RHPAB

8-29-18

Board Packet Materials & Presentations

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Redacted Public Comment is provided as a supplemental packet on line here:

http://doa.alaska.gov/drb/alaskacare/retiree/advisory.html

Retiree Health Plan Advisory Board
Meeting Agenda

Meeting:	Advisory Board
Date:	August 29, 2018
Time:	9:00am to 4:00pm
Location:	Juneau: State Office Building, 333 Willoughby Ave, 10th Floor Large Conference Room Anchorage: Atwood Building, 550 W 7th, Suite 1270 Conference Room
Teleconference:	**855-244-8681** / Event Number: 803 265 240 WebEx Link: https://stateofalaska.webex.com/stateofalaska/onstage/g.php?MTID=e9fd015a76a4a7dd17949c7c079877879
Board Members:	Mark Foster, Joelle Hall, Gayle Harbo, Dallas Hargrave, Mauri Long, Judy Salo, Cammy Taylor

August 29, 2018

9:00am **Call to Order – Judy Salo, Board Chair**
Roll Call
Approval of Agenda*
Ethics Disclosure
Approval of Minutes*
- May 8, 2018

Calendar 2018,2019 Approval*
Bylaws, Final w/ one correction - ARB to ARMB*

9:30am **Public Comment**

10:00am **Department Update -** Leslie Ridle, Commissioner

10:10am **Break**

10: 30am **Modernization Committee Report**

12:00pm **Lunch on your own**

1:00pm **EGWP Discussion**

2:30pm **Break**

2:45pm **Action Items:**
EGWP Advisory Vote

3:45pm **Closing remarks**

4:00pm **Adjourn***

**Indicates a required motion*

Meeting Minutes
5/8/18

Retiree Health Plan Advisory Board

Board Meeting Minutes

Date: Tuesday, May 8, 2018 9:00 a.m. to 4:00 p.m.

Location: State Office Building 333 Willoughby Avenue 10th Floor Juneau, AK 99801 and Robert B. Atwood Building 550 West 7th Avenue Suite 1970 Anchorage, AK 99501

Meeting Attendance

Name of Attendee	Title of Attendee	
Retiree Health Plan Advisory Board (RHPAB) Members		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Mark Foster	Member	Present
Joelle Hall	Member	Present
Gayle Harbo	Member	Present
Dallas Hargrave	Member	Present
Mauri Long	Member	Present
State of Alaska, Department of Administration Staff		
Leslie Ridle	Commissioner, Alaska Department of Administration	
Natasha Pineda	Deputy Health Official	
Vanessa Kitchen	Administrative Assistant	
Ajay Desai	Director, Retirement + Benefits	
Emily Ricci	Health Care Policy Administrator, Retirement + Benefits	
Michele Michaud	Deputy Director of Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Kevin Worley	CFO, Retirement + Benefits	
Others Present + Members of the Public		
Richard Ward	Segal Consulting (designated actuary for state health plans)	
Linda Gable	Manager of Client Services, Aetna	
Haley Duran	Local Representative + Associate Account Manager, Aetna	
Brad Owens	Public, representing Retired Public Employees of Alaska	
Sharon Hoffbeck	Public, representing Retired Public Employees of Alaska	
Clair Martin	Public	
Phil Mundy	Public	
Dorne Hawxhurst	Public	
Grant Callow	Public	
Lisa Fitzpatrick	Public	

Common Acronyms

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

- ACA = Affordable Care Act
- CMS = Center for Medicaid and Medicare Services
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (for Tier 4 PERS employees and 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
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- 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
- 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.
- RHPAB = Retiree Health Plan Advisory Board

Meeting Minutes

Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 9:00 a.m.

Agenda + Minutes Approval

Materials: Agenda packet for RHPAB Meeting 5/8/18; Draft minutes from RHPAB Meeting 2/7/18

- **Motion** by Gayle Harbo to approve the agenda as presented. **Second** by Cammy Taylor.
  - **Discussion**: None.
  - **Result**: No objection to approval of agenda as presented. Agenda is approved.
- **Motion** by Gayle Harbo to approve the 2/7/18 minutes as presented. **Second** by Joelle Hall.
  - **Discussion**: Board members reviewed the minutes. Judy Salo, Gayle Harbo and Dallas Hargrave identified corrections to their personal information. Natasha Pineda recorded the changes and identified she would make the necessary adjustments in the final version of the minutes.
  - **Result**: No objection to approval of minutes as presented, pending typos and other minor corrections identified. Minutes are approved.

Ethics Disclosure

Materials: Ethics Disclosure Form in 5/8/18 meeting agenda packet

Judy Salo introduced the ethics disclosure form that board members are required to complete and sign.

Calendar Review

Materials: Meeting Calendar Options in 5/8/18 meeting agenda packet

Discussion to determine which month would be best to hold future meetings. Dates in February, May, August and November were identified as quarterly meeting months and potential dates for each month were identified. The board also discussed how to align the quarterly board meetings with other required meetings, such as with quarterly Third Party Administrator meetings.

May was a concern due to expense and February a concern due to the legislature being in session. Gayle Harbo proposed that November 6, 2018 would likely be the least expensive. Judy Salo identified that at today's meeting she would like to firm up August and November 2018 meeting dates, and tentatively decide on when the 2019 in-person board meeting would be. Judy Salo stated that this discussion would be continued later in the agenda.

Upcoming board meeting: August 29, 2018 (8/29/18). Future meetings are discussed under Item 4.

Public Comment Process

Materials: Public Comment Guidelines in 5/8/18 meeting agenda packet

Discussion of public comment guidelines document for the board. Natasha Pineda led the review of the Public Comment Guidelines document, noting that recommended changes are highlighted. Ms. Pineda stressed the need to be cautious about publishing protected health information (PHI), including in public comments, because the state is the administrator for the health plan. Additionally, the board's role is advisory only and focused at the policy level related to the state's health plans. The board does not have a role in hearing medical appeals. The public comment guidelines should make this clear and encourage the public to limit sharing of their personal information on the public record, and instead use the proper channels for appeals. Staff will request legal guidance on how to handle these situations in the future and avoid sharing PHI from members of the public. Concerns regarding a specific case or administrative issues should be directed to Aetna, their concierge number is 1 (855) 784-8646. Ms. Pineda will add this to the public comment guidelines.

There was mention of the 3-minute time limit for public comment, as RHPAB had previously identified a 2-minute time limit. Judy Salo requested it be left at 3-minutes and proposed giving more time (up to 5 minutes) for someone who is speaking on behalf of an organization or group. It was clarified that the Chair is tasked with running the meeting and can grant additional time as needed.

Emily Ricci provided a brief description of protected health information: A provision under the HIPAA laws that protects any and all health information that is identifiable at an individual level (Examples given: types of coverage, types of services they are receiving, a specific diagnosis, names and addresses).

Mark Foster asked about cases when a person making a comment has been asked whether they would waive their confidentiality to share the information, and the person has indicated yes. Michele Michaud responded that this question would also be referred to Department of Law for their opinion on these issues. Emily Ricci identified specific concerns about posting transcripts online and wanting to get legal guidance in this matter.

Cammy Taylor suggested developing a form for individuals commenting to check off if they want to waive their confidentiality, so that there is a physical record regarding their comments. Natasha Pineda

identified that this has been discussed. Emily Ricci stated that this is a good solution for people testifying in-person, but this will not necessarily address the issue of people testifying by phone or online.

Cammy Taylor was concerned that written comments needing to be received thirty days prior to the board meeting may preclude people from participating in the process. The group discussed time needed to review comments, set agenda and post the board packet: staff noted that they need sufficient time to review each comment and redact any protected health information that should not be in the public record. Additional board members identified a desire to shorten the thirty-day window for written comments. Joelle Hall proposed notification for public comment and posting of the agenda thirty days prior to each board meeting and setting a schedule so the public knows they have two weeks to provide comment. Additionally, members of the public can submit comments at any time, they just may not be included in the next board meeting packet if there is not enough time to review and post the comment. The public can also attend or call into board meetings and share their comments verbally during the meeting in the public comment period. Natasha Pineda proposed using this schedule for the 8/29/18 meeting; the board agreed.

Cammy Taylor also requested that all board materials (agenda packets, minutes, additional documents) be available online, including cumulative materials from past meetings. Staff confirmed that they can implement this and make sure board meeting materials are posted and kept online as a resource, provided that they do not contain confidential or protected health information.

Item 2. Bylaws Review and Adoption

Meeting materials: Draft Retiree Health Plan Advisory Board Bylaws in 5/8/18 meeting agenda packet

Judy Salo invited Dallas Hargrave to walk the group through the bylaws.

Mr. Hargrave stated that Natasha Pineda prepared a draft of the bylaws for the Bylaws Subcommittee to review, following the guidelines in Administrative Order 288 (AO 288). Dallas Hargrave, Cammy Taylor, Judy Salo, and public member Pat Nault participated in the subcommittee meeting and reviewed the draft bylaws on 4/11/18. Joelle Hall was also a member of the subcommittee, she was unable to attend that meeting but reviewed the bylaws separately. The subcommittee decided that a second meeting was not necessary and has endorsed the draft shared with the board for approval. Dallas Hargrave led an article by article discussion of the bylaws.

- Article 1: No discussion or revisions.
- Article 2: Discussion of Section 3, regarding language "qualify as administration in support of health plan."
    - **Motion** by Mauri Long to amend Article 2, Section 3 to read "… the board is advisory only." Strike language about administration of the health plan. **Second** by Mark Foster.
        - **Discussion**: Board members discussed their advisory role and how it relates to administration of the health plan. RHPAB does not hear appeals and does not have a quasi-judicial role. However, the proposed bylaws language was taken from AO 288, which is ultimately the authority for this board.
        - **Result**: The board voted. 3 Yes, 4 No. Motion fails.

- **Motion** by Mauri Long to amend Article 2, Section 3 to read "the Board is advisory only and may not engage in activity in administration of the health plan." **Second** by Joelle Hall.
    - **Discussion**: Question from Mauri Long about whether it is appropriate to make reference to AO 288 or whether the bylaws are changing the intent of AO 288. The group agreed the administrative order itself is not changing.
    - **Result**: The board voted.

Foster	Hall	Harbo	Hargrave	Long	Salo	Taylor
Yes	Yes	Yes	Yes	Yes	N/A	Yes

Motion passes, bylaws will be amended accordingly.

- Article 2: Typos identified in Section 4, these will be corrected. No motion required.
- Article 3: No additional changes. Dallas Hargraves noted that the subcommittee discussed Section 3 regarding compensation and travel expenses, and that it should be consistent with Article 5, Section 2.
- Article 4: No additional changes. RHPAB will have a Chair and Vice Chair, chosen annually.
- Article 5: No additional changes. Committees will be established by the Chair, must have at least two board members, and will serve until discharged by the Chair.
    - Dallas Hargraves noted that the references to travel expenses is consistent with Article 3, Section 3 and that all travel is subject to approval by DOA. The purpose of organizing in-person meetings in different locations each year is to allow for members in different communities to meet in the same place, and to rotate the location periodically so it is not always in Anchorage, for example.
    - Mauri Long asked whether the language in Article 3, Section 3 and Article 5, Section 2 is repetitive, does it need to be included twice? Dallas shared that the committee's rationale was that it was included in AO 288 and is relevant in both sections. No motion.
- Article 6: The subcommittee proposed not establishing standing committees, but giving the board the authority to establish committees as needed: for example, the bylaws subcommittee performed its function and saved the board from a detailed discussion about the bylaws before this final review and approval.
- Article 7: No additional changes. The board will follow Robert's Rules of Order in meetings.
- Article 8: No additional changes. The board will follow the Alaska Executive Branch Ethics Act.
- Article 9: No additional changes. Proposed amendments to the bylaws require 30 days notice.

- **Motion** by Dallas Hargraves to adopt the bylaws as amended during the meeting, and pending technical edits and correction of typos by staff. **Second** by another board member.
    - **Discussion**: None.
    - **Result**: The board voted: Judy Salo stated that the chair typically only votes in the case of a tie. She opted to vote this time because the adoption of bylaws is important.

Foster	Hall	Harbo	Hargrave	Long	Salo	Taylor
Yes	Yes	Yes	Yes	Yes	Yes	Yes

Motion passes. Bylaws are adopted.

Item 3. Public Comment

Before beginning public comment, the board established who was present in Anchorage and Juneau, on the phone or online, and who intended to provide public comments. Sharon Hoffbeck (RPEA), Phil Mundy, Dorne Hawxhurst, Grant Callow, and Lisa Fitzpatrick attended and did not wish to testify.

Public Comments

Brad Owens, Executive Vice President of the Retired Public Employees of Alaska (RPEA). Brad stated that he is providing comments on behalf of RPEA. Mr. Owens requested that the RHPAB consider the information he provides, investigate it, and make recommendations to the Department of Administration (DOA). He provided comments on several topics:

- RPEA was created in 1996 and incorporated in 1998. Its membership includes retired public employees, current public employees, and dependents. RPEA's mission is to educate, assist and advocate on behalf of all retirees in Alaska.
- Employer Group Waiver Program (EGWP): DOA proposes to change the current pharmacy benefit subsidy program to EGWP. EGWP is a federal program under Medicare and can be modified, suspended or terminated at any time; the current subsidy program is constitutionally protected from changes. EGWP would impose a substantial burden on retirees through the complex regulations and procedures that would apply, and don't apply to the program retirees have now. It appears DOA is proposing the EGWP primarily for cost savings, which is a valid goal but should be accompanied by due diligence to make sure the changes don't hurt retirees. Additionally, DOA has stated they are proposing implementation in 2018, which is of concern.
- Retiree Health Plan Modernization: DOA says that it proposes to make changes by amendments to the plan over the next two years, but if you look at the time cycle in the materials, it looks like it is already in process for implementation in 2018. There needs to be a balancing of the costs and benefits of these changes, to make sure that they are not implemented simply for the sake of cost savings, or take away protected benefits. The materials seem focused on cost-saving efforts rather than benefits, protection, or enhancement. RPEA feels that the State has failed to perform sufficient analysis of these changes as required by the 2003 Alaska Supreme Court Case *Duncan vs. RPEA*. The case established that the State must demonstrate that the changes are not a diminishment of benefits; if it is a diminishment, they must be offset by comparable enhancements to benefits to maintain or improve the overall value of the plan.
- DOA seems to be systemically denying retirees their right to appeal denials to the DOA. They do that by settling certain claims, such as physical therapy or occupational therapy, and that the settlement resolves the case but is not applicable to future cases which would require a new appeal. RPEA believes that retirees should have the ability to take their full appeal before the Office of Administrative Hearings (OAH).

Mark Foster asked Mr. Owens whether or not specific concerns about the EGWP have been raised with the DOA? Mr. Owens identified that RPEA and other retiree organizations have been in regular contact with DOA about proposed changes over the past eight years. DOA has described the EGWP program and potential benefits in these conversations, but there has not been a discussion about or clear documentation of the process or procedures that were followed to reach the conclusion that, for example, the EGWP change will not diminish benefits.

Written comments with redacted information. Two written public comments were submitted as hardcopy documents to the board, but were not read into the record. It was identified that these comments, with redactions, would be published on the RHPAB website as part of the minutes.

A board member commented that he would like the board to consider how best to utilize public comments, especially when they raise policy issues of interest to RHPAB and the Department. Commissioner Ridle commented that these are relevant questions for the modernization project, there will be a presentation (*see 5/8/18 agenda packet*) to provide a status update. The board will continue to be involved in this project and certainly can make policy recommendations to DOA.

Clair Martin, public member (later in the meeting). Clair Martin commented that she had technical difficulties connecting during the public comment period. She commented that she wished the RHPAB would suggest to Aetna that they include preventative programs such as "Silver Sneakers" (a wellness program available through many Medicare secondary insurance programs) into retirees' benefits. She would like to see better coverage of preventive care and wellness programs, they have many physical and mental health benefits for seniors.

Judy Salo commented that preventive care is something the commissioner may bring up during the modernization discussion in the afternoon. Commissioner Ridle also invited the speaker to attend future meetings about the modernization project to learn more about what is being proposed and to stay involved in the effort.

Item 4. Scheduling Calendar of 2018 and 2019 RHPAB Meetings

Meeting materials: 2018-2019 Calendar Options in 5/8/18 meeting agenda packet

The August meetings dates have already been determined and will take place in Juneau. The quarterly retiree plan meeting will be on August 28, 2018 (8/28/18) and the RHPAB Board Meeting will be on August 29, 2018 (8/29/18).

The board and staff discussed relevant deadlines and other recurring events. Michele Michaud gave the example of quarterly review of the plan's performance with the vendors (Aetna and Moda), and reviewing actual claims data to understand cost and utilization trends. For example, some procedures or services are costly, and understanding trends for these services can help with plan design in the future. Emily Ricci added that this information is formatted like a dashboard and typically includes information about claims, demographic information about members served, and other measures.

Joelle Hall asked whether these quarterly review documents can be shared with the public? Emily Ricci noted that general, high-level information such as overviews of claims denials and customer service performance can be shared publicly, staff provides this information to stakeholder groups. The full reports can be shared with RHPAB as well, there is a lot of detailed information about the plans.

Cammy Taylor asked whether RHPAB members can participate in the quarterly review meetings with DOA staff and their vendors? Michele Michaud indicated that they can, and shared that the next meeting will be May 23, 2018. Judy Salo also noted that there is not a requirement for board members to attend, but the information may be helpful to better understand the AlaskaCare plans.

Cammy Taylor also requested that staff compile a high-level summary of information for RHPAB to review, pulled from the quarterly dashboard reports from each of the plans' vendors.

- **Motion** by Cammy Taylor to set the following RHPAB meeting for November 28, 2018 (11/28/18), coinciding with the Aetna Quarterly Retiree Plan stakeholder meeting on November 27 (11/27/18). **Second** by Joelle Hall.
    - **Discussion**: Gayle Harbo shared her rationale for the proposed dates: meeting once per quarter, during the months that the vendor will be visiting Alaska, and earlier in the month is less disruptive particularly in May and November. Judy Salo noted that she is a part year resident so she is not typically in state year round. Joelle Hall commented that she also prefers meetings not adjacent to holidays, she has children in school. Dallas Hargraves requested an electronic calendar invite from staff to reserve these dates.
    - **Result**: No objection to November date. The RHPAB will meet on 11/28/18 in Juneau.

The board then discussed potential dates for 2019: RHPAB has quarterly meetings, and the group discussed having these dates coincide with vendors' travel to Alaska for quarterly meetings.

- **Motion** by Gayle Harbo to set the following dates for 2019 RHPAB meetings: February 6, May 8, August 7 and November 6, 2019. Which meeting(s) will be in person versus telephonic will be determined later. **Second** by Judy Salo.
    - **Discussion**: None.
    - **Result**: No objection to November date. The RHPAB will meet on 11/28/18 in Juneau.

Item 5. Department Update – Leslie Ridle, Commissioner

Commissioner Leslie Ridle provided updates on several items:

Legislative Updates

- HB 240, the Pharmacy Benefit Manager Bill or PBM bill. This bill passed May 7, 2018. The bill had widespread support and an almost-unanimous vote.
- HB 306, which pertains to how tier 4 retirements would be dispersed to members. [Note: HB 306 passed on May 8, 2018 and was signed into law on June 18, 2018].

Procurement for Third Party Administrator for Some Health Plan Services

- Leslie shared an overview and status of the procurement process for each, including evaluation committees. For procurements impacting active employees, the Health Benefits Evaluation Committee was also consulted.
- Leslie noted that DOA is working on three procurements related to health care services:
    - Travel benefits (concierge service to make travel arrangements upfront rather than reimbursement). RHPAB member Cammy Taylor was an evaluation committee member.
    - Pharmacy benefit management (PBM) to manage prescription drug benefits. RHPAB member Judy Salo was an evaluation committee member.
    - Third party administrator for medical and dental benefits. DOA is currently reviewing and finalizing the RFP for this procurement. Leslie requested that one RHPAB member join the evaluation committee, which will require in-person interviews and committee

meetings to discuss the proposals. The plan is to release this RFP in the third quarter of 2018.

- Cammy Taylor commented that in 2014, the medical and dental plans were proposed as separate contracts, but this is the first time the pharmacy benefit will be carved out and managed by a vendor under a separate contract from the other benefits.

