COOK COUNTY/FOREST PRESERVE DISTRICT

ANNUITY AND BENEFIT FUND

SPECIAL AUDIO MEETING OF THE HEALTH BENEFITS COMMITTEE

STENOGRAPHIC REPORT OF PROCEEDINGS had at the audio meeting of the above-entitled matter, held at 70 West Madison Street, Suite 1925, in the City of Chicago, County of Cook, State of Illinois, on Wednesday, April 28, 2020, commencing at the hour of 9:30 a.m.

APPEARANCES

TRUSTEES PRESENT BY AUDIO CONFERENCE:

LAWRENCE L. WILSON, President
PATRICK McFADDEN, Vice-President
DIAHANN GOODE, Secretary
JOHN BLAIR
STEPHEN HUGHES
JOSEPH NEVIUS
KEVIN OCHALLA
JAMES M. O'ROURKE

STAFF PRESENT IN PERSON OR BY AUDIO CONFERENCE:

REGINA TUCZAK, Executive Director
MARGARET FAHRENBACH, Legal Advisor
CAROLINE VULLMAHN, Deputy Executive Director
JANE HAWES, Director of Health Benefits
RACHELLE HOWLIET, Senior Health Benefits Specialist
TONYA JACKSON, Health Benefits Associate

ATTORNEY FOR THE BOARD:
BURKE, BURNS & PINELLI, LTD.
BY: MS. MARY PATRICIA BURNS

ALSO:

CVS HEALTH
SEAN DONOVAN
JAMES HOGAN
KATHY GOERGES

UNITED HEALTHCARE
MICHAEL MORRIS
BETHANY BUMP-WHITE
MICHAEL WALL

SEGAL
DAN LEVIN
CRISTINA DELEON
PETER CAVANAUGH
THOMAS WYSZOMIRSKI

MS. FAHRENBACH: This is the recording of the Health Benefits Committee on April 28, 2020. It is recorded pursuant to the Governor's Executive Order.

CHAIRMAN McFADDEN: The time being nine o'clock, on April 28th, Tuesday, I'd like to convene this Special Audio Meeting of the Cook County and Forest Preserve District Annuity and Benefit Fund Health Benefits Committee for Tuesday, April 28th of 2020.

Mary Pat, as we discussed in the preparation for this audio meeting, will you please outline the procedures that you as fiduciary counsel are recommending that we follow for this meeting in order to comply with all applicable orders and laws?

MS. BURNS: Thank you, Chairman McFadden.

Let me explain to those on the call that this meeting is being held pursuant to Governor Pritzker's Executive Order Number 2020-07 and guidance provided by the Illinois Attorney General Kwame Raoul, which allows trustees to conduct meetings where the trustees are not physically present.

Consistent with those directives from both the Governor and the Attorney General, Notice of this meeting consistent with the Open Meetings Act has been provided. Notice has been publicly put on the website and members of the public have been provided with the call-in number in order to participate in the meeting.

Consistent with the Governor's Order, the agenda for the meeting has been pared down by staff to only deal with what the Committee deemed to be essential items and that agenda was prepared with the guidance of the Chair of the Committee.

Today's meeting is in effect an educational meeting and it is not expected that the Committee will take any action or that there will be a lot of dialogue today amongst the committee members. The purpose of the meeting is intended to allow trustees to receive information with the expectation that future meetings will be the better forum where the public can be physically present, for trustees to ask those questions and discuss the information provided today.

We are going to ask the Committee to be respectful of the hours set for the meeting. Both

the members of the committee and the vendors who are participating in this meeting need to watch the time constraints established prior to the meeting. The meeting is going to end at or before 10:30. That time has been set for a lot of reasons and we would ask people to respect the timeframes that the Executive Director has set up prior to the meeting with the individual vendors.

I believe vendors each have been given 20 minutes to make their presentation so trustees on the phone can adjust their schedules accordingly. It is our expectation there would be 20 minutes from the various vendors that are presenting today, and then Segal will present.

Again, at the request of the Chair and the Executive Director and with guidance from your legal staff, we are going to ask you once we start to hold your questions and if you have questions regarding the information that you are receiving today that you direct those questions to Gina after the meeting and Gina will work to get you answers to prepare for what comes in the future. And that is important because your questions can either be directed to Gina or you can hold them until you as

a committee are back together in-person where you can discuss the information amongst yourselves.

The reason we're asking you to follow this format is that because of the limited nature of the audio call it is sometimes hard for questions to be articulated and the system we are using doesn't allow for discussion amongst the trustees.

Again, it is a little bit different than usual, but if you could jot down your questions, if you have them when you are listening to the information, you could direct those questions to Gina. Gina will make sure you get answers to those questions and then she will circulate the answers to the other members of the Committee and the other members of the Board that are on the call so that everybody has access to the same information that every other trustee has.

As a predicate, we want to remind the Trustees on the call and the members of the public that this informational or educational meeting is meant to give Trustees, including our newer Trustees, the foundation that will help them make an informed decision on health care issues down the

road, hopefully, in August, when the Health Benefits Committee meets to make recommendations to the full board regarding the rates that will be in effect for the next year.

So this is sort of a foundational meeting, educational meeting if you will, to then allow that informed decision to be made in August.

Now today's meeting as I said before is open to the public and I remind both the Trustees, the vendors and the members of the public who may dial in that this meeting is being recorded.

A transcript or summary of the meeting will be made available on the Fund's website at a later date and we will work with the vendors to make sure that the information conveyed in that transcript is accurate.

Now my final request, at the request of the Chair and on behalf of the Board and the Committee, is that everybody on the phone who is not talking mute their phones to minimize the background noise and allow the vendors to be able to present their materials to the members of the Committee and the Board in a manner where they can hear it and understand it.

So with that, sir, I think you are ready to proceed.

CHAIRMAN McFADDEN: Okay.

TRUSTEE O'ROURKE: Pardon the interruption. This is Trustee O'Rourke. I have joined the meeting.

MS. BURNS: Trustee O'Rourke, thank you for joining us. You will be noted in the minutes.

TRUSTEE O'ROURKE: Thank you.

CHAIRMAN McFADDEN: Did you hear Mary Pat's comments, Jim?

MR. O'ROURKE: Yes.

CHAIRMAN McFADDEN: Thank you.

Peggy, would you please call the roll.

MS. FAHRENBACH: Yes, Trustee McFadden.

Trustee Blair.

TRUSTEE BLAIR: I am here. Good morning.

MS. FAHRENBACH: Trustee Goode.

TRUSTEE GOODE: Present.

MS. FAHRENBACH: Trustee Hughes.

TRUSTEE HUGHES: Present.

MS. FAHRENBACH: Trustee Kouruklis.

Trustee McFadden.

CHAIRMAN McFADDEN: Present.

MS. FAHRENBACH: Trustee O'Rourke.
TRUSTEE O'ROURKE: Present.
MS. FAHRENBACH: Trustee Wilson.
TRUSTEE WILSON: Present.
MS. FAHRENBACH: Trustee Ochalla.
TRUSTEE OCHALLA: Here.
MS. FAHRENBACH: There is a quorum present.
CHAIRMAN McFADDEN: Thank you.
MS. FAHRENBACH: Trustee Nevius. I think I omitted him.
TRUSTEE NEVIUS: Yes. Present.
MS. BURNS: That is above and beyond, Trustee Nevius, to be on the call.
TRUSTEE NEVIUS: Yes. I am a non-member.
MS. BURNS: I know. It is great. Welcome.
TRUSTEE NEVIUS: Thank you.
CHAIRMAN McFADDEN: Now the next point would be an opportunity for public comment consistent with the Public Act 91-0715, with reasonable constraints determined by the Board of Trustees.
At each meeting of the Board, including

committee meetings, members of the public may request a brief time to address the Committee on relevant matters within its jurisdiction.

Are there any requests for public comment today? If any member of the public wants to speak, please identify yourself for the record.

With apparently no one from the public wanting to comment today, we will proceed to the agenda for today.

The first item on the agenda are the minutes from the meeting of October 24th of 2019.

Have you had an opportunity to take a look at the Minutes and would someone please make a motion to approve those minutes?

TRUSTEE WILSON: This is Trustee Wilson.

I move that the minutes for October 24, 2019 be approved.

CHAIRMAN McFADDEN: Seconded by?

TRUSTEE HUGHES: This is Trustee Hughes.

I second Trustee Wilson's motion.

CHAIRMAN McFADDEN: Thank you. Motion to approve the minutes of the meeting from October 24th of last year.

All in favor?

(Chorus of ayes.)

CHAIRMAN McFADDEN: Opposed?

Thank you. The minutes have been approved.

I am now going to ask Gina to handle the presentations, coordinate the presentations, and remind everyone that we have asked those participating today to limit their comments to 20 minutes.

I would ask my fellow trustees to keep any questions until such time we are together in-person or direct any questions to Gina or myself who will make sure to answer the questions and share the information with all the other members of the Committee along with the questions so that we may be educated on all the matters covered today.

Gina, the first item I believe is we are going to hear from CVS on the benefits plan performance for the last calendar year.

MS. TUCZAK: Yes. Thank you, Chairman McFadden.

CVS is going to have two presentations. The first presentation is with respect to the Medicare program for pharmacy benefits also

referred to as the EGWP SilverScript and Wrap Plan.

At this time there are three members of the CVS team that will walk you through the presentation.

And I will ask Sean Donovan if you could introduce the other two members with you and begin your presentation. Thank you.

MR. DONOVAN: Good morning, everyone. Again, my name is Sean Donovan. I am with CVS Health or SilverScript.

My focus has historically always been the SilverScript or Medicare. The EGWP Plan that we always refer to for the Medicare retirees of the Pension Fund.

Also on the line today, I have Jim or James Hogan, who has been with the Pension Fund for many years. His focus is on the commercial pre-Medicare population.

And then finally on the phone, I have Kathy Goerges, who is our Clinical Advisor here at CVS. She can answer all matters or all questions clinical related when it comes to specific drugs or a clinical specific question.

Again, the first topic today will be the

Medicare or EGWP population and their drug utilization for 2019. And then after that I will hand it over to Jim to go over the pre-Medicare population.

Am I set to get going, Gina?

MS. TUCZAK: Absolutely, please do, and I have started your time so if you could proceed onward. Thank you, Sean.

MR. DONOVAN: Thanks, Gina.

I am on the slide labeled Cook County Pension Fund EGWP on slide one. It references the Medicare Employer Group Waiver Plan for 2019.

If you can please move to Page Number 2 and at the top there it is labeled Key Metrics at a Glance and I will kind of look through the slide from top to bottom and go through the numbers.

Again, this is the focus on your EGWP Medicare population. And on the top here, we have got a couple of columns, and we can see that we are going to be comparing January through December of 2018 and how those figures change moving forward January through December of 2019.

I'm sorry. I heard some feedback. Was there a question already?

MS. BURNS: No. I would ask people to mute their phones if they are not speaking.

MR. DONOVAN: Thank you.

Again, looking at the top of the slide here, we can see that the average members did raise almost 300 or about -- just over 200 members for 2018 into 2019. So as of 2019 we are looking at just under 9300 members being in this EGWP Medicare benefits and of that population we can see the next row below about 71 and a half or 72 percent of those numbers are actually utilizing the benefits and getting prescriptions on an annual basis.

In that far right-hand column, where it is labeled "Peers" at the top there, that is our comparison numbers showing our EGWP book of business.

You can see as we go through this slide how some of these figures compare to our EGWP book of business for all of our other EGWP book of business clients that we have today.

Moving down going to the next bracket which is labeled "Total Medicare Part D Drug Costs".

We can see from an overall gross drug

cost prospective for your medications, it raised about 4 million dollars every year or about 9 percent. So you went from 42.4 million to 46.3 million in 2019.

Now the next row below is labeled "Rebates".

In case there is any parties on the call today that need a refresher on what a rebate is, this is a set amount that we have negotiated, along with your consultant Segal. It is a set amount for any brand name medication that a Member receives. It is a said amount that the Pension Fund receives back from the pharmaceutical manufactures and we pass this amount back to the Pension Fund at 100 percent.

So on this EGWP Plan, many members are buying brand name medications and for each brand name medication you are getting a set amount back and sometimes it is an amount over that, if the pharmaceutical manufacturer is actually giving us more. But essentially it is set amounts that you are receiving back for any brand name medication that a Member fills.

For 2019, those rebates added up to just

over 11 million dollars, which you can see when compared to 2018 was a healthy increase of about 34 percent. This is again in large part due to the increase in rebates and pricing that we negotiated on your behalf.

When you factor in rebates, that moved the gross cost with rebates down to about 35.3 million in 2019. You can see about 3.3 percent increase from 2018 where it was 34.2 million.

The next row below is labeled "Member Cost". These are essentially your member copays that have added up throughout the year.

Not much changed there from 2018 to 2019 because the Pension Fund did not make any copay changes. We saw a little movement in terms of the amount of copays members were paying.

That Member Cost Share percentage or the percentage of copays overall was a slight decrease of about 7 and a half percent average Member Cost Share in 2019.

If you look at the far right-hand side there, the column labeled "Peers", that is a 6.7 percent. We can see that you're still managing costs well in terms of a plan design prospective,

but numbers are still contributing to the benefits and it is about average of what we're seeing for the book of business as well.

So we factor in rebates and all those member copays or cost share, that dropped the total net cost down to 31.8 million for 2019. Which again there is only about 3, 3 and a half percent, increase over 2018 where it was 30.8 million.

I will keeping moving down on the slide to the bracket labeled "EGWP Offsets and Subsidies"

So, again, you are in an EGWP because you receive many different flows or subsidies coming back from CMS or from Medicare. These greatly help offset the costs for this Medicare population.

And for 2019 the total for all those offsets or subsidies coming back from Medicare equalled about 18.7 million for the whole year, which was almost a 35 percent increase from 2018 where that was 13.9 million.

CMS made some positive changes in 2019 and increased some subsidies. You can see that 34 percent increase really drove home and reflected here for that 18.7 million that the Pension Fund received back.

So when we factor in all those rebates I went over, the member cost share, and now the EGWP offset and subsidies I just mentioned, that dropped the Fund's liability down to 13.1 million in 2019. Which when you look at the figure on the left-hand side there from 2018, it was 16.9 million. So we are showing about a 22 percent decrease in overall costs year over year for 2019 for the Pension Fund. So that is great news to report back.

