care. This has helped clarified administrative issues for both Aetna and providers.
- Judy asked, if the benefit aligns with the calendar year?
    - Emily responded yes, it is with the plan year, which is the calendar year.

Item 4. Preliminary Prior Authorization Reporting

Materials: Retiree Prior Authorization starting page 41 in agenda packet for 5/5/22 RHPAB Meeting

Emily asked Sara Guidry to share a presentation about OptumRx's prior authorization process:

This program was put into place January 2022 for certain medications; the data presented today is the preliminary first quarter data and should be seen as a preliminary report-back, not an analysis of outcomes from implementing this program (it is too early to draw conclusions, and they do not yet have data about people switching prescriptions and other related outcomes).

The slide on page 42 includes data on the cases by group (EGWP and non-EGWP), and their outcome: approved, denied, overturned and upheld. As the slide notes, denial does not mean the member did not receive care. It could mean that the denial required more information from the provider and may have

been updated (under Overturned); it could also mean that they were prescribed an alternative medication, which generates a new case. She noted the number of cases is not the number of members, a single member may have multiple cases. Denials are listed as approximately 30% of cases, but this may also include cases in other columns that had a different outcome. She also noted this does not only include specialty medications prior authorization, but also includes other prior authorizations such as erectile dysfunction medications, which was an existing program separate from this one. This is only a high-level review.

- Judy asked for more detail: what are examples of the types of cases that were denied?
    - Sara responded there are different possibilities, it could include denial based on the quantity requested or other factors.

There are multiple types of prior authorization (PA), but there are general categories: prior authorization review (using the clinical guidelines when required), quantity limit review (rejection only based on quantity). Example of this type of review: CMS requires a review for certain opioid prescription for EGWP members. Exclusion is a medication that is not generally covered by the plan, but a provider can submit a review request for a specific member's case and makes the argument it should be covered. She also noted that the data charts specify whether the data on each slide is based on disposition date, versus date of outcome, which can be slightly different numbers.

The slide on page 44 illustrates the method of receiving PAs, with most common (over 73% for EGWP members and 66% for non-EGWP members) being electronic submission through their website, followed by fax and phone, which are utilized by prescribers. The RxWeb and Web lines are directly through members, which is less common, but done through the OptumRx portal or by calling customer service to initiate the PA. Sara noted the goal is to have as many people as possible submit PAs through the web portal by providers, in part because it prompts them to answer all the questions before it can be submitted, versus other methods that may not answer all of the necessary questions. Incomplete PAs are one of the biggest issues, having to ask the provider to submit more information takes time. Using the electronic PA system is the fastest and most convenient way to complete PAs.

The slide on page 45 illustrates the volume of cases by month, including both standard and urgent PAs.

Page 46 illustrates the approval and denial rate by member group (EGWP, non-EGWP) and communication type. PAs submitted by fax and phone have higher denial rates, mostly because of the frequency of missing information.

Page 47 illustrates the rate of providers utilizing the electronic PA system, meaning they submitted at least one ePA in one month. It may mean they used other methods as well, such as fax, but at least one ePA. Providers who did not utilize the electronic system at all in a month is counted in second column.

Page 48 illustrates turnaround time for cases by month and group. This includes time that OptumRx had requested more information from providers and was waiting for a response. Almost all of the cases (well over 90%) were resolved in less than 2 days, with a few cases that took longer, mostly waiting for providers to respond within information.

Page 49 shows turnaround time by the hour; over 50% are resolved in less than 12 hours, with a range for cases up to multiple days. The large majority of ePA cases were resolved within that range, as well as some phone and fax.

- Judy thanked Sara for the presentation, and looks forward to hearing more details in August, when there is two quarters of data.
- Cammy commented she is interested in the issue of excluded cases, discussed yesterday, and this information is helpful since it includes that. She also asked if OptumRx can share examples of letters members might receive if they are denied, particularly if it is an EGWP wrap service, versus when they get a letter about an exception provided? Are the letters the same as the prior authorization letters people receive for specialty medication?
    - Emily responded staff review the letters and communications to members, including the templates OptumRx uses. These are standard, but the templates can be included in a future board packet for Board review.

The Board took a break at 10:21 a.m., and returned to the meeting at 10:33 a.m.

Item 5. Gene-Based, Cellular, and Other Innovative Therapies (GCIT) Network

Materials: Draft health plan proposal starting page 51 in agenda packet for 5/5/22 RHPAB Meeting

Emily invited Betsy Wood to present.

Betsy shared the updated proposal about coverage of GCIT network services, with changes based on the Board's discussion and questions in the last quarterly meeting. She will give an overview and ask the Board to identify additional questions now, before a recommendation vote at the August meeting.

Updates to the original proposal document:

In the background section, there is additional language about how these new therapies are different than other therapies and information on the market: they use genetic material, modifying cells that may be collected from the patient, then manufactured in a lab for that patient's treatment. This is very different than most medications, which are prepared and sold as is through a pharmacist or administered at a doctor's office with a standard formula. The section about current coverage explains what is covered now, but that because these are very specialized and require administration in different ways, they are best administered through the medical plan not the pharmacy plan. The intent is to steer utilization to the appropriate providers and sites of care, given that they are complex and specialized. These therapies will be covered by the medical plan, with specific guidance about when and how they are covered.

In the summary of proposed changes (starting page 53), there is more information about how approved providers are determined by Aetna, which means they have the expertise, facilities and equipment to properly administer these therapies. This is critical for member safety, ensuring they can access these therapies from the appropriate and qualified providers.

Page 54 illustrates the 3 specific products that would be covered under this program, with more information about each product's administration and dosing regimen. Patients will be able to travel for care, they have serious conditions but would need to travel to have the treatment. Aetna can also work with people to access care for people who are unable to travel, through a prior authorization request, and work with the member and an alternative site to administer the medication, if it is not one of the approved facilities within network.

- Cammy asked about the provisions for Spinraza, it is supposed to be approved for children under a certain age: this should be corrected to "under age 2."
    - Emily confirmed this is correct.
- Cammy asked what happens now, without a review? If a member requests therapy, what happens?
    - Emily noted these are new, they have seen some of these cases in the employee plan, they want to be proactive in the retiree plan given the complexity and cost of these therapies. Because of the nature of these therapies, even though there is no required PA in the plan currently, when a member or provider seeks this therapy, it is typical to essentially seek a prior authorization for this service already. While this is currently infrequent, they do anticipate having more of these services available on the market, and this can be expanded in future to include those.
- Cammy asked whether there would need to be a plan amendment to include future therapies, or does this include those if they are FDA approved?
    - Emily noted only 3 have been FDA approved, but more are moving through the process and would likely be added in future.
    - Kim Krebs added the gene therapies (these 3 drugs) go through the PA process; there is another therapy for hemophilia by the end of the calendar year and would also be added to the list if/when approved. There have only been 3 so far.
- Cammy asked for clarification: the process is similar to what happens now with PA, correct?
    - Emily confirmed yes, it is a PA, but currently there is no travel benefit associated with this program, so it is not covered.
- Cammy asked whether Aetna could provide a copy of the current list of approved providers?
    - Betsy noted it was provided in the February 10 meeting packet, and staff will re-send it, it is updated by Aetna regularly as additional providers are approved and added to the network.
    - She also responded to a prior question, whether this GCIT network providers are also generally in network? All network providers for Aetna include this network; not all are on the GCIT network, but the Aetna overall network list is inclusive. The goal is to steer people to in-network providers, to avoid balance billing for members, especially given the cost.
- Cammy asked what happens if a person seeks services from an out of network provider? It looks like there is a process to negotiate price with that provider.
    - Betsy noted there is no current policy requiring using a non-network provider, however Aetna will also get a call from that provider to seek authorization to ensure the service is covered. At that point, the non-network provider can negotiate with Aetna to determine price and ensure the member gets treatment. Providers are aware of this high-cost service needing to be coordinated with an insurer.
    - Cammy clarified: the proposal says that out of network care will not be reimbursed at all, but if the person cannot travel or they need to use a non-network facility, would that be a consideration for negotiating price, rather than simply denying the out of network care?
    - Kim responded there are two options for Aetna: to either not cover the service at all; to cover the service as an out-of-network service, which exposes the member to balance billing charges; or to work with the provider to negotiate a price.
    - Laura Price added her billing team would work with the provider to attempt to negotiate a price on a case-by-case basis, they have a dynamic network since this is a new service (versus a static network, that applies to most services). So, there is a mechanism to

negotiate with a non-network provider, including attempting to remove the surcharges that many facilities charge for this therapy if there is no negotiated price.
    - Betsy summarized: there are two options, either stating "there is no out of network coverage" and requiring using a provider who is in-network or who can negotiate a single-case rate with an out-of-network facility; or the policy can include out-of-network coverage as an option for members, but this requires the member to seek pre-certification and also makes the member exposed to the possibility of balance billing. When the service can be $1.2 million or more in price, and can be inflated further by the provider, this could be an extremely risky prospect for the member financially. The first option protects members and removes the financial risk for this service and protects the patient.
    - Emily added that under option 2, covering out of network providers, is similar to how they handle organ transplants at an out of network provider. However, this also exposes the member to balance billing, and there is no travel benefit provided. She restated that for the reasons above, staff recommend option 1 as better protection for members.
- Cammy asked if the $2 million lifetime maximum applies to these services, how is that addressed?
    - Emily stated the therapies are for rare genetic conditions and is anticipated to be very, very rare in the retiree plan. However, this still needs to be addressed. There are other reasons the Division wants to review the $2 million care limit, so Emily recommends that the plan move forward with this proposal, and still plan to discuss that lifetime maximum with the Board. They also have recommended including it in the medical plan not the pharmacy plan, but the lifetime maximum would need to be addressed for multiple reasons.
- Cammy asked whether there are issues with the formulary used by the AlaskaCare plan, would this be included or excluded? She clarified that she is concerned about a situation where a third-party administrator in future would not cover certain medications, like GCIT.
    - Emily noted the formulary and other benefits are defined in the plan documents, including the formulary, she cannot speak to all future situations, but they do already cover non-standard benefits, such as compound pharmacy products. This would be similar, they can tell the third-party administrator that certain things need to be covered.
- Cammy noted that in the retiree plan, there appear to be an extremely low number of infants and toddlers, so it is unlikely (but not impossible) to come up in the retiree plan.
    - Emily agreed, and noted that for Luxterna as example, there were less than 10 cases in the entire country.
    - Laura clarified that some drugs are one-time administrations, Luxterna can be administered up to age 26, although it is most common in infants. Zolgensma must be administered by age 2. Spinraza would not be a single application but may have doses administered later in life. This is therefore the most likely therapy that will occur in the retiree population.
- Judy asked what other potential products they are anticipating seeing approved in future?
    - Laura responded the hemophilia drugs are the next to come on the market, there are two moving through the approval process. There are also 16 GCIT products on the market now, but most do not fit the definition of this type of service. There are only 3, and a 4th on the way with the hemophilia treatment, so they are primarily focused on getting this structure in place, with the few treatments available now, in order to have a standard approach if and when there are several other therapies on the market.
- Judy asked whether there are other edits and corrections to make to the proposal?

- Betsy noted they will make corrections, such as information about Spinraza only administered up to age 2, but otherwise they have made the updates they intend to make.
- Emily responded staff would like to bring this to the Board for a recommendation vote at the August quarterly meeting. She asked whether the Modernization committee should plan to review this proposal again and discuss before that meeting?
- Judy agreed, she recommends the Modernization committee plan to review this in summer.

- Cammy asked what percent of providers who currently cover GCIT therapies are in Aetna's network?
  - Laura responded it differs by the therapy: Luxterna has only 10 facilities approved total, with the manufacturer recently adding 4 more. Aetna is contracted with 9 of the 10 and are in contact with the other 4 to establish a relationship. For Zolgensma, there are over 100 facilities, but Aetna has contracts with 43, potentially up to 48 soon. Spinraza is more common, they have contracts with 43 facilities so far, and continue to expand their network as possible. There are also facilities that the manufacturer works with, the list continues to grow and change, Aetna attempts to stay current and reach out to all providers to establish a relationship.
  - Cammy requested a list of providers, in network and out of network, for the Modernization subcommittee to review for information.
  - Emily noted there was a list of providers in the February board packet, but this is now out of date, they can provide an updated list.
- Nan asked whether there are non-approved sites, i.e., not approved by a manufacturer? And are many not in the network?
  - Judy agreed, she would like to see an updated current list in the committee meeting.
  - Betsy will follow up with Aetna about additional information to provide to the committee and where Aetna has contracted, and which providers are considered approved sites for this service. Not all are in the Aetna network.
  - Emily again stressed the benefit of utilizing network facilities because they can also access travel support and other assistance to reach the site. This provides financial support to be able to reach the facility and seek the therapy.
  - Judy commented it is also important to ensure the member can access a quality facility and having support for making the right choice for treatment.
  - Betsy agreed, patient support is very important, staff want to address this as well.

Judy asked whether members have additional questions or want more information for the meeting? She noted the group will discuss timeline and upcoming meetings for this item, and other tasks for the Division staff and Board members.

- Dallas asked whether the group should press ahead and finish business now?
  - Judy noted they do want to have enough time to discuss the other committees, but to make time for members of the public and to be prepared to discuss the schedule. She also commented one member of the public intends to come back for the afternoon session, she wants to ensure they maintain the public comment period in the afternoon as stated.

The Board took a lunch break at 11:30 a.m., and returned to the meeting at 1:00 p.m.

Chair Salo called the meeting back to order.

Before moving to the next item, Judy asked to return the GCIT discussion for two additional questions:

- Cammy noted there is a typo on page 52, "AlaskaCare Gene Therapy Experience," 5th line, re: medical benefit, should read "4 doses," not "dose" singular.
- Cammy also asked whether the cost of Spinraza per dose is $612,000, or total? What is the per dose cost, for reference? This medication is taken for life, so it would be difficult to estimate total cost.
    - Emily responded the individual dose is about $100,000, but people take multiple in a lifetime: she will coordinate with Aetna to get a response.
- Cammy also asked what the travel benefit rates are, and whether they match other benefits? For example, the lodging estimate is $50 per person per night?
    - Betsy confirmed they will look at the rates, but it is $50 per person per night, up to 2 people, so that would be $100 per night.
    - Emily also noted this is separate from what they outline in the booklet, the rates are determined by the third-party administrator for the program, not the plan.
    - Cammy suggested discussing this further at Modernization committee.

Item 6. Subcommittee Reports and Next Steps

Modernization Subcommittee Report

Chair Cammy Taylor gave an update: the committee met on April 11th to discuss a timeline for the 3 topics routed to this committee from the settlement agreement. They intend to start with 1. precertification process, timeline and policy. They will have an overview of the timeline, what services are subject to precertification, and how penalties are applied.

The other 2 items are: 2. travel and precertification penalties, which they will take up next after the precertification process, and 3. coverage for experimental and investigational services and supplies.

They have not scheduled a next meeting but do need to meet this summer. There were issues around staff availability and having time to collect and present information. They want to discuss scheduling of the next meeting after these reports.

Regulations Subcommittee Report

Chair Lorne Bretz referred the group to the minutes from the meeting, but they met April 20, 2022 and heard an overview of the regulations development process, and the timeline for making this a formal regulation draft. They made comments and highlighted items to address in the draft and anticipate seeing a draft regulation mid-June for further comments.

Bylaws Subcommittee Report

Chair Dallas Hargrave reported there is no update yet, and Judy reminded the group the prior discussion was to push this item further out, given the other priorities and timelines already required.

Emily suggested that the group table this item after the August Board meeting, to determine when to take this up later in the year.

Meeting Scheduling

Judy asked staff what they recommend for future committee meetings?

Emily recommended no meetings for the Regulation subcommittee in June, but to schedule a meeting in mid-July, after they have prepared the draft regulation. For the Modernization subcommittee, she noted Betsy will be the staff person for that work, and potentially they could hold a meeting in June. The group

will talk about the GCIT network proposal, as well as discussing the prior authorization/precertification process. She suggested meeting the week of June 20th or June 27th, to give staff time to prepare for the meeting, but also enough time before the August Board meeting.

Cammy confirmed the timeline works for her, and they will connect by e-mail with the full Board and committee membership to confirm a specific date.

Judy proposed the second week of July for the Regulations subcommittee. Lorne confirmed that time should work for him, they will coordinate with the committee for scheduling.

- Lorne asked for confirmation: the draft regulation will be published for comment mid-June?
    - Emily responded staff are aiming for late June, rather than mid-June, but a scheduled meeting in mid-July would be appropriate time for committee members to review the draft regulation in advance.

The Bylaws committee will meet later in the year, schedule to be determined.

Item 7. Public Comment

See Item 2 in the minutes for public comment guidelines.

Chair Salo reminded meeting attendees of the guidelines for public comments provided in the meeting and invited anyone who wishes to provide public comment at this time to speak.

- Brad Owens, retiree dependent. He overall thought the website redesign, at first glance, looks great; he will look in further detail, but he believes it will be an improvement and easier to find things. He pointed out that the website, and instructions how to use it, are all computer-based. He asked whether the Division would send information out to members, especially thinking of retirees who don't have access to or do not feel comfortable using computers.
    - Emily noted that typically the Board and staff do not answer questions during public comment, but she offered that it would be difficult to help people connect to the website if they are not already using a computer or electronic device. Members can always call the Division's call center to connect with staff and ask questions. She noted there are public access sites such as libraries to use the Internet as well. She also noted the division will be sending a postcard to all retiree members notifying them of the website redesign.

Item 8. Closing Thoughts + Meeting Adjournment

Motion by Cammy Taylor to adjourn the meeting. **Second** by Lorne Bretz.
Result: No objection to adjournment. The meeting was adjourned at 1:20 p.m.

The next Retiree Health Plan Advisory Board meeting will be Thursday, August 4, 2022.

Check RHPAB's web page closer to the meeting to confirm the schedule, location and to download materials for upcoming meetings. https://drb.alaska.gov/retiree/rhpab/

Retiree Health Plan Advisory Board

Modernization Committee Meeting Minutes

Date: Wednesday, July 20, 2022 9:00 a.m. to 12:00 p.m.

Location: Atwood Building, Anchorage; Microsoft Teams (virtual)

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB)		
Cammy Taylor	Committee Chair (RHPAB)	Present
Nanette (Nan) Thompson	Committee Member (RHPAB)	Present
Mauri Long	Committee Member (RPEA)	Present
Judy Salo	Board Chair	Present
Paula Harrison	Board Member	Present
Lorne Bretz	Board Member	Absent
Dallas Hargrave	Board Member	Absent
State of Alaska, Department of Administration Staff		
Ajay Desai	Division Director, Retirement & Benefits	
Emily Ricci	Chief Health Administrator, Retirement & Benefits	
Betsy Wood	Deputy Health Official, Retirement & Benefits	
Teri Rasmussen	Program Coordinator, Retirement & Benefits	
Chris Murray	Member Liaison, Retirement & Benefits	
Andrea Mueca	Health Operations Manager, Retirement & Benefits	
Kathy O'Leary	Office Assistant, Retirement & Benefits	
Others Present + Members of the Public		
Blythe Keller	Aetna (medical third-party administrator)	
Breeanne Fisher	Aetna (medical third-party administrator)	
Kimberly Krebs	Aetna (medical third-party administrator)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Stephanie Messier	Segal Consulting (contracted actuarial)	
Randall Burns	Guest	
Delisa Culpepper	Guest	
Wendy Woolf	Guest	
Inmaly Inthaly	Agnew::Beck Consulting (contracted support)	
Dorne Hawxhurst	Guest	

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
- RPEA = Retired Public Employees of Alaska
- 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 committee meeting to order at 9:07 a.m.

Approval of Meeting Agenda

Materials: Agenda packet for 7/20/22 RHPAB Modernization Committee Meeting

1. **Motion** by Mauri Long to approve the agenda as presented. **Second** by Nan Thompson.
    - **Result**: No objection to approval of agenda as amended. Agenda is approved.
2. **Motion** by Nan Thompson to approve the June meeting minutes as presented. **Second** Mauri Long.
    - **Result**: No objection to the approval of June meeting minutes.

Ethics Disclosure

Cammy Taylor requested that committee members state any ethics disclosures in the meeting.

- No members made ethics disclosures.

Item 2. Working Session

Materials: Presentation beginning on page 17 of 7/20/2022 agenda packet

Precertifications in the AlaskaCare Retiree Health Plan

Emily Ricci introduced the focus for today's meeting: pre-certifications for AlaskaCare plans. Aetna team members joined today's meeting and have reviewed questions from the committee at its last meeting and developed new materials for review.

Blythe, Director of Account Management at AETNA, introduced herself and other present AETNA staff and shared a follow-up presentation that overviews the prior discussion and answer questions raised in the last meeting.

- Slide 1: Page 18 of the packet gives an overview of the definition of precertification as it pertains to AlaskaCare plans. The slide reiterates that certain services require precertification.
    - Nan asked which national services are not covered by Medicare. Blythe answered that cochlear and dental implant services are not covered by Medicare, but are on Aetna's national precertification list.
    - Cammy asked for clarification on the definitions of the terms "precertification", "predetermination", and "preauthorization".
        - All three terms are used interchangeably.
    - Cammy noted that there is a separate category for requested approval for services that are not on the precertification list. If a provider contacts Aetna, can they receive preapproval of services and how is this different from the precertification process?
        - Precertification and preauthorization processes are the same and Aetna requires that for items that are on the national precertification list posted online. Predetermination is a separate process. If a plan sponsor requests a service for review pre-service, it becomes a predetermination and not a

precertification. This process is a plan sponsor requirement to have services reviewed pre-service. One of the biggest differences between pre-certification and predetermination is that this option is not available for peer-to-peer and appeal rights are not given through a predetermination process as they are through the precertification process. Cammy noted that AlaskaCare processes do not operate the same way and Emily answered that this is the first time they are hearing of this and wants to ensure that this information applies to the AlaskaCare plan.

- ✓ **ACTION ITEM:** Blythe and Emily will follow up about this topic.

  - Cammy asked if there is a process available to providers to learn more about a procedure that may not be on the national precertification list.
    - A formal process is not available that formally approves services. If the service is not on the national precertification list, the provider may call to verify coverage and eligibility for a member. However, the request would not undergo a medical necessity review that precertified services undergo.

- Emily stated that an outcome for this meeting is for the plan members to have what is outlined in the book as precertification match the standard precertification list from Aetna. The recommendation is to align; this has not done in the past due to not making large changes to the plan due to litigation.
- Slide 3 gives an overview of the types of precertification (urgent and routine) and the definitions.
  - Cammy stated that in the AlaskaCare plan book, the definition of emergency is different and asked if this would be a third category; Blythe answered that it is not since these definitions describe Aetna's turnaround time for precertification.
- Slide 4 gives an overview of the precertification standard turnaround times.
- Slide 5 gives an overview of the AlaskaCare retiree turnaround times in days. From January 1, 2022 through June 30, 2022, the turnaround time is 3.5 days.
  - Cammy asked how many services are subject to precertification annually. Blythe estimated the figure to be in the thousands. Blythe shared some data for AlaskaCare plans for actives and retirees:
    - In 2020, there were 2,900 unique outpatient precertification requests.
    - In 2020, there were 5,700 inpatient precertification requests for all actives. (*This figure may be overstated as there may be multiple requests for one service.*)
  - Cammy asked if there is a standard process for receiving precertifications and if there is a specific form that should be filled out or a checklist. Blythe answered that it depends on the provider and how they choose to proceed in services. Some services undergo an automated online process while others are submitted electronically.
- Slide 6 gives an overview of the precertification process when Aetna is the secondary provider.
  - Judy asked if the secondary provider covers the cost of follow-up lab tests that may not be covered by Medicare considering they only cover certain types of lab tests a certain number of times annually. Blythe will follow up with the committee on this.
    - ✓ **ACTION ITEM:** Blythe will follow up on secondary coverage on follow up testing.