Pending Decision on 2014 Court Case Regarding Health Plan Amendments

- DOA is facing litigation connected to 2014 amendments to the dental, vision, audio (DVA) plans for retirees; retirees pay for that coverage, although it is also administered by the State. In 2016 a lawsuit was filed and RPEA won a summary judgment that ruled that dental plans are constitutionally protected and that DOA should go to court to determine if the 2014 amendments resulted in diminishment of benefits. The court case is in progress and is scheduled to be heard for two more days in June.
- Leslie noted that actuarial analysis of the changes estimated about 10 to 14 percent in annual savings, or $13 to $18 million in savings since the change. This represents additional assets for the DVA (dental, audio, vision plan) trust, which have kept premiums for the DVA lower despite an increase in the price of services due to inflation. Depending on the outcome of the court case, if the DVA plan could not maintain those savings, it would necessitate an increase in premiums to offset increasing claims costs and maintain sufficient assets.
- There will be more information once the judge makes a decision, and this item will be discussed further at the August meeting unless the case is still pending.
- Judy Salo asked whether dental coverage has always been separate from the medical plan? Michele Michaud confirmed that this benefit has been separate. Emily Ricci added that unlike other plans they administer, all members pay for this directly.
- Mauri Long asked for clarification about the court decision and how it impacts future decision making about the plans? Leslie stated that she does not know the specifics yet, but the judge could give the State a certain timeframe to address these issues, and there will hopefully be time to further discuss the implications of the changes while still complying with the court's decision.
- Board members and Commissioner Ridle generally discussed the implications of this court decision and other decisions about the health plans (such as the *Duncan* case) as it relates to the modernization project and other issues RHPAB will have a role in. What basis for comparison and decision making will the State use, and RHPAB use, to consider proposed changes to the plans?
- Mark Foster asked staff to create a template for evaluating the proposals for future decisions. Leslie agreed that this would be helpful, and that staff are still developing the process for considering these changes under the modernization project. Many of the changes being considered are benefits that members have said they want, it is a matter of following a clear process in light of the legal issues associated with plan changes.
- Judy Salo agreed that a framework would be helpful, it establishes some certainty about the future for retirees, and also will help future boards (RHPABs) when discussing future changes or issues related to the health plans.
- Mauri Long asked whether there have been significant changes to the health plan since 2000? The plan booklet has had some changes to it since then. Michele Michaud clarified that the plan

has had some specific changes, documented as amendments in the front of the booklet, but no significant changes to the plan itself. There was a comprehensive amendment to the booklet in 2014. Emily Ricci added that the purpose of clearly documenting the booklet changes is that, even if the plan itself isn't changing substantially, clearly noting changes in the booklet increases transparency to members.

Item 6. Employee Group Waiver Program (EGWP)

Materials: EGWP presentation and frequently asked questions in 5/8/18 meeting agenda packet

Emily Ricci and Michele Michaud provided an overview presentation for the Employee Group Waiver Program. The state's health benefit consultant and actuary, Richard Ward of Segal Consulting, was also available to answer questions or clarify technical issues.

Presentation

The presentation gave an overview of the Employer Group Waiver Program (EGWP) and its purpose, a group pharmacy benefit plan under Medicare Part D. This change would impact only retirees and dependents eligible for Medicare, since it is a Medicare program; retirees who do not qualify for Medicare would remain on the non-EGWP pharmacy plan.

The State is exploring use of an enhanced EGWP, which allows the State to provide coverage for additional medications beyond what is covered under Medicare Part D and maintain member's existing benefits. This subsidy program was included in the RFP for the new Pharmacy Benefit Manager (PBM) contract, so the presenters noted that many specific questions will need to be resolved with the vendor when they have been selected, since many details about plan design will depend on the vendor.

The State currently participates in the Retiree Drug Subsidy program and receives approximately $19 to $21 million per year, compared with a total expenditure of $240 million in pharmacy benefits for retirees—this is approximately 45% of total retiree health plan expenditure, much higher than the typical 20% for commercial insurance plans. EGWP has three types of subsidies: direct per member subsidy, regardless of how many benefits the individual used; coverage gap subsidy with a 50% discount on brand name drugs if the member falls into the coverage gap; and catastrophic coverage subsidy, where Medicare provides 80% reimbursement for high utilizers (pharmacy spending over $7,500 per year). The State would retain the RDS to subsidize costs for non-EGWP eligible members, but this will be a much smaller subsidy going forward.

The projected savings by changing to an EGWP do not only affect the State's health trust, it may also help decrease or offset the State's assistance payments, which could represent between $40 and $60 million in State General Fund payments. State assistance payments are funds transferred for the State's unfunded liability in the benefits system for pension, health plan, and other benefits, with the goal of making regular payments to this system to close the gap by year 2039. State assistance payments have ranged between $100 million and $500 million.

Emily Ricci and Michele Michaud also commented that the demographics of the plan are changing: more retirees are Medicare eligible. Gayle Harbo commented that she's heard the statistic, approximately 70 percent of retirees are Medicare eligible.

Staff identified additional impacts, either during the initial transition period or going forward:

- Co-pays will remain the same as the current plan, so generally members will not be impacted when filling prescriptions.
- Additional required communications from CMS, who oversees Medicare.
- Pre-authorizations for medications cannot be carried forward into the EGWP. Members will need to obtain new authorizations.
- Some members with multiple health conditions and high utilization will be enrolled in the Medicare Medication Therapy Management Program, unless they opt out. CMS considers this to be a member protection. The program will provide assistance and resources for people to better manage their medications—it does not require the patient to follow the advice.
- There is an appeal process for Medicare Part D claims, members in the enhanced EGWP will need to follow this appeal process. It is comparable to the state's current appeal process, but involves the federal court system rather than state courts.
- Per CMS rules, the benefit will require up to a 90-day supply, not 100 units. Past claims data shows that very few retirees utilize the 100 unit refill option currently.
- Medicare Part D has a formulary with specified tiers of medications, and what can be covered in each tier. The enhanced or "wrap" of benefits with EGWP allows the State to cover additional medications, which is important to maintaining members' current pharmacy benefits.
- Members may need to present two ID cards for the plan to their pharmacist, one for Medicare Part D benefits and another for the enhanced EGWP benefits. This will depend on the vendor.
- Members who opt out of the enhanced EGWP plan will be enrolled in the alternative plan, the same for those in the defined contribution (DCR) plan.
- Members who are high income (individual income over $85,000 or a married couple with income over $170,000) would be required to pay an additional premium, like other Medicare plans. The State is working on options for reimbursement so this is not an additional out of pocket expense for impacted members.
- There are additional questions to resolve with the new vendor, such as how pre-authorizations will be handled, ensuring that members are not subject to "step therapy" meaning that they have to switch to lower cost medications first, inclusion of pharmacies in the network, and accessing information about benefits (such as explanation of benefits documents).

Questions and Discussion from Board Members

Cammy Taylor asked for clarification about whether medical pharmacy and hospital pharmacy expenses are covered under this plan or separately? Hospital and medical (drugs administered at the doctor's office) pharmacy costs are typically covered under the medical plan.

Joelle Hall asked whether the recently-passed HB 240, regulating PBMs, impacts the state? Leslie Ridle commented that the bill does not pertain to the state plans, more to private insurance plans. Emily Ricci added that staff have been engaging with independent pharmacists about specific issues impacting them, such as generic versus brand name medications.

A board member asked how often subsidies are paid to the State? RDS payments are quarterly, and rely on past claims data. EGWP payments are made monthly, and because it is a per member payment, it is easier to forecast the subsidy amount. Gap coverage and catastrophic coverage payment would be more delayed, as they deal with individual claims.

Mauri Long asked about the meaning of the State being the plan fiduciary, and what this means for the new PBM contract? Is this required in statute or case law? Michele Michaud answered that because the State is considered self-insured, in statute the State is responsible as the plan fiduciary. In the enhanced EGWP, per CMS rules, the Pharmacy Benefit Manager becomes the plan fiduciary for pharmacy benefits—it is buying a fully insured product from the PBM vendor, rather than being fiduciarily responsible as an insurer.

Joelle Hall asked if and how the formulary can be adjusted, if it is set by Medicare Part D? Emily Ricci and Michele Michaud commented that the State can still work with the vendor to include or change coverage of prescription drugs—this is not being given only to the PBM to manage. Additionally, in addition to the Medicare Part D formulary, the enhanced EGWP wrap from the state can be used to cover other prescriptions or at different levels. Additionally, Joelle Hall shared a concern that the PBM will agree to cover a certain number of drugs in an initial formulary, then remove coverage over time, a "lock leader" once the plan is secured. Emily Ricci and Richard Ward explained the CMS-mandated process for establishing formularies, which requires advance filing for next year's formulary.

Joelle Hall also asked whether this shift to the enhanced EGWP would mean that the same benefit protections still apply, or does this become a different system so the question of constitutionally protected benefits would not apply in this situation? Commissioner Ridle answered that she believes it is the benefits themselves, not a specific program, that are constitutionally protected. The current RDS program is, for example, a reimbursement system not a benefit itself. EGWP would be the same, it is an administrative change, with the goal that the actual benefit (such as co-pay amount) remains the same.

A board member asked for clarification about the process of re-evaluating or changing when the state begins the EGWP? Can the State choose to discontinue the new plan? And what would happen if significant changes in federal law (such as, discontinuation or defunding of the EGWP program) occurred? How would the State ensure benefits are not disrupted? Michele Michaud and Emily Ricci responded that there is an annual renewal of EGWP so changes could be made at that time, or the State could unenroll if it is not working. Additionally, the State cannot predict what changes might happen at the federal level, the current subsidy program is also a federal program that can change. Regardless of how the pharmacy benefits are paid for, the State has an obligation to provide benefits, and the large expenditure on the pharmacy plan (either the largest in the state, or one of the largest) is an area where the State is trying to contain costs and consider options in order to continue providing these benefits.

Item 7. Introduction of Retiree Modernization Concepts

Materials: Retiree Health Plan Modernization presentation in 5/8/18 meeting agenda packet

Commissioner Ridle gave opening remarks: The Division is working on several initiatives to improve the retiree health plan and its sustainability long term, under the umbrella term of "modernization project." The State has to evaluate each proposal in terms of actuarial value and cost to the State, to ensure benefits are not diminished in the plan (retaining or gaining in actuarial value) as well as whether they have the resources to implement or offer new benefits. The comparison is not a simple trade off of "gaining four things, losing two things" because of how the health plan must be evaluated. The Division is consulting with stakeholders including retirees, legislators, the governor's office, and others. Staff will introduce the changes being considered, some of these proposed changes are benefits that retirees and members have asked for.

Emily Ricci and Michele Michaud provided an overview presentation of Retiree Health Plan Modernization. Michele clarified that the proposals being discussed relate specifically to the Defined Benefit (DB) retiree health plan, and not the Defined Contribution Retirement (DCR) plan. The goal of the modernization project is to provide value to the members by incorporating common benefits not currently available, while preserving the overall benefit of the plan and implementing standard cost-saving mechanisms. The current retiree health plan is considered an "old" plan because it does not have several common benefits in other health plans, and also does not have cost control mechanisms common in most other health plans. Balancing the quality and value of benefits offered, against the need to sustainably pay for the plan over the long term in order to meet the State's constitutional obligations, is complicated. This will take time, and the Division intends to collaborate with retirees and with the board to consider these changes. The timeline would be to begin implementation of some changes in 2019, after careful consideration and analysis, and that it would take several years to fully implement changes to the plan.

The Division has an annual cycle for reviewing and making changes to the health plan: the plan renews on January 1, and there are several steps including identifying issues or improvements, considering solutions, conducting analysis of the options, seeking public input on the proposals, and finalizing the decisions in the fall before the new plan takes effect on January 1. The Division has to follow this process and be mindful of the annual cycle for the plan, to properly time this process to go into effect in the following year if possible.

Staff gave historical background: the plan was created in 1975, and was written primarily as a plan to address illness or injury. The health care field has evolved since then, with one of the biggest changes being more of a focus on wellness and preventive care than the current plan provides for. In 1997, the State changed the plan from purchasing a fully-insured plan (like commercial insurance) to a self-insured plan, meaning the State has ultimate financial liability for health care expenditure in the plan. The presentation includes a comprehensive list of changes from 1983 to 2000. There were several changes to the plan in 1999-2000.

The Constitution and Alaska case law have established the following guidelines for changes to the plans: first, when considering the disadvantages of changes, they must be offset by new advantages, taken as a whole—not necessarily on an individual member basis. An individual's situation can, however, be considered, if an individual can demonstrate serious hardship (which is not currently defined in law).

Staff have identified 12 areas of concern that members have communicated to the Division, and the team is working on possible solutions. The table on slide 9, reproduced below, summarizes the 12 areas.

#	Concern	Possible Solution
1	Limited preventive care services	Add coverage for full suite of preventive services
2	Lifetime limit of $2M	Remove or increase limit
3	Low cost share reduces sensitivity to price & increases unnecessary services	Increase deductible and out-of-pocket maximum
4	Increasing costs of pharmacy benefits	Implement 3-tier pharmacy benefit, change out-of-network benefits
5	Outdated pharmacy design	Limit to 90 day fill, exclude OTC equivalents
6	Safety and efficacy of drugs	Limit compound coverage for non-FDA approved drugs
7	Limited travel benefits	Enhance travel benefits
8	Confusion over rehabilitative services	Implement clear service limits or hire specialized vendor
9	Confusion over dental implants	Exclude some implants from medical plan and cover under dental plan
10	High use of hi-tech imaging & testing	In-network enhanced clinical review
11	Dependent coverage limits	Statutory change
12	Confusing plan booklet	Update to include regulations, amendments & benefit clarifications

Judy Salo asked for clarification about constitutional protections for accrued benefits, and the impacts of the 1999-2000 changes? Michele Michaud explained that the lawsuit filed after these changes were made (*Duncan v. RPEA*) was the case that established the guidelines for changes to the health plan. The court ruled in that case that the changes made to the health plan were not a diminishment of benefits, but also that the health plan is constitutionally protected. The case did not give detailed guidance, however, and relied on actuarial analysis of the plan to establish that the benefits were equivalent to the old plan. More legal guidance is needed to clarify what is protected.

More information about components:

- Updating plan booklet: the booklet has not been substantially updated since 2003, and changes have been documented in the front of the book not in the sections they apply to. The Division will be publishing a new draft booklet and seek public comments—the booklet draft will highlight what changes have been made, so readers can clearly understand the revisions. The changes are not substantive to the benefits themselves, it is basically a reorganization and cleanup of the booklet to make it easier to use.
- Preventive services: the current plan covers limited preventive services, such as mammograms, and PSA tests. Members have asked for more preventive benefits. The State is considering how to expand these benefits, such as focusing on in-network care versus out-of-network, and exceptions for areas without in-network options.
    - Mauri Long asked for clarification about what full preventive services would be? Emily Ricci answered that there are established best practices available nationally, such as recommendations from the U.S. Preventive Services Task Force, that would inform what services would be covered.

    - Mauri followed up to ask, has the State analyzed the additional cost of providing these services, and compared this against additional health care costs for not covering these services that would occur? Is this change cost neutral, or what is the additional cost that needs to be offset to offer these benefits? Emily Ricci responded that the State is still conducting analysis on this, but initial work has shown that there will be an additional cost for providing this. They have not yet compared the potential savings, which can be difficult to quantify. Staff will do more analysis in this area.
- Lifetime limit: Currently the plan has a $2 million lifetime limit, but some members with extremely costly medical episodes have ended up using a quarter ($500,000) or half ($1 million) of this benefit in a short time, particularly as health care costs have increased. Staff is looking into removing the lifetime limit.
    - Mauri Long requested information about the last change of lifetime limit (from $1 million to $2 million) in 2000, and how many members have reached this limit. She would like to understand the financial implications of the higher limit, and therefore possibly removing this limit.
    - Staff commented that the number of retirees reaching this limit is increasing.
- Cost sharing (co-pays and deductibles: The retiree health plan has lower cost sharing for members than most other health plans. There is a delicate balance between keeping costs manageable and making sure people have access to necessary care, and ensuring that members remain price sensitive and utilize care appropriately (meaning, not using unnecessary services because they do not feel the impact of the costs of those services). Because Alaska only has a fee for service health care system, it is difficult to incentivize cost containment. One tool to do this in the current system is to increase deductibles or out of pocket maximum amounts. This is a controversial proposal and needs more discussion, since it impacts out of pocket costs for members, but is necessary to consider due to inflation over time, and rising health care costs.
    - Mauri Long asked how many members have more than two family members in their household? If most individuals have only two members, this is a potential area to change the plan without significant negative impact.
- Cost of pharmacy benefits: Staff analysis has found that a significant portion of members are using brand name medications when a generic or another alternative is available. One option to address this is a three-tier pharmacy plan, with incentives for using generic drugs or lower cost / preferred brands, with lower co-payments, and having a higher co-pay for those brand name drugs for which alternatives are available.
    - Joelle Hall commented that this may be an education issue, not plan design: could the plan provide focused education to members using high cost medications? They may be unaware that there is another option, or perhaps the medication options for their situation changed since they got their initial prescription.
    - Emily Ricci agreed that education is very important, but also pointed out that the Division has heard from multiple vendors that the plan design could better incentivize those choices and incentivize lower cost medications. The financial incentive to choose a different medication, as long as it is not medically necessary to use a specific brand, is an effective way to nudge members to contain costs. Emily used the analogy of in-network versus out-of-network providers: in-network providers are typically more cost effective for the plan, and members are less exposed to balance billing, where the

provider bills the patient for any costs not covered by insurance, which may be significant if the provider is out of network.

  - The group discussed comparison of the state plan (dispensing generic drugs) with other plans: Aetna shared their data, Alaska's rate is 80% generic dispensing compared with 84% in other plans. The 4% difference represents significant cost. Richard Ward added that for every percent of generic utilization (increase in generic use versus brand name), the State can save 2 to 3% in pharmacy costs, approximately $2 million for each 1%.

- Pharmacy plan design: The State is also considering other changes to the pharmacy plan, such as changing the dispensing amount from 90-day supply or 100 units to remove the 100 unit option, a standard in the Medicare Part D plan and many other plans. Most members are not filling 100-unit prescriptions. Another change would be to cease coverage of drugs with an over the counter (OTC) equivalent, since they are available without a prescription. The number of OTC medications available has increased over time. Emily Ricci added that the health plan was previously amended to make this change in 2014, but was rescinded because of pushback from members. The State would like to consider this change again, and analyze the potential costs and benefits given the increased availability of OTC medications or equivalents.
- Concerns about compounded medications: Some medications are compounded, meaning that the pharmacist mixes them onsite or adds a medication to other products to make it easier to ingest or take. The FDA and national provider groups have expressed concern about safety for patients and oversight of this practice. The retiree health plan has much higher use of compound medications than comparable plans with Aetna, for example, and it is not being sufficiently monitored to see if lower-cost options are available and protect patient safety. Other states have seen increasing fraud and misuse with compounded medications, so this is worth investigating further. There are several valid uses of compound medications, so the benefit would not go away, but may limit coverage to only some situations, or require use of approved drugs.
- Travel benefits: Currently travel benefits are limited, and members have to make their own arrangements and shoulder the costs upfront. The plan does have enhanced travel benefits for some procedures. Generally speaking, health care services are more expensive in Alaska and therefore it may be more cost effective to travel for certain procedures. Having better coverage of travel related expenses for care would benefit members and make it easier to consider travel for a non-emergency or specialty treatment. This would apply to in state travel, for example someone traveling to Anchorage or Fairbanks from their community, as well as out of state. There are already systems in place for medical travel, used by some plans in Alaska, that work with recognized high-quality providers for procedures like hip and knee replacements, to provide better service at better cost.
- Rehabilitative services: This is the top issue in plan appeals, and is very confusing for members and adds significant administrative burden to the State. These include physical therapy, occupational therapy, chiropractic, massage therapy (as part of physical therapy), and speech therapy. One solution is to limit the number of visits per year by service type, and not base coverage of those services on "significant improvement". Although the number of visits per benefit year may be restricted, it could result in enhancing benefits for people with chronic conditions that require these services as a form of maintenance.

    - Gayle Harbo asked if rolfing is included in these benefits? Rolfing is not covered in the current health plan, but it would be covered as this type of service.
    - Mauri Long asked if acupuncture is covered? Acupuncture is only covered in lieu of anesthetic during surgery, not as a general benefit.
- Dental implants: There is confusion about coverage of dental implants, due to loss from injury or disease, including periodontal disease. As of 2014, the dental plan also covers implants. The current confusion has to do with coverage of periodontal disease, whether that should be part of the medical or dental plan, and because the medical and dental plans do not coordinate benefits.
- High-tech imaging services: Members are currently utilizing high-tech, high-cost imaging services even if other alternatives are available. These include radiology, diagnostic cardiology, sleep management studies, and cardiac rhythm implant devices. Considering when and how to incentivize alternatives to these high cost imaging services is an option.
- Coverage of dependents: Currently, the plan is governed by state statute which allows coverage of dependents up to age 23. The Affordable Care Act requires most plan to cover dependents up to age 26, but the State is not subject to this as it is exempt, as are all retiree only health plans per the ACA. Members have requested expanded coverage, but this is a change that requires change to state statutes, not simply a plan change. Cammy Taylor added that the employee health plan was grandfathered under the ACA, but made changes to the plan that mean it is now subject to ACA requirements. The retiree plan remains exempt under the ACA, it is a part of that federal law. Michele Michaud added that many states include both employees and retirees in the same plan, so those states are also subject to ACA requirements for retirees.

Other questions and comments from board members

- Mauri Long asked about implications for Medicare eligible and enrolled members on the retiree plan? Michele Michaud noted that if someone is enrolled in Medicare, Medicare is their primary coverage and the state plan is secondary. They would need to go to a Medicare provider, and not necessarily follow the network for the state plan. Medicare does have some preventive care coverage, that may be separate from the state plan. Non-Medicare-eligible retirees have the state plan as primary payer. Staff are investigating the gaps between systems and figuring out how to ensure consistent coverage.
- Joelle Hall asked about the extent and quality of network coverage outside Alaska? Michele Michaud responded that Aetna has a national network, and the State works closely with the vendor to maintain a network for out of state retirees.

