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1. Will the presentation be provided to us?

Yes, a copy of the presentation will be shared.

Prior Authorization & Continuity of Care

1. Prior authorization for "acute in-patient care"?

“Acute inpatient care” refers to care received in a hospital.

2. Does durable medical equipment require preauthorization? Does durable medical equipment include wheelchairs and walkers now?

No, prior authorization is not required for durable medical equipment including wheelchairs and walkers.

3. Please explain the last bullet point on the PA slide

Modification of the City of New York prior authorization list will require the mutual agreement of the parties before any service will be added to the City of New York customized list.

4. Will Continuity of Care program provide information on network status of provider or facility provide steerage and identify any out of pocket cost risks for patients?

Yes, but it is important to note that Aetna does not steer in this plan. The plan allows members to access out of network providers at the same cost share as in network providers.

5. With Prior Authorizations, does Aetna conduct the approval/denial process internally or is there an independent outside entity?

Aetna conducts the initial denial approval process internally. Aetna has a team of physicians that will make the denial decision if medical necessity is not met. Every member is provided with information on how to appeal any denial decision. If the member or provider appeals the denial decision, the case will go to a dedicated Aetna Medicare Advantage physician who has not been involved with the previous decision. If the Aetna appeals physician agrees that the member does not meet medical necessity, the case (including all medical notes) is forwarded to Maximus (an independent external reviewer assigned by the Centers for Medicare and Medicaid Services). If the physician with Maximus believes the member meets medical criteria for the service, they will notify Aetna and Aetna will approve the services. Aetna is bound by the decision of Maximus. The member and provider will be notified of the approval.

6. How long does it take to get a decision on prior authorization?

For standard, non-urgent requests, CMS allows for up to 14 days to make a decision on medical necessity, however Aetna strives to make that decision as quickly as possible. Requests that doctors call in as expedited (urgent), CMS allows for up to 72 hours to make a decision. Urgent requests are defined by CMS regulations. Again, we try best to make all decisions as quickly as possible.

7. Can we get a list of the custom prior authorization list?

Yes, a copy of our custom prior authorization list will be provided.

8. What is the timeline for the appeal process?

Please see the response above for question 6.

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9. Who decides if the appeal is upheld? Is it the same board that denies the services? The appeal will only go to CMS and reviewed by IRE if the appeal is upheld? Correct?

Please see the response above for question 5.

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10. What percentage of appeals are denied?

Maximus (the independent reviewer assigned by the Centers for Medicare and Medicaid Services) agrees with Aetna's denial decisions approximately 97% of the time.

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11. How much will the reduced prior authorizations cost Aetna each year-estimated?

The City has agreed to pay Aetna $15 per enrolled member per month for the reduced prior authorization program.

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12. What is the FULL list of prior authorizations required and how will it change after the honeymoon period of the contract?

Prior authorization is limited to inpatient hospital stays, acute rehabilitation stays, skilled nursing stays, home health care, select medications, and services that could be experimental/investigational and/or cosmetic in nature. The full list of Part B and Part D drug prior authorizations will be made available shortly. The customized City of New York precertification list can only be modified when there is mutual agreement between the City, MLC, and Aetna every two years. We would only review new-to-market services, medications, testing that could impact Medicare members every two years.

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13. On the retrospective review for doctors out of network, who is stuck with the bill if AETNA refuses to cover it? The doctor or our retiree?

If a City of New York member enrolled in the Aetna Medicare Advantage PPO plan receives services from an out of network (OON) physician who participates in Medicare and accepts the Aetna Medicare Advantage PPO plan OON and submits a claim to Aetna for services that are not covered under Medicare and Aetna retrospectively reviews the claim and denies coverage, the OON physician would be financially responsible for the claim and is not permitted by CMS to balance bill the member.

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14. AETNA removed 80% of the prior authorizations. Why didn't it remove them all? And what are the 20% itemized? This is still more than in Traditional Medicare.

Aetna did not remove the remaining 20% of services from the prior authorization requirement because these services are generally being utilized by ill and/or frail retirees for whom Aetna wants to ensure that their safety and well-being are key variables in treatment decisions. This also allows Aetna the opportunity to work closely with the retiree and their caregivers for thorough discharge planning to ensure that the retirees are returning home with a specific care plan and that they have the necessary tools and access to services at home to facilitate their return to health.

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15. Some retirees are currently living in assisted living or memory care. They are not going to know you are auto enrolling them into this plan. If their care center does not accept this plan, this creates a continuity of care issue as well a potentially holds the retiree liable for costs. It further puts them at risk if AETNA doesn't approve them for care in skilled nursing, who takes care of them? Medicare does not have this problem.

Any residential fees (rent, payment for housing, custodial care) for example, memory care units and assisted living facilities, or living in a nursing home, are not covered by Traditional Medicare, or any Medicare Advantage plan. This coverage is not impacted by the switch to the Aetna Medicare Advantage plan. However, any service provided that is medically necessary would be covered under Medicare and would be covered by the Aetna Medicare Advantage PPO plan while the member is in those facilities. Aetna will work diligently with the facilities and providers of care to help them understand the plan and how it works.

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16. What is the initial term that prior authorizations are not required? Is it 2 years?

The services listed in attachment H of the contract will not require prior authorization for the initial term of the contract (5 years and 4 months). These services will not require prior authorization in the future unless there is mutual agreement between the City, MLC, and Aetna.