- Judy asked if it is technically correct to state that Medicare does not do precertification. Blythe has not researched if they complete medical necessity reviews, but whether they precertify a service or not that is covered by Medicare with a secondary AlaskaCare plan, Aetna does not look for precertification in the Aetna system.
- Cammy noted that there is a category of people 65 and older who don't qualify for Medicare Part A and asked Blythe for more information on this as it seems that people in this category make their own precertification approvals. Blythe answered they may need to review the experience to answer this. Blythe currently does not have any data points on this and noted that any provider may still submit a precertification request and even if there is not a formal network, the providers that are otherwise in network with Aetna may still behave as in-network providers. Cammy asked to understand how the precertification process impacts this group of about 400 people currently. Emily noted the importance of everyone understanding that some of the operational limitations, due to the customization, drive differences on the backend of the system; this background is important to know as special populations are discussed.
  - ✓ **ACTION ITEM:** Emily will follow up with information on how the precertification process impacts the special population of 65 years and older.

- Slide 7 gives an overview of the process after pre-certification.
- Slide 8 gives an overview of the definition and process for peer-to-peer review. Data on the slide shows that 32% of offered peer-to-peer reviews resulted in a discussion and 46% of completed peer-to-peer discussions resulted in a partial or full overturn. Usually, denied precertifications are due to a lack of provided information.
  - Cammy asked that if 32% engage in discussion, are the rest appealed or left as is? Blythe answered that she is unsure if the decision becomes appealed; It could be appealed and possibly be overturned depending on the information given.
- Slide 9 shows data on the appeals Aetna handles related to precertification denials.
- Slide 10 describes what would happen if there is a failure to precertify.
- Slide 11 will have information on data for precertification penalties; Blythe does not yet have this information in hand but will follow up.
  - ✓ **ACTION ITEM:** Blythe will follow up with precertification penalties data and travel requests data.
  - ✓ **ACTION ITEM:** Blythe will coordinate with the DRB team on how to provide all follow-up information to the committee.

Emily closed out the discussion and highlighted the following:

- Follow-up from Aetna will be given to the committee.
- Upon review of the data, Emily found that are about 250 to 300 people who are not Medicare age eligible.
- The precertification process generally works well with a few areas to be worked out (discussed in this meeting). An area that should be reviewed and changed are on travel pre-certifications, chemical dependency, mental health, and substance abuse limits penalties that are currently in place and reduces co-insurance to 50%; the team is amenable to removing these.
- From the state's perspective, the policy and operational issues to address are the differences in the static list in the book and the national precertification list of the changes. Staff believes that

adopting the national precertification list is the cleanest way for members and providers to understand the precertification requirements.

- Emily proposed a package that removes penalties for travel, chemical dependency, and substance abuse precertifications and references the national precertification list.
- Emily also proposed to review the member requirement to precertify when seeing an out-of- whether it provides the value that is intended by the plan.
- Mauri asked if there are any restraints on allowing administrators to decide what is on their precertification list without input from DRB or the population of beneficiaries?
    - Emily answered that they rely on third-party experts to help identify items on the list. On restraints, they see updates as it is updated through the quarterly provider e-newsletter. DRB also coordinates a meeting to understand the impacts to their providers and population. Usually, problematic precertifications are due to a difference in how services are being adopted and practiced against the evidence in coverage requirements and the precertification process catching it, or a precertification hasn't been put in time so it's very new and members are very surprised to have a denial. DRB usually finds out when members contact them.
    - Emily emphasized the importance of adopting a precertification list that is not static because with emerging technologies there will be concerns with what is being prescribed and promoted to patients versus what is medically necessary; it may only be a few services where this is happening, but when it does happen, the precertification process helps members and providers avoid being stuck on the backend of services.

✓ Mauri asked about DRB staff's experience during the pandemic when the AlaskaCare plan suspended precertifications.

- Emily answered that staff began to see more frustrated providers and members who'd anticipated that a service would be covered. Clarification on the suspension of precertifications was not made until after the service was denied. In Fall 2021 when COVID began to rise again and hospital capacity was low, DRB staff spoke with the hospital association and other groups and offered to suspend precertifications again and DRB was asked not to suspend precertifications and asked for this information on the frontend.

✓ Cammy reviewed DRB staff's recommendations:

- Change the plan's static list to the national precertification list
- Remove penalties for travel and behavioral health precertifications
- Leave out-of-network penalties as is (*it was noted that it is not unusual for network members to go to an out-of-network provider, but the precertification penalty would be unusual as the member would be denied for not being precertified. This is how most providers handle services that are not on the precertification list*)
- In the future, evaluate if the committee would like to make changes to how out-of-network pre-certifications and penalties are applied
- DRB staff to internally evaluate removal of the precertification penalty that reduces benefits by $400 and then bring this topic back to the committee

✓ **ACTION ITEM:** Emily and staff will create a proposal for the September Board meeting through a resolution, then incorporate the changes into the 2023 plan booklet which will

undergo a drafting and public comment process. Emily recommended having one more meeting before the September meeting to talk through the proposal further.

The Board took a break at 10:18 a.m., and returned to the meeting at 10:32 a.m.

Chair Taylor called the meeting back to order.

Betsy Wood gave an overview of the GCIT Designated Network update, a topic discussed at prior committee meetings. The intent in discussing this topic is give a final presentation at the next board meeting. The proposal contemplates adding specific steering coverage for gene-based, cellular, and other innovative therapies through the medical benefit, specifically to Aetna's GCIT Designated Network program that not only ensures people receive the exit therapies through providers who've agreed to certain reimbursement levels, but also adds travel coverage and clinical support for members experiencing conditions requiring them to undergo more advanced and complex therapies.

Betsy shared the GCIT Network Benefits draft proposal and highlighted the changes outlined in the proposal in response to committee discussions at the last meeting:

- **UPDATE #1:** Add Aetna's GCIT Designated Network program
    - This addition ensures that provider care fees are covered through the network.
    - Not all gene therapies are included as a network benefit.
    - Aetna has a Governance Committee that consists of representatives from the pharmacy, clinical, finance, legal, network, and product sectors to review therapies in the FDA pipeline. The committee will determine which therapies should be included in the program. Aetna is currently in the process of identifying standard criteria to evaluate all products. So far, the first three included in the benefit were selected due to cost and considerations with administration of these therapies. There is more to come on this topic.
    - Once a therapy has been identified for inclusion, discussions with providers specific to this therapy are held. To participate, providers must be approved by a manufacturer, become Aetna credentialed, and willing to execute an Aetna GCIT-specific agreement. There is not an independent third party to determine whether these standards are met, but there is hope that this can be implemented in the future.
- **UPDATE #2:** Exclude the cost of therapy of GCIT drugs or products from accumulating toward a member's lifetime maximum benefit
    - This exclusion only applies to the cost of the drug or product and not the associated travel or medical expenses.
    - This addresses the concerns that were expressed by the committee and the last meeting.
    - Adopting this proposal would not have any different impact on a member's lifetime medical benefit if the therapy was considered and paid under the pharmacy benefit rather than the medical benefit.
    - Aetna anticipates that some hemophilia treatments and therapies may be included in the program. When Aetna expands the drugs and products included in the program, they will keep DRB and the board informed.

    - A near-term priority for DRB is to address the lifetime maximum, and the issues caused by them.
    - Previously, under the summary section there was specific information on estimated savings. This section has been moved down to the financial impacts section and the language was unchanged.
    - Betsy briefly went over the OptumRx Medical Benefit Specialty Vigilant Drug Program List which is implemented to include the exclusion list in the medical plan. These drugs are not excluded to the $2 million cap. Betsy explained how Medicare covers the drugs on this list. Coverage is mostly through Medicare Part B. For more information on Medicare coverage, Betsy would have to defer to a Medicare office representative. There is a sense that AlaskaCare coverage is broader than what would be experienced in Medicare coverage.
    - Aetna is looking at the entirety of gene therapy services and products on the market and are determining which drugs make sense to be included in the designated network program. If a drug is included, they must be approved through a manufacturer that is participating in the GCI Designated Network program. In addition, travel benefits, care coordination, and clinical support is provided.
    - Kim noted that there Aetna has 16 total gene therapies that all require precertification and 3 are part of the GCI Designated Network program.
    - The plan has not contemplated this area before as these therapies are new to the medical space. Through this proposal, DRB hopes to direct members to the right place before the treatments and therapies become more mainstream.
- **UPDATE #3:** Previously, the summary section included drug-specific information, including anticipated estimated savings when claims are made. This section has been moved to the section on financial impacts, but the language is unchanged.
- Staff have discussed a potential change in the plan language stating that the plan administrator has the authority to approve an out-of-network provider under certain circumstances. After discussion, staff concluded that this ability already exists in the plan through the appeals process which is available to members. Therefore, the current process will be maintained.
    - Cammy asked what the basis of an appeal would be for Aetna denying a precertification for an out-of-network provider as her understanding on the discussion from the last meeting was that going to an out-of-network provider would result in no reimbursement as opposed to a reduced reimbursement. Betsy answered that this depends on the individual circumstances. DRB staff are worried about lowering the value of the program and want to ensure that people receiving these complex treatments are taking advantage of the additional benefits and supports that come with this program.
    - Staff want to avoid predatory behaviors at some facilities where they are increasing charges for some gene therapies to substantial amounts; by carving these out of the lifetime maximum limit
    - Due to the minimal DRB staff believes that the existing language used for this is sufficient as it currently is.
- Next Steps:

- Staff are ready to bring this to the full board to ask for a resolution to update the plan for 2023. Staff would like to have this conversation with the full board in September.
    - Cammy requested that the proposal package be sent to the board as early as possible to allow them time to fully read through the proposal.
    - It was requested that a list be included of precertification requirements and facilities that Aetna currently has under network for the 3 gene therapies.
- As this topic is evolving, the board will hear reports from staff at quarterly meetings. As technology evolves, DRB should continue making periodic changes every 5 years to prioritize what is best for members at the current time.

Item 4. Public Comment

Before beginning public comment, the Chair established who was present on the phone or online, and who intended to provide public comments, and reiterated reminders about these comments being part of the public record, and that commenters cannot share protected health information (PHI).

- **Wendy Woolf, RPEA**. Wendy noted that implementation of OptumRx Medical Benefit Specialty Vigilant Drug Program List in the proposal seems is the list is moving from the pharmacy to the medical plan, therefore being subject to the lifetime maximum. However, only 3 are excluded. Wendy asked DRB to consider having all 20 drugs in the exclusion of the lifetime maximum.

Chair Taylor reminded everyone that public comments can also be submitted in writing.

Item 5. Closing Thoughts + Meeting Adjournment

Upcoming meetings:

- The Modernization Subcommittee meets Thursday, September 8, 2022, 9 a.m. to 12 p.m.
- The next Retiree Health Plan Advisory Board quarterly meeting was rescheduled from Thursday, August 4 and is now Thursday, September 27, 2022.

1. **Motion** by Nan Thompson to adjourn the meeting. **Second** by Mauri Long.
    - **Result**: No objection to adjournment. The meeting was adjourned at 11:32 a.m.

AlaskaCare Retiree Dental, Vision, and Audio (DVA) Plan

2023 Dental Benefit Enrollment Guide

The Division of Retirement and Benefits will host a retiree DVA plan open enrollment period from October 12, through November 23, 2022.

You can choose the plan that works best for you and your family for the upcoming 2023 benefit year.

We want you to make an informed decision and choose the option that best meets your needs.

This enrollment guide contains information about your choices, and instructions for participating in open enrollment. It is designed to answer questions about your options and how to enroll.

Open enrollment is a four-step process:

1. **Learn:** Learn about the open enrollment process
2. **Verify:** Verify your eligibility to participate in open enrollment
3. **Compare:** Compare your options for dental benefits in the DVA plans
4. **Enroll:** Enroll in the plan of your choice

AlaskaCare Retiree Health Plan

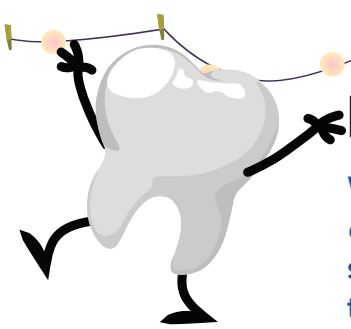
- **October 12, 2022**
  Open Enrollment Begins
- **November 23, 2022**
  Open Enrollment Ends
- **January 1, 2023**
  New Benefit Elections Take Effect

Dental, Vision, and Audio Open Enrollment Period

October 12 through November 23, 2022

Find the online enrollment form at **AlaskaCare.gov/DVA**

For more information about the DVA plan, to view the FAQs, or to sign up for the AlaskaCare Retiree e-newsletter visit **AlaskaCare.gov/DVA**



Frequently Asked Questions

What are some of the *differences* between the standard plan benefits and the legacy plan benefits?

Standard Plan

- Features access to Delta Dental's wide Premier network of providers, as well as access to an additional PPO network that saves you even more money when you use a PPO dentist. Better prices mean you can receive coverage for more services before you reach your annual benefit maximum.
- Supports evidence-based coverage limitations, including those developed by the American Dental Association, such as frequency and age limitations for exams, cleanings, and periodontal maintenance.
- Pays less if you visit an out-of-network dentist.

Legacy Plan

- Does not have pre-determined frequency or age limitations on most services.
- Features access to Delta Dental's wide Premier network of providers that save you money when you use a network dentist.
- Pays out-of-network dentists at a higher rate.

What are some of the *similarities* between the standard plan benefits and the legacy plan benefits?

- Both plans have the same annual benefit maximum: $2,000.
- Both plans provide coverage for dental preventive, restorative, and prosthetic services.
- Both plans have the same coinsurance levels:
  - Class I (Preventive): 100%
  - Class II (Restorative): 80%
  - Class III (Prosthetic): 50%
- Both plans have the same annual deductible: $50 per individual (Class II and III Services).
- Both plans are fully funded by member premiums.
- Vision and audio benefits are the same.

Standard and Legacy Plan Premiums for 2023

Premiums are subject to change annually and can be found on the AlaskaCare website at ***drb.alaska.gov/retiree/healthplans.html#dvapremiums*** or by calling the AlaskaCare Member Service Center at (907) 465-4460.

If I have dental services scheduled before the end of the plan year, will this impact my benefits?

The benefit election you make during open enrollment will become effective January 1, 2023. This means that the coverage you have today will still apply through December 31, 2022, including any claims for services provided before the end of the plan year.

Can I change my plan next year?

You will be able to change your dental plan during the open enrollment period. Outside of the open enrollment period, you will not be able to make changes to your selections unless you have a qualifying life event or would like to decrease your coverage. You may decrease your coverage at any time by contacting the Division.

Do I need to participate in the DVA Open Enrollment?

We encourage all eligible AlaskaCare retirees to review the plan options and participate in open enrollment. If you do not participate in Open Enrollment, your benefit selections will not change from what you have now.

For information about the 2023 Retiree DVA plan monthly premiums, please visit

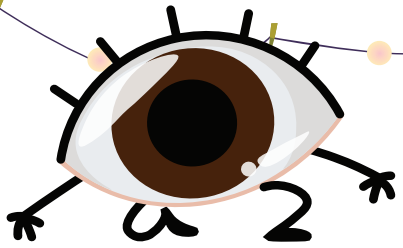
drb.alaska.gov/retiree/healthplans.html#dvapremiums

I am currently enrolled in the DVA plan with coverage for myself and my dependent spouse. Can I choose the legacy plan, and can my spouse choose the standard plan?

No, a retiree may only select one plan for themselves and any covered dependents. However, if you and your spouse each have a separate AlaskaCare DVA policy, you may select different plans and cover each other as dependents.

Can I see any dentist?

Yes, both the standard plan and the legacy plan let you see any licensed dentist you want. Both plans give you access to the wide Premier network of dental providers that will save you money. If you choose the legacy plan and see an out-of-network provider, the plan will cover a greater portion of the charges so you may pay less for out-of-network services. If you choose the standard plan, you have access to an additional PPO network of providers that offer deeper discounts, saving you more money, but you may pay more if you use out-of-network dentists.



Remember, if you use an out-of-network dentist, you may receive additional bills for charges that the plan will not cover.

Will I get a new ID card?

If you change your elections for 2023, you will receive a new ID card in the mail in late December. If you do not make any changes, you will not receive a new ID card.

Some dental procedures fall into different service classes, depending on which plan you elect. If you would like to know how a specific service would be covered under each plan, call Delta Dental of Alaska at (855) 718-1768.

Please consult the AlaskaCare Retiree DVA Plan: 2023 Dental Benefit Comparison for more details about the differences between the plans. The AlaskaCare Retiree Insurance Information Booklets will contain the complete benefit provisions for both the standard and legacy dental plans.

Key Terms

Deductible
The amount you pay each benefit year before a portion of your costs are paid by the dental plan. The deductible for both the standard and legacy retiree dental plans is $50 for class II and III services.

Coinsurance
The percent of covered expenses paid by AlaskaCare once you meet your deductible. Coinsurance levels vary depending on the class of service.

Annual Benefit Maximum
The total amount that the plan will pay for dental services you receive during that benefit year. The annual maximum for both the standard and legacy retiree dental plans is $2,000.

Need More Information?

There are additional Frequently Asked Questions (FAQ) on our website. You can find answers to questions retirees have asked. Check our FAQ page often, new questions are added regularly!

AlaskaCare.gov/DVA

Send us an email at **doa.drb.benefits@alaska.gov** or call us toll-free at (800) 821-2251 or in Juneau at (907) 465-4460.

Ready to Enroll?

Find the Online Enrollment form at AlaskaCare.gov/DVA

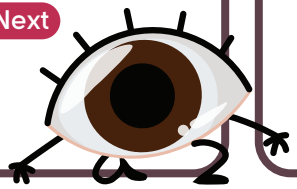
You can make elections 24 hours a day, 7 days a week from **October 12 through November 23, 2022**, closing at 5 p.m. Alaska Time.

Online Enrollment Instructions

- **Open your web browser and navigate to AlaskaCare.gov/DVA**
- Click on the enrollment link: **"Ready to Enroll? Click Here!"** You will be taken to the Retiree DVA Plan Open Enrollment online form.
- The online enrollment form is completed in four easy steps. Click on Get Started to begin!

Step 1. *Learn*

Open enrollment begins with important reminders about your plan options, eligibility information, and where to find answers if you have questions. After reviewing the information, click the Next button to move on.



Step 2. *Verify*

You will be prompted to enter information to verify that you are eligible to enroll. Enter the information and click on Check Eligibility.

- If your eligibility was confirmed, you will see the message **Eligibility Verified!** Confirm or update your contact information and click the Next button.
- If your eligibility was not confirmed, you will see the message **Unable to Verify.**
- *If the system is unable to verify your identity, please contact the Division at (800) 821-2251 or (907) 465-4460 in Juneau as soon as possible so we can help.*

Step 3. *Compare*

Review the monthly premium rates, the benefit comparison table, and your plan booklet to decide which plan is best for you. After reviewing the information, click the Next button to move on.

Step 4. *Enroll*

Make your plan election, choose your coverage level, and click Enroll.

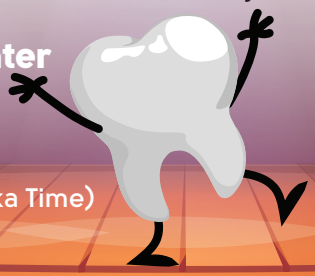
- Please print the confirmation page for your records.

- If you need to update your dependent information, complete the Retiree Health Dependent Change Form provided on this page and submit it to the Division of Retirement and Benefits.
- If you click on the Exit to AlaskaCare webpage button, you will close the enrollment site. Congratulations! You have successfully completed your AlaskaCare DVA open enrollment!
- You may change your plan election at any time during the open enrollment period by filling out the online enrollment form. The last election you make before open enrollment closes will determine your plan election for the 2023 benefit year.

If you need assistance to complete your enrollment, or if you need a paper enrollment form, contact:

AlaskaCare Member Service Center

Juneau: (907) 465-4460
Outside Juneau, toll-free: (800) 821-2251
Email: **doa.drb.benefits@alaska.gov**
Monday - Thursday, 8:30 a.m. to 4 p.m. (Alaska Time)
Friday, 8:30 a.m. to 3 p.m. (Alaska Time)



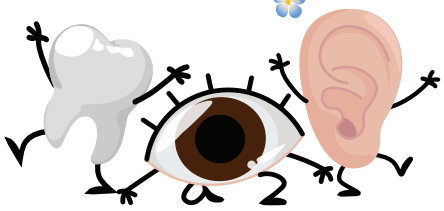
If you have questions about how a specific service would be covered under each plan, contact **Delta Dental of Alaska at (855) 718-1 768**

AlaskaCare Retiree Dental, Vision, and Audio Plan

2023 Dental Benefit Comparison

AlaskaCare retiree Dental-Vision-Audio (DVA) plan members have a choice between the Standard Dental Plan and the Legacy Dental Plan for the 2023 benefit year. You can choose the plan that works best for you and your family.

This comparison provides an overview of the two plans and highlights some, but not all, of the benefit provisions. For complete coverage details, please consult the plan booklets available at AlaskaCare.gov.



For information about the 2023 Retiree DVA plan monthly premiums, please visit:

drb.alaska.gov/retiree/healthplans.html#dvapremiums

Plan Structure, Annual Deductible, Coinsurance, and Maximum Benefit		
	Standard Plan	**Legacy Plan**
Covered household member options	Retiree only Retiree and spouse Retiree and child(ren) Retiree and family	Retiree only Retiree and spouse Retiree and child(ren) Retiree and family
Plan funding	100% funded by member-paid premiums.	100% funded by member-paid premiums.
Annual deductible	$50 per individual. Applies to class II (restorative) and class III (prosthetic) services.	$50 per individual. Applies to class II (restorative) and class III (prosthetic) services
Coinsurance	Class I (preventive): 100% Class II (restorative): 80% Class III (prosthetic): 50%	Class I (preventive): 100% Class II (restorative): 80% Class III (prosthetic): 50%
Annual individual benefit maximum	Plan will pay up to $2,000 for dental services each benefit year.	Plan will pay up to $2,000 for dental services each benefit year.

Network Provisions		
	Standard Plan	**Legacy Plan**
Access to Delta Dental's broad Premier network of dental providers	Yes	Yes
Access to an additional exclusive dental network, Delta Dental's PPO network, with deeper discounts for the same services	Yes	No
Recognized charge: In-Network	Lesser of 100% of negotiated fees, billed charges, or covered expense.	Lesser of 100% of negotiated fees, billed charges, or covered expense.
Recognized charge: Out-of-Network	75% of the 80th percentile; members may be billed for additional charges. You can find examples of the cost of services under each plan at ***drb.alaska.gov/events/dvaenrollment.html***	100% of the 90th percentile; members may be billed for additional charges. You can find examples of the cost of services under each plan at ***drb.alaska.gov/events/dvaenrollment.html***

Dental Necessity Requirements		
	Standard Plan	**Legacy Plan**
To be eligible for coverage, dental services and supplies must meet these dental necessity requirements and be a covered service or supply under the plan.	The Retiree Standard Dental Plan covers dental services and supplies when performed by a dentist or dental care provider and when determined to be dentally necessary.	The Retiree Legacy Dental Plan does not provide benefits for dental services or supplies that are not necessary for diagnosis or treatment of dental condition as determined by the claims administrator even if prescribed, recommended, or approved by a dental professional.