Staff shared some ideas for engaging with retirees and members going forward: there is an existing annual survey, but the Division would like to do a more in depth survey and get a representative sample of members to better understand the impacts of these changes. Only a subset of retirees contact the Division and usually to address a specific issue or problem. The Division is still working on the proposed process to analyze and discuss each of the options presented, and has not prioritized the options at this time, other than highlighting possible changes to the plan that can be done sooner and will enhance the package of benefits in the retiree health plan.

The board discussed forming subcommittees to work further on each topic, and what additional research will be helpful. While some of these changes could just be executed by staff, such as the

revision of the booklet, the Division wants to engage the board and other interested stakeholders in discussion to communicate the purpose of the modernization project, and let people know that changes are happening, such as to the booklet. The Division has encountered a great deal of resistance to change in the past, which has prevented more improvements to the plan from happening. Mark Foster commented that he is also interested in considering the Division's and vendor's customer service performance, whether there are better technology solutions to improve the customer experience (such as electronic funds transfers instead of paper checks), and encouraged creation of a customer service focused policy. He is interested in considering customer service as part of overall value of the plan. Staff agreed that this is important to consider, and that the Division is working on internal improvements to improve communications and customer service. For example, they are ensuring there is a concierge service available to members.

The board decided to form a modernization committee. Members volunteered to serve on the committee: Joelle Hall, Cammy Taylor, Mark Foster. Chair Judy Salo approved formation of this committee and appointed the three members to the committee. Staff will share information and notices of meetings with all board members if they would like to participate as well.

The board has a general e-mail address for communications: alaskaRHPAB@alaska.gov. The staff member supporting the board (Vanessa Kitchen) has access and will route communications to the board as needed. Public comments have been received through this e-mail and will continue to be.

- **Motion** by Judy Salo to adjourn the meeting. **Second** by Cammy Taylor.
    - **Discussion**: None.
    - **Result**: No objection to adjournment. The meeting was adjourned at 4:00.

Calendar for RHPAB Meetings 2018/2019

RHPAB Board Meeting Dates & Locations

Meeting Dates - 2018	Conference Rooms in Anchorage	Conference Room in Juneau
August 29th, 2018	Atwood Conf Rm Suite #1270	10th Floor of State Building
November 28, 2018	Atwood Conf Rm Suite #1270	10th Floor of State Building
Meeting Dates - 2019	**Conference Rooms in Anchorage**	**Conference Room in Juneau**
February 6, 2019	ACC Atwood Conf Rm 102	10th Floor of State Building
May 8, 2019	ACC Atwood Conf Rm 102	10th Floor of State Building
August 7, 2019	ACC Atwood Conf Rm 102 & 104	10th Floor of State Building
November 6, 2019	ACC Atwood Conf Rm 102 & 104	10th Floor of State Building

Atwood Building Address:

550 W 7th Avenue
Anchorage, AK 99501

SOB Building Address :

333 Willoughby Avenue, 10th Floor
Juneau, AK 99801

Bylaws
Final Draft
Retiree Health Plan
Advisory Board

Article I
Name

The name of the organization is the Retiree Health Plan Advisory Board, hereinafter referred to as "the Board" or "RHPAB."

Article II
Purpose and Responsibilities

Section 1. Pursuant to Administrative Order No. 288 the Board was created to facilitate engagement and coordination between the State's retirement systems' members, the Alaska Retirement Management Board (ARMB), and the Commissioner of the Department of administration of the retiree health plan.

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 is advisory only.

Section 4. Duties and Responsibilities
The Board shall review available 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 care plans of the State's retirement systems, including optional life insurance, long-term care insurance, and optional dental-visual-audio programs.

The recommendation must consider:

1. The cost of the services or changes to 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 care plans from the perspective of plans sponsors, participating employers and plan beneficiaries, including the effect of premiums assets to benefits; 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 to provide input on the performance of service providers including third-party administrators, insurance providers, and annuity providers to the State's retiree health care plans.

Article III
Membership and Terms of Office

Section 1. Composition

The RHPAB consists of seven voting members who are appointed by the Governor.

1. One member who is an ARMB trustee by virtue of AS 37.10.210(b)(2)(C) or (D).
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.

The Commissioner or the Commissioner's 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 three year-terms consistent with AS 39.05.055(5).

2. The Governor may choose from the nominee list, request further solicitation, or make an appointment of the Governor's choosing.
3. Members serve at the pleasure of the Governor.
4. 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 it's 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. Four members-or a majority of the Board if a vacancy exists -constitute a quorum for doing business.

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 filed in the office of the Commissioner of Administration and made publicly available.

Article VI
Committees

Section 1. The Chair may establish committees as the need arises and shall assign such duties and responsibilities to the committees.

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.

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 35.52).

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.

Public Comment Guidelines

Public Comment	
Purpose	The public comment period allows individuals to inform and advise the Retiree Health Plan Advisory Board about policy-related issues, problems or concerns. It is not a hearing and cannot be used to address health benefit claim appeals. The protected health information of an identified individual will not be addressed during public comment.
Protocol	Individuals are invited to speak for up to three minutes. • A speaker may be granted the latitude to speak longer than the 3-minute time limit only by the Chair or by a motion adopted by the Full Advisory Board. • Anyone providing comment should do so in a manner that is respectful of the Advisory Board and all meeting attendees. The Chair maintains the right to stop public comments that contains Private Health Information, inappropriate and/or inflammatory language or behavior. **Members providing testimony will be reminded they are waiving their statutory right to keep confidential the contents of the retirement records about which they are testifying. See AS 40.25.151.**

Protected Health Information
Protected Health Information (PHI) submitted to the Board in writing will be redacted to remove all identifying information, for example, name, address, date of birth, Social Security number, phone numbers, health insurance member numbers. If the Board requests records containing protected health information, the Division will redact all identifying information from the records before providing them to the Board.

Frequently Asked Questions	
How can someone provide comments?	**IN PERSON** - please sign up for public comment using the clipboard provided during the meeting. **VIA TELECONFERENCE** – please call the meeting teleconference number on a telephone hard line. To prevent audio feedback, do not call on a speaker phone or cell phone. You may use the mute feature on your phone until you are called to speak, but do not put the call on hold because hold music disrupts the meeting. If this occurs, we will mute or disconnect your line. **IN WRITING** – send comments to the address or fax number below or email AlaskaRHPAB@alaska.gov. For written comments to be distributed to the Advisory Board prior to a board meeting they must be received thirty days prior to the meeting to allow time for distribution and identifying information will be redacted (see "Protected Health Information"). **PRIVATE HEALTH INFORMATION**: The state must comply with federal laws regarding Private Health Information. Written information submitted for public comment which contains identifying information will be redacted to ensure compliance with privacy laws. **Address**: Department of Administration, Attn: RHPAB, 550 W 7th Avenue, Ste 1970, Anchorage, AK 99501 Fax: (907) 465-2135
Can I bring my questions or concerns about a claim or medical issue to the Board?	The Board does not have authority to decide health benefit claim appeals. Members should call Aetna at 1-855-784-8646 to address their question and/or concern. After contacting Aetna, members can also contact the Division of Retirement and Benefits at 1- 800-821-2251 or 907-465-8600 if in Juneau.
For additional information:	For additional information please call 907-269-6293 or email AlaskaRHPAB@alaska.gov if you have additional question.

Modernization Table

Retiree Modernization Topics

#	Topic
1	Expand preventive coverage to add full suite of preventive services
2	Remove or increase lifetime limit (currently $2M)
3	Increase deductible and out-of-pocket maximum
4	Implement 3-tier pharmacy benefit, change out-of-network pharmacy benefits
5	~~Remove the "or 100 unit" option for pharmacy fill limits (leave 90 day limit in place,~~ exclude OTC equivalents
6	Limit compound coverage for non-FDA approved drugs **AMEND** Limit compounding to high-quality, narrow network of pharmacies***
7	Enhance travel benefits
8	Implement clear service limits for rehabilitative care such as chiropractic, physical therapy, occupational therapy, etc.
9	Exclude implants related to periodontal disease from medical plan and cover under dental plan
10	In-network enhanced clinical review of high-tech imaging and testing
11	Network steerage: 70% out-of-network and 90% in-network
12	Implement high-value pharmacy network with lower copays for chronic meds, medical synchronization, counseling, and packaging options for participating members.
13	Expand rehabilitative services to include Rolfing, Acupuncture, and Acupressure – Proposed through public comment
14	Add wellness benefits such as gym membership or program like Silver Sneakers –Proposed through public comment
15	Add medically necessary treatment of gender dysphoria including surgery– Proposed through public comment

Modernization Proposal Preventative Care

Proposed change: Expanded preventive services subject to network steerage.

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board, Alaska Retirement

Proposed implementation date: January 1, 2019

Review Date: August 29, 2018

Table 1: Plan Design Changes

	Member	Actuarial	DRB Ops	Financial	Clinical	TPA	Provider
No impact							
Minimal impact			**X**			**X**	
High impact	**X**	**X**		**X**	**X**		**X**
Need Info							

Description of proposed change:

Expanding preventive services will add value to the plan for most retirees and will increase the overall actuarial value of the plan. Expanding preventive will have a positive clinical and provider impact. However, expanding benefits will increase claims cost and have a negative financial impact to the plan. The Division and the Medical and Pharmacy Third Party Administrators will be minimally impacted by the changed.

The plan was first developed in 1975 and provides extensive and valuable benefits for retirees and their dependents necessary for *the diagnosis and treatment* of an injury or disease. The plan was not established as a preventive or 'wellness' plan. Preventive services that are used to screen individuals prior to symptoms being exhibited are limited to mammograms, Pap smears and Prostate Specific Antigen tests (to detect prostate cancer in males).

One of the main reoccurring complaints the Division of Retirement and Benefits (Division) receives is related to the retiree plan's lack of preventive care coverage. This is a complex topic since the plan serves two very distinct populations: those retirees and their dependents who are eligible for Medicare, and the retirees under the age of 65 (U65) who do not yet qualify for Medicare coverage. As Medicare already offers many preventive services at no cost to the beneficiary, adding preventive coverage is not as high a priority for those eligible for Medicare benefits.

Around 2010, in conjunction with certain requirements in the Patient Protection and Affordable Care Act (ACA), insurance coverage for age-specific guidelines indicating

the utilization of screening and preventive services for older adults grew increasingly common. Despite these industry changes, the omission of most preventive benefits in the plan may cause retirees to forego getting recommended age-specific vaccinations, screenings, and other preventive services. The goal of preventive services is to increase early detection and treatment of health conditions in order to improve clinical outcomes, arrest disease at an earlier stage when it is easier and more effectively treated, and to promote health-conscious behavior.

Simply adding preventive screening does not necessarily save a plan money as articulated by the Robert Woods Johnson Foundation in their 2009 study.[1] They found high-risk groups often stay away from screenings,[2] and health-conscious members may use the screenings in excess. The result is higher procedure volume and total costs without the net savings associated with early detection or treatment.

> "It is unlikely that substantial cost savings can be achieved by increasing the level of investment in clinical preventive care measures. On the other hand, research suggests that many preventive measures deliver substantial health benefits given their costs.
>
> Moreover, while the achievement of cost savings is beneficial, it is important to keep in mind that the goal of prevention, like that of other health initiatives, is to improve health. Even those interventions that cost more than they save can still be desirable. Because health care resources are finite, however, it is useful to identify those interventions that deliver the greatest health benefits relative to their incremental costs."[3]

The objective in adding preventive care to the AlaskaCare defined benefit retiree health plan is not to save money, but to save lives, and to support the members in maintaining their health. Preventive services are both mainstream and greatly desired by the membership, particularly those who are not Medicare-eligible and do not have any coverage for these services.

The Division proposes adding the full suite of evidence based preventive services to the plan that mirror those provided in most employee plans in accordance with the Affordable Care Act. These expanded services include those with an "A" or "B" rating

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

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

[3] Ibid.

by the United States Preventive Task Force.[4] The specific services will change as the USPTF updates their recommendations to reflect the most current research and evidence.

The Division proposes that preventive services would be subject to normal cost-share provisions (annual deductibles, coinsurance, copay and annual maximum out-of-pocket limits, etc.), with the exception that the coinsurance paid by the plan will be reduced by 20% when the preventive care services are provided by an out-of-network provider. Further, those out-of-network expenses will not count towards the annual out-of-pocket maximum.

Table 2: Comparison of Current to Proposed Change

Benefit	Current	Proposed in-network	Proposed out-of-network
Coinsurance / Out-of-Pocket Limits	• 80% after deductible. (100% after annual out-of-pocket reached.)	• 80% coinsurance after deductible. (100% after annual out-of-pocket reached.)	• 60% coinsurance after deductible. (Does not apply if no network access) Not subject to the individual out-of-pocket maximum (exception if no network access)

[4] A current list of A and B services is available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Benefit	Current Covered Preventive Serviced	Proposed Covered Preventive Services
Mammograms	• One baseline between age 35-40. • One every two years between age 40-50. • Annually at age 50 and above and for those with a personal or family history of breast cancer.	• Biennial screening between age 50-74 • Earlier or additional screenings for those at high risk[5]
Pap Smear	One per year for women 18 years of age and older. Also includes limited office visit to collect the pap smear.	One every 3 years for women age 21 to 65, or every 5 years with a combination of cytology and HPV testing.
Prostate specific antigen (PSA)	• One annual screening test for men between ages 35 and 50 with a personal or family history of prostate cancer, • One annual screening test for men 50 years and older.	The Task Force gave a "C" recommendation to men ages 55 to 69, encouraging them to make an individual decision about prostate cancer screening with their clinician. The Task Force recommends against routine screening for men age 70 and older.[6]

[5] **Risk Factors That May Influence When to Start [Breast] Screening:** Advancing age is the most important risk factor for breast cancer in most women, but epidemiologic data from the BCSC suggest that having a first-degree relative with breast cancer is associated with an approximately 2-fold increased risk for breast cancer in women aged 40 to 49 years.2, 9 Further, the CISNET models suggest that for women with about a 2-fold increased risk for breast cancer, starting annual digital screening at age 40 years results in a similar harm-to-benefit ratio (based on number of false-positive results or overdiagnosed cases per 1000 breast cancer deaths avoided) as beginning biennial digital screening at age 50 years in average-risk women.7, 8 This approach has not been formally tested in a clinical trial; therefore, there is no direct evidence that it would result in net benefit similar to that of women aged 50 to 74 years. However, given the increased burden of disease and potential likelihood of benefit, women aged 40 to 49 years who have a known first-degree relative (parent, child, or sibling) with breast cancer may consider initiating screening earlier than age 50 years. Many other risk factors have been associated with breast cancer in epidemiologic studies, but most of these relationships are weak or inconsistent and would not likely influence how women value the tradeoffs of the potential benefits and harms of screening. Risk calculators, such as the National Cancer Institute's Breast Cancer Risk Assessment Tool (available at www.cancer.gov/BCRISKTOOL), have good calibration between predicted and actual outcomes in groups of women but are not accurate at predicting an individual woman's risk for breast cancer.10

[6] https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1

Benefit	Current Coverage of Preventive Service	Proposed Coverage of Preventive Services
Vaccines	Not Covered	Coverage for those recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention[7]
Annual Routine Physical	Not Covered	Covered
Well Woman Preventive Visit	Not Covered (exception of limited exam to collect the pap smear)	Subject to any age, family history and frequency guidelines that are evidence-based items or services that have in effect a rating of A or B in the recommendation so the United States Preventive Services Task Force and Evidence informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
Routine Cancer Screening	Not Covered (except Mammograms, PSA and Pap Smear as outlined above)	Subject to any age, family history and frequency guidelines that are evidence-based items or services that have in effect a rating of A or B[8] in the recommendation so the United States Preventive Services Task Force and Evidence informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration[9]

[7] https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf
https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf
[8]Includes breast cancer, cervical cancer, colorectal cancer, lung cancer, and skin cancer screenings: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
[9] https://www.hrsa.gov/womens-guidelines/index.html

Member impact:

Studies suggest that increase in coverage for prevention may increase the use of preventive services. This will be an added benefit for all members, providing access to preventive care previously excluded under the retiree health plan.

As an example, one of the more expensive preventive services is a screening colonoscopy. The USPSTF guidelines recommend screening colonoscopies once every 10 years for non-high-risk adults starting at age 50. The AlaskaCare retiree plan has approximately 20,000 retiree adults between the ages of 50-64. Colonoscopy is a covered benefit under Medicare for whom most retirees age 65 and above are eligible.

Medicare eligible members will have access to preventive care not covered under Medicare, such as vaccination against shingles and an annual full physical examination.

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

Actuarial impact

Neutral / Enhancement / Diminishment

Table 3: Actuarial Impact

	Actuarial Impact	Notes
Current	N/A	N/A
Expanded preventive	0.75% increase[10]	80% coinsurance in network/60% out-of-network

DRB operational impacts:

The Division anticipates the expansion of preventive benefits in the retiree health plan will reduce calls, complaints and appeals to the Division related to lack of preventive coverage.

The retiree health plan is an antiquated plan design and is unusual in its lack of coverage for most preventive services. For this reason, there is a substantial communication and education need for the Division to notice members regarding the lack of preventive services. That need would no longer exist if the benefits were expanded.

[10] Attachment A: *Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan,* Segal Consulting memo dated July 25, 2018

Financial impact to the plan:

Based on a Segal Consulting's preliminary retiree claims projection of $680,000,000 for 2019, the anticipated fiscal impact is estimated to be approximately $5,000,000 in additional annual costs.[11]

Segal's analysis looked at 2016 and 2017 medical and pharmacy claims data, and projected to 2019 at 3.0% and 6.0% annual trends respectively. For Medicare member, Medicare covers many of these services, including colonoscopies, at 100%. For these member, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. The analysis for non-Medicare members focused on the approximate 20,000 members between age 50 and 65.[12]

Clinical considerations:

It is largely agreed that the recommended preventive services can help detect disease, delay their onset, or identify them early on when the disease is most easy to manage or treat. Adding these services could have a positive clinical impact.

An example is colonoscopies. Excluding skin cancers, colorectal cancer is the third most common cancer diagnosed in both men and women. Screening can prevent colorectal cancer by finding and removing precancerous polyps before they develop into cancer. The cost of treatment is often lowest, and the survivor rates are better, when the tumor is found in the earlier stages.

Third Party Administrator (TPA) operational impacts:

Using the industry standard set by the Affordable Care Act to determine what services are covered, the impact to the TPA is minimal. This is often an "yes/no" indicator switch in a TPA's claims adjudication system. The change would simplify the administration of the AlaskaCare retiree health plan, which currently requires customization to provide the limited preventive services covered by the plan today.

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

Last, offering the full suite of preventive services allows greater flexibility in disease management and broader communication options when there is not a concern about recommending a service not covered under the health plan.

[11] *Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan,* Segal Consulting memo dated July 25, 2018.
[12] Ibid.

DRAFT

Provider considerations:

The Division expects that expanding preventive coverage will have a positive impact on providers. They may gain customers in members who previously would have forgone the non-covered services, and they should see ease in administration in that they will not need to bill the member directly for the non-covered services.

The coinsurance differential may incentivize some doctors to join the network, as many members may look for a network provider to maximize their health plan benefits.

Documents attached include:

Document Name	Attachment	Notes
Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan, Segal Consulting memo dated July 25, 2018	A	 Segal Preventive Memo
USPSTF A and B Recommendations	B	https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
Recommended Adult Immunization Schedule	C	https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf
Recommended Child Immunization Schedule	D	https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf
Redacted Public Comment 5/9/18 - 8/22/18	E	 RHPAB 8.29.18 Board Packet Redacted Publ

Attachment A

Segal Consulting

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MEMORANDUM

To: Ajay Desai, Director, Division of Retirement and Benefits

From: Richard Ward, FSA, FCA, MAAA

Date: July 25, 2018

Re: Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan

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

- One pap smear per year for all women age 18 or older. Charges for a limited office visit to collect the pap smear are also covered.

- Prostate specific antigen (PSA) tests as follows:
  - One annual screening PSA test for men between ages 35 and 50 with a personal or family history of prostate cancer, and
  - One annual screening PSA test for men 50 years and older

- Mammograms as follows:
  - One baseline mammogram between age 35 and 40
  - One mammogram every two years between ages 40 and 50, and
  - One annual mammogram at age 50 years and above, and for those with a personal or family history of breast cancer.

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

member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered.

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

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	
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

A change to the benefits under consideration would align the scope of benefits with those required of non-Grandfathered plans under the Affordable Care Act (ACA). Note that retiree plans, such as the AlaskaCare Retiree Plan, are not subject to the same provisions under the ACA that apply to the AlaskaCare Employee Plan. Preventive benefits will continue to be subject to deductibles, coinsurance and other plan provisions that apply in 2018.

Actuarial Value

Our analysis determines the impact of expanding the scope of covered services to align the scope of benefits with those required of non-Grandfathered plans under the ACA would be an increase of 0.75% in actuarial value.

Financial Impact

Based on a preliminary retiree claims projection of $680,000,000 for 2019, this equates to approximately $5,000,000 in additional annual costs to the Plan.

This analysis is based on 2016 and 2017 medical and pharmacy claims data, projected to 2019 at 3.0% and 6.0% annual trends, respectively. The data was reviewed, but not audited, and found to be sufficient and credible for this analysis.

