April 8, 2025
Commission on Government Forecasting and Accountability
Group Insurance Meeting

Co-Chair Davidsmeyer: Good morning, everyone. I'd like to call the meeting of COGFA today to order. If we can start with the clerk calling the roll.

(Clerk) Eight members present

Davidsmeyer: Thank you. And we do not need, we're not taking any votes today, so we do not need a quorum, but we do have one, so that's good. We're going to go ahead and start with bringing up CMS, CMS Director Raven DeVaughn. And I want to start by thanking you for meeting with COGFA staff and being very easy to work with. Your staff and everybody has been good to work with, so thank you very much.

Director DeVaughn: Thank you. Good morning. Thank you, co-chairs Koehler and Davidsmeyer and members of the commission. My name is Raven DeVaughn, and it is my absolute honor to serve as director of the Illinois Department of Central Management Services. CMS has an essential role in delivering critical services to a broad spectrum of stakeholders, including state agencies, boards, commissions, and even local municipalities. Among our most fundamental responsibilities is providing comprehensive health care coverage to employees, retirees, and their eligible dependents within the State of Illinois government and university systems. Our dedication to providing reliable health services highlights our commitment to the well-being and vitality of both our workforce and the wider community. CMS oversees broad

health care administration and management portfolio covering more than 466,000 lives. We are continually striving to offer comprehensive support that enhances the well-being of our state's employees and retirees while also reducing operational burdens and minimizing taxpayer costs. Right now, much of that support is centered on helping our members who are currently covered by Health Alliance navigate their next steps as Health Alliance made the independent business decision to exit the insurance marketplace at the end of this calendar year. Having been a vendor with the state in excess of 30 years, the Health Alliance Plan has approximately 64,000 subscribers within the state. These members include a mix of employees, retirees, and dependents. They're impacted by the market exit and will be required to select a different health care plan during this year's upcoming open enrollment period, which will run from May 1st, 2025 through June 2, 2025. With customer service and transparent communication at the forefront of our work at CMS, within 24 hours of being notified of Health Alliance leaving the marketplace, CMS updated our website to notify members that we were aware of the change and communication would be forthcoming regarding the transition. We developed and have been executing a strategic communication plan to ensure affected members are aware of their options and the associated timelines. Members received correspondence to include a robust FAQ outlining next steps via postal mail and email where an email address was provided. We are also sending out postcards starting next week to members as well. In-person and virtual seminars will be held all four weeks in May throughout the state. Typically, we only do the first three weeks because folks have usually made decisions, but we're trying to expand that to ensure we reach as many folks as possible. So members can learn more and ask questions during the benefit choice open enrollment period. We also created a micro-website. dedicated

to current Health Alliance members, which house the FAQ and other important information regarding this change. My team and I have met with legislators with high numbers of affected members and provided our communication plan. Finally, during open enrollment, we will send weekly reminders to every employer slash agency, providing updates on the number of members whose open enrollment remains incomplete. So the employer, or the agency, can support in engaging affected members. We know the importance of choice and we are working to ensure members have ample time and information to choose their next health plan. That is why we are leveraging such an aggressive communication plan. It's important to note that members who have Health Alliance will need to select a different plan during open enrollment, if no selection is made, members will be put in the default health plan. New benefits will be effective July 1st, 2025. As we reflect on the fiscal year 2025 and look ahead to fiscal year 2026, CMS continues to prioritize our mission of providing exceptional health care while managing costs within the market. Through the State Employees Group Insurance Program, CMS strives to provide quality health, prescription, vision, dental, and life benefits to over 375,000 members in the most cost-effective manner possible. Although the program has seen relatively stable costs in recent years, fiscal year 2025 saw a sizable growth in program costs. These cost increases are expected to continue into fiscal year 2026, driven in part by recent prescription drug trends, the post-COVID return to elective procedures, and overall healthcare inflation being experienced by the entire industry. Despite recent increases in costs and this major change in our health plan market, CMS remains dedicated to providing best-in-class health coverage options and delivering effective, cost-efficient, and high-quality service to all employees and members we serve. This includes offering programs and championing initiatives that are ensuring

health and well-being of our members are at the forefront. In 2024, 3% more members participated in colon cancer screenings compared to 2023 through the Be Well Illinois program. The returned test kits resulted in a 5% positivity rate. This early detection saves lives and lessens the need for intense treatment, resulting in an additional $96 million in cost avoidance. We've also expanded our CMS health support initiatives by offering webinars and resources which thousands of members have utilized. Additionally, more than 14,000 members enrolled in their health plans lifestyle management program during 2024 to assist in their journey toward weight loss or glucose improvement proves that these activities are helpful. Ultimately, CMS remains dedicated to providing strong health services. We are committed to supporting the well-being and vitality of both our workforce and the wider community. Today, I'm joined by Deputy Director of CMS Benefits, Carrie Wolf, and Benefits Finance Manager, Colm Brewer, to my right, along with other members of my senior leadership team in the audience. Thank you for the opportunity to speak before the Commission today, and we're happy to take any questions you may have.

Davidsmeyer: Thank you, Director. Do we have any questions? Senator Koehler?

Co-Chair Koehler: Thank you, Director, for your report, for being here. You answered one of my questions, and that was knowing that you sent a lot of correspondence out to all the folks that are covered under Health Alliance, there still may be some that fall through the cracks and don't sign up on time. So there is a default. And, who is that, and how do you determine that?

DeVaugn: So that is, is that still being, it will be the Aetna PPO.

Koeher: Okay. All right. So I'll speak of myself. I'm a Health Alliance, you know, enrollee right now. I've enjoyed them for all the time I've been in the Senate. I'm sorry to see them leave the market. Will any members be caught in any pre-existing condition things? I've got knees, total knee replacement surgery due in early June. Now, that makes me a little nervous. So, is Health Alliance going to cover it all the way through, and is my new plan going to pick it up?