This document is to supplement, but not replace, the information in the AlaskaCare plan documents. Should there be a conflict between this document and the relevant plan document, the plan document prevails.

Covered Dental Services: Class I - Preventive		
	Standard Plan	**Legacy Plan**
Diagnostic		
Oral exam	Covered two times per benefit year.	Covered
Complete series x-rays/panoramic	Covered once every five years.	Covered if required for diagnosis; not more than one full mouth or series per year.
Bitewing x-rays	Covered once per benefit year.	Covered
Diagnostic casts & study models	Not covered	Covered
Preventive		
Cleanings (prophylaxis)	Covered two times per benefit year; additional cleanings available for persons with diabetes, periodontal disease, or in last trimester of pregnancy. Other exceptions allowed.	Covered
Periodontal maintenance	Covered as a class I service at 100% and no deductible. Two times per benefit year; additional cleanings available for persons with diabetes, periodontal disease, or in last trimester of pregnancy. Other exceptions allowed.	Covered as a class II service at 80% and $50 deductible.
Topical fluoride: 18 years or younger	Covered two times per benefit year.	Covered
Topical fluoride: 19 years or older	Covered two times per benefit year if recent periodontal surgery or high risk of decay due to chemotherapy or medical disease.	Covered
Sealants: 18 years or younger	Covered once every five years with tooth limitations.	Covered
Sealants: 19 years or older	Covered once every five years with tooth limitations.	Not Covered
Space maintainers	Covered for 14 years and younger, once per tooth space with tooth limitations.	Covered as a class II service at 80% and $50 deductible.

Covered Dental Services: Class II - Restorative		
	Standard Plan	**Legacy Plan**
Restorative		
Fillings	Covered	Covered
Inlays	Covered, considered an optional service. Alternate benefit of composite filling. Covered as a class II service at 80% and $50 deductible.	Covered as a class III service at 50% and $50 deductible.
Crown buildups	Covered as a class II service at 80% and $50 deductible if necessary for tooth retention.	Covered as a class III service at 50% and $50 deductible.
Oral Surgery		
Extractions (including surgical)	Covered	Covered
Alveoplasty (procedure to smoothen or re-shape jaw bone)	Covered when performed as part of other covered service. Not covered as a separate charge.	Covered
Brush Biopsy	Covered two times per benefit year.	Covered
Endodontic		
Root canal & treatment	Covered; retreatment not covered for same tooth by same dentist within 24 months. Initial service should include retreatment within this timeframe if necessary.	Covered
Pulpal therapy (pulp capping)	Covered when pulp is exposed.	Covered

Covered Dental Services: Class II - Restorative Continued		
	Standard Plan	Legacy Plan
Periodontics		
Gum disease and supporting tissue treatment	Covered	Covered
Periodontal maintenance	Covered as a class I service, 100% and no deductible. Two per benefit year; additional cleanings available for persons with diabetes, periodontal disease, or in last trimester of pregnancy. Other exceptions allowed.	Covered as a class II service at 80% and $50 deductible.
Periodontal scaling & root planing	Once per quadrant in any two-year period.	Covered
Periodontal splinting	Not Covered	Covered
Full mouth debridement	Covered once in a three-year period if no cleaning (prophylaxis) occurred within preceding 24 months.	Covered
Anesthesia		
Nitrous Oxide	Covered	Covered
General anesthesia / IV sedation	Covered for surgical procedures only or if needed due to a medical condition.	Covered
Other		
Palliative care	Covered	Covered
Apicoectomy (surgical removal of root tip)	Covered	Covered
Denture repair	Covered as a class III service, 50% coverage and $50 deductible	Covered
Denture reline	Covered as a class III service, 50% coverage and $50 deductible	Covered
Denture adjustments	Covered as a class III service, 50% coverage and $50 deductible	Covered
Tissue conditioning	Covered as a class III service, 50% coverage and $50 deductible	Covered

Covered Dental Services: Class III - Prosthetic		
	Standard Plan	Legacy Plan
Restorative		
Crowns (cast restoration)	Covered once in seven-year period on any tooth.	Covered
Onlays (cast restoration)	Covered once in seven-year period on any tooth.	Covered
Lab veneers (cast restoration)	Covered once in seven-year period on any tooth.	Covered
Crown buildups	Covered as a class II service at 80% and $50 deductible if necessary for tooth retention.	Covered as a class III service at 50% and $50 deductible.
Inlays	Covered, considered an optional service. Alternate benefit of composite filling. Covered as a class II service at 80% and $50 deductible.	Covered as a class III service at 50% and $50 deductible.
Porcelain restorations	Covered for visible teeth. Coverage limited to cost of metallic prosthetic if placed on upper second or third molars or lower first, second, or third molars.	Not covered if tooth can be restored with amalgam (metallic) filling. Coverage limited to appropriate charges for amalgam or similar material.

Covered Dental Services: Class III - Prosthetic Continued		
	Standard Plan	**Legacy Plan**
Prosthodontic		
Bridges	Covered once in seven-year period if tooth, tooth site, or teeth have not received a cast restoration benefit in last seven years.	Covered
Dentures full & partial	Covered once in seven-year period if tooth, tooth site, or teeth have not received a cast restoration benefit in last seven years.	Covered once every five years if previous dentures cannot be made serviceable or if previous denture was temporary and installed within previous 12 months.
Dentures temporary	Partial denture covered if placed within two months of anterior tooth extraction. Additional limitations may apply.	Covered
Denture adjustment	Covered twice in 12-month period, unless received within first six months of initial placement (this is included in the initial placement charge).	Covered as a class II service, 80% coverage and $50 deductible.
Denture repairs	Covered unless received within first six months of initial placement (this is included in the initial placement charge).	Covered as a class II service, 80% coverage and $50 deductible.
Denture reline	Covered once in 12-month period, unless received within first six months of initial placement (this is included in the initial placement charge).	Covered as a class II service, 80% coverage and $50 deductible.
Tissue conditioning	Covered twice per denture in a 36-month period.	Covered as a class II service, 80% coverage and $50 deductible.
Implants	Covered. Limited to once per lifetime per tooth space. Some implant charges may be eligible for coverage under medical plan. Associated cast restoration over implant and other implant related procedures are covered as a Class III prosthetic service.	No coverage for implants under dental plan. Some implant charges may be eligible for coverage under medical plan. Associated cast restoration over implant and other implant related procedures are covered as a Class III prosthetic service.
Other		
Athletic mouthguards	Covered once per year if 15 or younger; covered once every two years if 16 or older.	Not covered

Other Services and Benefits		
	Standard Plan	**Legacy Plan**
Orthodontics	Orthodontic services are not covered in the AlaskaCare Dental Plan.	Orthodontic services are not covered in the AlaskaCare Dental Plan.
Vision Benefits	No changes to plan benefits.	No changes to plan benefits.
Audio Benefits	No changes to plan benefits.	No changes to plan benefits.

For information about dental benefits or questions about how specific services may be covered under each plan, contact Delta Dental of Alaska toll-free at (855) 718-1768.

You can find examples of the cost of services under each plan when you visit a network or out-of-network provider at ***drb.alaska.gov/events/openenrollment.html***.

For information about Vision and Audio benefits, contact Aetna Concierge toll-free at (855) 784-8646.

Contact the AlaskaCare Member Service Center

Juneau: (907) 465-4460
Toll-free, Outside Juneau: (800) 821-2251
E-mail: **doa.drb.benefits@alaska.gov**

P.O. Box 110203, Juneau, AK 99811-0203

Monday - Thursday, 8:30 a.m. to 4 p.m.
Friday, 8:30 a.m. to 3 p.m. (Alaska Time)

Proposal Title	GCIT Network Benefits
Health Plan Affected	AlaskaCare Retiree Health Plan
Proposed Effective Date	January 1, 2023
Reviewed By	Retiree Health Plan Advisory Board
Review Date	September 27, 2022

Contents

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 products are distinct in that they are highly specific, engineered using genetic material, and may require harvesting the patient's cells (or a donor cell population) to be modified in a laboratory setting before being used to treat the patient.

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 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.

In limited circumstances, some plans may cover portions of GCIT therapies under both medical and pharmacy plans. However, these treatments are typically complex to administer, requiring specialized equipment, clinical expertise, and specific facility capabilities. Because of these requirements, GCIT therapies are most commonly and appropriately billed through medical plans.

The AlaskaCare Plan currently includes an individual lifetime medical benefit maximum of $2 million.[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. AlaskaCare has experienced claims for Zolgensma (approximately $2.1 million per dose) and for Spinraza (approximately $128,000 per dose, 3-6 doses per year). 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 Designated 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.

[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

3) Summary of Proposed Changes

Aetna's GCIT Designated Network

The proposed change ensures eligible therapies are covered through providers participating in Aetna's GCIT Designated Network. These providers have been manufacturer-approved to administer the drugs and have agreed to contractual pricing terms for the therapies. Members receiving GCIT services from a designated 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.

Aetna's GCIT Governance Committee, consisting of representatives from pharmacy, clinical, operational, finance, actuary, legal, network, and product areas, reviews FDA pipeline therapies to determine appropriate classification for inclusion in the GCIT Designated Network program. All drugs in the FDA pipeline are reviewed and identified as GCIT (or not) in advance of FDA approval. The first three GCIT services to be included in the GCIT Designated Network benefit were selected due to cost and administration criteria. Aetna is in the process of identifying criteria for including other GCIT products into the network benefit. Before any additional GCIT products are included in the benefit, appropriate notification will be provided.

Once a therapy has been identified for inclusion in the GCIT Designated Network benefit, Aetna begins contracting conversations with providers that are identified through information provided by the drug manufacturers or through prior authorization requests. Aetna's criteria for provider participation in the GCIT Designated Network is that they are approved by the manufacturer, they become Aetna credentialed, and that they are willing to execute an Aetna GCIT-specific agreement.

Steering utilization to manufacturer-approved providers helps to ensure that member receive GCIT services from providers that have the right skills and capabilities to safely administer these therapies. Given that GCIT services are highly specialized, most manufacturers will certify centers where their product can be administered safely. Some GCIT products require personalization and specialist care available at a select few sites around the country. GCIT product manufacturers provide on-site training and technical assistance with machine use and calibration where applicable. They also confirm that the facility can handle and store the specific GCIT product in accordance with their guidelines (*e.g.*, proper sterilization techniques or cold storage levels).

Because this area of medicine is relatively new, there are not currently any independent GCIT accrediting organizations. As the industry grows, a more formalized accrediting organization may develop.

Plan Coverage for GCIT Services

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 would clarify that these products are covered under the medical plan, rather than the pharmacy plan. This would align with the current plan language, emerging industry standards, and ensure members are accessing these benefits through a coordinated approach.

This proposal also contemplates excluding the cost of GCIT drugs or products included in the GCIT Designated Network program from accumulating toward a member's lifetime maximum benefit. This exclusion would only apply to the cost of the drug or product and would not apply to the cost of any associated travel expenses or other medical expenses. These other associated expenses (provider, facility, and travel charges) are currently billed through the medical plan and would remain so. GCIT products obtained through the medical benefit that are not part of the GCIT Designated Network program would continue to accrue towards a member's lifetime maximum benefit, as they do today.

To clarify coverage of GCIT services between the medical and pharmacy plans, this proposal contemplates implementing the Pharmacy Benefit Manager's (OptumRx) Medical Benefit Specialty Vigilant Drug Program Exclusion List. This list includes approximately 20 specialty products that meet the following criteria:

1. Designated as an orphan drug[2] and/or exhibits Gene Therapy technology;
2. Annual drug cost is over $500,000;
3. Is **not** self-administered; and
4. The first dose may be administered in an inpatient setting.

Some of the drugs on the Medical Benefit Specialty Vigilant Drug list are Medicare Part D-covered drugs.[3] Medicare Part D-covered drugs cannot be excluded from coverage for group Medicare Part D plans, such as the AlaskaCare enhanced Employer Group Waiver Plan (EGWP). As a result, the Medicare Part D-covered drugs on the OptumRx Medical Benefit Specialty Vigilant Drug list will continue to be covered under both the pharmacy and medical plans for members who participate in the AlaskaCare enhanced EGWP prescription drug plan.

Drugs appearing on the Medical Benefit Specialty Vigilant Drug list would be covered through the medical benefit (as they are today), rather than the pharmacy benefit. As new products enter the market, this list may evolve and be updated over time.[4]

4) Impacts

Member Impact | Minimal

The Retiree Plan has experienced fewer than five claims for the therapies included in the GCIT Designated Network program across all plans. Out of all drugs currently listed on OptumRx's Medical Benefit Specialty Vigilant Drug Program Exclusion List, only one member is utilizing one drug. Current utilizers of any impacted GCIT services on both the medical and pharmacy plan would be able to continue their

[2] Orphan Drug: A drug or a biological product that prevents, diagnoses, or treats a rare disease or condition. *Designating an Orphan Product: Drugs and Biological Products.* U.S. Food & Drug Administration. https://www.fda.gov/industry/developing-products-rare-diseases-conditions/designating-orphan-product-drugs-and-biological-products

[3] As of September 2022, these drugs are Exondys 51, Givlaari, Krystexxa, Provenge, Spinraza, Viltepso, and Vyondys 53.

[4] See the attached "OptumRx Medical Benefit Specialty Vigilant Drug Program List" for a current list of products.

current course of treatment, and 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. This includes the additional benefit of travel support beyond what is provided for in the current plan should a member require travel outside of their community to receive treatment.

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.

The FDA has approved administration of these therapies in very limited circumstances. Many patients who qualify to receive GCIT therapies have underlying genetic defects and therefore may be experiencing many medical needs. Even so, most patients are able to travel to a facility where it is safe and cost-effective to administer the therapy. If patient travel is not possible, Aetna's GCIT Network program team will work with the member and the facility where the patient is admitted to secure an exception so that the appropriate care may be delivered at network rates.

Currently there are no facilities or providers in Alaska participating in Aetna's GCIT network, meaning it is likely members residing in Alaska will travel to receive care.[5] While the manufacturer-approved list of facilities that can administer GCIT services does not perfectly align with Aetna's provider network, there is a great deal of overlap. As of May 2022:

- of the 14 facilities approved by the manufacturer to administer Luxturna, 10 are Aetna GCIT-designated;
- of the 127 facilities approved by the manufacturer to administer Zolgensma, 48 are Aetna GCIT-designated; and
- the manufacturer does not provide a full listing of facilities approved to administer Spinraza, however 43 of the approved facilities are Aetna GCIT-designated.

Aetna works closely with their network facilities approved to administer GCIT services to negotiated specific discounts. To further support members who need to travel to receive care, the GCIT Network program covers travel costs beyond those typically available, providing important financial support for members.

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. Single case rate negotiations are initiated when a pre-authorization request is submitted to Aetna for a GCIT product to be administered at a facility that is not part of the GCIT Network. When this occurs, Aetna reaches out to the facility to discuss capabilities and options. Whenever possible and appropriate, Aetna will continue to pursue negotiation of single case agreements in Alaska.

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

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 or the Medical Benefit Specialty Vigilant Drug Program Exclusion List.

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.

Use of Aetna's 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 to treat children less than two years of age with spinal muscular atrophy.[6]
- One time infusion.
- Infusions administered sooner (closer to birth) have better outcomes.
- 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.[7]
- Only available at a few sites across the country.
- A pre-treatment visit is required, including a treatment and examination. After the product is administered (one dose per eye), the patient must return within a specified time frame for a post-dose visit.
- AWP: $510,000 per dose; $1.02 million total
- Average savings: $170,000

Spinraza

- Approved by the FDA for children and adults with spinal muscular atrophy.[8]
- Administered via four initial loading doses over a 60-day period, and then one dose every four months for life or as long as a benefit from the product is demonstrated. Six doses are

[6] https://www.fda.gov/news-events/press-announcements/fda-approves-innovative-gene-therapy-treat-pediatric-patients-spinal-muscular-atrophy-rare-disease

[7] https://www.fda.gov/news-events/press-announcements/fda-approves-novel-gene-therapy-treat-patients-rare-form-inherited-vision-loss#:~:text=The%20U.S.%20Food%20and%20Drug,that%20may%20result%20in%20blindness.

[8] https://www.fda.gov/news-events/press-announcements/fda-approves-first-drug-spinal-muscular-atrophy

administered in the first 12 months of treatment, followed by three doses in each 12-month period thereafter.
- AWP: $153,000 per dose
- Average savings: $100,000

Actuarial Impact to AlaskaCare| Neutral

The proposed change is an administrative change that does not change coverage or limit access to necessary care, and as such would not have an actuarial impact on the Plan.[9]

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.

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.

The initial impact to the Pharmacy Benefit Manager (PBM), OptumRx, is anticipated to be minimal, primarily because OptumRx already administers the Medical Benefit Specialty Vigilant Drug Program Exclusion List for their fully-insured book of business and for other self-insured customers who elect to participate:

- OptumRx will update, code, and test their system to ensure that the changes associated with the program have been properly loaded.

[9] Segal Consulting Memorandum forthcoming.

- OptumRx will ensure that their customer service staff are aware of the change and can properly communicate about and articulate specifics of the change to members.
- OptumRx will ensure continuity of care for any currently utilizing members.

After implementation, the ongoing operational impacts are anticipated to be minimal and will include regular updates to the list of drugs impacted.

5) Considerations

Clinical and Provider Considerations

Ensures patients receive GCIT benefits in facilities committed to cost and quality management. A dedicated clinical team guides the members through the process, from 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	6/23/2022, 7/20/2022, 9/02/2022
Reviewed by RHPAB	11/01/2021, 02/10/2022, 05/05/2022, 09/27/2022

OptumRx Medical Benefit Specialty Vigilant Drug Program List

September 2022

Drug	Indication*	Medicare+	Aetna
ABECMA	Treatment of adult patients with relapsed or refractory multiple myeloma		Y
AMONDYS	Treatment of Duchenne muscular dystrophy (DMD)		Y
BREYANZI	Treatment of adult patients with large B-cell lymphoma		Y
BRINEURA	Treatment for a specific form of Batten disease; approved to slow loss of walking ability in symptomatic pediatric patients three years of age and older		Y
CARVYKTI	Treatment of adult patients with relapsed or refractory multiple myeloma		Y
ELZONRIS	Treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults and in pediatric patients, two years of age and older		Y
EXONDYS 51	Treatment of Duchenne muscular dystrophy (DMD)	Part D	Y
GIVLAARI	Treatment of adult patients with acute hepatic porphyria, a genetic disorder resulting in the buildup of toxic porphyrin molecules which are formed during the production of heme (which helps bind oxygen in the blood)	Part D	Y
IMLYGIC	Local treatment of unresectable cutaneous, subcutaneous, and nodal lesions in patients with melanoma recurrent after initial surgery		Y
KRYSTEXXA	Treatment of chronic gout in adult patients refractory to conventional therapy	Part D	Y
KYMRIAH	Treatment of adult patients with relapsed or refractory follicular lymphoma after two or more lines of therapy	Part B	Y
LUXTURNA	Treatment of patients with confirmed biallelic RPE65 mutation-associated retinal dystrophy	Part B	Y
PROVENGE	Treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer	Part B Part D	Y
RETHYMIC	Immune reconstitution in pediatric patients with congenital athymia		Y
SPINRAZA	Treatment of children and adults with spinal muscular atrophy (SMA)	Part B Part D	Y
TECARTUS	Treatment of adult patients with relapsed or refractory mantle cell lymphoma (MCL); adult patients with relapsed or refractory (r/r) B-cell precursor acute lymphoblastic leukemia (ALL)		Y
VILTEPSO	Treatment of Duchenne muscular dystrophy (DMD)	Part D	Y
VYONDYS 53	Treatment of Duchenne muscular dystrophy (DMD)	Part D	Y
YESCARTA	Treatment of adult patients with large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy.	Part B	Y
ZOLGENSMA	Treatment of Spinal Muscular Atrophy (Type I)		Y

**Indications summarized from www.FDA.gov*

Medicare Part D coverage summarized by OptumRx, Part B as described in the Medicare Coverage Database: https:A21//www.cms.gov/medicare-coverage-database/search.aspx

--Actual Medicare coverage may differ--Call 1-800-MEDICARE for coverage information

Aetna Institutes ™ Gene Based, Cellular and Other Innovative Therapy (GCIT™) Designated Centers

Gene Based, Cellular and Other Innovative Therapy (GCIT) services are gene-based, cellular and/or innovative therapies that have a basis in genetic/molecular medicine. GCIT products and services, as determined by Aetna, are FDA approved therapies that have the potential to cure previously untreatable, often fatal, conditions.

All GCIT services will be authorized in accordance with Aetna's Drug Infusion Site of Care Policy and with the Aetna Member's specific benefit plan. Preauthorization is required for coverage to be effective for all GCIT services.

Providers that offer GCIT services and have met our criteria are designated to participate in the Aetna Institutes™ GCIT designated network ("Designated GCIT Providers"). Designated GCIT Providers have demonstrated a commitment to providing value for our members.