With over 60,000 members and a high incidence rate of preventive care, the data is considered credible for this analysis. For Medicare members, many of these services, including colonoscopies, are currently covered at 100% by Medicare. For these members, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. For non-Medicare members, our analysis focused those between ages 50 and 65. There are approximately 20,000 such members.

Please note that 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 Consulting 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. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

cc: Michele Michaud, Division of Retirement and Benefits
Emily Ricci, Division of Retirement and Benefits
Linda Johnson, Segal
Michael Macdissi, Segal
Noel Cruse, Segal
Dan Haar, Segal

Attachment B

USPSTF A and B Recommendations

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	June 2014*
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013*
Aspirin preventive medication: adults aged 50 to 59 years with a ≥10% 10-year cardiovascular risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	B	April 2016*
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening: adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A	October 2015*
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	B	December 2013*
Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B	September 2013*
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002†
Breastfeeding interventions	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.	B	October 2016*
Cervical cancer screening	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).	A	August 2018*
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.	A	June 2016*
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.	B	May 2014*
Depression screening: adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	February 2016*
Depression screening: adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	January 2016*
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B	October 2015*
Falls prevention: older adults	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.	B	April 2018*
Folic acid supplementation	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	January 2017*
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011*
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	B	August 2014*
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.	B	May 2014
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	June 2013
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	April 2013*
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013*
Hypothyroidism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Intimate partner violence	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner	B	January 2013

screening: women of childbearing age	violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.		
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	December 2013
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012*
Obesity screening: children and adolescents	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.	B	June 2017*
Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.	B	June 2018
Osteoporosis screening: women 65 years and older	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.	B	June 2018*
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	B	March 2008
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	B	September 2014
Preeclampsia: screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.	B	April 2017
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.	B	September 2014*
Skin cancer behavioral counseling	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.	B	March 2018*
Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.	B	November 2016*
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.	A	September 2015*
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.	A	September 2015*
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Tuberculosis screening: adults	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.	B	September 2016
Syphilis screening: nonpregnant persons	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.	A	June 2016*
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Vision screening: children	The USPSTF recommends vision screening at least once in all children ages 3 to 5 years to detect amblyopia or its risk factors.	B	September 2017*

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

Current as of: August 2018

Internet Citation: *USPSTF A and B Recommendations.* U.S. Preventive Services Task Force. August 2018. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Attachment C

Recommended Immunization Schedule for Adults Aged 19 Years or Older, United States, 2018

In February 2018, the *Recommended Immunization Schedule for Adults Aged 19 Years or Older, United States, 2018* became effective, as recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC). The adult immunization schedule was also approved by the American College of Physicians, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Nurse-Midwives.

CDC announced the availability of the 2018 adult immunization schedule in the *Morbidity and Mortality Weekly Report* (*MMWR*).[1] The schedule is published in its entirety in the *Annals of Internal Medicine*.[2]

The adult immunization schedule consists of figures that summarize routinely recommended vaccines for adults by age groups and medical conditions and other indications, footnotes for the figures, and a table of vaccine contraindications and precautions. Note the following when reviewing the adult immunization schedule:

- The figures in the adult immunization schedule should be reviewed with the accompanying footnotes.
- The figures and footnotes display indications for which vaccines, if not previously administered, should be administered unless noted otherwise.
- The table of contraindications and precautions identifies populations and situations for which vaccines should not be used or should be used with caution.
- When indicated, administer recommended vaccines to adults whose vaccination history is incomplete or unknown.
- Increased interval between doses of a multidose vaccine series does not diminish vaccine effectiveness; it is not necessary to restart the vaccine series or add doses to the series because of an extended interval between doses.
- Combination vaccines may be used when any component of the combination is indicated and when the other components of the combination are not contraindicated.
- The use of trade names in the adult immunization schedule is for identification purposes only and does not imply endorsement by the ACIP or CDC.

Special populations that need additional considerations include:

- Pregnant women. Pregnant women should receive the tetanus, diphtheria, and acellular pertussis vaccine (Tdap) during pregnancy and the influenza vaccine during or before pregnancy. Live vaccines (e.g., measles, mumps, and rubella vaccine [MMR]) are contraindicated.
- Asplenia. Adults with asplenia have specific vaccination recommendations because of their increased risk for infection by encapsulated bacteria. Anatomical or functional asplenia includes congenital or acquired asplenia, splenic dysfunction, sickle cell disease and other hemoglobinopathies, and splenectomy.
- Immunocompromising conditions. Adults with immunosuppression should generally avoid live vaccines. Inactivated vaccines (e.g., pneumococcal vaccines) are generally acceptable. High-level immunosuppression includes HIV infection with a CD4 cell count <200 cells/µL, receipt of daily corticosteroid therapy with ≥20 mg of prednisone or equivalent for ≥14 days, primary immunodeficiency disorder (e.g., severe combined immunodeficiency or complement component deficiency), and receipt of cancer chemotherapy. Other immunocompromising conditions and immunosuppressive medications to consider when vaccinating adults can be found in *IDSA Clinical Practice Guideline for Vaccination of the Immunocompromised Host*.[3] Additional information on vaccinating immunocompromised adults is in *General Best Practice Guidelines for Immunization*.[4]

Additional resources for health care providers include:

- Details on vaccines recommended for adults and complete ACIP statements at www.cdc.gov/vaccines/hcp/acip-recs/index.html
- Vaccine Information Statements that explain benefits and risks of vaccines at www.cdc.gov/vaccines/hcp/vis/index.html
- Information and resources on vaccinating pregnant women at www.cdc.gov/vaccines/adults/rec-vac/pregnant.html
- Information on travel vaccine requirements and recommendations at www.cdc.gov/travel/destinations/list
- CDC Vaccine Schedules App for immunization service providers to download at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html
- Adult Vaccination Quiz for self-assessment of vaccination needs based on age, health conditions, and other indications at www2.cdc.gov/nip/adultimmsched/default.asp
- *Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger* at www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html

Report suspected cases of reportable vaccine-preventable diseases to the local or state health department, and report all clinically significant postvaccination events to the Vaccine Adverse Event Reporting System at www.vaers.hhs.gov or by telephone, 800-822-7967. All vaccines included in the adult immunization schedule except 23-valent pneumococcal polysaccharide and zoster vaccines are covered by the Vaccine Injury Compensation Program. Information on how to file a vaccine injury claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. Submit questions and comments to CDC through www.cdc.gov/cdc-info or by telephone, 800-CDC-INFO (800-232-4636), in English and Spanish, 8:00am–8:00pm ET, Monday–Friday, excluding holidays.

The following abbreviations are used for vaccines in the adult immunization schedule (in the order of their appearance):

IIV	inactivated influenza vaccine
RIV	recombinant influenza vaccine
Tdap	tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine
Td	tetanus and diphtheria toxoids
MMR	measles, mumps, and rubella vaccine
VAR	varicella vaccine
RZV	recombinant zoster vaccine
ZVL	zoster vaccine live
HPV vaccine	human papillomavirus vaccine
PCV13	13-valent pneumococcal conjugate vaccine
PPSV23	23-valent pneumococcal polysaccharide vaccine
HepA	hepatitis A vaccine
HepA-HepB	hepatitis A vaccine and hepatitis B vaccine
HepB	hepatitis B vaccine
MenACWY	serogroups A, C, W, and Y meningococcal vaccine
MenB	serogroup B meningococcal vaccine
Hib	*Haemophilus influenzae* type b vaccine

1. MMWR Morb Mortal Wkly Rep. 2018;66(5). Available at www.cdc.gov/mmwr/volumes/67/wr/mm6705e3.htm.
2. Ann Intern Med. 2018;168:210–220. Available at annals.org/aim/article/doi/10.7326/M17-3439.
3. Clin Infect Dis. 2014;58:e44-100. Available at www.idsociety.org/Templates/Content.aspx?id=32212256011.
4. ACIP. Available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html.

Figure 1. Recommended immunization schedule for adults aged 19 years or older by age group, United States, 2018

This figure should be reviewed with the accompanying footnotes. This figure and the footnotes describe indications for which vaccines, if not previously administered, should be administered unless noted otherwise.

Vaccine	19–21 years	22–26 years	27–49 years	50–64 years	≥65 years
Influenza[1]	1 dose annually				
Tdap[2] or Td[2]	1 dose Tdap, then Td booster every 10 yrs				
MMR[3]	1 or 2 doses depending on indication (if born in 1957 or later)				
VAR[4]	2 doses				
RZV[5] (preferred)				2 doses RZV (preferred)	
or				or	
ZVL[5]				1 dose ZVL	
HPV–Female[6]	2 or 3 doses depending on age at series initiation				
HPV–Male[6]	2 or 3 doses depending on age at series initiation				
PCV13[7]	1 dose				
PPSV23[7]	1 or 2 doses depending on indication				1 dose
HepA[8]	2 or 3 doses depending on vaccine				
HepB[9]	3 doses				
MenACWY[10]	1 or 2 doses depending on indication, then booster every 5 yrs if risk remains				
MenB[10]	2 or 3 doses depending on vaccine				
Hib[11]	1 or 3 doses depending on indication				

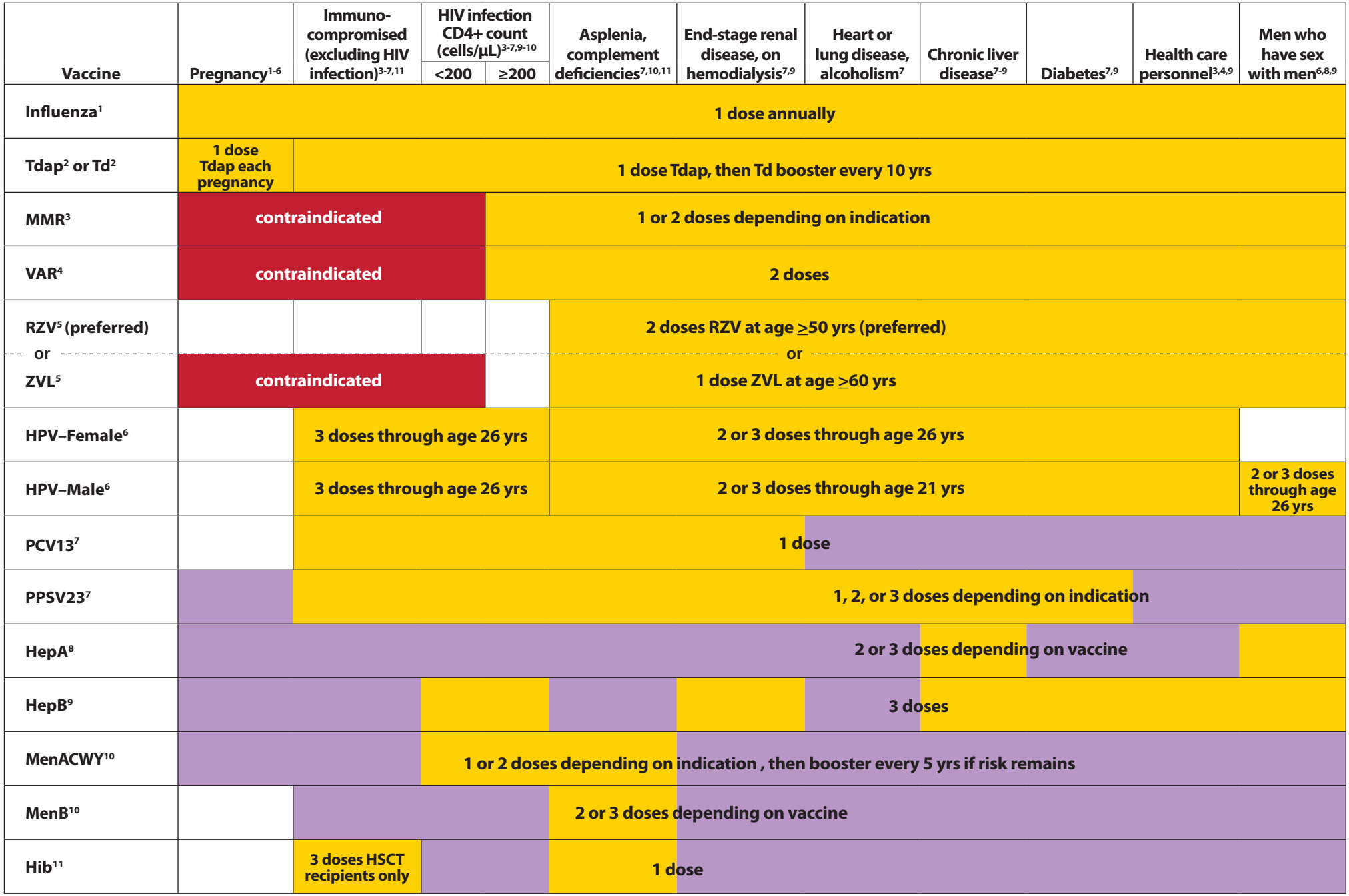
Recommended for adults who meet the age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended for adults with other indications

No recommendation

Figure 2. Recommended immunization schedule for adults aged 19 years or older by medical condition and other indications, United States, 2018

This figure should be reviewed with the accompanying footnotes. This figure and the footnotes describe indications for which vaccines, if not previously administered, should be administered unless noted otherwise.



Footnotes. Recommended immunization schedule for adults aged 19 years or older, United States, 2018

1. Influenza vaccination
www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

General information

- Administer 1 dose of age-appropriate inactivated influenza vaccine (IIV) or recombinant influenza vaccine (RIV) annually
- Live attenuated influenza vaccine (LAIV) is not recommended for the 2017–2018 influenza season
- A list of currently available influenza vaccines is available at www.cdc.gov/flu/protect/vaccine/vaccines.htm

Special populations

- Administer age-appropriate IIV or RIV to:
  - **Pregnant women**
  - Adults with **hives-only egg allergy**
  - Adults with **egg allergy other than hives** (e.g., angioedema or respiratory distress): Administer IIV or RIV in a medical setting under supervision of a health care provider who can recognize and manage severe allergic conditions

2. Tetanus, diphtheria, and pertussis vaccination
www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/tdap-td.html

General information

- Administer to adults who previously did not receive a dose of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) as an adult or child (routinely recommended at age 11–12 years) 1 dose of Tdap, followed by a dose of tetanus and diphtheria toxoids (Td) booster every 10 years
- Information on the use of Tdap or Td as tetanus prophylaxis in wound management is available at www.cdc.gov/mmwr/preview/mmwrhtml/rr5517a1.htm

Special populations

- **Pregnant women**: Administer 1 dose of Tdap during each pregnancy, preferably in the early part of gestational weeks 27–36

3. Measles, mumps, and rubella vaccination
www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html

General information

- Administer 1 dose of measles, mumps, and rubella vaccine (MMR) to adults with no evidence of immunity to measles, mumps, or rubella
- Evidence of immunity is:
  - Born before 1957 (except for health care personnel, see below)
  - Documentation of receipt of MMR
  - Laboratory evidence of immunity or disease
- Documentation of a health care provider-diagnosed disease without laboratory confirmation is not considered evidence of immunity

Special populations

- **Pregnant women and nonpregnant women of childbearing age** with no evidence of immunity to rubella: Administer 1 dose of MMR (if pregnant, administer MMR after pregnancy and before discharge from health care facility)
- **HIV infection and CD4 cell count ≥200 cells/μL for at least 6 months** and no evidence of immunity to measles, mumps, or rubella: Administer 2 doses of MMR at least 28 days apart
- **Students in postsecondary educational institutions, international travelers**, and **household contacts of immunocompromised persons**: Administer 2 doses of MMR at least 28 days apart (or 1 dose of MMR if previously administered 1 dose of MMR)
- **Health care personnel born in 1957 or later** with no evidence of immunity: Administer 2 doses of MMR at least 28 days apart for measles or mumps, or 1 dose of MMR for rubella (if born before 1957, consider MMR vaccination)
- Adults who **previously received ≤2 doses of mumps-containing vaccine and are identified by public health authority to be at increased risk for mumps in an outbreak**: Administer 1 dose of MMR
- MMR is contraindicated for pregnant women and adults with severe immunodeficiency

4. Varicella vaccination
www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/varicella.html

General information

- Administer to adults without evidence of immunity to varicella 2 doses of varicella vaccine (VAR) 4–8 weeks apart if previously received no varicella-containing vaccine (if previously received 1 dose of varicella-containing vaccine, administer 1 dose of VAR at least 4 weeks after the first dose)
- Evidence of immunity to varicella is:
  - U.S.-born before 1980 (except for pregnant women and health care personnel, see below)
  - Documentation of receipt of 2 doses of varicella or varicella-containing vaccine at least 4 weeks apart
  - Diagnosis or verification of history of varicella or herpes zoster by a health care provider
  - Laboratory evidence of immunity or disease

Special populations

- Administer 2 doses of VAR 4–8 weeks apart if previously received no varicella-containing vaccine (if previously received 1 dose of varicella-containing vaccine, administer 1 dose of VAR at least 4 weeks after the first dose) to:
  - **Pregnant women without evidence of immunity**: Administer the first of the 2 doses or the second dose after pregnancy and before discharge from health care facility
  - **Health care personnel without evidence of immunity**
- Adults with **HIV infection and CD4 cell count ≥200 cells/μL**: May administer, based on individual clinical decision, 2 doses of VAR 3 months apart
- VAR is contraindicated for pregnant women and adults with severe immunodeficiency

5. Zoster vaccination
www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/shingles.html

General information

- Administer 2 doses of recombinant zoster vaccine (RZV) 2–6 months apart to adults aged 50 years or older regardless of past episode of herpes zoster or receipt of zoster vaccine live (ZVL)
- Administer 2 doses of RZV 2–6 months apart to adults who previously received ZVL at least 2 months after ZVL
- For adults aged 60 years or older, administer either RZV or ZVL (RZV is preferred)

Special populations

- ZVL is contraindicated for pregnant women and adults with severe immunodeficiency

6. Human papillomavirus vaccination
www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hpv.html

General information

- Administer human papillomavirus (HPV) vaccine to **females through age 26 years** and **males through age 21 years** (males aged 22 through 26 years may be vaccinated based on individual clinical decision)
- The number of doses of HPV vaccine to be administered depends on age at initial HPV vaccination
  - **No previous dose of HPV vaccine**: Administer 3-dose series at 0, 1–2, and 6 months (minimum intervals: 4 weeks between doses 1 and 2, 12 weeks between doses 2 and 3, and 5 months between doses 1 and 3; repeat doses if given too soon)
  - **Aged 9–14 years at HPV vaccine series initiation and received 1 dose or 2 doses less than 5 months apart**: Administer 1 dose
  - **Aged 9–14 years at HPV vaccine series initiation and received 2 doses at least 5 months apart**: No additional dose is needed

Special populations

- Adults with **immunocompromising conditions (including HIV infection)** through age 26 years: Administer 3-dose series at 0, 1–2, and 6 months
- **Men who have sex with men** through age 26 years: Administer 2- or 3-dose series depending on age at initial vaccination (see above); if no history of HPV vaccine, administer 3-dose series at 0, 1–2, and 6 months
- **Pregnant women** through age 26 years: HPV vaccination is not recommended during pregnancy, but there is no evidence that the vaccine is harmful and no intervention needed for women who inadvertently receive HPV vaccine while pregnant; delay remaining doses until after pregnancy; pregnancy testing is not needed before vaccination

7. Pneumococcal vaccination
www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html

General information

- Administer to immunocompetent adults aged 65 years or older 1 dose of 13-valent pneumococcal conjugate vaccine (PCV13), if not previously administered, followed by 1 dose of 23-valent pneumococcal polysaccharide vaccine (PPSV23) at least 1 year after PCV13; if PPSV23 was previously administered but not PCV13, administer PCV13 at least 1 year after PPSV23
- When both PCV13 and PPSV23 are indicated, administer PCV13 first (PCV13 and PPSV23 should not be administered during the same visit); additional information on vaccine timing is available at www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf

Special populations

- Administer to adults aged 19 through 64 years with the following chronic conditions 1 dose of PPSV23 (at age 65 years or older, administer 1 dose of PCV13, if not previously received, and another dose of PPSV23 at least 1 year after PCV13 and at least 5 years after PPSV23):
  - **Chronic heart disease** (excluding hypertension)
  - **Chronic lung disease**
  - **Chronic liver disease**
  - **Alcoholism**
  - **Diabetes mellitus**
  - **Cigarette smoking**
- Administer to adults aged 19 years or older with the following indications 1 dose of PCV13 followed by 1 dose of PPSV23 at least 8 weeks after PCV13, and a second dose of PPSV23 at least 5 years after the first dose of PPSV23 (if the most recent dose of PPSV23 was administered before age 65 years, at age 65 years or older, administer another dose of PPSV23 at least 5 years after the last dose of PPSV23):
  - **Immunodeficiency disorders (**including B- and T-lymphocyte deficiency, complement deficiencies, and phagocytic disorders)
  - **HIV infection**
  - **Anatomical or functional asplenia (**including sickle cell disease and other hemoglobinopathies)
  - **Chronic renal failure and nephrotic syndrome**
- Administer to adults aged 19 years or older with the following indications 1 dose of PCV13 followed by 1 dose of PPSV23 at least 8 weeks after PCV13 (if the dose of PPSV23 was administered before age 65 years, at age 65 years or older, administer another dose of PPSV23 at least 5 years after the last dose of PPSV23):
  - **Cerebrospinal fluid leak**
  - **Cochlear implant**