DeVaugn: So, that's a great question. One, we hope the surgery goes well. Two, you're having surgery early June. Let's take your surgery out of it. Let's say something happened June 29th. and you had Health Alliance and you were in coverage, Health Alliance is still required to provide service to you until such time that your physician gives you the okay to move either out of some sort of recovery, like rehab care. So it's not the date switched and then things are different. They have to statutorily provide or contractually provide service to you until such time your doctor has given you the permission, has released you from that service so you will be okay presumably that you are not in rehab or any sort of thing but regardless if you if something goes differently than we expect you will still be covered until such time you're released from your doctor's orders and that's across the board no matter who you are.

Koehler: Will you have a phone number or somebody that can answer the phone in case I mean with 64,000 covered lives out there. There's going to be somebody that falls through the cracks at some point or has a question. Who do they call?

Carrie Wolf, Deputy Director, CMS Benefits: Health Alliance will continue to basically provide services to members. They are continuing to answer questions. Specific questions regarding continuing care for procedures and things like that are best addressed to them to determine what the status of those will be as far as pre-authorizations and things like that.

Koehler: Is there somebody in your office, though, say that I don't have satisfaction with that. Do you have a backup that I can call?

Wolf: Yes, our Benefits and Claims Support Unit is available to address any questions for members, and they will work with the carrier to make sure that any claims are being addressed within accordance of the contract.

Koehler: And myself and other members won't get caught up in...Switching plans and having them pre-authorization problems catch up with us. I mean, if you've been pre-approved for what we have now, does that carry over?

Wolf: No. If you've been pre-approved for a service currently and you have to switch carriers, I believe you will have to get a pre-authorization from your new carrier. So I'm sure your new carrier would work with you to ensure that that is done, but all of that is handled through our carriers. We do not handle that in-house.

Koehler: Again, if there's any problems with that, I mean, I've already talked to the group that I'm going to choose next, but if there's any issues, then do you still have, you know, a backup as a phone number or somebody that I can talk to?

Wolf: Yes.

Koehler: And that'll be publicized, you know, throughout all the folks that are making the switch?

Wolf: Yes, our phone number is in the FAQ for our My Benefits Center. In addition, we can add, we will add our internal 800 number where they can reach us to future communications.

Koehler: Okay. All right. Well, I just, I feel a little better now. Thank you.

Davidsmeyer: Thank you, Senator DeWitte.

Senator DeWitte: Thank you, Mr. Chairman. Welcome. I just had one quick question, kind of a look back. One of the most significant increases in this year's budget for health care was the approval of semaglutide drugs that were eventually, after many questions, eventually approved purely for weight loss purposes. These drugs initially were researched and designed to deal with type 2 diabetes issues, which brought on weight loss issues, but eventually the program was approved purely for weight loss. What kind of means testing has been put into place through CMS to warrant whether someone truly is in need of weight loss drugs to reduce what are obvious health benefits related to carrying too much weight? As opposed to the person that simply wants to drop 10 or 20 pounds to get into the suits they bought a year ago.

DeVaughn: So if a member is seeking GLP-1 drug, there are a couple different pathways. One, if you are being prescribed for diabetes, and

you meet the requirements of the drug, it will be approved. If you are seeking that drug for other purposes, weight loss with a comorbidity, you have to participate in a lifestyle management program that all of the carriers have deemed. So that ranges from whether or not you're meeting with a nutritionist regularly, you have to input your body metrics, meaning your weight, You have a number of, I call them gadgets. They might send you a scale, like a smart scale, or you get the opportunity for some sort of fitness tracker to be able to see where you're going in terms of your usage with those drugs. So those are in place to ensure that the drugs are being used for the purpose of ensuring that we're cost-avoiding other issues in the future.

DeWitte: Okay, so just to clarify, a diagnosis of a comorbidity related to excessive weight is required for the prescription to be approved and paid for?

Wolf: Not necessarily. The FDA requires that an individual has to have a BMI of 27 with a comorbidity in order to, that's the indication on the drug itself. If an individual has a BMI of 30 or more, no comorbidity is required for that individual. But they do have to meet those indications for use of the drug that was established by the FDA.

DeWitte: So which is it? Is it the BMI with a comorbidity or?

Wolf: It depends on what your BMI is. You have to have a certain BMI in order to be eligible for the drug. If it is between 27 and 30, you have to have a comorbidity. If it is 30 or more, there is no comorbidity required.

DeWitte: Okay. That's not high. 27 to 30 is not considered, I wouldn't consider. In my layman's interpretation of BMI, it's not obese.

Wolf: 27 is considered obese.

DeVaughn: Those are FDA requirements.

DeWitte: Okay. Okay, thank you.

Davidsmeyer: Thank you, Senator. Can we add Representative Weaver? Senator Syverson?

Senator Syverson: Thank you. Good morning. A few questions. When we talked about the increase this year, which is slightly lower than last year, but our two-year increase is obviously the largest in history, more than any other state. What is the driving factor of why Illinois' healthcare costs are going up so much more than all the surrounding states?

DeVaughn: So, I will say, I don't know that we are more than everyone.

Syverson: We are.

DeVaughn: There are, the medical inflation is consistent across the country in terms of that percentage. There's a mix here. One, we're coming out of COVID and people are going back to the doctor doing elective procedures, things that we just didn't see. We had decreases in those deep COVID years. Two, in another committee, people complained for years that people weren't being hired at the state. And so CMS has, with the help of the Senate, we've been able to transform

how we hire. So we're adding a lot more bodies to the state's program. When I appeared first in 2023, the state's code coverage employees was at about 42,000, 43,000. Today it's 47,000. So there's an increase there. And things are costing more, and so we have to respond to it. There's no secret Illinois has a benefit-rich, statutorily advanced benefit-rich program, and we're trying to do our best to control costs.