For the following GCIT therapies, Designated GCIT Providers are listed below:

Luxturna (Voretigene Neparvovec-rzyl):

Provider Name	City	State	Zip	Phone
Children's Hospital Los Angeles	Los Angeles	CA	90027	(323) 361-2347
University of Iowa Hospital and Clinics	Iowa City	IA	52242	(319) 356-1616
Massachusetts Eye and Ear Infirmary	Boston	MA	02114	(617) 523-7900
University of Michigan - Kellogg Eye Center	Ann Arbor	MI	48109	(877) 475-6688
Cincinnati Children's Hospital & Medical Center	Cincinnati	OH	45229	(513) 636-4200
Oregon Health & Sciences University Hospital - Casey Eye Institute	Portland	OR	97239	(503) 494-8311
Children's Hospital of Philadelphia	Philadelphia	PA	19104	(800) 879-2467
Penn Presbyterian Medical Center (Scheie Eye Institute)	Philadelphia	PA	19104	(215) 662-8000
St. Luke's Health Baylor College of Medicine Medical Center	Houston	TX	77030	(713) 785-8537

Spinraza (Nusinersen):

Provider Name	City	State	Zip	Phone
Banner University Medical Center Tucson Campus	Tucson	AZ	85719	(520) 694-0111
Banner University Medical Center Phoenix Campus	Phoenix	AZ	85006	(602) 839-2000
Diamond Children's Hospital, part of Banner University Tucson Campus	Tucson	AZ	85719	(520) 694-5437
Children's Hospital Los Angeles	Los Angeles	CA	90027	(323) 361-2347
Lucile Packard Children's Hospital	Palo Alto	CA	94304	(650) 497-8000
Rady Children's Hospital San Diego	San Diego	CA	92123	(858) 576-1700
Stanford Medical Center	Stanford	CA	94305	(650) 723-4000
Children's Hospital Colorado	Aurora	CO	80045	(720) 777-0123
Connecticut Children's Medical Center	Farmington	CT	06032	(860) 545-9000
Children's National Medical Center	Washington	DC	20010	(888) 884-2327
MedStar Georgetown University Hospital	Washington	DC	20007	(202) 444-2000
Nemours Children's Hospital Delaware	Wilmington	DE	19803	(302) 651-4000
Joe DiMaggio Children's Hospital	Hollywood	FL	33021	(954) 265-5324
Nemours Children's Hospital	Orlando	FL	32827	(407) 567-4000
Nicklaus Children's Hospital	Miami	FL	33155	(305) 666-6511
St. Josephs Woman's Hospital (Baycare)	Tampa	FL	33607	(813) 879-4730
Memorial Regional Hospital	Hollywood	FL	33021	(954) 966-4500
Children's Healthcare Of Atlanta – Scottish Rite Hospital/Egleston Children's Hospital	Atlanta	GA	30342	(404) 785-1285
University of Iowa Hospital and Clinics	Iowa City	IA	52242	(319) 356-1616
Ann and Robert H Lurie Children's Hospital of Chicago	Chicago	IL	60611	(312) 227-4000
University of Kansas Medical Center	Kansas City	KS	66160	(913) 588-1227
Boston Children's Hospital	Boston	MA	02115	(617) 355-6000
Children's Hospital of Michigan	Detroit	MI	48201	(313) 745-KIDS
Children's Hospital of Michigan	Grand Blanc	MI	48439	(313) 745-KIDS
University Of Michigan Medical Center	Ann Arbor	MI	48109	(734) 936-6641
C S Mott Children's Hospital	Ann Arbor	MI	48109	(877) 475-6688
Gillette Children's Specialty Healthcare	Saint Paul	MN	55101	(651) 291-2848

Provider Name	City	State	Zip	Phone
The Children's Mercy Hospital	Kansas City	MO	64108	(816) 234-3000
Children's Hospital and Medical Center	Omaha	NE	68114	(402) 955-5400
Goryeb Children's Hospital at Morristown Medical Center	Morristown	NJ	07960	(973) 971-5200
Cincinnati Children's Hospital and Medical Center	Cincinnati	OH	45229	(513) 636-4200
Nationwide Children's Hospital	Columbus	OH	43205	(614) 722-2000
Ohio State University – Arthur James Cancer Center	Columbus	OH	43210	(614) 293-3300
The Children's Hospital at Oklahoma University Medical Center	Oklahoma City	OK	73104	(405) 271-5437
Oregon Health & Sciences University Hospital – Doernbecher Children's	Portland	OR	97239	(503) 494-8311
Children's Hospital of Philadelphia	Philadelphia	PA	19104	(800) 879-2467
Milton Hershey Medical Center Pennsylvania State University	Hershey	PA	17033	(800) 243-1455
Hospital of The University of Pennsylvania Health System	Philadelphia	PA	19104	(800) 789-7366
Cook Children's Medical Center	Fort Worth	TX	76104	(682) 885-4000
Children's Medical Center of Dallas	Dallas	TX	75235	(214) 456-7000
Children's Hospital of The King's Daughters	Norfolk	VA	23507	(757) 668-7000
Seattle Children's Hospital	Seattle	WA	98105	(206) 987-2000
University of Wisconsin Hospital and Clinics	Madison	WI	53792	(608) 263-6400

Zolgensma (Onasemnogene abeparvovec-xioi):

Provider Name	City	State	Zip	Phone
Children's Hospital Los Angeles	Los Angeles	CA	90027	(323) 361-2347
Lucile Packard Children's Hospital	Palo Alto	CA	94304	(650) 497-8000
Rady Children's Hospital San Diego	San Diego	CA	92123	(858) 576-1700
Ronald Reagan UCLA Medical Center	Los Angeles	CA	90095	(310) 267-8000
Stanford Medical Center	Stanford	CA	94305	(650) 723-4000
Children's Hospital Colorado	Aurora	CO	80045	(720) 777-0123
Connecticut Children's Medical Center	Farmington	CT	06032	(860) 545-9000
Children's National Medical Center	Washington	DC	20010	(888) 884-2327
Nemours Children's Hospital Delaware	Wilmington	DE	19803	(302) 651-4000
Jackson Memorial Hospital	Miami	FL	33136	(305) 585-1111
Joe DiMaggio Children's Hospital	Hollywood	FL	33021	(954) 265-5324
Nemours Children's Hospital	Orlando	FL	32827	(407) 567-4000
Nicklaus Children's Hospital	Miami	FL	33155	(305) 666-6511
St. Josephs Woman's Hospital (Baycare)	Tampa	FL	33607	(813) 879-4730
Memorial Regional Hospital	Hollywood	FL	33021	(954) 966-4500
Children's Healthcare of Atlanta – Scottish Rite Hospital/Egleston Children's Hospital	Atlanta	GA	30342	(404) 785-1285
University of Iowa Hospital and Clinics	Iowa City	IA	52242	(319) 356-1616
Ann and Robert H Lurie Children's Hospital of Chicago	Chicago	IL	60611	(312) 227-4000
University of Kansas Medical Center	Kansas City	KS	66160	(913) 588-1227
University of Kentucky Hospital	Lexington	KY	40536	(859) 257-1000
Children's Hospital New Orleans	New Orleans	LA	70118	(504) 899-9511
Massachusetts General Brigham	Boston	MA	02114	(617) 726-2000
Boston Children's Hospital	Boston	MA	02115	(617) 355-6000
Children's Hospital of Michigan	Detroit	MI	48201	(313) 745-KIDS
Children's Hospital of Michigan	Grand Blanc	MI	48439	(313) 745-KIDS
University of Michigan Medical Center	Ann Arbor	MI	48109	(734) 936-6641
C S Mott Children's Hospital	Ann Arbor	MI	48109	(877) 475-6688
Gillette Children's Specialty Healthcare	Saint Paul	MN	55101	(651) 291-2848
The Children's Mercy Hospital	Kansas City	MO	64108	(816) 234-3000
Children's Hospital and Medical Center	Omaha	NE	68114	(402) 955-5400
Goryeb Children's Hospital at Morristown Medical Center	Morristown	NJ	07960	(973) 971-5200
Columbia University Medical Center	New York	NY	10032	(212) 305-2862

Provider Name	City	State	Zip	Phone
University of Rochester Medical Center Health System – Strong Memorial Hospital	Rochester	NY	14642	(585) 275-2182
Cincinnati Children's Hospital and Medical Center	Cincinnati	OH	45229	(513) 636-4200
Nationwide Children's Hospital	Columbus	OH	43205	(614) 722-2000
Akron Children's Hospital	Akron	OH	44308	(330) 543-1000
Integris Southwest Medical Center	Oklahoma City	OK	73109	(405) 636-7000
The Children's Hospital at Oklahoma University Medical Center	Oklahoma City	OK	73104	(405) 271-5437
Oregon Health & Sciences University Hospital - Doernbecher Children's	Portland	OR	97239	(503) 494-8311
Children's Hospital of Philadelphia	Philadelphia	PA	19104	(800) 879-2467
Milton Hershey Medical Center Pennsylvania State University	Hershey	PA	17033	(800) 243-1455
Cook Children's Medical Center	Fort Worth	TX	76104	(682) 885-4000
Texas Children's Hospital	Houston	TX	77030	(832) 824-1000
Children's Medical Center of Dallas	Dallas	TX	75235	(214) 456-7000
Children's Hospital of The King's Daughters	Norfolk	VA	23507	(757) 668-7000
Seattle Children's Hospital	Seattle	WA	98105	(206) 987-2000
University of Wisconsin Hospital and Clinics	Madison	WI	53792	(608) 263-6400

Your plan may include additional Designated GCIT Providers that are not listed above. Your health care provider can call Aetna to obtain information regarding Aetna's GCIT program and the requirements for becoming a Designated GCIT Provider.

Note: Some GCIT Designated Providers may not be part of your plan's network. Please confirm the provider is participating in your plan before obtaining services.

The following services are administered primarily in a home health setting and may be directed to a designated home health care provider, in accordance with Aetna's Drug Infusion Site of Care Policy and your specific benefit plan.

Amondys 45 (Casimersen)
Exondys 51 (Eteplirsen)
Viltepso (Viltolarsen)
Vyondys 53 (Golodirsen)

For the following other GCIT services, refer to Aetna.com and utilize the online provider search to find an Aetna provider in your area that participates in your plan. Not all providers offer GCIT services. Your health care provider can call Aetna to obtain information regarding Aetna's GCIT program and the requirements for becoming a Designated GCIT Provider.

Givlaari (Givosiran)
Imlygic (Talimogene Laherparepvec)
Onpattro (Patisiran)
Oxlumo (Lumasiran)

The lists of GCIT services above are subject to change.

Note: Some GCIT Designated Providers may not be part of your plan's network. Please confirm the provider is participating in your plan before obtaining services.

State of Alaska
RETIREE HEALTH PLAN ADVISORY BOARD
Related to the Removal of Penalties for Failure to Precertify Certain Services in the AlaskaCare Defined Benefit Retiree Health Plan

Resolution 2022-01

WHEREAS, the Retiree Health Plan Advisory Board (Board) is authorized by Administrative Order No. 336 to facilitate engagement and coordination between the State of Alaska's retirement systems' members, the Alaska Retirement Management Board, and the Commissioner of Administration regarding the administration of the retiree health plan; and

WHEREAS, the Alaska retiree health care trusts provide health coverage through the AlaskaCare Defined Benefit Retiree Health Plan (Plan) to retirees and their dependents; and

WHEREAS, Gene-based, Cellular, and other Innovative Therapies (GCIT) are a relatively new and rapidly advancing area of medical treatment that are intended to treat or cure previously untreatable or difficult to treat conditions; and

WHEREAS, GCIT therapies can range in cost from $600,000 to $2.5 million per course of treatment, and 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; and

WHEREAS, because these therapies are so new, charges for these services are not contemplated by many standard network agreements; and

WHEREAS, GCIT therapies are complex to administer, requiring specialized equipment, clinical expertise, and specific facility capabilities, and as a result GCIT therapies are most commonly and appropriately billed through medical plans; and

WHEREAS, the Plan's current Third-Party Administrator (TPA) offers a GCIT Designated Network program which provides price protection, specialized clinical support and care coordination, and additional travel benefits to members seeking GCIT services; and

WHEREAS, providers participating in the GCIT Designated Network program have been manufacturer-approved to administer the therapies and have agreed to contractual pricing terms; and

WHEREAS, the TPA operates a GCIT Governance Committee, consisting of representatives from pharmacy, clinical, operational, finance, actuary, legal, network, and product areas to review FDA pipeline therapies to determine appropriate classification for inclusion in the GCIT Designated Network program; and

WHEREAS, implementing limited pharmacy exclusions and updating the Plan language accordingly to clarify that GCIT therapies are covered under the medical plan, rather than the pharmacy plan, would align with emerging mainstream industry standards, and ensure members are accessing these services through a coordinated approach, and

WHEREAS, excluding the cost of GCIT drugs or products included in the GCIT Designated Network program from accumulating toward a member's lifetime maximum benefit would provide some financial protection to members seeking these services; and

WHEREAS, the Division of Retirement and Benefits (Division) has proposed to update the Plan's provisions related to GCIT services as outlined in detail in the GCIT Network Benefits Program Proposal presented to the Retiree Health Plan Advisory Board on September 27, 2022; and

WHEREAS, the Program Proposal has been evaluated by an independent certified Fellow of the Society of Actuaries, who found that the proposed change is administrative in nature and would not change coverage or limit access to necessary care, and as such would not have an impact on the actuarial value of the Plan; and

WHEREAS, the proposed change is anticipated to save the Plan an average of 17% below the listed Average Wholesale Price for applicable therapies; and

WHEREAS, the Division's analysis has included: evaluation of the need and rationale for the proposed change, data analysis based on actual experience, evaluation of the impact of the changes to the current benefits; evaluation of any gaps, restrictions, reductions, eliminations, expansions, or additions to the current benefits; the number of members potentially impacted by changes and the seriousness of any impacts;

NOW THEREFORE, BE IT RESOLVED THAT THE RETIREE HEALTH PLAN ADVISORY BOARD recommends the AlaskaCare retiree health plan adopt and implement the proposed update to the Plan's GCIT benefits as outlined in the proposal submitted to the Board on September 27, 2022, to be effective January 1, 2023.

DATED this 27th day of September 2022.

DRAFT/EXAMPLE

Proposal Title	Precertification Penalty Removal
Health Plan Affected	AlaskaCare Retiree Health Plan
Proposed Effective Date	January 1, 2023
Reviewed By	Retiree Health Plan Advisory Board
Review Date	September 27, 2022

Contents

1) Background

Precertification is a process used by medical plan administrators to confirm the medical necessity of care for certain procedures before services are delivered. Precertification helps members and their providers determine whether the services being recommended are covered expenses under the terms of the AlaskaCare Retiree Health Plan (Plan). Precertification typically considers whether the proposed procedure or service is clinically appropriate for that individual member. Precertification is a standard component of mainstream health plans.

Precertification Requirements

AlaskaCare's precertification process is handled by the current medical Third-Party Administrator (Aetna). Aetna creates and maintains a publicly available Participating Provider Precertification List, also known as

the National Precertification List (NPL) that details the services requiring precertification.[1] Behavioral Health (BH) services requiring precertification are detailed on a separate BH precertification list.[2] Aetna's NPL and BH precertification lists are applicable to providers who have agreed to participate in Aetna's network. As part of their contract, network providers agree to precertify these medical services on behalf of their patients. If a network provider fails to precertify one of these services, Aetna may conduct a retrospective review after claims are received to determine if the services were appropriate and medically necessary. If the retrospective review determines the services delivered by the network provider are not eligible for payment, the claim for that service may be denied, but the member will be held harmless.

The AlaskaCare Retiree Insurance Information Booklet contains unique, specific requirements[3] related to precertification. When Plan members receive services from network providers, that provider is responsible for obtaining precertification. There is no additional out-of-pocket cost to the member as a result of a network provider's failure to precertify services. When a member receives services from an out-of-network provider, though the provider *may* obtain precertification on the member's behalf, the member is ultimately responsible for obtaining the necessary precertification for any services listed in the Plan booklet under *Section 3.2.2, Services Requiring Precertification*. If a service is not precertified, it does not necessarily mean that it will not be covered by the Plan. If a retrospective review determines that the services met medical necessity requirements, the Plan would still provide coverage. However, if the appropriate precertification is not obtained for services delivered by an out-of-network provider, the Plan's benefits will be reduced or limited as outlined in Table 1 below. Currently, these benefit reductions are applied even if the service is deemed medically necessary and eligible for coverage.

The Plan also contains an AlaskaCare-specific requirement that members must precertify travel expenses prior to traveling. Providers (both network and non-network) are not responsible for precertifying travel expenses – the member is responsible. During the precertification process for travel benefits, Aetna uses information submitted by the member (e.g., proposed travel dates and locations) to determine the maximum payable benefit for that instance of travel (the cost of coach class commercial air transportation from the site of the illness or injury to the nearest professional treatment). If a member fails to precertify their travel, no travel benefits will be paid.

Table 1. Plan Penalties for Failure to Precertify Services[4]

Circumstance	Penalty
Failure to obtain precertification for certain medical services.	$400 benefit reduction
In-patient mental disorder treatment without precertification.	Coinsurance is reduced from 80% to 50%

[1] See https://www.aetna.com/content/dam/aetna/pdfs/health-care-professionals/2022-precert-list.pdf and Attachment 1.
[2] See https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/healthcare-professionals/documents-forms/bh_precert_list.pdf and Attachment 2.
[3] 2022 AlaskaCare Retiree Insurance Information Booklet. Section *3.2 Precertification*.
[4] 2022 AlaskaCare Retiree Insurance Information Booklet. Section *1.1 Medical Benefits*.

Circumstance	Penalty
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
Travel benefits without precertification.	No benefits will be paid
Failure to obtain precertification for use of an out-of-network provider **for preventive care services**	$400 benefit reduction does not apply, however all charges incurred for preventive care services in this circumstance will be subject to normal cost sharing provisions

Services Requiring Precertification

As noted above, Aetna maintains and actively updates the lists of services requiring precertification that apply to their contracts with network providers. The Plan booklet contains a list of services requiring precertification specific to the AlaskaCare plan. These two lists overlap considerably but are not exactly the same. Table 2 provides a comparison of services appearing on both lists, with differences between the two lists called out in **bold**.

Table 2. Services Requiring Precertification: Aetna NPL vs. AlaskaCare Comparison

Service	Aetna NPL	AlaskaCare
Medical Services		
Inpatient stays: hospital	x	x
Inpatient stays: skilled nursing facility	x	x
Inpatient stays: rehabilitation facility	x	x
Inpatient stays: maternity/newborn, exceeding the standard length of stay	x	*not specifically noted, but covered under "stays in a hospital"*
Inpatient admissions: behavioral health [BH NPL]	x	*not specifically noted, but covered under "stays in a hospital"*
Inpatient stays: hospice facility		**x**
Outpatient hospice care		**x**
Home health care		**x**
Air Ambulance	x	x (for non-emergent transportation only)
Ground Ambulance (non-emergent)		**x**
Applied behavioral analysis (ABA) [BH NPL]	x	x
Arthroscopic hip surgery	**x**	
Autologous chondrocyte implantation	x	x
Chiari malformation decompression surgery	**x**	
Cochlear device and/or implantation	x	x
Cognitive skills development		**x**
Customized braces (physical - i.e. non-orthodontic braces)		**x**

Service	Aetna NPL	AlaskaCare
Coverage at an in-network benefit level for out-of-network provider or facility unless services are emergent	x	x (preventive care services)
Dental implants	x	x
Dialysis visits	x (for network provider at out-of-network facility)	x (all dialysis visits)
Dorsal column (lumbar) neurostimulators: trial or implantation	x	x
Electric or motorized wheelchairs and scooters	x	x
Endoscopic nasal balloon dilation procedures	x	
Functional endoscopic sinus surgery	x	
Gender affirmation surgery	x	
Gastrointestinal tract imaging through capsule endoscopy		x
Hyperbaric oxygen therapy	x	x
Infertility services and pre-implantation genetic testing	x	
Limb prosthetics	x (lower limb prosthetics only)	x (all limb prosthetics)
Nonparticipating freestanding ambulatory surgical facility services, when referred by a participating provider	x	
Oncotype DX (a method for testing genes that are in cancer cells)		x
Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint	x	x
Osseointegrated implant	x	x
Osteochondral allograft/knee	x	x
Partial hospitalization programs (PHPs) [BH NLP]	x	
Private duty nursing	x	x
Proton beam radiotherapy	x	x
Reconstructive or other procedures that may be considered cosmetic	x	x
Residential treatment center (RTC) admissions [BH NLP]	x	*not specifically noted, but covered under "stays in a hospital" and/or "stays in a rehabilitation facility"*
Shoulder arthroplasty including revision procedures	x	
Spinal procedures (surgical)	x	x
Transcranial magnetic stimulation (TMS) [BH NPL]	x	
Uvulopalatopharyngoplasty, including laser- assisted procedures	x	x
Ventricular assist devices	x	x
Whole exome sequencing	x	
Travel		x
Medical Pharmacy/Special Programs		
Blood clotting factors (outpatient infusion for entire drug class)	x	

Service	Aetna NPL	AlaskaCare
Certain specialty medications (covered through medical pharmacy)	x	
BRCA genetic testing	x	
Chiropractic precertification	*Not Applicable*	*Not Applicable*
Cataract surgery	*Not Applicable*	*Not Applicable*
Diagnostic cardiology (cardiac rhythm implantable devices, cardiac catheterization) (non-emergent)	*Not Applicable*	*Not Applicable*
Hip and knee arthroplasties	*Not Applicable*	*Not Applicable*
Home health care	*Not Applicable*	*Not Applicable*
Infertility program	*Not Applicable*	*Not Applicable*
Mental health or substance abuse services precertification	x *see BH precert list*	some but not all
National Medical Excellence Program	x	x
Outpatient PT and OT	*Not Applicable*	*Not Applicable*
Pain management	*Not Applicable*	*Not Applicable*
Polysomnography	*Not Applicable*	*Not Applicable*
Pre-implantation genetic testing	*Not Applicable*	*Not Applicable*
Radiology imaging	*Not Applicable*	*Not Applicable*
Radiation oncology	*Not Applicable*	*Not Applicable*
Site of service	*Not Applicable*	*Not Applicable*

2) Goals and Objectives

Removing the Plan's penalties related to precertification and aligning the plan's precertification requirements with the Third-Party Administrator's requirements is intended to:

1. Align precertification requirements to conform with changed evidence, practices and emerging technologies.
2. Ensure medical necessity is determined in advance of services being rendered for certain procedures or treatments.
3. Ease administrative tasks for members and providers.
4. Support members needing to travel to obtain services.
5. Remove barriers to behavior health treatment.

3) Summary of Proposed Changes

Precertification Penalties

This proposal contemplates removing the Plan's penalties and benefit limitations associated with failure to obtain precertification for services as detailed in Table 3 below.

Table 3. Failure to Obtain Precertification: Proposed Changes

Circumstance	Current Penalty	Proposed Change
Failure to obtain precertification for certain medical services obtained from out-of-network provider.	$400 benefit reduction	No benefit reduction
In-patient mental disorder treatment without precertification.	Coinsurance is reduced from 80% to 50%	No coinsurance reduction

Circumstance	Current Penalty	Proposed Change
Individual limit per benefit year on substance abuse treatment without precertification. *Subject to change every three years.*	$12,715	No benefit limitation
Individual lifetime maximum on substance abuse treatment without precertification. *Subject to change every three years.*	$25,430	No lifetime maximum limitation
Travel benefits without precertification.	No benefits will be paid	Travel benefits will be capped at $500 per instance of travel, not to exceed actual travel costs
Failure to obtain precertification for use of an out-of-network provider for preventive care services	$400 benefit reduction does not apply, however all charges incurred for preventive care services in this circumstance will be subject to normal cost sharing provisions	No change

Obtaining precertification for services listed or referenced in the Plan booklet under *Section 3.2.2 Services Requiring Precertification* will still be required (for both network and out-of-network providers), as the member (and provider) run the risk of incurring significant charges for services that may not be eligible for coverage under the terms of the plan. A precertification determination mitigates this risk and ensures that the member knows what to expect after their claims have been submitted. However, under this proposal there will be no benefit reduction applied to services or treatment received by members from an out-of-network provider which were not precertified.

As noted above, precertification requests for travel expenses provide Aetna with information necessary to adjudicate the claim. Without a precertification request, it is difficult to determine the maximum payable benefit for that instance of travel. Actual travel expenses can vary greatly depending on the member's location, treatment requirements, and personal preferences. Members may elect to purchase a first class seat, or to seek care in a location other than the nearest site of professional treatment. In either case, the Plan would still cover the cost of coach class commercial air transportation from the site of the illness or injury to the nearest professional treatment, but the member would be responsible for any additional expenses over and above that amount. For example, a member residing in Juneau may need to obtain services outside of Alaska. The nearest site of care may be Seattle, but the member may prefer to travel instead to Chicago to seek care because they have family in the area. In this scenario, the member could purchase a ticket to Chicago, but the Plan's maximum payable benefit would be the price of a coach class ticket from Juneau to Seattle. The difference in price between a Seattle ticket and a Chicago ticket would be the member's responsibility. Without a precertification request submitted before the travel occurs, it would be very difficult for Aetna to determine what the cost of a ticket to Seattle would have been on the date of travel.

