From:	Rob Gundermann
To:	ETF SMB Board Feedback
Subject:	Navitus' Copay-Max Plus Program
Date:	Tuesday, May 16, 2023 2:40:11 PM
Attachments:	WI ACCC Letter to Group Insurance Board .docx FEHB Letter 03.01.23.pdf

---

CAUTION: This email originated from outside the organization.
Do not click links or open attachments unless you recognize the sender and know the content is safe.

Please find attached our letter opposing Implementation of Navitus' Copay-Max Plus Program as well as the FEHB Program Carrier Letter 2023-04 from the U.S. Office of Personnel Management Healthcare and Insurance. Maximizer / Accumulator language is located on page six of the document.

Thank you for you time and consideration,

Rob Gundermann

--

Robert M. Gundermann
President and CEO
Coalition of Wisconsin Aging & Health Groups
30 West Mifflin Street, Suite 406
Madison, WI 53703
www.cwag.org

FEHB Program Carrier Letter
All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter Number 2023-04

Date: March 1, 2023

Fee-for-service [4] Experience-rated HMO [4] Community-rated HMO [4]

Subject: Federal Employees Health Benefits Program Call Letter

Submission of Proposals

This is our annual call for benefit and rate proposals from Federal Employees Health Benefits (FEHB) Program Carriers. This letter sets forth the policy goals and initiatives for the FEHB Program for 2024. You must submit your benefit and rate proposals for the contract term beginning January 1, 2024 on or before May 31, 2023. OPM expects to complete benefit negotiations by July 31 and rate negotiations by mid-August to ensure a timely Open Season. As a reminder, Call Letter responsiveness is evaluated by your Contracting Officer as an element of Plan Performance Assessment (PPA).

FEHB Program Benefits and Initiatives

OPM's focus for the upcoming plan year are on the following critical Program priorities: Fertility Benefits, FEHB and Medicare Coordination, and Pharmacy Benefit Design. Recognizing that several Biden-Harris Administration initiatives from the 2023 plan year will span beyond one plan year and that there may be more action that Carriers can take on these initiatives, OPM is continuing to emphasize the importance of Gender Affirming Care and Services, Maternal Health, Prevention and Treatment of Obesity, and Mental Health and Substance Use Disorders.

We also remain committed to reducing pharmacy costs and, in particular, are encouraging FEHB Carriers to focus on managing specialty prescription drug costs, which have experienced a high-cost growth rate across the industry. The annual Consolidated Pharmacy Benefits Guidance for the FEHB Program with comprehensive information about the pharmacy benefit was recently released. Carriers must comply with this guidance when preparing proposals.

We continue to require cost neutrality as outlined in Carrier Letter 2019-01 with the exception of Fertility Benefits, as noted under Section I, below.

I. Fertility Benefits

Fertility Benefit Requirements

OPM continues to support fertility benefits for FEHB enrollees and their eligible family members. As of June 2022, there are 20 states that have passed fertility insurance coverage laws and as in prior years, OPM has been monitoring state efforts. In addition, there continues to be a steady, upward trend among large employers in offering various coverage options for Assisted Reproductive Technology (ART) and other fertility treatments. Recent studies have shown that large employers report coverage of a wide array of fertility benefits. Increasing numbers of large employers offer an evaluation by a reproductive endocrinologist or infertility specialist, and many provide additional coverage beyond an evaluation. There has been an upward trend in large employers who cover infertility services such as drug therapy, intrauterine insemination, in vitro fertilization (IVF), and egg freezing.[1] The cost of an IVF cycle can range from $15,000 to $30,000 with medications accounting for up to 35 percent of the total cost, making coverage of drugs a meaningful contribution to overall cost.[2] OPM strongly supports the provision of benefits that will help enrollees build their families and recognizes the valuable role ART and other fertility benefits play in

[1] "2021 Survey on Fertility Benefits." Mercer.
[2] "How Much Does IVF cost?" Forbes, 23 January 2023.

recruitment and retention. As a result, the following are **requirements** for Plan Year 2024:

- Carriers are required to provide coverage of artificial insemination (intrauterine insemination, intracervical insemination, and intravaginal insemination). This requirement to cover artificial insemination does not include a requirement to cover donor sperm.

