Table of Contents

Documents Submitted by the Public to the SEBC: Retiree Healthcare Benefits Advisory Subcommittee

Document Submitted
By
Amanda Kilby

Good afternoon,

I am an educator in the State of Delaware. I have taught for 25 years. I have dedicated my life to young children as many of my colleagues have. We were promised a fair wage and that our benefits actually made up for the lack of salary that our master's degrees deserved.

I read the RHBAS notes from the August 10th meeting with dismay. In the notes and the appendix, it states that you are considering lowering the spousal share to 50%. It states that you might "eliminate vested retirees from eligibility from healthcare" for those of us retiring after January 2025.

I had planned to teach 30 years. If I continue to teach for 30 years, I would be one of the many state workers that would have their healthcare "eliminated" by this committee. Why is it that you don't think that I have contributed enough in my 25-30 years to deserve any healthcare? Please explain. And I really do not want to hear about how you cannot afford it. As the State PROMISED all of us quality healthcare at affordable prices NOT the elimination of it!

Do you think there will be anyone in the State that will continue to teach if you choose model A or C for this elimination? Model A according to the PDF shows the elimination if you were hired after 2015. And the one that really strikes me is the Model C which means if any of us retire after January 2025 we lose healthcare. I would assume you would have MANY state employees (teachers, correctional officers, police, etc) that would retire prior to this date just to get the retirement benefits we deserve. New staff hired after 2015 would be encouraged to work for the private sector for better pay and benefits packages!

Model B is to eliminate healthcare for those hired after January 2025. Well at least these folks would know in advance they would not have it. Unlike those of us that have worked 25 + years and were told upon retirement.."Oh well, your healthcare was eliminated".

Finally, I want to address this Medicare Advantage which is basically BIG COMPANIES grabbing cash by privatizing our medicare. How the Federal government allows this is beyond me. I value going to the chiropractor and I think this keeps me healthy. In the MA plan, I would not be able to see one unless I paid full cost or it was approved by some arbitrary person that might not even be a doctor. MA plans pass on costs to the consumers as well with higher deductibles, copays and the insistence on prior authorizations from non medical staff. Many states are dealing with lawsuits, Delaware included, for pushing these plans on to retirees. It is not fair or just. Again, we have dedicated our time and energy to the service of the State as we were promised good quality healthcare. In fact, many of the great hospitals in our surrounding MD, VA, PA area do not accept MA plans. And if we move, less doctors accept it.

Please exclude MA plans from our healthcare for good. Say NO to these plans and stick with what we have had. Also, I implore you to NOT vote to change retirement for those after January 2025. Current state employees should be "grandfathered" in to any changes you might make to our healthcare.

Thank you for listening.

Sincerely,
Amanda Kilby

Document Submitted
By
Bob Clarkin

PUBLIC COMMENTS FOR THE 8/24/2023 RHBAS MEETING - SUBMITTED BY ROBERT CLARKIN, 8/18/23

The RHBAS public meeting calendar indicates just three meetings remain before the Subcommittee will be presenting a final report to the Governor and Legislature. Below are a number of topic areas that I would like to bring to the attention of the RHBAS for your consideration during your upcoming meetings.

"Medicare Request for Proposal Scope and Timeline" Agenda Item on SEBC 8/21/23 Meeting Agenda

The agenda for the 8/21/23 SEBC meeting contains an item titled "Medicare Request for Proposal **Scope** and Timeline". I can understand the SEBC discussing the timeline for the Medicare RFP, as long as the development and release dates are a reasonable time after the release of the RHBAS report. However, discussing the **Scope** of the RFP is very problematic prior to the release of the RHBAS report. The **Scope** of an RFP traditionally refers to the Scope of Work and is defined as "what the company is looking to achieve as a result of the RFP" and "helps ensure that the product or service meets the company's needs and establishes the parameters of what could be included in the resulting contract". In the not too distant past, agencies that drive the SEBC lead the Committee down the path of approving a move to Medicare Advantage prior to the release of the RBSC's final report on March 31, 2022. A number of SEBC and SEBC Subcommittee members have since stated that they were lead to believe that the Medicare Advantage coverage was substantially the same as Medicfill coverage - a misrepresentation that has been exposed over and over again. Now, it appears that the same agencies that drive the SEBC will be speaking to the Scope of a Medicare RFP prior to the release of the RHBAS's report to the Governor and Legislature.