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17. Is it correct that we can add or delete more prior authorizations every two years?

Yes, the customized City of New York precertification list can only be modified when there is mutual agreement between the City, MLC, and Aetna every two years. Aetna would only review new-to-market services, medications, and testing that could impact Medicare members every two years.

18. Who is the Prior authorization vendor handling these PAs?

Aetna has removed services from the prior authorization list that vendors managed except for selected home health care organizations Carelon (MyNexus) for authorizations, where applicable.

19. On the list, Acute hospital inpatient, long-term acute care, acute physical rehabilitation, skilled nursing facility, and home care services requires Prior authorization, but it does not in Traditional Medicare, why are we imposing this?

While Traditional Medicare does not have prior authorization in place for selected services, Medicare requires that these services meet their coverage criteria and can review for medical necessity retrospectively. Traditional Medicare will not pay for services that do not meet medical necessity per their guidelines. Traditional Medicare will not pay for services if their coverage criteria are not met. By Aetna requiring a PA for these services, Aetna is ensuring in advance that the medical service is medically necessary. This also allows Aetna the opportunity to work closely with the retiree and their caregivers for thorough discharge planning and ensure that the retirees have easy access to their extra benefits as part of the new contract.

20. If someone has breast cancer and has a full radical mastectomy, can they have breast reconstruction and why would this be a prior authorization?

Breast reconstruction after having a full radical mastectomy is always covered. Aetna may require documentation to validate that the mastectomy took place.

21. What's the list of PART D Drugs that needs PA? and why?

CMS requires Part D plans to have PAs. Attached in the excel file contains is alphabetical list of the drugs on the 2023 formulary that require a prior authorization. Additionally, attached are the exact criteria for reviewing for authorization. Both the formulary and criteria are also publicly available for members and providers in an effort to be transparent and to simplify obtaining the needed medications. At a high level, the reasons for a PA include drug safety. Examples include:

- Medications deemed higher risk when used in patients over age 65 due to increased risk of falls/confusion; or in the case of opioids, for patients who are newly taking the opioid, the PA ensures the dose is safe/appropriate and titrated to prevent accidental overdose (IR before ER)

- Compliance with requirements for payment, such as making sure the drug is used for a Part D-allowed use or in according with FDA labeling requirements (such as Fentanyl Citrate- which is only covered by Part D for cancer-related pain)
- Other PA criteria are to help members save money when lowered tiered options are available.

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22. Is insulin (injectable or pump) and statins as currently in Part B included in the list of those needing PA?

Statins are covered by Part D formulary and do not require a PA. The Open (comprehensive) formulary the City offers provides a very robust selection of low cost statins. Most of our insulins are covered under Part D. However, if the insulin is administered through a DME pump it would be covered under Part B and PA is required to determine coverage under Part B or Part D. Aetna works with members to solve any administrative requirements, so the process is as seamlessly as possible.

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23. If Medicare covers this, why would this be subject to us also covering it? Doesn't that mean we are not mirroring Medicare? "Select drugs, therapies, procedures, services, and technologies covered by Medicare after the Effective Date of the MA plan, subject to mutual agreement of the Parties."

We cover what Traditional Medicare covers following Medicare regulations called National Coverage Determinations as well as Local Coverage Determinations.

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24. Don't you think sending letters to the members telling them their doctor provided a service that required PA will freak them out? If they don't have this with Medicare now, then this plan does not mirror their current benefit, right?

Aetna believes education of members and providers is key to easing anxiety and creating and smooth transition to the new plan. Aetna reviews services for medical necessity prior to the services taking place, Traditional Medicare may review services retrospectively for medical appropriateness.

Medical Plan

1. The positives in the presentation are evident. Are there any negative comparisons that were not compared to current Medicare members?

We compared all Senior Care plan benefits when designing this plan. All benefits are either equal to or better than the Senior Care program. However, 1/12/23 injunction temporarily restored $0 copays to certain benefits that had a $15 copay.

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2. Is the Hearing Aid $500 reimbursement available universally or only in available thru a limited network of providers? What is the process?

Yes, it is available universally. Member would just submit to the plan for reimbursement.

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3. What are co-pays for the various pre-auth procedures?

- Prior Authorization under the MA plan is only required for the following services:
  - Acute inpatient, long-term acute care, acute physical rehabilitation, residential behavioral health/substance abuse treatment, skilled nursing, transplant, and home care services.
  - Services/items that are not covered by Medicare.
  - Services that could be considered experimental and investigational in nature.
  - Services that are cosmetic in nature (e.g., breast augmentation, removal of excessive skin/tummy tuck or eyelid surgery).
  - Specialty medications, some of which are Part B medications.
  - New drugs, therapies, procedures, services, and technologies covered by Medicare.
- Cost shares for these services follows place of services, below are some examples:
  - Inpatient - $300 cost share per stay, with maximum of $750 year
  - Skilled nursing – $0 cost share for days 1 to 100 for each benefit period
  - Part B drugs - $0 cost share
  - Specialist Office: $15 cost share

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4. There are 5 Aetna Medicare Advantage PPO Plans with different names listed on medicare.gov. Which plan is the CONY plan or closest to the CONY plan?

Plans listed on Medicare.gov are standard HMOs and PPOs offered in the open market. The City plan is not available in the open market with all the customizations included.

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5. Why doesn't the Part B deductible apply to Aetna MA plan?