The bottom bracket here is some of those costs reflected on a Per Member Per Month or PMPM rate.

I am not going to go through all of this but I will just focus on the bottom figures there that I drew the black box around and you can see from a Per Member Per Month figure, when you add up all the subsidies, rebates, and how they drive down the costs, the Per Member Per Month cost in 2019 for the Cook County Pension Fund Medicare members was $124.02. As you can see, it is a healthy decrease year over year from 2018 where it was $161.30. A negative rate of 23.1 percent year over year and that negative 23.1 decrease is directly reflected in that graph on the right-hand side

there, that large bar going down. It is always great to report back a negative trend like that when it is so significant.

I will move on to slide Number 3. This one is also labeled "Key Metrics at a Glance". It is a bit shorter.

This is essentially the different drug mix for medication that the numbers are using from a high level prospective. In terms of how the members are using various brand name medications or generics, everything was pretty much in line in 2019 from what we saw in 2018. There weren't any major shifts.

Then from comparing the Cook County Pension Fund to the peers or book in business trade with again no major outlayers. The Pension Fund is using about 87 percent generics compared to the book in business so you are doing well there. Your members are using generics where they can and that is great to see.

The middle section is labeled "Utilization". These are the various channels they are utilizing. Whether they are going to retail, mail or many of the Cook County pension members

love that Choice Script option where they can get a 90 day supply of their maintenance medications at CVS retail locations, including the Target location.

We really like to drive home that maintenance choice option. It is a win-win for your members and the Pension Fund essentially getting a better bang for its buck for that level there. You can see almost 45 percent of the prescriptions were eligible for that maintenance choice option.

When you look at the book of business on the right-hand side there, it is only showing about 13 percent. Again, Cook County Pension Fund members really love that maintenance choice option to get their medications filled.

On the bottom here, we have the high cost medications. Often times the injectables that cost a lot of money. And we can see that the increase was about 19 to 20 percent year over year. You went from 15.4 million in 2018 to 18.4 million in 2019. This is essentially what we are seeing across our book of business. So the increase in the specialty section is not specific to the Cook

County Pension Fund. It is a large increase but it is exactly what we are seeing across the book of business.

I will go ahead and move on to slide Number 4. This one is labeled "Your Top Ten Therapeutic Class Review".

This is a review of the top ten therapeutic classes that your members are essentially utilizing throughout the whole benefit year.

On the top left-hand side of the chart, we have got the book of business rank. Again, that is your EGWP peers. All the Medicare clients that we also manage for the EGWP population. And then we have the Prior Rank, which is the 2018 level. Current Rank is your 2019 rank as well.

I will go through it and kind of give a brief overview of what this slide is showing.

From a ranking prospective, ranks one through seven, and I have the black box around ranks one through seven. The Pension Fund ranks for 2018 and 2019 and there was no change for those top seven therapeutic classes. There was no real major shifts of utilization in terms of how members

or what types of medication members are filling throughout the year.

Antidiabetics is always Number 1. You can see on the left-hand side there is also the book of business or peer is Number 1 as well.

You see about almost 45 percent of prescriptions were eligible for that Maintenance Choice option.

When you look at the book of business on the far right-hand side there, that is showing about a 13 percent.

Again, Cook County Pension Fund members really love that Maintenance Choice option for getting their medications filled.

On the bottom here, we have got the specialty section. High cost medication. Often times they are the injectables that cost a lot of money. And we can see that the gross cost increase is about 19 to 20 percent year over year. So you went from 15.4 million in 2018 to 18.4 million in 2019.

This is essentially what we are seeing across our book of business so it is not specific to the Cook County Pension Fund. Across the EGWP

book of business or Medicare book of business, we're seeing similar increases for specialty medications.

It is a large increase but exactly what we are seeing across the book of business.

I will go to slide Number 5. This is more for your own reference in case you are wondering back from the previous slide what sort of drugs may be reflected and shown in the various classes and what drugs may be driving some of those costs.

Number 1 there on the top, we can see a drug there called Revlimid, which you can see on the right-hand side there. The dispense type is labeled a Specialty medication.

As we just went over, your specialty costs are going up about 20 percent year over year. This is one of the reasons why because of drugs like Revlimid that are being utilized more and more by members.

This drug specifically, towards the right-hand side, you can see the gross cost was about 2.6 million for 2019. Only having about 23 utilizers with about 180 prescriptions.

It is a very costly drug. About $14,000 or so per prescription and it is a Number 1 drug for the Cook County Pension Fund and the Number 2 drug EGWP book of business.

Again, this slide is more for your own reference in case you are wondering off of the previous slide which drugs may be impacting the top ten therapeutic classes.

If you have any followup questions in terms of these specific medications, feel free to let Jane and Gina know and we can get our clinical advisor answer those for you.

The next slide is slide Number 6. This one is labeled "Your Enhanced Benefits Only. Therapeutic Class Review".

And what enhanced means is it essentially that Wrap benefit that Gina mentioned when she was introducing me.

Again, in case you are not too familiar in terms of what an EGWP is, it has two various plans working behind the scene. It has a Medicare plan on the front end and on the back end you have this enhanced or Wrap benefit that kind of wraps around the standard Medicare plan and offers many

additional benefits in terms of drug coverage.

This slide specifically speaks to that wrap around coverage or the extra coverage that the Pension Fund provides for its members.

These classes are only those drugs that are going through that Wrap coverage specifically.

So, again, in terms of ranking 2018 into 2019, we can see that there was no shift or movement for Classes 1 through 6. So 1 through 6, no change from 2018 into 2019. So there weren't any really major pull outs here.

Only thing I was going to mention is that in terms of if there is any strategic outlook for the future that you need to change in future years, this would be one of those categories we look at first in terms of any changes.

Again, we're seeing that healthy negative trend from 2018 to 2019 from an overall net cost prospective. The costs are looking really great right now for the Pension Fund for the EGWP population. There is nothing in particular I would recommend, but this is more of an FYI in terms of those specific drugs.

I will move to slide Number 7. This is

another top drug slide similar to the one I went through a couple of slides ago.

This one differs in that it only applied to the previews slide I just went through for those Wrap only drug classes. These top 25 drugs speak only to those drugs going through that Wrap or enhanced benefit.

You can take a look at this after the presentation, or if you have already seen it, please let Jane and Gina know if you have any questions.

But it goes through the Wrap only drugs and the 25 Wrap drugs that the Pension Fund members are utilizing.

A lot of these are diabetic supply related, number one. And the One-Touch test strips for the blood glucose monitors. Quite often number one for many clients in terms of the diabetic usage.

You can go through the rest of the slide at your own leisure in terms of if you have any questions or comments to make to Gina and Jane and they can get them back to my team here.

That was the portion of my presentation

in terms of Medicare or EGWP review. Again, if you have any questions specifically, please feel free to let Gina and Jane know. We are happy to address any questions after this presentation.

With that said, Gina, I will turn it over to Jim for focus on the pre-Medicare population.

MS. TUCZAK: Thank you, Sean, for your presentation and for keeping it concise and summarized.

We will move on to the next presentation by CVS, which is the non-Medicare pharmacy benefit.

And with that, as you suggest, we will turn this over to Jim Hogan.

Jim, I will let you take this from here and introduce anybody else from your team that is on the call that Sean has not already introduced.

Thank you.

MR. HOGAN: Thank you, Gina. Thank you for the opportunity to present today.

I have Kathy Goerges on the line with me as well as Sean introduced earlier. She is a pharmacist by trade and will be helping support the presentation entitled CCPF Non-Medicare.

So similar to what Sean had just

presented, this is the same timeframe so 2018 versus 2019. This is, of course, the non-Medicare benefit.

I'd like to begin today on Page 2. Page 2 is entitled "Your Prescription Benefit Financial Summary".

What you will see at the very top is your prescription costs AWP.

(Phone interruption.)

MS. BURNS: I hate to be the bully, but if everybody could please mute their phones, if they are not speaking. Only Mr. Hogan's phone should not be on mute.

MR. HOGAN: Thank you.

You will see the AWP is your prescription costs before the discount. The 2018 versus '19 relatively flat. Total discount relatively flat as well at about 13.3 to 13.4 million.

This brings us down to our cost components. This is where we get to the Fund's total gross cost.

As you can see, in 2018, on the left-hand column, you will see 14.1 million. A slight reduction or a 1.1 percent on the 13.9.

Now when we get into the member costs, this is the member copays. In 2018, we had a million dollars of copay coming from members. That is down 12 percent to $900,000.

Similar to what Sean referenced in the earlier presentation, the member cost share has an erosion as well. So as member co-pays remain the same and as utilization and inflation go up, the Fund is assuming a larger percentage of the total cost of the prescription from 7.3 percent in 2018 with an 11.1 percent reduction moving into 2019 resulting in a 6.5 percent members cost share.

This brings the total net cost before rebates to 13 million in 2018. Slight reduction of negative .3 percent. 13.05 million in 2019.

So very flat out of the gate here, with the exception of the member cost share which experienced an erosion.

Now we get into the rebates for the Fund. So same definition as Sean had previously articulated where these are monies that come back to the Fund based on brand drugs that are dispensed.

3.3 million in 2018. A 5.3 percent

increase up to 3.5 million in 2019 further helping mitigate the Fund's cost.

The end of day costs for the Fund went from 9.7 million. Now it is down 2.2 percent to 9.5.

On the next page, Page 3, we'll get into the details of what is driving those costs.

The next slide is entitled "Key Metrics at a Glance". I will start at the very top with Eligibility.

You will see the top row the Average Eligible Members Per Month. These are your non-Medicare members. Slight reduction of 3.9 percent.

There is about 3,500 members in 2019 who were eligible for this plan. Relatively flat utilization of the percentage of members at 56 percent. A bit higher than the peer that we have here.

So we have our employer book of business as a benchmark and then on the far right-hand column you will see employers over 64. This is a more suitable alignment for the Fund where we are recognizing that a lot of your members are under 64

in the non-Medicare group.

The utilization pattern, based on age, are more closely aligned with an over 64 plan than an average employer plan with a lot of young dependents.

As you will see in the bottom row of the Eligibility section, the average member age for the Fund is flat at 59 where our employer book of business is 36 over 64 and 74.

Moving down to the Cost with Rebate section, what I'd like to do is convey some of the moving parts within your cost component.

As we saw in the earlier page, the total gross cost is at 14. Relatively flat over to '18 and '19.

Now here's where we get into your gross Cost with Rebates. Slight reduction of 3 percent. Net cost after rebates slight reduction as previously shown. Negative 2.2.

As we move down to the Gross Cost with Rebates PMPM, this is where we divide by the total number of members eligible for the plan.

This is where we see, even after the reduction in the size of the population for this

group, it is a relatively flat trend. $246 up to $248. It is less than 1 percent increase for the plan year over year.

From a net prospective, based on that moderate erosion in member cost share, your net cost PMPM is up an extra point. So 1.8 percent from a total trend prospective.

You will see the box that I have called out in the bottom row of that Cost with Rebate section called Member Cost Share.

I wanted to give the Fund an idea where you stand in relation to our other benchmarks. So the average employer in our book of business and the employees over 64. The plan has a 6.5 percent Member Cost Share with its members where the averages are at about 10.

Moving into Drug Mix, this gets to what types of medications are actually being utilized by the Fund membership. Single source brand, multi source, generic dispensing rate. You have your brand and generic.

Very positive to see the box that is called out, second to bottom row, as your generic dispensing rate. You have 87.3 percent of all

medications being dispensed for this population going through as generic, that is great for cost sustainability.

So your members are going to save money by using generics because their copays are lower and the Fund is going to save money because those medications are less expensive. On top of that, you have a deeper discount on those medications as well because there is more competition in the market so all very good.

Similar to what Sean had commented on earlier in the Utilization section, you will see a box that I called out on the Maintenance Choice row second from the bottom.

Your members really do prefer the CVS or Target 90-day supplies. So helping keep the Fund's cost down is this metric as well. Lots of generics and a lot of 90-day utilization, which is a preferred channel from a cost containment prospective for the Fund. Better rebates, better discounts and lower cost share for the member. So everybody is following into that channel.

Total Days' Supply PMPM is your overall utilization of just 1 percent. Pretty much in line

with the benchmark with the 88.9 compared to 88.5.

So the amount of the medication being utilized by your plan is pretty consistent with what we see within our book of business.

What I'd like to do is take your attention down to the Specialty section. This is where we did see some increase that Kathy is going to review in a couple of slides.

At a high level, you will see that up to this point everything is being driven into cost mitigating channels quite well.

There is a lot you can control for in the nonspecialty area. In the specialty area, we do see some increases primarily related to some unique medications that are being used by Pension Fund members and this is an area where the Fund has a great deal of management on all specialty medication that are dispensed through the CVS health contract and through the efforts of Segal to introduce some of those cost mitigating edits.

However, as I mentioned, some of the specialty utilization is in some ways the hand that you were dealt. You have just a handful of members who are driving a lot of this cost.

Just a couple boxes before we move on. You will see that the number of -- or the percentage of utilizers who are on specialty medication went up quite a bit. 18.6 percent. And specialty is a percentage of your gross cost which is also a bit higher with a 3.4 percent rise.

Now what I'd like to do is bring you to Page 4 and speak about adherence. Leading up to this slide, I have conveyed that you have members who are utilizing --

TRUSTEE WILSON: Let me ask a question. I was trying not to interrupt. You were going so good.

Lawrence Wilson. Trustee Wilson.

You were looking at the PMPM. Is there a number on the non-Medicare that we should compare against for the Medicare just to see the comparable metric for the cost PMPM?

MR. HOGAN: Sure, Lawrence. I will actually ask if Dan Levin could answer that.

MR. LEVIN: I am on the line.

MR. HOGAN: He may have a comparable response on that.

MR. LEVIN: So I would just take a look

at the gross cost, which is your claims, because we don't want to get EGWP subsidies that come from the Government or the rebates involved yet. We just want to see what the claims are.

The PMPM -- does it even have it on here, Sean, without the rebates?

MR. HOGAN: On the commercial side, Dan, we do not. I will turn it over to Sean to comment on the EGWP presentation.

MR. DONOVAN: On the EGWP side, gross cost from a Per Member Per Month perspective for the EGWP is $415 gross cost.

MR. HOGAN: I will add to that, a lot of that is based on utilization as well. Just the demographics of the EGWP population are prone to more medication being dispensed, that is usually a major component of it.

