ILLINOIS COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

Co-Chair Senator Michael Frerichs - Co-Chair Representative Jil Tracy

RECORD OF COMMISSION WITNESS

May 20, 2013

SUBJECT MATTER: GROUP INSURANCE

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TESTIMONY: ☒ Oral ☐ Written Statement Filed ☐ Record of Appearance Only

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WRITTEN COMMENTS:

ILLINOIS COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

Co-Chair Senator Michael Frerichs - Co-Chair Representative Jil Tracy

RECORD OF COMMISSION WITNESS

May 20, 2013

SUBJECT MATTER: **GROUP INSURANCE**

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TESTIMONY: ☒ Oral ☐ Written Statement Filed ☐ Record of Appearance Only

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WRITTEN COMMENTS:

STATEMENT OF THE RETIRED STATE EMPLOYEES ASSOCIATION

OPPOSE Motion to Concur on HA 1 & HA 2 to SENATE BILL 1515

ALLOWING CMS TO IMPLEMENT A MEDICARE ADVANTAGE PLAN WITHOUT THE NORMAL

REVIEW & APPROVAL UNDER THE ILLINOIS PROCUREMENT CODE & BY COGFA

If the Senate concurs with House Amendments 1 and 2 to Senate Bill 1515, the Department of Central Management Services will be allowed to establish a Medicare Advantage Plan that all Medicare eligible State retirees and their Medicare eligible dependents will arbitrarily and without choice be required to transfer from their current state supplemental plan effective January 1, 2014. This could be done without going through the normal state procurement process as well as subsequent legislative review and approval by the Commission on Government Forecasting & Accountability.

Make no mistake – this is not a supplement of our existing Medicare coverage. It represents a mandatory replacement of all State retirees' existing coverage under Parts A & B of original Medicare with coverage that will be provided and "managed" by a private insurance company. We are opposed to mandatory privatization of our existing Medicare coverage, and want the option for each state retiree to keep their existing state provided coverage supplementing original Medicare.

According to Medicare, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral from your primary care physician to see a specialist or if you have to go to doctors, facilities, or suppliers that belong to the Plan for non-emergency or non-urgent care). This could create a major problem for retirees who travel or spend part of the year out-of-state, and are out of the Plan's service area. Exceptions for emergency care are often limited to 10-14 days after which you have to be transferred back to a hospital within the service area. It could also limit a retiree's ability to obtain necessary tests, labs, radiation, chemo, rehab or therapy unless the primary care physician approves and provides a referral. Currently, with coverage under original Medicare, which pays 80% of Medicare approved charges, a state retiree can go to any medical provider in the country who accepts Medicare assignment.

CMS admits that the "savings" from moving to a Medicare Advantage Plan includes the application of new deductibles and co-insurance requirements that take effect July 1, 2013. Each state retiree and their eligible dependents on Medicare will immediately have to satisfy a $350 deductible before receiving any supplemental benefits under the existing state plan. Approximately $30 million in savings will result from this change alone (87,500 retirees and dependents on Medicare times $350). In addition there will be savings from the application of new co-insurance requirements, separate deductibles for hospital admissions and emergency room visits, and decreased utilization due to these new out-of-pocket costs which retirees will be responsible for.

We are also concerned with the persistent and growing problem with the delay in payment of state retiree medical claims, which currently are paid as much as twelve months late for the other 20% of these claims which Medicare currently does not pay for. What happens to provider payments and resulting interest costs, not to mention diminishing access to Doctors and other providers, if 100% of these claims are now to be paid by a state funded Medicare Advantage Plan?

If these Medicare Advantage Plans are so outstanding and provide the same access to care as retirees currently have, why do only three to five percent of eligible retirees in other large public and private employer groups typically enroll in such a Plan when offered the opportunity on pure choice basis (according to one of largest insurers currently offering these private Medicare Advantage Plans nationwide).