As "Discussion and Recommendations on SEBC Medicare Request for Proposals" is on the agenda for the 8/24/23 RHBAS meeting, RHBAS leadership should request that, during the 8/24/23 RHBAS meeting, the Co-Chairs of the SEBC, who are also RHBAS members, present an overview of the 8/21/23 SEBC "Medicare Request for Proposal Scope and Timeline" presentation and discussion. The overview should also include their perspectives regarding how the recommendations contained in the final RHBAS report will guide the SEBC.

Extension of Current Special Medicfill Contract Through 12/31/24

During the 8/10/23 RHBAS meeting, the Subcommittee approved a motion to grandfather current retirees and those active empoyees who retire prior to 1/1/25 into Medicfill/CVS-RX at the current cost to retirees. As the current Medicfill contract extention expires on 6/30/24, the RHBAS should vote during the 624/23 meeting to encourage the SEBC to extend the Medicfill contract through 12/31/24.

Sharing the RHBAS Report with Retirees

In order to foster transparency and universal retiree awareness, I believe it is imperative to mail a copy of the Subcommittee's Final Report to current retirees, including all pre-65 retirees and Medicare eligible retirees, as well as all active employees within five (5) years of retirement. In order to reach out to the maximum number of retirees and active employees, the mailing should include retirees and applicable employees from/at state agencies, school districts, DTCC, and affiliated employers (U of D, Del State, Charter Schools, etc.).

Healthcare Cost Containment

During the 7/20/23 RHBAS meeting, Bill Oberle spoke eloquently about the problem of ever increasing healthcare costs. As a SEBC Subcommittee member, he has raised the issue of controlling cost many times in the past. According to the Kaiser Family Foundation, the average per capita cost of healthcare in Delaware during 2023 was $12,769 - fourth highest in the nation. Forbes also lists Delaware as fourth highest in the nation at $12,294. The Delaware Health Care Commission (housed in DHSS) was created in 1990 and charged with developing a pathway for basic, affordable health care for all Delawareans. In 2013, the Commission issued the State's Health Care Innovation Plan which contained a goal of reducing healthcare costs by 6% by 2019. In 2019, the Governor tasked the Commission with establishing healthcare benchmarks. Along came Covid and reaching the benchmarks understandably fell to the wayside.

While addressing healthcare costs in detail is beyond the scope of the RHBAS, the committee could certainly widen it's lens, acknowledge the bugetary problems associated with increasing costs, and make a general recommendation to the Governor and the Legislature that existing entities such as the SEBC and the HCC be tasked with further defining and tackling this problem - significant efforts in reigning in healthcare costs have been accomplished by states including Oregon and Maryland.

Standalone Medicare Part D CVS/Caremark Prescription Plan Choice

On numerous occasions, Claire DeMatties has raised the issue of the cost borne by current Medicare eligible retirees who pay more than a 5% share and the additional current Medicare eligible retirees who are not covered by Medicfill (implying they are unable to afford the cost). I have a solution to help address her concerns. Allow Medicare eligible retirees to choose standalone CVS/Caremark Part D prescription coverage. This will allow those who cannot afford to pay more than 5% to obtain a less expensive Supplemental plan or a Medicare Advantage plan on the open market, if they so choose, and maintain their prescription coverage. This option (choice) will reduce the cost of their monthly share by up to 57%. In other words —- Medicfill is currently offered with or without prescription coverage —— Prescription coverage should be offered with or without Medicfill.

Document Submitted
By
Connie Merlet
John Kowalko

Dear Chairwoman Hall-Long and members of the RHBAS and SEBC,

We are writing to you today to urge you to take a Medicare Advantage option out of consideration for any present or future retirees' plan.

