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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

President, Retired State Employees Association

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