There remains a lot of confusion and unanswered questions regarding which insurer(s) would be providing these proposed Medicare Advantage Plan(s), what limits it would place on State retirees' access to medical care & treatment, and whether retirees would have the option to keep their existing state coverage. We know what we have with traditional Medicare and the current state supplement. The concept of requiring state retirees to give up their existing Medicare coverage and move to coverage provided entirely by a single private insurer could be fraught with problems both initially and in the future.

Do not repeat the mistake which the Chicago City Council made in approving the privatization of their city parking meter program. Insist on a thorough review and evaluation of all bids received by CMS in accordance with existing requirements of the State Procurement Code, and the subsequent review and approval by the Commission on Government Forecasting & Accountability before any such Medicare Advantage Plan is implemented. Any new and complicated health insurance plan worth implementing will stand the test of going through the normal review and approval process.

May 20, 2013

For further information contact

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ILLINOIS COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

Co-Chair Senator Michael Frerichs - Co-Chair Representative Jil Tracy

RECORD OF COMMISSION WITNESS

May 20, 2013

SUBJECT MATTER: GROUP INSURANCE

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TESTIMONY: ☒ Oral ☐ Written Statement Filed ☐ Record of Appearance Only

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WRITTEN COMMENTS:

ILLINOIS COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

Co-Chair Senator Michael Frerichs - Co-Chair Representative Jil Tracy

RECORD OF COMMISSION WITNESS

May 20, 2013

SUBJECT MATTER: **GROUP INSURANCE**

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TESTIMONY: ☑ Oral ☑ Written Statement Filed ☐ Record of Appearance Only

WRITTEN COMMENTS:

INTRODUCTION

Co-Chairmen Frerichs and Tracy and Members of the Committee:

Good morning. My name is John Corrigan and I want to thank you for giving me the opportunity to present testimony on retiree healthcare today on behalf of my client Extend Health. I believe that Extend Health has the best solution for providing the most comprehensive networks for Illinois's retirees and, at the same time, achieving the cost savings originally projected by CMS.

Extend Health, founded in 2004, operates the largest private Medicare exchange in the country. Extend has helped over a million retirees and their dependents find the appropriate healthcare plan that suits their unique needs. Extend help companies and government entities reduce the amount they spend on retiree healthcare while enabling Medicare eligible retirees to obtain the same or better health care coverage for less cost. Extend's clients include 100 of the Fortune 500 including here in Illinois, Archer Daniels Midland, Caterpillar, Motorola, Allstate, and Fortune Brands and nationally such household names as DuPont, Ford, Goodyear and Kimberly Clark.

First, I want to provide some background information of one of Extend's largest public clients: the State of Nevada Public Employees Benefit board. The challenges faced by Illinois today, providing excellent yet fiscally responsible healthcare coverage to their post 65 retirees, were the exact ones faced by Nevada in 2010. Rising healthcare costs and the increasing post-65 population are forcing organizations, public and private, to re-examine how to most affordably deliver healthcare benefits to this population. By the end of my testimony, I hope you will agree that Nevada's decision to use a private Medicare exchange, a solution that saved the state money, saved its retirees money, and provided its retirees better healthcare coverage and service, is a solution worth evaluating.

We know a Medicare exchange is the right solution to not only help reduce the State's health care spend but also meet the goals of the new labor agreement with AFCSME which are "to maintain comparable benefits and networks with no diminishment of plan design and access to providers." Transitioning to a single group Medicare Advantage plan with a passive network simply cannot accomplish both and achieve the significant annual cost savings originally projected by CMSat the last CGFA meeting in April 2013.

SITUATION IN NEVADA

In 2010, the Nevada Public Employees' Benefit Program (Nevada) had approximately 12,000 Medicare eligible retirees, both union and non-union. These retirees were offered either a group PPO or group HMO, depending on where the retiree lived.