Syverson: Well, I guess that's the point because these other states had COVID as well and these other states had problems, yet we exceeded all the other states. So, and that's, I guess that's what I'm driving to. The fact that we've passed now in the last, I think the last three years, 42 insurance mandates would have to have some impact on overall cost of care since those mandates that we passed on small business gets put onto the state plan. So have we had any kind of indication of how much of this increase is due to all the new mandated coverages that aren't out there in other ERISA-based plans?

DeVaughn: Sure. So whenever a bill is presented, we certainly do a cost analysis. And we track what we think it might cost. That is certainly part of the calculus in terms of our position on mandates and bills, and that's across the board whether or not it's benefits or any other mandate. Ultimately, once it's put into law, it's our job to administer.

Syverson: We hope as these mandates come up, knowing that the impact it's going to have on the state's plan, that CMS would weigh in more on what the impact to some of these new mandates are going to be. I know earlier this year we met with your staff and your staff was going to be opposing any of these health mandates that have cost.

And now you've changed that. Now you're not opposing all the mandated ones, which is disappointing. I don't know what the change was, or why that was, you know, why that was changed. But there is obviously an impact for that. But next question was on the different estimates between yours and COGFA on some of these cost differences. Is there a, especially for, your RX estimator, you're quite a bit different than what COGFA's estimate is. Is there a reason for that? Because it looks like you're talking about estimating your RX costs are only going to be going up by 1.6%, which is way less than the national average. How is that going to... or is it something that's driving your Rx cost to be so much lower?

DeVaughn: I'm going to ask Colm Brewer to answer that.

Colm Brewer, Benefits Finance Officer: I think the figure you're referring to is on page five of the recent COGFA report, where 11.4% is shown as the national trend. There's probably just a difference in the way that the numbers are being presented here by COGFA. The 1.6% is the relative change in the total spend for the PPO plan only, okay? I am projecting that there will be a lower number of lives in the PPO plan next year so that the overall spend, even though the underlying costs of prescription drugs, and I believe it was 11.7% was the trend that I was using for the underlying cost. But the overall spend is going to not go up as much because I expect fewer people in that program.

Syverson: Okay.

Brewer: But the difference between COGFA and CMS, you can see on that same page, is that relative to total spend, their estimate is 3.4%

compared to our 1.6%. So that would be a good component of why their liability overall is greater than ours.

Syverson: Okay. And then let's talk a little bit about the...I'm trying to wrap my head. We offer a number of plans, which is great. And the...What I'm trying to figure out is your QCHP, which is kind of your Cadillac plan. Your out-of-pocket costs for those, under that plan, the maximum out-of-pocket cost is $1,700 per individual. And your HSA plan has a $3,000 out-of-pocket difference. So that's a $1,300 difference in out-of-pocket expenditure, yet an employee who chooses to go with the HSA, the premium savings is only $480 less. When we look at how small our HSA enrollment is, and we talked a little bit about that previously, you know, I've been consulting for 30 years. We've never had a company that would disincentivize HSAs. It should be just the opposite. And when we look at the state liability costs, according to your booklet, QCHIP is $17,000 per person. Your HSA plan is $9,200 per person. You're saving almost $8,000 a year for being in the HSA. We're saving the taxpayers. And yet, it's only a $480 difference. So from a layperson, if they have more serious health conditions, they're saving $480 to get $1,300 more out of pocket. Doesn't make sense. But are we going to be looking at doing anything to change that incentive to encourage more people moving into the HSA plan where it's going to save significant dollars?

DeVaughn: Senator, i think just a couple weeks ago you and i kind of in passing talked about this. I think first step is an education gap for our members to understand what it is, HAS's are a little bit, I grew up on a HMO. I'm sure most of us if you grew up with insurance you probably had a HMO so you kind of do what your parents did. There's an opportunity certainly for CMS and I'm willing to lead obviously

have the team work on explaining what the options are a little bit more. I still think just our membership, if we look at Health Alliance, most folks, they set it and forget it. And I think, unfortunately, people are not understanding how to be able to take a little bit more of a leadership role. And you do what's familiar. So, to the extent we can provide additional information and education and webinars on what these different plans provide, then certainly we would be willing to do that. And I've already talked to Carrie about how we can lead that. Beyond that, we do have a level of choice here, and so we continue to provide that to members to be able to make decisions based on their specific family makeup and needs.

Syverson: But are we looking at adjusting what the premium contributions are? I mean, to have a – to tell an individual, you're going to save the state $8,000, but we're only going to let you – we're only going to reduce your premium by $480 – your out-of-pocket costs are going to go up by $1,300. That's not an incentive to move to an HSA. Are we looking at larger, either a lower cost to get into the HSA since it's saving the state so much money. Why can't we adjust your HSA employee contributions downward enough that it's going to save the state? I mean, we're talking about tens of millions of dollars of savings by moving to the HSA plan. But if it's only a $480 premium savings to go to a high deductible, people just aren't going to do that.

Brewer: Senator, yes, I completely agree. The member premiums for the high deductible plan relative to the cost of the plan are a greater percentage than a lot of our other plans. That's a little bit of a legacy from the last recent round of collective bargaining with AFSCME that we had. But we do meet with the labor committee. That is not the big negotiation committee, but we meet with them on a little bit more

than a quarterly basis to discuss various issues. And the premiums for the high deductible plan are something that is on the table right now that we're discussing with them. So we do recognize that we could incentivize this program more, but it is a collectively bargained amount. And so we have to work through AFSCME to get that changed.

Syverson: I guess why would AFSCME not be supportive of the idea of lowering the cost for a choice of a health care plan? I mean, we still have time to do this for the July...you know, for the July open enrollment, but we're talking about tens of millions of dollars difference, and it just doesn't seem to make sense that we don't incentivize that, besides all the other benefits of having an HSA, what it means from a tax standpoint for the individual to save as well. So it's not just the education, but education without the math to make it work doesn't make sense. And I'll wrap it up with this. Is there any serious discussions about getting that done and why would there be a holdup in dealing with labor on offering to lower the premium for a plan? I would think labor would certainly be supportive of that.