MR. LEVIN: That demographic, of course, that population is a bit older. So they are using quite a few of those oncology medications. Many of those happen to be those specialty high cost medications these days.

TRUSTEE WILSON: That is the 248 on the non-EGWP?

MR. LEVIN: That is after rebate. It is a little bit higher than 248. It is still a lot lower than the 400 which Sean just said. A lot more expensive for the older population before you take into account the government subsidies.

TRUSTEE WILSON: Okay. Thank you, very much.

MR. HOGAN: You're welcome.

We left off on Page 4 entitled "Executive Summary: Your Adherence Metrics".

What we are doing here is we are calling out a lot of what we reviewed on the previous pages where the Fund is making an investment in their members. You have a good cost share with your membership where there is seemingly lack of a financial hurdle to obtain their medication. They are using a lot of medication. They are using generics when they can. They are also using 90-day supplies in the most cost effective channel to the Fund and to the Member.

What that is leading to, as you will see, on Page 4, is a healthy adherence rate. The goal of the Fund, or I should say most of our employers if not all, is that an investment made in the

pharmacy plan is something you want to see having a benefit to members and to the overall health of the population.

In one key area where we can see the utilization pattern work in a plan's favor is in the adherence. If people in the plan are taking their medication as prescribed by their doctor and not missing refills or simply filling medication and then we see big gaps in the time it takes them to refill it, those would be metrics we would want to address.

However, for the Fund, we're seeing, as you will see on Page 4, a very good adherence rate and I will explain how we do this comparison.

You will see CCPF NM, Cook County Pension Fund Non-Medicare, in the left-hand column. You will see 78.7 percent for diabetes. That means that nearly 80 percent of your members are obtaining their medication as prescribed by their physician at a rate compared to the column moving to the right for the 50th percentile is our average CVS health employer.

Then we have plans who are in line with the mandatory Maintenance Choice plan that the

Pension Fund has in place.

Their members benefit better because you have people on primarily 90-day supplies versus 30 days.

And the metric being monitored there is when somebody has a 30-day supply of medication, the onus is on the member to refill it 12 times a year. That opens up the door for opportunity to miss refills or otherwise just going to the pharmacy 12 times a year is more cumbersome than four.

Moving to the right, we have our 90th percentile so this is where the Fund is very closely aligned.

These are plans that have not only mandatory Maintenance Choice, but also a low member cost share, high generics. Often times a member might even pay less than their co-pay for the generic.

These are probably kind of your best in class 90th percentile adherence claims. As you see in the top several classes on the far left-hand side; diabetes, hypertension, hyperlipidemia, the Fund is performing quite well.

What I'd like to do now, since I called out earlier in the presentation the fact that specialty is really a key driver --

Did I hear a question come in? Okay. Very good.

I called out earlier that specialty is the key driver of costs from 2018 to '19 for the Fund.

Kathy is going to walk through a few slides which showcase the costs.

Kathy, I will turn it over to you.

MS. GOERGES: First, good morning, everyone.

I am looking at the particular slide that is Page Number 5. "Financial Review of Specialty Population".

The other slide is setup in the left-hand column where the utilization and expenditures are and we move over to the next couple of columns, which is the total global cost column. It will be the prior year for 2018 versus the 2019 year.

We also provide any co-member per month percentage change, that will be the change in the global cost.

Then we have utilizers. Then we are providing a comparison of the prior utilizers in 2018 versus the 2019. And then what that particular change was, that is how the slide is setup.

As you can see, there are quite a few specialty classes that are provided on this particular slide. These are the top categories.

If there are more that you would like for me to address, please let me know.

The first and foremost is Oncology. Within the specialty class, the prevalence of oncology increases. The people diagnosed are between the ages of 65 to 74, with a median around 66.

So it is of no surprise that there would be an increase when you look at the utilizer column from 18 to 26 utilizers within that particular category. So that difference would be the change of utilizers to the plan in 2019.

Next on HIV, because that may be of interest, that even in an older population there are newly diagnosed individuals. It is not as prevalent but it does exist so that is not new in

this particular population. It does happen.

Here is where you see the utilizer column where you look to the current utilization. There's an increase in overall with HIV, which was around 35 to 38,000 new cases a year.

Next is Psoriasis. You will see here from a Per Member Per Month change. If you look over to that particular column, it is a 227th percent increase and that increase is not only with the Fund population but across the book of business.

An increase in the utilization of specialty medication to treat some of that could be provided due to the commercialization that we are seeing. It may simply be the doctors recommending it for them.

Another is Movement Disorders. You do have that one member with $221,000 for that particular medication that they are taking. This is the same number in 2018, but they did have a decrease in the amount that they needed to take. It is a medication that you take anywhere from three to five times a day.

The next is Sleep Disorder. So once

again there is one individual. Here you see a significant increase from 54,000 to 126,000 dollars. For this particular, this sleep disorders, this is for like narcolepsy or catalepsy. Difficulty in falling asleep, meaning you fall asleep out of the blue per se. So it is an opportunity in order to have more wakefulness. And so you have the member and we have the medication on the next particular slide where we drill down to the specifics.

MS. TUCZAK: Kathy, this is Gina. Just to keep us on track here, we are at about 20 minutes for this presentation. You're doing such a nice job, but if we could try to get this into the wrap up mode so we can move on to UHC.

MS. GOERGES: Certainly.

So on the next page, this is where we have our breakdown of Your Top 25 Drugs by gross cost.

This particular slide is broken out by our Employer Benchmark Rank, Prior Rank and Current Rank. And then we can kind of go into the Therapeutic Class and then we have the other metrics from both costs as well as utilizers.

So here is where I would like to take you to Drug Number 10. It would be in your third column under Current Rank of Apokyn, that is the Parkinson's medication that I was describing previously.

CHAIRMAN McFADDEN: This is Pat McFadden. I'm sorry to interrupt you, Kathy.

I think we're going to have -- I don't want to shortchange these other people so can you wind it up and let us go on then.

MS. GOERGES: Absolutely.

CHAIRMAN McFADDEN: Sorry to interrupt you. I apologize.

MS. GOERGES: No apology needed. This is your presentation and you need to get to what you need to get to.

This particular slide shows various medications. If you have an opportunity to look over those, if you have any questions, by all means provide those to me and I will provide explanation of those at a later time.

CHAIRMAN McFADDEN: Thank you.

MS. GOERGES: Certainly.

MS. TUCZAK: Thank you, very much, to all

of our CVS representatives that were on the call. I appreciate all of the effort that went into making this educational and informational presentation. I think it was very informative.

The Trustees certainly can take a look at this. Absorb it. Again, if you have questions, please let me know, and I can provide information and forward it to the Committee as appropriate.

At this time I am going to turn the presentation over to UHC and I will have Michael Morris take the lead on UHC and introduce your team and begin with your presentation, which is labeled "Cook County Pension Fund Medical Plan Performance Review" from UnitedHealthcare. Thank you.

MR. MORRIS: Thank you, very much. Good morning, everyone.

My name is Mike Morris from UnitedHealthcare. Joining with me this morning is Bethany Bump-White our Health Analyst Consultant and Mike Wall from Optum.

We're going to get started in the presentation. I am going to turn things over to Bethany to walk us through it. Thank you.

MS. BUMP-WHITE: Thanks, Mike.

Turning to Page 2, this is an overview from the data printer that we are going to walk through today.

So where you see references to a current time period, we are looking at data that has dates of service within 2019. So January 1st to the end of December and then we are using one month up to the payment of claims to the end of January of 2020.

The prior time here does narrow that. So we are looking at service dates of January, 2018 to December of 2018. Also it is one month of run out.

We will have some references as we walk through to catastrophic cases. We identify catastrophic cases as an individual that has $50,000 in total medical spend. If you have $50,000 or more in total spend in 2019, you would have been classified as a catastrophic case. The data does not include any stop loss reimbursements.

Let's move on to Page 3 labeled "Executive Summary".

At the very top of the page, there is a table that lists out the Per Member Per Month or PMPMs for each of the populations and the subsets

that we delve into on the medical side. We are looking at data from 2017, 2018 and also 2019 just to kind of give you a little bit of a longer prospective on what we're seeing in terms of increases and decreases.

If we look from 2017 to 2018, for example, on the Total Population line, the Per Member Per Month cost went from $404 and it dropped down to $370 and then we had the cost come back up in 2019 up to $397.

From the decreases that we saw in 2017 to 2018, we have seen some offsetting increases in 2019. Really when we look over the other years costs have been relatively flat.

If we move on to just focus in on the cost from 2018 to 2019, which is really what the rest of the presentation focuses in on. When we look just at your Medicare population, we saw a 8.4 increase from the prior time period. When we look at the non-Medicare under 65 population, that Per Member Per Month Cost increased about 7.1 percent from a prior time period. And then the non-Medicare over 65, which used to be called the exempt population, that cost increase was about

15.8 percent from the prior time period. That population continues to have the highest medical spend compared to the other subsets that we look at.

One of the big cost drivers that we saw in 2019 was circulatory. That category impacts about 64 percent of the members that we are looking at across the whole population.

So circulatory think things like heart attacks, strokes, high blood pressure, those are all the examples of things that fall within that circulatory category.

Another reason for the cost going up in 2019 was we saw an increase in the number of spine and joint surgeries. Those went up about 25.5 percent.

We did see an increase in need for Urgent Care, that went up 17 percent, which is what we want to see. We want to see more Urgent Care use versus the Emergency Room so that is a good thing to have happened.

I know there's been a lot of efforts in the past to try to educate the population and do more providing the network guides and maps to

identify where those Urgent Cares are. That education has been very effective.

Finally, on Page 3, we have a note here about the non-Medicare over 65 population. They have the highest use of an Emergency Room. So they have the biggest opportunity to reduce the use of Emergency Room and move it into a lower cost setting. For example, an Urgent Care would be a setting where some of the care could go, instead of the ER.

We turn to Page 4, Demographic Metrics.

What we are looking at here is the number of annuitants and the total population.

The large market there we are looking at the overall population. There were 9,633 annuitants in 2019 compared to the population size in 2018.

When we look at the overall membership, we see about 12,792 members on the plan. That is about .8 percent increase from the prior time period. The average age of the members is 70.6 years.

Underneath in the smaller bars, we are looking at the individual subsets of the

population. So we are looking at the non-Medicare under 65. We see about 1,789 annuitants. Pretty much flat compared to what we saw in 2018. Only two additional annuitants from 2018 to 2019.

Membership is very similar. Relatively flat compared to what we saw in 2018, that 2,570 number, and the average age for that population is 56.5.

The third bar down labeled "Non-Medicare over 65", you see about 469 annuitants. This is the population that actually has the largest change. This population shrunk by about 4 percent compared to what we saw in the prior time period.

In terms of the number of members, there were 513 members and that was a 4.5 percent decrease compared to what we saw in the prior time period. Average age for this population is 74.2.

Finally, the very bottom bar is looking at your Medicare population. There were 7,354 annuitants with a 1.3 percent increase in the prior time period. The overall number of members also increased by 1.3 percent to 9,683 and the average age for them is 74.2.

On Page 5, we are looking at the

Financial Metrics. These are similar to what we looked at in the Executive Summary. This one gives you a little bit more detail and does the same breakout by population.

The very top bar, like the previous page, looks at the total population. We are looking at the Per Member Per Month cost. $396.68 was the Per Member Per Month cost for your whole population in 2019. A 7.3 percent increase from the prior period.

The second metric right next to it where it says "Allowed PMPM", this is really gross cost. This is looking at all costs in total, not just what the plan has paid. That first number, where it says "Paid PMPM", that is just the plan paid amount.

When we look at the "Non-Medicare under 65", the PMPM for them was $1,200, that is a 7.1 increase over what we saw in the prior time period.

The "Non-Medicare over 65", $1,534 Per Member Per Month, that is a 15.8 percent increase from what we saw in the prior time period.

And then finally the Medicare population of $171.61 Per Member Per Month, that is a 8.4

increase compared to what we saw in the prior period.

If we move to Slide 6, the slide is "Where is the Money Going". This slide looks at clinical categories. It really identifies the clinical categories where we are seeing the most amount of cost in your population.

The first category that we see is labeled "Circulatory". Things that fall in here are going to be high blood pressure, hypertension, strokes, heart attacks. Those are chronic conditions that we see in the Circulatory category.

Within your population, 15 percent of the overall spend that we saw in 2019 was in this one particular category. The Per Member Per Month cost is $61 and that is a 18 percent increase compared to what we saw in 2018. As I mentioned in the Executive Summary, this is impacting 64 percent of the members.

The very bottom of the page there is some individual diagnostic conditions. These are the conditions by cost that we are seeing within the Circulatory category.

The number one condition that we are

seeing is hypertension with complications. These are individuals that have high blood pressure and we are seeing complications because of that. When we see complications, those things tend to be things like things that impact the veins. We can see kidney failure. We can see heart attacks and strokes with all of these complications of having high blood pressure.

The secondary condition is cardiac dysrhythmia. Like irregular heartbeat, that is the secondary condition that we are seeing.

And, finally, in this category is coronary atherosclerosis. People that have high cholesterol have plaque buildup within the arteries in the heart and that results in injury to the heart.

The second category that covers 15 percent is your Cancer diagnosis. The Per Member Per Month cost is about $59 and 28 percent of your members have a cancer diagnosis.

The top things we're seeing in this Cancer category, if you look at the very bottom of the page, are people that are undergoing active cancer treatment. Radiation is the number one

category in terms of cost.

Secondarily, we are seeing high levels of breast cancer in the population.

And, finally, we're seeing high levels of lung cancer in your population. Those are all driving costs with the cancer category.

The third category is Musculoskeletal. About 13 percent of this spend is the Musculoskeletal category. The Per Member Per Month cost in this category is about $51 and the cost has increased 10 percent compared to what we saw in 2018. This category impacts about 55 percent of the members.

Musculoskeletal would encompass things like back pain. When you look at the bottom of the page, intervertebral disc disorder. Back pain for that. Osteoarthritis. Things related to the joints. If we see joint replacement surgeries, that would fall into that Osteoarthritis category.

The final category we see in the Musculoskeletal is in the connective tissues. So if you have a ligament tear or you need to get an ACL repair done, that would fall into the connective tissue repair category within the

Musculoskeletal.

