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Documents Submitted by the Public to the State Employee Benefits Committee

Documents Submitted by Steven LePage

SEBC Committee Members,

For the Meeting on Monday, April 24, 2023, the SEBC will be voting to extend the Medicfill until June 30, 2024.

I am glad that Medicfill is being extended, however I do have concerns. I do know that there are certain things that allow changes during a time that is not during Medicare open enrollment, however those are for an emergency type of situation. I am not sure if Medicare would consider a choice by the State to impose a mid-year change in healthcare that may…or may not occur….as an emergency situation….especially since they could have negotiated it for the full year cycle.

I am also not sure why the State would wreak havoc on the elderly community by putting them through a situation that could be avoided if they extended Medicfill until a normal open enrollment period.

I also do not know the options that retirees, who do not want the MA plan would have? Would they have the option to opt out? Is there enough time for them to make a decision and opt out? Will there be time for them to pick a supplemental plan?

I also believe that this would require the State to do two enrollment mailings in one year as well….to explain all the options available to retirees and with dates that could also be problematic.

I feel that while I am grateful the extension until June 30, 2024 is being considered, I believe a more organized transition would be to allow Medicfill to continue through it's normal cycle.

I think this would be best, not only for the retiree, but the State as well….and it would make more sense than to attempt a transition in the middle of a year.

Very Respectfully,
Steven LePage
Persian Gulf War Veteran – Desert Shield/Desert Storm
USAF, Retired
State of Delaware, Department of Technology and Information, Retired

Subject: Proposed Medicfill/Rx Rate Increases

Dear SEBC Committee Members,

I would whole heartedly like to endorse Robert Clarkin's prior email on this issue. I would also like to submit to you the attached data and ask this question.

Why would the SEBC increase premium rates on Medicare Retirees when the data clearly shows that Medicare Retirees' healthcare has had a surplus since 2016, with the surplus growing from $4.1 million in FY2016 to the largest surplus yet of $25.7 million last year? In other words, the premiums for Medicare Retirees have increasingly exceeded the total of their claims costs (Medical + Rx) for the last seven years so I do not see a justification for raising those rates at this time.

To increase rates on Medicare Retirees now is particularly troublesome given the Administration's incorrect public assertions about the relative expense of the Medicare benefit as compared to the costs of the healthcare benefit for active employees and for pre-Medicare retirees. This is because 80% of the cost of medical claims is covered by the Federal Medicare Trust Fund.

Also, increasing rates on Medicare Retirees when they have a surplus adds fuel to the concern that the Medicare Retiree Surplus is being used, at least on the books, as a means to reduce the deficit of the rest of the GHIP.

I hope you find the attached information relevant to the discussion concerning the Premium Rates.

Very Respectfully,
Steven LePage
Persian Gulf War Veteran – Desert Shield/Desert Storm
USAF, Retired
State of Delaware, Department of Technology and Information, Retired

Medicare Retiree Premium & Cost History

MEDICARE PREMIUM BREAKDOWN		FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Medical Premium	56.69%	$241.86	$241.86	$260.44	$260.44	$260.44	$260.44	$260.44	$260.44
Rx Premium	43.31%	$184.74	$184.74	$198.94	$198.94	$198.94	$198.94	$198.94	$198.94
Total Premiums	**100%**	**$426.60**	**$426.60**	**$459.38**	**$459.38**	**$459.38**	**$459.38**	**$459.38**	**$459.38**

MEDICARE RETIREE PROGRAM COSTS	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Medical Total Program Costs	$46,178,511	$56,305,512	$60,511,368	$61,758,352	$65,879,694	$57,529,818	$60,949,455	$65,909,026
RX Total Program Costs	$62,394,418	$57,005,136	$55,090,895	$61,580,115	$68,663,309	$76,529,731	$74,876,940	$65,690,250
Operational Expenses	$1,479,326	$923,206	$1,027,104	$949,172	$929,373	$1,117,892	$1,178,487	$1,228,029
Total Costs	**$110,052,255**	**$114,233,854**	**$116,629,367**	**$124,287,639**	**$135,472,376**	**$135,177,441**	**$137,004,882**	**$132,827,305**
Total Premiums	$101,271,557	$118,376,181	$129,328,354	$143,731,554	$147,432,645	$151,402,038	$154,786,952	$158,519,947
Surplus/Deficit	**($8,780,698)**	**$4,142,327**	**$12,698,987**	**$19,443,915**	**$11,960,269**	**$16,224,597**	**$17,782,070**	**$25,692,642**

Medical-Rx-Operational Expenses Breakdown

Medical	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Medical Total Program Costs	$46,178,511	$56,305,512	$60,511,368	$61,758,352	$65,879,694	$57,529,818	$60,949,455	$65,909,026
Medical Premiums	$57,415,703	$67,113,134	$73,322,447	$81,488,311	$83,586,637	$85,837,077	$87,756,147	$89,872,561
Surplus/Deficit	**$11,237,192**	**$10,807,622**	**$12,811,079**	**$19,729,959**	**$17,706,943**	**$28,307,259**	**$26,806,692**	**$23,963,535**

Rx	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Rx Total Program Costs	$62,394,418	$57,005,136	$55,090,895	$61,580,115	$68,663,309	$76,529,731	$74,876,940	$65,690,250
Rx Premiums	$43,855,854	$51,263,047	$56,005,907	$62,243,243	$63,846,008	$65,564,961	$67,030,805	$68,647,386
Surplus/Deficit	**($18,538,564)**	**($5,742,089)**	**$915,012**	**$663,128**	**($4,817,301)**	**($10,964,770)**	**($7,846,135)**	**$2,957,136**

Operational Expenses	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Operational Expenses	**($1,479,326)**	**($923,206)**	**($1,027,104)**	**($949,172)**	**($929,373)**	**($1,117,892)**	**($1,178,487)**	**($1,228,029)**

NOTES:

WTW Reports only provide total premiums collected.

Medical and Rx Premium Breakdown utilized DHR individual premiums as a source for the percentage breakdown.

