trail TOTAL RETIREE ADVANTAGE ILLINOIS

The State of Illinois' Medicare Advantage Prescription Drug (MAPD) Provider for Retiree Medical and Prescription Drug Coverage is Changing from UnitedHealthcare to Aetna, Effective January 1, 2023

On July 12, 2022, the State of Illinois determined that our MAPD provider for retiree medical and prescription drug coverage will change from UnitedHealthcare and various HMOs to Aetna, effective January 1, 2023. We are informing you of this change as soon as legally possible.

What You Need to Know

On December 31, 2022, the current MAPD contracts will expire. Because of this, the State of Illinois was legally required to enter a request for proposal (RFP) process. During this process, we reviewed all the documents provided by each bidder, and found that Aetna offered the richest, low-cost plan, tailored to the needs of our retirees. This plan—known as the Aetna MAPD PPO plan—will not only save retirees and the State of Illinois money in medical and prescription drug premiums each month, but it will also offer our retirees wider access to support programs—such as Be Well Illinois and Sliver Sneakers—so we can continue to focus on the total well-being of our members.

By using the opportunity to award only a MAPD PPO plan, the State of Illinois will see a savings of slightly more than $1 billion across the three programs administered by the Department of Central Management Services. Retirees and dependents under the three programs will also see a significant reduction in their contributions for the plan year.

One thing that has remained at the forefront of our minds in this decision-making process is the transition for our retirees. When learning more about the Aetna MAPD PPO plan, we found that there would be little to no disruption to retirees' current medical providers or prescription drug coverage. Retirees will be able to use any doctor, hospital, or specialist in or out of the Aetna Medicare Advantage network, without paying more for out-of-network services if the provider accepts the plan and has not opted out of Medicare. These factors have played an important role in determining the best value when comparing proposals and making the decision to switch MAPD providers.

As you all know, the health and well-being of our retirees is a top priority for the State of Illinois. Our employees have spent years working, and we want them to enjoy retirement knowing their retiree benefits are here to protect them. We feel confident that our new MAPD provider will be a smooth transition for retirees and allow them to fully enjoy their next chapter in retirement, knowing they are supported by a comprehensive MAPD plan.

What's Next

Unless a choice is made by the member during the open enrollment period (November 1 – November 30), anyone currently enrolled in the TRAIL Medicare Advantage Prescription Drug (MAPD) Program—regardless of whether enrolled in a PPO or HMO today—will be automatically re-enrolled in the new plan for 2023.

We understand that our retirees may have a lot of questions, and we're dedicated to keeping them informed. In the coming weeks, there will be many opportunities for retirees to learn more about this change. Retirees will receive a welcome kit in the mail from Aetna with more information about the Aetna MAPD PPO plan. They'll also receive materials from the Center for Medicare and Medicaid Services, as required by law. Finally, the State of Illinois will be issuing several communications to retirees, detailing the changes, including: an announcement letter and email, in-person seminars will be held during open enrollment, and a medical plan decision guide.

For additional information, contact CMS Governmental Affairs at 217-685-9947.

Federal Requirements for Network Adequacy

The federal requirements for network adequacy in regards to Medicare Advantage plans are found through the federal Centers for Medicare and Medicaid Services (CMMS). The following link goes directly to their most recent document regarding network adequacy for Medicare Advantage plans:

https://www.hhs.gov/guidance/sites/default/files/hhs-guidance documents/Medicare%20Advantage%20and%20Section%201876%20Cost%20Plan%20Network%20Adequacy%20Guidance_03_04_2022.pdf

42 C.F.R. 422.116 is the federal code detailing the components of network adequacy and details the specific travel time/distance/population components involved with determining adequacy:

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116

For federal network adequacy standards, a network-based Medicare Advantage plan must meet specific network standards for a number of areas:

1. Access – a provider must have access to covered services in accordance with standards described in certain sections of 42 C.F.R. 422.116. These services run the gamut from basic primary care options up to specialty surgery.
2. Standards – a provider must meet maximum time/distance standards and contract with a specified minimum number of each provider, service, and facility-specialty type. These time/distance standards vary depending on county population, with urban counties having overall shorter time/distance requirements than rural counties.
3. Certain types of providers and facilities must be covered and available. This information and a listing of such is located in the link provided above.
4. At least 85-90% (depending on population of county) of MA plan beneficiaries must have access to at least one provider/facility of each type within specific time/distance standards.
5. Telehealth services (and/or in the case of states with Certificate of Need laws that impose anti-competitive restrictions limiting the number of providers/facilities available) provide a credit towards the standards for access, but do not count as the entire total for access.
6. Based on population, a minimum number of service providers must be available depending on the specialty of the medical provider.
7. Certain exceptions are available for requesting based on the availability of medical service providers. For example, in the case of extremely rural populations wherein no providers are available for coverage, an exception can be made.