DeVaughn: It's a matter that we've raised before, and we continue to keep it.

Syverson: So labor is opposed to that, which is saying that if you've raised it, it hasn't been agreed to. So we're saying labor is opposed to the idea of lowering the premiums?

DeVaughn: I am not saying they're opposed. I'm saying we've not been able, we continue to advance that, and we've not been able to get to an agreement there.

Syverson: Okay. What's the holdup with the agreement that I guess I'm confused?

DeVaughn: I can't speak on behalf of our labor partners.

Syverson: So there was no answer. It’s common sense, that lowering the cost saves the state money and it saves the employee money. Why would labor ever be opposed to lowering a premium? Why would the state be opposed to saving money? I guess I'm confused.

DeVaughn: You are not incorrect. And your logic is Sound

Syverson: When's your next meeting with them?

DeVaughn: April 9th.

Syverson: Okay. So that'll be discussed about the idea of lowering, making that more cost effective as a win-win. Can you report back to this committee as to how that goes?

DeVaughn: We will certainly do that.

Syverson: Great. I appreciate it. And thanks for your willingness to look at that and for your answering on the Health Alliance thing. I think the transfer, that happens all the time in the private sector. I think that'll transition pretty easily. People are not going to lose their doctors and their benefits are going to stay the same. So it'll be pretty seamless except for the pre authorization thing that, uh, that the Senator talked about, but it's, this is not uncommon that that occurs.

DeVaughn: Yeah. I mean, would we have wanted more time? Of course, but, um, Health Alliance has been, they've been stand up since the news was made public. And so this happens, we, we are doing everything that we can to make sure people are aware. and if things don't go the way we want them to go um we at least want members to have the information to contact us and figure out how to navigate it. There are solutions for folks who are who are moving, who have to leave a Health Alliance so this is the best of a we're doing all things considered we're not too concerned except just member experience you know people are very much so committed to Health Alliance again you've been with somebody 20 years or whatever it is, we are we're doing our best and Health Alliance has been pretty helpful with us.

Syverson: It’s important that people realize it's going to be, everything's going to be the same. There's no problems that pre-existing, they're going to keep the same doctors the same benefits will be the same so.

Devaughn: Maybe that's right. It depends on the plan you choose. So, we can't steer. However, if you are in Health Alliance, it is likely that either the Aetna OAP or the Blue Cross Blue Shield OAP will still provide a good portion of the providers that you currently have under Health Alliance at a Tier 1 level, which means whatever copay you're paying today under Health Alliance, it will likely be the same. Will there be deviations? I'm certain. It's too many folks and too many doctors. But the lion's share of folks, if they choose a plan, and that's why we said, hey, go out and play on the website and look and see who your main providers are and make sure they're in network for one of the

remaining eight options, which really boils down to about two for this group, for the Health Alliance group. And we're, you know, We're hopeful that a majority. Will there be some deviations? I can't say that everybody's going to get their exact same everything.

Syverson: Sure. No, I appreciate that. And again, it's a big change, but it should go pretty smooth. So we appreciate your leadership on getting that message out.

DeVaughn: Thank you, Senator.

Davidsmeyer: Can we add Representative Harper to the roll? And Representative Moeller for questions.

Representative Moeller: Thank you. Thank you for your presentation. I had a question regarding the proposed plan changes that are outlined on page three in our COGFA booklet. In addition to the change with Health Alliance, it looks like in FY26 CMS is introducing a system of plan splitting for our employees and retirees under the change when a retiree reaches Medicare eligibility. If they have dependent children, only the retiree will be moved to a Medicare Advantage plan, while the dependent children may remain on the existing HMO, OAP, et cetera. I'm hearing from folks who are concerned about the difficulty in managing those two different plans with this change. Have you had discussions with employees about how they're going to manage this?

Wolf: Well, first of all, I want to clarify, this does not affect any currently employed individual. This is strictly for retirees. On the state plan, Most, it is only if an individual, a retiree has one dependent, which is 98% of the time is a spouse, not a child. If an individual on

the, if a retiree on the state plan has two or more dependents, they are not moving, they are not going, they are not transitioning plans until such time that that child, in most cases, turns 26 and would naturally fall off the plan, according to statute, and it remains just the retiree and their spouse. That is when they would split. Doing a split family type of plan has become an industry standard with regards to Medicare for groups that offer a Medicare plan. We have been in constant communications with the retirement system so that they are all five retirement systems so they are aware of what exactly an individual has to do in order to make this enrollment change. We have sent a communication to all state of Illinois retirees, whether they are in the state, CIP, TRIP, regarding their retirement. Regarding this change, in addition, language was sent regarding their statutory requirements that a retiree must enroll in Medicare Part A and B, regardless of if they're moving to the MAPD plan or not. And then what would happen once they do become Medicare eligible as far as their enrollment in the MAPD plan and the individual requirements.

Moeller: So the concern, I think, is mostly with the spouse. As you indicated, most retirees don't have young dependents who would be affected by this. But if the spouse has a complicated medical issue and now they're having to change, is there, aside from this being industry standard, is there a cost savings? What's the rationale for the state moving in this direction?

Brewer: With regard to the state employees program alone, we're projecting about approximately a $33 million savings in FY26.

Moeller: But the spouse is going to continue to get the same level and are they going to have to change doctors, hospitals, providers?

Wolf: The Medicare, our MAPD plan, our Medicare Advantage Prescription Drug Plan is a passive PPO plan. So as long as the provider accepts Medicare and is willing to bill Aetna for the claim, the claim is paid at the plan rate.

Moeller: Okay. So they will not have to change providers?

Wolf: As long as the provider accepts Medicare and is willing to bill Aetna.

Moeller: And if they don't, then they will have to change it.

Wolf: If the provider is not willing to bill Aetna, either they will have to change providers or they will have to pay for the cost of the claim and submit the claim to Aetna for reimbursement.

Moeller: Okay. So they can only use Aetna?