Sources Used:

2015-2016 - Rates Effective Jan 1, 2016 - https://web.archive.org/web/20160509022927/http://ben.omb.delaware.gov/medical/documents/fy16-published-rates-effective-jan16.pdf

2017 - Present: https://open.omb.delaware.gov/information/counseling/2016/SEPP%20Medicare%20Supplement%20Rates%20Effective%2001012017.pdf

WTW Reports are listed on the SEBC Website - https://dhr.delaware.gov/benefits/sebc/sebc-materials.shtml

Prepared by: SRL-04-23-2023

Documents Submitted by Diana Noonan

HIGHMARK DELAWARE FREEDOM BLUE PPO SPONSORED BY the State of Delaware

MEDICAL BENEFITS CHART

The following is a comparison of coverages as shown in the Highmark Medical Benefits Chart under Medicare Advantage compared to the coverage that we currently posse under traditional Medicare with Medicfill. The items in quotes are quotes from The Medical Benefits Chart..

"The Medical Benefit Chart on the following pages lists the services Freedom Blue covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met." "Your Medicare covered services must be provided according to the coverage guidelines established for Medicare."

> These two statements would encourage the Retiree to believe that all coverages under Medicare Advantage are equal to the coverages we currently receive under traditional Medicare and Medicfill This is a misleading statement and not true. Not all services covered under Medicare are i covered under Medicare Advantage.

Highmark Comment: The Highmark custom Freedom Blue Medicare Advantage PPO plan is designed so that all Medicare-covered benefits are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service). According to the 2023 Medicare & You Handbook, Medicare Advantage plans must cover all medically necessary services that Original Medicare covers.

The services listed in the Medical Benefits Chart (MBC) that are not covered equally under traditional Medicare, with our current Medicfill plan, and Medicare Advantage are addressed below. This is not a complete list.

The MBC states that out-of-pocket costs for each service are stated, but the items below clearly state differences in coverage. Also, the contractual costs are not defined, or identified in the MBC.

> The language for cost, cost sharing, $1000 out of pocket, and coinsurance is vague and ambiguous. All services are subject to the review for *"medically necessary."* In the MBC, there are 41 pages of services that must have prior authorization and are subject to cost sharing. It is important to note that all cost sharing must be paid at the time of service, in other words, prior to the procedure or service. An example of this would be when a retiree needs surgery, the provider would, in many cases need to obtain prior authorization, and the retiree would then be notified of the cost sharing amount that would have to be paid prior to the procedure. This means that the retiree would only be able to obtain the procedure, if they could afford the cost sharing. The cost sharing could be a small amount that would be difficult for a fixed income retiree to handle.

The Out-of-Pocket Maximum of $1,000 applies to all Medicare Part A and Part B services and Foreign Travel-Professional Provider Services. All Medicare Part A

and Part B services are covered at a 100%* % for both in-network and out-of-network providers both locally and nationally (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service). The *Foreign Travel-Professional Provider Services is the only benefit that would apply to the Out-of-Pocket Maximum. This is one of the many enhancements offered under the custom Medicare Advantage plan.

> *"Medically necessary" are services, supplies or drugs that are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice."*
>
> Cost sharing is not specifically defined in any of the Highmark literature.

Highmark Comment: The Highmark custom Freedom Blue Medicare Advantage PPO plan is designed so that all Medicare-covered benefits are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

Throughout the State and Highmark printed documents, terms are vaguely used and not definitively explained. The Statement that there is $1,000 out of pocket maximum would make the retiree believe that the most they would be accountable for in a year is $1000. In fact, services that require cost sharing are excluded from the $1000 out-of-pocket limit, and the charges that would be applied to the $1000 are not identified in the MBC.

Highmark Comment: The Out-of-Pocket Maximum of $1,000 applies to all Medicare Part A and Part B services and Foreign Travel-Professional Provider Services. All Medicare Part A and Part B services are covered at a 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service). The Foreign Travel-Professional Provider Services as the only benefit that would apply to the Out-of-Pocket Maximum.

In a March 27th presentation at the SEBC subcommittee meeting, the $1000 was stated in the footnotes as *"Applicable to any medical costs incurred by members during travel outside of the U.S. but would otherwise be defined by Medicare as covered services."* (Page 20 of the slide presentation *on March 27)* The MBC itself states that this item would not be covered by Medicare Advantage but would be covered by Medicare.

Highmark Comment: The Foreign Travel benefit is for services that occurred outside of the US but would be defined as a Medicare covered service if received within the US. The member cost share is an 80% coinsurance plus any amount exceeding the Highmark Delaware Plan Allowance up to the $1,000 Out-of-Pocket Maximum. This is one of the many enhancements offered under the custom Medicare Advantage plan.

> *However, Page 96 of Chapter 10 'Definitions of Important words" Of the " 2023 Evidence of Coverage for Freedom Blue PPO"* section of the Highmark and State of Delaware Contract states:

> Combined Maximum Out-of-Pocket Amount – *"This is the most you will pay in a year for all Part A and Part B services from both network(preferred) providers and out of network (non-preferred) providers See Chapter 4 Sect 1. Information about your combined maximum out-of-pocket amount."*
>
> Chapter 4 Section 1.2 Page 36 "*What is the most you will pay for Medicare Part A and Part B covered medical services? Can be found in the Medical Benefits Chart appendix." "The amounts you pay for deductibles (if applicable), copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount (The amounts you pay for services from out-of-n network providers do not count toward in-network maximum or out-of-pocket amount)." "In addition, amounts you pay for some services do not count toward your in-network services from network providers, "*

I believe it is easy to see that the terminology used throughout the Highmark literature is confusing to the retiree. What exactly is covered under the $1000 maximum remains a mystery.

Highmark Comment: The Foreign Travel benefit is for services that occurred outside of the US but would be defined as a Medicare covered service if received within the US. The member cost share is an 80% coinsurance plus any amount exceeding the Highmark Delaware Plan Allowance up to the $1,000 Out of Pocket Maximum.

The MBC also does not precisely define *"Medically necessary."* A service could be given to a retiree and then Highmark might decide that it was not medically necessary and deny coverage. Retirees face an unsure financial liability under Medicare Advantage; Medicare Advantage poses a threat to our very health and economic security.