In regards to the steps are taken by IL CMS to verify network adequacy, the following is their official response:

What steps does CMS take to verify network adequacy for the MAPD providers?

"Section 5 of the RFP requires each bidder to verify if providers (both medical and RX) currently reporting claims are in-network, out of network but accepting the plan or out of network not accepting the plan. The listing of providers reporting claims within the RFP is a nationwide listing, it is not limited to Illinois providers only."

Do you have a particular list of criteria that you look for/verify?

"Through the utilization of the criteria above a network analysis is completed to determine the provider disruption if the bidder should be awarded the contract. In the case of the Aetna PPO plan the provider disruption was evaluated as 1.09% in billed claims and 1.3% in provider count."

Finally, in regards to the question of whether network adequacy is judged on a statewide basis or are certain provider numbers required in each region, as mentioned in the response to Sen. Rose's first question, network adequacy requires providers to be accessible within certain time/distance standards depending on the population of the county in question. A statewide basis does not count for the purposes of network adequacy.

The following chart details the federal time/distance standards for Medicare Advantage plans. The definitions of Large Metro County through CEAC are as follows.

(1) Large metro. A large metro designation is assigned to any of the following combinations of population sizes and density parameters: (i) A population size greater than or equal to 1,000,000 persons with a population density greater than or equal to 1,000 persons per square mile. (ii) A population size greater than or equal to 500,000 and less than or equal to 999,999 persons with a population density greater than or equal to 1,500 persons per square mile. (iii) Any population size with a population density of greater than or equal to 5,000 persons per square mile.

(2) Metro. A metro designation is assigned to any of the following combinations of population sizes and density parameters: (i) A population size greater than or equal to 1,000,000 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 999.9 persons per square mile. (ii) A population size greater than or equal to 500,000 persons and less than or equal to 999,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 1,499.9 persons per square mile. (iii) A population size greater than or equal to 200,000 persons and less than or equal to 499,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 4,999.9 persons per square mile. (iv) A population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to 100 persons per square mile and less than or equal to 4999.9 persons per square mile. (v) A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 1,000 persons per square mile and less than or equal to 4999.9 persons per square mile.

(3) Micro. A micro designation is assigned to any of the following combinations of population sizes and density parameters: (i) A population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 99.9 persons per square mile. (ii) A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 50 persons per square mile and less than 999.9 persons per square mile.

(4) Rural. A rural designation is assigned to any of the following combinations of population sizes and density parameters: (i) A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density of greater than or equal to 10 persons per square mile and less than or equal to 49.9 persons per square mile. (ii) A population size less than 10,000 persons with a population density greater than or equal 50 persons per square mile and less than or equal to 999.9 persons per square mile.

(5) Counties with extreme access considerations (CEAC). For any population size with a population density of less than 10 persons per square mile.

Federal Medicare Advantage Coverage Time and Distance Standards

	Large Metro		Metro		Micro		Rural		CEAC	
Provider/Facility type	**Max time**	**Max distance**	**Max time**	**Max distance**	**Max time**	**Max distance**	**Max time**	**Max distance**	**Max time**	**Max distance**
Primary Care	10	5	15	10	30	20	40	30	70	60
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OB/GYN	30	15	45	30	80	60	90	75	125	110
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Oncology - Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology - Radiation/Radiation Oncology	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physiatry, Rehabilitative Medicine	30	15	45	30	80	60	90	75	125	110
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Acute Inpatient Hospitals	20	10	45	30	80	60	75	60	110	100
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Critical Care Services - Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Diagnostic Radiology	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Inpatient Psychiatric Facility Services	30	15	70	45	100	75	90	75	155	140
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100

* Time is measured in minutes, while distance is measured in miles for the purposes of this chart

The CMMS also provides a table for minimum ratios of the number of beneficiaries to cover. The numbers in the following chart reflect the minimum number of providers per 1,000 beneficiaries (the acute inpatient hospital number reflects the minimum number of beds per 1,000 beneficiaries).