8. Hepatitis A vaccination

www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepa.html

General information

- Administer to adults who have a specific risk (see below), or lack a risk factor but want protection, 2-dose series of single antigen hepatitis A vaccine (HepA; Havrix at 0 and 6–12 months or Vaqta at 0 and 6–18 months; minimum interval: 6 months) or a 3-dose series of combined hepatitis A and hepatitis B vaccine (HepA-HepB) at 0, 1, and 6 months; minimum intervals: 4 weeks between first and second doses, 5 months between second and third doses

Special populations

- Administer HepA or HepA-HepB to adults with the following indications:
  - **Travel** to or work in countries with high or intermediate hepatitis A endemicity
  - **Men who have sex with men**
  - **Injection or noninjection drug use**
  - **Work with hepatitis A virus in a research laboratory or with nonhuman primates infected with hepatitis A virus**
  - **Clotting factor disorders**
  - **Chronic liver disease**
  - Close, personal **contact with an international adoptee** (e.g., household or regular babysitting) during the first 60 days after arrival in the United States from a country with high or intermediate endemicity (administer the first dose as soon as the adoption is planned)
  - Healthy adults **through age 40 years who have recently been exposed to hepatitis A virus**; adults older than age 40 years may receive HepA if hepatitis A immunoglobulin cannot be obtained

9. Hepatitis B vaccination

www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html

General information

- Administer to adults who have a specific risk (see below), or lack a risk factor but want protection, 3-dose series of single antigen hepatitis B vaccine (HepB) or combined hepatitis A and hepatitis B vaccine (HepA-HepB) at 0, 1, and 6 months (minimum intervals: 4 weeks between doses 1 and 2 for HepB and HepA-HepB; between doses 2 and 3, 8 weeks for HepB and 5 months for HepA-HepB)

Special populations

- Administer HepB or HepA-HepB to adults with the following indications:
  - **Chronic liver disease** (e.g., hepatitis C infection, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice the upper limit of normal)
  - **HIV infection**
  - **Percutaneous or mucosal risk of exposure to blood** (e.g., **household contacts** of hepatitis B surface antigen [HBsAg]-positive persons; adults younger than age 60 years with **diabetes mellitus** or aged 60 years or older with diabetes mellitus based on individual clinical decision; adults in predialysis care or receiving **hemodialysis or peritoneal dialysis**; recent or current **injection drug users**; **health care and public safety workers** at risk for exposure to blood or blood-contaminated body fluids)
  - **Sexual exposure risk** (e.g., sex partners of HBsAg-positive persons; sexually active persons not in a mutually monogamous relationship; persons seeking evaluation or treatment for a sexually transmitted infection; and **men who have sex with men** [MSM])
  - Receive care in **settings where a high proportion of adults have risks for hepatitis B infection** (e.g., facilities providing sexually transmitted disease treatment, drug-abuse treatment and prevention services, hemodialysis and end-stage renal disease programs, institutions for developmentally disabled persons, health care settings targeting services to injection drug users or MSM, HIV testing and treatment facilities, and correctional facilities)
  - **Travel** to countries with high or intermediate hepatitis B endemicity

10. Meningococcal vaccination

www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html

Special populations: Serogroups A, C, W, and Y meningococcal vaccine (MenACWY)

- Administer 2 doses of MenACWY at least 8 weeks apart and revaccinate with 1 dose of MenACWY every 5 years, if the risk remains, to adults with the following indications:
  - **Anatomical or functional asplenia (**including sickle cell disease and other hemoglobinopathies)
  - **HIV infection**
  - **Persistent complement component deficiency**
  - **Eculizumab use**
- Administer 1 dose of MenACWY and revaccinate with 1 dose of MenACWY every 5 years, if the risk remains, to adults with the following indications:
  - **Travel to or live in countries where meningococcal disease is hyperendemic or epidemic**, including countries in the African meningitis belt or during the Hajj
  - At risk from a **meningococcal disease outbreak attributed to serogroup A, C, W, or Y**
  - **Microbiologists** routinely exposed to *Neisseria meningitidis*
  - **Military recruits**
  - **First-year college students who live in residential housing** (if they did not receive MenACWY at age 16 years or older)

General Information: Serogroup B meningococcal vaccine (MenB)

- May administer, based on individual clinical decision, to young adults and adolescents aged 16–23 years (preferred age is 16–18 years) who are not at increased risk 2-dose series of MenB-4C (Bexsero) at least 1 month apart or 2-dose series of MenB-FHbp (Trumenba) at least 6 months apart
- MenB-4C and MenB-FHbp are not interchangeable

Special populations: MenB

- Administer 2-dose series of MenB-4C at least 1 month apart or 3-dose series of MenB-FHbp at 0, 1–2, and 6 months to adults with the following indications:
  - **Anatomical or functional asplenia** (including sickle cell disease)
  - **Persistent complement component deficiency**
  - **Eculizumab use**
  - At risk from a **meningococcal disease outbreak attributed to serogroup B**
  - **Microbiologists** routinely exposed to *Neisseria meningitidis*

11. *Haemophilus influenzae* type b vaccination

www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hib.html

Special populations

- Administer *Haemophilus influenzae* type b vaccine (Hib) to adults with the following indications:
  - **Anatomical or functional asplenia** (including sickle cell disease) or undergoing elective splenectomy: Administer 1 dose if not previously vaccinated (preferably at least 14 days before elective splenectomy)
  - **Hematopoietic stem cell transplant** (HSCT): Administer 3-dose series with doses 4 weeks apart starting 6 to 12 months after successful transplant regardless of Hib vaccination history

Table. Contraindications and precautions for vaccines recommended for adults aged 19 years or older*

The Advisory Committee on Immunization Practices (ACIP) recommendations and package inserts for vaccines provide information on contraindications and precautions related to vaccines. Contraindications are conditions that increase chances of a serious adverse reaction in vaccine recipients and the vaccine should not be administered when a contraindication is present. Precautions should be reviewed for potential risks and benefits for vaccine recipients.

Contraindications and precautions for vaccines routinely recommended for adults

Vaccine(s)	Contraindications	Precautions
All vaccines routinely recommended for adults	• Severe reaction, e.g., anaphylaxis, after a previous dose or to a vaccine component	• Moderate or severe acute illness with or without fever

Additional contraindications and precautions for vaccines routinely recommended for adults

Vaccine(s)	Additional Contraindications	Additional Precautions
IIV[1]		• History of Guillain-Barré syndrome within 6 weeks after previous influenza vaccination • Egg allergy other than hives, e.g., angioedema, respiratory distress, lightheadedness, or recurrent emesis; or required epinephrine or another emergency medical intervention (IIV may be administered in an inpatient or outpatient medical setting and under the supervision of a health care provider who is able to recognize and manage severe allergic conditions)
RIV[1]		• History of Guillain-Barré syndrome within 6 weeks after previous influenza vaccination
Tdap, Td	• For pertussis-containing vaccines: encephalopathy, e.g., coma, decreased level of consciousness, or prolonged seizures, not attributable to another identifiable cause within 7 days of administration of a previous dose of a vaccine containing tetanus or diphtheria toxoid or acellular pertussis	• Guillain-Barré syndrome within 6 weeks after a previous dose of tetanus toxoid-containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of tetanus or diphtheria toxoid-containing vaccine. Defer vaccination until at least 10 years have elapsed since the last tetanus toxoid-containing vaccine • For pertussis-containing vaccine, progressive or unstable neurologic disorder, uncontrolled seizures, or progressive encephalopathy (until a treatment regimen has been established and the condition has stabilized)
MMR[2]	• Severe immunodeficiency, e.g., hematologic and solid tumors, chemotherapy, congenital immunodeficiency or long-term immunosuppressive therapy[3], human immunodeficiency virus (HIV) infection with severe immunocompromise • Pregnancy	• Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product)[4] • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing[5]
VAR[2]	• Severe immunodeficiency, e.g., hematologic and solid tumors, chemotherapy, congenital immunodeficiency or long-term immunosuppressive therapy[3], HIV infection with severe immunocompromise • Pregnancy	• Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product)[4] • Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination)
ZVL[2]	• Severe immunodeficiency, e.g., hematologic and solid tumors, chemotherapy, congenital immunodeficiency or long-term immunosuppressive therapy[3], HIV infection with severe immunocompromise • Pregnancy	• Receipt of specific antiviral drugs (acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination (avoid use of these antiviral drugs for 14 days after vaccination)
HPV vaccine		• Pregnancy
PCV13	• Severe allergic reaction to any vaccine containing diphtheria toxoid	

1. For additional information on use of influenza vaccines among persons with egg allergy, see: CDC. Prevention and control of seasonal influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices—United States, 2016–17 influenza season. MMWR. 2016;65(RR-5):1–54. Available at www.cdc.gov/mmwr/volumes/65/rr/rr6505a1.htm.
2. MMR may be administered together with VAR or ZVL on the same day. If not administered on the same day, separate live vaccines by at least 28 days.
3. Immunosuppressive steroid dose is considered to be daily receipt of 20 mg or more prednisone or equivalent for 2 or more weeks. Vaccination should be deferred for at least 1 month after discontinuation of immunosuppressive steroid therapy. Providers should consult ACIP recommendations for complete information on the use of specific live vaccines among persons on immune-suppressing medications or with immune suppression because of other reasons.
4. Vaccine should be deferred for the appropriate interval if replacement immune globulin products are being administered. See: Best practices guidance of the Advisory Committee on Immunization Practices (ACIP). Available at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html.
5. Measles vaccination may temporarily suppress tuberculin reactivity. Measles-containing vaccine may be administered on the same day as tuberculin skin testing, or should be postponed for at least 4 weeks after vaccination.

* Adapted from: CDC. Table 6. Contraindications and precautions to commonly used vaccines. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices. MMWR. 2011;60(No. RR-2):40–1 and from: Hamborsky J, Kroger A, Wolfe S, eds. Appendix A. Epidemiology and prevention of vaccine preventable diseases. 13th ed. Washington, DC: Public Health Foundation, 2015. Available at www.cdc.gov/vaccines/pubs/pinkbook/index.html.

Abbreviations of vaccines

IIV	inactivated influenza vaccine
RIV	recombinant influenza vaccine
Tdap	tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine
Td	tetanus and diphtheria toxoids
MMR	measles, mumps, and rubella vaccine
VAR	varicella vaccine
RZV	recombinant zoster vaccine
ZVL	zoster vaccine live
HPV vaccine	human papillomavirus vaccine
PCV13	13-valent pneumococcal conjugate vaccine
PPSV23	23-valent pneumococcal polysaccharide vaccine
HepA	hepatitis A vaccine
HepA-HepB	hepatitis A and hepatitis B vaccines
HepB	hepatitis B vaccine
MenACWY	serogroups A, C, W, and Y meningococcal vaccine
MenB	serogroup B meningococcal vaccine
Hib	*Haemophilus influenzae* type b vaccine

CS270457-L

Attachment D

Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2018

- Consult relevant ACIP statements for detailed recommendations (www.cdc.gov/vaccines/hcp/acip-recs/index.html).
- When a vaccine is not administered at the recommended age, administer at a subsequent visit.
- Use combination vaccines instead of separate injections when appropriate.
- Report clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) online (www.vaers.hhs.gov) or by telephone (800-822-7967).
- Report suspected cases of reportable vaccine-preventable diseases to your state or local health department.
- For information about precautions and contraindications, see www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

Approved by the

Advisory Committee on Immunization Practices
(www.cdc.gov/vaccines/acip)

American Academy of Pediatrics
(www.aap.org)

American Academy of Family Physicians
(www.aafp.org)

American College of Obstetricians and Gynecologists
(www.acog.org)

This schedule includes recommendations in effect as of January 1, 2018.

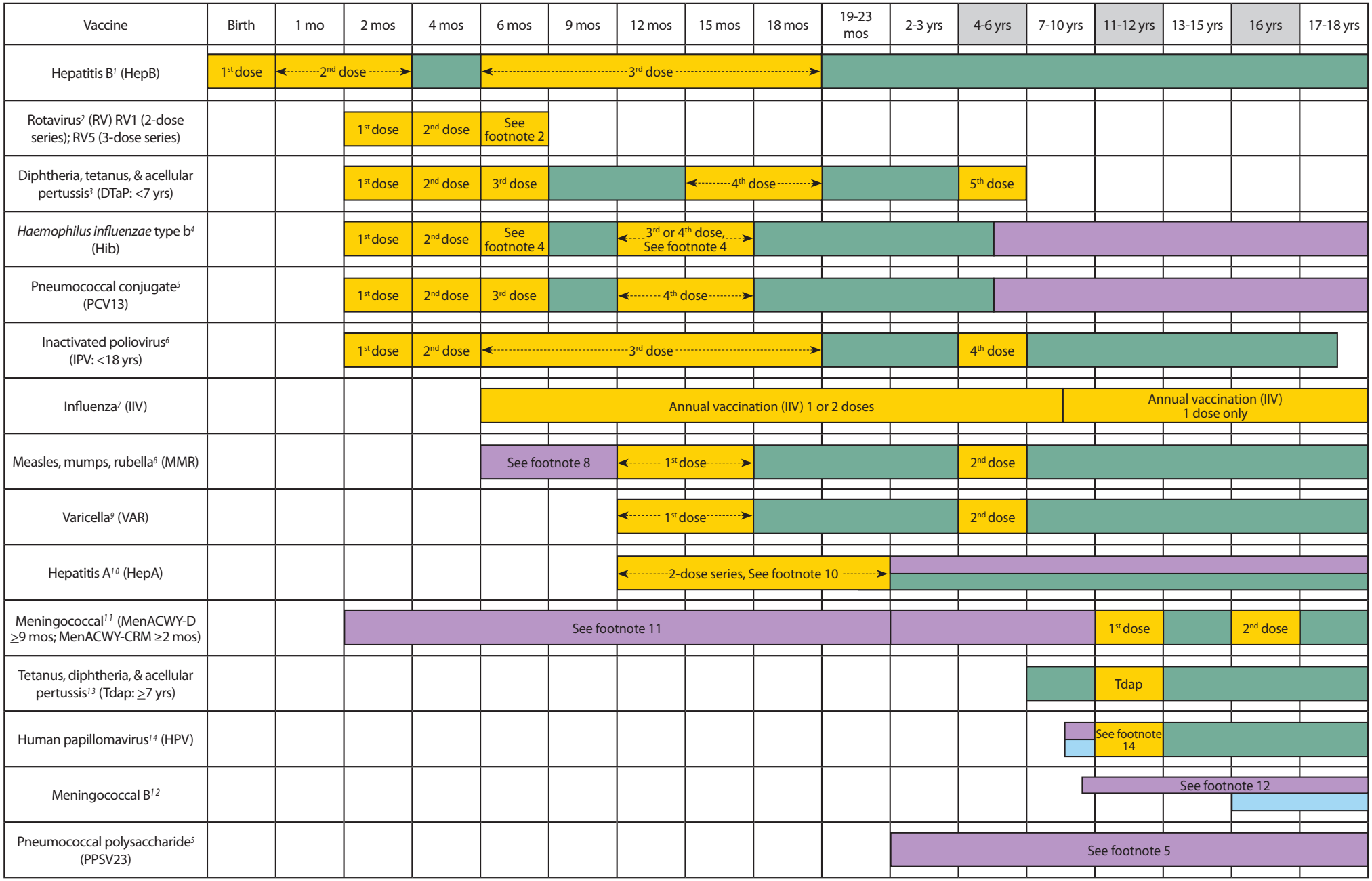
The table below shows vaccine acronyms, and brand names for vaccines routinely recommended for children and adolescents. The use of trade names in this immunization schedule is for identification purposes only and does not imply endorsement by the ACIP or CDC.

Vaccine type	Abbreviation	Brand(s)
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel Infanrix
Diphtheria, tetanus vaccine	DT	No Trade Name
Haemophilus influenzae type B vaccine	Hib (PRP-T) Hib (PRP-OMP)	ActHIB Hiberix PedvaxHIB
Hepatitis A vaccine	HepA	Havrix Vaqta
Hepatitis B vaccine	HepB	Engerix-B Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated)	IIV	Multiple
Measles, mumps, and rubella vaccine	MMR	M-M-R II
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM	Menactra Menveo
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero Trumenba
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax
Poliovirus vaccine (inactivated)	IPV	IPOL
Rotavirus vaccines	RV1 RV5	Rotarix RotaTeq
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel Boostrix
Tetanus and diphtheria vaccine	Td	Tenivac No Trade Name
Varicella vaccine	VAR	Varivax
Combination Vaccines		
DTaP, hepatitis B and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix
DTaP, inactivated poliovirus and *Haemophilus influenzae* type B vaccine	DTaP-IPV/Hib	Pentacel
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix Quadracel
Measles, mumps, rubella, and varicella vaccines	MMRV	ProQuad

Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2018.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.



NOTE: The above recommendations must be read along with the footnotes of this schedule.

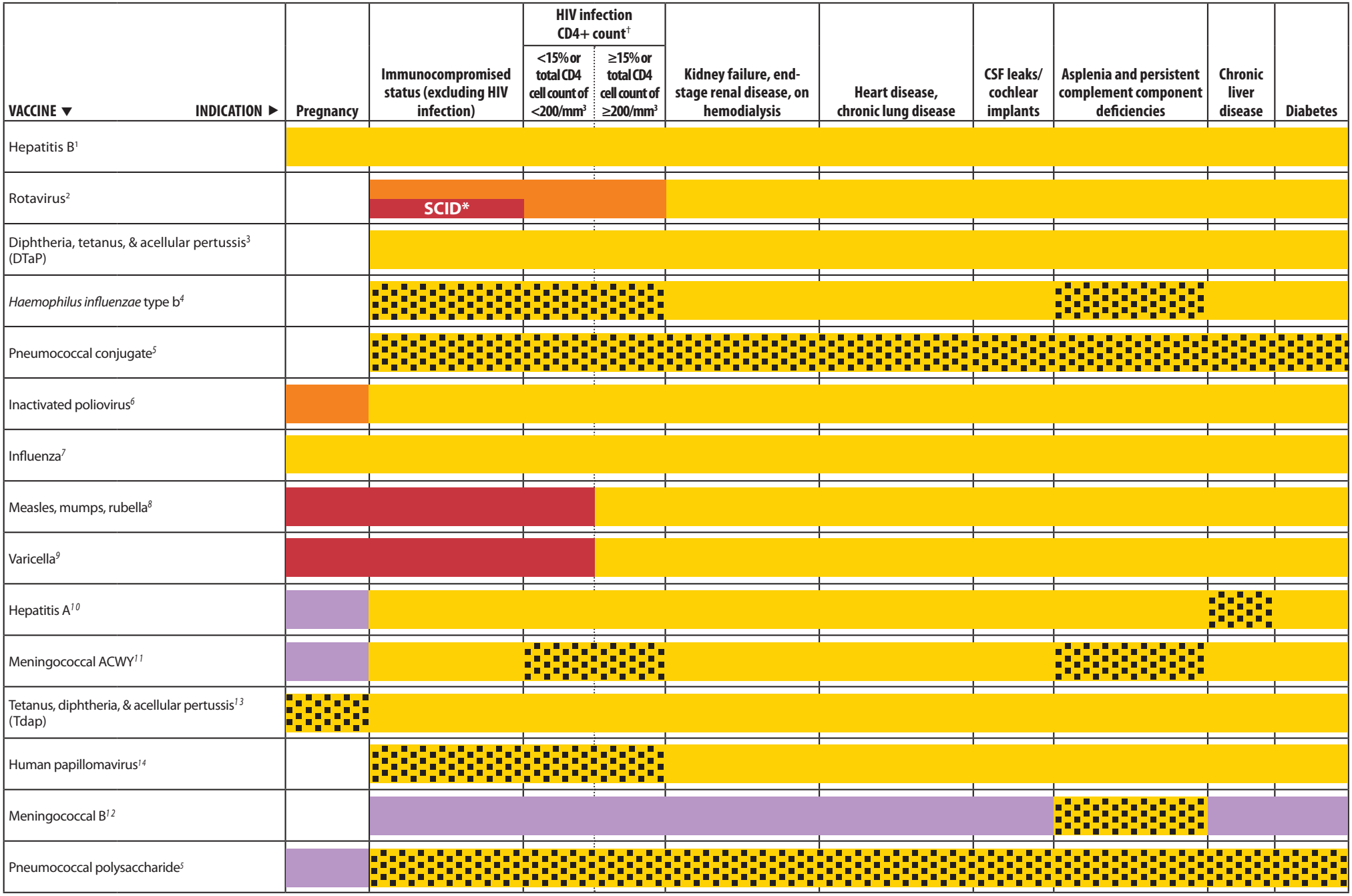
FIGURE 2. Catch-up immunization schedule for persons aged 4 months–18 years who start late or who are more than 1 month behind—United States, 2018.