In 2010, the State was dealing with a $3 billion shortfall in its $7 billion budget. Part of this shortfall was healthcare costs - a $111.2 million gap between what the State could contribute and the amount required to maintain the current benefits at the same contribution ratio. If Nevada chose to remain with the group PPO/HMO model, it would have needed to implement several changes to close that shortfall, and those changes fell in three main considerations: reduce benefits or eliminate benefits, increase participant premium cost sharing, or convert the self-funded Preferred Provider Option (PPO) plan to a Consumer Driven PPO High Deductible Plan (CD PPO HDHP). Each would hurt its retirees in a different way, and each had its own public relations risk.

This first consideration, reducing retiree benefits, would have required the retirees to pay more when they saw the doctor, went to the hospital, or bought a prescription. For those who had the misfortune of getting sick or hurt, those trips to the doctor's office would be much more expensive.

The second consideration would have increased the amount retirees contributed to the premium each month. The $112 million required cost savings would be spread across all retirees. Every retiree was going to feel the pain.

The final consideration, switching to a new, high deductible health plan would not only have required the retirees to pay more when they saw the doctor; it presented other challenges for the retirees. What if the retiree's current doctor was not in this new insurance carrier's network? What if the closest doctor in this provider's network was 40 miles away for retirees who lived in rural areas? For retirees who may have spent 30 years seeing the same doctor, the idea of forcing them to switch when they needed that relationship and comfort simply was not an option.

No matter what blend of the above solutions Nevada thought to implement, the result was clear – all retirees were going to be paying more for a health plan that would provide less.

It was the reality of these outcomes that made Nevada Public Employees Benefits Program Executive Officer James Wells search for solutions outside of a traditional healthcare business model. The solution Nevada found was a Medicare exchange.

WHAT IS A MEDICARE EXCHANGE

Before talking about the Medicare exchange solution embraced by Mr. Wells and the PEBP, I want to briefly explain what a Medicare exchange is and why it works. A Medicare Exchange is a marketplace that connects individuals to carriers and plans that compete for individual retiree's business in a very organized and systematic way. Our licensed benefit advisors are salaried based. They receive no commission or incentive to enroll retirees in any plan or carrier. Our advisors' primary objective is to make sure the retiree is comfortable with the process and confident in the decision. Managing the change of retirees from a groupo to an exchange is the heart of Extend's business model and they do it very well.

Retirees – with the help of licensed benefit advisors - shop for individual Medicare Advantage, Medigap, prescription drug plans, dental, and vision plans from a multitude of health insurance carriers across the entire country. To help them make an informed and confident choice, Medicare Exchanges provide licensed benefit advisors who seek to understand the retiree's needs and direct him or her to the most appropriate plan with the lowest cost. Plans are tailored to individuals needs and circumstances.

Why it works?

Retiree medical coverage on a Medicare exchange typically costs less than a traditional employer group plan because the number of people participating in Medicare—40 million and growing—is significantly larger than any single large employer. The carriers are able to spread risk across millions of people versus tens of thousands in the State plan.

This market is guaranteed issue. When someone turns 65 or when someone 65 or older moves off of an employer's group plan, they enter a guaranteed issue period meaning there is no medical underwriting. No one can be denied coverage or pay a higher premium due to medical situations.

Medicare exchanges often provide better healthcare coverage for retirees for one simple reason: choice. On Extend Health's exchange, for example, retirees can compare and choose from thousands of private Medicare plans – and doctor networks - offered by more than 80 insurance carriers. If a retiree chooses Medigap coverage, then they get access to ANY doctor participating in Medicare It is this choice of plans and networks (in Illinois and elsewhere), competition, and support of licensed advisors that makes an exchange a powerful solution for retirees.

THE SOLUTION IN NEVADA

At the end of 2010, after looking at Medicare exchanges, Mr. Wells and the Nevada Public Employees Benefit Program hired Extend Health to serve as the Medicare exchange to serve its post-65 retiree population starting in 2011.