Medicare Advantage plans administer the Medicare Parts A & B, plus supplemental benefits, in an all-in-one plan. This means Aetna pays on behalf of Medicare and Supplement (all-in-one). The deductible is based on the plan design requested by the plan sponsor, in this case the MLC and City. The MLC and City negotiated a lower deductible as an enhanced benefit to their retirees.

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6. Is the MA deductible traditionally cheaper than the traditional Medicare plan?

Yes, the deductible is determined by the plan sponsor, in this case the City & the MLC negotiated a lower deducible.

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7. What will determine the Aetna deductible cost in 2029?

The contract renewal date is 2029. The MLC and the City will make a determination at that time

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8. Do the hospital copays / and admission charges count towards the 1500 dollar OOP cost cap?

Yes, Medicare-covered hospital cost shares will go toward the out-of-pocket maximum.

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9. The only choice is AETNA or HIP VIP (not a nationwide plan option), or you have to opt out and lose your city coverage and Medicare B reimbursement

Confirmed.

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10. The AETNA deductible is waived for 2023. WHAT IS IT? And how much will it increase annually?

Deductible is $150 (waived for 2023) and will not increase annually. The deductible is based on the plan design requested by the plan sponsor, in this case the MLC and City. The MLC and City negotiated a lower deductible as an enhanced benefit to their retirees and guaranteed until the contract renewal date in 2029.

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11. What is the GHI Senior Care Deductible and what is the AETNA plan deductible?

Senior Care requires members to pay the Part B deductible first (2023 $226 and changes annually) PLUS the GHI deductible of $50, so before any benefits are paid under the Senior Care plan members are required to pay $276 in 2023 (changes annually). The Aetna annual deductible of $150 guaranteed for the next five years. For the balance for 2023, there will not be a deductible.

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12. This chart lists hearing and vision exams as not covered under Senior Care, but the retirees have these benefits through their welfare funds?

This benefit is in addition to any benefit currently received through their welfare fund. Retirees can use both benefits.

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13. HOSPITALIZATION section – both plans are basically the same if the retiree has the 365-hospital rider, correct?

Confirmed, Aetna matched the plan, and the 365 Day rider is now included to all enrollees at no additional cost.

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14. Medicare covers behavior health and medical health by telephone or video visit. Senior care has to cover it because Medicare does right now. (page 5) Teledoc IS covered, and doctors allow calls and email communication.

Telemedicine services provided by your doctor and can be via telephone or virtual and covered by Medicare and by Aetna Medicare Advantage. Teladoc is a different service. It's virtual or telephonic services for urgent medical care 24/7. It is not covered by Traditional Medicare but is covered by Aetna Medicare Advantage. Aetna also offers virtual behavior health services through MD Live.

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15. What plan enhancements on page 5 require prior authorization?

None of the plan enhancements below require PA.

Plan enhancements	
Fitness Benefit	**SilverSneakers at no cost**

Healthy Home Visit by a licensed clinical professional who provides a health assessment	**Annual home visit at no cost**
Hearing Aid Reimbursement	**Up to $500 reimbursement, every 12 months**
Hearing Exams (non-Medicare covered)	**$0**
Healthy Rewards	**Earn up to $200 (voluntary incentive Gift Card) by completing wellness services**
MDLive Telemedicine Behavioral Health	**$0 cost share per visit no deductible & unlimited visits**
Meals after each Hospital Stay & after each Skilled Nursing Facility Stay	**28 meals, up to 14 days**
Medical Alert System to be immediately connected to a care specialist at LifeStation for emergency care	**Included at no cost - the device and monthly monitoring fee**
Non-Emergency Transportation to and from medical appointments	**24 one-way rides, per calendar year and up to 60 miles, per ride**
Over the Counter (OTC) Allowance	**$120 annual ($30 per quarter) allowance on health & wellness products**

Network

1. Do we have a percentage of how many doctors currently accept GHI Senior Care that will accept the new Aetna plan?

   Based on the data provided and Aetna's analysis, 96.19% of utilized providers are either in-network or known to accept the plan (88.16% are in-network and 8.3% known to accept the plan) For 3.81%, we have not received claims. These providers could be retired, no longer practicing, etc.)

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2. Could you please enlighten us regarding the percentage of utilized providers who are, in fact, in-network? (i.e., not the combined percentage of providers of in-network providers and those that simply accept Medicare and agree to take Aetna on an out-of-network basis)? Are the non-network providers prevented from balance billing their patients, if they agree to bill Aetna directly on an out-of-network basis?

88.16% are in network. Providers who are eligible to participate in Medicare and accept the plan, cannot balance bill.

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3. Do patients have to fill out waivers to receive care with these in network providers of Aetna's

No waivers for in-network services are required

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4. Under specialty hospitals what about the Mayo Clinic and the Cleveland Clinic

Mayo Clinic has indicated they will not accept future patients out of network but if members are currently receiving services, they may accept out of network on a case by case basis. Cleveland Clinic is in network.

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5. What about other hospital networks such as Northwell or NY Presbyterian? what is the number of providers who will accept Aetna's plan/payment schedule?

Both hospital networks are in the Aetna Medicare Advantage PPO network. Based on the utilization data provided to Aetna for analysis, 131,949 providers out of 137,175 either are in Aetna's network or are known to accept the plan.

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6. Does this plan have incentives for network providers who have fewer than average hospital admissions and/or lower than average use of high-tech imaging?