Your fourth category are things related to the Kidney. 9 percent of the spend in 2019 was related to the Kidney category. The cost is about $36 and this is an increase of about 14 percent compared to what we saw in 2018. The Kidney category impacts about 33 percent of your population.

The top diagnostic category within this category, number one, is under like chronic kidney failure. Those members that are on dialysis on a routine basis. The secondary category is the acute kidney failure. Maybe they had more of an acute condition long-term that we see.

Finally, Injury and Poisoning. About 8 percent of your spend in 2019 was driven by this specific category. Per Person Per Month cost is $31. There is an increase of about 24 percent compared to 2018. This is impacting about 24 percent of your members.

The number one category that we see within the larger category is complications due to a device or a surgery. The number two is a surgical complication and then there was also a

number of femur fractures where they had to go in and do repairs due to an accident. Those are all driving costs within the injury category.

With that, I am going to turn it over to Mike Wall to talk about Member Connection on the next page.

MR. WALL: Thank you, Bethany.

Good morning, everyone.

I am going to give you an understanding of the key clinical costs now focused on the programs that we have in place to support members with the various conditions Bethany covered.

So I am on Slide 7 entitled "Member Connections".

On the left side are those who reach out telephonically. In a few minutes we will talk about those folks who were low to moderate risk.

On the left side, 8.4 percent on individuals actively working with the UnitedHealthcare nurse. This is favorable compared to our other clients. We have a higher rate of engagement in your population which is a good sign.

We focus with our telephonic programs on those at highest risk. In the Cook County

population, there were over 3300 that qualified for these programs.

Not all will choose to participate. We did have some opt out, that is their choice. They may have a primary caregiver in the family that may be very comfortable with their doctor and don't need our support.

To those who do benefit and do enroll in our program, over 1023 individuals of those who qualify are engaged with the nurse. That engaged individuals represent 46 percent of your claims.

So where you have high dollars in the categories and diseases that Bethany addressed is where we are really focusing our interventions. And the interventions are an outreach by our nurses to your members and then focus on those that understand their care, do an assessment by our clinical team, and then work with them on their opportunities for improved health.

So this is the folks on the high risk category. Those on the low and moderate risk are doing well, but we want to sort of keep health on their minds. We will send mailings to them. Over 5800 individuals were sent mailings to basically

help them with possibly their diabetes, their heart conditions, any number of things that we see in the claims data and this is both the medical and pharmacy claims data which we get on an electronic feed from CVS.

We are also sending a letter to their providers. It could be their primary care provider. It could be if they have diabetes their endocrinologist or if they have heart disease possibly also their cardiologist. And together the members get the letter. The providers often will reach out to the members because they received a letter from UnitedHealthcare and then they work towards closing that gap in care.

That gap is measured by if they are diabetic and they are not getting an annual A1C test or seeing their doctor on an annual basis, we consider that a gap in care. A friendly reminder to their home and also a reminder to their doctor is to help close that gap in care. There is a 50 percent gap closure rate within the year.

We also have reminders around screenings. Primarily with the female population to get breast and cervical cancer screening.

I am going to skip ahead to the next slide, Slide 8, which is the "Member Connections".

This is a result of our inbound. The inbound calls that Cook County members are making to us. They often may be calling on a billing issue or a benefits issue. We will focus on the immediate need in question, but we will also realize we have been trying to reach them and get them to a nurse advocate.

As a result we have the opportunity to introduce them to the programs available to them, personal health support or cancer treatment or any number of conditions. And when we have them on the phone, we can really get them to accept that referral and work with us.

MS. TUCZAK: Excuse me. I just want to remind you that you have about two minutes. So, thank you, I know you are going into a lot of great detail, but if we can keep on schedule. Thank you so much.

MR. WALL: Okay. Sure. Thanks, Gina.

Let's skip to Slide 9 and focus on those members in active treatment. We have a special program called a Cancer Support Program. These are

oncology trained nurses that focus on those going in for chemotherapy, radiation therapy, or surgery. And over 199 individuals qualify for that.

And as mentioned, cancer is a high cost driver that was confirmed by Bethany.

Bethany, do you want to finish up with the musculoskeletal?

MS. BUMP-WHITE: Thank you.

Turning to Page 10, this just gives a little bit more detail on what we have in the Executive Summary.

If you look at the box in the middle of the page, the numbers there, there were 111 back surgeries in 2019 versus 76 in the prior year and then there were 185 knee and hip replacement surgeries in 2019 versus 160 in the prior year.

We do a breakdown between Medicare and non-Medicare population between the two populations.

I just have one more slide I want to touch on. Slide 11 is "Adult Prevalence of Disease".

Here it looks at what we would expect the disease prevalence, which is the light blue bar,

when we look at members of similar age and gender. We are able to sort of identify what we expect the percent of a particular disease to be. Then what we do is compare that to the actual disease burden we are seeing within your population which is the dark blue bar.

I will call your attention more to the right side of the page where it says Congestive Heart Failure, Chronic Renal Failure and COPD which is a condition of the lungs.

Those blue bars are all higher than the lighter blue bars. That indicates the disease burden in those particular categories is higher than what we would expect based on other members of similar age/gender split.

The left side of the graph where it says Diabetes, Hypertension, Acute Myocardial Infarction, we see less disease burden in those particular categories compared to what we see in your population.

MS. TUCZAK: Great. Thank you, very much. Thank you to UHC for putting together a nice summarized picture of the health costs of the plan.

The last item on the agenda is the Segal

2019 Actual Health Expenses Versus the Budget Projections.

At this time I will turn this over to Dan Levin our main contact at Segal.

And, Dan, if you can introduce your team and give your presentation, that would be great.

MR. LEVIN: Thank you, Gina.

Again, this is Dan Levin. The team on the call, you won't be hearing from all these people today due to the function of the meeting and our limited time, but I do want you to know who is here.

Cristina DeLeon, who is the pharmacy expert and was listening in to the CVS presentations. We have Peter Cavanaugh, who is the Associate Relationship Manager to my main Relationship Manager. We also have Tom Wyszomirski, who is an Actuarial Analyst who helps me with the financials.

And what we're going over today -- the purpose of this presentation is two-fold. One, in 2019 how did the actual health span come in compared to what Segal had budgeted for 2019 when we did it in 2018.

And then, number two, a very preliminary look at what the total cost increases would have to be for 2021 compared to 2020 by plan and by Medicare and non-Medicare.

And those are preliminary because we are actually going to go back and refresh the data and give a more accurate calculation when we do the August -- typically it is the August Health Benefit Committee meeting.

With that, I am going to turn this over to Tom Wyszomirski to go through the key points here.

MR. WYSZOMIRSKI: Hi everyone.

So on the agenda we have three slides we prepared. If you open up the presentation we prepared, this is the one that is labeled "Health Benefits Committee Meeting, Cook County Pension Fund". An Executive Summary, the Actual Versus Projected Expenses and the Preliminary 2021 Rates.

The Executive Summary provides a high level look at the other two pages and it provides high level takeaways for them.

I am going to skip this for now because I want to speak directly to those points while we are

looking at the numbers that they relate to.

If everybody could refer to Slide Number 3, we'll start off with the actual versus projection expenses for 2019.

Each year in the fall, we prepare projections for the upcoming calendar year, based on projected claims for medical, prescription drug business, and offset for rebates subsidy and we add in applicable administration costs for UHC and CVS.

The 2019 claim projections illustrated here were based on three years of experience through June 30th of 2018.

And there are two charts on this page. The chart on the top shows the actual experience broken down by month and broken down by each category on each column. The Segal projection is all the way to the right.

The chart on the bottom summarizes those 2019 figures and compares them on an aggregate and a per capita basis.

If you look at the bottom chart, the projected expenses for 2019 came in at 99 million 568 thousand dollars.

The actual expenses for 2019 came in at

90 million 716 thousand. A difference of about 8.9 million dollars.

This was largely due to better than projected subsidies for the Fund's EGWP prescription drug plans for Medicare retirees.

You will also see that the average contract, so that is average over the course of the entire year, so for each of the months; January, February, March, the average of all those years, there was 9,652 contracts. We projected 9,531. It was about 1.2 percent higher than projected.

Again, that contract doesn't include dependents.

On the per capita basis, the actual 2019 stream came out 10 percent better than projected.

So, if we turn now to Page 4, we'll go over the 2021 total cost rate. So now that we have additional experience for the Fund, per January of 2020, we project that we create a preliminary projection for 2021.

These rates are preliminary and are for illustrated purposes.

Like as Dan said, we will update for the August Health Benefits Committee meeting.

Typically we'll do it with data through June of the year so June of 2020.

The figures in this chart include both the Fund and the per member portion. Those are the total costs and then the participant's typically pay a portion of it.

Our preliminary rates illustrate that there are modest increases for the non-Medicare retiree rates, which increases 6.7 for the Choice Plan and 9.5 percent for the Choice Plus Plan.

This increase is largely due to increase in our projected medical claims.

Meanwhile, the rates for the Medicare retirees are mild. A 5 point increase for the Choice Plans and a 1.1 percent for the Choice Plus Plan.

The Medicare retiree rates continue to see slight increases largely due to the offset for subsidies and rebates that we have been seeing.

So the industry standard that we are seeing for medical and medical trend is about 7 percent for non-Medicare and 5 percent for Medicare.

That would mean that if all things were

equal and the experience came in as projected, we would actually expect the non-Medicare rates to go up 7 percent and non-Medicare rates to go up 5 percent.

So, like we said, the non-Medicare rates are going up slightly more than 10 percent; 6.7 and 9.5. Medicare rates are doing slightly better than trend, which is 5.2 and 1.1 percent.

That concludes my report. Dan, would you like to add anything?

MR. LEVIN: Yes. So, thanks, Tom.

Again, the key here is that we actually rate each plan by themselves so the Choice and the Choice Plus. We look at the claims separately. And, of course, the Medicare and non-Medicare, we look at them separately and that is why there is four different percent changes shown on Page 4.

And, again, the non-Medicare is at or slightly above market trends because of the experience of the UHC medical claims not being as favorable that has recently come in. The Medicare side is at or below depending on the plan you look at trend and that is because again of the continued increases in rebates and Federal subsidies on the

employer group EGWP Medicare prescription drug group.

Those numbers will change when we reconvene in August.

I think I got us back on track here in terms of time.

MS. TUCZAK: Thank you, very much, Dan and Tom, for your analysis and your comments.

At this time that concludes all of the presentations and information that was scheduled for this meeting.

Again, this is educational in nature to help the Trustees, especially the new Trustees, develop some understanding of the plans and the types of costs that are experienced and provide a backdrop of information so that when we come together in-person, hopefully in August, the rates setting meeting will be more meaningful.

But to the extent that you have questions, please feel free to contact me and I can provide the appropriate response that can be shared with the committee members. And if there is an interest to convene in-person to discuss in more detail, we can certainly do that when this economic

and pandemic environment lifts.

CHAIRMAN McFADDEN: This is Pat McFadden

I would like to reiterate what Gina just said. I would have to think that there is certainly several questions about the flow of the activity from one year to the next. And, please, don't hesitate to contact Gina or myself and raise the issue or the question.

If there is no more comments, I'd like to ask if there any new business or any old business?

TRUSTEE WILSON: This is Trustee Wilson. I make a motion that we adjourn the Health Committee Meeting.

CHAIRMAN McFADDEN: Is there a second?

TRUSTEE GOODE: Trustee Goode seconds the motion to adjourn.

CHAIRMAN McFADDEN: All in favor?

(Chorus of ayes.)

CHAIRMAN McFADDEN: Opposed?

The motion passes. We are adjourned.

Thank you, everyone, for your cooperation and understanding going through this. This is pretty awkward.

The April 28, 2020 Health Benefits

Committee meeting is adjourned.

The full board next regular scheduled meeting is scheduled for May 7th of 2020.

Thank you, very much, everyone, for participating.

MS. BURNS: Thank you, everyone.

MS. TUCZAK: The meeting is adjourned.

(WHICH WERE ALL THE PROCEEDINGS IN THE ABOVE-ENTITLED MEETING AT THIS DATE AND TIME.)

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

DEBORAH TYRRELL, being a Certified Shorthand Reporter, on oath says that she is a court reporter doing business in the County of DuPage and State of Illinois, that she reported in shorthand the proceedings given at the taking of said cause and that the foregoing is a true and correct transcript of her shorthand notes so taken as aforesaid; and contains all the proceedings given at said cause.