> I have not had one item denied as medically unnecessary in the over ten years that I have had traditional Medicare and Medicfill, nor have I paid coinsurance, or had to obtain a prior authorization. There are many items covered by Medicare, that would need prior authorization under MA, and if the retiree or doctor did not know all the 41 pages. necessary of prior authorizations, before the service, coverage would be denied. Medicare Advantage does not have copays for most preventive services, that is true, however, if the preventive service becomes diagnostic during the procedure, it changes from a preventive service without copay to a diagnostic service that requires coinsurance, and/or one that could be denied, coverage. An example would be that a colonoscopy which would be covered as preventative but if surgery or polyp removal became necessary, only the part of the procedure that was preventative would be covered. The additional removal of the polyps would be subject to cost sharing, or denial when it became diagnostic, and the cost sharing would be required at the time of service.

The term *"meet accepted standards of medical practice"* could also be deceptively interpreted and the retiree could then be stuck with an expensive medical bill.

Highmark Comment: According to the Centers for Medicare and Medicaid Services (CMS), which oversees the Medicare program, Medicare Advantage plans must cover all medically necessary services that Original Medicare covers. Additionally,

Highmark uses nationally standardized criteria and national and local "Medicare Coverage Determinations" to review the medical necessity of services.

CMS defines Medical Necessity standards (as opposed to a member's doctor) for both Original Medicare and Medicare Advantage plans. In both original Medicare (and with Medicfill) as well as in a Medicare Advantage plan, if a service provided is determined by CMS to be "not medically necessary" the Medicare beneficiary maybe liable for payment for the service.

> *"Some of the services listed in the Medical Benefits Chart are covered as in-network services only or if your doctor or other network provider gets approval in advance (sometimes called "prior authorization")."*
>
> There are over 2000 medical procedures and services listed in the 41 pages of the Contract, along with many prescription drugs, that require prior authorization under Medicare Advantage. These items and medications are currently covered under traditional Medicare and Medicfill and would not be subject to prior authorization. Of course, the worry that seniors have is that these items could be denied, though ordered by our doctor and considered medically necessary in the eyes of our doctor. In the case that a procedure or test is denied, or that the retiree could not afford the coinsurance, there will be a pensioner whose very life might be in jeopardy.

Highmark Comment: If a service that requires prior authorization was provided prior to obtaining the prior authorization, the provider will need to submit the authorization request retrospectively (post-service). If a post-service authorization is denied, the contracted network provider is responsible for the cost of the service (this is not a member liability).

"Covered services that need approval in advance to be covered as in-network services are marked by an asterisk (*) in the Medical Benefits Chart."

> The State retiree population varies from those just 60 or 65 to retirees in their 90's. Some live in nursing homes, some have difficulties with their eyesight, and some do not have access to a computer. Marking items in the booklet with asterisks, check marks, which are supposed to apply to the Out-of-Pocket maximum, and a picture of an apple, which is supposed to be next to the preventive services listed in the MBC can, and will, be confusing to many seniors. This verbiage in entire MBC is vague, with ambiguous wording and confusing symbols, or in the case of cost sharing, preauthorizations, coinsurance and copays extremely deceptive.

Highmark Comment: The Medical Benefits Chart is a Centers for Medicare & Medicaid Services (CMS) standardized document that must be used by all Medicare Advantage Organizations, Medicare Prescription Drug Plans, and section 1876 Cost Plans exactly as provided. CMS regularly reviews and audits all aspects of Medicare Advantage plans, including documents shared with prospective and current members of the Medicare Advantage plan.

"You never need approval in advance for out-of-network services from out-of-network providers."

What the MBC does not state, is that if a service is out-of-network, it is subject to an unspecified cost sharing that must be paid at the time of service. Also, the service could be denied coverage as not medically necessary, or for a lack of preapproval.

Highmark Comment: All Medicare Part A and Part B services are covered at 100%* for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service). *Prior authorizations are not required for services received from an out-of-network provider. While you don't need approval in advance for out of network services, your or your doctor can ask us to make a coverage decision in advance.

"For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from."

"If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plans reimbursement rate (as determined in the contract between the provider and the plan).'

The coinsurance percentage has not been identified in any of the literature that I have seen, nor have Retirees been made aware of the intricacies of cost sharing, or a *"percentage multiplied by the plan reimbursement rate?"*

Highmark Comment: The Highmark custom Freedom Blue Medicare Advantage PPO plan is designed so that all Medicare benefits are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service). Example: Inpatient cost share is 0% coinsurance. Zero (0) multiplied by the reimbursement rate would be zero (0).

How can Retirees decide on Medicare Advantage, when we do not have the complete information, and the information that we do have is vague, and filled with inconsistences.

"If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers."

Again, we have not been notified of the particulars of coinsurance for out of network providers and are unaware of what it means in terms of dollars.

Highmark Comment: The Highmark custom Freedom Blue Medicare Advantage PPO plan is designed so that all Medicare benefits are covered at 100% for both In-network and out of network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

How can the SEBC Subcommittee make a recommendation without full knowledge of what you are recommending. It does not seem you that you can without an understanding of the total risk that the Pensioners will face?

MNC Pages A1-5

The following MBC pages describe benefits. I will only address most of those that are not covered, or if the coverage is inconsistent with traditional Medicare and Medicfill.

"Abdominal aortic aneurysms"

Coverage only applies to a diagnostic screening once a year. "Diagnostic cost sharing may apply."

This coverage would be an issue for people who have an abdominal Aortic aneurysm and may require more than one scan a year. My own husband falls in this case.

Traditional Medicare and Medicfill cover the costs.

Highmark Comment: Intent is to provide the benefit that is part of Medicare's preventive schedule (apple image). Diagnostic screenings can be covered for high risk if medically necessary and would require a prior authorization. All Medicare benefits are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Acupuncture for chronic low back pain"'

Visits are limited to 12 visits per 90 days in total.

Services are covered only, if not associated with surgery or pregnancy.

An additional 8 sessions are possible, if preapproved, for a total of 20 per year.

"Treatment must be discontinued if the patient is not improving or is regressing."

Many pregnant women might require this service and not be covered under MA.

\ Medicare and Medicfill cover Acupuncture.

