Document Submitted by Roger Jones

DELAWARE RETIREE HEALTHCARE BENEFITS ADVISORY SUBCOMMITTEE COMMMENTS OF ROGER L. JONES APRIL 17, 2023

In an effort to move efforts of the Subcommittee forward toward equitable solutions for State of Delaware retirees, I would like to make the following suggestions.

First, request the State's actuarial consultant, Cheiron evaluate and chart the recommendations of eligibility changes proposed for potential implementation by the Retirement Benefits Subcomittee (RSBC 11/1/2021), if not already done. This includes the following:

1) Reduce the State share/subsidy for spouses of retirees from 100% to 50% for future retirees after a certain effective date (perhaps 6/30/2025?), for those who have not reached retirement eligibility status.
2) Modify the eligibility (YOS) schedule for State share/subsidy for those hired since 1/2007 to 20 years of service = 50%, 25 years = 75%, and 30 years – 199%, after a certain effective date (perhaps 6/30/2025?).
3) Establish a minimum age to enroll on the retiree medical plan of 60 for State employees subject to a mandatory retirement age, providing a deferred benefit for those that retire prior to the minimum. This would apply after a certain effective date (perhaps 6/30/2025?), for those that have not reached retirement eligibility.
4) Eliminate the ability to access retiree medical benefits for vested employees that terminate their State service without filing with the Pension Office for retirement. This would apply to employees that terminate after a certain effective date (perhaps 9/30/2025?), and require employees in the future to retire from State service in order to receive the retiree medical benefits.

Additionally, as part of this analysis, include a projection of a legislatively mandated 1% of future fiscal year budget contributions to the Other Postemployments Benefits (OPEB) Fund Trust.

Request Cheiron analyze potential future cost reductions of these potential implementation steps. In this way the RHBAS can determine which proposed implementation steps have the most positive impact, how much they "bend down the projected shortfall gap", and provide a reasonable estimate of the shortfall gap in future years. Care should be taken in selecting how many years to project costs out due to the large number of assumptions required by this analysis. It would also be helpful to illustrate the above referenced changes on the cost per retiree, which I believe averaged approximately $4900 last year.

With this base of information and projected implementation impacts, the RHBAS can enter into an informed discussion about retiree health care options moving forward. It might also be prudent to poll legislative caucuses regarding a proposed legislative 1% OPEB budget contribution to determine their appetite for approving this budgetary commitment.

With this analysis in hand, the RHBAS can then begin some grounded discussions regarding retiree health care plan options and premium levels to program participants if, after the proposed analysis indicates, there is still a projected shortfall. I recommend that the shortfall analysis be based on continued enrollment of all retirees in the current Medicfill plan program. Even if the RHBAS recommends and State adopts a Medicare Advantage Plan option, using this approach will project a worse case shortfall projection.

To me this approach gets Subcommittee members to a place where they can have a reasonable discussion regarding shared cost. In effect it is a gap analysis, where the State puts its best foot forward in terms of providing a benefit promised to retirees and recognizes the health care costs are likely to increase at a rate greater than inflation into the future.

In closing, I would also point out that there has been limited input from health care experts into discussions to date. It might be helpful to query a few doctors, nurses, etc. and ask them to answer the following question: "Would you recommend enrolling a family member in a Medicare Advantage Program?"

Thank you for your consideration of these recommendations.

Sincerely,

Roger L. Jones
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Document Submitted
By
Nancy Alteri

Nancy Alteri - Public Comment on April 17, 2023

There is wording on p.10 of the WTW presentation document titled Options to reduce OPEB liability which states that the proposed Medicare Advantage plan closely mirrors Medicfill. That is untrue. The proposed Medicare Advantage plan does not closely mirror the Medicfill supplement.

Currently, on Medicfill I can make an appointment to see my primary care physician or a specialist and receive recommended services or tests without being concerned about prior authorization or whether a doctor or facility is in-network or if there will be any denied benefits or hidden costs.

On Medicfill I do not have to: (1) call the provider to make sure they are still in network,
On Medicfill I do not have to: (2) call customer service to make sure that type of provider is covered under my plan and
On Medicfill I do not have to: (3) call customer service to make sure the treatment which is recommended by that network provider who is still in network and is covered by my particular plan is, in fact, covered.

Again, of most importance on Medicfill I do not have to worry nor be in a constant state of uncertainty about my health insurance. I have confidence that I can use physicians and facilities of my choosing and receive their recommended treatment plans with assurance that my medical bills will be paid without concerns about any hidden costs.

Document Submitted
By
Karen Peterson

At the April 3rd subcommittee meeting,

Highmark submitted a "Frequently Asked Questions" document

about their Medicare Advantage plan -- that I read in disbelief.

Now I know how Dominion Voting Systems felt

when Fox News kept making false claims about the 2020 election results.

First, Highmark claims that the DE Medicare Advantage plan was designed to "mirror" the current coverage state retirees have.

As Superior Court Judge Calvin Scott said in granting our Motion for a Stay of the Medicare Advantage plan, "it is undisputed that the Medicare Advantage plan is substantially different from retirees current State-funded health insurance."

Second, Highmark continues to claim that the plan is designed so that all Medicare benefits are covered at 100% -- with $0 co-pays and $0 co-insurance payments. It says that all Medicare benefits are covered "in full" with no member cost share.

That claim is contradicted by their own "Medical Benefits Chart" that lists co-pays, co-insurance, cost-share fees, and out-of-pocket expenses capped at $1,000.

If there is no cost to the member, why is there a cap of $1,000 on out-of-pocket charges??? That doesn't even make sense!

Third, Highmark states that there are only 24 categories of benefits that require pre-authorization – and some "select" drugs and supplies.

But those mere "24 categories" happen to include 1,690 tests and procedures – and 340 drugs and supplies – for a total of 2,030 required pre-authorizations.

While the State claims that active employees have to get prior-authorizations, their list is miniscule compared with the Medicare Advantage list.

And the notion that Highmark knows what's best for us is laughable.

Fourth, Highmark claims that the $1,000 out-of-pocket limit is an "enhancement" since our current Medicfill plan does not have any cap on out-of-pocket expenses.

That's because Medicfill doesn't have any out-of-pocket expenses – that's why there's no cap.

And as for their claim that Medicfill does requires some co-insurance payments,

I've been in the plan for seven years and have never had a co-insurance cost.

Finally, Highmark brags that their prior-authorization rate is 92% -- like that's something wonderful.

That means that 8% are denied. For me, that means that Highmark would deny, on average, $8,636 worth of my claims each year. So, I would either have to pay those claims out-of-pocket (since they're not included in the $1,000 cap) – or file eight appeals a year.

If one of those denials were for monthly infusions I get for rheumatoid arthritis, my out-of-pocket costs would be $93,210 a year.

If I were the president of Highmark making $8.6 million a year,
I could probably afford that. But I'm not – and I can't.