Due to this variability, this proposal contemplates maintaining the requirement that member precertify travel expenses. However, rather than paying no benefits for travel that was not precertified but would

otherwise be eligible for coverage, the maximum payable benefit for non-precertified travel benefits would be capped at $500 per instance of travel, not to exceed actual travel costs. This figure was derived from actual Plan data and is greater than the average per-claim reimbursement for travel expenses in 2021.[5] This amount is intended to provide reasonable reimbursement for members needing to travel to obtain care, while also establishing some financial guard rails for the Plan, to protect against inflated travel costs associated with members traveling further than the nearest site of care or in an other-than-coach airline cabin. If members do precertify their travel, their maximum payable benefit would be determined from the information specific to their circumstances and would remain the same as it is today: the cost of coach class commercial air transportation from the site of the illness or injury to the nearest professional treatment.

Medical Services Requiring Precertification

This proposal contemplates updating the Plan Booklet's language related to medical services requiring precertification to align with Aetna's NPL and BH precertification list. This change would both remove items from the current precertification list and add items that do not appear in the Plan Booklet currently.

While the proposed Plan Booklet update would detail common services requiring precertification, the language would incorporate Aetna's publicly available NPL and BH precertification lists by reference to ensure that the Plan's coverage provisions keep up with changing medical technology.

The current process for obtaining precertification of medical services would remain the same and is detailed in *Section 3.2.1 The Precertification Process* in the AlaskaCare Retiree Insurance Information Booklet.

Travel Expenses Requiring Precertification

The AlaskaCare-specific requirement for members to precertify travel expenses would remain in the Plan. This requirement is specific to travel expenses only, and is not applicable to any medical services a member may obtain while traveling. Those medical services, as with all medical services, would be subject to the Medical Services precertification requirements outlined above.

Member Impact | Minimal

The member impact is expected to be minimal and positive. Removing the precertification penalties makes it easier for member to access their benefits and removes some of the perceived red tape sometimes associated with submitting claims. In particular, removing the penalty for failure to precertify travel is expected to ease the administrative burden for members associated with traveling to obtain care. Due to the remote nature of the state, many AlaskaCare members find themselves in the position of needing to travel in order to seek medical attention.

Because the $400 penalty can practically only be applied to claims that are eligible for payment, and the travel penalty impacts claims that would have otherwise been covered, it is only people receiving covered services who are truly impacted by the current penalties. Removing these penalties will positively impact members seeking covered services.

[5] In 2021, average per claim reimbursement for travel expenses was as follows: Q1 $408, Q2 $419, Q3 $423, Q4 $463, CY21 $428. AlaskaCare Retiree Plan CY2021 Annual Reporting, Aetna Service Update.

To provide a sense of the number of members who may be impacted by this change, Table 4 provides an overview of the number of members who have been impacted by precertification penalties in recent years.

Table 4. Volume of Penalties for Failure to Precertify Services

Reporting Period	Failure to Precert. OON Services	Failure to Precert. Mental Disorder	Failure to Precert. Travel	Total
2022 YTD	518	55	13	**586**
2021	840	93	35	**968**
2020	648	81	40	**769**

In addition, as of August 2022 the following volumes of members are impacted by the Plan's current limitations on substance abuse treatment without precertification:

- $12,715 individual limit per benefit year on substance abuse treatment without precertification
  - 8 members have incurred claims that accrue towards this limit. All 8 members remain active members of the Plan
  - 2 of those 8 members have reached the calendar year maximum.
- $25,430 individual lifetime maximum on substance abuse treatment without precertification
  - 4 members reached this lifetime maximum, 2 of whom have termed from the Plan.
  - 91 other members have incurred claims that accrue towards the $25,430 lifetime maximum, but have not yet reached the lifetime maximum for these services. 22 of those members have termed from the Plan.

Financial Impact to AlaskaCare | Minimal Cost Increase

A minimal cost increase to the Plan is expected as a result of this change. This financial impact will be the result of the Plan foregoing monetary penalties for failure to precertify services that are currently collected from retirees. The annual impact to the plan is expected to be a cost increase of approximately $1-1.25 million, or a 0.15 - 0.20% increase in additional annual costs to the plan.[6]

Actuarial Impact to AlaskaCare | Neutral

The proposed change is an administrative change that does not change coverage or limit access to necessary care, and as such would not have an actuarial impact on the Plan.[7]

Operational Impact (DRB)| Minimal

The Division anticipates the initial operational impacts associated with implementation and member communication to be moderate, given the following considerations:

- Staff will need to create, review, and distribute communications to educate and increase awareness of the impacts to members associated with the removal of the precertification penalties and updates to the travel coverage.
- Staff will need to initiate the process for amending the Plan Booklet.

[6] Segal Consulting, Memorandum: Removal of Retiree Plan Precertification Requirements. September 2, 2022.
[7] Segal Consulting, Memorandum: Removal of Retiree Plan Precertification Requirements. September 2, 2022.

- 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, fiscal impact monitoring, and updates to communication materials as appropriate.

Operational Impact (TPA) | Minimal

The operational impact to Aetna is anticipated to be minimal, given the following considerations:

- Aetna will need to update and test their internal precertification and travel claim processing workflows and systems to ensure that the changes are appropriately applied and implemented.

After implementation, the ongoing operational impacts are anticipated to be minimal, and will include preparing reporting, fiscal impact monitoring, and updates to communication materials as appropriate.

4) 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	09/08/2022
Reviewed by RHPAB	09/27/2022

Attachments

Attachment 1	Participating Provider Precertification List for Aetna (National Precertification List)
Attachment 2	Behavioral Health Precertification List for Aetna
Attachment 3	Segal Consulting, Memorandum: Removal of Retiree Plan Precertification Requirements. September 2, 2022.

Participating provider precertification list for Aetna®

Effective September 1, 2022

This document is a quick guide for your office to use for precertification with patients enrolled in Aetna health plans. This process is also known as prior authorization or prior approval.

You can use this document as an overview of best practices working with Aetna. It will be your reference for **Current Procedural Terminology** (CPT®) codes for services, programs and prescriptions that require approval for coverage.

Make sure you review and understand how to submit a precertification request to Aetna. To learn more, refer to the **How to Submit** section.

Check out the table of contents on the next page for a closer look at what you'll find in this guide.

aetna®

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services on behalf of its affiliates. Banner|Aetna, Texas Health Aetna and Sutter Health | Aetna are affiliates of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to these entities.

1013000-01-02 (9/22)

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Click on the tabs above to go directly to each section.
You can also use **Ctrl + F** on Windows® (**Command + F** on Mac®) to search the document for keywords.

This information applies to:

- Aetna® plans
- Aetna Medicare plans
- Banner|Aetna plans
- Innovation Health® plans
- Sutter Health | Aetna plans
- Texas Health Aetna plans

This information doesn't apply to members in a Traditional Choice® plan, an indemnity plan, a Foreign Service Benefit Plan, a Mail Handlers Benefit Plan or a Rural Carrier Benefit Plan.

This document was last updated on September 1, 2022.

Submission of precertification requests

IMPORTANT: As the patient's attending physician, you must complete all sections of a submission. If you don't send all medical records we ask for, it may delay our review or cause a denial of coverage.

You must submit precertification requests at least two weeks in advance. You can save time by requesting precertification online. Doing so is fast, secure and simple.

You can submit most requests through our Availity® provider portal. You can also send requests for specialty drugs with Novologix® through Availity.

Go to **Availity.com** to start a request.

Note: Your office may also send in an electronic request. Just use your own Electronic Medical Record (EMR) system.

Go to **Aetna.com/ProviderPrecertificationList** to learn more about the precertification process.

What happens next

Once we have the requested information, we'll perform a clinical review. We will let you know when we make a coverage determination.

How we make coverage determinations

If you are asking for precertification for a Medicare Advantage member, we use CMS benefit policies to make our coverage decisions. This includes national coverage determinations (NCD) and local coverage determinations (LCD), when available. If there isn't an available NCD or LCD to review, we'll use the Clinical Policy Bulletin and Precertifications List. You can find them by going to the website on the back of the member's ID card.

Questions?

If you have any questions about submitting a request or about our precertification process, call us:

- Commercial plans: **1-888-632-3862**
- Medicare plans: **1-800-624-0756**

Or visit **Aetna.com/ProviderPrecertificationList** to learn more.

You should know

- This material is for your information only. It's not meant to direct treatment decisions.
- The review of items on this list may vary at our discretion. If you receive approval for a service or supply, it's for that service or supply only.
- Services that don't need precertification are subject to the coverage terms of the member's plan.

Special information for members in Texas

- For precertification in Texas, we use the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage. Precertification doesn't mean payment for care or services to fully insured HMO and PPO members as defined by Texas law.

Coverage changes and updates

- If member eligibility and plan coverage for the procedure or service you asked for hasn't changed, precertification approvals are valid for six months. This is true for all states. This is also the case unless we tell you otherwise when you receive the precertification decision.
- We update the precertification list each year. We usually do this in January and July. But we may add new drugs approved by the Federal Drug Administration (FDA) to the list at other times.

For more information

- Visit **Clinical Policy Bulletins** and our **online provider directory**.
- The precertification process doesn't include verbal or written requests for information about benefits or services not on the precertification lists. Our staff can assess if a caller is making an inquiry or asking for a coverage decision or organization determination.
- We don't offer all plans in all service areas. Not all plans include all services listed. For example, precertification programs don't apply to fully insured members in Indiana.

Innovation Health

- Innovation Health Insurance Company and Innovation Health Plan, Inc. (Innovation Health) are affiliates of Aetna Life Insurance Company (Aetna) and its affiliates. Aetna and its affiliates provide certain management services for Innovation Health.
- Find more information about **notification and coverage determinations**.
- We require precertification when Aetna or Innovation Health is the secondary payer.

Maternity information

We require precertification for maternity and newborn stays that are more than the standard length of stay (LOS). Standard LOS for:

- Vaginal deliveries is three days or fewer
- Cesarean section is five days or fewer

Oral medications and injections

Contact Aetna Pharmacy Management for precertification of oral medications not on this list.

- Their number is **1-800-414-2386**.
- Call **1-866-782-2779** for information on injectable medications not listed.

For drugs administered orally, by injection or infusion:

- Drugs newly approved by the FDA may require precertification review.
- Members of fully insured Texas and Louisiana plans have coverage for drugs we add to the precertification list according to their current plan design until their plan renews.
- Fully insured California HMO members and fully insured Connecticut PPO members covered for drugs added to the precertification list continue to have coverage.
  - Drug coverage continues for these California members as long as the doctor prescribes it appropriately. It must also be a safe and effective treatment for the medical condition.
  - Drug coverage continues for these Connecticut members as long as the drug is medically necessary and more medically beneficial than other covered drugs.
  - The prescribing provider must respond to requests for more information. For fully insured members with a Colorado state contract, we'll approve or deny precertification requests within time frames mandated by Colorado Regulation 4-2-49 RX Prior Authorization.

Foreign Service and Student Health plan information

For members enrolled in Foreign Service Benefit Plan, Mail Handlers Benefit Plan (MHBP) or Rural Carrier Benefit Plan: They do not need precertification for cardiac catheterization, cardiac imaging, chiropractic services, transthoracic echocardiogram or physical/occupational therapy.

- Visit online provider directories: **Foreign Service Benefit Plan**; **MHBP**; **Rural Carrier Benefit Plan**
- Except as noted for drugs and medical injectables and special programs, for all other services:
  - **Foreign Service Benefit Plan**, call **1-800-593-2354**
  - **MHBP**, call **1-800-410-7778**
  - **Rural Carrier Benefit Plan**, call **1-800-638-8432**

For members enrolled in Aetna Student Health precertification is not required for the following outpatient services:

- Diagnostic cardiology
- Hip and knee arthroplasties
- Physical therapy and occupational therapy
- Pain management
- Polysomnography
- Radiology imaging
- Radiation oncology

For more information, read all general precertification guidelines

For Commercial members, certain elective procedures, as noted with an asterisk (*), are subject to the medical necessity review of the procedure and the site of service.

	Procedure name/description	CPT code(s)
1.	**Inpatient confinements (except hospice)** For example, surgical and nonsurgical stays, stays in a skilled nursing facility or rehabilitation facility, and maternity and newborn stays that exceed the standard length of stay (LOS). (See "**Maternity information**" in the General Information section.)	
2.	**Ambulance** Precertification required for transportation by fixed-wing aircraft (plane)	A0140, A0430, A0435, A0999, T2004, T2007, S9960
3.	**Arthroscopic hip surgery to repair impingement syndrome including labral repair**	29914, 29915, 29916, 29862
4.	**Autologous chondrocyte implantation***	27412, J7330, S2112
5.	**Chiari malformation decompression surgery***	61343
6.	**Cochlear device and/or implantation***	69930, L8614, L8619
7.	**Coverage at an in-network benefit level for out-of-network provider or facility unless services are emergent.** Some plans have limited or no out-of-network benefits.	
8.	**Dental implants**	21245, 21246, 21248, 21249
9.	**Dialysis visits** When a participating provider starts a request and dialysis is to be performed at a nonparticipating facility.	90935, 90937, 90999
10.	**Dorsal column (lumbar) neurostimulators: trial or implantation**	63650, 63655, 63663, 63664, 63685, 63688, C1767, C1816, C1820 or C1822 when requested or used with one or more of the above CPT codes

*For Commercial members, this elective procedure is subject to the medical necessity review of the procedure and the site of service.

Services that require precertification (continued)

	Procedure name/description	CPT code(s)
11.	Electric or motorized wheelchairs and scooters	E1230, E0983, E0984, E1007, K0010, K0011, K0012, K0013, K0014, K0800, K0801, K0802, K0806, K0807, K0808, K0812, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, K0898, K0899
12.	Endoscopic nasal balloon dilation procedures*	31295, 31296, 31297, 31298
13.	Functional endoscopic sinus surgery (FESS)	31253, 31254, 31255, 31256, 31257, 31259, 31267, 31276, 31287, 31288
14.	Gender affirmation surgery	55970, 55980, 56805, 57335, 11950, 11951, 11952, 11954, 15771, 15772, 15775, 15776, 15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793, 15824, 15825, 15826, 15828, 17380, 19301, 19303, 21270, 30400, 30410, 30420, 30430, 30435, 30450, 53430, 54125, 54400, 54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417, 54520, 54660, 54690, 55175, 55180, 56625, 56800, 56810, 57106, 57107, 57110, 57111, 57291, 57292, 58150, 58180, 58260, 58262, 58275, 58280, 58285, 58290, 58291, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58661, 58720

*For Commercial members, this elective procedure is subject to the medical necessity review of the procedure and the site of service.

Services that require precertification (continued)

	Procedure name/description	CPT code(s)
15.	Hyperbaric oxygen therapy	G0277, 99183
16.	Infertility services and pre-implantation genetic testing	0357T, 58321, 58322, 58323, 58970, 58974, 58976, 76948, 89250, 89251, 89253, 89254, 89255, 89257, 89258, 89264, 89268, 89272, 89280, 89281, 89337, 89342, 89346, 89352, 89353, S4011, S4013, S4014, S4015, S4016, S4017, S4018, S4020, S4021, S4022, S4023, S4025, S4035, 89290, 89291
17.	Lower limb prosthetics, such as microprocessor-controlled lower limb prosthetics	L5781, L5782, L5856, L5857, L5858, L5859, L5968, L5969, L5980, L5987, L5999
18.	Nonparticipating freestanding ambulatory surgical facility services, when referred by a participating provider	
19.	Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint	21120*, 21121*, 21122*, 21123*, 21125*, 21127*, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21159, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21208*, 21209*, 21210*, 21215, D7296, D7297, D7940, D7941, D7943, D7944, D7945, D7946, D7947, D7948, D7949, D7950, D7951, D7952, D7955, D7995, D7996, 21010, 21050, 21060, 21070, 21073, 21240, 21242, 21243, 21244, 21247, 21255, 21480, 21485, 21490, 21497, 29800, 29804, D6050, D7810, D7820, D7830, D7840, D7850, D7852, D7854, D7856, D7858, D7860, D7865, D7870, D7871, D7872, D7873, D7874, D7875, D7876, D7877, D7899, D7991
20.	Osseointegrated implant*	69714, 69716, L8690, L8691, L8692, L8693
21.	Osteochondral allograft/knee*	27415
22.	Private duty nursing	S9123, S9124, T1000, T1030, T1031

*For Commercial members, this elective procedure is subject to the medical necessity review of the procedure and the site of service.

	Procedure name/description	CPT code(s)
23.	**Proton beam radiotherapy**	77520, 77522, 77523, 77525 Also see Special Programs; **Radiation oncology**
24.	**Reconstructive or other procedures that maybe considered cosmetic, such as:**	• Blepharoplasty* 15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908 • Breast reconstruction/ breast enlargement* 19355, 19340, 19342, 19350, 19357, 19364, 19370, 19371, 19380, 19396, S2066, S2067, S2068 • Breast reduction/mammoplasty* 19316, 19318, 19325, 19328, 19330 • Excision of excessive skin due to weight loss* 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847 • Gastroplasty/gastric bypass 43631, 43632, 43633, 43634, 43644, 43645, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, 43999, 49999 • Lipectomy or excess fat removal* 15876, 15877, 15878, 15879 • Surgery for varicose veins, except stab phlebectomy* 36475, 36476, 36478, 36479, 37500, 37700, 37718, 37722, 37735, 37760, 37761, 37780, 37785, 0524T
25.	**Shoulder arthroplasty including revision procedures***	23470, 23472, 23473, 23474

*For Commercial members, this elective procedure is subject to the medical necessity review of the procedure and the site of service.

Services that require precertification (continued)

	Procedure name/description	CPT code(s)
26.	**Site of service**	For commercial members only, see **special programs** for more information.
27.	**Spinal procedures, such as:**	• Artificial intervertebral disc surgery (cervical spine) 22856, 22858, 22861 • Arthrodesis for spine deformity 22800, 22802, 22804, 22808, 22810, 22812 • Cervical laminoplasty 63050, 63051 • Cervical, lumbar and thoracic laminectomy and\or laminotomy procedures 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63052, 63053, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63200, 63265, 63266, 63267 • Kyphectomy* 22818, 22819 • Laminectomy with rhizotomy 63185, 63190 • Spinal fusion surgery C1821, 22210, 22214, 22220, 22222, 22224, 22532, 22533, 22534, 22548, 22551, 22552, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22633, 22634, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22853, 22854, 22859, 27279, 27280 • Vertebral corpectomy 63081, 63082, 63085, 63086, 63090, 63091

*For Commercial members, this elective procedure is subject to the medical necessity review of the procedure and the site of service.

Services that require precertification (continued)

	Procedure name/description	CPT code(s)
28.	**Uvulopalatopharyngoplasty, including laser- assisted procedures***	42145, 42140, 42299, S2080
29.	**Ventricular assist devices**	33975, 33976, 33977, 33978, 33979, 33980, 33981, 33982, 33983, 33990, 33991, 33992, 33993, 33995, 33997, 92970
30.	**Whole exome sequencing**	81415, 81416, 81417

*For Commercial members, this elective procedure is subject to the medical necessity review of the procedure and the site of service.

Blood-clotting factors (precertification for outpatient infusion of this drug class is required)

For the following services, providers should call **1-855-888-9046** for precertification, with these exceptions:

- Precertification of pharmacy-covered specialty drugs
  - For the Foreign Service Benefit Plan, call Express Scripts at **1-800-922-8279**
  - For MHBP and the Rural Carrier Benefit Plan, call CVS Caremark® at **1-800-237-2767**
- J7175, J7177, J7178, J7179, J7180, J7181, J7182, J7183, J7185, J7186, J7187, J7188, J7189, J7190, J7191, J7192, J7193, J7194, J7195, J7196, J7197, J7198, J7200, J7201, J7202, J7203, J7204, J7205, J7207, J7208, J7209, J7210, J7211, J7212, J7170

Drug name	Description
Advate	antihemophilic factor, human recombinant
Adynovate	antihemophilic factor [recombinant], PEGylated
Afstyla	antihemophilic factor [recombinant], single chain
Alphanate	antihemophilic factor/von Willebrand factor complex [human]
AlphaNine SD	coagulation factor IX [human]
Alprolix	coagulation factor IX [recombinant], Fc fusion protein
Bebulin	factor IX complex
BeneFix	coagulation factor IX [recombinant]
Coagadex	coagulation factor X [human]
Corifact	factor XIII concentrate [human]
Eloctate	antihemophilic factor [recombinant], Fc fusion protein
Esperoct	antihemophilic factor [recombinant], glycopegylated-exei
FEIBA, FEIBA NF	anti-inhibitor coagulant complex
Fibryga	fibrinogen, human
Helixate FS	antihemophilic factor [recombinant]
Hemlibra	emicizumab-kxwh
Hemofil M	antihemophilic factor [human]

Blood-clotting factors (continued)

Drug name	Description
Humate-P	antihemophilic factor/von Willebrand factor complex [human]
Idelvion	antihemophilic factor [recombinant]
Ixinity	coagulation factor IX [recombinant]
Jivi	antihemophilic factor [recombinant], PEGylated-aucl
Koate, Koate-DVI	antihemophilic factor [human]
Kogenate FS	antihemophilic factor [recombinant]
Kovaltry	antihemophilic factor [recombinant]
Monoclate-P	antihemophilic factor [human]
Mononine	coagulation factor IX [human]
NovoEight	antihemophilic factor [recombinant]
NovoSeven RT	coagulation factor VIIa [recombinant]
Nuwiq	simoctocog alfa
Obizur	antihemophilic factor [recombinant], porcine sequence
Profilnine	factor IX complex
Rebinyn	coagulation factor IX [recombinant], glycoPEGylated
Recombinate	antihemophilic factor [recombinant]
RiaSTAP	fibrinogen concentrate [human]
Rixubis	coagulation factor IX [recombinant]
Sevenfact	coagulation factor VIIa [recombinant]-jncw
Tretten	coagulation factor XIII a-subunit [recombinant]
Vonvendi	von Willebrand factor [recombinant]
Wilate	von Willebrand factor/coagulation factor VIII complex [human]
Xyntha, Xyntha Solofuse	antihemophilic factor [recombinant]

Other drugs and medical injectables

For the following services, providers call 1-866-752-7021 for precertification. Fax request forms to 1-888-267-3277, with the following exceptions:

- For precertification of pharmacy-covered specialty drugs (noted with *) when the member is enrolled in a commercial plan, call **1-855-240-0535**. Or fax applicable request forms to **1-877-269-9916**.
- Providers can use the drug-specific Specialty Medication Request Form located online under "Specialty Pharmacy Precertification."
- Providers can submit Specialty Pharmacy precertification requests electronically using provider online tools and resources on **our provider portal** with Aetna.
- See our **Medicare online resources** for more about preferred products or to find a precertification fax form.
- Providers should use the contacts below for members enrolled in a Foreign Service Benefit Plan, MHBP or Rural Carrier Benefit Plan:
  - For precertification of pharmacy-covered specialty drugs — Foreign Service Benefit Plan, call Express Scripts at **1-800-922-8279**. For MHBP and Rural Carrier Benefit Plan, call CVS Caremark® at **1-800-237-2767**.
  - For precertification of all other listed drugs — Foreign Service Benefit Plan, call **1-800-593-2354**. For MHBP, call **1-800-410-7778**. For Rural Carrier Benefit Plan, call **1-800-638-8432**.