Wolf: Aetna is our only Medicare Advantage provider.

Brewer: But keep in mind that we currently don't split families. So when they both turn 65 and are eligible for Medicare, they are mandated to move to MAPD. So just because we're splitting the family doesn't necessarily mean they're facing a decision that's different than they would have already been making. It's just the timing of when the people are moving to MAPD.

Moeller: And under the current process, they would not have, they would continue to?

Brewer: If both the spouse, if both the retiree and the spouse become Medicare eligible, they are transitioned over to an MAPD. So they would be facing that same exact decision. The only difference is that it is maybe the spouse or the retiree moving at a different time than the other, but it's still the same transition.

Moeller: But right now that transition's not required if the spouse is not 65 or eligible for Medicare.

Brewer: Correct. Now it's just the entire family unit being 65 and Medicare eligible.

Moeller: Okay. Can I get some more information on that? Also, when does this take effect? I know it's FY, it says July 1st.

Wolf: Yes. They will make an election during open enrollment in May for a 7-1 effective date.

Moeller: Okay. Okay. And if someone's like in the middle of cancer treatment or some type of chronic illness, are they going to be required to transition?

Wolf: Yes. There are transition of care laws in place regarding those situations. And either the individuals that are here from Aetna, from our Medicare plan, can answer those questions better for you.

Moeller: Okay.

Davidsmeyer: Any other questions? I have a few questions that I'd like to ask. So what are we expecting the overall cost of the group insurance plan this year? And what's it related to? Are there increased costs directly for the insurance? Or are we looking at, we obviously know there's a growth in state employment. So that's going to have an impact as well.

Brewer: Sure. The projected total liability of the program is just under $4.2 billion for fiscal year 2026, and that represents a 7.7% increase over fiscal year 2025. As the director explained earlier, there are several different factors that are causing those increases. Prescription drug costs, the COVID bounce back, as she mentioned. We recently renegotiated with all of our remaining HMOs and have rates for next year for that. And there are increases built into that as well.

Davidsmeyer: Okay. Thank you. And I kind of want to piggyback on what Senator Syverson was talking about earlier about directing. You're not allowed to steer people towards a specific plan, but are you allowed to incentivize plans that save the state money?

Brewer: Yes. In conjunction with our labor partners, we negotiated two contracts ago where we used to have a single employee premium and dependent premium for the PPO versus a premium for all HMOs. We recently split that all of the managed care world apart, so each individual managed care plan, HMOs and OAPs, have their own premiums. And over the course of the last eight years, we've been kind of spreading those apart, putting if the premium was going up by $6 in one particular year, the more expensive plan might have gone up by $7 and the other one went up by $5. So in small incremental amounts,

we've been trying to incentivize people through premiums to enroll in the more cost-effective plants.

Davidsmeyer: And on the HSA side that he was talking, would it behoove the state to incentivize? I mean, because that sounded like a pretty significant savings to the state of Illinois. Does it make sense to incentivize by saying you'll cover the first $1,500 of their deductible Or am I off on this?

Brewer: Well, I mean, the $1,500 deductible in the HSA program is the minimum allowed by federal statute in the IRS code, and that's also been agreed to with the union. But we do provide for anybody enrolling in the program at the beginning of the year a $500 employer contribution towards their HSA. So effectively, they really only have $1,000 deductible in that program. There is some employer contribution to it.

Davidsmeyer: Okay, and what were you...Senator Syverson saying was the deductible for the other, yeah max out of pocket okay i'm thinking gotcha okay i'll talk to you about that a little bit later. As people migrate from Health Alliance. Maybe I wasn't meant to ask that question. As people migrate away from Health Alliance, are we looking at, what are we looking at as a fiscal impact to the state's overall insurance?

DeVaughn: So we're still modeling, but right now this will save the state. We're modeling a bit of a saving to the state. And let me clarify that. We don't know where people are going to go. So this is kind of the most made-up stuff of our work because we have to forecast. But

there are only so many choices. And so based off of that, we believe the state will be better fiscally for this.

Davidsmeyer: Okay. Let's see. Are you aware of any network issues? Network access issues?

Devaughn: No

Davidsmeyer: Okay. And then as we move forward with some of the Governor's initiatives, some of which I am a proponent of, the Prescription Drug Affordability Act, have you looked at the impact of that and how it will impact employee health insurance.

Wolf: So, a portion of that, currently we have what is called a maintenance choice network for providers. If the languages as that currently stands will eliminate our ability to provide that benefit to our membership. It's approximately $5 million savings annually on both sides for both the state and the member. It's a lower cost on co-pay on maintenance drugs.

Davidsmeyer: So...Is there anything that you've tried to do to change that bill to allow us to continue to see those savings for our employees as well as our...

DeVaughn: As it continues to unfold, we're active with it in stating our position and potential...risks and benefits, and we continue to aggressively respond to bills as they come through.

Davidsmeyer: Have you taken a stance on this bill?

DeVaughn: We've entered our position.

Davidsmeyer: Are you a proponent or an opponent?

DeVaughn: Are we neutral? Neutral.

Davidsmeyer: Strong neutral.

Devaughn: Strong neutral.

Davidsmeyer: Okay, so I think that's an ongoing issue, and I think you understand the savings to the employee as well as the State of Illinois.

DeVaughn: Absolutely.

Davidsmeyer: Hopefully we can find a resolution to that to keep those savings.

DeVaughn: Understood.

Davidsmeyer: Okay, unless there are any more questions...I want to thank you for coming in this morning and being prompt and having answers to all our questions.

DeVaughn: Thank you so much.

Davidsmeyer: Next panel is Health Alliance to discuss the contract coming to a close.