Privatization of Medicare should never be an option and we will never support such a plan. As elected officials you have an obligation to support the wellbeing of your constituents, and state retirees are especially vulnerable to decisions made by state administrators. It is time for you to take decisive action. We expect to hear of your support for state workers' entitlements, and as you support us, we will support you in your future political endeavors.

Thank you,

John Kowalko

Connie Merlet

RISE Delaware Cofounders

Document Submitted
By
Retired Senator
Karen Peterson

Dear Subcommittee Members,

Several RHBAS members have expressed a concern about the high premiums paid by some State retirees and have suggested that Medicare Advantage be offered to them as an option. If you really want to help this group, you could start by not over-charging them for their "premiums."

Currently, the State is charging them a percentage of the faux "premium" of $459.36 a month. The actual cost to the State, however, is only $389.35*. Therefore, retirees who pay the full amount are being charged $840.12 a year more than their coverage actually costs the State. When the "premiums" increase to $482.34 on January 1st, they will be paying in excess of $1,000.00 a year more than they cost the State.

I realize that the State does not want to separate the Medicare retirees' costs from the employees' costs because Medicare retirees are subsidizing the employees' coverage. But the State cannot have it both ways. They cannot pretend to care about retirees paying so much for their benefits -- while continuing to over-charge them. Using those retirees to justify offering an inferior Medicare Advantage plan as a "choice" is shameful.

On another note, the "Retiree Healthcare Newsletter" (which arrived in today's mail) explains the increased co-pays for prescription drugs -- but says nothing about the $23.00 monthly increase in healthcare "premiums" effective January 1st. That will be a real shock to the retirees who (once again) received no pension increase.

Karen Peterson

*__2023__
# of retirees: 29,327
Premiums: $161,919,690
Costs: $135,835,768
Surplus: $ 24,639,494
Overpayment per person per month: $70.01
(on premiums of $459.38 per month).

Document Submitted
By
Rebecca Scarborough

Please send my latest public comment to the members of the RHBAS **AND** copy this to the SEBC Committee.

Thank you!

Rebecca Scarborough

Dear RHBAS Members,

Little did I know that when I first started making public comments to your committee that I would experience a medical emergency that resulted in me having to undergo serious abdominal surgery. In the ER I had several tests , including a CT scan to diagnose my illness. Upon my release I was referred to a surgeon, whom I saw several days later. In order to be more certain about the extent of my illness, he ordered another CT scan, but this time with bowel preparation. Imagine my relief when the surgeon's nurse, while writing the order for this second CT scan, remarked that it was a good thing I was on Medicare or they would have had to get prior authorization! Time was of the essence, and the second scan revealed that I had developed an abscess and needed immediate surgery.

Luckily I am on the road to recovery, but upon reflecting back on this whole sudden health emergency, I am so grateful for RISE and the fact that I had not been moved to the State's inadequate and inferior Medicare Advantage plan! How long would it have taken to have gotten prior approval for the CT scan which resulted in my need for surgery? Could I have fallen between the cracks? How many of the State's retirees have also experienced such a close call? And how many more retirees will be lucky to still be on traditional Medicare if they should experience a serious health issue during this reprieve we have for the time being?

This committee has received a plethora of information about the threat that **any** Medicare Advantage plan has on America's health care system for seniors. You have heard about the denials of care, the prior-authorizations, the out-of-network problems, and, yes, even the fraudulent billing practices that are endangering traditional Medicare. It is unbelievable to me that Delaware would even want to be a participant in the privatization of Medicare! Please take Medicare Advantage off the table completely as a solution to the State's liability problem. You have already seen other, more humane ways, to address the problem.

Thank you for your hard work thus far!