Highmark Comment: Per Medicare.gov, Medicare Part B covers up to 12 acupuncture visits in 90 days for chronic low back pain. The Medicfill Part B-Surgical-Medical Benefits chart also lists the acupuncture for back pain, only. The Highmark custom Freedom Blue Medicare Advantage PPO plan mirrors this benefit, which is covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

“Ambulance services* “(Require Prior Authorization)”

Medicare Advantage only covers Emergency Ambulance Service if it is **PREAPPROVED,** or if any other form of transportation would endanger the retiree’s life. If preapproval is not obtained, the service may be denied as not *“medically necessary.”*

There is a question if Medicare Advantage will cover the Paramedic that provides the care in the Ambulance. Paramedics could be an out-of-pocket charge to the retiree but would be covered by traditional Medicare and Medicfill. Also, MA could decide that the transport was not medically necessary, and coverage could be denied.

Nonemergency transport is only covered if the Retiree’s condition would be endangered with another form of transportation. Highmark will not cover ambulance services it they determine that another means of transpiration would have been safe for the patient.

Traditional Medicare and Medifill would cover this service fully.

MA will only authorize payment of transport to the nearest facility that they deem appropriate.

There is an * next to Ambulance Services which indicates that prior authorization is needed. The service could be denied if deemed not medically necessary, or if prior authorization was not obtained.

Advanced life support services delivered by paramedics in Delaware would not be covered. These services seem only to have coverage if the paramedics work out the fire station that houses the ambulance.

Non-emergency ambulance services require a Physician Certification Statement.

Traditional Medicare and Medicfill cover Ambulance and Paramedic services.

Highmark Comment: Prior Approval is NOT required for Emergency Ground Ambulance. All non-emergency transportation by ambulance must be prior authorized (approved in advance) by a plan or a delegate of the plan. The member’s non-emergent ambulance provider is responsible for obtaining prior authorization. Any non-emergency transportation services not prior authorized will not be covered. Advanced life support services (ALS) delivered by paramedics that operate separately from the agency that provides the ambulance transports are not covered. This mirrors the Medicare Part B benefit.

MBC Pages A6-8

“Bone Mass Measurement”

THE MBC states that there is no coinsurance or copayment or deductible but does not address coverage for treatment,

Traditional Medicare pays for Bone Mass Measurement and treatment.

Highmark Comment: Intent is to provide the benefit that is part of Medicare's preventive schedule (apple image). The treat for osteoporosis would be a separate benefit. All Medicare Part A and Part B are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Breast cancer screening"

MA allows for one screening mammogram every calendar year for women aged 40 and older and that includes a 3D mammogram.

"A screening mammogram may convert to a diagnostic mammogram at the time services are rendered. Diagnostic testing will be subject to diagnostic cost sharing."

If a lump or suspicious image is found, then the test goes from preventative to diagnostic, there is a cost sharing despite the MBC indication that there is no cost sharing for this procedure. This wording is suspicious and confusing for a retiree. At the time of service and/or procedure, the retiree is expected to pay the cost sharing charge; a charge they did not expect and most likely are unprepared to pay.

Highmark Comment: The intent is to provide the benefit that is part of the Medicare preventive schedule (apple image). Both routine (preventive) and medically necessary (diagnostic) mammograms are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Cardiovascular disease testing"

Blood tests for cardiovascular disease is allowed once every five years and are covered if the disease associated with the need for the blood tests is covered.

Again, vague wording and unpredictable costs.

This service would be covered by Medicare and Medicfill.

Highmark Comment: The intent is to provide the benefit that is part of the Medicare preventive schedule (apple image). Both routine (preventive) and medically necessary (diagnostic) cardiovascular disease testing are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

“Cervical and vaginal cancer screening.”

The MBC does not explain that should the preventative test turn diagnostic, there would be cost sharing.

Medicare and Medifill would cover this procedure.

Highmark Comment: The intent is to provide the benefit that is part of the Medicare preventive schedule (apple image). Both routine (preventive) and medically necessary (diagnostic) cancer screenings are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

“Correctol cancer screening”

If a biopsy is taken during the colonoscopy, or there is a removal of a polyp or growth, it becomes a diagnostic procedure and there is cost sharing for the portion that is not strictly preventative. A cost sharing that the retiree did not anticipate but will be expected to pay at the time of service.

Highmark Comment: The intent is to provide the benefit that is part of the Medicare preventive schedule (apple image). Both routine (preventive) and medically necessary (diagnostic) colonoscopies are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

MBC Pages A9-12

“Diabetes Screening”

Blood test screening is covered only if the patient meets a list of risk factors, or other requirements, such as family history. Based on test results, patient may be eligible for up to two diabetes screening every 12 months. Currently diabetes blood screening can happen every 6 months and even 3 months if medically necessary under traditional Medicare.

Diabetes screening is covered under Medicare and Medicfill.

Highmark Comment: The intent is to provide the benefit that is part of the Medicare preventive schedule (apple image). Both routine (preventive) and medically necessary (diagnostic) diabetes screenings are covered at 100% for both in-

network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Diabetes self-management training, services and supplies*

The booklet does not address medications. It also does not address services covered under Medicare for dietary care, exercise, or out-of-network coverage. There is a question about what diabetes supplies are covered. **MBC states the Retiree should call Member Services for details.**

These services are covered under Medicare and Medicfill.

Highmark Comment: The intent is to provide the benefit that is part of the Medicare preventive schedule (apple image). Both Part B routine (preventive) and medically necessary (diagnostic) diabetic services and supplies are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

Booklet Pages 10 – 16

"Durable medical equipment (DME) and related supplies"

"(For a definition of "durable medical equipment," see Chapter 12 and Chapter3, Section 7 of the Evidence of Coverage.)" I believe they are referring to the contract, which a retiree would not possess, but I cannot be sure because they do not specify.

Highmark Comment: Evidence of Coverage can be requested through Highmark Delaware Customer Service and was posted to the State Pensioner's Medicare Eligible website under the Medicare Advantage icon. https://dhr.delaware.gov/benefits/medicare/documents/ma-evidence-of-coverage.pdf?ver=1010

The MBC states that DME is 0% coinsurance for Medicare covered items but then it says cost sharing for Medicare Oxygen equipment is covered but the oxygen contents are subject to coinsurance for 36 months. The language is confusing, and it is uncertain what exactly is covered. Prior authorization is required for certain items, but it does not state what those items are.