Effective July 1, 2011, those retirees over 65 years of age who were eligible for Medicare were transitioned from the Nevada PEBP group health care plan to Extend Health's Individual Medicare Market Exchange (IMME). In lieu of the existing premium contribution that PEBP paid towards the group plan prior to this conversion, PEBP provided each eligible retiree and eligible spouse a flat dollar amount, based on years of service, in the form of a Health Reimbursement Arrangement (HRA). Retirees can select the plan and carrier that meets their specific needs and use their HRA funds for premium and out of pocket reimbursements. Under this contribution arrangement, any balance remaining in the HRA rolls forward month-to-month and at the end of the year, any unused amount will continue to roll forward for future plan years. In other words, retirees never lose any unused funds.

The financial benefits to the state were significant and instant. With the conversion, the state reduced its annual required contribution for the OPEB [Other Post-Employment Benefits] liability 45%, from $222.1 million to $120 million, a savings of $102.1 million. The OPEB liability itself decreased by 54%, from $3.26 billion to $1.77 billion, a savings of $1.49 billion. Finally, the actuarial accrued liability decreased by 48%, from $1.9 billion to $977 million, a savings of $923 million. I would like to remind the board that pre-conversion, the state was looking at a shortfall of $111.2 million.

From information publicly available, we estimate the State of Illinois can reduce the amount it spends on Medicare eligible retiree coverage by about $100 million per year. The liability reductions will be a multiple of those cash savings and need to be calculated.

And while the financial benefits for the state were large, it could be argued that the benefits to the retirees were even larger. I'd like to address those benefits by dividing them into three main categories: personal choice, personal guidance, and cost savings.

EMPOWERS RETIREES WITH PERSONAL CHOICE OVER CRITICAL HEALTHCARE DECISIONS

As stated earlier, Extend Health's Medicare exchanges offer thousands of plans provided by over 80 national, regional and local health insurance carriers. Explicitly, retirees don't ask for this much choice – in fact they probably don't even want to know how many options they have. What retirees do ask for is to have their specific needs met, whether those needs be specific health conditions, specific prescription drug requirements, preferences for a family doctor, an essential specialist, peace of mind when you travel or move outside of Illinois, or other important needs. We learned long ago that the only way to meet each retiree's needs is to offer many plans across many carriers. The choice is a means to the end.

This choice was a major benefit to Nevada retirees—and spouses—since they could now enroll in a plan and carrier that met their individual needs. This benefit of choice applied to every retiree—even those

living in rural or smaller areas—because with the Medicare exchange every Nevada retiree had access to multiple plans across multiple carriers in every zip code or county. Therefore, a healthy Nevada retiree could choose a plan with a lower premium but higher out of pocket costs when they go to the doctor, whereas an individual with more medical needs could select a plan with a slightly higher monthly premium but lower out of pocket expenses at the point of care. Or a retiree who does not want to switch doctors could choose a plan that ensures continuity of coverage while another who is open to switching doctors might be able to find a different plan with overall lower costs. A retiree who lived in Nevada part of the year and Maine the other part, could choose a Medigap plan that covers them in both states, rather than a Medicare Advantage plan that would only cover them in one.

Did they take advantage of this choice? Absolutely. Nevada retirees enrolled in 342 different plans across 53 different carriers with 73% of retirees selecting a Medigap plan and the remaining 27% of retirees selecting a Medicare Advantage plan.

In short, the one-size-fits-all group model does not meet the needs of retirees. Nevada realized this and provided their 12,000 retirees meaningful choice leaving retirees thankful.

PERSONAL GUIDANCE

Choice is important but finding the right plan is critical. How does a retiree navigate through all that choice and pick a plan that is best for them? I'll be the first to admit, healthcare is confusing – and this is my profession. This is the second benefit of the Medicare exchange to the Nevada state retirees—personal guidance. Extend Health provides comprehensive personalized guidance, making sure that every retiree has the opportunity to work with a licensed benefit advisor and is comfortable through the transition and confident in their coverage moving forward.