Drug name/description

Abraxane (paclitaxel protein-bound particles, J9264) – precertification required for Medicare Advantage members only

Acthar Gel/H. P. Acthar (corticotropin, J0800)

Adakveo (crizanlizumab-tmca, J0791) – precertification for the drug and site of care required

Adcetris (brentuximab vedotin, J0791)

Aduhelm (aducanumab-avwa, J0172) — precertification for drug and site of care required

Alpha 1-proteinase inhibitor (human) (precertification for the drug and site of care required):

Aralast NP (alpha 1-proteinase inhibitor, J0256)
Glassia (alpha 1-proteinase inhibitor, J0257)
Prolastin-C (alpha 1-proteinase inhibitor, J0256)
Zemaira (alpha 1- proteinase inhibitor, J0256)

Alymsys (bevacizumab, J3490, J3590) — precertification required effective July 8, 2022, for oncology indications only

Amyotrophic Lateral Sclerosis (ALS) drugs:

Radicava (edaravone, J1301) — precertification for the drug and site of care required

Other drugs and medical injectables (continued)

Autoimmune Infused Infliximab

- Avsola (infliximab-axxq, Q5121) — precertification for the drug and site of care required
- Inflectra (infliximab-dyyb, Q5103) — precertification for the drug and site of care required
- Remicade (infliximab, J1745) — precertification for the drug and site of care required
- Renflexis (infliximab-abda, Q5104) — precertification for the drug and site of care required

Avastin (bevacizumab, J9035) — precertification required for oncology indications only

Aveed (testosterone undecanoate, J3145)

Belrapzo (bendamustine HCl, J9036)

Bendeka (bendamustine HCl, J9034)

Benlysta (belimumab, J0490) — precertification for the drug and site of care required

Besponsa (inotuzumab ozogamicin, J9229)

Blenrep (belantamab mafodotin-blmf, J9037)

Bortezomib J9044 — precertification required for multiple myeloma only

Botulinum toxins:

- Botox (onabotulinumtoxinA, J0585)
- Dysport (abobotulinumtoxinA, J0586)
- Myobloc (rimabotulinumtoxinB, J0587)
- Xeomin (incobotulinumtoxinA, J0588)

Cablivi (caplacizumab-yhdp, C9047)

Calcitonin Gene-Related Peptide (CGRP) receptor inhibitors

- Vyepti (eptinezumab-jjmr, J3032) — precertification for the drug and site of care required

Cardiovascular — PCSK9 inhibitors:

- Leqvio (inclisiran, J1306) — precertification required effective March 23, 2022

Chimeric Antigen Receptor T-Cell Therapy (CAR-T) — contact National Medical Excellence at **1-877-212-8811**

- Abecma (idecabtagene vicleucel, Q2055)
- Breyanzi (lisocabtagene maraleucel, Q2054)
- Carvykti (ciltacabtagene autoleucel, J3490, J3590, C9098) — precertification required effective May 27, 2022
- Kymriah (tisagenlecleucel, Q2042)
- Tecartus (brexucabtagene autoleucel, Q2053)
- Yescarta (axicabtagene ciloleucel, Q2041)

Cortrophin Gel (repository corticotropin, J3490, J3590) — precertification required effective February 9, 2022

Cosela (Trilaciclib, J1448)

Crysvita (burosumab-twza, J0584) — precertification for the drug and site of care required

Cyramza (ramucirumab, J9308)

Danyelza (naxitamab-gqgk, J9348)

Darzalex (daratumumab, J9145)

*For precertification when the member is enrolled in a commercial plan, call 1-855-240-0535. Or fax applicable request forms to 1-877-269-9916.

Other drugs and medical injectables (continued)

Darzalex Faspro (daratumumab and hyaluronidase-fihj, J9144)

Empliciti (elotuzumab, J9176)

Enjaymo (Sutimlimab-jome, J3490, J3590, C9094) — precertification for the drug and site of care required effective May 1, 2022

Enzyme replacement drugs:

- Aldurazyme (laronidase, J1931) — precertification for the drug and site of care required
- Brineura (cerliponase alfa, J0567)
- Cerezyme (imiglucerase, J1786) — precertification for the drug and site of care required
- Elaprase (idursulfase, J1743) — precertification for the drug and site of care required
- Elelyso (taliglucerase alfa, J3060) — precertification for the drug and site of care required
- Fabrazyme (agalsidase beta, J0180) — precertification for the drug and site of care required
- Kanuma (sebelipase alfa, J2840) — precertification for the drug and site of care required
- Lumizyme (alglucosidase alfa, J0220, J0221) — precertification for the drug and site of care required
- Mepsevii (vestronidase alfa-vjbk, J3397) — precertification for the drug and site of care required
- Naglazyme (galsulfase, J1458) — precertification for the drug and site of care required
- Nexviazyme (avalglucosidase alfa-ngpt, J0219) — precertification for the drug and site of care required
- Strensiq (asfotase alfa, J3490, J3590)

Enzyme replacement drugs (continued):

- Vimizim (elosulfase alfa, J1322) — precertification for the drug and site of care required
- VPRIV (velaglucerase alfa, J3385) — precertification for the drug and site of care required

Erbitux (cetuximab, J9055)

Erythropoiesis-stimulating agents:

- Aranesp (darbepoetin alfa, J0881)
- Epogen (epoetin alfa, J0885)
- Mircera (methoxy polyethylene glycol-epoetin beta, J0887)
- Procrit (epoetin alfa, J0885)
- Retacrit (recombinant human erythropoietin-epbx, Q5105)

Evkeeza (evinacumab-dgnb, J1305) — precertification for the drug and site of care required

Evrysdi (risdiplam, J8499)

Feraheme (ferumoxytol, Q0138, Q0139)

Fusilev (levoleucovorin, J0641)

Fyarro (sirolimus protein-bound particles for injectable suspension, J9331) — precertification required effective March 15, 2022

Gattex (teduglutidem, J3490)

Givlaari (givosiran, J0223) – precertification for drug and site of care required

*For precertification when the member is enrolled in a commercial plan, call 1-855-240-0535. Or fax applicable request forms to 1-877-269-9916.

Other drugs and medical injectables (continued)

Granulocyte-colony stimulating factors:

- Fulphila (pegfilgrastim-jmdb, Q5108)
- Granix (tbo-filgrastim, J1447)
- Leukine (sargramostim, J2820)
- Neulasta (pegfilgrastim, J2506)
- Neupogen (filgrastim, J1442)
- Nivestym (filgrastim-aafi, Q5110)
- Nyvepria (pegfilgrastim-apgf, Q5122)
- Releuko (filgrastim-ayow, J3490, J3590, C9096) – precertification required effective May 25, 2022
- Udenyca (pegfilgrastim-cbvq, Q5111)
- Zarxio (filgrastim-sndz, Q5101)
- Ziextenzo (pegfilgrastim-bmez, Q5120)

Growth hormone:

- Skytrofa* (lonapegsomatropin-tcgd, J3490, J3590) — precertification required for Medicare Advantage members only effective September 1, 2022
- Sogroya* (somapacitan-beco, J3490, J3590) — precertification required for Medicare Advantage members only effective September 1, 2022

Hereditary angioedema agents:

- Berinert (C1 esterase inhibitor, J0597)
- Cinryze (C1 esterase inhibitor, J0598) — precertification for the drug and site of care required
- Firazyr (icatibant acetate, J1744)
- Haegarda (C1 esterase inhibitor subcutaneous [human], J0599)
- Kalbitor (ecallantide, J1290)
- Ruconest (C1 esterase inhibitor, J0596)

Hereditary angioedema agents (continued):

- Takhzyro (lanadelumab-flyo, J0593)

Hereditary Transthyretin-mediated Amyloidosis (ATTR) Drugs

- Amvuttra (vutrisiran, J3490, J3590, C9399) — precertification required effective September 22, 2022
- Onpattro (patisiran, J0222) — precertification for the drug and site of care required
- Tegsedi (inotersen, 90378, S9562)

HER2 receptor drugs:

- Enhertu (fam-trastuzumab deruxtecan-nxki, J9358)
- Herceptin (trastuzumab, J9355)
- Herceptin Hylecta (trastuzumab and hyaluronidase-oysk, J9356)
- Herzuma (trastuzumab-pkrb, Q5113)
- Kadcyla (ado-trastuzumab emtansine, J9354)
- Kanjinti (trastuzumab-anns, Q5117)
- Margenza (margetuximab-cmkb, J9353)
- Ogivri (trastuzumab-dkst, Q5114)
- Ontruzant (trastuzumab-dttb, Q5112)
- Perjeta (pertuzumab, J9306)
- Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf, J9316)
- Trazimera (trastuzumab-qyyp, Q5116)

Ilaris* (canakinumab, J0638)

Imlygic (talimogene laherparepvec, J9325)

*For precertification when the member is enrolled in a commercial plan, call 1-855-240-0535. Or fax applicable request forms to 1-877-269-9916.

Immunoglobulins (precertification for the drug and site of care required):

- Asceniv (immune globulin, C9072)
- Bivigam (immune globulin, J1556)
- Carimune NF (immune globulin, J1566)
- Cutaquig (immune globulin, J1551)
- Cuvitru (immune globulin SC [human], J1555)
- Flebogamma (immune globulin, J1572)
- GamaSTAN S/D (immune globulin, J1460, J1559)
- Gammagard, Gammagard S/D (immune globulin, J1569)
- Gammaked (immune globulin, J1561)
- Gammaplex (immune globulin, J1557)
- Gamunex-C (immune globulin, J1561)
- Hizentra (immune globulin, J1559)
- HyQvia (immune globulin, J1575)
- Octagam (immune globulin, J1568)
- Panzyga (immune globulin, J1599)
- Privigen (immune globulin, J1459)
- Xembify (immune globulin, J1558)

Immunologic agents:

- Actemra (tocilizumab, J3262) — precertification for the drug and site of care required
- Actemra* SC (tocilizumab, J3590, J3490) — precertification required for Medicare Advantage members only effective September 1, 2022
- Cimzia* (certolizumab pegol, J0717)
- Cosentyx* (secukinumab, J3490, J3590) — precertification required for Medicare Advantage members only effective September 1, 2022
- Enspryng* (satralizumab, J3490, J3590) — precertification required for Medicare Advantage members only effective September 1, 2022

Immunologic agents (continued):

- Entyvio (vedolizumab, J3380) — precertification for the drug and site of care required
- Ilumya* (tildrakizumab, J3245)
- Orencia SQ* (abatacept, J0129) — precertification required for Medicare Advantage members only effective September 1, 2022
- Orencia IV (abatacept, J0129) — precertification for the drug and site of care required
- Riabni (rituximab-arrx, Q5123)
- Rituxan (rituximab, J9312)
- Rituxan Hycela (rituximab/hyaluronidase human, J9311)
- Ruxience (rituximab-pvvr, Q5119)
- Simponi Aria (golimumab, J1602) — precertification for the drug and site of care required
- Skyrizi* (risankizumab-rzaa, J3490, J3590) — precertification required for Medicare Advantage members only effective September 1, 2022
- Skyrizi IV (Risankizumab-rzaa, J3490, J3590, C9399) — precertification required effective September 12, 2002
- Stelara* (ustekinumab, J3357) — precertification required for Medicare Advantage members only effective September 1, 2022
- Stelara IV (ustekinumab, J3358)
- Tremfya* (guselkumab, J1628) — precertification required for Medicare Advantage members only effective September 1, 2022
- Truxima (rituximab-abbs, Q5115)
- Vyvgart (efgartigimod alfa-fcab, J9332) — precertification required effective March 15, 2022

*For precertification when the member is enrolled in a commercial plan, call 1-855-240-0535. Or fax applicable request forms to 1-877-269-9916.

Other drugs and medical injectables (continued)

Injectable infertility drugs:

(J0725, J3355, S0122, S0126, S0128, S0132)
chorionic gonadotropin
Bravelle (urofollitropin)
Cetrotide (cetrorelix acetate)
Follistim AQ (follitropin beta)
Ganirelix AC (ganirelix acetate)
Gonal-f (follitropin alfa)
Gonal-f RFF (follitropin alfa)
Menopur (menotropins)
Novarel (chorionic gonadotropin)
Ovidrel (choriogonadotropin alfa)
Pregnyl (chorionic gonadotropin)

Injectafer (ferric carboxymaltose injection, J1439)

Jelmyto (mitomycin, J9281)

Khapzory (levoleucovorin, J0642)

Kimmtrak (tebentafusp-tebn, J3490, J3590, C9095) — precertification required effective April 15, 2022

Kyprolis (carfilzomib, J9047) — precertification for multiple myeloma only

Lartruvo (olaratumab, J9285)

Luteinizing hormone-releasing hormone (LHRH) agents:

Camcevi (leuprolide mesylate, J1952)
Eligard (leuprolide acetate, J9217)
Firmagon (degarelix, J9155)
Lupron Depot (leuprolide acetate, J9217), 7.5 mg — precertification required for oncology indications only

Luteinizing hormone-releasing hormone (LHRH) agents (continued):

Trelstar (triptorelin pamoate, J3315)
Zoladex (goserelin, J9202)

Lumoxiti (moxetumomab pasudotox-tdfk, J9313)

Makena (hydroxyprogesterone caproate, J1726)

Monjuvi (tafasitamab-cxix, J9349)

Multiple sclerosis drugs:

Avonex* (interferon beta-1a, J1826, Q3027) — precertification required for Medicare Advantage members only effective September 1, 2022
Kesimpta* (ofatumumab, J3490, J3590) — precertification required for Medicare Advantage members only effective September 1, 2022
Lemtrada (alemtuzumab, J0202) — precertification for the drug and site of care required
Ocrevus (ocrelizumab, J2350) — precertification for the drug and site of care required
Tysabri (natalizumab, J2323) — precertification for the drug and site of care required

Muscular dystrophy drugs:

Amondys 45 (casimersen, J1426) — precertification for the drug and site of care required
Exondys 51 (eteplirsen, J1428) — precertification for the drug and site of care required
Viltepso (viltolarsen, J1427) — precertification for the drug and site of care required

*For precertification when the member is enrolled in a commercial plan, call 1-855-240-0535. Or fax applicable request forms to 1-877-269-9916.

Other drugs and medical injectables (continued)

Muscular dystrophy drugs (continued):

Vyondys 53 (golodirsen, J1429) — precertification for the drug and site of care required

Mvasi (bevacizumab-awwb, Q5107) — precertification required for oncology indications only

Myalept (metreleptin, J3490, J3590)

Natpara (parathyroid hormone, J3490, J3590)

Nulibry (fosdenopterin, J3490, J3590)

Ophthalmic injectables:

Beovu (brolucizumab-dbll, J0179)
Byooviz (ranibizumab-nuna, Q5124)
Eylea (aflibercept, J0178)
Lucentis (ranibizumab, J2778)
Luxturna (voretigene neparvovec-rzyl, J3398) — precertification for the drug and site of care required
Macugen (pegaptanib, J2503)
Susvimo (ranibizumab, J2779) — precertification required effective February 1, 2022
Tepezza (teprotumumab-trbw, J3241) — precertification for the drug and site of care required
Vabysmo (faricimab-svoa, J3490, J3590, C9097) — precertification required effective May 1, 2022

Osteoporosis drugs:

— precertification required for Medicare Advantage members only effective September 1, 2022
Bonsity* (teriparatide, J3490)
Evenity* (romosozumab-aqqg, J3111)
Forteo* (teriparatide, J3110)

Osteoporosis drugs (continued):

Miacalcin (calcitonin, J0630)
Prolia (denosumab, J0897)

Oxlumo (lumasiran, J0224) — precertification for the drug and site of care required

Padcev (enfortumab vedotin, J9177)

Paroxysmal Nocturnal Hemoglobinuria (PNH)

Soliris (eculizumab, J1300) — precertification for the drug and site of care required
Ultomiris (Ravulizumab-cwvz, J1303) — precertification for the drug and site of care required

Parsabiv (etelcalcetide, J0606)

PD1/PDL1 drugs (precertification for the drug and site of care required):

Bavencio (avelumab, J9023)
Imfinzi (durvalumab, J9173)
Jemperli (dostarlimab-gxly, J9272)
Keytruda (pembrolizumab, J9271)
Libtayo (cemiplimab-rwlc, J9119)
Opdivo (nivolumab, J9299)
Opdualag (relatlimab and nivolumab, J3490, J3590) — precertification required effective July 1, 2022
Tecentriq (atezolizumab, J9022)

Pepaxto (melphalan flufenamide, J9247)

Polivy (polatuzumab vedotin-piiq, J9309)

Provenge (sipuleucel-T, Q2043)

*For precertification when the member is enrolled in a commercial plan, call 1-855-240-0535. Or fax applicable request forms to 1-877-269-9916.

Other drugs and medical injectables (continued)

Pulmonary arterial hypertension drugs:

(J1325, J3285, J7686, J7699, Q4074)
All epoprostenol sodium and sildenafil citrate*
Flolan (epoprostenol sodium)
Remodulin (treprostinil sodium)
Tyvaso (treprostinil)
Veletri (epoprostenol sodium)
Ventavis (iloprost)

Reblozyl (luspatercept-aamt, J0896)

Respiratory injectables (precertification required and site of care required):

Cinqair (reslizumab, J2786)
Fasenra (benralizumab, J0517)
Nucala (mepolizumab, J2182)
Tezspire (tezepelumab-ekko, J2356) — precertification for the drug and site of care required effective March 23, 2022
Xolair (omalizumab, J2357)

Rybrevant (amivantamab-vmjw, J9061)

Ryplazim (plasminogen, human-tvmh, J2998)

Saphnelo (anifrolumab-fnia, J0491) — precertification for the drug and site of care required

Sarclisa (isatuximab-irfc, J9227)

Somatostatin agents:

Bynfezia (octreotide, J2354)
Sandostatin (octreotide, J2354)
Sandostatin LAR (octreotide acetate, J2353)
Signifor (pasireotide, J3490, J3590)
Signifor LAR (pasireotide, J2502)
Somatuline (lanreotide, J1930)
Somavert (pegvisomant, J3490, J3590)

Spinraza (nusinersen, J2326) — precertification for the drug and site of care required

Spravato (esketamine, S0013)

Synagis (palivizumab, 90378)

Tivdak (tisotumab vedotin-tftv, J3490, J3590)

Treanda (bendamustine HCl, J9033)

Trodelvy (sacituzumab govitecan-hziy, J9317)

Uplizna (inebilizumab-cdon, J1823) — precertification for the drug and site of care required

Vectibix (panitumumab, J9303)

Velcade (bortezomib, J9041) — precertification for multiple myeloma only

Viscosupplementation:

(J7320, J7321, J7322, J7323, J7324, J7325, J7326, J7327, J7328, J7329, J7331, J7332, Q9980)
Durolane (Hyaluronic acid)
Euflexxa, Hyalgan, Genvisc, Supartz FX, TriVisc, Visco 3 (sodium hyaluronate)
Gel-One (cross-linked hyaluronate)
Gelsyn-3, Hymovis (hyaluronic acid)
Monovisc, Orthovisc (sodium hyaluronate)
Synojoynt, Triluron (1% sodium hyaluronate)
Synvisc, Synvisc-One (hylan)

Xgeva (denosumab, J0897)

Xofigo (radium Ra 223 dichloride, A9606)

Yervoy (ipilimumab, J9228) — precertification for the drug and site of care required

BRCA genetic testing — 1-877-794-8720

See "Foreign Service and Student Health plan information" in the General information section for more guidance.

81163, 81165, 81212, 81215, 81216, 81217, 81162 (precertification for 81162 for Medicare only)

Through our expanded national provider network:

- Quest — **1-866-436-3463**
- Ambry — **1-866-262-7943**
- Baylor Miraca Genetics Laboratories, LLC — **1-800-411-GENE (1-800-411-4363)**
- BioReference, GeneDX, Genpath — **1-888-729-1206**
- Invitae — **1-800-436-3037**
- LabCorp — **1-855-488-8750**
- Medical Diagnostic Laboratories — **1-877-269-0090**
- Myriad Genetics — **1-800-469-7423**

Providers can use the online BRCA form under the "Medical Precertification" section to send precertification requests.

Find genetic counselors online

For a list of our contracted providers, including our telephonic provider (Informed DNA), go to our provider directory.

Chiropractic precertification

See "Foreign Service and Student Health plan information" in the General information section for more guidance.

Chiropractic precertification needed only in the states listed HMO-based plan members only.

AZ through American Specialty Health (ASH) **1-800-972-4226**

HMO-based plan and group Medicare members only

CA through American Specialty Health (ASH) **1-800-972-4226**

For all members (with commercial and Aetna Medicare Advantage plans applicable to this precertification list):

GA through American Specialty Health (ASH) **1-800-972-4226**

Chiropractic precertification (continued)

For all members (with certain commercial plans, and Aetna Medicare Advantage plans, applicable to this precertification list):

DE, NJ, NY, PA, WV: through National Imaging Associates **1-866-842-1542**

Online at **www.RADMD.com**

97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97129, 97130, 97139, 97140, 97150, 97530, 97533, 97535, 97542, 97750, 97760, 97761, 97763, 98940, 98941, 98942, 98943, G0283, G0515, S8948

Cataract surgery

Georgia Medicare

Contact iCare Health Solutions to ask for preauthorization for cataract surgery related requests. You can reach iCare at **1-844-210-7444**.

Florida Medicare

Contact iCare Health Solutions to ask for preauthorization for cataract surgery related requests. You can reach iCare at **1-855-373-7627**.

Diagnostic cardiology (cardiac rhythm implantable devices, cardiac catheterization)

33206, 33207, 33208, 33212, 33213, 33214, 33221, 33224, 33225, 33227, 33228, 33229, 33230, 33231, 33240, 33249, 33262, 33263, 33264, 33270, 33271, 33272, 33273, 33274, 33275, 33289, 0515T, 0516T, 0517T, 0518T, 0519T, 0520T , 0614T

78429, 78430, 78431, 78432, 78433, 78434, 78451, 78452, 78453, 78454, 78459, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78491, 78492, 78494, 78496, 93350, 93351, 93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 0501T, 0502T, 0503T, 0504T, C9762, C9763

See "**Foreign Service and Student Health plan information**" in the General information section for more guidance.

Precertification for all members with plans applicable to this precertification list unless services are emergent:

- Providers in all states where applicable, should contact eviCore healthcare to request preauthorization. You can reach eviCore healthcare:
  - Online at **evicore.com**
  - By phone at **1-800-420-3471** between 7 AM and 8 PM ET
  - By fax at **1-800-540-2406**, Monday through Friday during normal business hours, or as required by federal or state regulations

Hip and knee arthroplasties

(27090, 27091, 27125, 27130, 27132, 27134, 27137, 27138, 27437, 27438, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 27486, 27487, 27488, S2118)

To learn more, see "**Foreign Service and Student Health plan information**" in the General information section.

Precertification for all members with plans applicable to this list unless services are emergent.

Home health care

(G0151, G0152, G0153, G0155, G0156, G0157, G0158, G0159, G0160, G0161, G0162, G0299, G0300, G0493, G0494, G0495, G0496)

You will need to get precertification through myNEXUS for all Georgia, Kentucky, Missouri, Ohio, Oklahoma, Pennsylvania, Texas, Virginia and West Virginia Medicare home health-related requests for in-home skilled nursing, physical therapy, occupational therapy, speech therapy, a home health aide and medical social work. Exception: Oklahoma and Virginia Dual Special Needs Plans).

Providers in these states should contact myNEXUS for precertification

- Go to **Portal.myNEXUScare.com/Account/Login** (registration is required).
- Fax the form to **1-866-996-0077**
- Questions? Call myNEXUS Intake at **1-833-585-6262** from 8 AM to 8 PM ET, Monday through Friday or
- Go to **http://www.mynexuscare.com/aetna** for more details

Infertility program — 1-800-575-5999

(0357T, 58321, 58322, 58323, 58970, 58974, 58976, 76948, 89250, 89251, 89253, 89254, 89255, 89257, 89258, 89264, 89268, 89272, 89280, 89281, 89337, 89342, 89346, 89352, 89353, S4011, S4013, S4014, S4015, S4016, S4017, S4018, S4020, S4021, S4022, S4023, S4025, S4035)

See "**Foreign Service and Student Health plan information**" in the General information section for more guidance.