Debbie Tyrrell
DEBBIE TYRRELL, CSR
License No. 084-001078

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$248 [1] - 31:19
$31 [1] - 55:11
$36 [1] - 54:22
$370 [1] - 47:2
$396.68 [1] - 50:24
$397 [1] - 47:3
$404 [1] - 47:1
$415 [1] - 36:5
$50,000 [2] - 46:9, 46:10
$51 [1] - 54:3
$59 [1] - 53:12
$61 [1] - 52:9
$900,000 [1] - 28:21

'

'18 [1] - 31:7
'19 [3] - 28:9, 31:8, 39:24

0

084-001078 [1] - 71:18

1

1 [8] - 21:20, 21:22, 23:5, 23:19, 25:2, 31:19, 33:17
1,789 [1] - 49:19
1.1 [3] - 28:17, 66:8, 67:1
1.2 [1] - 65:4
1.3 [2] - 50:13, 50:15
1.8 [1] - 31:23
10 [6] - 32:9, 43:19, 54:4, 60:2, 65:8, 66:23
100 [1] - 15:7
1023 [1] - 57:2
10:30 [1] - 4:24
11 [2] - 15:18, 60:14
11.1 [1] - 29:4
111 [1] - 60:6
12 [3] - 28:21, 38:24, 39:3
12,792 [1] - 49:12
126,000 [1] - 42:19
13 [4] - 20:7, 22:4, 29:7, 54:1
13.05 [1] - 29:8
13.1 [1] - 17:21
13.3 [1] - 28:11
13.4 [1] - 28:11
13.9 [2] - 17:12, 28:17
14 [2] - 31:7, 54:22
14.1 [1] - 28:16
15 [2] - 52:6, 53:10
15.4 [2] - 20:14, 22:13
15.8 [2] - 47:18, 51:14
16.9 [1] - 17:23
160 [1] - 60:9
17 [1] - 48:11
18 [2] - 41:11, 52:9
18.4 [2] - 20:14, 22:13
18.6 [1] - 34:21
18.7 [2] - 17:10, 17:16
180 [1] - 23:17
185 [1] - 60:8
19 [2] - 20:13, 22:12
1925 [1] - 1:13
199 [1] - 59:20
1st [1] - 45:23

2

2 [5] - 13:6, 23:20, 27:21, 27:22, 45:18
2,570 [1] - 49:23
2.2 [2] - 29:21, 31:12
2.6 [1] - 23:16
20 [7] - 5:4, 5:7, 11:1, 20:13, 22:12, 23:10, 43:5
200 [1] - 13:23
2017 [3] - 46:19, 46:23, 47:4
2018 [44] - 13:14, 13:24, 15:19, 16:2, 16:6, 17:1, 17:11, 17:23, 18:14, 19:5, 20:14, 21:8, 21:15, 22:13, 24:24, 25:3, 25:11, 27:18, 28:9, 28:15, 28:19, 29:3, 29:7, 29:17, 39:24, 40:14, 40:20, 42:13, 46:4, 46:5, 46:19, 46:23, 47:5, 47:9, 49:10, 49:20, 49:21, 49:23, 52:10, 54:5, 54:23, 55:12, 62:17, 64:5
2019 [60] - 10:4, 10:10, 12:19, 13:5, 13:15, 13:24, 14:21, 15:17, 16:1, 16:6, 16:13, 16:23, 17:8, 17:13, 17:21, 18:1, 18:11, 19:5, 20:15, 21:9, 21:15, 22:14, 23:16, 25:1, 25:3, 25:11, 27:19, 29:4, 29:8, 29:18, 30:8, 40:14, 40:20, 41:13, 45:23, 46:10, 46:19, 47:3, 47:6, 47:9, 47:23, 48:7, 49:9, 49:21, 51:2, 52:7, 54:20, 55:9, 60:7, 60:9, 61:18, 62:15, 62:16, 63:21, 64:3, 64:12, 64:15, 64:17, 65:7
2020 [9] - 1:15, 3:2, 3:10, 46:2, 62:20, 65:12, 65:19, 69:17, 69:20
2020-07 [1] - 3:20
2021 [4] - 62:20, 63:12, 65:10, 65:13
22 [1] - 17:24
227th [1] - 42:1
23 [1] - 23:16
23.1 [2] - 18:15, 18:16
24 [3] - 10:9, 55:11, 55:12
248 [2] - 36:16, 36:19
24th [2] - 10:4, 10:16
25 [3] - 25:22, 26:6, 43:11
25.5 [1] - 48:8
26 [1] - 41:11
28 [4] - 1:15, 3:2, 53:12, 69:17
28th [2] - 3:6, 3:10

3

3 [9] - 16:24, 18:21, 29:8, 29:23, 31:10, 46:13, 48:20, 63:20
3,500 [1] - 30:8
3.3 [2] - 16:1, 29:17
3.4 [1] - 34:23
3.5 [1] - 29:18
3.9 [1] - 30:6
30 [1] - 38:20
30-day [1] - 38:23
30.8 [1] - 17:1
300 [1] - 13:23
30th [1] - 64:5
31.8 [1] - 16:23
33 [1] - 54:24
3300 [1] - 56:18
34 [2] - 15:19, 17:14
34.2 [1] - 16:2
35 [2] - 17:11, 41:22
35.3 [1] - 15:24
36 [1] - 31:2
38,000 [1] - 41:22

4

4 [10] - 14:19, 20:22, 35:1, 37:2, 37:15, 38:6, 49:4, 50:5, 65:9, 67:10
4.5 [1] - 50:8
400 [1] - 36:20
42.4 [1] - 14:20
45 [2] - 20:2, 21:23
46 [1] - 57:4
46.3 [1] - 14:20
469 [1] - 50:3

5

5 [6] - 22:23, 40:8, 50:17, 66:7, 66:15, 66:20
5.2 [1] - 67:1
5.3 [1] - 29:17
50 [1] - 58:13
50th [1] - 38:14
513 [1] - 50:8
54 [1] - 47:24
54,000 [1] - 42:19
55 [1] - 54:5
56 [1] - 30:11
56.5 [1] - 50:1
568 [1] - 64:16
5800 [1] - 57:17
59 [1] - 31:1

6

6 [4] - 24:6, 25:2, 51:20
6.5 [2] - 29:5, 32:7
6.7 [3] - 16:15, 66:2, 66:23
64 [6] - 30:15, 30:17, 30:20, 31:2, 32:7, 52:11
65 [8] - 41:7, 47:13, 47:16, 48:21, 49:19, 50:3, 51:11, 51:13
66 [1] - 41:8

7

7 [5] - 16:12, 25:17, 56:6, 66:15, 66:20
7,354 [1] - 50:12
7.1 [2] - 47:14, 51:11
7.3 [2] - 29:3, 51:2
70 [1] - 1:13
70.6 [1] - 49:14
71 [1] - 14:3
716 [1] - 64:18
72 [1] - 14:3
74 [2] - 31:2, 41:7
74.2 [2] - 50:10, 50:16
76 [1] - 60:7
78.7 [1] - 38:10
7th [1] - 69:20

8

8 [3] - 49:13, 55:8, 58:19
8.4 [3] - 47:11, 51:17, 56:11
8.9 [1] - 64:18
80 [1] - 38:11
87 [1] - 19:10
87.3 [1] - 32:17
88.5 [1] - 33:18
88.9 [1] - 33:18

9

9 [3] - 14:19, 54:20, 59:15
9,531 [1] - 65:3
9,633 [1] - 49:8
9,652 [1] - 65:3
9,683 [1] - 50:15
9.5 [3] - 29:22, 66:3, 66:24
9.7 [1] - 29:21
90 [2] - 19:19, 64:18
90-day [4] - 33:9, 33:11, 37:11, 38:20
90th [2] - 39:5, 39:14
91-0715 [1] - 9:14
9300 [1] - 14:1
99 [1] - 64:16
9:30 [1] - 1:16

A

a.m [1] - 1:16
A1C [1] - 58:9
able [2] - 7:14, 60:19
ABOVE [1] - 70:3
above-entitled [1] - 1:12
ABOVE-ENTITLED [1] - 70:3
absolutely [2] - 12:23, 44:4
absorb [1] - 44:23
accept [1] - 59:7
access [1] - 6:11
accident [1] - 55:19
accordingly [1] - 5:6
account [1] - 36:22
accurate [2] - 7:9,

62:24
ACL [1] - 54:16
Act [1] - 9:14
action [1] - 4:14
active [2] - 53:16, 59:16
actively [1] - 56:12
activity [1] - 68:23
actual [6] - 60:21, 62:15, 63:20, 64:7, 64:17, 65:7
Actual [2] - 61:18, 63:11
Actuarial [1] - 62:11
acute [2] - 55:5, 55:6
Acute [1] - 61:10
add [4] - 18:9, 36:6, 64:1, 67:3
added [2] - 15:17, 16:5
additional [3] - 24:18, 49:21, 65:11
address [4] - 9:19, 26:20, 38:4, 41:3
addressed [1] - 57:6
adherence [5] - 35:1, 37:15, 37:23, 38:6, 39:14
Adherence [1] - 37:3
adjourn [2] - 69:5, 69:9
adjourned [3] - 69:13, 69:18, 69:24
adjust [1] - 5:6
administration [1] - 64:2
Adult [1] - 60:14
Advisor [2] - 2:9, 12:13
advisor [1] - 24:5
advocate [1] - 59:2
aforesaid [1] - 71:12
age [7] - 30:19, 30:24, 49:14, 49:24, 50:10, 50:16, 60:18
age/gender [1] - 61:8
agenda [6] - 4:8, 4:10, 10:2, 10:3, 61:17, 63:7
ages [1] - 41:7
aggregate [1] - 64:12
ago [1] - 25:19
ahead [2] - 20:21, 58:18
aligned [2] - 30:20, 39:7
alignment [1] - 30:16
ALL [1] - 70:2
allow [3] - 6:2, 6:24, 7:14
Allowed [1] - 51:5
allows [1] - 3:22
almost [4] - 13:23, 17:11, 20:2, 21:23
ALSO [1] - 2:12
amount [11] - 15:2, 15:3, 15:5, 15:7, 15:11, 15:12, 16:9, 33:19, 42:14, 51:9, 51:24
amounts [1] - 15:14
analysis [1] - 68:1
Analyst [2] - 45:12, 62:11
AND [2] - 1:2, 70:4
annual [3] - 14:5, 58:9, 58:10
annuitants [6] - 49:6, 49:9, 49:19, 49:21, 50:3, 50:13
Annuity [1] - 3:8
ANNUITY [1] - 1:2
answer [4] - 11:6, 12:14, 24:5, 35:13
answers [3] - 5:16, 6:7, 6:8
antidiabetics [1] - 21:20
Apokyn [1] - 43:20
apologize [1] - 44:6
apology [1] - 44:7
APPEARANCES [1] - 2:1
applicable [2] - 3:15, 64:2
applied [1] - 25:20
appreciate [1] - 44:19
appropriate [2] - 45:1, 68:14
approve [2] - 10:7, 10:15
approved [2] - 10:10, 10:21
April [5] - 1:15, 3:2, 3:6, 3:10, 69:17
area [4] - 34:6, 34:9, 37:21
arteries [1] - 53:7
articulated [2] - 6:1, 29:14
asleep [2] - 42:22, 42:23
assessment [1] - 57:10
Associate [1] - 62:9
assuming [1] - 29:2
AT [1] - 70:4
atherosclerosis [1] - 53:6
attacks [3] - 48:3, 52:4, 52:23
attention [2] - 33:23, 60:24
Attorney [2] - 3:21, 4:2
ATTORNEY [1] - 2:10
AUDIO [3] - 1:3, 2:2, 2:8
Audio [1] - 3:7
audio [3] - 1:12, 3:12, 5:23
August [7] - 6:19, 6:24, 63:1, 65:17, 67:21, 68:10
available [2] - 7:6, 59:4
Average [1] - 30:4
average [14] - 13:22, 16:12, 16:19, 30:21, 30:24, 32:6, 38:14, 49:14, 49:24, 50:10, 50:15, 64:23, 64:24, 65:2
averages [1] - 32:9
awkward [1] - 69:16
AWP [2] - 28:1, 28:8
ayes [2] - 10:18, 69:11

B

backdrop [1] - 68:9
background [1] - 7:13
bang [1] - 20:1
bar [6] - 18:18, 50:2, 50:11, 50:22, 60:17, 60:23
bars [3] - 49:16, 61:4, 61:5
based [7] - 29:15, 30:19, 31:21, 36:7, 61:7, 63:23, 64:4
basis [5] - 14:5, 55:5, 58:10, 64:13, 65:7
begin [3] - 11:23, 27:21, 45:5
behalf [2] - 7:11, 15:22
behind [1] - 24:14
below [4] - 14:3, 14:22, 16:3, 67:15
Benchmark [1] - 43:14
benchmark [2] - 30:14, 33:18
benchmarks [1] - 32:5
Benefit [3] - 3:9, 27:22, 63:1
benefit [9] - 21:2, 24:10, 24:16, 25:24, 27:4, 27:20, 37:19, 38:19, 57:1
BENEFIT [1] - 1:2
Benefits [7] - 3:2, 3:9, 6:19, 24:7, 63:10, 65:17, 69:17
BENEFITS [1] - 1:3
benefits [6] - 11:11, 11:17, 14:2, 14:4, 16:18, 24:18
best [1] - 39:13
BETHANY [1] - 2:17
Bethany [7] - 45:12, 45:16, 55:24, 56:5, 57:6, 59:22, 59:23
better [8] - 4:17, 20:1, 33:13, 38:19, 64:20, 65:8, 66:24
between [3] - 41:7, 60:10, 60:11
beyond [1] - 9:6
big [2] - 38:2, 47:22
biggest [1] - 48:23
billing [1] - 58:22
bit [10] - 6:3, 18:23, 30:11, 34:21, 34:23, 36:12, 36:19, 46:20, 50:20, 60:3
black [2] - 18:8, 21:13
bladder [1] - 58:23
BLAIR [2] - 2:5, 8:10
Blair [1] - 8:9
blood [5] - 26:10, 48:3, 52:3, 52:19, 53:1
blue [5] - 42:23, 60:17, 60:23, 61:4, 61:5
BOARD [1] - 2:10
Board [5] - 6:10, 7:11, 7:16, 9:15, 9:17
board [2] - 6:20, 69:19
book [22] - 14:8, 14:11, 14:12, 16:20, 19:8, 19:11, 20:5, 20:16, 20:19, 21:5, 21:22, 22:2, 22:16, 22:18, 22:22, 23:21, 30:13, 31:1, 32:6, 33:21, 42:3
bottom [15] - 13:9, 18:3, 18:7, 20:10, 22:8, 30:23, 32:2, 32:16, 33:7, 50:11, 52:13, 53:15, 54:8, 64:11, 64:14
box [6] - 18:8, 21:13, 32:1, 32:15, 33:6, 60:5
boxes [1] - 34:18
bracket [3] - 14:14, 17:3, 18:3
brand [8] - 15:4, 15:10, 15:15, 19:3, 29:15, 32:12, 32:14
breakdown [2] - 43:11, 60:10
breakout [1] - 50:21
breast [2] - 53:20, 58:16
brief [2] - 9:19, 21:11
bring [1] - 34:24
brings [2] - 28:12, 29:6
broken [3] - 43:13, 64:8
buck [1] - 20:1
Budget [1] - 61:18
budgeted [1] - 62:16
buildup [1] - 53:7
bully [1] - 28:3
BUMP [3] - 2:17, 45:17, 60:1
Bump [1] - 45:12
BUMP-WHITE [3] - 2:17, 45:17, 60:1
Bump-White [1] - 45:12
burden [3] - 60:21, 61:6, 61:11
BURKE [1] - 2:11
BURNS [9] - 2:11, 2:11, 3:17, 7:24, 9:6, 9:9, 13:18, 28:3, 69:23
business [26] - 14:9, 14:12, 14:13, 16:20, 19:8, 19:11, 20:5, 20:16, 20:20, 21:5, 21:22, 22:2, 22:16, 22:18, 22:22, 23:21, 30:13, 31:2, 32:6, 33:21, 42:4, 64:1, 69:3, 71:8
buying [1] - 15:10
BY [3] - 2:2, 2:8, 2:11