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

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B[1]	Birth	4 weeks	8 weeks ***and*** at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus[2]	6 weeks Maximum age for first dose is 14 weeks, 6 days	4 weeks	4 weeks[2] Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis[3]	6 weeks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 weeks	4 weeks if first dose was administered before the 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months. No further doses needed if first dose was administered at age 15 months or older.	4 weeks[4] if current age is younger than 12 months **and** first dose was administered at younger than age 7 months, **and** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. 8 weeks ***and*** age 12 through 59 months (as final dose)[4] • if current age is younger than 12 months **and** first dose was administered at age 7 through 11 months; OR • if current age is 12 through 59 months **and** first dose was administered before the 1st birthday, **and** second dose administered at younger than 15 months; OR • if both doses were PRP-OMP (PedvaxHIB; Comvax) **and** were administered before the 1st birthday. No further doses needed if previous dose was administered at age 15 months or older.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate[5]	6 weeks	4 weeks if first dose administered before the 1st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1st birthday or after. No further doses needed for healthy children if first dose was administered at age 24 months or older.	4 weeks if current age is younger than 12 months and previous dose given at <7 months old. 8 weeks (as final dose for healthy children) if previous dose given between 7-11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months. No further doses needed for healthy children if previous dose administered at age 24 months or older.	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus[6]	6 weeks	4 weeks[6]	4 weeks[6] if current age is < 4 years 6 months (as final dose) if current age is 4 years or older	6 months[6] (minimum age 4 years for final dose).	
Measles, mumps, rubella[8]	12 months	4 weeks			
Varicella[9]	12 months	3 months			
Hepatitis A[10]	12 months	6 months			
Meningococcal[11] (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)	6 weeks	8 weeks[11]	See footnote 11	See footnote 11	
Children and adolescents age 7 through 18 years					
Meningococcal[11] (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)	Not Applicable (N/A)	8 weeks[11]			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis[13]	7 years[13]	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1st birthday. 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	6 months if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus[14]	9 years	Routine dosing intervals are recommended.[14]			
Hepatitis A[10]	N/A	6 months			
Hepatitis B[1]	N/A	4 weeks	8 weeks **and** at least 16 weeks after first dose.		
Inactivated poliovirus[6]	N/A	4 weeks	6 months[6] A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella[8]	N/A	4 weeks			
Varicella[9]	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older.			

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Figure 3. Vaccines that might be indicated for children and adolescents aged 18 years or younger based on medical indications



*Severe Combined Immunodeficiency

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

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Footnotes — Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2018

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.
For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information

- For information on contraindications and precautions for the use of a vaccine, consult the *General Best Practice Guidelines for Immunization* and relevant ACIP statements, at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 3-1, *Recommended and minimum ages and intervals between vaccine doses,* in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccine requirements and recommendations is available at wwwnc.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, *Vaccination of persons with primary and secondary immunodeficiencies,* in *General Best Practice Guidelines for Immunization,* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html; and Immunization in Special Clinical Circumstances. (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2015 report of the Committee on Infectious Diseases. 30th ed.* Elk Grove Village, IL: American Academy of Pediatrics, 2015:68-107).
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information; see www.hrsa.gov/vaccinecompensation/index.html.

1. Hepatitis B (HepB) vaccine. (minimum age: birth)

Birth Dose (Monovalent HepB vaccine only):

- **Mother is HBsAg-Negative:** 1 dose within 24 hours of birth for medically stable infants ≥2,000 grams. Infants <2,000 grams administer 1 dose at chronological age 1 month or hospital discharge.
- **Mother is HBsAg-Positive:**
  - Give **HepB vaccine** and **0.5 mL of HBIG** (at separate anatomic sites) within 12 hours of birth, regardless of birth weight.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Give **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants <2,000 grams, give **0.5 mL of HBIG** in addition to HepB vaccine within 12 hours of birth.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, give **0.5 mL of HBIG** to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine Series:

- A complete series is 3 doses at 0, 1–2, and 6–18 months. (Monovalent HepB vaccine should be used for doses given before age 6 weeks.)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Figure 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum age** for the final (3rd or 4th) dose: 24 weeks.
- **Minimum Intervals:** Dose 1 to Dose 2: 4 weeks / Dose 2 to Dose 3: 8 weeks / Dose 1 to Dose 3: 16 weeks. (When 4 doses are given, substitute "Dose 4" for "Dose 3" in these calculations.)

Catch-up vaccination:

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, and 6 months.
- Adolescents 11–15 years of age may use an alternative 2-dose schedule, with at least 4 months between doses (adult formulation **Recombivax HB** only).
- For other catch-up guidance, see Figure 2.

2. Rotavirus vaccines. (minimum age: 6 weeks)

Routine vaccination:

Rotarix: 2-dose series at 2 and 4 months.

RotaTeq: 3-dose series at 2, 4, and 6 months.

If any dose in the series is either RotaTeq or unknown, default to 3-dose series.

Catch-up vaccination:

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

3. Diphtheria, tetanus, and acellular pertussis (DTaP) vaccine. (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination:

- 5-dose series at 2, 4, 6, and 15–18 months, and 4–6 years.
  - **Prospectively:** A 4th dose may be given as early as age 12 months if at least 6 months have elapsed since the 3rd dose.
  - **Retrospectively:** A 4th dose that was inadvertently given as early as 12 months may be counted if at least 4 months have elapsed since the 3rd dose.

Catch-up vaccination:

- The 5th dose is not necessary if the 4th dose was administered at 4 years or older.
- For other catch-up guidance, see Figure 2.

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

4. *Haemophilus influenzae* type b (Hib) vaccine. (minimum age: 6 weeks)

Routine vaccination:

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

Catch-up vaccination:

- **1st dose at 7–11 months:** Give 2nd dose at least 4 weeks later and 3rd (final) dose at 12–15 months or 8 weeks after 2nd dose (whichever is later).
- **1st dose at 12–14 months:** Give 2nd (final) dose at least 8 weeks after 1st dose.
- **1st dose before 12 months and 2nd dose before 15 months:** Give 3rd (final) dose 8 weeks after 2nd dose.
- **2 doses of PedvaxHIB before 12 months:** Give 3rd (final) dose at 12–59 months and at least 8 weeks after 2nd dose.
- **Unvaccinated at 15–59 months:** 1 dose.
- For other catch-up guidance, see Figure 2.

Special Situations:

- **Chemotherapy or radiation treatment**
  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

  Doses given within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT)**
- 3-dose series with doses 4 weeks apart starting 6 to 12 months after successful transplant (regardless of Hib vaccination history).
- **Anatomic or functional asplenia (including sickle cell disease)**
  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart.
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

  Unimmunized persons 5 years or older*
  - Give 1 dose
- **Elective splenectomy**
  Unimmunized* persons 15 months or older
  - Give 1 dose (preferably at least 14 days before procedure).
- **HIV infection**
  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses 8 weeks apart.
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

  Unimmunized persons 5–18 years*
  - Give 1 dose
- **Immunoglobulin deficiency, early component complement deficiency**
  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart.
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

**Unimmunized* = Less than routine series (through 14 months) OR no doses (14 months or older)

5. Pneumococcal vaccines. (minimum age: 6 weeks [PCV13], 2 years [PPSV23])

Routine vaccination with PCV13:

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

Catch-up vaccination with PCV13:

- 1 dose for healthy children aged 24–59 months with any incomplete* PCV13 schedule
- For other catch-up guidance, see Figure 2.

Special situations: High-risk conditions: Administer PCV13 doses before PPSV23 if possible.

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

Age 2–5 years:

- Any incomplete* schedules with:
  - 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
  - <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

Age 6-18 years:

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

Cerebrospinal fluid leak; cochlear implant:

Age 2–5 years:

- Any incomplete* schedules with:
  - 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
  - <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

Age 6–18 years:

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

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

Age 2–5 years:

- Any incomplete* schedules with:
  - 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
  - <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2nd dose of PPSV23 5 years later.

Age 6–18 years:

- No history of either PCV13 or PPSV23: 1 dose of PCV13, 2 doses of PPSV23 (1st dose of PPSV23 administered 8 weeks after PCV13 and 2nd dose of PPSV23 administered at least 5 years after the 1st dose of PPSV23).
- Any PCV13 but no PPSV23: 2 doses of PPSV23 (1st dose of PPSV23 to be given 8 weeks after the most recent dose of PCV13 and 2nd dose of PPSV23 administered at least 5 years after the 1st dose of PPSV23).

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

- PPSV23 but no PCV13: 1 dose of PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2nd dose of PPSV23 to be given 5 years after the 1st dose of PPSV23 and at least 8 weeks after a dose of PCV13.

Chronic liver disease, alcoholism:

Age 6–18 years:

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

*Incomplete schedules are any schedules where PCV13 doses have not been completed according to ACIP recommended catch-up schedules. The total number and timing of doses for complete PCV13 series are dictated by the age at first vaccination. See Tables 8 and 9 in the ACIP pneumococcal vaccine recommendations (www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for complete schedule details.

6. Inactivated poliovirus vaccine (IPV). (minimum age: 6 weeks)

Routine vaccination:

- 4-dose series at ages 2, 4, 6–18 months, and 4–6 years. Administer the final dose on or after the 4th birthday and at least 6 months after the previous dose.

Catch-up vaccination:

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- If 4 or more doses were given before the 4th birthday, give 1 more dose at age 4–6 years and at least 6 months after the previous dose.
- A 4th dose is not necessary if the 3rd dose was given on or after the 4th birthday and at least 6 months after the previous dose.
- IPV is not routinely recommended for U.S. residents 18 years and older.

Series Containing Oral Polio Vaccine (OPV), *either mixed OPV-IPV or OPV-only series*:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements. For guidance to assess doses documented as "OPV" see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Figure 2.

7. Influenza vaccines. (minimum age: 6 months)

Routine vaccination:

- Administer an age-appropriate formulation and dose of influenza vaccine annually.
  - o **Children 6 months–8 years** who did not receive at least 2 doses of influenza vaccine before July 1, 2017 should receive 2 doses separated by at least 4 weeks.
  - o **Persons 9 years and older** 1 dose
- Live attenuated influenza vaccine (LAIV) not recommended for the 2017–18 season.
- For additional guidance, see the 2017–18 ACIP influenza vaccine recommendations (*MMWR* August 25, 2017;66(2):1-20: www.cdc.gov/mmwr/volumes/66/rr/pdfs/rr6602.pdf).

(For the 2018–19 season, see the 2018–19 ACIP influenza vaccine recommendations.)

8. Measles, mumps, and rubella (MMR) vaccine. (minimum age: 12 months for routine vaccination)

Routine vaccination:

- 2-dose series at 12–15 months and 4–6 years.
- The 2nd dose may be given as early as 4 weeks after the 1st dose.

Catch-up vaccination:

- Unvaccinated children and adolescents: 2 doses at least 4 weeks apart.

International travel:

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

Mumps outbreak:

- Persons ≥12 months who previously received ≤2 doses of mumps-containing vaccine and are identified by public health authorities to be at increased risk during a mumps outbreak should receive a dose of mumps-virus containing vaccine.

9. Varicella (VAR) vaccine. (minimum age: 12 months)

Routine vaccination:

- 2-dose series: 12–15 months and 4–6 years.
- The 2nd dose may be given as early as 3 months after the 1st dose (a dose given after a 4-week interval may be counted).

Catch-up vaccination:

- Ensure persons 7–18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4], at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine:
  - o **Ages 7–12:** routine interval 3 months (minimum interval: 4 weeks).
  - o **Ages 13 and older:** minimum interval 4 weeks.

10. Hepatitis A (HepA) vaccine. (minimum age: 12 months)

Routine vaccination:

- 2 doses, separated by 6-18 months, between the 1st and 2nd birthdays. (A series begun before the 2nd birthday should be completed even if the child turns 2 before the second dose is given.)

Catch-up vaccination:

- Anyone 2 years of age or older may receive HepA vaccine if desired. Minimum interval between doses is 6 months.

Special populations:

Previously unvaccinated persons who should be vaccinated:

- Persons traveling to or working in countries with high or intermediate endemicity
- Men who have sex with men
- Users of injection and non-injection drugs
- Persons who work with hepatitis A virus in a research laboratory or with non-human primates
- Persons with clotting-factor disorders
- Persons with chronic liver disease
- Persons who anticipate close, personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity (administer the 1st dose as soon as the adoption is planned—ideally at least 2 weeks before the adoptee's arrival).

11. Serogroup A, C, W, Y meningococcal vaccines. (Minimum age: 2 months [Menveo], 9 months [Menactra].

Routine:

- 2-dose series: 11-12 years and 16 years.

Catch-Up:

- Age 13-15 years: 1 dose now and booster at age 16-18 years. Minimum interval 8 weeks.
- Age 16-18 years: 1 dose.

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

Special populations and situations:
Anatomic or functional asplenia, sickle cell disease, HIV infection, persistent complement component deficiency (including eculizumab use):

- **Menveo**
  - 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 12 months.
  - 1st dose at 7–23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  - 1st dose at 24 months or older: 2 doses at least 8 weeks apart.
- **Menactra**
  - Persistent complement component deficiency:
    - 9–23 months: 2 doses at least 12 weeks apart
    - 24 months or older: 2 doses at least 8 weeks apart
  - Anatomic or functional asplenia, sickle cell disease, or HIV infection:
    - 24 months or older: 2 doses at least 8 weeks apart.
    - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.

Children who travel to or live in countries where meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or during the Hajj, or exposure to an outbreak attributable to a vaccine serogroup:

- Children <24 months of age:
  - **Menveo (2-23 months):**
    - 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 12 months.
    - 1st dose at 7-23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  - **Menactra (9-23 months):**
    - 2 doses (2nd dose at least 12 weeks after the 1st dose. 2nd dose may be administered as early as 8 weeks after the 1st dose in travelers).
- Children 2 years or older: 1 dose of **Menveo** or **Menactra**.

Note: Menactra should be given either before or at the same time as DTaP. For MenACWY booster dose recommendations for groups listed under "Special populations and situations" above, and additional meningococcal vaccination information, see meningococcal *MMWR* publications at: www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

12. Serogroup B meningococcal vaccines (minimum age: 10 years [Bexsero, Trumenba].

Clinical discretion: Adolescents not at increased risk for meningococcal B infection who want MenB vaccine.

MenB vaccines may be given at clinical discretion to adolescents 16–23 years (preferred age 16–18 years) who are not at increased risk.

- **Bexsero**: 2 doses at least 1 month apart.
- **Trumenba**: 2 doses at least 6 months apart. If the 2nd dose is given earlier than 6 months, give a 3rd dose at least 4 months after the 2nd.

Special populations and situations:
Anatomic or functional asplenia, sickle cell disease, persistent complement component deficiency (including eculizumab use), serogroup B meningococcal disease outbreak

- **Bexsero**: 2-dose series at least 1 month apart.
- **Trumenba**: 3-dose series at 0, 1-2, and 6 months.

Note: **Bexsero** and **Trumenba** are not interchangeable.
For additional meningococcal vaccination information, see meningococcal *MMWR* publications at: www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

13. Tetanus, diphtheria, and acellular pertussis (Tdap) vaccine. (minimum age: 11 years for routine vaccinations, 7 years for catch-up vaccination)

Routine vaccination:

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

Catch-up vaccination:

- **Adolescents 13–18 who have not received Tdap**: 1 dose, followed by a Td booster every 10 years.
- **Persons aged 7–18 years not fully immunized with DTaP**: 1 dose of Tdap as part of the catch-up series (preferably the first dose). If additional doses are needed, use Td.
- **Children 7–10 years** who receive Tdap inadvertently or as part of the catch-up series may receive the routine Tdap dose at 11–12 years.
- **DTaP inadvertently given after the 7th birthday**:
  - **Child 7–10**: DTaP may count as part of catch-up series. Routine Tdap dose at 11-12 may be given.
  - **Adolescent 11–18**: Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Figure 2.

14. Human papillomavirus (HPV) vaccine (minimum age: 9 years)

Routine and catch-up vaccination:

- Routine vaccination for all adolescents at 11–12 years (can start at age 9) and through age 18 if not previously adequately vaccinated. Number of doses dependent on age at initial vaccination:
  - **Age 9–14 years at initiation:** 2-dose series at 0 and 6–12 months. Minimum interval: 5 months (repeat a dose given too soon at least 12 weeks after the invalid dose and at least 5 months after the 1st dose).
  - **Age 15 years or older at initiation:** 3-dose series at 0, 1–2 months, and 6 months. Minimum intervals: 4 weeks between 1st and 2nd dose; 12 weeks between 2nd and 3rd dose; 5 months between 1st and 3rd dose (repeat dose(s) given too soon at or after the minimum interval since the most recent dose).
- Persons who have completed a valid series with any HPV vaccine do not need any additional doses.

Special situations:

- **History of sexual abuse or assault**: Begin series at age 9 years.
- **Immunocompromised* (including HIV)** aged 9–26 years: 3-dose series at 0, 1–2 months, and 6 months.
- **Pregnancy:** Vaccination not recommended, but there is no evidence the vaccine is harmful. No intervention is needed for women who inadvertently received a dose of HPV vaccine while pregnant. Delay remaining doses until after pregnancy. Pregnancy testing not needed before vaccination.

*See MMWR, December 16, 2016;65(49):1405–1408, at www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6549a5.pdf.

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Attachment E

Public Comment available in

Meeting Materials,

RHPAB 8.29.18 Board Packet Redacted Public Comment

on line at:

http://doa.alaska.gov/drb/alaskacare/retiree/advisory.html

Summary Table
for
Updated Defined
Benefit Plan Booklet

Public Comment Suggestion Summary	Action
Make available online in electronic format to include links from table of contents to relevant section, keep hyperlinks active.	The Division will incorporate this suggestion into the final electronic document.
Each page should have a return to the Table of Contents	The Division will incorporate this suggestion into the final electronic document.
Notice retirees when a paper copy of the booklet is available.	Notice will be sent when the updated booklet is available online. There may be a delay before printed copies are available.
Add an alert at the beginning of the booklet related to the effects of Medicare.	A statement will be added to the benefit summary under section 1, *Health Plan* .
Correct the typo on page 61 from “signal” to “single”.	The Division will make this correction in the final document.
Number the pages to match the Adobe Reader page number.	We are unable to adopt this change, but we will include hyperlinks from the table of contents which should resolve the underlying concern.
Consider keeping the references to statute and regulation.	The comments were temporary for purposes of clarifying the intent of changes. However, a permanent citation to applicable statutes will be referenced under section 2.1., *Introduction.*
Add a space in 2.2.1	The Division will make this correction in the final document.
Give examples of the out-of-network recognized charge potential impacts.	This request will be considered for future changes to the Retiree Insurance Information Booklet addressed through the Retiree Health Plan Advisory Board.
When a referral is made to another section please include either or both the page number or the paragraph reference in the referral so one does not have to look up the location.	The Division will incorporate this suggestion into the final document, including hyperlinks in the electronic document.

Specifically address coverage of IV and injected drugs.	This request will be considered for future changes to the Retiree Insurance Information Booklet addressed through the Retiree Health Plan Advisory Board.
Include additional information on coordination of benefits with a Health Maintenance Organization such as a Medicare Advantage Plan.	This request will be considered for future changes to the Retiree Insurance Information Booklet addressed through the Retiree Health Plan Advisory Board.
The table for Non-emergency Admissions and Outpatient Non-emergency services need to be expanded to show the full text.	The Division will make this correction in the final document.
Retitle from *Retiree Insurance Information Booklet* to *The AlaskaCare Defined Benefit Retiree Health Plan Insurance Policy and Information Handbook*	This request will be considered for future changes to the Retiree Insurance Information Booklet addressed through the Retiree Health Plan Advisory Board.
Refrain from making any revisions to the handbook that incorporate any of the coverage benefit changes made since 2013 until a final determination whether those changes comply with the Alaska Constitution and the requirements of *RPEA v. Duncan* opinion.	The amendments effective on or after January 1, 2014 are the current terms of the health plan regardless of whether they are in the body of the document or left in the front. Although portions of the benefits are under litigation, the litigation process can be quite lengthy. Once concluded, should any changes to the plan be required, the booklet will be updated as appropriate.
Reward members who make health lifestyle changes.	This request will be considered for future changes to the Retiree Insurance Information Booklet addressed through the Retiree Health Plan Advisory Board.
Rewrite the plan document to be less confusing.	This request will be considered for future changes to the Retiree Insurance Information Booklet addressed through the Retiree Health Plan Advisory Board.

Don’t use Aetna’s definition of “medical necessity”.	The Department believes that documented determinations of medical necessity is appropriate to provide transparency in the plan. Making specific reference is necessary for members and their providers to access and understand the basis of the TPA’s medical necessity determinations and can be updated when there is a change in third party administrator(s).
Section 3.3.20, *Medical Treatment of Mouth, Jaws and Teeth,* make it clear that it is distinct from the dental plan.	Amend the first paragraph to reference the separate dental plan under section 5, *Dental Benefits.*
Section 3.4.2, *Mail Order Program*, clarify if there is a cost associated with shipping and handling	This request will be considered for future changes to the Retiree Insurance Information Booklet addressed through the Retiree Health Plan Advisory Board.
3.4.4, *Exclusions*, clarify coverage of “device of any type”	Amend the first sentence of 3.4.4. to read “Benefits are not payable under the Prescription Drug benefit for:”

EGWP
Proposal

Proposed change: Enhanced Employer Group Waiver Program (EGWP)

Plans affected: DB Retiree Plan

Reviewed by: Retiree Health Plan Advisory Board, Alaska Retirement Management Board

Proposed implementation date: January 1, 2019

Review Date: August 29, 2018

Table 1: Plan Design Changes

	Member	Actuarial	DRB Ops	Financial	Clinical	TPA	Provider
No impact		**X**					
Minimal impact	**X**				**X**		**X**
High impact			**X**	**X**		**X**	
Need Info							

Description of proposed change:

The proposed change has a neutral actuarial impact and results in no changes to the drugs covered by the plan or member copays.[1]

An Employer Group Waiver Program (EGWP) is one method offered by the federal government to provide subsidies to the State of Alaska retiree health trusts for qualifying prescription drug costs while retaining existing retiree benefits. An EGWP, pronounced "egg whip", is a *group* Medicare Part D prescription drug plan option. An enhanced EGWP is an EGWP plan offered with a supplemental prescription drug benefit (also known as a "wrap") that provides additional coverage for drugs not covered under the Medicare Part D program.