Mental health or substance abuse services precertification

See the member's ID card. See "**Foreign Service and Student Health plan information**" in the General information section for more guidance.

National Medical Excellence Program

By phone at **1-877-212-8811** for the following:

- Abecma (idecabtagene vicleucel), Breyanzi (lisocabtagene maraleucel), Kymriah (tisagenlecleucel), Tecartus (brexucabtagene autoleucel) and Yescarta (axicabtagene ciloleucel)
- All major organ transplant evaluations and transplants including, but not limited to, kidney, liver, heart, lung and pancreas, and bone marrow replacement or stem cell transfer after high-dose chemotherapy

Outpatient physical therapy (PT) and occupational therapy (OT) precertification

See "Foreign Service and Student Health plan information" in the General information section for more guidance.

Through OrthoNet **1-800-771-3205**

- CT— for all members with plans applicable to this precertification list

Through Optum Health **1-800-344-4584** (Only Optum Health/Aetna-contracted providers should call this number for questions and service requests.)

- DC, GA, NC, SC, VA — For all members with plans applicable to this precertification list
- Program also applies to members in Chicago, northern IL and northwest IN (Lake and Porter counties)
- For DE, NJ, NY, PA, WV members with certain commercial plans, and Aetna Medicare Advantage plans, applicable to this precertification list

  Through National Imaging Associates **1-866-842-1542**

  Online at **www.RADMD.com**

  97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97129, 97130, 97139, 97140, 97150, 97530, 97533, 97535, 97542, 97750, 97760, 97761, 97763, 98940, 98941, 98942, 98943, G0283, G0515, S8948

Pain management

27096, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 64479, 64480, 64483, 64484, 64490, 64491, 64492, 64493, 64494, 64495, 64510, 64520, 64633, 64634, 64635, 64636 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0627T, 0628T, 0629T, 0630T G0259, G0260

See "Foreign Service and Student Health plan information" in the General information section for more guidance.

- Precertification for all members with plans applicable to this precertification list unless services are emergent.
- To request preauthorization, providers in all states where applicable, except New York and northern New Jersey, should contact eviCore healthcare. Exception: New York and northern New Jersey. To reach eviCore healthcare:
  - Online at **evicore.com**

Pain management (continued)

- By phone at **1-888-693-3211** between 7 AM and 8 PM ET
- By fax at **1-844 -822-3862**, Monday through Friday, during normal business hours, or as required by federal or state regulations

• Providers in New York and northern New Jersey should contact eviCore healthcare to request preauthorization. You can reach eviCore healthcare:

- Online at **evicore.com**
- By phone at **1-888-622-7329** for New York or **1-888-647-5940** for northern New Jersey

Polysomnography (attended sleep studies)

95782, 95783, 95805, 95807, 95808, 95810, 95811

See "**Foreign Service and Student Health plan information**" in the General information section for more guidance.

Precertification for all members with plans applicable to this precertification list when performed in any facility except inpatient, emergency room and observation bed status

• Providers in all states where applicable should contact eviCore healthcare to request preauthorization. Exception: New York and northern New Jersey. You can reach eviCore healthcare:

- Online at **evicore.com**
- By phone at **1-888-693-3211** between 7 AM and 8 PM ET
- By fax at **1-844-822-3862**, Monday through Friday during normal business hours, or as required by federal or state regulations

• Providers in New York and northern New Jersey should contact eviCore healthcare to request preauthorization. You can reach eviCore healthcare:

- Online at **evicore.com**
- By phone at **1-888-622-7329** for New York or **1-888-647-5940** for northern New Jersey

Pre-implantation genetic testing — 1-800-575-5999

(89290, 89291)

See "**Foreign Service and Student Health plan information**" in the General information section for more guidance.

Radiology imaging

70336, 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 71250, 71260, 71270, 71271, 71275, 71550, 71551, 71552, 71555, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 73200, 73201, 73202, 73206, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73700, 73701, 73702, 73706, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74181, 74182, 74183, 74185, 74261, 74262, 74263, 74712, 74713, 75557, 75559, 75561, 75563, 75565, 75571, 75572, 75573, 75574, 75635, 76380, 76390, 77021, 77022, 77046, 77047, 77048, 77049, 77084, 78451, 78452, 78453, 78454, 78459, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78491, 78492, 78494, 78496, 78608, 78609, 78811, 78812, 78813, 78814, 78815, 78816, 0042T, 0609T, 0610T, 0611T, 0612T, 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, 0710T, 0711T, 0712T, 0713T S8035, S8037, S8042, S8092

See “**Foreign Service and Student Health plan information**” in the General information section for more guidance.

All members with plans that use this list need precertification. Exception: When members receive care in any inpatient facility or emergency room, or in an observation bed status.

- Providers in all states where applicable, should contact eviCore healthcare to request preauthorization.
- You can reach eviCore healthcare:
  - Online at **evicore.com**
  - By phone at **1-800-420-3471** between 7 AM and 8 PM ET
  - By fax at **1-800-540-2406**, Monday through Friday during normal business hours or as required by federal or state regulations

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Radiation oncology

- Complex
- 3D Conformal
- Stereotactic Radiosurgery (SRS)
- Stereotactic Body Radiation Therapy (SBRT)
- Image Guided Radiation Therapy (IGRT)
- Intensity-Modulated Radiation Therapy (IMRT)
- Proton Beam Therapy
- Neutron Beam Therapy
- Brachytherapy

Radiation oncology (continued)

- Hyperthermia
- Radiopharmaceuticals

See "**Foreign Service and Student Health plan information**" in the General information section for more guidance.

Precertification for all members with HMO-based, Aetna Medicare Advantage plans, and insured Aetna commercial when performed in any facility except inpatient, emergency room and observation bed status.

- Providers should contact eviCore healthcare to request preauthorization. You can reach eviCore healthcare:
  - Online at **evicore.com**
  - By phone at **1-888-622-7329**

Site of Service

Precertification is required for the following when all of the following apply:

- The member is enrolled in an Aetna fully insured commercial plan; and,
- Service(s) in an outpatient hospital setting (NOT an ambulatory surgical facility or office setting); and,
- The procedure is one of the following:
  - Carpal tunnel surgery (29848, 64721)
  - Complex wound repair (13101, 13132)
  - Cystourethroscopy (52000, 52005, 52204, 52224, 52234, 52235, 52260, 52281, 52310, 52332, 52351, 52352, 52353, 52356, 57288)
  - Hemorrhoidectomy (46250, 46255, 46257, 46258, 46261, 46262, 46320)
  - Hernia repair (49505, 49585, 49587, 49650, 49651, 49652, 49653, 49654, 49655)
  - Hysteroscopy (58558, 58563, 58565)
  - Intranasal dermatoplasty (30620)
  - Lithotripsy (50590)
  - Prostate biopsy (55700)
  - Septoplasty (30520)
  - Skin tissue transfer or rearrangement (14040, 14060, 14301)
  - Subcutaneous soft tissue excision (21552, 21931)
  - Tonsillectomy, age 12 and older (42821, 42826)

Whole Exome Sequencing (WES)

(81415, 81416, 81417)

Through our expanded national provider network:

- Quest — **1-866-436-3463**
- Ambry — **1-866-262-7943**
- Baylor Miraca Genetics Laboratories, LLC — **1-800-411-GENE** (**1-800-411-4363**)
- BioReference, GeneDX, Genpath — **1-888-729-1206**
- Invitae — **1-800-436-3037**
- LabCorp — **1-866-248-1265**

Providers can use the **Whole Exome Sequencing (WES)** form for precertification requests. It's online under the "Medical Precertification" section.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change. Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. The formulary, provider and/or pharmacy network may change at any time. You will receive notice when necessary.

1013000-01-02 (9/22)

Services that require precertification* or authorization

The behavioral health precertification list

These behavioral health services require precertification or authorization**

This requirement applies only to services covered under the member's benefits plan, including:

- Applied behavioral analysis (ABA)
- Inpatient admissions
- Partial hospitalization programs (PHPs)
- Residential treatment center (RTC) admissions
- Transcranial magnetic stimulation (TMS)

How to request precertification or authorization

Behavioral health services, which include treatment for substance use disorders, require either precertification or authorization, as outlined above. You can submit an electronic precertification request on **Availity.com**, our provider website.

Or you can choose any other website that allows precertification requests. Go to **Aetna.com/provider/vendor** to see our vendor list.

You can also inquire electronically about previously submitted requests.

Go to **AetnaElectronicPrecert.com** for more information about precertification.

The information in this document applies to:*** Aetna Choice® Point-of-Service (POS), Aetna Choice POS II, Aetna Health Network Only℠, Aetna Health Network Option℠, Aetna HealthFund®, Aetna Medicare℠ Plan Health Maintenance Organization (HMO), Aetna Medicare℠ Plan Preferred Provider Organization (PPO), Aetna Open Access® Elect Choice®, Aetna Open Access HMO, Aetna Open Access Managed Choice®, Aetna Select℠, Choose and Save℠, HMO, Managed Choice POS, Open Access Aetna Select℠, Open Choice®, Quality Point-of-Service® (QPOS®), Savings Plus, and Traditional Choice® benefits plans, as well as to all products that may include the Aexcel® networks† or the Aexcel or Aexcel Plus designations.

*The term precertification means the utilization review process to determine whether the requested service or procedure meets the company's clinical criteria for coverage. It does not mean precertification as defined by Texas law as a reliable representation of payment of care or services to fully insured health maintenance organization (HMO) and preferred provider organization (PPO) members.

**Precertification requirements apply unless state law expressly dictates otherwise. As of January 1, 2019, the following services no longer require precertification or authorization: intensive outpatient, outpatient detoxification (ambulatory withdrawal management) and psychological or neuropsychological testing.

***Not all plans are offered in all service areas. Aetna Choice POS, Aetna Choice POS II, Aetna HealthFund Managed Choice, Aetna HealthFund PPO, Aetna Medicare, Aetna Open Access Managed Choice, Aexcel and QPOS benefits plans may include the option for members to elect to go outside the network and receive reduced benefits.

†Aexcel is not available with HMO plans. The Aexcel designation is only a guide to choosing a physician. Members should confer with their existing physicians before making a decision. Designations have the risk of error and should not be the sole basis for selecting a doctor.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies (Aetna). Aetna Behavioral Health refers to an internal business unit of Aetna.

Aetna.com

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83.03.885.1 (7/20)

Segal

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: September 2, 2022

Re: Removal of Retiree Plan Precertification Requirements

The State currently requires retirees to obtain precertification for certain benefits or they are assessed a monetary penalty. The State is considering the impact of removing the monetary penalties associated with failure to pre-certify services. Below is a summary of circumstances and the associated penalty that the State is assessing the impact of removing or adjusting.

Circumstance	Current Penalty	Proposed Change
Failure to obtain precertification for certain medical services obtained from out-of-network provider	$400 benefit reduction	No benefit reduction
In-patient mental disorder treatment without precertification	Coinsurance is reduced from 80% to 50%	No coinsurance reduction
Individual limit per benefit year on substance abuse treatment without precertification *Subject to change every three years*	$12,715	No benefit limitation
Individual lifetime maximum on substance abuse treatment without precertification *Subject to change every three years*	$25,430	No lifetime maximum limitation
Travel benefits without precertification	No benefits will be paid	Travel benefits will be capped at $500, not to exceed actual travel costs

The Plan applies the general benefit provisions, such as deductible, coinsurance and out-of-pocket limits, 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:

Deductibles		
Annual individual / family unit deductible	$150 / up to 3x per family	
Coinsurance		
Most medical expenses	80%	
Most medical expenses after out-of-pocket limit is satisfied	100%	
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%	
Out-of-Pocket Limit		
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	$800	
Benefit Maximums		
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000	
Annual reinstatement once lifetime maximum is reached	$5,000	
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	
Prescription Drugs	Up to 90 Day or 100 Unit Supply	
	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

Actuarial Value

We reviewed precertification penalties that have been applied since calendar year 2020. The current assessment is that there is no impact to plan actuarial value due to precertifications being a care management measure that does not limit access to necessary care.

Financial Impact

The financial impact of the proposed changes would be due to the loss of monetary penalties that the State currently collects from retirees. The impact to the Plan is estimated to be approximately $1,000,000 to $1,250,000. Based on the most recent retiree medical and pharmacy claims projection of $646,000,000 for 2023 (dated September 2, 2022), this equates to approximately a 0.15-0.20% increase in additional annual costs to the Plan.

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 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 continue to impact the US economy and health plan claims projections for most Health Plan Sponsors in 2022 and beyond. As a result, projections could continue to be altered by emerging events. 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 additional federal or state fiscal relief is also not contemplated in these budget projections. Additional projections may be out of scope.

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
Stephanie Messier, Segal
Quentin Gunn, Segal

State of Alaska
RETIREE HEALTH PLAN ADVISORY BOARD
Related to the Removal of Penalties for Failure to Precertify Certain Services in the AlaskaCare Defined Benefit Retiree Health Plan

Resolution 2022-02

WHEREAS, the Retiree Health Plan Advisory Board (Board) is authorized by Administrative Order No. 336 to facilitate engagement and coordination between the State of Alaska's retirement systems' members, the Alaska Retirement Management Board, and the Commissioner of Administration regarding the administration of the retiree health plan; and

WHEREAS, the Alaska retiree health care trusts provide health coverage through the AlaskaCare Defined Benefit Retiree Health Plan (Plan) to retirees and their dependents; and

WHEREAS, the Plan currently contains provisions requiring certain medical services to undergo precertification to confirm the medical necessity of care before services are delivered; and

WHEREAS, the Plan's medical Third-Party Administrator (TPA) actively maintains and updates publicly available lists of services requiring precertification in alignment with current medical evidence that apply to the TPA's contracts with network providers; and

WHEREAS, if a member fails to obtain precertification for certain medical services, the Plan's coverage may be reduced or limited; and

WHEREAS, the Plan's penalties and benefit limitations for failure to precertify certain services can practically only be applied to claims that are otherwise eligible for payment, meaning it is only people receiving covered services who are impacted by the current penalties; and

WHEREAS, aligning the services requiring precertification cited in the plan booklet with the precertification lists maintained by the Plan's TPA would provide clarity for members and providers; and;

WHEREAS, this alignment does not result in any change to how the precertification process is currently administered; and

WHEREAS, removing the Plan's penalties and benefit limitations associated with failure to precertify certain medical services would not change the current requirement that care must meet medical necessity standards in order to be eligible for coverage, and

WHEREAS, providing limited coverage for travel expenses that are not precertified would ease the administrative burden for members needing to travel to obtain care; and

WHEREAS, the Division of Retirement and Benefits (Division) has proposed to update the Plan's precertification provisions as outlined in detail in the Precertification Penalty Removal Program Proposal presented to the Retiree Health Plan Advisory Board on September 27, 2022; and

WHEREAS, the Program Proposal has been evaluated by an independent certified Fellow of the Society of Actuaries, who found that the proposed change is administrative in nature and would not

change coverage or limit access to necessary care, and as such would not have an impact on the actuarial value of the Plan; and

WHEREAS, the Program Proposal has been evaluated by an independent certified Fellow of the Society of Actuaries, who found that the proposed change is anticipated to increase annual Plan costs by approximately $1 – 1.25 million, representing 0.15 – 0.20% of annual plan costs; and

WHEREAS, the Division's analysis has included: evaluation of the need and rationale for the proposed change, data analysis based on actual experience, evaluation of the impact of the changes to the current benefits; evaluation of any gaps, restrictions, reductions, eliminations, expansions, or additions to the current benefits; the number of members potentially impacted by changes and the seriousness of any impacts;

NOW THEREFORE, BE IT RESOLVED THAT THE RETIREE HEALTH PLAN ADVISORY BOARD recommends the AlaskaCare retiree health plan adopt and implement the proposed update to the Plan's precertification provisions as outlined in the proposal submitted to the Board on September 27, 2022, to be effective January 1, 2023.

DATED this 27th day of September 2022.

DRAFT/EXAMPLE

Optum Rx® | AlaskaCare Pharmacy Plans

Member Support Opportunity: Orphan Drug Program

Sara Guidry, PharmD, CSP, AAHIVP
Sr. Clinical Consultant

August 2022 (RHPAB)

Support for members on high-cost therapies for rare conditions

Orphan drugs are defined by the US Food and Drug Administration (FDA) as drugs intended for the treatment, prevention, or diagnosis of a rare disease or condition (affects less than 200,000 persons in the US) or meets cost recovery provisions of the Orphan Drug Act. The Orphan Drug Act encourages development of these drugs.

High-cost products that treat **~7,000 rare conditions** impacting **one in ten Americans**

44% of new FDA approvals in 2019 **were for orphan drugs**

Predicted to reach **>18% of total worldwide prescription sales** by 2024

2020 EvaluatePharma® Orphan Drug Report

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Optum Rx Orphan Drug Program

Personalized clinical assessment and support for members treating extremely rare conditions with no change in coverage and no change to the prescription filling process

Dedicated support
Board-certified pharmacists specialize in orphan drugs

Comprehensive medication review (CMR)
Complete medication history and orphan drug benefit

Medication action plan
Establishes therapy goals and timelines

Personalized alerts
Identification of drug interactions and nonadherence

Targeted focus
On clinical opportunities and cost savings

One-on-one coaching
Tailoring individual experiences for members

Therapy Optimization
Drug safety and effectiveness drives discontinuation and/or alternative options

Provider Engagement
to supplement member monitoring and advise on appropriate therapy changes

Specialized clinical resource for those with extremely rare conditions

Orphan drugs may be effective for some people and not others because of differences in response and tolerability. That sensitivity, combined with often complicated dosing, opens up opportunities for pharmacists to optimize care.

With the Orphan Drug program, we provide ongoing personalized support for members who take one of 36 orphan drugs we've identified as having the greatest opportunity for clinical intervention and cost savings.

Optum Rx pharmacists, who specialize in orphan drugs, tailor one-on-one experiences for these members, offering advanced clinical counseling to address unique medication needs.

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Member Experience

How the Orphan Drug Program delivers personalized care

Day 1

Member identification
Participation in this program begins when prescription claim activity review identifies a member who has received a targeted orphan drug. Orphan drugs are costly medications used to treat rare conditions such as cystic fibrosis and amyotrophic lateral sclerosis (ALS).

Day 3

Welcome letter
Three days after program enrollment, the member gets a welcome letter that also gives them an opportunity to opt out.

Day 13

Initial consultation
A pharmacist specially trained in rare diseases and therapies calls the member for an initial consultation.

Ongoing consultations
Up to four pharmacist consultations are scheduled per year based on comprehensive medication review, effectiveness and therapy goals, with the opportunity to engage further if needed. These include:

- A conversation about the member's response to the orphan drug
- A review of the orphan drug therapy for effectiveness, appropriateness, safety, adherence, tolerability and interactions that may need to be addressed

Provider outreach
The pharmacist communicates any clinical concerns to the member's provider, along with supporting rationale for modification, intervention or discontinuation of therapy.

After each consultation, the member is monitored continuously for any discontinuation or changes to their medication regimen.

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Member journey: Pam’s story

Early detection helps ensure the right medication

Pam | age 62
Diagnosed with narcolepsy and anxiety

Pam fills Xyrem at her pharmacy and receives prior authorization approval

As Xyrem is included in the Orphan Drug program, Pam is enrolled and receives a welcome letter

During her first counseling session, Pam and Optum Rx pharmacist Ken establish therapy goals and a medication action plan

Pam later tells Ken she recently started alprazolam for anxiety. As that contradicts with Xyrem, Ken calls Pam’s doctor

Pam’s doctor discontinues Xyrem and switches Pam to Armodafanil, a safer narcolepsy alternative

Pam’s anxiety and narcolepsy are managed safely and effectively, and she sees improvement going forward

Used for illustrative purposes only, not based on an actual member.

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Orphan drug pharmacist stories

Making a difference through tailored support

David | age 57
Diagnosed with hypocalcemia

1. Optum Rx member David is taking **Natpara** for his **hypocalcemia**, a condition in which the blood has too little calcium
2. During his **consultation** with Optum Rx Pharmacist Joel, David reports recent **hand numbness and chest pain**
3. Joel identifies these serious symptoms as **adverse effects from Natpara** and quickly **alerts David's provider**
4. The **provider switches** David **to Calcitrol**, a safer medication that also happens to cost less
5. Joel **follows up** to confirm the provider's action. David **does well** on his new medication and the symptoms do not return

Used for illustrative purposes only, not based on an actual pharmacist or member.