Aetna does have value-based care arrangements that reward providers based on health outcomes and closing gaps in care, i.e., diabetes, hypertension, etc. Aetna also removed prior authorization for radiology services.

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7. With respect to HSS and MSK, are individual doctors employed by the hospital also in-network, or is it just the hospitals?

Employed doctors are also in the network.

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8. What happens to plan participants currently in Assisted living, LTC or Nursing Homes facilities that do not accept Medicare Advantage plans?

Assisted living, LTC or Nursing Home facilities are considered custodial care services and are not covered by Medicare. However, Medicare medical services normally covered for patients living in one of these facilities would be covered. We will work with the member and provider to ensure services are covered and we have done so in many cases.

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9. For the "Known to accept Aetna MAP payment, would the member be responsible for any charges from the provider that Aetna does not pay?

Known to accept providers are providers who are eligible to participate in Medicare and are reimbursed at the Medicare allowable rate as long as it's a Medicare covered service. These providers cannot bill over and above the Medicare rate.

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10. Does Aetna MA have a website that will allow retirees to check their provider eligibility now?

Yes, the Aetna website will be available upon MLC approval.

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11. AETNA acknowledges it does not have ALL Medicare accepting doctors in its network.

Aetna has over 1,200,000 providers and 4,200 hospitals in our Aetna Medicare Advantage PPO network. The Aetna Medicare Advantage PPO plan allows members to go outside of the PPO network and access any Medicare accepting provider that is willing to accept the plan.

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12. Is the reimbursement for non-AETNA participating providers at the Medicare reimbursement rate or the AETNA rate? (AETNA pays out at a lower rate than Medicare). Medicare and Senior Care pay 100% of the allowable rate. Aetna rate is lower which is why many doctors do not accept Medicare advantage.

Out of network providers will be reimbursed the Medicare allowable rate for Medicare covered services. Out of network reimbursement follows Traditional Medicare billing rules, Medicare fee schedule and Medicare limiting charges. Providers receive 100% of the Medicare allowed rate.

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13. In what areas is AETNA's provider network not strong? And what happens when there is no doctor in the area?

98% of City of New York eligible members reside in our PPO service areas which shows that members will have access to in-network providers. However, whether the member is in one of Aetna's network service areas or outside of a service area, they would still have access to any Medicare accepting provider that is willing to accept the plan.

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14. I am concerned that we would be requiring retirees to pay up front to their doctor who is NOT in AETNA's network and does not accept AETNA for billing. This is a burden retiree do not currently have and can delay them getting care. It also subjects the retiree to have that bill denied for medical necessity and burdens those who cannot afford to pay out of pocket.

It is rare that a member will have to pay a claim up front. In most instances, the member would only be responsible for their applicable cost share, while at the provider's office. Our provider contracts require all in-network providers to bill Aetna directly for the services provided. So, a member should never have to pay the claim up front while at the provider's office. In fact, 88% of the CoNY members are accessing in-network providers. While Aetna does not have a contract with out-of-network providers to do so, most will still bill Aetna directly for the service. If a member pays a claim up front, which neither Aetna nor CMS wants the member to do, they can simply submit the claim to Aetna to the address on the back of their ID card and Aetna will reimburse the member directly for the Medicare allowable amount minus their cost share (if any). If a provider is refusing to see the member without payment up front, the member or provider's office can call Aetna and speak with a specialist who will do a one-time "pay and educate" through our Provider Pass program. This allows our designated specialist to speak with the provider's office about the Aetna Medicare Advantage PPO plan, how it works, how to submit a claim, and what Aetna pays out-of-network providers. The representative will then ask the provider's office to submit the claim directly to Aetna, however, if the office still requires payment up front the Aetna representative will authorize a onetime payment directly to the provider's office over the phone.

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15. The chart states 95% of "utilized providers" are either in network or accept Medicare. What percentage of providers in America currently accept AETNA Medicare Advantage?

The chart presented at the MLC meeting is based on the utilization data provided of all providers used nationally across the country by GHI Senior Care retirees. The data reflect that 96.19% of providers used nationally by GHI Senior Care retirees are either in the Aetna network or known to accept the Aetna Medicare Advantage PPO plan.

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16. This chart state 95% of "utilized" providers accept AETNA, what does that mean? Doctors from Empire BCBS or doctors in EMBLEM? 94 % of doctors in America Accept Traditional Medicare right now. If this plan accepts less than that, our members may have trouble finding new doctors as they become more ill.

We analyzed the data provided to us which showed providers (meaning doctors, hospitals, and other facilities where care/services have been rendered based on those currently used under the Senior Care plan) that have been accessed by City of New York members over the past year, to see which providers are in Aetna's Medicare PPO network, and which are out-of-network and have accepted the plan over the past 12 months, and which are out of network and have not submitted a claim to Aetna Medicare Advantage. After the analysis, we were able to tell that 88.16% of the providers were in our Medicare Advantage PPO network, 8.03% were out-of-network but accepted the plan, and additional 3.81% were out of network and have not submitted a claim to Aetna in the past 12 months. That last 3.81% could mean that the provider didn't submit a claim to Aetna recently, we were unable to identify the provider, they are no longer in business, have passed away, etc. It doesn't mean they will not accept the plan; Aetna just simply hasn't received a claim from them in the past 12 months. It is part of our implementation process to outreach to these providers, educate them on the plan, what we pay, how to file claims, etc. and get them to continue to care for the membership. We will also try to contract with those providers who are interested.