First, Extend Health provided extensive communication and proactive outreach to each retiree to make sure that no Nevada retiree was left behind. That communication began with 20 in-person group educational meetings in the fall of 2010 to ease retiree concerns and anxiety. During the pre-enrollment period (January to April), Extend Health mailed Getting Started Guides to each retiree and had initial phone conversations with retirees—both outbound calls and through a dedicated toll-free number for the Nevada retirees—aimed at getting to know the retiree and their specific situation and set up personalized appointment times for enrollment. This pre-enrollment period also included 62 additional in-person educational meetings in Reno, Carson City, and Las Vegas. During the enrollment period (April through June 30), Extend Health mailed Enrollment Guides to each retiree, participated in an additional 39 in person educational meetings and completed enrollments for over 10,000 retirees.

During this entire process, retirees spoke to one of our benefit advisors an average of 2.1 times before enrolling in a plan. Advisors, guiding retirees through the plan evaluation with the patience and hand-holding they deserve, assess each retiree's specific needs and ultimately recommend a plan and carrier based on those needs. These advisors are salaried individuals—they do not receive any commission. Their entire objective is to make sure the retiree is comfortable with the process and confident in the decision. It is also important to note that the enrollment process is not the end of our relationship with the retiree. Nevada retirees look to Extend Health for all of their ongoing questions, concerns, plan changes or any other health care need.

And through the enrollment season, if there were still retirees that had not enrolled, Extend Health identified those retirees and actively contacted each of them again, including sending certified letters. At the end of the enrollment period, there were only 51 retirees—less than .5% of the total

population—who had not spoken to Extend Health. Some retirees chose not to enroll in a medical plan but it was not because Extend Health wasn't there ready to help them – some were on a spouses plan, others were on military benefits. The point is that no retiree was left behind, whether they used the exchange or not.

Were the state retirees of Nevada happy with the guidance and experience with Extend Health? After every retiree enrollment, retirees have the opportunity to provide feedback by answering a simple question: "On a scale of 1 – 10, how satisfied are you with Extend Health's service?" 86% of the surveys that were completed scored Extend Health's guidance in the "Extremely Satisfied Category".

COST SAVINGS

As stated, the cost savings to the state of Nevada were significant, but so to were the cost savings for the Nevada retirees. I would like to quote from the notes of a March 4, 2011 hearing in which Mr. Wells stated, perhaps better than I could, why his retirees were going to save money by using the exchange. "According to Mr. Wells, transitioning Medicare-eligible retirees to the IMME (Individual Medicare Market Exchange) was a method of preserving healthcare benefits for retirees while lowering the cost, not only for the plan, but also for the participants. Mr. Wells explained that the individual market covered between 40 and 50 million individuals, which provided a much broader pool of participants over which to spread risk. That provided more competitive rates because of the size of the risk pool and the competition in each geographic location."

Prior to the conversion to the Medicare exchange, per Mr. Wells, the premium for the current Nevada group medical plan was $283.55 for a single Medicare retiree. With the Medicare exchange, based on the plans and carriers Nevada retiree's enrolled in, the average monthly Medigap premium was $186, a savings of $97.55 or 34%. The average premium for Medicare Advantage plans was $18.00.

We estimate the average Medicare eligible retiree will save over $500 in total costs (premiums and out of pocket costs) by utilizing a Medicare Exchange versus what they pay in the existing group plan.

CONCLUSION

This panel has been more than generous with its time and attention and for that I thank you. In closing I would just ask that you consider this final point. Traditional employer group Medicare plans have been in place since President Nixon enacted the Health Maintenance Organization Act of 1973 and they are not always the right approach. More than 300 large public and private employers have leveraged a different and better way to deliver benefits to Medicare retirees—a Medicare exchange. Adjusting the settings on your traditional healthcare model is not going to fix the problem, and may very well exasperate problems for and with the State's retirees by severely limiting their choice of doctors and hospitals.

Thank you.

