Submitted by email to GIB's Liaison Officer on March 13, 2018

AN OPEN LETTER TO MEMBERS OF THE GROUP INSURANCE BOARD

At GIB's 21 February 2018 meeting, ETF staff presented a document titled "Health Benefit Program Agreement & Uniform Benefits for the 2019 year." This letter focuses on the "Pharmacy Benefit Change Concepts" outlined on pages 6 and 7 (see *Attachment A* below) and urges all members of the GIB to investigate thoroughly each of the issues raised below before endorsing any of these "benefit change concepts." GIB members have a fiduciary responsibility to act "prudently." "Prudence" implies not only "caution" and "due-diligence" but more broadly, the capacity for judging in advance the consequences of one's actions and decisions. Without a thorough understanding of the issues raised below, "prudent" action and decision-making are impossible.

Re: Proposed "**Carve out [of] Pharmacy Uniform Benefit language from the GHIP Agreement.**"

- Would a "de-linked" and "carved-out" pharmacy health plan **STILL** be subject to Federal Affordable Care Act (ACA) coverage requirements and non-discrimination protections? (For example, would ACA's list of required "essential health benefits" still apply? What about ACA's protections for "pre-existing medical conditions" or current prohibitions on charging women higher premiums than men?)

- Would it **STILL** be subject to Wisconsin-mandated health benefit requirement? [Note: Fully- insured HMO plans fall under the jurisdiction of Wisconsin's Office of the Commissioner of Insurance (OCI) and, for that reason, must provide state-mandated benefits. In contrast, "self-insured" health plans—including all "Medicare Advantage" and "Medicare Plus" plans--are not governed by Wisconsin's OCI and are not required statutorily to provide state-mandated health benefits.]

- What would happen to the "Medicare-wrap"/supplement pharmacy benefits currently guaranteed to all "Medicare-retirees" enrolled in one of the "fully-insured,"Medicare Prime (**Original Medicare**) UBD, HMO health plans? These pharmacy benefits augment those provided by Navitus' MedicareRX plan.

Re: Proposed "**Remov[al] of all out-of-pocket limits (OOPLs) for drugs**" for all GIB group health plans (except HDHP plans) so that "all covered drug costs would accrue to the federal maximum out of pocket limit (MOOP)."

- Clearly, Federal MOOPs are higher than pharmacy-linked OOPLs for all GIB, UBD group health plans, the question is how much higher? How much more burdensome will this proposed "shifting" of pharmacy expenses onto active and retired government workers be?

- What are "all" of the drug-related OOPLs being considered for elimination? (For example, will the "maximum $200-dollar limit" on a patient's "co-insurance" liability for EACH purchase of a "Tier 3" drug be preserved?)

- What are current "federal maximum out of pocket limits" (MOOPs) for individual-level ("self-only") and family-level ("other-than-self-only")? Do they mirror ACA's MOOPs for "essential health benefits," which encompass both medical and pharmacy patient costs, and which are set during CY2018 at **$7,340** for "self-only" and **$14,700** for "other than self-only" contracts?

- What are the OOPLs for annual drugs deductibles for the roughly, 98% of GIB program participants enrolled in one of the fully-insured, comprehensive, UBD, group health plans? Are these not $600 for individuals and $1200 for families? And only $340 for Medicare-retirees?

- What about cumulative annual OOPLs for Tier 1, 2 and 4 drugs? GIB members should require, at a minimum, separately aggregated, dollar-figures for the OOPLs expenses borne by STATE-BASED "Medicare", "pre-Medicare-age retirees" and "active employees" for the three largest HMO plans in GIB's program dating back to 2014 in the program. CY2014 was the last year in which smaller, dollar-denominated, drug-tiered, co-pays (ranging between $5-$35) were used. CY2015 was the year in which Segal Consulting switched these to much larger and less transparent "co-insurance" co-pays for pharmacy benefits. Without any concrete "dollar figures" to determine the "scale" of policy change currently being considered, GIB members are working in the dark. No responsible or prudent fiduciary decisions can be made.

- What is the concrete basis of the "drug price" used to determine plan member "co-insurance" liabilities? Does this "price" represent the true, "net cost" of each drug after **ALL** manufacturer rebates from pharmaceutical companies calculated into it? Or is this "drug price" artificially inflated in ways that require patients to pay a larger co-insurance costs than the final cost of the drug to Navitus and its insurers? Drug rebates may come in many forms, including Medicare Part D subsidies and "Special Help" discounts for impoverished plan members.

- How are year-ended, volume-indexed pharmaceutical rebates channeled through Navitus and ETF to benefit plan members? Are they deposited into <u>any</u> ETF trust fund? If so, which one? Or are they split in some way between Navitus and ETF, as an arm of the State? How is any of this money cycled actually cycled back to benefit of "Medicare retirees" themselves?

- Has ETF staff deemed "confidential" any portion or Appendix of any Navitus' PBM and Medicare RX contracts with the GIB Program UBD health plans? If so, have <u>all</u> GIB members been given access to them? Do any such "confidential" segments govern pharmaceutical company rebates?

Re: Proposed **"Removing of copay maximums and increasing OOPL for Medicare RX,"** with the intention to **"move a Medicare RX member into the Medicare Part D catastrophic coverage phase sooner, in order to take advantage of greater subsidies"**

- Both ETF staff and Segal Consulting acknowledge that Medicare-retirees pay 100% of their health insurance premiums with their own monies. (They also pay separate monthly premiums for medical (Part B) and pharmacy (Part D) coverage directly to Medicare.) Segal Consulting also acknowledges that the total "net ETF cost" of medical and pharmacy benefits for "Medicare-retirees" is zero dollars, as determined by Segal Consulting, GIB's actuary. (See *Attachment B*).