- Carriers are required to cover drugs associated with artificial insemination procedures.

- Carriers are required to cover the cost of IVF-related drugs for three cycles annually to defray the overall cost of IVF cycles for FEHB enrollees.

- The 2015 Call Letter and supporting 2015 Technical Guidance stated that brochures should include a definition of infertility and clearly describe how members qualify for any available diagnostic and therapeutic infertility benefits. Currently, many brochures do not make the plan's definition of infertility and qualifications for these benefits easily apparent. Carriers must provide a definition of infertility and qualifications for these benefits in an easily accessible manner in their brochure, website, and other consumer-facing materials.

- Applicable medical policy related to infertility coverage must also be easily accessible to members on each Carrier's website.

We encourage FEHB Carriers to consider offering benefits beyond the above requirements. FEHB Carriers will be permitted to propose cost sharing and other benefit maximums (e.g., number of attempts).

A waiver to the cost neutrality requirement will be considered for proposals of coverage outlined above.

Affinity Benefits

In addition to the Plan Year 2024 requirements outlined above, OPM continues to strongly encourage FEHB Carriers to provide members with access to discounted or negotiated rates for non-covered ART procedures as previously referenced in Carrier Letter 2022-03. This information should be available on a CPT-code basis and described via the affinity benefits shown on the non-FEHB page of the plan brochure.

II. FEHB and Medicare Coordination

FEHB and Medicare Part D Prescription Drug Coordination

OPM announced in Carrier Letter 2023-02 that it will entertain proposals that allow FEHB Program members to benefit from Medicare Part D coverage by enrolling in Carriers', or their affiliated sponsors', CMS-approved Medicare Advantage Prescription Drug Plan Employer Group Waiver Plans (MA-PD EGWPs) or Prescription Drug Plan Employer Group Waiver Plan (PDP EGWPs). For years, FEHB Program members have already benefited from similar arrangements Carriers have effectuated with MA-PD EGWPs.

FEHB Program members are not required to enroll in Medicare. For the Medicare group products (MA-PD EGWPs) that Carriers have made available to FEHB Program members to date, members have been given a choice prior to enrollment in the Medicare product to receive the additional, enhanced coverage. We will now entertain proposals that feature automatic group-enrollment for PDP EGWPs. If you make such a proposal there should be a seamless, customer-friendly approach to allowing the affected members to opt-out of the enhanced Medicare product, if they so choose. If you utilize automatic group-enrollment, you must comply with all of the requirements for group enrollment contained in CMS guidance, including those requirements contained in the PDP Enrollment and Disenrollment Guidance. Your proposal should recognize the potential effect to your members caused by the Income Related Monthly Adjustment Amount (IRMAA) premium required from certain individuals. You must fully describe your strategy for

educating members, processing enrollments, and providing customer service before, during, and after enrollment to these individuals.

FEHB Program members who have Medicare, or any other primary coverage, must not receive reduced FEHB benefits based on the added coverage. Your members for whom Medicare is primary must receive coverage equal to or greater than the coverage they would have received without Medicare. These parameters must be followed when filing your MA-PD EGWP or PDP EGWP product and when examining the waivers offered by Medicare.

We will provide information in the Technical Guidance on how to submit your proposal regarding EGWP coordination and what we expect to see in your proposal related to CMS approval documentation including, but not limited to, the formulary that annuitants will have access to under these plans and the cost sharing you will propose.

Coordination of Benefits – Medicare Part B vs FEHB drugs

OPM requires that Carriers coordinate benefits for FEHB members that have other healthcare coverage, including Medicare Part B. Approximately 75% of FEHB annuitants who are eligible for Medicare are currently enrolled in Medicare Part B. Medicare Part B covers outpatient physician services including drugs that are typically administered by a physician in an office setting. Medicare Part B also covers some drugs available in the outpatient pharmacy setting such as immunosuppressant drugs, some anti-cancer drugs, some anti-emetic drugs, and some dialysis drugs. In such instances, existing technology allows a Carrier to electronically coordinate benefits in real time and determine which insurer is the primary payer.