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17. If the union or a member submits the name of a doctor who is not in plan, my understanding is that the Aetna outreach will try and contact that doctor and explain the plan. What would be the expected wait time to hear back from Aetna?

The expected turnaround time is 48 business hours or less to provide status. The Plan Sponsor Liaison will also provide status updates throughout the process.

Eligibility & Enrollment

1. Does this plan have any effect on the separate $6000 Express Scripts plan through ASO that my members have now? If members opt out, what are the available options, and what is the cost if HIP-VIP is chosen?

If your union welfare fund does not offer prescription drug coverage or if the union welfare fund's commercial Rx plan has a maximum benefit limit/cap, or if they are enrolled in an individual Medicare Part D plan, they can purchase the Aetna Medicare Rx offered by SilverScript
The 2023 basic plan member premium for HIP-VIP is $0. PMPM. The Rx Rider cost for HIP-VIP is $177.59 for individual and $355.18 for family coverage. They must live in the NYC surrounding area (the five boroughs, Suffolk, Nassau, Rockland, Westchester, and Orange Counties).

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2. Is it correct that "enrollment" reads as everyone who has Medicare will be moved to the plan?

- All Medicare eligible retirees and their Medicare eligible dependents (except those enrolled in the HIP-VIP Premier Medicare Plan) will be automatically enrolled in the Aetna Medicare Advantage PPO Plan effective 9/1/2023 unless they opt out of coverage.
- All members enrolled in the HIP-VIP Premier Medicare plan will remain in that plan unless they want to enroll in the Aetna Medicare Plan. The HIP-VIP plan is available in the five boroughs of New York City, Nassau, Suffolk, Rockland, Orange, and Westchester Counties.
- To opt out of the Aetna Medicare PPO plan members will need to call the Aetna Retiree service center or go online to the dedicated website and opt out between May 1st and June 30th, 2023.
- If a member opts out of both the Aetna Medicare Advantage PPO plan and HIP-VIP Premier Medicare plan, they will have to find coverage outside of the City health benefits and will not be eligible for the Part B reimbursement and/or IRMAA, if applicable.

3. Cost of continuing Senior Care if a member chooses not to switch to Aetna?

The Senior Care plan will be eliminated effective 9/1/2023 to comply with the administrative code and the judge’s determination in the prior litigation. The only two options through the City health benefits will be the Aetna Medicare Advantage PPO plan and the HIP-VIP Premier Medicare plan (which is only available in the NYC surrounding area).

4. Do members whose unions provide creditable coverage have access to Aetna's PDP?

- If a union offers a commercial prescription drug benefit that provides creditable coverage to its retirees but the plan has a benefit maximum/cap, retirees would be able to enroll in the Aetna Medicare Rx through SilverScript.
- If there is no cap, members would not be able to enroll in the additional Rx coverage.

5. Can such members purchase other stand-alone PDP's or are they limited to Aetna's PDP?

Once enrolled in the group Aetna Medicare Advantage PPO Plan, members would not be able to enroll in an individual Medicare Part D plan. CMS, the Centers for Medicare and Medicaid Services, does not allow a Medicare beneficiary to be enrolled in a standalone

group MA and individual Part D plan at the same time. However, a member would be able to enroll in a separate group Part D plan, if eligible through another employer (such as a spouse's plan) or another unions prescription drug plan.

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6. Are all the 9000 current CONY plan participants, in the NY/NJ/PA and the Other locations plan being folded into the new Aetna MA CONY Plan?

Confirmed. Approximately 9000 City of New York retirees currently enrolled in the Aetna Medicare Advantage plans will automatically be enrolled in the new Aetna Medicare Advantage PPO plan effective 9/1/2023

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7. Are Retirees that become enrolled in the Aetna Medicare Advantage Program entitled to not take the prescription coverage and continue with their current Union benefits? How do they insure they are not removed from their current Union Prescriptions?

Confirmed. Members currently enrolled in prescription drug coverage through their union will not be automatically enrolled in the Aetna Rx through SilverScript. Only those members who have prescription drug coverage through the City (except those enrolled in the GHI Senior Care plan & HIP VIP) will be automatically enrolled in the Aetna Medicare Rx plan through SilverScript. Those members enrolled in the GHI Senior Care plan with the prescription drug rider will be enrolled in the Aetna Medicare PPO plan effective 9/1/2023 and the Aetna Medicare Rx plan effective 1/1/2024.

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8. If a member opts out and does not live in the NYC area, they lose the Medicare reimbursement? Is this due to a current law or is it being implemented with this plan?

The City of New York administrative code requires that in order to be eligible for the Part B reimbursement and/or IRMAA reimbursement, the retiree must be enrolled in City Health benefits.

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9. Are those who are currently in the health plan under COBRA being automatically transferred to the AETNA MA PPO Plan?

Yes.

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10. Medicare eligible retiree who opts out of coverage from either Aetna or HIP should be able to get Part B reimbursement. It won't cost the City anything if they are already eligible.

The City of New York administrative code requires that in order to be eligible for the Part B reimbursement and/or IRMAA reimbursement, the retiree must be enrolled in City Health benefits.

11. If a retiree is auto enrolled into Aetna and opts out back into a Traditional Medicare, will they be able to buy back into a part D?