More than 90% of states that provide drug benefits to Medicare retirees have already implemented EGWPs and have already begun to realize cost savings.[2] By implementing an enhanced EGWP, it is estimated that additional federal subsidies will save the State

[1] Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting memo dated July 24, 2018.

[2] *State Retiree Health Plan Spending* by The Pew Charitable Trusts and MacArthur Foundation (May 2016), supplemented with research by Segal of publicly available documents.

of Alaska retiree health trust $16 million to $23 million annually.[3] In addition, the future liabilities for Other Post-Employment Benefits (OPEB) will be reduced, which decreases the State assistance payment by an estimated $40 million to $52 million annually.[4]

In plan year 2017, the AlaskaCare defined benefit retiree health plan paid a total of $523 million in combined medical and pharmacy benefits across all members.[5] Approximately 44%, or $231 million of that was spent on pharmacy benefits. Among Medicare-eligible members, the plan covered $172 million in pharmacy claims.

The AlaskaCare EGWP would be available to all individuals who are: 1) eligible for Medicare; 2) enrolled in Part A or Part B; and 3) and are covered by the AlaskaCare retiree health plan. The AlaskaCare EGWP will provide prescription drug coverage in a way that preserves the benefits Medicare-eligible retirees enjoy today while also promoting cost savings for the health trusts. The additional savings will assist the State in keeping its promise to retirees to provide health benefits into the future. This will require some administrative changes that are anticipated to be minor as outlined below.

The Alaska Retirement Management Board passed a resolution on December 8, 2017 in support of the adoption and implementation of an EGWP effective January 1, 2019.[6]

If the Division of Retirement and Benefits (Division) later determines that the enhanced EGWP is not meeting the needs of our members or the State, the Division can disenroll from the program.

Member impact:

WHO IS IMPACTED-

The AlaskaCare EGWP would be available to all individuals who are: 1) eligible for Medicare; 2) enrolled in Part A or Part B; and 3) and are covered by the AlaskaCare retiree health plan.

Based on 2017 reporting, this is estimated to be approximately 48,889 individual policies for Medicare eligible retirees covered under the health plan. In general, approximately 60% of all retirees reside in Alaska, and 40% reside outside of Alaska.

[3] Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting memo dated July 24, 2018.
[4] Attachment B: *State of Alaska Estimated EGWP Savings Projections* Conduent 1/24/2018
[5] Aetna quarterly report for claims incurred January 1, 2017 through December 31, 2017.
[6] Attachment C: ARMB Res 2017-20 Employer Group Waiver Program

Retiree members who otherwise meet the EGWP criteria but who are in the following circumstances will not be enrolled:

- Retiree members living outside of the United States, Guam and Puerto Rico (estimated to be 175 individuals)
- Retiree members who are actively working and therefore do not qualify for Medicare Part A with no premium (estimated to be 125 individuals)

BENEFIT IMPACT-

EGWP represents an administrative change, rather than a change in plan benefits. There is no anticipated impact to the benefits that members will receive. An AlaskaCare EGWP would be an enhanced EGWP, which is an EGWP provided with a "wrap," or a supplemental benefit package. This "wrap" allows the plan to cover medications that would not typically be covered through a group Medicare Part D plan, and to also reduce or eliminate aspects of the Standard Part D benefit such as the Deductible or Coverage Gap.

The EGWP is subject to Centers for Medicare & Medicaid Services (CMS) regulations. For example, CMS approves a formulary, or a list of prescription drugs, that qualify for a federal subsidy and are covered under the EGWP. Drugs that are not on the CMS formulary will be covered through the wrap benefit. This ensures that if a drug is covered in the AlaskaCare plan today, it will be covered under an AlaskaCare EGWP. The member will pay the same copay ($8 brand, $4 generic or $0 for all mail order) as they do today.

The determination of prescription drugs covered under the EGWP and the wrap plan will occur through the Pharmacy Benefit Manager (PBM) point-of-sale claims adjudication software.[7] The pharmacist will run the prescription as they do today, and the software program will apply appropriate coding so that the plan receives a subsidy if eligible, or covers the full cost of the medication under the wrap if not eligible for a federal subsidy.

Fill Requirements- No change from current benefit which allows members "to fill up to a 90-day or 100-unit supply, whichever is greater, at one time."

The plan allows for vacation overrides and other exceptions as necessary; this would be preserved under an AlaskaCare EGWP.

[7] A pharmacy benefits manager (PBM) is a vendor the Division of Retirement and Benefits hires to process and adjudicate pharmacy claims and to maintain a network of contracted pharmacies.

OTHER

CMS requires that retirees enrolled in an AlaskaCare EGWP that have multiple medical conditions or high drug utilization be enrolled in a Medication Therapy Management Program (MTMP).[8] This program helps the member and their doctor make sure the medications are working to improve the health of the member, and provides a comprehensive review if medications have side effects or might have interactions with other medications the member is taking. Members may opt out of this program at any time.

Additional analysis is needed to understand how many AlaskaCare retirees meet the criteria for enrollment into the MTMP. However, on average enrollment into the MTMP is about 12%.

FINANCIAL IMPACT-

a. Copayments - There is no anticipated impact to member's co-pay.

Table 2: Comparison of Current to Proposed AlaskaCare EGWP (no change)

	Mail Order Copay	Retail Generic Copay	Retail Brand Name Copay	Drugs Covered
Current	$0	$4	$8	Open Formulary[9]
AlaskaCare EGWP	$0	$4	$8	Open Formulary

b. Coordination of Benefits - An AlaskaCare EGWP will continue to coordinate with other AlaskaCare plans the same way it does today, so if a member with multiple coverages under the AlaskaCare plan does not pay copayments today for medications, they would not have to pay them under an AlaskaCare EGWP.

   There are no restrictions on allowing an AlaskaCare EGWP to coordinate benefits with a plan that is not an EGWP or individual Medicare Part D plan with two exceptions:

[8] Additional information specific to the conditions and definition of high drug utilization is underway.
[9] A formulary is a list of covered prescription drugs that will be paid under a health plan. An open formulary means there are no restrictions on which drugs will be covered as long as the drug meets the definition of "prescription drug", i.e. a medical substance which must bear a label that states, "Caution: Federal law prohibits dispensing without a prescription" and is not otherwise excluded under the plan.

1) CMS does not allow coordination of benefits with prescriptions filled at a Veterans Administration Pharmacy. In some situations, this is a change from how AlaskaCare benefits are coordinate with VA pharmacy claims today.
    - AlaskaCare does not currently cover pharmacy benefits related to a service connected medical condition, so this does not represent a change for military service-related prescriptions.
    - For non-service related conditions, the VA will bill AlaskaCare, but is unable to bill Medicare. Additional research is being conducted to determine how many members may be impacted by this restriction.
    - For non-service related conditions, if the member pays the VA pharmacy directly for the copay, the member is precluded from seeking reimbursement under federal regulation. This scenario would not represent a change.
    - There are about 1,400 members utilizing VA pharmacies. Of these only about 100 members will not have an EGWP pharmacy option within 5 miles of the VA pharmacy currently being utilized. Members can also fill their maintenance medications through mail order for a $) copay.
2) CMS does not permit a member to have more than one EGWP or individual Medicare part D plan.
    - We are unable to determine how many retirees may have outside EGWP plans, until the enrollment process begins. Once they are identified, they can be enrolled in an alternative plan based on who is the primary versus secondary payer. If AlaskaCare is primary they can be enrolled in a zero-copay plan, allowing the trust to receive the additional federal subsidies while protecting the member from the financial impact of losing their secondary coverage. If AlaskaCare is secondary, they can be enrolled in the pharmacy plan for non-Medicare eligible members allowing the plan to continue to coordinate benefits.
    - We are similarly unable to determine how many retirees may be currently purchasing an individual Medicare part D plan. CMS charges a base premium of $390 per year for an individual part D coverage. This equates to almost 49 brand name (90-day) prescription fills under the AlaskaCare plan. In most cases, the cost of Part D coverage outweighs any benefit to having a secondary plan coordinate benefits with AlaskaCare.

c. Premiums - CMS requires certain high-income retirees to pay an extra surcharge. This is the same requirement for members who are covered today under Medicare Part B. This surcharge is called the Part D Income Related Monthly Adjustment

Amount (IRMAA). Monthly Adjusted Gross Income (MAGI) is determined by the amount on the last line of the individual/couples IRS 1040 tax form (line 37 on form 1040, line 21 on form 1040A, or line 4 on form 1040EZ), **plus** any tax-exempt interest income (line 8b on form 1040). This information from two years prior is used to determine the Part D IRMAA for the current premium year. For example, information from 2017 will determine the 2019 Part D IRMAA. The below table shows the Part D IRMAA for 2018, but this is subject to change.

Table 3: Overview of MAGI and Surcharge Categories

Individuals MAGI	Couples MAGI	Extra Monthly Surcharge Amount
Equal to or below $85,000	Equal to or below $170,000	$0
$85,001-$107,000	$170,001-$214,000	$13.00
$107,001-$133,500	$214,001-$267,000	$33.60
$133,501-$160,000	$267,001-$320,000	$54.20
Above $160,000	Above $320,000	$74.80

No member will be required to shoulder this additional cost for their pharmacy benefits. The Division will fund a Health Reimbursement Arrangement (HRA) account to offset the full amount of Part D IRMAA associated with the EGWP.[10]

The number of impacted members is unknown because the Division does not have access to member's household income, however based on Alaska pension information alone an estimated 650 retirees meet the minimum income threshold.[11] The Division will work to inform retirees of the income thresholds and encourage them to proactively contact the Division to: 1) understand if they will be impacted; and 2) to make arrangements for compensation.

Members paying a surcharge for Medicare Part B today can expect to be assessed a surcharge under EGWP.[12] The requirements are the same.

There are two methods the Division could use to compensate members subject to the surcharge. Both require the Division to establish and pre-fund an HRA for the impacted member.

[10] A Health Reimbursement Arrangement (HRA) account is an IRS-approved, employer funded, tax-advantaged account that can be used to reimburse for individual health insurance premiums.
[11] Based on 2016 pension data.
[12] Medicare premiums for high income beneficiaries. https://www.ssa.gov/pubs/EN-05-10536.pdf

1) If a retiree/member has the Part D IRMAA deducted from their social security benefit, the HRA can reimburse the member on a monthly-basis.
2) If a retiree/member does not have social security and is invoiced by Medicare, the HRA can be set up to automatically pay Medicare directly each month so the member does not have to pay out-of-pocket.

Members will need to provide the Division with documentation to ensure the HRA is being funded accurately. Per discussions with the State Medicare Information Office, members will receive annually each fall, either an *Annual Income-Related Monthly Adjustment Amount (IRMAA) Notice for Title II Beneficiaries with a Cost of Living Adjustment (COLA)*[13] or *Annual Income-Related Monthly Adjustment Amount (IRMAA) Notice for Beneficiaries Who Directly Remit Premiums to CMS*[14] from Social Security. This notice will contain sufficient information for the Division to determine the individuals IRMAA related to the pharmacy benefits, but must be provided by the member. As an alternative, members can provide the relevant portion of their tax return[15].

As household income can fluctuate, members may need to contact the Division annually to provide updated information to ensure the HRA funding aligns with the surcharge.

d. Serious hardship – through the addition of the wrap benefits, we have found no circumstances that we believe rise to the level of serious hardship. However, should a member present a situation that can be verified as a serious hardship, that individual could be removed from the enhanced EGWP and placed in the unsubsidized plan offered to non-Medicare eligible retirees.

ADMINISTRATIVE IMPACT: There are several areas where member's may experience administrative impact. These are listed below:

a. Enrollment - The health plan will enroll Medicare eligible members into the AlaskaCare EGWP. Members do not have to apply individually, and the Division does not anticipate additional administrative impact to the member.

[13] https://secure.ssa.gov/apps10/poms.nsf/lnx/0601194005
[14] https://secure.ssa.gov/apps10/poms.nsf/lnx/0601194020
[15] line 37 on form 1040, line 21 on form 1040A, or line 4 on form 1040EZ, plus any tax-exempt interest income (line 8b on form 1040)

b. ID Cards - Members will have an ID card specifically for pharmacy benefit claims, a separate card from their Medical plan. Historically member's have had a single card for both medical and pharmacy claims, so this will be a new change and may require additional effort by the member to keep track of the cards and ensure they are submitting the correct card. The Division and the PBM will work to educate members to avoid confusion.
c. Premiums – See description of Part D IRMAA above. Impacted members would need to undertake actions similar to what they do today in terms of paying their Medicare Part B surcharge; however, they would need to submit and complete additional paperwork to establish and maintain the plan-funded HRA to cover the IRMAA related to the pharmacy benefit.
d. Pre-authorization - CMS requires a new prior authorization on certain medications and requires prior authorizations on medication that previously did not require one. Prior authorization reviews will not only review the type of drug, but the diagnosis it is being used to treat, as that can impact if it is covered on the EGWP formulary or under Medicare Part B or excluded from the EGWP formulary.

   CMS does <u>not</u> require step therapy. Step therapy is when a member is required to try a less expensive medication before the plan will cover a more expensive drug.

CMS requires prior authorization for the following:

1) Medicare Part B or Part D determination-
   - This review focuses on identifying if a drug qualifies for subsidy under the prescription program or should be covered under Medicare Part B the medical plan.
   - It is not anticipated to impact either the plan benefits or the member copayment. For example, if its determined that the drug is covered under Medicare Part B instead of the EGWP, the member will continue to receive the same drugs they are getting today for the same copay they are paying today.

2) EGWP formulary determination-
   - This review focuses on determining if a drug is covered or excluded under the EGWP formulary.
   - It is not anticipated to impact either the plan benefits or the member copayment. For example, if a drug is not covered through the EGWP

formulary, it will be covered by the wrap. If its covered by EGWP, the plan benefits from the federal subsidy. If it is not covered under EGWP, the plan pays for the medication through the wrap benefits and the member can continue to receive the drugs they are getting today for the same copay they are paying today.

There are approximately 5,000 members who are taking a medication that fall on the prior authorization list. Some of the prior authorizations can be auto-resolved, reducing this number. For example, most nebulizer solutions have the Medicare part B vs. part D prior authorization auto-resolved at the point of sale. Prior to implementation of an AlaskaCare EGWP, the members who are taking a medication that require prior authorization that cannot be auto-resolved, will be notified by the PBM and either the member, or their doctor, will have to complete and submit the required form. This will need to be completed even if the medication was already authorized under the existing plan. The Division will work with PBM to streamline this process and mitigate this administrative burden on the membership. Members will get an automatic one-time 30-day transition supply of the medication and will receive a letter in the mail 3 business days later explaining the need for prior authorization to have the drug covered under the EGWP formulary. If denied, the medication can be covered under the wrap.

Following implementation, if a member is prescribed medication requiring prior authorization for the first time, they or their doctor will need to complete and submit the required form.

For most medications, once a prior authorization is established it is in effect for a year or longer; however, some medications may require more frequent reviews. These include opioids, specialty medications, etc.

Appeals – Should a member be denied prior authorization under the EGWP, the member would be automatically provided approval under the enhanced wrap benefit. The member will receive a letter indicating the denial under Part D, however the letter will also include language that the drug is covered under the enhanced wrap benefit. Although the medication will be covered by the enhanced wrap, the member may still choose to file an appeal through the federal process if they wish to contest whether the medication should have been eligible for coverage under the EGWP and therefore qualifying for any applicable federal subsidy. There is limited likelihood this would occur as the member would have already received their medication with no financial impact.

e. Opt-out - CMS requires the AlaskaCare plan to offer Medicare eligible retirees the option to Opt-Out of the EGWP. To disincentivize members from opting out of this program, many plans choose not to cover prescription drug benefits at all should members opt-out. The Division proposes instead enrolling members who opt-out into an alternative pharmacy benefit plan which mirrors the prescription drug benefits offered in the Defined Contribution Retirement health plan. A summary of the opt-out plan is shown below.

Table 4: Opt-out plan based on current DCR health plan

Prescription Tier	**Coinsurance**	**Minimum Covered Person Payment**	**Maximum Covered Person Payment**
Retail 30 Day at Network Pharmacy			
Generic prescription drug	80%	$10	$50
Preferred brand-name prescription drug	75%	$25	$75
Non-preferred brand-name prescription drug	65%	$80	$150
Mail Order 31-90 Day at Network Pharmacy			
Prescription Tier		**Copayment**	
Generic prescription drug		$20	
Preferred brand-name prescription drug		$50	
Non-preferred brand-name prescription drug		$100	
Out-of-Network Pharmacy			
Coinsurance for all **prescription drugs**		60%	
Out-of-Pocket Limit			
Annual individual **out-of-pocket limit**		$1,000	

This type of disincentive is already applied to the medical benefit as the plan assumes that individuals who are eligible for Medicare have enrolled and calculates the benefits assuming they are. If members have delayed or declined to enroll in Medicare, they bear the additional cost, the plan does not make up the difference.

A member who opts-out, can reenroll during the annual open enrollment for the next benefit year.

Benefits will not coordinate between opt-out plans for members covered under multiple AlaskaCare retiree plans who elect to opt-out of EGWP. Opting-out is strongly discouraged and members who do will be subject to higher out-of-pocket costs.

f. Other - CMS has many mandatory communications that will be mailed to members. These communications will be provided to all members covered under the AlaskaCare EGWP. The Division can include cover letters and guidance but cannot suppress these communications.

   CMS may require members with a mailing address that is a post-office box to attest that they are a resident of the United States, Guam or Puerto Rico. Additional research is ongoing to understand the number of retirees required to attest to residency.

ACCESS IMPACT: Members may experience some change in the network of pharmacies they can access, however any difference is anticipated to be minimal with the Division providing alternatives. This is not unlike what occurs under the existing plan when there is a change from one PBM to another.

CMS has established certain requirements for a pharmacy to participate in an EGWP network. In an initial analysis based on information obtained and evaluated in the PBM Request For Proposal (RFP), it appears that 19 pharmacies in Alaska are not in the EGWP network, however many of these are in areas where there are other network pharmacies members can access. As it has in past transitions or changes in networks, the incoming PBM, OptumRx, will work with non-participating pharmacies to bring them in the network prior to January 1, 2019.

At this point in time, Dillingham, Bethel, Petersburg and Wrangell have no pharmacies participating in the EGWP network. Of these four communities, one (Bethel) currently has no network pharmacy while the remaining 3 have one network option.

If OptumRx is not able to bring them into the network, members can still utilize these pharmacies but will need to submit paper claims as is required for out-of-network pharmacies today. For prescriptions for which it is appropriate, members can also fill their prescriptions through mail order or the specialty mail services. Additional analysis will be conducted on pharmacies outside of Alaska. Additional analysis will be conducted to determine the number of members utilizing pharmacies not currently in the network. In Alaska this is estimated to be around 600 members, of which over 150 are utilizing a pharmacy that is not in the current Aetna/CVS network.

Actuarial impact[16]

Neutral / Enhancement / Diminishment

The implementation of an enhanced EGWP will provide the same cost share structure as members receive today (see *Table 2* above). For this reason, there is no change in the actuarial value of the plan.[17] Based on Attachment A developed by Segal Consulting,[18] implementation of the AlaskaCare EGWP does not impact the plan's overall actuarial value based on the following:

a. The primary change associated with the transition to EGWP is the change in federal subsidies, which do not impact the actuarial value.
b. As previously noted, there will be no change to copay structure, which will remain $4 (generics), $8 (brands) and $0 (mail order).
c. There will be no change to the members that have multiple coverages in the State Plan. For these members their net drug costs will remain $0.
d. Members' access to covered drugs and pharmacies will not be impacted by the EGWP transition.

There is no change in the value of the benefits associated with the EGWP implementation. Therefore, there will be no impact on the actuarial value of the Retiree Plan.

Table 5: Actuarial Impact (none)

	Actuarial Impact	Notes
Current	N/A	N/A
Proposed change	None	No changes in member cost share.

DRB operational impacts:

The Division is responsible for procuring the services through a Pharmacy Third-Party Claims Administrator, more commonly referred to as Pharmacy Benefit Manager(PBM). The Division will work with the vendor to auto enroll Medicare-eligible retirees and dependents through CMS into the group Medicare Part D plan. For those whose enrollment is denied by CMS (e.g. those living outside the United States, Guam or

[16] "Under the ACA, a health insurance plan's actuarial value indicates the average share of medical spending that is paid by the plan, as opposed to being paid out of pocket by the consumer." https://www.actuary.org/files/Actuarial_value_basics_for_NAIC_040113.pdf

[17] Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting memo dated July 24, 2018

[18] Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting memo dated July 24, 2018

Puerto Rico, or those currently working and not eligible for Medicare A), will be enrolled in the plan provided to non-Medicare eligible retirees and dependents.