- If the total health insurance cost of "Medicare-retirees" is "cost neutral" with respect to ETF and the State, what possible benefit can come from magnifying the "out-of-pocket" drug costs for Medicare-retirees, many of whom have been experiencing stagnant or shrinking WRS pension payments? What is to be gained by whom?

- How would pushing "Medicare-retirees" more rapidly into "Medicare Part D catastrophic coverage" benefit them? Would it not require "front-loading" many thousands of dollars in added drug-related "deductibles," "co-pays" and "co-insurance" expenses onto all of them? Since they already pay 100% of their premium costs, imposed no "net ETF cost" and, indeed, bring in tens of millions of dollars of federal subsidies and manufacturer discounts and rebates into ETF each year, how is this a "fiduciarily responsible" option?

- Finally, why consider such a massive shifting of the actual or real drug costs onto Medicare retirees for CY2019, when the "donut hole" separating Medicare's "initial drug coverage phase" from the "catastrophic coverage phase" will close completely at the end of 2020? (See *Attachment C*)

- This is important because "Medicare" pays first, before "retiree insurance" (insurance from your or your spouse's former employment). (See *Attachment D*)

Re: One very important difference between "ORIGINAL MEDICARE" RETIREE INSURANCE PLANS and "MEDICARE ADVANTAGE" RETIREE PLANS operating in the State of Wisconsin.

- "Medicare Advantage Plans are not regulated by the State of Wisconsin, Officer of Commissioner of Insurance (OCI). Therefore, these plans are NOT required to cover Wisconsin mandated benefits, nor are they guaranteed renewal for life like Medicare supplement plans." (Source: State of Wisconsin, OCI-Wisconsin Guide to Health Insurance for People with Medicare—2018, see *Attachment E*)

- **What are the State-Mandated Benefits that Medicare Advantage plans are NOT required to provide?** (Source: State of Wisconsin, OCI--Wisconsin Guide to Health Insurance for People with Medicare—2018, see *Attachment* F)

These include:

1. Up to 30 days coverage for **Skilled Nursing Facilities**
2. Up to 40 days of **Home Health Care** per year
3. Up to $30,000 in inpatient and outpatient expenses for **Kidney Disease;**
4. **Diabetes Treatment** coverage even when Medicare does not cover a claim
5. Medically necessary **Chiropractic Care**
6. **Hospital and Ambulatory Surgery Charges for Anesthetics for Dental Care**
7. **Breast Reconstruction**
8. **Colorectal Cancer Screening**
9. **Coverage of Certain Health Care Costs in Cancer Clinical Trials**
10. 80% coverage for **Catastrophic Prescription Drugs** (after a deductible of no more than $6,250 per calendar year) for Medicare beneficiaries who do not enroll in Medicare Part D but had obtained supplemental coverage prior to January 1, 2006.

Medicare Advantage Plans also have the "disadvantage" of "not being guaranteed for life like Medicare Supplemental Plans"—such as all fully-insured, UBD, HMO plans. Moreover, Medicare Advantage" plans "can terminate at the end of any contract year if either the plan or CMS decides to terminate their agreement." (See earlier *Appendix C* and *Appendix G*)

- Is the ultimate aim—as earlier advocated by Segal Consulting in its March and November 2015 Reports—to eliminate all HMO Original Medicare health plans from the program and thereby, force all state "Medicare-retirees" to enroll in some form of "Medicare Advantage Plan"—**on pain of forfeiting their entire sick-leave accounts?**

- A few years ago, ETF declared that any retired state worker who FAILS to maintain continuous enrollment in one of the health insurance plans offered through GIB's program AUTOMATICALLY forfeits all rights to his or her remaining "sick-leave" account balance! These EARNED BENEFITS can involve many tens of thousands of dollars. *[Note: The unused sick-leave/vacation benefits of some local government workers, in contrast, are calculated and transferred upon retirement into individually controlled, health-insurance premium investment account owned by the retiree.]*

- Will State "Medicare-retirees" face the choice of sacrificing the right to "Original Medicare" or sacrificing their rights to their sick-leave account? Or will GIB members

safeguard the right of age-65+ retirees to choose or retain “original Medicare” coverage by preserving one or more fully-insured, “Medicare Prime,” UBD group health plan options in every geographical region?

Thank you for your attention to these issues.

Respectfully,

Dr. S. E. Hutchinson

Publicly available email address: sehutchi@wisc.edu

Electronically Linked State Government Sources for Appendices A – G

A. http://etf.wi.gov/boards/agenda-items-2018/gib0221/item4b.pdf, pages 6-7.
B. http://etf.wi.gov/boards/agenda-items-2015/gib0325/item4c.pdf & http://etf.wi.gov/boards/agenda-items-2015/gib0325/item4c.pdf
C. https://oci.wi.gov/Documents/Consumers/PI-002.pdf, page 9.
D. Paper only: Please see “Medicare & You 2018, U.S. Dept. of Health and Human Services, Centers for Medicare and Medicaid Services, Official US Government Handbook for Wisconsin Residents, page 24
E. https://oci.wi.gov/Documents/Consumers/PI-002.pdf, page 15.
F. https://oci.wi.gov/Documents/Consumers/PI-002.pdf , page 20-21.
G. https://oci.wi.gov/Documents/Consumers/PI-002.pdf, page 14