Yes, if a member opts out of both the Aetna Medicare PPO Plan and HIP-VIP plan (if eligible) then they would be reverted back to Traditional Medicare and can elect an individual Part D plan on the individual market. They will not receive their Medicare Part B/IRMAA reimbursement from the City.

12. How would currently enrolled retirees in another CONY Medicare plan enroll in the AETNA MA Plan? What would be the premiums for the health plan and Part D for COBRA members?

All members will be automatically enrolled in the Aetna Medicare Advantage plan if they currently have City Health benefits (other than the HIP-VIP Plan). Members would not have to take any action to enroll in the Aetna MA plan. However, if a member is enrolled in the HIP-VIP Premier Medicare plan and wants to enroll in the Aetna Medicare Advantage PPO Plan, they will need to complete a health benefits application/change form, located on the NYC Office of Labor Relations Website. COBRA premiums will continue to be 102% of the total premium or $15.30 per enrolled member per month and $105.57 per enrolled member per month for the Rx rider in 2023.

13. My Union does not offer Rx to retirees. What happens to my retired military members that get their Rx from the Federal Gov.?

If your union does not offer Rx coverage, they can enroll in the Aetna Medicare Rx through SilverScript by completing a health benefits application/change form, located on the NYC Office of Labor Relations Web site.
If members have VA benefits or Tricare, they can continue to use those benefits while enrolled in the Aetna Medicare PPO plan and Aetna Medicare Rx through SilverScript. They do not need to purchase the Rx Rider.

14. If this contract is accepted, does this affect the Welfare Fund benefits, including 6k prescription provided at no extra cost to retirees through ASO?

If your welfare fund offers prescription drug coverage, it will not be impacted by the Aetna Medicare Rx plan through SilverScript since your members would not be enrolled in the new Aetna Rx plan. Only those members without Rx coverage through the unions, those with commercial Rx plans with benefit caps/maximums, or those enrolled in an individual Part D plan would be eligible for the new Aetna Medicare Rx plan through SilverScript.

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15. How would those who are currently enrolled in another CONY Medicare Plan under COBRA enroll in the AETNA MA Plan? What are the COBRA premiums for the AETNA MA health plan and Part D rider?

COBRA premiums will continue to be 102% of the total premium (City & Member paid for part D rider) or $15.30 per enrolled member per month and $105.57 per enrolled member per month for the Rx rider in 2023.

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16. Are retirees eligible to forego the MA program, continue with traditional Medicare and purchase their own addl. Medicare Supplemental coverage, is there any reimbursement / credit from the city?

Yes, retirees can opt out of the Aetna Medicare Advantage PPO plan and continue Traditional Medicare coverage. They may be able to purchase their own Medicare supplemental plan. However, they would not be eligible for a premium subsidy or Part B/IRMAA reimbursement.

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17. If a retire wants to completely opt out and get their own secondary plan, do they lose their welfare sub benefits?

This question is for the City and MLC unions.

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18. Are Retirees that become enrolled in the Aetna Medicare Advantage Program entitled to not take the prescription coverage and continue with their current Union benefits? How do they insure they are not removed from their current Union Prescriptions?

Yes, if a retiree's union offers prescription drug coverage, they do not have to take the Aetna Medicare Rx plan and will not be automatically enrolled. Only those members currently enrolled in a medical plan with the Rx Rider will be automatically enrolled, except for Senior Care & HIP-VIP members. Senior Care members who purchase the Rx Rider will transition to the plan on 1/1/2024.

19. What is happening with the retirees with eligibility situations, MA age eligible retiree, partner who is not entitled to MA yet. And vice versa.

For those split family situations, the Medicare eligible member will be enrolled in the Aetna Medicare PPO plan, and the non-Medicare eligible member will be enrolled in the GHI-CBP/EBCBS.

20. Are Retirees eligible to continue to collect IRMA reimbursements and credits?

Confirmed, members will continue to be eligible for and collect Part B and IRMAA reimbursement if they are enrolled in City health coverage.

Communications

1. Does Aetna MA have a website that will allow retirees to check their provider eligibility now?

Yes, the website will be available as soon as the MLC has approved the contract.

2. What steps have been taken to minimalize disruption with split contracts ex file sharing?

For 9/1/2023 Medicare eligible retirees with non-Medicare family member(s) (family coverage), the Medicare eligible members will be automatically enrolled in Aetna Medicare PPO plan.
Non-Medicare family member(s) will either remain covered under GHI – CBP/EBCBS or move to coverage under the GHI-CBP/EBCBS plan if they are enrolled in another City plan option. Those enrolled in HIP VIP will remain in that plan.

Pharmacy

1. Is there a formulary that is used? For instance, an individual who gets an infusion every two months, which Medicare covered completely/Remicade (Infliximab) Systemic Anti-psoriatic / Immunosuppressant as an IV infusion q 2 mo at NYU/Winthrop 2-4hrs

When the drug is obtained in a manner that makes it Part D covered- our formulary and requirements are posted and updated regularly as new drugs come to market for full transparency. Other times infusion drugs and services based upon how they are obtained belong under Part B instead of Part D. Part B does not have a formulary per say- we cover what original Medicare covers following Medicare regulations called National Coverage Determinations as well as Local Coverage Determinations.

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2. How are current Senior Care plan participants, currently enrolled in independent PDP Plans, going to be transitioned and enrolled in the Aetna PDP rider? Are there any member disenrollment safeguards?