Sinead Rice-Madigan: Good morning. My name is Sinead Rice-Madigan, and I'm Chief Executive Officer for Health Alliance. I've been with Health Alliance 17 years, and probably before this committee, about as many as those, so appreciate the invitation. I've been working with CMS on the decision that was not made lightly, by my owner, Carl Clinic, Carl Health System. On February 25th, we made that difficult decision to exit the commercial insurance market in the State of Illinois, as well as one of our subsidiaries in North Carolina. We are going to be working over the course of the next 18 months to 24 months to run out the cost of claims and pay the claims to our providers. And they will collect cost sharing from our employees for our individuals that are currently state employees who are enrolled in Health Alliance HMOs. The contract that we currently have is the fourth year of a five-year contract that we were awarded back in 2021. Our contract runs through June 30th of 2025. We will continue to provide continuity of care to those people who are inpatient on the day that ends June 30 and continues until they are no longer inpatient, and they will obviously have selected another plan, and that plan will take on those costs of care or dates of service following their discharge from that inpatient stay. We will pay claims to our providers in accordance to the contract that we have with those providers, as well as in compliance with the Illinois Department of Insurance requirements. We have, on average, mostly 90 days for providers to submit a claim for a date of service that a person was enrolled in our plan. We do have some 180-day contracts, and we certainly have to follow state Medicaid reclamation claims, which requires some coordination of benefits between HFS and commercial plans in the State of Illinois. So we'll meet those obligations. We've also met with HFS to ensure that we have that in place. Make sure I hit on some other things here. I'm happy to take any questions, of course, from any

of you or any clarifications you would like to hear from me in response to CMS's presentation today. I have enjoyed a great relationship with the Sate of Illinois for many years, as our organization has, and we are open to working with any communication plans that they have asked us to do. We have shared disruption reports with them with regards to our provider network, which is very robust. And we anticipate that our providers across the state in the 96 counties that were offered will be in contracts with the other vendors that exist and continue and have been and will continue to serve as state employees as they have done heretofore. So I'm happy to take any questions if you have any.

Davidsmeyer: Thank you so much. Senator Koehler.

Koehler: Thank you. I'm sorry that Health Alliance is exiting the market because I think I've been a member of Health Alliance longer than you've been working there.

Rice I think we did establish that.

Koehler: Is that what it was?

Rice-Madigan: Hey, if he talks about it in public.

Koehler: How many members do you have in Illinois under the state plan?

Rice-Madigan: Under the state plan, it's 64,000. It's about 25 subscribers. Those are dependents included in that. So the elections are not being made by each of those 64,000 people. That will be the employer or the retiree making those elections.

Koehler: And are most of them located in central Illinois?

Rice-Madigan: I would say, yes, central and southern. We do not operate in the Cook County or the Collar County, so 96 counties.

Koehler: Yeah. And I'm going to be paying attention to the transition because it involves me. But one of the things that I'd just suggest to you is that you're communicating for the department as well. Communicate with legislators because whenever there's a big change in health care for the state employees, my office and all of our offices get a lot of calls. And so we just need to know what to tell them, who to call. So if you'd please make that available to all the legislative offices because we just get inundated with calls when any kind of change happens.

Rice-Madigan: Yes, We definitely value the interactions that we've had with legislators over the years. And within a couple of days after providing the information publicly on, as I said, February 25th, And just hours before that with state CMS, we met with legislators in Peoria, Bloomington area, as well as Champaign County. And we will continue to do that wherever you need us to be to help support that. And I know there's Benefits Choice meetings coming up. The director said they are planning to over-communicate, and we're definitely supporting that as well through both our email communication with approval from the state as well as the conversations we have with our members every day on the telephone and or chat and that kind of thing.

Koehler: And how long will you have support staff available to answer calls and to help the transition? I mean, at the end of the calendar year?

Rice-Madigan: Yes. So we will – we're statutorily obligated to continue to process claims in accordance with our contract, and we're, you know, financially able to do that, and we will do that. Our run out - It's essentially one year for the State of Illinois, but there will be reasons why we would have potentiality for claims to go past claims – incurred prior to 7/1/25 that could process after 7/1/26 based on appeals, issues related to member questions and things like that. So we anticipate continuing to be in operation as an insurance entity. I want to be very clear to my regulator that we'll continue to meet those obligations and ensure that we're answering those questions, processing claims in accordance with our obligations with state CMS as well as the Illinois Department of Insurance and the Illinois Department of Health Care and Family Services. And I will say, 17 years ago, I exited state employment, so I understand how important these are personal things for people to make their selection, and so it doesn't go unclear to me that this is an important decision and we want to help the State through that.

Koehler: So what I'm hearing is until the last claim is processed, you're there.

Rice-Madigan: In accordance with all state and federal requirements.

Koehle: Gotcha. That's all.

Davidsmeyer: Thank you Senator. Any more questions? Okay. I want to thank you for coming here. I know you weren't obligated to be here, but we appreciate your service over the years to state employees and many others throughout the State of Illinois, so thank you for being here.

Rice-Madigan: Great. Thank you so much, and I appreciate the interaction I've had with all of you and state and federal regulators, and so we appreciate the opportunity to serve. Thank you.

Davidsmeyer: Okay. Our next panel, we're going to go with our HMOs. We have Blue Cross Blue Shield and Aetna.

Tracy Womack: Good morning, Commission. My name is Tracy Womack. I'm representing Blue Cross Blue Shield. I've been with the organization 14 years, and I am newly appointed to this role as Vice President of Sales and Account Management, a whopping two months. I am eager and honored to be in front of you all this morning, so I look forward to any questions that you all might have and be able to appropriately answer as such. So thank you.