The Division will be responsible for leading the transition to an AlaskaCare EGWP in conjunction with the PBM and all associated activities. This will require significant effort by staff.

The Division will need to make technical changes to its eligibility reporting system to support the transition to an AlaskaCare EGWP.

The Division will need to provide an attestation that existing retirees were covered under a pharmacy benefit that was at least as good as those offered under the EGWP (was Creditable Coverage).

The Division will need to design the pharmacy "wrap" benefit to ensure formulary and network gaps are covered by the plan in accordance with the *Retiree Insurance Information Booklet*. This will be completed with the assistance of the benefit consultants and the PBM.

The Division will need to establish processes and protocols for identifying members subject to Part D IRMAA and necessary information to establish and maintain Health Reimbursement Arrangement (HRA) for those members.

The Division will need to establish process and protocols related to retroactive termination of coverage when untimely notified of the death of a member or a divorce as there are some CMS limitations that conflict with the existing process.

The Division will need to maintain existing support for the Retiree Drug Subsidy (RDS) program as an additional source of federal subsidies for those retirees who are not eligible for EGWP subsidies.

It was initially thought that the PBM would be the fiduciary for an EGWP, however **CMS does not require a change in fiduciary**[19]. This applies only to fully-insured plans and will have no impact on the AlaskaCare EGWP. The plan's fiduciary status will remain as it is today.

Financial impact to the plan:

An AlaskaCare EGWP is estimated to provide substantial savings to the plan, outlined below. Several consultants have provided a range of estimated savings in various reports

[19] Title 42, 423.501, 423.504 and 423.505

over the last three years. The savings estimated in table 6 are based on a review of those estimates from Conduent outlined in Attachment B[20].

Table 6: EGWP estimated savings

	Current RDS program	Proposed enhanced EGWP
CMS Subsidies	$19M to $21M annually	$35M to $44M annually (net of additional expenses)
OPEB Liability Impacts	None	$520M to $694M[21]
Reduction of State Assistance	None	$40M to $52M in annual savings[22]
Summary of Public Comments	Pending	Pending

The current federal Retiree Drug Subsidy (RDS) are about 28% of qualified drug costs, which calculates to about $19 million to $21 million annually. However, RDS has limitations:

- No subsides are received for the first $405 in an individual retiree's drug spend
- No subsidies will be paid for prescription drug costs in excess of $8,350[23]
- The amount of the subsidies cannot be used in forecasting plan experience for purposes of Other Pension Employment Benefits (OPEB).

The EGWP offers 3 substantial subsidies estimated to total between $35 million to $44 million ($16 million to $23 million over the RDS) annually:

- A direct subsidy for each member per year, even if they have $0 in drug spend
- A Coverage Gap Discount subsidy, which provides a 50% manufacturer discount (increasing to 70% in 2019) on brand-name drugs when the member is in the coverage gap ($3,750-$7,508.75)
- Catastrophic coverage reinsurance subsidy, where Medicare provides 80% reimbursement for highest utilizers (greater than $7,508.75)[24]

In addition, the EGWP subsidies can be used in forecasting plan experience for purposes of OPEB, which results in an estimated reduction of between $40 million and $52 million to the State assistance payments annually.[25] State assistance payments are the

[20] Attachment B: *State of Alaska Estimated EGWP Savings Projections,* Conduent dated January 24, 2018.
[21] This represents a 5-7% improvement in the unfunded liability of the PERS and TRS plans.
[22] Attachment B: *State of Alaska Estimated EGWP Savings Projections* Conduent dated January 24, 2018.
[23] Based on 2018 CMS program information and are subject to change.
[24] Based on 2018 CMS program information and are subject to change.
[25] Ibid.

difference between the Alaska Retirement Management Board adopted contribution rates and the contribution rate caps paid by employers.[26]

The savings analysis looked at pharmacy claims data from 2016 and 2017. Assumptions were also made that claims cost through 2019 would increase at 6.0% annual based trend, and that member copays would vary due to fluctuation in drug utilization.[27] Projected EGWP subsides were developed based on claims experience and average subsidies received by other similar groups. These savings were then reduced by the estimated increase in administrative fees, fees associated with the Patient Protection and Affordable Care Act (ACA), projected Part D IRMAA reimbursements, changes in rebates and the estimated subsidies that would have been received under the Retiree Drug Subsidy program.

Clinical considerations:

There are no plans to implement "step therapy" or "fail first" provisions in the retiree plan, that would require additional information from clinicians. "Step therapy" is when an insurance plan requires a member to try certain lower-cost medications first before covering a more expensive type of medication.

For a very limited number of drugs, the retiree health plan already requires prior authorization, and in a few cases where a drug is extraordinarily expensive and other alternative medications are available, the plan requires members try those medications first or have a medically necessary reason why those would not work. This is not a requirement of EGWP, this is part of the current plan administration. This is limited to a very small number of drugs and should not be impacted by an AlaskaCare EGWP.

Third Party Administrator (TPA) operational impacts:

The impacts to the Medical, Dental and Long-Term Care Third Party Administrator will be minimal. The impact to the Pharmacy Benefit Manager (PBM) will be significant. There is a heavy back-end administrative burden that is performed by the PBM to minimize member impacts. This includes, but is not limited to:

- gaining approval from CMS to be an EGWP sponsor;
- creating and publishing a custom EGWP formulary that is compliant with Medicare Part D program requirements;

[26] In attachment B: *State of Alaska Estimated EGWP Savings Projections,* the FY19 total contribution rates provided in the September 15, 2017 letter referenced in footnote #1 are 27.58% for PERS and 28.90% for TRS. Because the employer contribution caps are 22% for PERS and 12.56 in TRS, the State Assistance Contribution Rates shown on the exhibit are 27.58% - 22.0% = 5.58% for PERS and 28.90% - 12.56% = 16.34% for TRS.
[27] Attachment A: *Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting memo dated July 24, 2018.

- administering the supplemental wrap benefits to ensure AlaskaCare benefits remain as they are today;
- enrolling Medicare eligible retirees under the EGWP;
- managing the CMS required Opt-out process;
- administering CMS required Medication Therapy Management Program;
- producing Prescription Drug Events (PDE) files, health plan management system reports, and other required CMS reporting;
- providing customer service support to retirees;
- mailing mandatory CMS communications;
- administering Part D Low Income Subsidies;
- administering the supplemental wrap benefits to ensure AlaskaCare benefits remain as they are today; and
- conducting CMS subsidy payment reporting.

Provider considerations:

Impacts to providers are anticipated to be minimal. However, the PBM will run detail analysis to verify what, if any, provider impacts will occur as a result of a transition to the enhanced EGWP.

The Division's current understanding is that participating pharmacies will not be required to do any more than they do today to fill a member's prescription. Members will have a single pharmacy card, and the claims adjudication system automatically attributes the claim to the AlaskaCare EGWP or the AlaskaCare wrap benefits without intervention by the pharmacist.

Documents attached include:

Document Name	Attachment	Notes
***Employer Group Waiver Program – Focus on Actuarial and Financial Impact,* Segal Consulting dated July 24, 2018**	A	 Segal EGWP Memo
***State of Alaska Estimated EGWP Savings Projections,* Conduent dated January 24, 2018.**	B	 Conduent
ARMB Res 2017-20 Employer Group Waiver Program	C	 ARMB Resolution

Redacted Public Comment 5/9/18 - 8/22/18	D	RHPAB 8.29.18 Board Packet Redacted Publ

Attachment A

Segal Consulting

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MEMORANDUM

To: Ajay Desai, Director, Division of Retirement and Benefits

From: Richard Ward, FSA, FCA, MAAA

Date: July 24, 2018

Re: Employer Group Waiver Program – Focus on Actuarial and Financial Impact

The AlaskaCare Retiree Plan currently participates in the Retiree Drug Subsidy (RDS), which is a federal program operated by the Centers for Medicare and Medicaid (CMS). This program provides federal subsidies to group plan sponsors to offset the cost of pharmacy benefits for Medicare retirees. To qualify, a plan must provide a minimum level of benefits, but otherwise a plan sponsor has latitude in the benefit structure and administration.

An Employer Group Waiver Program (EGWP) is an additional CMS program that provides a greater subsidy level than RDS. To qualify as an EGWP, the plan must comply with the CMS requirements and mandates for all Medicare Part D plans. An EGWP is a group plan, and the plan sponsor retains control of the design and administration provided the CMS mandates are met.

Actuarial Value

The transition to an EGWP is largely a "behind-the-scenes" change. The implementation of the AlaskaCare EGWP will not impact member benefits or cost share (copays will be identical), and there will be a negligible impact on how members' will receive their medications.

Therefore, the implementation of the AlaskaCare EGWP does not impact the Plan's overall actuarial value:

- CMS mandates that all Medicare Part D prescription drug plans limit the maximum supply per script to a 90-day fill. The current AlaskaCare benefit covers a 100-unit supply if greater than the 90-day fill.

Under either provision, members can receive a full year's supply with four (4) fills, which are $0 when the mail order benefit is utilized. Therefore, there is no impact on actuarial value.

- There will be no change to copay structure, which will remain $4 for retail generic, $8 for retail brand name and $0 for mail order prescriptions.

	Mail Order Copay	Retail Generic Copay	Retail Brand Name Copay	Drugs Covered
Current RDS	$0	$4	$8	Open Formulary[1]
AlaskaCare EGWP	$0	$4	$8	Open Formulary

- There will be no change to the members that have multiple coverages in the State Plan. For these members their net drug costs will remain $0.

- Members' access to covered drugs and pharmacies will not be impacted by the EGWP transition.

- Some high-income members will be subject to the Income Related Monthly Adjustment Amount (IRMAA), which will result in some retirees paying an additional surcharge. This is the same requirement for members who are covered today under Medicare Part B. This does not impact actuarial value. However, it is worth noting that the Division of Retirement and Benefits will reimburse any retiree that is impacted by the Part D IRMAA.

Financial Impact

The current RDS program provides approximately $16M-$23M in annual subsidies, which is used to offset the annual claims cost of about $250M-$260M (Medicare and non-Medicare retirees). Annual projected EGWP subsidies are $35M-$44M, resulting in a net gain of $19M-$21M annually. These figures are net of additional administrative costs and projected IRMAA reimbursements.

This analysis is based on 2016 and 2017 pharmacy claims data, projected to 2019 at 6.0% annual trend. Projected RDS subsidies are based on recent subsidies received by the State. Projected EGWP subsidies were developed collaboratively with the State's current Pharmacy Benefit Manager (Aetna) and are based on claims experience and average subsidies received by other similar group plans.

[1] A formulary is a list of covered prescription drugs that will be paid under a health plan. An open formulary means there are no restrictions on which drugs will be covered as long as the drug meets the definition of "prescription drug", i.e. a medical substance which must bear a label that states, "Caution: Federal law prohibits dispensing without a prescription" and is not otherwise excluded under the plan.

Please note that 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 Consulting 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. Unless otherwise noted, these projections do not include any cost or savings impact resulting from The Patient Protection and Affordable Care Act (PPACA) or other recently passed state or federal regulations.

cc: Michele Michaud, Division of Retirement and Benefits
Emily Ricci, Division of Retirement and Benefits
Linda Johnson, Segal
Michael Macdissi, Segal
Noel Cruse, Segal
Dan Haar, Segal

Attachment B

State of Alaska

Estimated EGWP Savings Projections

$ in millions

		Segal Estimates		Aetna Estimates		
		Low Range	**High Range**	**Existing Plan**	**Alternate Plan**	**Aetna Proposed**
(1)	Base Subsidy	$9.0	$10.0	$9.0	$9.0	$9.0
(2)	Coverage Gap Discount	22.0	25.0	25.2	24.9	23.4
(3)	Catastrophic Reinsurance	12.0	15.0	13.8	16.4	13.8
(4)	Total Subsidies (1) + (2) + (3)	$43.0	$50.0	$48.0	$50.3	$46.2
(5)	Change in Gross Claims	2.0	3.0	2.4	2.4	12.6
(6)	Change in Member Costs	(0.1)	0.1	(0.2)	0.9	0.9
(7)	Additional Admin Fees	(6.8)	(6.5)	(6.6)	(6.6)	(6.6)
(8)	ACA Fees	(0.5)	(0.4)	(0.5)	(0.5)	(0.5)
(9)	Rebate Change	(2.5)	(1.5)	3.5	3.5	9.1
(10)	Net EGWP (4) + (5) + (6) + (7) + (8) + (9)	$35.1	$44.7	$46.6	$50.0	$61.7
(11)	RDS Subsidy	19.0	21.0	21.0	21.0	21.0
(12)	Estimated Savings	$16.1	$23.7	$25.6	$29.0	$40.7
(13)	Percentage Savings Increase (10) / (11) - 1	85%	113%	122%	138%	194%

Important Notes:

- The Segal and Aetna estimates were provided to Conduent by the State of Alaska. The Segal estimates were in a presentation dated May 4, 2017 and the Aetna estimates were provided in a spreadsheet dated June 21, 2017.
- The RDS Subsidy used in the Aetna estimates was set equal to the high range from the Segal estimates. Aetna used an amount of $28.8M in their estimates, but indicated that Segal would have the best estimate. For reference, the actual RDS received for the 2016 plan year was $21.2M (as provided by State of Alaska).
- Additional details on the plan designs modeled by Aetna can be found in their analysis dated June 21, 2017.

Final FY19 Contribution Rates - State Assistance Contributions[1]					
PERS	5.58%	5.58%	5.58%	5.58%	5.58%
TRS	16.34%	16.34%	16.34%	16.34%	16.34%
JRS	32.45%	32.45%	32.45%	32.45%	32.45%
FY19 Contribution Rates Reflecting EGWP Savings - State Assistance Contributions					
PERS	4.18%	3.70%	3.57%	3.54%	3.43%
TRS	15.57%	15.53%	15.52%	15.48%	15.42%
JRS	32.45%	32.45%	32.45%	32.45%	32.45%
FY19 Projected Payroll[1]					
PERS	$2,423.3	$2,423.3	$2,423.3	$2,423.3	$2,423.3
TRS	784.4	784.4	784.4	784.4	784.4
JRS	15.1	15.1	15.1	15.1	15.1
FY19 Projected State Assistance Contributions Savings					
PERS	$33.9	$45.6	$48.7	$49.4	$52.1
TRS	6.0	6.4	6.4	6.7	7.2
JRS	0.0	0.0	0.0	0.0	0.0
Total	$39.9	$52.0	$55.1	$56.1	$59.3
Reduction in Normal Cost as of June 30, 2016[2]					
PERS DB	$3.2	$4.3	$4.6	$5.2	$7.4
PERS DCR	0.2	0.5	0.6	0.8	1.4
TRS DB	0.9	1.1	1.2	1.4	1.9
TRS DCR	0.0	0.1	0.1	0.2	0.3
JRS	0.1	0.1	0.1	0.1	0.1
Total	$4.4	$6.1	$6.6	$7.7	$11.1
Reduction in APBO as of June 30, 2016[2]					
PERS DB	$375.1	$498.8	$538.5	$609.1	$856.4
PERS DCR	2.1	4.5	5.3	6.6	11.3
TRS DB	141.4	188.0	203.0	229.6	322.8
TRS DCR	0.6	1.4	1.6	2.1	3.6
JRS	1.0	1.3	1.4	1.6	2.3
Total	$520.2	$694.0	$749.8	$849.0	$1,196.4

[1] Documented in letter dated September 15, 2017, providing Allocation of Additional State Contributions for FY19

[2] Reduction measured as of June 30, 2016, which is the basis for calculating the FY19 State Assistance Contrtibutions

Except for the EGWP savings adjustments noted above, all of the data, assumptions, methods and plan provisions used in the above calcualtions are documented in the valuation reports for the 2017 fiscal year (valuation date of June 30, 2016).

Attachment C

ALASKA RETIREMENT MANAGEMENT BOARD

Subject: Employer Group Waiver Program ACTION: x

Date: December 8, 2017 INFORMATION

Resolution 2017-20

WHEREAS, the Alaska Retirement Management Board (Board) was established by law to serve as trustee to the assets of the State's retirement systems; and

WHEREAS, under AS 37.10.210-220, the Board is to establish and determine the investment objectives and policy for each of the funds entrusted to it; and

WHEREAS, AS 37.10.071 and AS 37.10.210-220 require the Board to apply the prudent investor rule and exercise the fiduciary duty in the sole financial best interest of the funds entrusted to it and treat beneficiaries thereof with impartiality; and

WHEREAS, the retirement trust provides prescription drug coverage plans to eligible retirees and dependents, including Medicare-qualifying retirees and dependents; and

WHEREAS, the AlaskaCare retiree health plan pharmaceutical costs in the retiree health plan were $218M in plan year 2016;

WHEREAS, the pharmaceutical costs account for approximately 42% of the plan expenditures in that year; and

WHEREAS, pharmaceutical expenditures have been one of the fastest growing trends in the AlaskaCare retiree plan averaging 11% annual increase between 2014 and 2016; and

WHEREAS, the AlaskaCare retiree health plan received $21.2M in federal subsidies through the Medicare retiree drug subsidy program in plan year 2016; and

WHEREAS, the Employer Group Waiver Program is an alternative mechanism by which the AlaskaCare retiree health trust can receive an estimated $43M to $50M in federal subsidies for prescription drug benefits per plan year; and

WHEREAS, the Employer Group Waiver Program will also reduce the unfunded liability for the Other Post Employment Benefit liability; and

WHEREAS, the benefits provided to retirees and their eligible dependents can be preserved with minimal impact; and

NOW THEREFORE, BE IT RESOLVED BY THE ALASKA RETIREMENT MANAGEMENT BOARD, supports the AlaskaCare retiree health plan adoption and implemention an Employer Group Waiver Program to be effective January 1, 2019.

DATED at Anchorage, Alaska this 8th day of December 2017.

Chair

ATTEST:

Secretary

Attachment D

Public Comment available in

Meeting Materials,

RHPAB 8.29.18 Board Packet Redacted Public Comment

on line at:

http://doa.alaska.gov/drb/alaskacare/retiree/advisory.html

EGWP
Draft Resolution

DRAFT

State of Alaska
RETIREE HEALTH PLAN ADVISORY BOARD
Related to a Medicare Employer Group Waiver Program
for the AlaskaCare Retiree Plan

Resolution 2018-01

WHEREAS, the Retiree Health Plan Advisory Board (Board) was established by AO288 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 retirement trust provides prescription drug coverage through the AlaskaCare defined benefit and defined contribution retirement plans to eligible retirees and dependents, including Medicare-qualifying retirees and dependents; and

WHEREAS, pharmacy claims are a large component of the overall plan spend accounting for $231 million, or 44% of total spend in calendar year 2017; and

WHEREAS, there is currently a 10.4 billion unfunded liability in the Public Employees' and Teachers' retirement systems; and

WHEREAS, the Employer Group Waiver Program (EGWP) is a mechanism by which the AlaskaCare retiree health trust can receive an additional $16 million to $23 million in federal subsidies over and above what is currently received through the Retiree Drug Subsidy for Medicare-qualifying retiree and dependents; and

WHEREAS, the implementation of an EGWP will also reduce the unfunded liability for the Other Post Employment Benefit liability by an estimated $520 million to $694 million, assisting the State in keeping its promise to current and future retirees to provide health benefits over the course of their lifetime; and

WHEREAS, the AlaskaCare retiree drug plan provides coverage of eligible prescription medications to eligible retirees and dependents, including Medicare-qualifying retirees and dependents for a $8 brand name copay at retail, $4 generic copay at retail and $0 copay at mail order; and

WHEREAS, the prescription drug benefits and copayments provided to Medicare-qualifying retirees and dependents would be preserved through an enhanced EGWP; and

DRAFT

WHEREAS, the implementation of an enhanced EGWP does not change the actuarial value of the AlaskaCare defined benefit retiree health plan; and

WHEREAS, the Division of Retirement and Benefits (the Division) has proposed adoption of an AlaskaCare EGWP as outlined in detail the Enhanced Employer Group Waiver Program Proposal presented to the Retiree Health Plan Advisory Board on August 29, 2018; and

WHEREAS, the Division's analysis has included evaluating the need and rationale for the proposed change, extensive data and statistical analysis from actual experience, the impact of the administrative change on the current benefits, any gaps, changes, restrictions, reductions, or elimination of the current benefits, the number of members impacted by changes and the seriousness of any impacts; and

WHEREAS, public comment on the proposal has been solicited, collected, and shared with members of the retiree health plan advisory board:

NOW THEREFORE, BE IT RESOLVED THAT THE RETIREE HEALTH PLAN ADVISORY BOARD recommends the AlaskaCare retiree health plan adopt and implement an enhanced EGWP as outlined in the proposal submitted to the board on August 29, 2018, to be effective January 1, 2019.

DATED at Juneau, Alaska this 29th day of August 2018.

_____
Chair

ATTEST:

_____
Secretary

DRAFT