Minimum Number of Provider Types (per 1,000 people)					
Minimum ratio	**Large metro**	**Metro**	**Micro**	**Rural**	**CEAC**
Primary Care	1.67	1.67	1.42	1.42	1.42
Allergy and Immunology	0.05	0.05	0.04	0.04	0.04
Cardiology	0.27	0.27	0.23	0.23	0.23
Chiropractor	0.1	0.1	0.09	0.09	0.09
Dermatology	0.16	0.16	0.14	0.14	0.14
Endocrinology	0.04	0.04	0.03	0.03	0.03
ENT/Otolaryngology	0.06	0.06	0.05	0.05	0.05
Gastroenterology	0.12	0.12	0.1	0.1	0.1
General Surgery	0.28	0.28	0.24	0.24	0.24
Gynecology, OB/GYN	0.04	0.04	0.03	0.03	0.03
Infectious Diseases	0.03	0.03	0.03	0.03	0.03
Nephrology	0.09	0.09	0.08	0.08	0.08
Neurology	0.12	0.12	0.1	0.1	0.1
Neurosurgery	0.01	0.01	0.01	0.01	0.01
Oncology - Medical, Surgical	0.19	0.19	0.16	0.16	0.16
Oncology - Radiation /Radiation Oncology	0.06	0.06	0.05	0.05	0.05
Ophthalmology	0.24	0.24	0.2	0.2	0.2
Orthopedic Surgery	0.2	0.2	0.17	0.17	0.17
Physiatry, Rehabilitative Medicine	0.04	0.04	0.03	0.03	0.03
Plastic Surgery	0.01	0.01	0.01	0.01	0.01
Podiatry	0.19	0.19	0.16	0.16	0.16
Psychiatry	0.14	0.14	0.12	0.12	0.12
Pulmonology	0.13	0.13	0.11	0.11	0.11
Rheumatology	0.07	0.07	0.06	0.06	0.06
Urology	0.12	0.12	0.1	0.1	0.1
Vascular Surgery	0.02	0.02	0.02	0.02	0.02
Cardiothoracic Surgery	0.01	0.01	0.01	0.01	0.01
Acute Inpatient Hospitals	12.2	12.2	12.2	12.2	12.2

October 31, 2022

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Carle Health reaches tentative contract agreement with Aetna

Urbana, Ill. – Carle Health and Aetna have reached a tentative agreement on an Aetna Medicare Advantage PPO contract effective January 1, 2023, with Carle hospitals and provider offices in Champaign, Urbana, Hoopeston, Danville, Mattoon, Charleston and surrounding communities. Finalization of this contract will allow Medicare-eligible state retirees to continue to be seen by the Carle providers they have come to know and trust throughout the years.

"We never lost sight of our patients," Dennis Hesch, Executive Vice President & Chief Financial/Strategy Officer, Carle Health says. "Negotiations have many moving parts that in the end, all need to balance but we were determined to keep trying until we reached a contract that is good for our patients, our hospitals and provider offices, and for the State and Aetna."

Earlier this year the State of Illinois moved forward with the implementation of the Aetna Medicare Advantage PPO as the only insurance option for Medicare-eligible State of Illinois retirees. At that time, Carle Health and Aetna did not have a contract for the Aetna Medicare Advantage PPO to partner with Carle's east Central Illinois region. Over the past few months, Carle and Aetna have worked diligently to negotiate a contract in good faith with the goal of ensuring continued access to the providers state retirees know and trust. We are both pleased negotiations are poised to conclude favorably for everyone involved.

For more information about Carle Health doctors and services, visit the Carle Health website.

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Claudia Lennhoff, Executive Director, Champaign County Health Care Consumers
Testimony to the Commission on Government Forecasting and Accountability
Tuesday, November 15, 2022
Topic: Illinois Retiree Health Insurance and Aetna plan

My name is Claudia Lennhoff and I'm the Executive Director of the non-profit Champaign County Health Care Consumers. I appreciate this opportunity to speak to this commission about the state retiree health insurance situation.