Robert Cascarano: And good morning. My name is Robert Cascarano with I've been with the organization for 20 plus years. And like my friend here, I'm relatively new to, not relatively new, but new to this chair. So I'm joined by many teammates, including Bonnie Cade, who's sitting over my shoulder here, who. manages the overall relationship that we have. I want to thank you, the Commission, for having us here today to discuss our contract and answer questions. I want to also take an opportunity to recognize the state's employees, hardworking employees, and retirees that we've had the opportunity to serve since

1984. And last but certainly not least, I also want to take the opportunity to thank the group insurance program for entrusting Aetna to serve those members. Today, we proudly serve approximately 265,000 members and retirees under four separate contracts. We have an HMO contract with approximately 10,000 enrolled members, an open access or OAP contract that we refer to with approximately 42,000 members. We have a PPO contract with approximately 45,000 enrolled members, and our MAPD Medicare PPO contract with over 168,000 enrolled members. And to the best of our knowledge, there are no regulatory or legal investigations by any State Attorney General pending against any of the Aetna companies holding contracts for the HMO, OAP, PPO, or MAPD plan serving the member. That was the most important thing I had to read. So thank you again and thank everybody I've mentioned.

Davidsmeyer: Thank you for bringing that up. I was supposed to say if any vendors have any pending regulatory issues with any state agency or under investigation by the Illinois Attorney General or other state's Attorney General, please state this during your testimony. So, appreciate you doing so. Do we have any questions at this time from members? Okay. We can, I guess we can move on to OAPs. We've got Blue Cross, Aetna, and Healthlink if you'd like to join us. And if you have a new statement, feel free. If you just want to continue with your opening statement, that's fine. Thank you. Hopefully we won't keep you there very long.

Stephanie Boerner: Good morning. I'm Stephanie Boerner with HealthLink. I'm here as the account manager, and thank you so much for having us.

Davidsmeyer: Try to talk as close as possible.

Boerner: I apologize. Can you hear me now? I'm Stephanie Boerner. I'm here as the HealthLink account manager. Thank you so much for having us today. We've got a ton of people here with us. Good morning.
Elizabeth Trakus: My name is Elizabeth Trakus, Senior Account Manager of HealthLink.

David Plaister: Good morning. My name is David Plaister. I'm the Regional Vice President for HealthLink. Thank you.

Davidsmeyer: And do you have any pending investigations? Okay, I'll just go ahead and hit that right off the bat.

Boerner: I apologize. I should have said that. No, we do not.

Davidsmeyer: And I appreciate that. So, any questions?

Koehler: Just a question in terms of the transition that many people have been going through. So how do you get involved with the transition of employees going from Health Alliance into one of your plans, presumably?

Boerner: Absolutely. Thank you for the question. We are working very closely with the CMS team, providing any support regarding benefit choice fairs, any issues or questions regarding providers that are in our networks, helping with the modeling that they're asking or that they're preparing. Just any needs that they have, we're here to help and we're available.

Womack: So here at Blue Cross Blue Shield, we have been active with state employees. We've sent out mailers to them, giving them awareness of access to our care and support for the payer. And we also are participating in open enrollment, upcoming open enrollment next month. So we are eager to answer any questions, address any issues and be able to transition over any state employees to our organization. Very similar process for that.

Cascarano: Bonnie, is there anything that you would like to mention in terms of how we're going to work with the plan to transition members?(

Koehler: Thank you. And I apologize on behalf of the Senate for the poor quality microphones. We'll be finalizing a report on that after the meeting. My concern is primarily when patients are caught up in previous conditions, so they've already had uh prior authorization for uh you know events that are going to you know that they would like to do or need to do how does that transition over i mean if somebody has had prior auth to get something done and it spills over into the new system how do you handle that is it is it going to be an inconvenience to the patient are they going to have to go through you know a waiting time to have that done?

Womack: So at Blue Cross School Shield, we execute a transition of care workflow. And that transition of care workflow encompasses basically bringing the member over towards the seamless coordination of care. So we are able to take on those pre-authorizations, even if they have already been approved, and then are able to continue that care so the member doesn't have the impact to support them through

their health care journey. So we are very vested in making sure that the state employees are being able to transition if they choose Blue Cross Blue Shield, we are able to transition those members effectively. And we do it all the time.

Boerner: Similar transition, if someone moves over to our organization, we have a transition of care process where we will receive prior authorizations that could be in play. And then our members, those members are identified by our case manager nurses. They immediately...come into play, they start reaching out to members, introduce themselves, and become like an advocate for the members. So they have someone to call in the event that there is maybe some bumps in the road in the transition, but we have nurses on point to be able to help with the transition if they move to HealthLink.

Bonnie Cade: Hello, me again. Same thing for Aetna. We have the mandatory transition of care provisions in place. As the member calls in, if they are identifying that they have a service that will go past June 30th, we then will take that information and turn it over to a case manager who will make the outreach to them to ensure that there's no gaps in care, but they will be able to continue through the transition of care provision with their current provider with that authorization. Same thing with the pharmacy benefits, that they are currently taking a prescription that maybe is a different level on our formulary. For the HMO plan or maybe require step therapy or something like that. They'll be allowed the one month bill and there will immediately be an outreach made to them and they will help them transition and get that pharmacy prescription transition to the new carrier.

Koehler: Yeah, thank you. And I assume this is something that's done as employees choose different plans during the enrollment period, but all of a sudden we're going to have about 64,000 that are going to come in at once. And I think between the department and what you do, it's really important that we make this as seamless as possible. So thank you for your answers.
Davidsmeyer: And outside of the transition, are there any major changes to your plans that we're going to see coming in fiscal year 26?

Boerner: No, sir. The only changes will be the ones that CMS previously posted.

Womack: None with Blue Cross Blue Shield

Davidsmeyer: Senator Syverson.

Syverson: Just quickly on the transition with the preauthorization, is there going to be notification given to the employees? A doctor is not going to know that they've changed health carriers. And so the requirement to do a new preauthorization for a treatment plan that they have, is a notice going to go to the employees that they...need to seek a new uh pre-authorization for something they've already been treated for so they don't run into that problem of a denial and then upset and then finding out they just needed to pre-authorize so will there be a notice given out to people.

Cade: Typically through this type of a situation for transition of care they're allowed their you know the first visit is just it just goes through for all the carriers and then after that that'll trigger case management or nurse notification or prior off, but they have that 90-day transition.