Through the Aetna implementation process, Aetna will identify these members and send them a specific communication regarding disenrollment from the individual market PDP. Information will also be provided during our informational meetings (virtual and in-person).

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3. The 2023 cost for Aetna PDP is currently $103.50 and will go to $135.50 in 2024. Is that for a family?

The Aetna PDP premium is per enrolled member, per month. It is not a family rate.

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4. What does 4-Tier Structure, 5-Tier Structure and Cost share mean? What is our plan cost share?

Formulary Tiers organize drugs into various groupings, usually based on drug cost. Each Tier has a corresponding member cost share as part of the plan design. The Aetna Medicare Rx offered by SilverScript prescription drug plan (PDP) formulary has 5 Tiers. Prior to reaching the catastrophic phase, the member's cost share is 25% on Tiers 2, 3, 4 and 5, and the Aetna PDP plan covers the remaining 75%. On Tier 1, the member's cost share is 25% when prescriptions are filled at standard pharmacies, and the Aetna PDP plan covers the remaining 75%. Tier 1 drugs filled at preferred pharmacies have $0 member cost share with the Aetna PDP plan pays 100% of these costs.

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5. Why is there a 31% increase in the rider premium from 2023 $103.00 to 2024 $135.50?

The PDP premium increases due to cost trend, utilization trend and benefit enhancements required by Inflation Reduction Act in 2024. Also, as stated during the MLC meeting, by Mr. Klinger, he requested from Emblem, their 2024 rates, and he stated that they had not set the rate yet.

6. The Rx Rider premium under the current Aetna Plans is $108 NY/NJ/PA and other locations $79.00?

The current premiums for the Aetna plans are for fully integrated MAPD. Not a standalone voluntary program.

7. How do they know the cost for one year from now?

Aetna completed projections for this plan design one year out and guarantees the 2024 monthly member premium for the PDP.

8. Why can't the Aetna guarantee the $103.50 thru 2025 until the passage Inflation Reduction Act of 2022 and CMS announces the direct subsidy amount for the upcoming year? Why does it have to go up to 135.50 in 2024 essentially costing a retiree more than what they paid for GHI Senior Care Drug plan

The PDP premium increases from 2023 to 2024 due to cost trend, utilization trend and benefit enhancements required by Inflation Reduction Act such as the $35 monthly cap on insulin cost share, $0 cost share for Part D vaccines and $0 cost share in the Catastrophic phase. Also, as stated during the MLC meeting, by Mr. Klinger, he requested from Emblem their 2024 rates, and he stated that they had not set the rate yet.

In 2025, the Inflation Reduction Act requires another substantial improvement in member benefits, moving from a 2024 TrOOP amount of $8,000 down to a maximum member OOP amount of $2,000.

9. Is the AETNA Part D plan the same as AETNA SILVERSCRIPT that some retirees have right now? If so, many of them are denied drugs that FDA approved. How is your plan different from the SilverScript plan if so?

Not all Aetna SilverScript plans are the same. The plan designs and formulary vary based on the plan sponsor's request of plan design and formulary. The City's plan has an OPEN formulary which means all Part D drugs are covered. Many of the drug plans unions offer to their retirees have either closed formulary or have a maximum benefit. The formulary that will be offered in the Aetna Medicare Rx offered by SilverScript drug rider is a very generous benefit, open formulary with an expanded rider that will cover all FDA approved drugs.

10. Are the DC37 SilverScript retirees losing their union drug plan?

No, DC37 will continue with their union prescription drug plan through SilverScript.

11. The Coinsurance on the drugs plans is extremely high.

As reflected in the prescription drug rider plan comparison, the Aetna Medicare Rx offered by SilverScript coinsurance matches the Senior Care prescription drug rider's coinsurance, except the Aetna plan also has a Tier 1 at $0 cost share for preferred generics filled at a preferred pharmacy (including CVS, Costco, Publix, Mail Order). Tier 1 preferred generics provide additional choice for members to get lower cost generics and provides savings they may not have today.

Financial

1. What is the stipulation within the agreement to allow you change the cost when CMS changes guidance?

The City has a Medicare Advantage rate guarantee until 2029 that is effective regardless of the CMS subsidy to Aetna.

2. Since Aetna's star ratings went down in the past and if it does in the future, will they move the City of NY members to different contracts to chase better star ratings? This may be disruptive to our members.

   i. New ID cards must be released
   ii. Opt out letter to all members

No. We have a commitment to continuous quality improvement and remain focused on offering high quality plans that the City and its retirees deserve while staying focused on the business.

3. If the CMS subsidy to AETNA is ever reduced, what happens to the cost? Will retirees have to pay premium? And or will services be reduced?

The City has the Medicare Advantage rate and plan design guaranteed until 2029 regardless of the CMS subsidy to Aetna. The City administrative code also requires that the City provides a premium-free retiree plan.

4. The Emblem Health PDP is currently $125. Why would AETNA undercut the rate for 3 months and then impose a 31% increase?

Aetna's rate for the 2023 full year is $103.50 and Emblem's rate is $125, but unfortunately, we could not start the program until September 1, 2023. The 2024 premium based on expected costs for price increases in 2024 due to cost trend, utilization trend and benefit enhancements required by the Inflation Reduction Act such as the $35 monthly cap on insulin cost share, $0 cost share for Part D vaccines and $0 cost share in the Catastrophic phase. Based on the impacted federal reduction act, we suspect the 2024 Emblem rate will be increased as well.