C

calculation [1] - 62:24
calendar [2] - 11:12, 63:23
call-in [1] - 4:5
Cancer [3] - 53:11, 53:15, 59:17
cancer [8] - 53:13, 53:17, 53:20, 53:22, 53:23, 58:17, 59:5, 59:21
capita [2] - 64:13, 65:7
cardiac [1] - 53:2
cardiologist [1] - 58:3
Care [3] - 48:11,

48:12, 49:1
care [6] - 49:2, 57:10, 57:24, 58:7, 58:11, 58:13
caregiver [1] - 56:22
Cares [1] - 48:18
case [5] - 14:24, 22:24, 23:23, 24:12, 46:11
cases [3] - 41:22, 46:7, 46:8
catalepsy [1] - 42:22
catastrophic [3] - 46:7, 46:8, 46:11
categories [7] - 25:8, 41:1, 51:22, 51:23, 57:6, 61:6, 61:12
category [31] - 41:12, 47:23, 48:5, 52:1, 52:5, 52:8, 52:16, 53:5, 53:10, 53:15, 53:18, 53:23, 53:24, 54:2, 54:3, 54:5, 54:12, 54:13, 54:17, 54:19, 54:21, 54:24, 55:2, 55:3, 55:5, 55:10, 55:14, 55:15, 55:20, 57:14, 64:9
CAVANAUGH [1] - 2:20
Cavanaugh [1] - 62:8
CCPF [2] - 27:16, 38:8
certainly [5] - 43:9, 44:16, 44:22, 68:17, 68:22
Certified [1] - 71:6
cervical [1] - 58:17
Chair [4] - 4:11, 5:10, 7:11, 7:15
CHAIRMAN [17] - 3:5, 7:20, 8:3, 8:6, 8:17, 9:2, 9:12, 10:11, 10:14, 10:19, 43:23, 44:5, 44:15, 68:19, 69:7, 69:10, 69:12
Chairman [2] - 3:17, 11:13
change [11] - 13:14, 21:15, 25:3, 25:7, 40:16, 40:21, 41:12, 41:24, 50:5, 67:20
changed [1] - 16:6
changes [4] - 16:8, 17:13, 25:9, 67:10
channel [3] - 33:12, 33:15, 37:12
channels [2] - 19:15, 34:4
chart [5] - 21:4, 64:7, 64:11, 64:14, 65:20
charts [1] - 64:6
chemotherapy [1] - 59:19
Chicago [1] - 1:14
Choice [12] - 19:18, 22:1, 22:6, 33:6, 38:17, 39:9, 66:2, 66:3, 66:8, 67:6, 67:7
choice [4] - 19:23, 20:4, 20:8, 56:21
cholesterol [1] - 53:7
choose [1] - 56:20
Chorus [2] - 10:18, 69:11
Chronic [1] - 61:2
chronic [2] - 52:4, 55:3
circulate [1] - 6:8
circulatory [3] - 47:23, 48:2, 48:5
Circulatory [2] - 52:5, 52:16
Circulatory" [1] - 52:2
City [1] - 1:14
claim [1] - 64:3
claims [11] - 35:18, 35:21, 39:14, 46:1, 57:4, 57:20, 57:21, 63:24, 66:5, 67:7, 67:13
class [2] - 39:14, 41:5
Class [3] - 20:23, 24:8, 43:16
Classes [1] - 25:2
classes [8] - 21:1, 21:16, 23:3, 24:1, 24:22, 25:22, 39:15, 40:24
classified [1] - 46:11
clients [4] - 14:13, 21:6, 26:11, 56:14
Clinical [1] - 12:13
clinical [7] - 12:15, 12:16, 24:4, 51:22, 51:23, 56:3, 57:11
close [1] - 58:13
closely [2] - 30:20, 39:7
closing [1] - 58:7
closure [1] - 58:14
CMS [2] - 17:6, 17:13
co [3] - 28:24, 39:11, 40:15
co-member [1] - 40:15
co-pay [1] - 39:11
co-pays [1] - 28:24
column [13] - 14:6, 16:15, 28:16, 30:15, 38:9, 38:13, 40:11, 40:13, 41:10, 41:19, 42:1, 43:20, 64:9
columns [2] - 13:12, 40:12
comfortable [1] - 56:23
coming [3] - 17:5, 17:9, 28:20
commencing [1] - 1:15
comment [4] - 9:13, 9:21, 10:1, 36:1
commented [1] - 33:4
comments [5] - 8:4, 11:1, 26:15, 68:1, 69:2
commercial [2] - 12:10, 35:24
commercialization [1] - 42:7
COMMITTEE [1] - 1:4
committee [5] - 4:15, 4:22, 5:20, 9:18, 68:15
Committee [18] - 3:2, 3:9, 4:9, 4:11, 4:13, 4:20, 6:9, 6:19, 7:11, 7:16, 9:19, 11:8, 45:1, 63:2, 63:10, 65:17, 69:6, 69:18
comparable [2] - 35:10, 35:15
compare [3] - 14:11, 35:9, 60:21
compared [19] - 15:19, 19:10, 33:18, 38:13, 47:20, 49:9, 49:20, 49:23, 50:6, 50:9, 51:18, 52:9, 54:4, 54:23, 55:12, 56:13, 61:12, 62:16, 62:20
compares [1] - 64:12
comparing [2] - 13:13, 19:7
comparison [3] - 14:8, 38:7, 40:19
competition [1] - 33:2
complication [1] - 55:17
complications [5] - 52:18, 52:20, 52:21, 52:24, 55:15
comply [1] - 3:15
component [2] - 31:5, 36:10
components [1] - 28:13
concise [1] - 27:1
concludes [2] - 67:2, 68:2
condition [5] - 52:17, 53:2, 53:4, 55:7, 61:3
conditions [6] - 52:4, 52:14, 52:15, 56:5, 57:19, 59:6
conduct [1] - 3:22
CONFERENCE [2] - 2:2, 2:8
confirmed [1] - 59:22
Congestive [1] - 61:1
Connection [1] - 55:22
Connections" [2] - 56:7, 58:19
connective [2] - 54:14, 54:17
consider [1] - 58:11
consistent [4] - 4:1, 4:7, 9:14, 33:20
constraints [1] - 9:15
consultant [1] - 15:3
Consultant [1] - 45:12
contact [3] - 61:21, 68:13, 68:24
containment [1] - 33:12
contains [1] - 71:13
continue [1] - 66:10
continued [1] - 67:16
continues [1] - 47:19
contract [3] - 34:12, 64:24, 65:5
contracts [1] - 65:3
contributing [1] - 16:18
control [1] - 34:5
convene [2] - 3:7, 68:16
convey [1] - 31:4
conveyed [2] - 7:8, 35:2
COOK [1] - 1:1
Cook [16] - 1:14, 3:7, 13:3, 18:12, 19:7, 19:17, 20:7, 20:17, 22:5, 22:17, 23:20, 38:8, 45:6, 56:17, 58:21, 63:10
cooperation [1] - 69:14
coordinate [1] - 10:23
copay [2] - 16:7, 28:20
copays [6] - 16:4, 16:9, 16:11, 16:22, 28:19, 32:22
COPD [1] - 61:2
coronary [1] - 53:6
correct [1] - 71:11
Cost [9] - 16:10, 16:12, 31:3, 31:10, 31:13, 32:2, 32:3, 32:8, 47:14
cost [67] - 14:18, 15:24, 16:22, 16:23, 17:19, 18:11, 20:10, 20:11, 22:9, 22:10, 22:11, 23:15, 25:11, 28:12, 28:14, 28:23, 29:3, 29:5, 29:6, 29:10, 29:19, 31:5, 31:7, 31:11, 31:22, 31:23, 32:19, 33:10, 33:12, 33:14, 34:3, 34:13, 34:17, 34:22, 35:11, 35:18, 36:4, 36:5, 36:14, 37:7, 37:12, 39:10, 40:13, 40:17, 43:12, 47:1, 47:2, 47:9, 47:17, 47:22, 48:6, 48:24, 50:24, 51:1, 51:5, 51:24, 52:8, 52:15, 53:12, 53:18, 54:3, 54:21, 55:10, 59:21, 62:19, 65:10
Cost" [1] - 16:4
costly [1] - 23:18
costs [25] - 16:17, 17:7, 18:1, 18:4, 18:11, 23:4, 23:10, 25:12, 28:1, 28:9, 28:18, 29:20, 29:24, 39:24, 40:3, 43:17, 47:7, 51:6, 53:23, 55:20, 56:3, 61:16, 64:2, 65:22, 68:8
Costs" [1] - 14:16
counsel [1] - 3:14
COUNTY [1] - 71:2
County [17] - 1:14, 3:8, 13:3, 18:12, 19:7, 19:17, 20:7, 20:18, 22:5, 22:17, 23:20, 38:8, 45:6, 56:17, 58:21, 63:10, 71:8
COUNTY/FOREST [1] - 1:1
couple [5] - 13:12, 25:19, 34:1, 34:18, 40:12
course [4] - 27:19, 36:11, 64:24, 67:8
court [1] - 71:7
coverage [4] - 24:18, 24:20, 24:23
covered [2] - 11:9, 56:5

covers [1] - 53:10
create [1] - 65:12
CRISTINA [1] - 2:19
Cristina [1] - 62:6
CSR [1] - 71:17
cumbersome [1] - 39:3
current [3] - 21:9, 41:20, 45:21
Current [2] - 43:14, 43:20
CVS [15] - 2:13, 11:11, 11:15, 11:20, 12:2, 12:14, 19:20, 27:4, 33:8, 34:11, 38:15, 44:18, 57:22, 62:7, 64:2

D

Dan [8] - 35:13, 35:24, 61:20, 61:22, 62:1, 65:16, 67:2, 67:24
DAN [1] - 2:19
dark [1] - 60:23
data [8] - 45:19, 45:22, 46:12, 46:19, 57:20, 57:21, 62:23, 65:18
date [1] - 7:7
DATE [1] - 70:4
dates [2] - 45:22, 46:4
days [2] - 36:15, 38:21
Days' [1] - 33:16
deal [2] - 4:9, 34:10
dealt [1] - 34:16
DEBBIE [1] - 71:17
DEBORAH [1] - 71:6
December [4] - 13:13, 13:15, 45:24, 46:5
decision [2] - 6:18, 6:24
decrease [6] - 16:11, 17:24, 18:14, 18:16, 42:14, 50:9
decreases [2] - 46:22, 47:4
deemed [1] - 4:9
deeper [1] - 33:1
definition [1] - 29:13
DELEON [1] - 2:19
DeLeon [1] - 62:6
delve [1] - 46:18
demographic [1] - 36:11
Demographic [1] - 49:4
demographics [1] - 36:8
dependents [2] - 30:22, 65:6
describing [1] - 43:21
design [1] - 16:17
detail [4] - 50:20, 59:12, 60:3, 68:17
details [1] - 29:24
determined [1] - 9:15
develop [1] - 68:7
device [1] - 55:16
diabetes [4] - 38:10, 39:16, 57:18, 58:1
Diabetes [1] - 61:10
diabetic [3] - 26:8, 26:11, 58:9
diagnosed [2] - 41:6, 41:16
diagnosis [2] - 53:11, 53:13
diagnostic [2] - 52:14, 55:2
DIAHANN [1] - 2:4
dial [1] - 7:4
dialogue [1] - 4:14
dialysis [1] - 55:4
difference [2] - 41:12, 64:18
different [4] - 6:3, 17:5, 18:24, 67:10
differs [1] - 25:20
difficulty [1] - 42:22
direct [3] - 5:15, 6:6, 11:5
directed [1] - 5:19
directives [1] - 4:1
directly [2] - 18:16, 63:17
Director [3] - 2:9, 5:2, 5:11
disc [1] - 54:9
discount [3] - 28:9, 28:10, 33:1
discounts [1] - 33:14
discuss [2] - 5:21, 68:16
discussed [1] - 3:11
discussion [1] - 6:2
disease [6] - 58:2, 60:17, 60:20, 60:21, 61:5, 61:11
Disease" [1] - 60:15
diseases [1] - 57:6
Disorder [1] - 42:17
disorder [1] - 54:9
Disorders [1] - 42:10
disorders [1] - 42:21
dispense [1] - 23:7
dispensed [4] - 29:16, 32:18, 34:11, 36:9
dispensing [2] - 32:13, 32:17
District [2] - 3:8, 65:21
DISTRICT [1] - 1:1
divide [1] - 31:14
doctor [4] - 37:24, 56:23, 58:10, 58:12
doctors [1] - 42:8
dollars [7] - 14:19, 15:18, 28:20, 42:20, 57:5, 64:16, 64:19
done [1] - 54:16
DONOVAN [4] - 2:14, 12:1, 13:2, 13:20
Donovan [2] - 11:22, 12:2
dONOVAN [1] - 36:3
door [1] - 39:1
down [22] - 4:8, 6:4, 6:18, 14:14, 15:24, 16:23, 17:2, 17:21, 18:10, 18:18, 28:12, 28:21, 29:21, 31:3, 31:13, 33:10, 33:23, 43:3, 47:2, 50:2, 64:8
drew [1] - 18:8
drill [1] - 43:3
drive [2] - 18:10, 19:22
driven [2] - 34:3, 55:9
driver [3] - 39:20, 39:24, 59:22
drivers [1] - 47:22
driving [5] - 23:3, 29:24, 34:17, 53:23, 55:20
dropped [3] - 16:22, 17:20, 47:1
drove [1] - 17:15
Drug [3] - 14:15, 32:10, 43:19
drug [14] - 12:18, 14:17, 18:24, 23:6, 23:14, 23:18, 23:19, 23:21, 24:18, 25:18, 25:22, 63:24, 64:22, 67:18
Drugs [1] - 43:11
drugs [12] - 12:15, 23:2, 23:3, 23:11, 23:24, 24:22, 25:16, 25:22, 25:23, 26:5, 26:6, 29:15
DU [1] - 71:2
due [8] - 15:20, 42:7, 55:15, 55:19, 62:3, 64:20, 66:4, 66:11
DuPage [1] - 71:8
dysrhythmia [1] - 53:3