So within that 90 days, everything's going to be covered without question.

Syverson: So it'll still be covered, but there'll be some notification letting them know that they need to get another new pre-authorization.
Cade: I believe for all the carriers that the claim will trigger notification and interaction from case management.

Syverson: And it is...possible that your company may not have the same approval as they may have been approved for potential service that you may not approve because you have a different guideline. So that could potentially happen as well. But the key thing is at least they're going to be notified that they have to take that additional step. But that would happen...anytime you went to a new employer or change plans anyway. So thank you.

Davidsmeyer: Thank you all for gathering around for that. Maybe we can, I think we have the QCHP with the Medicare Advantage plan for that as well. You can check it. Anything to add for the QCHP or the Medicare.

Cascarano: Nope.

Davidsmeyer: Okay. Any questions from the committee on those two plans, the QCHP or the Medicare Advantage at this time? Senator Severson.

Syverson: Just a quick question. We've had some issues raised, obviously with the transition going to Medicare. So a person that's in

the middle of a treatment plan under the Aetna employee plan they retire and go on to the Aetna retiree plan. The retiree plan being a Medicare Advantage plan has different contracts or different language. So we've had cases, one just recently, that a person was under, from an accident, rebuilding a jaw and dental work being done that was covered under the medical plan. But the Advantage plan doesn't cover that because Medicare doesn't cover that. So the treatment plan ended at that point. Are there other dramatic contractual differences that when someone's transitioning from full-time Aetna over to the retiree Advantage plan that there are differences?

Cade: We don't typically see a lot of those kind of scenarios. It is important to note that on the Medicare Advantage plan, the TRAIL program, that we have to follow all of federal CMS or Medicare guidelines. So they're the ones that set the criteria. Their criteria could be different than the commercial plans that they may be rolling off of. So when we get into those scenarios, it's important for our commercial case management people folks to talk to our TRAIL or the Medicare Advantage folks. If there are some differences, they try to work with the provider to get the appropriate documentation. Usually, if there's an issue, it's because we haven't gotten appropriate documentation to meet the federal guidelines. But we usually work through those. And I will say, because I have to touch these all the time, that it's pretty rare that that happens. But I won't say that it doesn't happen, but it's rare. But the clinical teams work together on that.

Syverson: It would have been nice if, it's not your fault, but it would have been nice if we had offered, even for a buy-up offering retirees the chance to get a Medicare supplement as opposed to the only

option being an Advantage plan. It would have been nice to have a dual choice so employees could have had, even if they wanted to pay the difference, to have a true Advantage or a pure supplement plan, which would have been obviously different. Different coverages and better. So I don't know if that can ever be changed in that contract, but it would be nice to be able to have that as an option for employees. Again, they would pay the difference anyways, but it would be something that would. It would avoid, I think, a lot of the issues that we had.

Cade: That would have to be through an RFP procurement process.

Syverson: Right. Well, you have a long-term contract, so we couldn't change that. It would have to be internally just with you.

Cade: It can't be because of the way that the RFP was written. There wasn't provisions for that, so it would have to go back out to bid to be able to do that and CMS could speak more directly about that.

Syverson: There'll be time for another discussion, but I appreciate that.

Cade: Thank you. And I did want to make note that as a benefit choice, Carrie spoke to earlier about the split family. I believe one of you had a question on that. We will have, not a lot of materials but we will have not going to have, like, their open enrollment materials, but we will have some FAQ documents there for those that are impacted that kind of give them an idea of who to call, if they have questions, and how it's going to work in the common questions that we get at their open enrollment meetings. So that will be available at the upcoming May

meetings as well at our table. So we'll be able to handle those questions as they come in as well.

Davidsmeyer: Thank you. No more questions. We'll move on to our final panel. See if we can get five people in these three chairs. CVS Caremark, Delta Dental, Compsych, Eyemed, MetLife. We can start with the first three and then we'll grab the next two after.

Laney Klar: Oh, okay, thank you. Hi. Hi. Can you hear me, guys? Okay. My name is Laney. I'm with CVS Caremark. I help to manage the overall prescription benefit under Caremark for the state employee plan. You guys have been in contract with us since 2015, and I'm happy to answer any of your questions.

Davidsmeyer: What did you say your name was again?

Klar: Laney.

Karyn Glogowski: My name is Karyn Glogowski. I'm a senior vice president with Delta Dental of Illinois. First of all, we are not under investigation by any Attorney General, so I wanted to get that off the table. And secondly, just wanted to say thank you. We're very grateful for the 54,000 TRIP employees that were moved on to our dental plan January 1st, with an additional 13,000 coming on July 1st. Thank you.

Tom Prinske: Good morning. Tom Prinske, ComPsych, account manager. I've been with the organization for about six years. Recently moved to transition to manager of the state's EAP. Oh, yeah. There's a button on this. Is it on? No, thank you. Sorry. Tom Prinske, account manager for the state's EAP program. Short-term counseling five-

session counseling model to help address any sort of mental and behavioral health for the 78,000 lives. And I've been servicing since 2021 and just first hearing here today, so look forward to answering any questions that I can answer as it relates to the plan or the contract.

Davidsmeyer: And any investigation or no investigation? CVS, any? No pending investigation. Okay. Thank you. Any questions? All right. Thank you for being here this morning. And we have our next two if you'd like to come up.

John Nicolay: Good morning. My name is John Nicolay, with Nicolay and Dart representing Eyemed. Eyemed has been privileged to work in the State of Illinois for over 20 years, recently entered into a new five-year contract with five-year options. We have approximately 387,000 members in the state, also just added TRIP as well, and we have no open investigations or litigation pending

Scott Rogers: Scott Rogers representing MetLife. We cover the life insurance for approximately 114,000 state employees and 102,000 annuitants. We also have no upcoming plan changes or outstanding litigation or pending investigations.

Davidsmeyer: Great. Any questions from members? Pretty easy this morning. Thank you all for being here. And with that...I move we adjourn.