Our organization is the only organization in our county that routinely helps consumers with all forms health insurance enrollment throughout the lifespan – Medicare, Medicaid, and Marketplace plans.

We are currently in two open enrollment periods. One is for Medicare Open Enrollment, and the other is for Marketplace Open Enrollment.

Normally, our small organization should not have to help state retirees with their Medicare-related health insurance enrollment. However, these past few months, we have been absolutely overwhelmed by state retirees experiencing problems with Aetna and its inadequate network, even before the state announced its new contract with Aetna, to the exclusion of any other Medicare related coverage.

Of course, it has been a relief to find out that Aetna and Carle seem to be reaching an agreement and will have a contract in place for the beginning of 2023.

However, the situation with the State's decision to contract with Aetna to the exclusion of any other options is deeply problematic for many reasons.

First of all, Aetna is known to be problematic. Aetna's Medicare plan has been downgraded in federal ratings for exactly the kind of situation that our community's State Retirees have been dealing with, as reported in our local media. The federal ratings issue was reported by Reuters.

https://www.reuters.com/business/healthcare-pharmaceuticals/cvs-health-expects-lower-medicare-performance-rating-impact-2024-2022-10-06/

Second, Aetna is also problematic for both consumers and providers because Aetna frequently denies claims or request for prior authorizations and very often does not pay on time. This is why providers like Carle often want a contract - it's a matter of accountability. A contract is not just for the security of the provider, but also for the security of the consumer/insured patient because if claims are being denied and prior authorizations denied, these things have a direct impact on the consumer as well as on the provider.

By the way, this issue with Aetna is true not only for their Medicare plan, but also for their Medicaid plan as well. It is a well-known issue with this company. In fact, it seems to be more of a feature than a bug in their health coverage.

Health insurance is supposed to do two things for the consumer: a) guarantee timely access to needed health care; and b) protect the consumer from the high cost of health care. When claims are denied and prior authorizations are denied, insurance fails the consumer.

Third, it is very problematic that the State TRAIL system is offering retirees only one plan. Why is that? One has to wonder if this was stipulated in the contract with CMS in order for Aetna to save the

state money. Our organization is advising state retirees to demand that they be offered more than one option.

Despite Aetna claiming that they have a nationwide network, local consumers need to know that the providers that *they* rely on are contracted with, and that their care with those providers will not be compromised.

Illinois is too large a state to only have one company's plan offered to state retirees. It just doesn't make any sense. It also doesn't make any sense that after all the news covering the problems with Aetna's network – or rather, lack of network – that the state would then move forward to contract with Aetna and then offer *only* the problematic Aetna plan.

Retirees in the state of Illinois deserve better. They should have at least two choices for their health insurance coverage. One plan does not fit in all areas, and the impact on retirees can be devastating if they have a disruption in their continuity of care or have to travel great distances to get the care that they need, that is actually available in their community.

Offering retirees only one option – and a problematic one at that – does seem to be a diminution of their hard earned benefits.

Aetna has promised to save the State of IL money on its retiree health plans. A lot of money. How does it plan to make that happen? Does it save money by having more claims denied, more procedures denied, etc.? This is worth investigating.

During Medicare Open Enrollment, we always encourage consumers to check their Medicare Advantage and Part D plans to make sure that the formularies for those plans will continue to cover their prescriptions. **Right now, we have retirees calling our office and telling us that they have called Aetna to see if their prescriptions will be covered under Aetna's formulary, and they are reporting to us that they are being told that the formulary has not been finalized yet.**

This is stunning, and should be of great concern to anyone who has to depend on this Aetna plans.

Medicare Advantage and Part D plans offered during open enrollment for the general population have all figured out their formularies for the coming year – this is part of the basis on which consumers compare and contrast plans and make a choice for what is best for them on Medicare.gov.

And yes, retirees always have the option of leaving the state's plan and opting for another Medicare Advantage or Part D plan through Medicare.gov – but, if they do that, they will be on their own to cover the costs of monthly premiums and co-pays. If someone has to leave the state's plan because their doctors are not in network or their life-saving medications are not on the formulary, this would surely constitute a diminution of benefits.