Rebecca Scarborough
Pensioner

Document Submitted
By
William Conaway

Count me on the side of not wanting a Medicare advantage plan. It's not an advantage to the retirees, the health care providers or I'm guessing Medicare. It's complicated for retirees and medical providers having to navigate the prior authorization requirements. A nurse at a doctors office in Lewes told me she spends way too much time on the phone waiting for approval, call backs, appeals and holds. Medicare is accepted by most providers and sets the rate standard for most procedures. Prior authorization is not an issue with Medicare coverage, so why make it so complicated? I cannot afford the cost of going to Johns Hopkins for treatment and having to pay the remaining part of the bill that Medicare Advantage doesn't pay. That harms me personally and denies me the healthcare of that excellent hospital. I've never been denied Medicare coverage. Thank you for giving me the opportunity to be heard.

William Conaway

Document Submitted
By
Diana Noonan

Chairwoman Bethany Hall-Long and Members of the RHBAS Subcommittee:

I have been deeply disappointed by the consistent support of some members of this committee for Medicare Advantage. In perusing the internet yesterday, I came across countless articles talking about Medicare Advantage in relation to fraud, overcharging and misuse of Medicare funds, not to mention the high preauthorization statistics, and inappropriate denials. How this committee can go forward with a recommendation to use Medicare Advantage for Retirees, current employees or future employees is beyond my comprehension. Why would you even consider a plan that possesses such a record? It is a dishonest plan that utilizes excessive pre-authorizations, copayments, hidden costs like cost sharing, and coinsurance with deceptive plan limits to garner profit from Medicare, a plan that we have paid into, and you have touted as a highly important part of our benefit plan for over 30 years.

The State has an obligation and a moral responsibility to ensure that current retirees receive the exact same coverage that we now possess. We have earned the coverage, we have been promised the coverage, and we rely on the Medigap plan to manage our retirement. We do not want an option of Medicare Advantage. You site lower premiums as a draw for retirees, but how will retirees on this Medicare Advantage pay for the added coinsurance, cost sharing and copays. They will certainly amount to more than the Medigap premiums. I also think it is important to remember that current and future employees are watching. They are gauging their incentive to work for the State against the State's treatment of its' retirees. I understand that there are about 28,000 current job openings in the State. I saw a bill passed that allows new hires immediate access to healthcare rather than the previous wait period prior to benefits kicking in. It is a costly bill, but what incentive does it offer if Medicare Advantage and its pitfalls is the option? I doubt you will acquire even one new hire who joins the State's workforce for such a healthcare plan.

I believe that this Committee's goal is to treat Retirees with the respect that we deserve, and I hope that you will hold in consideration our views and our needs above a budget shortfall that is none of our doing.

Respectfully.

Diana Noonan

Document Submitted
By
Tom Pledgie

Dear Members of RHBAS Subcommittee:

I address you today from room 747 of Nelson Hall @ Johns Hopkins Hospital where my wife Ginger — a DE teacher with 30 years of experience— is being treated for a GI Bleed. This by the way is a hospital that does NOT accept Medicare Advantage patients. So, we are able to be here today because the disastrous SEBC change from the Medicfill Plan to Medicare Advantage failed. Retirees have absolutely NO TRUST in the current SEBC leadership, practices and Proposal review processes. New processes are needed. Thank you Representative Baumbach for your proposals.

I want to thank the Parties to the Litigation that skillfully stopped the Administration from making a terrible mistake.

Yesterday at 10 AM, my wife and her doctor decided to utilize a new technology to identify GI bleeds: The Cam-pill. Without any need for prior approval, the pill was digested at 2:30 PM, and the results were available this morning. It did not take a 3–5-day prior approval by HighmarkDE, and didn't include an 8% rejection factor. The doctor and patient made a decision as to the best course of study and implemented it. Prior Approvals by a profit-making insurance company is the only way that MA works.

We thank this Committee for all of your work. We hope you will not allow the Administration to make a mockery of your work. They are very skillful 'bean counters & manipulators' that want to be sure that Room 747 of Nelson Hall @ Johns Hopkins Hospital is never filled again by a State Retiree. What a terrible legacy the SEBC has left us.

Tom Pledgie