E

economic [1] - 68:17
edits [1] - 34:13
educate [1] - 48:16
educated [1] - 11:9
education [1] - 48:19
educational [5] - 4:12, 6:15, 6:23, 44:20, 68:5
effect [2] - 4:12, 6:21
effective [2] - 37:12, 48:19
effort [1] - 44:19
efforts [2] - 34:12, 48:15
EGWP [28] - 11:18, 12:5, 12:18, 13:4, 13:10, 14:1, 14:8, 14:11, 14:12, 15:9, 17:3, 17:4, 17:19, 21:6, 21:7, 22:17, 23:21, 24:13, 25:13, 26:18, 35:19, 36:2, 36:3, 36:5, 36:8, 36:17, 64:21, 67:18
either [1] - 5:18
electronic [1] - 57:21
Eligibility [2] - 30:3, 30:24
eligible [4] - 20:3, 21:24, 30:9, 31:15
Eligible [1] - 30:5
Emergency [3] - 48:13, 48:22, 48:24
employees [1] - 32:7
Employer [2] - 13:5, 43:14
employer [6] - 30:13, 30:21, 31:1, 32:6, 38:15, 67:18
employers [2] - 30:15, 37:16
encompass [1] - 54:7
end [6] - 4:24, 24:15, 29:20, 45:23, 46:1
endocrinologist [1] - 58:2
engaged [2] - 57:3
engagement [1] - 56:15
Enhanced [1] - 24:7
enhanced [3] - 24:9, 24:16, 25:24
enroll [1] - 57:1
entire [1] - 65:1
entitled [6] - 1:12, 27:16, 27:22, 30:1, 37:2, 56:6
ENTITLED [1] - 70:3
environment [1] - 68:18
equal [1] - 66:18
equalled [1] - 17:10
ER [1] - 49:3
erosion [3] - 28:24, 29:11, 31:22
especially [1] - 68:6
essential [1] - 4:9
essentially [8] - 15:14, 16:4, 18:24, 19:24, 20:15, 21:2, 22:15, 24:9
exactly [2] - 20:19, 22:21
example [2] - 46:24, 49:1
examples [1] - 48:4
exception [1] - 29:10
excuse [1] - 59:9
Executive [12] - 2:9, 3:3, 3:20, 5:2, 5:11, 37:2, 46:14, 50:19, 52:11, 60:4, 63:11, 63:13
exempt [1] - 47:17
exist [1] - 41:17
expect [4] - 60:16, 60:19, 61:7, 66:19
expectation [2] - 4:17, 5:7
expected [1] - 4:13
expenditures [1] - 40:11
expenses [3] - 63:21, 64:15, 64:17
Expenses [2] - 61:18, 63:12
expensive [2] - 32:24, 36:21
experience [5] - 64:4, 64:7, 65:11, 66:18, 67:13
experienced [2] - 29:11, 68:8
expert [1] - 62:7
explain [2] - 3:18, 38:7
explanation [1] - 44:13
extent [1] - 68:12
extra [2] - 24:20, 31:23

F

fact [1] - 39:19
factor [3] - 15:23, 16:21, 17:18
FAHRENBACH [11] - 2:9, 3:1, 8:8, 8:11, 8:13, 8:15, 8:18,

8:20, 8:22, 8:24, 9:3
failure [3] - 52:23, 55:4, 55:6
Failure [2] - 61:2
fall [6] - 42:23, 48:4, 52:2, 54:12, 54:16, 63:22
falling [1] - 42:22
familiar [1] - 24:12
family [1] - 56:22
far [5] - 14:6, 16:14, 22:3, 30:14, 39:15
favor [3] - 10:17, 37:22, 69:10
favorable [2] - 56:13, 67:14
February [1] - 65:2
Federal [1] - 67:17
feed [1] - 57:22
feedback [1] - 13:16
fellow [1] - 11:3
female [1] - 58:16
femur [1] - 55:18
few [4] - 36:13, 40:2, 40:23, 56:9
fiduciary [1] - 3:13
figure [2] - 17:22, 18:9
figures [5] - 13:14, 14:11, 18:7, 64:12, 65:20
filled [2] - 20:9, 22:7
filling [2] - 21:18, 38:1
fills [1] - 15:16
final [2] - 7:10, 54:13
finally [7] - 12:12, 48:20, 50:11, 51:16, 53:5, 53:21, 55:8
Financial [3] - 27:22, 40:8, 50:18
financial [1] - 37:9
financials [1] - 62:12
finish [1] - 59:23
first [9] - 10:3, 11:10, 11:16, 12:17, 25:9, 40:5, 41:4, 51:7, 52:1
five [1] - 42:16
flat [10] - 28:10, 29:9, 30:9, 31:1, 31:7, 31:18, 47:7, 49:20, 49:23
flow [1] - 68:22
flows [1] - 17:5
focus [11] - 12:4, 12:10, 13:10, 18:7, 26:23, 47:8, 56:16, 57:9, 58:23, 59:15, 59:18
focused [1] - 56:3
focuses [1] - 47:10
focusing [1] - 57:7
fold [1] - 62:14
folks [2] - 56:10, 57:13
follow [1] - 3:14
following [1] - 33:15
followup [1] - 24:2
FOR [1] - 2:10
foregoing [1] - 71:11
foremost [1] - 41:4
Forest [1] - 3:8
forum [1] - 4:18
forward [2] - 13:14, 45:1
foundation [1] - 6:17
foundational [1] - 6:22
four [2] - 39:4, 67:10
fourth [1] - 54:19
fractures [1] - 55:18
free [3] - 24:3, 26:19, 68:13
friendly [1] - 58:11
front [1] - 24:15
full [2] - 6:20, 69:19
function [1] - 62:3
Fund [47] - 3:9, 12:7, 12:9, 13:4, 15:5, 15:7, 16:7, 17:16, 18:1, 18:12, 19:8, 19:9, 19:24, 20:7, 20:18, 21:14, 22:5, 22:17, 23:20, 24:21, 25:13, 26:6, 29:2, 29:12, 29:15, 29:20, 30:16, 31:1, 32:4, 32:12, 32:23, 33:13, 34:8, 34:9, 37:6, 37:13, 37:16, 38:5, 38:9, 38:18, 39:6, 39:17, 40:1, 42:3, 45:6, 65:11, 65:21
FUND [1] - 1:2
Fund" [1] - 63:11
Fund's [6] - 7:6, 17:21, 28:13, 29:19, 33:9, 64:21
future [4] - 4:17, 5:17, 25:7
FYI [1] - 25:15

G

gap [5] - 58:7, 58:8, 58:11, 58:13, 58:14
gaps [1] - 38:2
gate [1] - 29:9
gender [1] - 60:18
General [2] - 3:21, 4:2
generic [5] - 32:13, 32:14, 32:16, 32:19, 39:12
generics [7] - 19:4, 19:10, 19:12, 32:22, 33:10, 37:11, 39:10
gina [1] - 6:6
Gina [21] - 5:15, 5:16, 5:19, 6:6, 10:22, 11:5, 11:10, 12:22, 13:2, 24:4, 24:10, 26:3, 26:15, 26:20, 26:22, 27:11, 43:4, 59:14, 61:24, 68:20, 68:24
given [3] - 5:4, 71:10, 71:13
Glance [1] - 13:8
Glance" [2] - 18:22, 30:2
global [2] - 40:13, 40:17
glucose [1] - 26:10
goal [1] - 37:15
Goerges [2] - 12:13, 27:13
GOERGES [6] - 2:15, 40:5, 43:9, 44:4, 44:7, 44:16
Going" [1] - 51:21
GOODE [3] - 2:4, 8:12, 69:8
Goode [2] - 8:11, 69:8
Government [1] - 35:20
government [1] - 36:22
Governor [2] - 3:19, 4:2
Governor's [2] - 3:3, 4:7
graph [2] - 18:17, 61:9
great [10] - 9:9, 18:2, 18:19, 19:13, 25:12, 32:19, 34:10, 59:11, 61:14, 61:23
greatly [1] - 17:6
Gross [1] - 31:13
gross [13] - 14:17, 15:24, 22:11, 23:15, 28:14, 31:7, 31:9, 34:22, 35:18, 36:3, 36:5, 43:11, 51:5
group [4] - 30:18, 31:18, 67:18, 67:19
Group [1] - 13:5
guidance [3] - 3:21, 4:11, 5:11
guides [1] - 48:17

H

half [3] - 14:3, 16:12, 16:24
hand [17] - 12:20, 14:6, 16:14, 17:22, 18:17, 20:6, 21:4, 21:21, 22:3, 23:7, 23:15, 28:15, 30:14, 34:15, 38:9, 39:15, 40:10
handful [1] - 34:16
handle [1] - 10:22
happy [1] - 26:20
hard [1] - 5:24
hate [1] - 28:3
Health [11] - 3:2, 3:9, 6:19, 12:3, 45:12, 61:18, 63:1, 63:9, 65:17, 69:5, 69:17
health [8] - 34:12, 37:19, 38:15, 57:12, 57:15, 59:5, 61:16, 62:15
HEALTH [2] - 1:3, 2:13
HEALTHCARE [1] - 2:16
healthy [4] - 15:19, 18:13, 25:10, 37:15
hear [4] - 7:17, 8:3, 11:11, 39:21
heard [1] - 13:16
hearing [1] - 62:2
heart [7] - 48:2, 52:4, 52:23, 53:8, 53:9, 57:18, 58:2
Heart [1] - 61:2
heartbeat [1] - 53:3
held [2] - 1:13, 3:19
help [5] - 6:17, 17:6, 57:18, 58:13, 68:6
helping [3] - 27:15, 29:18, 33:9
helps [1] - 62:11
hesitate [1] - 68:24
Hi [1] - 63:6
high [18] - 19:2, 20:10, 22:9, 34:2, 36:14, 39:10, 48:3, 52:3, 52:19, 53:1, 53:6, 53:19, 53:21, 57:5, 57:13, 59:21, 63:13, 63:15
higher [7] - 30:11, 34:23, 36:19, 56:14, 61:4, 61:6, 65:4
highest [3] - 47:19, 48:22, 56:17
hip [1] - 60:8
historically [1] - 12:4
HIV [2] - 41:14, 41:21
HOGAN [8] - 2:14, 27:11, 28:7, 35:12, 35:15, 35:24, 36:6, 37:1
Hogan [2] - 12:9, 27:6
Hogan's [1] - 28:5
hold [2] - 5:13, 5:19
home [3] - 17:15, 19:22, 58:12
hopefully [2] - 6:18, 68:10
hour [1] - 1:16
hours [1] - 4:21
Hughes [2] - 8:13, 10:12
HUGHES [3] - 2:5, 8:14, 10:12
hurdle [1] - 37:9
hyperlipidemia [1] - 39:16
Hypertension [1] - 61:10
hypertension [3] - 39:16, 52:3, 52:18

I

idea [1] - 32:4
identifies [1] - 51:22
identify [4] - 9:23, 46:7, 48:18, 60:19
ILLINOIS [1] - 71:1
Illinois [3] - 1:14, 3:21, 71:9
illustrate [1] - 65:24
illustrated [2] - 64:3, 65:15
immediate [1] - 58:24
impact [1] - 52:22
impacting [3] - 23:24, 52:11, 55:12
impacts [3] - 47:23, 54:5, 54:24
important [1] - 5:18
improved [1] - 57:12
IN [2] - 2:8, 70:3
in-person [4] - 5:20, 11:5, 68:10, 68:16
inbound [2] - 58:20, 58:21
include [3] - 46:12, 65:5, 65:20
including [3] - 6:16, 9:17, 19:20
increase [36] - 15:19, 15:21, 16:2, 17:1, 17:11, 17:15, 20:12, 20:16, 20:18, 22:11, 22:21, 29:18, 31:19,

33:24, 41:10, 41:21, 42:2, 42:5, 42:19, 47:12, 47:17, 48:7, 48:10, 49:13, 50:13, 51:2, 51:12, 51:14, 51:18, 52:9, 54:22, 55:11, 66:4, 66:7
increased [4] - 17:14, 47:14, 50:15, 54:4
increases [10] - 22:19, 34:7, 41:6, 46:22, 47:5, 62:19, 66:1, 66:2, 66:11, 67:17
indicates [1] - 61:5
individual [5] - 5:3, 42:18, 46:8, 49:17, 52:14
individuals [7] - 41:16, 52:19, 56:12, 57:2, 57:4, 57:17, 59:20
industry [1] - 66:13
Infarction [1] - 61:11
inflation [1] - 29:1
information [10] - 4:16, 5:14, 5:21, 6:5, 6:11, 7:8, 11:7, 44:24, 68:3, 68:9
informational [2] - 6:15, 44:20
informative [1] - 44:21
informed [2] - 6:18, 6:24
injectables [2] - 20:11, 22:10
injury [2] - 53:8, 55:20
Injury [1] - 55:8
instead [1] - 49:2
intended [1] - 4:16
interest [2] - 41:15, 68:16
interrupt [3] - 35:5, 43:24, 44:5
interruption [2] - 7:22, 28:2
interventions [2] - 57:7, 57:8
intervertebral [1] - 54:9
introduce [6] - 11:23, 27:8, 34:13, 45:4, 59:4, 61:22
introduced [2] - 27:9, 27:14
introducing [1] - 24:11
investment [2] - 37:6, 37:17
involved [1] - 35:20
irregular [1] - 53:3
issue [3] - 58:23, 69:1
item [3] - 10:3, 11:10, 61:17
items [1] - 4:10

J

JAMES [2] - 2:7, 2:14
James [1] - 12:9
Jane [4] - 24:4, 26:3, 26:15, 26:20
January [7] - 13:13, 13:15, 45:23, 46:1, 46:4, 65:1, 65:11
Jim [6] - 8:4, 12:8, 12:20, 26:23, 27:6, 27:7
job [1] - 43:7
JOHN [1] - 2:5
joined [1] - 7:23
joining [2] - 8:1, 45:11
joint [2] - 48:8, 54:11
joints [1] - 54:11
JOSEPH [1] - 2:6
jot [1] - 6:4
June [3] - 64:5, 65:18, 65:19
jurisdiction [1] - 9:20

K

Kathy [7] - 12:13, 27:13, 33:24, 40:2, 40:4, 43:4, 43:24
KATHY [1] - 2:15
keep [5] - 11:3, 33:9, 43:5, 57:15, 59:12
keeping [2] - 17:2, 27:1
KEVIN [1] - 2:6
Key [3] - 13:7, 18:22, 30:1
key [6] - 37:21, 39:20, 39:24, 56:3, 63:4, 67:5
Kidney [3] - 54:20, 54:21, 54:23
kidney [3] - 52:23, 55:3, 55:6
kind [6] - 13:8, 21:10, 24:16, 39:13, 43:15, 46:20
knee [1] - 60:8
Kouruklis [1] - 8:15
Kwame [1] - 3:22