OPM expects FEHB Carriers to coordinate drug coverage for FEHB annuitants and covered family members with Medicare Part B.

III. Pharmacy Benefit Design

Copay Maximizer/Optimizer or Similar Programs

In the past few years, FEHB Carriers have approached OPM asking to integrate copay maximizer or optimizer programs in their plan offerings. These programs require a deviation in the prescription drug benefit design to capture savings from manufacturer non-needs-based copay assistance. Under 5 U.S.C. 8902(d), each FEHB contract "shall include such maximums, limitations, exclusions, and other definitions of benefits as [OPM] considers necessary or desirable." OPM has declined offering these programs in the FEHB Program and **will not** entertain any proposals that manipulate the prescription drug benefit design, or incorporate copay maximizer or optimizer programs, or other similar programs to capture such savings.

Programs that eliminate or bypass the copay/coinsurance maximums negotiated as protections in the benefit design are not in the best interest of the enrollee or the Federal government. Negative member impacts may occur midyear if a manufacturer's copay assistance is discontinued or modified, leaving the member with unanticipated out-of-pocket costs.

Manufacturer non-needs-based copay assistance programs are available to FEHB enrollees without third party intervention, so FEHB enrollees will still have access to copay assistance programs.

Finally, transparency is a requirement of the FEHB contract. All contracts, agreements, documentation, or other evidence related to the pharmacy benefit design and costs must be available without redaction to Healthcare and Insurance staff for oversight purposes and are subject to audits by the Office of the Inspector General. A lack of access to the underlying contracts or other arrangements with third-party vendors does not satisfy the FEHB pass-through transparency requirements outlined in the contracts between the Carrier and OPM.

IV. Advancing Biden-Harris Administration Priorities

Portions of our 2022 Call Letter for the 2023 plan year focused on several Biden-Harris Administration priorities. FEHB Carriers should continue their focus on these important initiatives.

Gender Affirming Care and Services

Executive Order 14035 directs OPM to promote equitable healthcare coverage and services for enrolled LGBTQ+ employees and their covered family members through the FEHB Program. Specific to gender affirming care and services, recent Carrier Letters (2021-05, 2022-03, and 2022-04) emphasize the importance and expectation that Carriers remain current in their medical policies such that coverage decisions reflect up to date standards of care.

FEHB Carriers should review updated information from recognized entities such as the World Professional Association of Transgender Health (WPATH), the Endocrine Society, and the Fenway Institute for changes and adjust their medical policies accordingly. For example, WPATH released its Standards of Care Version 8[3] (SOC 8), updating the previous version from 2012. Carriers should pay specific attention to:

- Reduction in the number of required evaluation letters for initiation of treatment;
- Medical necessity of facial gender affirming surgery;
- Gender-affirming hormone therapy; and
- Health care workforce cultural-awareness training.

Maternal Health

FEHB Carriers should continue efforts related to Maternal Health referenced in Carrier Letter 2022-03. In June 2022, the Biden-Harris Administration released the White House Blueprint for Addressing the Maternal Health Crisis

[3] This link may not be accessible if using a Virtual Private Network (VPN). OPM recommends accessing it while not on VPN.

("Maternal Health Blueprint"). As referenced initially by OPM in Carrier Letter 2022-03 (p.3-5) and Carrier Letter 2022-04 (p.18-21), several efforts were reinforced in the Maternal Health Blueprint and should be prioritized for any additional action in the 2024 plan year. Additional information and updates related to these efforts will be released in the Technical Guidance.