Statement provided by John Corrigan as part of testimony to CGFA on 5/20/13

Inaccurate Statements Made By CMS at the Senate Executive Committee Hearing on May 15, 2013

1. CMS statement: Advisors get paid a commission.

Correct response: This is not true of Extend Health. Our licensed benefit advisors are salaried based. They receive no commission or incentive to enroll retirees in any plan or carrier. Our advisors' primary objective is to make sure the retiree is comfortable with the process and confident in the decision.

2. CMS statement: Nevada's rates under Extend Health were based on 12,000 retirees. Illinois can get better rates with their 100,000 retirees in the group plan.

Correct response: With Extend Health, a private Medicare exchange, medical and prescription plans are fully insured, individual policies. Therefore, the premium rates for these individual plans are not based on the risk pool of the State of Illinois' employer group plan with 98,000 retirees but instead are based on the risk pool of the millions of people enrolled in these individual plans. Transitioning Medicare-eligible retirees from the traditional group plan to the individual market is a method of preserving healthcare benefits for retirees while lowering the cost, not only for the State, but also for the retiree participants. The individual Medicare market covers between 40 and 50 million individuals, which provides a much broader pool of participants over which to spread risk. The result is more competitive rates because of the size of the risk pool and the competition in each geographic location.

From information publicly available, we estimate the State of Illinois, leveraging a Medicare exchange, can reduce the amount it spends on Medicare eligible retiree coverage by 20%, a cash savings of about $100 million per year. The liability reductions will be a multiple of those cash savings and need to be calculated. Furthermore, with this reduced and capped contribution amount, we estimate the majority of retirees have the opportunity to purchase an individual plan on our exchange that provides equal to or better coverage than the group plan for less cost.

3. CMS statement: January is the only month CMS can make this switch to Medicare Advantage plans because of the federal open enrollment period is the time in which our retirees can enroll without underwriting.

Correct response: At the point in which someone turns 65 or when someone 65 or older moves off of an employer's group plan, they enter a guaranteed issue period meaning there is no medical underwriting. In other words, no one can be denied coverage or pay a higher premium due to medical situations. For example, the State of Illinois can transition Medicare-eligible retirees from the group plan for an effective date of July 1, 2014 and this event will open a special enrollment period allowing Medicare-eligible retirees who are enrolled in the State's group plan to purchase any plan (Medicare Advantage, Medigap, Part D) across any carrier (BCBS IL, Health Alliance, Humana, AARP etc.) without any medical underwriting.

CMS Statements/Topics Requiring More Clarity

1. CMS: The HRA allocation doesn't reduce the state's budget/cost.

EH response: From information publicly available, we estimate the State of Illinois, leveraging a Medicare exchange, can reduce the amount it spends on Medicare eligible retiree coverage by 20% on average, a cash savings of about $100 million per year. The liability reductions will be a multiple of those cash savings and need to be calculated. Furthermore, with this reduced and capped contribution amount, we estimate the majority of retirees have the opportunity to purchase an individual plan on our exchange that provides equal to or better coverage than the group plan for less cost.

2. CMS: There is not enough time to implement.

EH response: Extend Health has completed over 300 unique client implementations including large, complex employers such as Ford Motors, General Motors and DuPont all with almost 100,000 retirees. We have a standard and proven transition process which requires only 8 to 10 months of implementation time prior to the effective date. For example, for a July 1, 2014 effective date, implementation would begin October 1, 2013.

3. CMS: Medicare Advantage plans will control the states cost by MANAGING the health care of the retiree.

EH response: The individual market is already proven to be more competitive and stable than the traditional employer group plans.

Question: How and by how much will these Medicare Advantage plans control the State's health care costs—especially when CMS is not proposing to implement wellness initiatives and retiree participation requirements?