I called Medicare to verify coverage, and they cover all DME at 80% and Medicfill picks up the 20%.

Highmark Comment: DME and oxygen equipment and supplies are a Medicare Part B benefit. Medicare states that after 36 months, suppliers can no longer submit claims for the equipment, only the contents. The Highmark custom Freedom Blue

Medicare Advantage PPO plan is designed so that all Medicare benefits are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Emergency care"

While the MBC states In and out-of-network emergency care has $0 copay, it also states*: "If you are admitted to the hospital with 3 days for the same condition, you pay $0 for the emergency room visit. The emergency room copayment applies if you are in the hospital for observation or rapid treatment and these are not considered hospital admissions."* The language is very vague, but all emergency treatment is subject to the plan's definition of medically necessary and is in danger of denied coverage.

Unless you are admitted as an inpatient, you will have to pay cost sharing amounts for overnight stays and until the MA coverage takes effect after the third day.

\Highmark Comment: The Medical Benefits Chart is a Centers for Medicare & Medicaid Services (CMS) standardized document that must be used by all Medicare Advantage Organizations, Medicare Prescription Drug Plans, and section 1876 Cost Plans exactly as provided. Some Medicare Advantage plans have different cost sharing for Inpatient and Outpatient hospital stays and a copayment for the Emergency Room. Under the Highmark custom Freedom Blue Medicare Advantage PPO plan, Inpatient and Outpatient hospital stays, and Emergency Room visits are covered at 100% for both **in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).**

Our current plan, under traditional Medicare and Medicfill covers outpatient stays in the hospital from the first day with zero copay or coinsurance.

Traditional Medicare does not limit a retiree's ability to be seen at an urgent care facility, and there is no charge with Medicare and Medicfill coverage for urgent care visits. If a retiree goes to an urgent care facilely on a weekend, MA can deny the coverage as not meeting the *"Medically necessary"* language in the policy. The retiree could then be responsible to pay the entire charge for the visit.

Highmark Comment: Urgent Care is a Medicare Part B service. All Medicare benefits are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

MA defines urgent care as being covered only in the case that the retiree cannot seek treatment from network providers, and it would be subject to cost sharing. They also can deny the visit making the retiree go through the appeal process. This entire section is subjective and relies on MA making fair and accurate decisions about the retiree's health.

All Urgent care visits and service are paid under traditional Medicare and Medicfill.

Highmark Comment: Urgent Care is a Medicare Part B service. All Medicare benefits are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Home health agency care*

MBC states that there is 0% coinsurance per visit, but there is an asterisk in the heading indicating that prior authorization is needed.

Currently, under Medicare and Medicfill there is no charge for these services, nor is a prior authorization necessary.

Highmark Comment: Yes, Home Health Agency Care does require prior authorization. If approved, this benefit is covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Home infusion therapy*

"Prior authorization is required for certain Part B drugs."

I understand that there is some concern for this item, but I am unaware of exactly what it is.

I called Medicare to verify the coverage and they cover home Infusion therapy at 80% and Medifill covers the additional 20%.

Highmark Comment: Yes, certain Part B drugs do require prior authorization. If approved, Part B drugs and Home Infusion Therapy are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Hospice Care"

Retirees would be subject to cost sharing: "You will be billed Original Medicare cost sharing." Our Medicfill plan would cover *the "cost sharing"* under traditional Medicare. The language is complicated and vague. However, the patient must continue to pay premiums to traditional Medicare and there will be different levels of payment and cost sharing depending on services and who provides the services.

Traditional Medicare and Medicfill will cover these services with no cost sharing. I know this, because I recently went through this with my mother, and there was no cost sharing involved.

I have to say, when reading this section, I was very troubled. Image a person who has just weeks or months to live, trying to decipher the language and intent of this section.

Highmark Comment: When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not the Medicare Advantage plan, at 100% (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

Booklet Pages 16 – 26

"Immunizations"

MA does not pay for the same variety of immunizations as traditional Medicare. MA only pays for Pneumonia, flu, Hepatitis B and Covid. I recently had to have a tetanus shot, and the doctor remarked that it was a good thing that I did not have MA because they would not have covered tetanus vaccines.

Medicare and Medicfill cover immunizations.

Highmark Comment: Tetanus shots are covered at 100% for both in-network and out-of-network providers both locally and nationally **- (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service)** ***if needed because of an accident or injury. Tetanus (TDAP) is not covered by Medicare as a preventive vaccine.***

"Inpatient hospital care"

Payment for inpatient care starts the day after a retiree is admitted and ends the day before they are discharged. This leaves the retiree libel for full payment of those two days.

Highmark Comment: Members would not be responsible for these two days. Providers can only bill for full days of inpatient. This is a Medicare Part A benefit that is covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

Traditional Medicare and Medicfill pay for these two days.

"Private Duty Nursing in an acute hospital setting is covered. You pay, 20% coinsurance up to a 240-hour maximum within a 12-month period. MA pays 100% after the maximum hours are met. The cost sharing for Private Duty Nursing is not applied to your Out-of-Pocket Maximum."

Highmark Comment: Private Duty Nursing in an acute hospital setting is covered. You pay 20% up to 240- max within 12 months. YOU pay 100% after the maximum hours are met. This service is excluded from the Out-of-Pocket Maximum and the benefit mirrors what is available on the Medicare + Medicfill plan, today.

Organ Transplants - There is a list of covered transplants in the brochure; cost sharing applies. Patients must call Member Services for more information. I did not see drugs mentioned. There is a limit to the number of days a patient may say inpatient, but the MBC does not identify the number and if it is longer than the allowed days and the Retiree is unaware of this limit, they may be responsible for a huge hospital bill.

Highmark Comment: There is no limit to the number of days of inpatient hospital care under the Highmark custom Freedom Blue Medicare Advantage PPO. There is a Medicare and Medicfill limit to the number of inpatient days available. This is one of the many enhancements offered under the custom Medicare Advantage plan.

The Medicare booklet says that there is coverage in a Medicare approved facility for surgery, additional services and immunosuppressant drugs.

"Medicare Part B Prescription Drugs"

There is confusion about what injectables are covered under the MA plan. Part of the MBC suggests that injectables must be self-administered. It states that there is a 0% copayment for certain drugs, yet there is an asterisk in this category suggesting that preauthorization is necessary.