Prevention and Treatment of Obesity

Released to FEHB Carriers on January 19, 2023, Carrier Letter 2023-01 provides updates and supplemental guidance on OPM's approach to the prevention and treatment of obesity. Carriers are expected to cover the full extent of the United States Preventive Services Task Force (USPSTF) recommendations addressing adults, children and adolescents, and pregnant women, which are consistent with the Biden-Harris Administration's National Strategy for Hunger, Nutrition, and Health. Nutrition and physical activity supports are essential components of a comprehensive benefit to prevent and treat obesity and remain necessary when applying pharmacologic and surgical treatments of obesity. Carriers are also expected to evaluate and update their coverage of anti-obesity drugs and provide access to a range of obesity drugs on their 2024 formulary. This coverage includes drug therapies indicated for adolescents age 12 years and older. Carriers are reminded to promptly adjust their criteria for metabolic surgery to reflect the most current guidelines such as those from the American Diabetes Association (adults and children/adolescents), the American Academy of Pediatrics (AAP), and the American Society for Metabolic and Bariatric Surgery. Plan proposals are expected to reflect these adjustments.

Mental Health and Substance Use Disorders

Mental Health: Network Adequacy

Carrier Letter 2019-01 strongly encouraged Carriers to improve access to and availability of mental health treatment. As noted in Carrier Letter 2022-03, Carriers should ensure adequate payment and access to providers for mental health services, including employing strategies suggested in the U.S. Surgeon General's Advisory on Protecting Youth Mental Health for pediatric

mental health services, investing in innovative payment models for integrated and team-based care, increasing the participation of mental health professionals in insurance networks, and ensuring compliance with mental health parity laws.

These strategies align with those listed in previous Carrier Letters as we address access concerns and known Health Professional Shortage Areas for Mental Health Services. In summary, Carriers should:

- Promote integration of mental health and primary care;
- Expand mental health provider networks;
- Utilize reimbursement models that integrate health, mental health and substance use disorder care, such as the Collaborative Care Model;
- Cover services provided by out-of-network providers at in-network rates when needed to provide timely access to specialized care; and
- Continue compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), including conducting comparative analyses of the design and application of non-quantitative treatment limitations (NQTLs) as previously noted in Carrier Letter 2021-16.

Mental Health: Addressing Mental Health in Youth

In Carrier Letter 2022-03, OPM highlighted the increasing incidences of mental health challenges and substance use disorders throughout the Coronavirus disease 2019 (COVID-19) pandemic. This concern, particularly about youth, continues. FEHB Carriers should ensure they are providing comprehensive mental health and substance use disorder benefits to meet these needs. Two USPSTF recommendations pertaining to mental health were released in October 2022: Depression and Suicide Risk in Children and Adolescents, and Anxiety in Children and Adolescents: Screening. FEHB Carriers should ensure that treatment options such as psychotherapy, pharmacotherapy, a combination of both, psychosocial support

interventions, and complementary and alternative medicine approaches are available, dependent on the diagnosis. Both screening recommendations are rated “B” and beginning in 2023 must be provided with no cost sharing, consistent with Carrier Letter 2022-03. To ensure parity, diagnosis and treatment cost and reimbursement models must align with medical and surgical benefits.

Substance Use Disorders

New guidance released by the Centers for Disease Control and Prevention (CDC) expands and updates the previous guidelines issued in 2016. OPM is asking FEHB Carriers to review the new CDC Clinical Practice Guideline for Prescribing Opioids for Pain and adjust their medical policies accordingly. Additional information and guidance will be provided in the Technical Guidance.

V. Technical Guidance

The 2023 Technical Guidance will provide detailed guidance on the initiatives described in this Call Letter, as well as guidance on submission of benefit and rate proposals and preparation of brochures.

Conclusion

OPM appreciates your attention to these important initiatives that allow us to serve our more than 8 million Federal employees, annuitants, their family members, and other eligible persons. Continuous open and effective communication between OPM contracting staff and FEHB Carriers should occur to ensure a smooth and successful negotiation cycle. Please discuss all proposed benefit changes with your Health Insurance Specialist.