4. CMS: CMS is talking to different insurance companies to build a passive PPO network among the Medicare Advantage plans. This will allow retirees to see any doctor that accepts Medicare and whether the doctor is in the Medicare Advantage plans network or not, the retiree will pay the same amount at the doctor. This eliminates the need for retirees to change doctors.

   a. Question: Are these insurance companies developing this special passive PPO network especially for the State of IL? If not, who else do they provide it for?

   b. Question: Does the passive PPO network include all hospitals? Does the same rules apply—retirees can go anywhere as long as the hospital accepts Medicare

   c. Question: What is the provider reimbursement arrangement (discounts, fee for service) for those out-of-network providers. In other words, what does the State have to pay these non-participating doctors and hospitals?

d. Question: How does this passive network manage the health of the retiree, since it is this managed care that is the catalyst for sustained State savings?

e. Question: How does this passive network still provide the State $100 million in annual cash savings?

f. Question: Are these insurance companies developing this special passive PPO network especially for the State of IL? If not, who else do they provide it for?

5. Choice—it seemed CMS believes offering multiple group Medicare Advantage plans is offering retirees choice.

EH Response: Extend Health's Medicare exchange offers thousands of plans provided by over 80 national, regional and local health insurance carriers including BCBS IL, Health Alliance, Humana, AARP, Aetna and more. Explicitly, retirees don't ask for this much choice – in fact they probably don't even want to know how many options they have. What retirees do ask for is to have their specific needs met, whether those needs be specific health conditions, specific prescription drug requirements, preferences for a family doctor, an essential specialist, peace of mind when you travel or move outside of Illinois, or other important needs. We learned long ago that the only way to meet each retiree's needs is to offer many plans across many carriers.

With our exchange, this benefit of choice will apply to every State of Illinois retiree—even those living in rural or smaller areas—because we will ensure every retiree has access to multiple plans across multiple carriers in every zip code or county across the country. Therefore, a healthy retiree can choose a plan with a lower premium but higher out of pocket costs when they go to the doctor, whereas an individual with more medical needs could select a plan with a slightly higher monthly premium but lower out of pocket expenses at the point of care. Or a retiree who does not want to switch doctors could choose a plan that ensures continuity of coverage while another who is open to switching doctors might be able to find a different plan with overall lower costs. A retiree who lives in Illinois part of the year and Florida the other part, can choose a Medigap plan that covers them in both states, rather than a Medicare Advantage plan that would only cover them in one.

Among our clients, retirees on average select 400 unique plans across more than 50 different carriers with 75% retirees selecting Medigap plans and the remaining 25% of retirees selecting Medicare Advantage plans. Retirees need choice among all types of plans and carriers.

6. CMS: A national PPO will be offered to retirees who live outside of Illinois.

a. Question: How does the national PPO impact the $100 million dollar savings?

b. Question: Is the national PPO network passive as well? If not, what is CMS planning for those retirees who live out of state and their doctor is not in the PPO network? Do these retirees have to pay more to stay with their same doctor?

c. Question: What about providing the out of state retirees choice? Is the personal needs of someone who worked for Illinois for 40 years and then had to move to Texas to move in with her son because of financial and health needs not as important?

7. CMS: Retirees are thrown out into the individual market and just left to talk to someone on the phone.

EH response: We are the Medicare experts—serving, guiding, advocating for 70, 80, 90 year old retirees is what we do 100 percent of the time, every single day. It is because of this focus and experience that so many employers have put their trust in us to serve their retirees. Our licensed benefit advisors—guiding retirees through the plan evaluation with the high-touch, patience and hand-holding they deserve—assess each retiree's specific needs and ultimately recommend a plan and carrier based on those needs. These advisors are salaried individuals—they do not receive any commission. Their entire objective is to make sure the retiree is comfortable with the process and confident in the decision. It is also important to note that the enrollment process is not the end of our relationship with the retiree. Retirees look to Extend Health for all of their ongoing questions, concerns, plan changes or any other health care insurance needs.