Lastly, I want to say that I think it was unethical for the state - CMS - and associated parties to try to put pressure on Carle for the problems with Aetna, rather than focusing on the state's process and decision to go with Aetna as the sole insurer. CMS's own FAQ from 10.11.22 encouraged members to contact Carle to pressure them to reach a contract with Aetna. This is diversionary and made it seem like the problem was Carle, rather than the fact that CMS has contracted with an insurer that is locally and nationally known to be very problematic. Yes, Carle can accept insured patients with insurers with whom they do not contract (like United Health). However, when an insurer has a bad reputation and has to be forced to pay on claims, I think it is understandable that the provider (Carle,

in this case) seeks a contract. It's about accountability. The pressure should have been on CMS to do better.

We wholeheartedly support retirees' efforts to pursue legal and legislative means to force CMS to offer retirees at least two options for Medicare-related health insurance coverage. Allowing only one health plan (and a problematic one at that) will spell trouble for the future because it is setting a precedent.

Aetna has promised to save the State of IL money on its retiree health plans. A lot of money. How does it plan to make that happen? Does it save money by having more claims denied, more procedures denied, etc.? This is worth investigating.

Retirees deserve better. They worked hard and played by the rules. No one should have to face the sort of fear and anxiety that state retirees in our area have faced when contemplating whether or not they could continue their health care with their providers.

Thank you for this opportunity to speak to you today.

Retired State Employees Association
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Testimony by Retired State Employees Association to COGFA Hearing
November 15, 2022
Regarding Change in State TRAIL Medicare Advantage Prescription Drug PPO Plan

Thank you, Senator Koehler and Representative Davidsmeyer, and other Members of the Commission.

I am Gayle Finigan, President of the Retired State Employees Association. With me today are our First Vice President, Randy Witter, and our Second Vice President, Rick Carlson. We appreciate that you are holding this important hearing on CMS' decision to move all TRAIL state retirees to a single MAPD **"passive"** PPO plan provided by Aetna effective January 1, 2023.

Thank you for this opportunity to present you with the concerns of our nearly 10,000 retired state employee members on this important subject. Approximately 85% of our members live throughout the State of Illinois and the other 15% live in forty-seven other states, Puerto Rico, and the District of Columbia. We have heard from many of these members who live both here in Illinois and out-of-state that their doctor has advised them that they will not accept the new plan with Aetna.

We had over 130 members at our last membership meeting on 10/26 and have heard from hundreds of other members who are happy with their current coverage with United HealthCare. They are all terribly upset about losing their existing coverage and do not understand why this change is being made.

We understand this contract had to be put out for bid, and the RFP provided that a contract would only be awarded for one PPO plan. We have been told by CMS that points awarded to the bids from UHC and Aetna were identical, including charging the State no premiums for this coverage. The difference that resulted in Aetna being awarded this contract was apparently that Aetna included giving CMS an extra $100,000 per year or about seventy-one cents per insured for each of five years for it to spend on wellness benefits. What is this going to be spent on and how for seventy-one cents each is that going to benefit each retiree? Given this contract will result in billions of dollars in claims for over 140,000 retired members and their dependents being paid each year, one can question why this award was made on such a small and narrow difference. We do not understand why continuity of coverage, satisfaction with and quality of the current plan, including access to approved providers, claim processing ease and reputation, and the Medicare rating each MAPD plan enjoyed (UHC is a 5 and Aetna a 4.5) were apparently not given more weight.

We understand that no one, particularly those retired and on Medicare, is happy about having to deal with a major change in their Medicare coverage. CMS has assured us and our members that the benefits under the new Aetna PPO MAPD plan will be the same as we currently have under the UHC PPO MAPD plan. While we would have preferred staying with UHC, we are not opposed per se to the State changing our TRAIL coverage to Aetna if the transition from UHC to Aetna is seamless and our state retirees do not experience any difference in coverage or benefits. This includes that all of us can continue to see our current doctor who has been covered under the UHC plan whether they are in or out of network anywhere in the U.S. as long as they accept Medicare assignment.

Two of our officers (Gayle and Rick) attended the TRAIL MAPD open enrollment meeting that CMS and Aetna held at the Crowne Plaza Hotel here in Springfield last Wednesday, November 9. Based on the answers which Aetna representatives gave to numerous questions about access to providers, medical and prescription drug benefits, it appears the benefits will be the same under Aetna as they have been with UHC. Deductibles, co-pays, and out-of-pocket maximums will be the same. We were told that other specific benefits that are broader than regular Medicare will also continue under the new Aetna plan. These include waiving the Medicare requirement that a patient be admitted and spend three days in the hospital before they are eligible for any skilled nursing facility (SNF) benefits and continuing to pay the same co-pays for prescription drugs while in the Medicare gap or "doughnut hole."