We look forward to the negotiations for the upcoming contract year. Thank you for your commitment to the FEHB Program.

Sincerely,

Laurie Bodenheimer
Associate Director
Healthcare and Insurance

May 9, 2023

Group Insurance Board
c/o Board Liaison
Wisconsin Department of Employee Trust Funds
PO Box 7931
Madison, WI 53707-7931

RE: Oppose Implementation of Navitus' Copay-Max Plus Program to Protect Wisconsin Patients

Members of the Group Insurance Board (GIB):

On behalf of the Coalition of Wisconsin Aging and Health Groups and the Wisconsin All Copays Count Coalition, we write to express our sincere concerns with the Navitus' Copay-Max Plus Program that the Group Insurance Board (GIB) is considering as part of proposed 2024 benefit changes for state employees and retirees. This program would threaten prescription drug affordability and access for vulnerable patients across our great state and build upon the harmful practices that Wisconsin health plans and pharmacy benefit managers (PBMs) use to degrade copay assistance.

On May 17, the Coalition of Wisconsin Aging and Health Groups and the Wisconsin All Copays Count Coalition urges members of the GIB to vote against the implementation of Navitus' Copay-Max Plus Program in the 2024 state employee and retiree health plans in order to protect Wisconsin patients.

In February, Governor Tony Evers included this critical "All Copays Count" legislation in his 2023-2025 Executive Budget Bill, highlighting the importance of copay assistance. This is the third time the Governor has included a ban in his budget proposal. **The Copay-Max Plus Program is in direct contrast to the Governor's proposal.**

This March, a bipartisan coalition of Wisconsin lawmakers introduced the "All Copays Count" legislation (AB 103 and SB 100) to improve patient access and affordability to prescription medications. This bipartisan legislation that has the support of nearly 50 co-sponsors in the legislature and nearly 50 patient and provider advocacy groups. **The Copay-Max Plus Program is in direct contrast to the Legislature's proposal.**

17 states have adopted copay accumulator bans and several other states (including Texas, Missouri and Colorado) are on pace to join them by the end of June. **The Copay-Max Plus Program is in direct contrast to the direction other states are going.**

Patients rely on copay assistance to access their medically-necessary medications, especially where no generic alternatives exist for their condition. Yet in Wisconsin, nothing stops insurance plans and pharmacy benefit managers (PBMs) from implementing "copay maximizer policies," such as the Copay-Max Plus Program. Copay maximizers take advantage of drug manufacturer coupons and copay assistance programs applied to many high-cost drugs at the expense of patients. Under the proposed program, the health plan determines the patient's copay based on the maximum amount of manufacturer copay assistance available to them, rather than on the list or net price of the medication. Enrollees may then be required to enroll in copay assistance in order to gain access to needed medication. By implementing this policy, the health plan receives the entire possible amount of copay

assistance, but this copay assistance does not count towards the individual's deductible or annual out-of-pocket limit, meaning the patient does not receive the intended benefit of the assistance.

There are no rules governing how copay maximizers are structured, and health plans can change them at will. The use of maximizer programs has also led to some health plans adopting a more aggressive definition of essential health benefits (EHBs), in order to maximize the patient's copay assistance. When insurers create barriers to treatment access, patients often skip doses or abandon treatment entirely, worsening individual health outcomes and increasing overall health care system costs.

The Coalition of Wisconsin Aging and Health Groups and the Wisconsin All Copays Count Coalition encourages members of the GIB to oppose implementation of Navitus' Copay-Max Plus Program in the 2024 state employee and retiree health plans and stand with patients and their physicians in helping those with chronic and complex conditions access the treatments they need to live a healthy and productive life.

Thank you for your leadership and continued commitment to Wisconsin communities.

Sincerely,

Rob Gundermann
President and CEO, Coalition of Wisconsin Aging and Health Groups
Chair, Wisconsin All Copays Count Coalition

More information about copay maximizers and the *Wisconsin All Copays Count* Coalition can be found at: https://www.wi4patients.com.