8. CMS: Exchanges have a bad connotation.

EH response: Extend Health began serving Medicare retirees in 2006 as a Medicare Connector—connecting retirees to value that exists in the individual market. The phrase "exchange" and now "marketplace" is just another way to describe that connection.

ILLINOIS COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

Co-Chair Senator Michael Frerichs - Co-Chair Representative Jil Tracy

RECORD OF COMMISSION WITNESS

May 20, 2013

SUBJECT MATTER: **GROUP INSURANCE**

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TESTIMONY: [ ] Oral [ ] Written Statement Filed [ ] Record of Appearance Only

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WRITTEN COMMENTS:

MEDIGAP SUP VS MEDADVANTAGE

ILLINOIS COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

Co-Chair Senator Michael Frerichs - Co-Chair Representative Jil Tracy

RECORD OF COMMISSION WITNESS

May 20, 2013

SUBJECT MATTER: **GROUP INSURANCE**

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TESTIMONY: ☐ Oral ☐ Written Statement Filed SB1515 ☐ Record of Appearance Only

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WRITTEN COMMENTS:

ILLINOIS COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

Co-Chair Senator Michael Frerichs - Co-Chair Representative Jil Tracy

RECORD OF COMMISSION WITNESS

May 20, 2013

SUBJECT MATTER: GROUP INSURANCE

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Address: _____ City: _____ State: _____ Zip: _____

Email: tclatfielter@yahoo.com

POSITION: ☐ Proponent ☒ Opponent SB 1515 ☐ No Position

TESTIMONY: ☐ Oral ☐ Written Statement Filed ☐ Record of Appearance Only

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WRITTEN COMMENTS:

Kapp, Lynnae

From: Bolton, Anthony R.
Sent: Monday, May 20, 2013 12:43 PM
To: Kapp, Lynnae
Subject: FW: 5/19/13 CGFA

From: jeri s [mailto:jshan18@sbcglobal.net]
Sent: Sunday, May 19, 2013 11:02 PM
To: Bolton, Anthony R.
Subject: 5/19/13 CGFA

Commission on Government Forecasting & Accountability
703 Stratton Ofc. Bldg.
Springfield, IL.62706
May 19, 2013

Mr. Dan Long and members of CGFA

Having noticed the agenda of your hearing scheduled for May 20, 2013 relates to retirees' Health Insurance, I wish to once again relate some major concerns.

Many "downstate" teachers who retired in 2004 were required to notify TRS , a year or two in advance that they were to retire in 2004. One month after we retired there was a TRS buy into Medicare Plan, which began on July 1, 2004. We were not able to take advantage of that opportunity. That information was not given to us in 2002 -2003.
Without Medicare we do not qualify for secondary health insurance.

Those of us who do not have the needed 40 quarters for Social Security/Medicare , and who made the choice to continue to reside IN Illinois since 2004, have been charged more than $ 56,800 for single coverage health insurance premiums with the State self-insured CIGNA plan.

At the same time those retirees, age 65+ enrolled in the very same CIGNA Health Insurance Plan, but made the choice to move OUT of the State of Illinois have been charged **1/2** the cost for their premiums $28,400 +.

According to the recent CMS notification retirees age 65+, without Medicare who make the choice to reside IN Illinois 2013 - 2014 will pay a monthly premium of **$719.96** for their CIGNA health insurance. At the same time, the retirees age 65+, without Medicare who make the choice to live OUT of Illinois, will be charged **$359.99** a month for the very same health insurance coverage.

Some of us reside IN the school districts from which we retired and have been charged disproportionate (double) premiums due to making the choice to continue to reside IN that Illinois School District.

As you address issues relating to retired teachers' health insurance plans etc. , I respectfully request you take into consideration these facts. May I also bring to your attention the many, many audits related to the TRS TCHP Health Insurance Plan and the lack of a written methodology for setting the premiums, as stated by the Office of the Auditor General.

Thank you.

Sincerely ,
Jeri Shanahan

***Mr. Bolton, Please let me know you received this for the record.
Thank you.