The MBC refers retires to HighmakStepBTargets.com for clarification. The retiree is at the mercy of the plan's interpretation of what drugs are medically necessary and/or covered, as well as what charges will be applied.

These Drugs are covered under our current Plan.

The whole issue of Step Drugs is disturbing, but I am not addressing this issue at this time.

Highmark Comment: The Highmark custom Freedom Blue PPO Medicare Advantage PPO plan follows Medicare guidelines regarding Part B drugs. Some Part B drugs require prior authorization. Medically necessary Part B drugs are covered at 100% - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Outpatient diagnostic tests and therapeutic services and supplies

The MBC says there is no coinsurance for lab services. However, the * in the heading, clearly indicates that preauthorization is necessary. The language again is vague and misleading to the retiree who has no idea what will or won't be covered for outpatient diagnostic tests. Even the Medicare yearly blood tests require a preauthorization.

These tests and services are fully covered by traditional Medicare and Medicfill.

Highmark Comment: Yes, some outpatient diagnostic tests and therapeutic services and supplies require prior authorization if received from an in-network provider. Medically necessary services are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Outpatient hospital observation"

"Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services."

A retiree would not be considered an inpatient until the third day; therefore, these charges would be open to cost sharing, or a determination of not medically necessary, and could be denied coverage.

These charges are fully covered under Medicare and Medicfill.

Highmark Comment: Both inpatient and outpatient hospital stays are covered at 100% *for both in-network and out-of-network providers both locally and nationally* - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Self-administered drugs covered under Part D that are administered in an outpatient setting cannot be billed under the medical coverage and must be submitted through your Medicare Part D Coverage." The language is vague as to what medical coverage would be paid, such as the Doctor or facility?

These charges would be paid under traditional Medicare and Medicfill.

Highmark Comment: Medicare does not pay for self-administered maintenance drugs under Part A or Part B when you are at the outpatient level of care. These are only covered under your Part D plan.

"Outpatient hospital services*

Outpatient hospital services require prior authorization.

*"Unless the provider h*as written an order to admit you as an inpatient to the hospital, you are an and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered and outpatient."

These services are covered by traditional Medicare and Medicfill.

Highmark Comment: Outpatient Hospital services are a Medicare Part B services. The Highmark custom Freedom Blue Medicare Advantage PPO plan is designed so that all Medicare benefits are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

'Outpatient mental health care," "Outpatient rehabilitation services," and "Outpatient substance abuse services" all contain an asterisk in their heading signaling the need for prior authorization.

Since these services are Outpatient, it would follow that there would be a coinsurance, or cost sharing, however, the MBC states $0 copay and it is unclear if there is a coinsurance.

These services are fully covered under traditional Medicare and Medicfill.

Highmark Comments: The Highmark custom Freedom Blue Medicare Advantage PPO plan is designed so that all Medicare benefits are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

"Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*"

All outpatient services are subject to cost sharing, though the Chart states that there is 0% coinsurance for these services.

These services are covered under traditional Medicare and Medicfill.

Highmark Comments: The Highmark custom Freedom Blue Medicare Advantage PPO plan is designed so that all Medicare benefits are covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

MBC Pages 27-38

"Physician/Practitioner services, including doctor's office visits."

"Services that are available via telehealth are listed in the description of this benefit. The cost sharing for an in-person telehealth visit will be the same for the type of service."

There are explicit categories of telehealth visits that would be covered; it is a long list. The Chart states $0 copay for primary care in-person and telehealth visits but then it limits when visits are an option as well as states that coinsurance is applied for telehealth visits. The language is vague and confusing.

Cost sharing for virtual visits: “all physician visits are covered under traditional Medicare and Medicfill.”

This statement is contradictory to the next section.

“Telehealth – Remote access.”

Telehealth visits for PCP or specialists’ coverage is only available if the call is for medications reconciliation post-discharge, nutritional counseling, and pharmacy clinic counseling (chronic disease and medication management.

This information is in direct contradiction of the previous section. The two sections are vague though they have $0 copay, it appears that they have coinsurance, if covered at all.

Traditional Medicare and Medicfill cover all Telehealth calls.

Highmark Comment: During the COVID-19 Public Health Emergency and through December 31, 2024, Medicare covers telehealth services for many services, like office visits. After this period, the only Medicare-covered telehealth benefit is the Telehealth – Remote Access benefit. Telehealth – Remote Access is a Medicare Part B benefit that provides coverage for members that live in rural areas to use interactive audio and video telecommunications on your computer, tablet or mobile device if offered by your PCP or Specialist. It is limited to the conditions mentioned above.

“Urgently needed services”

Services needed on a weekend or while the Retiree is out of network, or unable to obtain care by a network provider, are covered with cost sharing and subject to *“medically necessary”* review. Any service not deemed *“medically necessary”* by Highmark would be denied coverage.

Traditional Medicare and Medicfill would cover these costs.

Highmark Comment: This is referencing the example provided in the Medical Benefits Chart. Urgently needed services do not require prior approval. *This service is covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).*

“Vision care”

Eye screening are covered once a year, if there is a diagnosis requiring care such as diabetes or glaucoma. There is no copay, but the Chart does not address coinsurance or cost sharing.

Traditional Medicare and Medicfill will cover yearly vision check-ups and medically needed rechecks.

Highmark Comment: Medicare and Medicfill does not cover routine vision check-ups. This service is only covered if there is a diagnosis and/or treatment of diseases or injuries of the eye. The Highmark custom Freedom Blue Medicare Advantage PPO plan mirrors this benefit. There is no limit to the medically necessary vision care you can have in a year. This service is covered at 100% for both in-network and out-of-network providers both locally and nationally - (i.e., at $0 copay or 0% coinsurance to the member – there is no member share of cost for any Medicare covered service).

April 21, 2023

To: Faith Rentz
From: Diana L. Noonan

In response to the email from Faith Rentz dated April 17, 2023

Thank you for your response, though I did not submit this Comparison to the Medical Benefits Chart as a list of questions; my intention is that the document will be distributed to the SEBC Subcommittee as a retiree comment, and I would like my response also submitted as a retiree comment. In addition, please submit the two documents to the members of the SEBC Committee.