The only exception we clearly identified is with hearing aids. Currently SOI retirees must go to a hearing aid provider that is in UHC's network, and that provider then bills UHC who has agreements with certain companies to accept UHC's approved rates. This means the retiree has not had to pay out of pocket for any of these costs and can receive state of the art hearing aids that retail for as much as $4,000 each for the maximum $2,500 per ear benefit. Under Aetna we are told there will be no network and retirees will have to pay the provider the full retail price with no discounts. Our members will then have to submit a copy of their paid invoice to Aetna for reimbursement up to a maximum benefit of $2,500 regardless of the retail price the retiree had to pay.

Our biggest concern remains with access to providers who are not part of Aetna's network and how Aetna will manage insurance claims. Will the benefits truly be the same in or out of network and will health care providers such as doctors, hospitals, and home health and durable medical equipment providers our members currently see or use now accept this new Aetna plan? Most of the calls we have received from our members concern their doctor or other provider telling them that they will not accept the Aetna plan. One of the Aetna Group Medicare Account Representatives at the Crowne Plaza meeting, Kimberly Nelson, told us that our members could go to any provider that accepts Medicare and agrees to bill Aetna. She also advised that if a provider tells a state retiree patient that they will not accept the plan, the member should call the Aetna customer care and Aetna will directly outreach to that provider "to take you out of the middle."

While similar to how UHC managed such problems, this seems contrary to what our members have told us the Aetna customer care center was telling them. Our members advised us they were told to tell their provider that the provider needed to sign a contract with Aetna and encourage them to do so. Ms. Nelson told us that was incorrect and promised that would be corrected. Our concern is does the provider need to agree to only bill Aetna for the State MAPD plan? The provider will likely agree to do that since they are currently doing it for United Healthcare. Or is Aetna using this as leverage to get them to agree to accept all of their Medicare plans? One possible reason for not agreeing to do this might be that the provider has had repeated problems with submitting claims to Aetna for other plans.

The written material which Aetna included in the packet given to retirees at the Crown Plaza meeting in Springfield included a brochure entitled "For your doctor" "Provider instructions for Aetna Medicare Plan (PPO) with Extended Service Area (ESA)." Inside there was a tear-off page for the provider to keep with their patient's file. It included sections on "What you need to know," "What we pay you," and "How to submit claims" with copies of what their patient's Aetna medical ID card will look like. In the section on "What we pay you," it reads "Medicare-allowable rates for clean claims on covered services under the patient's plan."

Our concern here is why does it refer to a PPO Network with an **"Extended** Service Area **(ESA)"** instead of using passive PPO with the same benefits in or out of network as CMS uses? Hopefully, it is distinction without a difference and Aetna will have a nationwide passive PPO plan with the same benefits in or out of network as long as the provider accepts Medicare assignment the same as UHC does. Also, it is worth highlighting the word **"clean"** in the sentence regarding what Aetna pays the providers. This could require repeated submissions if **Aetna's** claim processing unit repeatedly bounces claims without providing advice on what is missing.

While all of us will not know for certain until after this change is implemented effective January 1, 2023, we receive the complete Evidence of Coverage booklet, and we have experience with actual claims, **any costs** our retirees end up incurring from out-of-network providers who accept Medicare assignment and accepted the UHC plan but **will not accept** the **Aetna plan** will constitute **a diminishment of our existing health care benefits**.

As all of you know, most state retirees devoted years to public service and have relied on the State of Illinois to keep its promise to continue to provide premium health care benefits for them and their dependents for the rest of their lives. The Illinois Supreme Court, in a case we previously brought, ruled that these benefits are constitutionally protected and cannot be diminished.

Mr. Chairmen, we again want to thank you and the other Members of the Commission for holding this important hearing on the changes that are set to occur January 1 in the Medicare Advantage coverage that our state retiree members currently have. We appreciate being able to provide you with this information regarding the problems and concerns our nearly 10,000 state retiree members are having regarding this pending change.

Sincerely,

Gayle Finigan

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