5. If I am reading this correctly, if the CMS rate is reduced, is AETNA asking the City for more money and will that be passed to the retiree?

As stated above, The City Medicare Advantage rate and plan design is guarantee until 2029 regardless of the CMS subsidy to Aetna. The City administrative code also requires that the City provides a premium-free plan to retirees.

6. What is the definition of TOTAL REQUIRED REVENUE? (for providing the guaranteed rate?)

Total required revenue = Projected Claim Liability / Target cost ratio. Our experience allows us to provide a guaranteed rate.

7. What happens if the average enrolled members drops? How does that affect rate and refunds?

The Aetna Medicare Advantage rates are guaranteed through 2029. The potential refund payout is determined based on how many average members enrolled and does not impact rate.

Additional Responses

1. Why do some people change plans at two different times of the year for pharmacy?

Based on negotiations, it was determined Aetna would transition populations with the Rx Rider at different times. Senior Care members will transition on 1/1/2024 and all other plans, except for HIP VIP, will transition for the Rx Rider on 9/1/2023.

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2. RE: Auditing: OLR-NYC can select its own auditor but who determines if an auditor is "independent and objective" and what is the basis of that criteria?

The proposed contract between Aetna and the City provides that the City has the right to select its own auditor; however, the auditor must be independent and objective. To this end, the proposed contract states that the City's auditor cannot be an individual or entity that is a competitor of, or has a material conflict with, Aetna that the Parties reasonably agree could jeopardize the integrity of the audit. The City also agrees not to select any auditor paid on a contingency basis, or to pay any auditor on such a basis or other similar basis. The City also agrees that all audit remuneration must be on a flat fee, or hourly, basis. These safeguards help ensure that the auditor is independent and objective.

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3. What percentage of Aetna employees working on the MA Plan are union members themselves?

Aetna employees are not union members.

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4. Why do some people change plans at two different times of the year for pharmacy?

Please see the response to question 1 above.

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5. Under reporting requirements what confidentiality and protection of personal info is in place for reviewing data of personal medical information? The MLC is not covered by HIPAA and this information is not currently shared.

Section 11.1 of the proposed agreement between the City and Aetna provides that Aetna will **not** provide personal health information or personally identifiable data to anyone.

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6. Under Reporting requirements why are we sharing contact information of the retiree and diagnosis and treatment information with the MLC? You want a report of all members using the perks in addition to all health information. This is a COMPLETE violation of retiree privacy.

Reporting will be on an aggregate basis and will not have any personal health information or personal identifiable data.

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7. Why does the MLC need to know all the data fields in the MMR (Monthly membership report)?

Any data in this report will be deidentified.

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8. The quarterly reports shall include legislative reports. What does that mean?

Includes any legislative changes that have been proposed or passed by CMS. For example, the Inflation Reduction Act passed by the Biden Administration – it impacted the cost of the drug plan.

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9. Annual MA Plan risk score reporting. What is it and is a way to raise premium? Will that cause a problem if the retiree leaves the plan for another plan, will it affect their ability to get other insurance?

Risk score reporting is provided in aggregate without any personal health information or personal identifiable information. This will not raise the City's premium or impact the ability for a retiree to get other health insurance.

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10. If the retiree wants to or has to leave the AETNA plan, will they be able to buy a Medigap plan at any time without ANY problem? No pre-existing condition issues or enrollment issue outside of open enrollment? What other choices does a retiree have?

Medigap policies are state regulated. In New York State, Connecticut, Massachusetts, and Maine retirees have guaranteed issue protections meaning they can purchase a Medigap plan at any time for any reason without pre-existing condition exclusions. Approximately 72% of members live in these states. In other states, Guaranteed Issue rights vary and therefore retirees should consult with a licensed advisor in their State. If they drop City coverage, they will lose Part B reimbursement and/or IRMAA, if applicable.

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11. Why are we using Martin Scheinman in this agreement? I understand he has knowledge but isn't it understandable at this time that we should bring in someone else? Familiarity does not always seem to work in this situation, has it?

The MLC and the City agreed to the following provision: Unless either Party disagrees, the mediator that will conduct the mediation will be Martin F. Scheinman of Scheinman Arbitration & Mediation Services. If either Party does not agree to appoint Mr. Scheinman

as the mediator, another mediator to conduct such mediation will be selected by mutual agreement of the Parties

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12. Will you provide proof of bulk mailing to ensure that you mailed out the materials to the retirees? Many retirees did not get the enrollment guides or letters last time.

Aetna confirms we can provide proof of bulk mailing to ensure mailing. We'll provide a report of undeliverable addresses to the City and request updated address for us to resend the materials.

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13. Is this a new plan, or is this a restructure of the current AETNA Medicare Advantage plan? How is this plan different to the one you currently offer?

Yes, this plan is a new one. The plan was customized for the City of New York, and it is not a standard offering. The new plan includes enhancements, and most of the PAs have been removed. The plan is available in all 50 states with the same plan design nationally. The current Aetna plans offered differ by location and are not offered nationally.

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14. If the copay litigation is successful, will you also remove the AETNA copays?

The copay litigation plan applies to the Senior Care Plan which will be discontinued as of September 1, 2023. The Aetna copays will remain as described in the plan.

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15. What's that phone number?

Aetna will be prepared to release the customer service telephone number if the MLC approves moving forward.