The Highmark booklets mailed to 30,000 State of Delaware Retirees indicate that there are incidents in which cost sharing is applied to procedures and services, as does the Medical Benefits Chart so indicate within the Contract. Cost sharing, and the manner in which it will be calculated, has never been addressed directly by either the State or Highmark. I attended an initial retirement benefits meeting in which a Highmark Representative was present, and I asked the representative to define cost sharing, and explain in what cases it would be applied. He told me that we would be getting a booklet in the mail that would explain cost sharing; we never did. I called the University to ask them what cost sharing meant in the booklets and was told that they also had asked about cost sharing and were never given an answer. The response in the Highmark comments that states that there is no "share of cost" to the retiree is troublesome. The issue of cost sharing is not a small issue for the retirees but seems to be one that no one will address in concise and direct terms.

Please address in writing the exact items that will involve cost sharing, how it will be calculated and the impact it will have financially on retiree benefits when it is applied. If there is indeed no cost sharing, I would like to see that clearly stated in writing as well. In several places, throughout the literature supplied by the State and Highmark, cost sharing is mentioned, as is the statement that once a procedure goes from preventive to diagnostic, the retiree would be subject to cost sharing. There is another statement that says that cost sharing does not apply to the $1000 yearly maximum. Again, if there is no cost sharing, or share of cost, I would like to see that stated in clear and definitive terms, and in writing as part of a contract. I think the $1000 yearly maximum is also questionable. If everything is covered at 100% why does Highmark state that this amount will contain Medicare A and B charges?

The response from Highmark states: "All Medicare Part A and Part B services are covered at a 100% for both in-network and out-of-network providers both locally and nationally. (i.e., at $0 copay or 0% coinsurance to the member. – there is no member share of cost for any Medicare covered service)." This statement is made in spite of the fact that the brochures produced and sent to retirees, as well as the Contract specify otherwise in the Medical Benefits Chart. If there is no cost sharing, I have to think that this Contract lacked review by the State's

attorneys; I doubt that they would approve a contract with such blatant inaccuracies. I would like to see a new Medical Benefits Chart that reflects your intent.

To that point, Highmark indicates in their response that "The Medical Benefits Chart is a Centers for Medicare & Medical Services standardized document that must be used by all Medicare Advantage Organizations…" This statement is confusing and misleading. What is the point of referring to the Chart as a "standardized document?" Either the contents of the Chart (which is included in the Medicare Advantage Contract), are irrelevant and don't apply to participants, or they are relevant and do apply. Please explain which is the case.

I am aware that the Medicare Booklet clearly states that all Medicare benefits must be covered by any other plan, such as Medicare Advantage, at the same coverage level, 100%. However, I am not naïve, nor a fool. I know that Medicare Advantage is making money. How I wonder? Are they going to deny even more than the typical 8% denial rate, or are there hidden costs to the consumer? I am thinking probably both. They are not in this Contract out of the kindness of their hearts, they are a business, and they are in business to make money. There is no way a business will survive charging a token premium, pay out at 100% for all medical procedures and services, and make money. I would like this question answered honestly.

I take Umbridge with many remarks in Highmark's reply, but the main issue to me is:

Is there, or is there not cost sharing, or share of cost, in the State's Contract with Highmark? If cost sharing exists in any form, we have a right to know exactly when it is applicable, and how it is calculated, and the manner it will be applied.

The State has signed a Contract with Highmark which includes statements that I believe are contrary to many of Highmark's comments in this reply. When a contract is signed, it is an obligation between the two parties. Retirees have a right to access that contract, and to know exactly what the coverage will be under Medicare Advantage. Also, I believe the RHBAS Subcommittee is tasked with trying to come up with a fair and workable recommendation, however, that does not seem possible, when they are not being given concise, or even contradictory, and inaccurate information.

It is important to acknowledge that all procedures and services are subject to "medical necessity," For example, Highmark has indicated that Emergency Ground Ambulance is not subject to prior approval but that all nonemergency transportation must be preauthorized. If a retiree is transported but Highmark later terms it a non -emergency, or that the patient could have been safely delivered by another means, the retiree could be subject to cost sharing, or total responsibility of the charges. Please clarify in writing.

Highmark stated in their comments: "CMS defines Medical Necessity standards (as opposed to a member's doctor) for both Original Medicare and Medicare Advantage plans. In both original Medicare (and with Medicfill) as well as in a Medicare Advantage plan, if a service provided is determined by CMS to be "not medically necessary" the Medicare beneficiary may be liable for

payment for the service." "Highmark uses nationally standardized criteria and national and local. "Medical Coverage Determinations" to review the medical necessity of services."

In all the years I have had Medicare, more than 10, I have never been denied a procedure or service for "medical necessity." The Medicare Advantage decisions are being made for MA by a care team, whom I believe are not doctors, and who do not know our medical history. I believe Medicare Advantage is nothing more than privatizing of our Federal Medicare program. A program that we have paid into for our entire working lives. Putting a private insurance company in-between coverages and procedures that a pensioner needs and deserves cannot come to any positive end. We deserve to be treated by our own doctors who know us, know our medical history and who are best suited to make medical decisions on our behalf; as professionals, their recommendations deserve to be honored.

I have no doubt that cost sharing will be part of Medicare Advantage. I am seriously concerned about the possible financial liability that retirees could face due to cost sharing charges. As I previously commented in a Retiree Subcommittee Meeting, I am concerned about how cost sharing will be calculated and applied.

The Medical Benefits Chart states (A1-2) that:

"For benefits where your cost sharing is a co-insurance percentage, the amount you pay depends on what type of provider you receive the services from. If you receive services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan"). If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers."

I am confused and I bet anyone reading this probably is also. What does any of this mean? The first time I spoke at a retiree benefits meeting, I asked about the 30% coinsurance amount referred to by the Consultant. I didn't understand then how it was determined, or in what case it was to be applied. I still don't understand which benefits included in Medicare Advantage Plan are subject to in this convoluted statement. I am further confused because Highmark's reply implies that there is no coinsurance and that we will be liable for $0 copay and coinsurance. Again, cost sharing is not addressed. Retirees have a right to understand the costs that they could, and will, be subject to for any, and all, insurance plans. In this case, we have no idea. exactly what the Highmark interpretation of these terms entails: "coinsurance percentage', the 'plan's reimbursement rate', and the 'Medicare payment rate,' as mentioned in the above quotation. Please clarify the statement and all terms within, in writing.