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All AlaskaCare Orphan Drug Program Opportunity Analysis

	Jan – Mar 2022				2021 Annual			
Plan	Utilizers	Rxs	Total Plan Paid	Plan Paid Projected Savings	Utilizers	Rxs	Total Plan Paid	Plan Paid Projected Savings
EGWP Retiree	24	45	$914,160	$27.4	28	154	$4,007,459	$120.2K
Non-EGWP Retiree	4	7	$144,775	$4.3	8	28	$412,547	$12.4K
Total	28	52	$1,058,935	$31.7	36	182	$4,420,006	$132.6K

- Utilizing members are not disrupted and would only benefit from personalized counseling, effective drug therapy review and medication action plan
- Members must opt-in to program. Fee is $300 per counseled member per program year.
- **$132.6K annual projected plan savings** net of program cost based on medication specific program savings with other clients using this program

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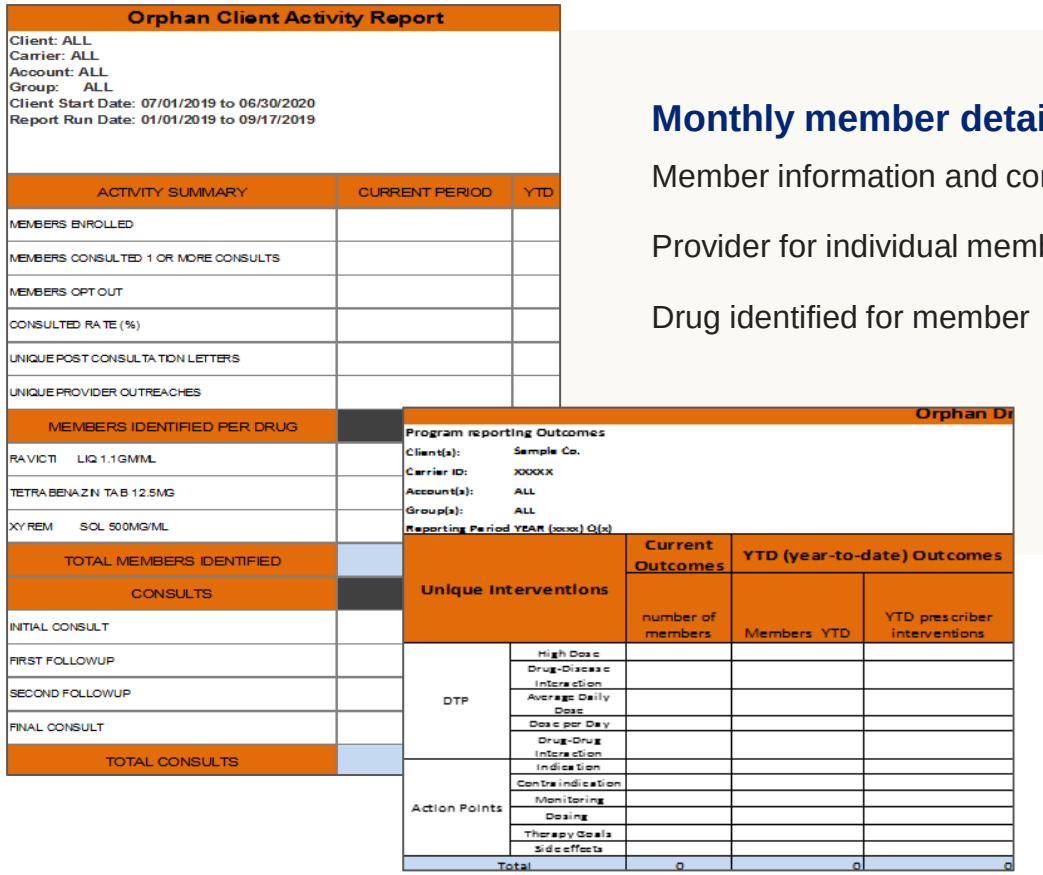
Program outcomes reporting

Monthly, quarterly and year-end reporting details



Orphan Client Activity Report

Client: ALL
Carrier: ALL
Account: ALL
Group: ALL
Client Start Date: 07/01/2019 to 06/30/2020
Report Run Date: 01/01/2019 to 09/17/2019

ACTIVITY SUMMARY	CURRENT PERIOD	YTD
MEMBERS ENROLLED		
MEMBERS CONSULTED 1 OR MORE CONSULTS		
MEMBERS OPT OUT		
CONSULTED RATE (%)		
UNIQUE POST CONSULTATION LETTERS		
UNIQUE PROVIDER OUTREACHES		
MEMBERS IDENTIFIED PER DRUG		
RAVICTI LIQ 1.1GM/ML		
TETRABENAZN TAB 12.5MG		
XYREM SOL 500MG/ML		
TOTAL MEMBERS IDENTIFIED		
CONSULTS		
INITIAL CONSULT		
FIRST FOLLOWUP		
SECOND FOLLOWUP		
FINAL CONSULT		
TOTAL CONSULTS		

Orphan Dr

Program reporting Outcomes
Client(s): Sample Co.
Carrier ID: XXXXX
Account(s): ALL
Group(s): ALL
Reporting Period YEAR (xxxx) Q(x)

Unique Interventions		Current Outcomes	YTD (year-to-date) Outcomes	
		number of members	Members YTD	YTD prescriber interventions
DTP	High Dose			
	Drug-Disease Interaction			
	Average Daily Dose			
	Dose per Day			
	Drug-Drug Interaction			
Action Points	Indication			
	Contraindication			
	Monitoring			
	Dosing			
	Therapy Goals			
	Side effects			
Total		0	0	0

Monthly member detail report

Member information and correlated consults

Provider for individual member

Drug identified for member

Quarterly Activity Report

Enrollment

Engagement

Consults

Outreaches

Provider communication

Year-end Outcomes

Total specific interventions

Discontinued therapies

Plan paid savings

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Orphan Drug Program currently targeted medications

We offer personalized support and interventions for members taking 36 orphan drugs

Brand (Generic)	Indication
ACTHAR (Corticotropin)	Amyotrophic lateral sclerosis
APOKYN (Apomorphine)	Acute intermittent hypomobility
AUSTEDO (Deutetrabenazine)	Chorea (involuntary movements) assoicated with Huntington’s disease and Tardive dyskinesia
CLOVIQUE (Trientine)	Wilson's disease in patients who cannot take the medication penicillamine
CYSTADROPS (Cysteamine)	Corneal cystine crystal accumulation in patients with cystinosis
CYSTARAN (Cysteamine)	Corneal cystine crystal accumulation in patients with cystinosis
DOJOLVI (Triheptanoin)	Molecularly confirmed long-chain fatty acid oxidation disorders (LC-FAOD)
EMFLAZA (Deflazacort)	Duchenne muscular dystrophy
EVRYSDI (Risdiplam)	Spinal muscular atrophy (SMA) in patients 2 months of age and older.
EXJADE (Deferasirox)	Chronic iron overload due to blood transfusions or alpha-thalassemia
GALAFOLD (Migalastat)	Fabry disease with an amendable GLA variant
GATTEX (Teduglutide)	Adult patients with short bowel syndrome who are dependent on parenteral support
HETLIOZ (Tasimelteon)	Non-24-hour sleep-wake disorder
ISTURISA (Osilodrostat)	Cushing’s disease
JADENU (Deferasirox)	Chronic iron overload due to blood transfusions or alpha-thalassemia
JUXTAPID (Lomitapide)	Low-density lipoprotein (LDL) cholesterol, total cholesterol, apolipoprotein B, and non-high-density lipoprotein (non-HDL) cholesterol in patients with homozygous familial hypercholesterolemia (HoFH)
KEVEYIS (Dichlorphenamide)	Primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis and paramyotonia congenita with periodic paralysis
KORLYM (Mifepristone)	Hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery

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Orphan Drug Program currently targeted medications (cont.)

We offer personalized support and interventions for members taking 36 orphan drugs

Brand (Generic)	Indication
KYNMOBI (Apomorphine)	Acute, intermittent treatment of “off” episodes in patients with Parkinson's disease (PD)
MYALEPT (Metreleptin)	Congenital or acquired generalized lipodystrophy
NATPARA (Parathyroid)	Hypocalcemia caused by hypoparathyroidism
NITYR (Nitisinone)	Hereditary tyrosinemia type 1 (HT-1) in combination with dietary restriction of tyrosine and phenylalanine.
NORTHERA (Droxidopa)	Symptomatic neurogenic orthostaic hypotension (NOH)
ORFADIN (Nitisinone)	Hereditary tyrosinemia type 1 (HT-1) in combination with dietary restriction of tyrosine and phenylalanine.
OXBRYTA (Voxelotor)	Sickle cell disease (SCD)
PROCYSBI (Cysteamine)	Nephropathic cystinosis
RAVICTI (Glycerol)	Urea cycle disorders (UCDs) that cannot be managed by dietary protein restriction and/or amino acid supplementation alone
STRENSIQ (Asfotase)	Perinatal/infantile- and juvenile-onset hypophosphatasia.
SYPRINE (Trientine)	Wilson's disease
THIOLA (Tiopronin)	Prevention of cystine stone formation in patients with severe homozygous cystinuria who are resistant to conservative treatment
VYNDAMAX (Tafamidis)	Cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis in adults
VYNDAQEL (Tafamidis)	Cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis in adults
WAKIX (Pitolisant)	Excessive daytime sleepiness (EDS) in adult patients with narcolepsy
XENAZINE (Tetrabenazine)	Chorea (involuntary movements) assoicated with Huntington’s disease and Tardive dyskinesia
XYREM (Sodium Oxybate)	Cataplexy and excessive daytime sleepiness in patients with narcolepsy
XYWAV (Calcium, Mag, Potassium, & Sod Oxybates)	Cataplexy and excessive daytime sleepiness in patients with narcolepsy

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Thank you for your time.

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State of Alaska

AlaskaCare 2023 Premium Rate Development

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

September 2022 / Richard Ward, FSA, FCA, MAAA

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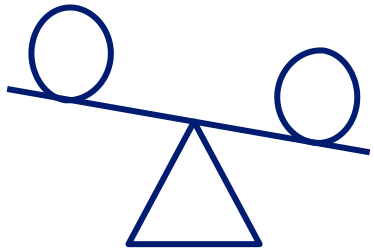
Segal

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

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
   - 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
   - There are less than 100 Retirees on the Defined Benefit plan that pay contributions
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 $12.6B in assets

Medical/Rx Projections

- Segal projects the following financial results for Calendar Year (CY) 2023:

	2023
Total Projected Claims	$646,604,000
Administration and Operational Expenses	$29,542,000
Pharmacy Contract Renegotiation/RFP	($11,000,000)
Rx Rebates	($52,109,000)
EGWP/RDS Subsidy	($76,306,000)
Total Projected Cost	$536,731,000
Premium Based Revenue*	$578,384,000
$$ Funding Overage/(Gap)	$41,653,000
% Funding Overage/(Gap)	7.8%

* Medical/Rx revenue is based on all participants at the Retiree composite rate 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 and not reflected in this projection.

- Experience continues to be favorable with a $41.7M projected overage.
- 2022 premium rates for Medical and Rx 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 approx. 50-65% less than a non-Medicare primary.
- Rates were unchanged for CY2022 over CY2021.
- Ongoing growth in Medicare membership continues to help offset increases in aggregate per capita costs due to trend.
- Modest increase projected for EGWP subsidies. Additional savings from renegotiating 2023 PBM contract.

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 continue to impact the 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, this current report 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. Additional projections may be out of scope

CY2023 Medical and Pharmacy Funding Rates

- There was a decrease in contributions effective CY2022 due to the growth in Medicare membership continuing to reduce aggregate per capita costs.
- Segal is not recommending any changes to the CY2023 contributions.

Baseline	2022	2023	$$ 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%

Medical and Pharmacy – Medicare and Non-Medicare

- Actual Medical/Rx plan experience for FY20 – FY22:

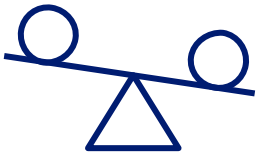
	Period 1	Period 2	Period 3	P1=> P2	P2=> P3
	Jul '19-Jun '20	Jul '20-Jun '21	Jul '21-Jun '22		
Members <65 PMPM	**$1,075.34**	**$1,137.45**	**$1,245.48**	**6%**	**9%**
Members 65+ PMPM	**$475.19**	**$473.63**	**$501.75**	**0%**	**6%**
Composite PMPM	**$629.22**	**$629.20**	**$663.08**	**0%**	**5%**
Total Medical/Rx Claims	**$558,974,442**	**$566,362,891**	**$603,579,956**	**1%**	**7%**

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 Waiver Plan (EGWP) from the Retiree Drug Subsidy (RDS) is providing additional drug subsidies and rebates from the federal government and will continue to help mitigate trend.
- Approximately 22% of the members used for the calculations in the table above are under age 65.

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 prior, and upcoming changes
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, resulting in final rates determined so that lower premiums in the near-term do not result in long-term solvency issues nor large premium increases when "excess" reserves are spent

DVA Background

- The Legacy Dental Plan was re-introduced effective January 1, 2020 and replicates the plan that was in effect prior to January 1, 2014. The 2020 Standard dental plan reflects the benefits that were in effect beginning in 2015 with minor/typical annual modifications.
  - Legacy Plan's 2020 rates reflect the difference in plan design, network configurations and recognized charge methodology for non-network provider payments compared to the Standard plan. Rates have not been adjusted since that time.
- Legacy Plan's 2020 rates were set equal to the difference in plan design, network configurations and recognized charge methodology for non-network provider payments with the Standard plan.
- The total differential between the Standard and Legacy plan is 14.3% (impact is multiplicative).

Plan Design Diff	Network Diff	Recognized Charge	Total
-1.0%	4.6%	10.4%	14.3%

- Recent experience indicates the Standard Plan has higher per capita costs than the Legacy Plan, due primarily to the large number of members with no claims in the Legacy Plan
- Due to the impact of COVID-19 on utilization, both the Legacy and Standard Plans lack sufficient credibility in their 24-month lookback experience periods to be individually rated at this time.

CY23 Dental, Vision, and Audio Funding Rates

- The Standard plan rates have remained level since CY17.
- Below shows a proposed option of holding rates flat for the Standard Plan and applying a reduction to the Legacy Premiums that would bring those rates in line with the Standard Plan for CY23.
- Premium levels, including the differential between the Standard and Legacy plans, will be re-evaluated for CY24.

Standard Plan Rates	2022	2023	$ Change
Retiree	$66.00	$66.00	$0.00
Retiree & Spouse	$131.00	$131.00	$0.00
Retiree & Child	$119.00	$119.00	$0.00
Retiree & Family	$187.00	$187.00	$0.00
Legacy Plan Rates			
Retiree	$73.00	$66.00	($7.00)
Retiree & Spouse	$145.00	$131.00	($14.00)
Retiree & Child	$132.00	$119.00	($13.00)
Retiree & Family	$207.00	$187.00	($20.00)

2023 DVA Projections

- Segal projects the following financial results for CY2023.
  - This is assuming Legacy Rates are reduced to Standard Rates effective January 1, 2023:

	Legacy	Standard	**Total**
Total Projected Claims	$27,741,000	$22,712,000	$50,453,000
Administration and Operational Expenses	$1,176,000	$994,000	$2,170,000
Total Projected Cost	$28,917,000	$23,706,000	$52,623,000
Premium Based Revenue*	$25,617,000	$20,679,000	$46,296,000
$$ Funding Overage/(Gap)	($3,300,000)	($3,027,000)	($6,327,000)
% Funding Overage/(Gap)	(12.9%)	(14.6%)	(13.7%)

- The Legacy and Standard Dental plans are being rated based on their own individual claims experience.
  - The Vision and Audio experience is not available based on member plan election and is assumed to be consistent for each Dental plan.
- Based on the changes in funding levels, there is a projected gap of approximately $6.3M between cost and revenue.
  - The DVA assets are expected to continue to be above the target funding range of 150%-250% of IBNR, even without a funding increase in CY2023.

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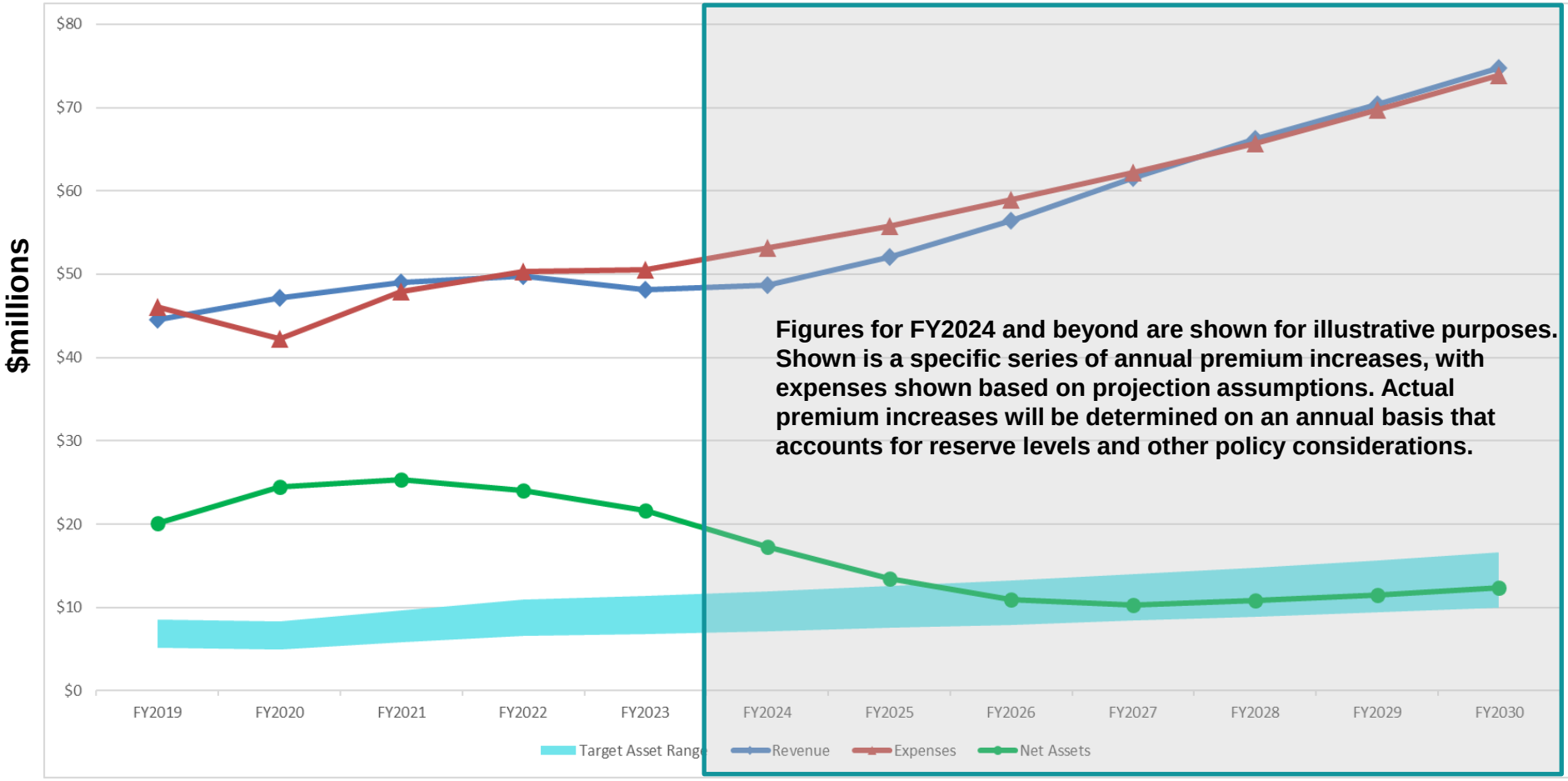
Projected DVA Revenues, Expenses, Net Assets ($millions)
0% Increase for CY23 and Moderate Subsequent Increases



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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. Rates will be re-evaluated during the next actuarial valuation as of June 30, 2023

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**

Questions?

Bylaws of the Retiree Health Plan Advisory Board

Article I
Name

The name of the organization is the Retiree Health Plan Advisory Board and is referred to in the bylaws as "the Board" or "RHPAB".

Article II
Purpose and Responsibilities

Section 1. Pursuant to Administrative Order No. 288, 319 and 336 the Board was created to facilitate engagement and coordination between members of the State of Alaska's retirement system, the Alaska Retirement Management Board (ARMB), and the Commissioner of the Department of Administration.

Section 2. The creation of the RHPAB will provide an efficient and transparent way to facilitate regular engagement, communication, and cooperation between the Office of the Governor, the ARMB, and the Commissioner, and retirement system members regarding the administration and management of the State's retirement systems.

Section 3. The Board's powers are limited to offering advice. The Board may not engage in activity directing the administration of the Plan.

Section 4. Duties and Responsibilities

The Board shall review non-confidential information, hold public meetings, and provide periodic reports to the Commissioner. The periodic reports may include recommendations to the Commissioner related to the health plansof the State's retirement systems, including optional life insurance, long-term care insurance, and optional dental-visual-audio programs.

In making recommendations, the Board should consider:

1. The cost of the services or changes relative to the long-term and short-term fiscal viability of the plans, including policies to retain prudent reserves in the plans;
2. The affordability of the health plans from the perspective of plan sponsors, participating employers and plan beneficiaries, including the effect of premiums and projected revenues, expenses and net assets; and
3. The clarity of the plan to beneficiaries, and the department's ability to offer consistent, transparent direction and oversight to third-party plan administrators.

The Board may also submit to the Commissioner, reports providing feedback on

the performance of service providers including third-party administrators, insuranceproviders, and annuity providers to the State's retiree health plans.

Article III
Membership and Terms of Office

Section 1. Composition

The Board shall consist of eight voting members, and one ex-officio member as detailed below. All voting members are appointed by and serve at the pleasure of the Governor.

1. One member who is an ARMB trustee by virtue of AS 37.10.210(b)(2).
2. One member who is a human resources official or financial officer employed by a political subdivision participating in the State's retirement systems.
3. One member who is a Public Employees' Retirement System (PERS) retired member, selected from a list of three individuals nominated by retiree groups that represent PERS members.
4. One member who is a Teachers' Retirement System (TRS) retired teacher or member, selected from a list of three individuals nominated by retiree groups that represent TRS members.
5. One member of the State's retirement system who is a retired member under PERS Tiers I, II, or III, TRS Tiers I or II, or the Judicial Retirement System (JRS).
6. One member who is an active or retired member of PERS or an active or retired teacher or member of TRS who is vested in the PERS Tiers I, II, or II or TRS Tiers I or II retiree plans. If an active member, the person should not be more than five years from eligibility for retirement.
7. One public member who is not a member or beneficiary of the PERS system, the TRS system, or the JRS; this person must have at least five years' relevant experience and expertise in health care administration, finance, or governmental budget issues, or other background helpful to the Board's mission.
8. One member who is an active member in good standing of the Retired Public Employees of Alaska (RPEA), selected from a list of three proposed candidates submitted by RPEA.
9. The Commissioner of Administration, or designee, shall serve as a non-voting, ex-officio member of the Board.

Section 2. Term of Office

1. Each member of the Board shall serve staggered terms consistent with AS

39.05.055, AS 39.05.060 and their appointment from the Governor.

2. The Governor may choose from the nominee list, request further solicitation, or make an appointment of the Governor's choosing.
3. If a vacancy occurs on the Board, the Governor may appoint an individual qualified for that seat to serve the balance of the unexpired term.

Section 3. Members of the Board receive no compensation for service on the Board but are entitled to per diem and travel expenses in the same manner permitted for members of State boards and commissions.

Article IV
Officers

Section 1. The Board shall annually select from its members a chair and a vice-chair.

Article V
Meetings

Section 1. The meetings of the Board shall be conducted in accordance with the AS 44.62.310-44.62.319 (Open Meetings Act).

Section 2. The Board shall meet at a date and time set by the Commissioner or the Commissioner's designee, expected to be quarterly. Board members are entitled to per diem and travel expenses in the same manner permitted members of state boards and commissions for at least one in person meeting per year.

Section 3. Five members, or a majority of the Board if a vacancy exists, constitutes a quorum.

Section 4. Proxy voting is not permitted.

Section 5. Members of the public present at the meeting of the Board shall be offered a reasonable opportunity to be heard in accordance with Board policy.

Section 6: The Board shall keep minutes of all of its board meetings and board committee meetings and a record of all proceedings of the Board. All minutes shall be maintained by the Commissioner of Administration, or their designee, and made publicly available.

Article VI
Committees

Section 1. The Chair may establish committees as the need arises including, but not limited to, a Modernization Subcommittee and a Regulations Subcommittee, and shall define the committees' duties and responsibilities.

Section 2. Committees of the Board shall, when specifically charged to do so by the Board, conduct studies, make recommendations to the Board, and act in an advisory capacity, but shall not take action on behalf of the Board.

Section 3. Unless otherwise determined by the Board, committees shall consist of no fewer than two board members and shall serve until the committee is discharged by the Chair of the Board.

Section 4. A committee shall be convened by the committee Chair or designee who shall report for the committee. The committee Chair shall ensure that minutes will be kept and submitted for Board review.

Section 5: Any member of the Board may attend a committee meeting.

Section 6: If the Chair convenes a Modernization Subcommittee or a Regulations Subcommittee, one position on each Subcommittee will be held by a member of the Retired Public Employees of Alaska, Inc. (RPEA) in good standing who will be selected by the Board from a list of three candidates to be submitted to the Division of Retirement and Benefits by RPEA. The selected RPEA representative shall abide by the Board Bylaws.

Article VII
Parliamentary Authority

Section 1. Meetings shall be conducted under Robert's Rules of Order, using the current edition, and such amendments of these rules as may be adopted by the Board.

Article VIII
Ethics

Section 1. Members of the Board shall at all times abide by and conform to the Alaska Executive Branch Ethics Act (AS 39.52).

Article IX
Amendments

Section 1. The Bylaws, as adopted, may be amended, altered, or repealed at any duly convened meeting of the Board provided that written notice of the proposed change(s) has been sent to each Board member at least (30) days before the meeting. Each time the Bylaws are amended the new version shall include the dates of amendment.

Version History

Adopted	05/18/2018
Amended	09/27/2022