I feel that Highmark's comments to my document are more of the same. Vague statements and repetitive rhetoric. They can say, and have now in writing, that they will cover at 100%

everything that Medicare covers at 100%. I would like to see that statement in the brochures, right along with the statement that there will be no share of cost to the retiree. I am further troubled by the lack of transparency concerning the terms “medically necessary,” “standard of care,” and the reality of how charges for diagnostic tests and procedures will be handled under Highmark. Preventative procedures and services are shown in the MBC as covered at 100% under Medicare Advantage, but then as the MBC states, once a preventive procedure becomes diagnostic, the retiree is charged cost sharing for the portion of the procedure that is deemed diagnostic? Please clarify in writing.

In many cases, Pensioner’s worked their whole careers for the State of Delaware and deserve better treatment. My husband was loyal, worked many hours for no extra pay because he was so loyal. These former employees were proud of their careers and that pride has been taken away from them by the actions of this administration.

Document Submitted
by
Lynda Hastings

Subject: Extending the Medicfill contract to Dec 31, 2024

I understand that, as a member of the SEBC, tomorrow you will be asked to vote on extending the Medicfill contract with Highmark to June 30, 2024. I respectfully request that you suggest amending this request until December 31, 2024.

I concur with others who have observed that this half-year extension puts an artificial constraint and unnecessary rush to figure out benefits concerns in a timeframe that is out of sync with the traditional Medicare cycle. It creates uncertainty, stress, and complications for retirees who might want to consider opting out of any different plan that would begin July 1, 2024. Such an unusual mid-year point created by a half-year extension leaves Delaware retirees out of sync to be able to make other Medicare choices.

Thank you.

Lynda Hastings
Retiree

Document Submitted
by
Nancy Alteri

Subject: SEBC meeting on April 24, 2023

Dear Ms. Rentz,

Thank you for your intent to extend our supplemental Medicfill plan through June 2024. This will allow for additional time to hear retiree concerns as well as research and address the healthcare issues brought before the RHBAS in its meetings.

While I applaud your intent to extend the supplemental Medicfill plan, I think an extension until the end of 2024 would prove advantageous. An extension until December 31, 2024 would allow for a normal Open Enrollment period in the Fall of 2024 for Delaware retirees as well as align with Medicare's Annual Enrollment Period which begins each year on October 15. Such an extension would avoid confusion and disruptions inherent in a mid-year changeover.

Thank you for your time and consideration.

Nancy R. Alteri

Document Submitted
by
Helene Diskau

Subject: Monday 4/24/2023 SEBC Extension of Medicfill

Dear Faith:

As a member of the SEBC, on Monday 4/24/2023 you will be asked to vote on extending the Medicfill contract with Highmark to June 30, 2024. I respectfully request that you suggest amending this request until December 31, 2024. This will allow for a better planning process in terms of better meeting the needs of State Retirees.

The Medicare Advantage (MA) initiative undertaken by the SEBC last year did not meet the needs or promised expected coverage of Retirees on Medicare at a crucial time of their lives. Your help in moving forward will be greatly appreciated.

Helene Diskau
Pensioner/Retiree
Milford, DE 19963

Document Submitted
by
Rebecca Scarborough

Subject: Extending the Special Medicfill plan until December 31, 2024

Dear SEBC Members,

I was relieved to hear of the administration's stated intent to continue the Special Medicfill Plan for Medicare retirees until June 30, 2024. Such a move has the potential of allowing the RHBAS to continue its important task of hearing public comments and studying potential ways to address the present healthcare liability. It also extends the timeline for this committee to make final and better researched recommendations to the Governor and the Legislature. However, in the interest of retirees who, after learning what the State may be changing, I feel that the timeline for continuing the Special Medicfill Plan should be extended until December 31, 2024, in order to limit any disruptions and problems that may occur with a deadline that is out of sync with the primary Federal Medicare timetable.

Thank you for your consideration of my request.

Rebecca H. Scarborough
Pensioner

Document Submitted
by
Barbara Philbin

Subject: June 2024 Extension

Dear SEBC Members,

In reference to your extension of Medicfill, I think it makes more sense to extend Medicfill until January l, 2025 for the following reasons. That is if you persist in recommending a MA Only policy for Medicare retirees.

How can I sign up for a medigap policy in June when the federal sign up date is only in October/ Time sequencing doesn't make sense to me.

It took the State more than a month to send me the opt out papers last time around so how would this work given the June deadline date so I can purchase a supplemental policy that begins on January 1? How will the State communicate with me honestly and effectively this time around and answer my questions?

I am 82. The State needs to make clear whether or not I have to go thru the "underwriting" process since, at my age, having preexisting conditions is pretty common, We need a legal opinion, not answered by customer service, about this issue based on Delaware Law.

Also, I would like to known why you picked this particular date since it doesn't make sense to me. What is your rationale? Does it have something to do wit the end of the legislative session? A change in the date from start to finish health care cycle from July to June rather than January to December/ How will the State communicate effectively with retirees. Would kindly like to know.

Thank you,

Barbara Philbin

Document Submitted
by
Linda Dion

Subject: EXtending Medicfill, the current plan, until only June 30 2024

Hello, I understand the the SEBC will be voting at its April 24th meeting to extend Special Medicfill coverage to June 30, 2024. THis does not seem to make any sense to me, and I am writing to request that it be extended until the end of 2024 - that is, until December 31, 2024.

I feel that extending it only until June 30 imposes an unnecessary rush to figure out medical benefits concerns. It will create uncertainty, stress, and complications for retirees who might, well in advance, want to consider opting out of any different plan that begins July 1, 2024. Requiring that they do this by June 30 is an unusual time for retirees to have to make a decision about health care choices, and will put Delaware out of sync with the primary Federal Medicare timetable.

I request that you extend the current Special Medicfill plan to December 31, 2024 which will keep the plan on the usual timetable for Medicare decisions. Sincerely Linda Dion, retired from Faculty at University of Delaware