L

labeled [18] - 13:3, 13:7, 14:7, 14:15, 14:22, 16:3, 16:15, 17:3, 18:22, 19:14, 20:22, 23:8, 24:7, 45:5, 46:13, 50:2, 52:1, 63:9
lack [1] - 37:8
large [5] - 15:20, 18:18, 20:18, 22:21, 49:7
largely [3] - 64:20, 66:4, 66:11
larger [2] - 29:2, 55:15
largest [1] - 50:4
last [3] - 10:16, 11:12, 61:17
Lawrence [2] - 35:7, 35:12
LAWRENCE [1] - 2:3
laws [1] - 3:16
lead [1] - 45:4
leading [2] - 35:1, 37:14
left [11] - 17:22, 21:4, 21:21, 28:15, 37:2, 38:9, 39:15, 40:10, 56:8, 56:11, 61:9
left-hand [7] - 17:22, 21:4, 21:21, 28:15, 38:9, 39:15, 40:10
Legal [1] - 2:9
legal [1] - 5:12
leisure [1] - 26:14
less [4] - 31:19, 32:24, 39:11, 61:11
letter [3] - 57:23, 58:4, 58:6
level [6] - 19:2, 20:1, 21:8, 34:2, 63:14, 63:15
levels [2] - 53:19, 53:21
LEVIN [7] - 2:19, 35:14, 35:17, 36:11, 36:18, 61:24, 67:4
Levin [3] - 35:13, 61:21, 62:1
liability [1] - 17:21
License [1] - 71:18
lifts [1] - 68:18
ligament [1] - 54:15
light [1] - 60:17
lighter [1] - 61:5
limit [1] - 11:1
limited [2] - 5:23, 62:4
line [7] - 12:8, 19:4, 27:13, 33:17, 35:14, 38:16, 46:24
listening [2] - 6:5, 62:7
lists [1] - 46:16
location [1] - 19:21
locations [1] - 19:20
long-term [1] - 55:7
look [31] - 10:6, 13:8, 16:14, 17:22, 20:5, 22:2, 25:8, 26:1, 35:17, 41:10, 41:20, 41:24, 44:11, 44:22, 46:23, 47:6, 47:11, 47:12, 47:20, 49:11, 51:10, 53:15, 54:8, 60:5, 60:18, 62:19, 63:14, 64:14, 67:7, 67:9, 67:15
looked [1] - 50:19
looking [18] - 13:21, 13:24, 25:12, 35:8, 40:7, 45:22, 46:4, 46:19, 47:24, 49:5, 49:7, 49:17, 49:18, 50:11, 50:17, 50:23, 51:6, 63:18
looks [3] - 50:23, 51:21, 60:16
loss [1] - 46:12
love [3] - 19:18, 20:8, 22:6
low [3] - 39:9, 56:10, 57:14
lower [4] - 32:22, 33:14, 36:20, 48:24
LTD [1] - 2:11
lung [1] - 53:22
lungs [1] - 61:3

M

Madison [1] - 1:13
mail [1] - 19:17
mailings [2] - 57:16, 57:17
main [2] - 61:21, 62:9
maintenance [4] - 19:19, 19:23, 20:3, 20:8
Maintenance [5] - 21:24, 22:6, 33:6, 38:17, 39:9
major [5] - 19:6, 19:9, 21:17, 25:4, 36:10
manage [1] - 21:7
management [1] - 34:10
Manager [2] - 62:9, 62:10
managing [1] - 16:16
mandatory [2] - 38:17, 39:9
manner [1] - 7:16
manufacturer [1] - 15:13
manufactures [1] - 15:6
maps [1] - 48:17
March [1] - 65:2
MARGARET [1] - 2:9
market [3] - 33:3, 49:7, 67:12
Mary [2] - 3:11, 8:3
MARY [1] - 2:11
materials [1] - 7:15
matter [1] - 1:12
matters [3] - 9:20, 11:9, 12:14
McFadden [24] - 2:4, 3:5, 3:17, 7:20, 8:3, 8:6, 8:8, 8:16, 8:17, 9:2, 9:12, 10:11, 10:14, 10:19, 11:14, 43:23, 44:5, 44:15, 68:19, 69:7, 69:10, 69:12
mean [1] - 66:17
meaning [1] - 42:22
meaningful [1] - 68:11
means [3] - 24:9, 38:10, 44:12
meant [1] - 6:16
meanwhile [1] - 66:6
measured [1] - 58:8
median [1] - 41:7
medical [9] - 46:9, 46:18, 47:19, 57:20, 63:24, 66:5, 66:14, 67:13
Medical [1] - 45:6
Medicare [57] - 11:17, 12:5, 12:6, 12:11, 12:18, 12:20, 13:5, 13:11, 14:1, 14:15, 17:6, 17:7, 17:9, 18:12, 21:6, 22:18, 24:14, 24:17, 26:18, 26:23, 27:4, 27:16, 27:19, 30:6, 30:18, 35:9, 35:10, 38:9, 47:11, 47:13, 47:16, 48:21, 49:18, 50:2, 50:12, 51:10, 51:13, 51:16, 60:10, 60:11, 62:21, 64:22, 66:1, 66:6, 66:10, 66:15, 66:16, 66:19, 66:20, 66:22, 66:24, 67:8, 67:11, 67:14, 67:18
medication [22] - 15:4, 15:11, 15:15, 19:1, 21:18, 22:9, 23:8, 33:19, 34:11, 34:21, 36:9, 37:9, 37:10,

37:24, 38:1, 38:12, 38:23, 42:6, 42:12, 42:15, 43:2, 43:21
medications [17] - 14:18, 15:10, 19:3, 19:19, 20:9, 20:11, 22:7, 22:20, 24:3, 32:11, 32:18, 32:24, 33:1, 34:8, 36:13, 36:15, 44:11
MEETING [2] - 1:3, 70:3
Meeting [3] - 3:7, 63:10, 69:6
meeting [30] - 1:12, 3:12, 3:15, 3:19, 4:3, 4:6, 4:8, 4:12, 4:21, 4:23, 5:16, 6:15, 6:23, 7:1, 7:4, 7:5, 7:23, 9:17, 10:4, 10:15, 62:3, 63:2, 65:17, 68:4, 68:11, 69:18, 69:20, 69:24
meetings [3] - 3:23, 4:17, 9:18
meets [1] - 6:19
member [19] - 9:8, 9:22, 16:4, 16:22, 17:19, 28:18, 28:19, 28:23, 28:24, 29:10, 30:24, 31:22, 33:14, 38:24, 39:9, 39:10, 40:15, 42:11, 43:1
Member [26] - 15:4, 15:16, 16:3, 16:10, 16:12, 18:4, 18:9, 18:11, 32:3, 32:8, 36:4, 37:13, 41:24, 46:16, 47:1, 47:14, 50:24, 51:1, 51:14, 51:17, 52:8, 53:11, 54:2, 55:22, 56:6, 58:19
Members [1] - 30:5
members [67] - 4:4, 4:15, 4:22, 6:9, 6:14, 7:3, 7:15, 9:18, 11:7, 11:19, 11:23, 13:22, 13:23, 14:1, 15:9, 16:9, 18:12, 19:3, 19:12, 19:17, 19:24, 20:8, 21:1, 21:17, 21:18, 22:5, 23:13, 24:21, 26:6, 28:20, 29:5, 30:6, 30:8, 30:10, 30:17, 31:15, 32:8, 32:21, 33:8, 34:9, 34:16, 35:2, 37:7, 37:19, 38:11, 38:19, 47:24, 49:12, 49:14, 50:7, 50:8, 50:14, 52:12, 53:13, 54:6, 55:4, 55:13, 56:4, 57:9, 58:4, 58:5, 58:21, 59:16, 60:18, 61:7, 68:15
membership [3] - 32:12, 37:8, 49:11
Membership [1] - 49:22
mention [1] - 25:5
mentioned [5] - 17:20, 24:10, 34:14, 52:10, 59:21
metric [4] - 33:10, 35:11, 38:22, 51:4
Metrics [5] - 13:7, 18:22, 30:1, 49:4, 50:18
metrics [2] - 38:3, 43:17
Metrics" [1] - 37:3
MICHAEL [2] - 2:16, 2:17
Michael [1] - 45:3
middle [2] - 19:14, 60:5
might [1] - 39:11
Mike [4] - 45:10, 45:13, 45:17, 55:22
mild [1] - 66:7
million [29] - 14:19, 14:20, 14:21, 15:18, 16:1, 16:2, 16:23, 17:1, 17:10, 17:12, 17:16, 17:21, 17:23, 20:14, 22:13, 23:16, 28:11, 28:16, 28:20, 29:7, 29:8, 29:17, 29:18, 29:21, 64:16, 64:18, 64:19
minds [1] - 57:16
minimize [1] - 7:13
minutes [13] - 5:5, 5:7, 8:1, 10:4, 10:6, 10:7, 10:9, 10:15, 10:20, 11:2, 43:6, 56:9, 59:10
miss [1] - 39:2
missing [1] - 38:1
mitigate [1] - 29:19
mitigating [2] - 34:4, 34:13
mix [1] - 19:1
Mix [1] - 32:10
mode [1] - 43:8
moderate [3] - 31:22, 56:10, 57:14
modest [1] - 66:1
Money [1] - 51:21
money [4] - 20:12, 22:11, 32:21, 32:23
monies [1] - 29:14
monitored [1] - 38:22
monitors [1] - 26:10
Month [17] - 18:4, 18:9, 18:11, 30:5, 36:4, 41:24, 46:16, 47:1, 47:14, 50:24, 51:1, 51:14, 51:17, 52:8, 53:12, 54:2, 55:10
month [4] - 40:15, 45:24, 46:5, 64:8
months [1] - 65:1
morning [6] - 8:10, 12:1, 40:5, 45:9, 45:11, 56:1
Morris [2] - 45:4, 45:10
MORRIS [2] - 2:16, 45:8
most [3] - 37:12, 37:16, 51:23
motion [6] - 10:7, 10:13, 10:14, 69:5, 69:9, 69:13
move [14] - 10:9, 13:6, 18:21, 20:21, 25:17, 27:3, 31:13, 34:18, 40:12, 43:8, 46:13, 47:8, 48:24, 51:20
moved [1] - 15:23
Movement [1] - 42:10
movement [2] - 16:8, 25:2
moving [9] - 13:14, 14:14, 17:2, 29:4, 31:3, 31:5, 32:10, 38:13, 39:5
MR [22] - 8:5, 12:1, 13:2, 13:20, 27:11, 28:7, 35:12, 35:14, 35:15, 35:17, 35:24, 36:3, 36:6, 36:11, 36:18, 37:1, 45:8, 55:24, 59:14, 61:24, 63:6, 67:4
MS [34] - 2:11, 3:1, 3:17, 7:24, 8:8, 8:11, 8:13, 8:15, 8:18, 8:20, 8:22, 8:24, 9:3, 9:6, 9:9, 11:13, 12:23, 13:18, 26:24, 28:3, 40:5, 43:4, 43:9, 44:4, 44:7, 44:16, 44:17, 45:17, 59:9, 60:1, 61:14, 67:24, 69:23, 69:24
multi [1] - 32:12
Musculoskeletal [4] - 53:24, 54:2, 54:14, 54:18
musculoskeletal [2] - 54:7, 59:24
mute [4] - 7:13, 13:19, 28:4, 28:6
Myocardial [1] - 61:10

N

name [7] - 12:2, 15:4, 15:10, 15:11, 15:15, 19:3, 45:10
narcolepsy [1] - 42:21
narrow [1] - 46:3
nature [2] - 5:23, 68:5
nearly [1] - 38:11
need [8] - 15:1, 25:7, 44:8, 44:9, 48:10, 54:15, 56:24, 58:24
needed [2] - 42:14, 44:7
negative [6] - 18:15, 18:16, 18:19, 25:10, 29:8, 31:12
negotiated [2] - 15:2, 15:21
net [6] - 16:23, 25:11, 29:6, 31:11, 31:21, 31:22
network [1] - 48:17
Nevius [2] - 9:3, 9:7
NEVIUS [4] - 2:6, 9:5, 9:8, 9:11
new [4] - 41:17, 41:22, 68:6, 69:3
newer [1] - 6:16
newly [1] - 41:16
news [1] - 18:2
next [21] - 6:21, 9:12, 14:2, 14:14, 14:22, 16:3, 24:6, 27:3, 29:23, 30:1, 40:12, 41:14, 41:23, 42:17, 43:2, 43:10, 51:4, 55:23, 58:18, 68:23, 69:19
nice [2] - 43:7, 61:15
nine [1] - 3:5
NM [1] - 38:8
noise [1] - 7:13
Non [5] - 27:16, 38:9, 50:2, 51:10, 51:13
non [20] - 9:8, 27:4, 27:19, 30:6, 30:18, 35:9, 36:17, 47:13, 47:16, 48:21, 49:18, 60:11, 62:21, 66:1, 66:15, 66:19, 66:20, 66:22, 67:8, 67:11
non-EGWP [1] - 36:17
non-Medicare [18] - 27:4, 27:19, 30:6, 30:18, 35:9, 47:13, 47:16, 48:21, 49:18, 60:11, 62:21, 66:1, 66:15, 66:19, 66:20, 66:22, 67:8, 67:11
Non-Medicare [5] - 27:16, 38:9, 50:2, 51:10, 51:13
non-member [1] - 9:8
nonspecialty [1] - 34:6
note [1] - 48:20
noted [1] - 8:1
notes [1] - 71:12
nothing [1] - 25:14
Notice [1] - 4:2
Number [15] - 3:20, 13:6, 18:21, 20:22, 21:20, 21:22, 22:23, 23:5, 23:19, 23:20, 24:6, 25:17, 40:8, 43:19, 63:19
number [22] - 4:5, 26:9, 26:10, 31:15, 34:19, 35:9, 42:13, 48:7, 49:5, 49:24, 50:7, 50:14, 51:7, 52:17, 53:17, 55:3, 55:14, 55:16, 55:18, 57:19, 59:6, 62:18
numbers [8] - 13:9, 14:4, 14:8, 16:18, 19:1, 60:6, 63:18, 67:20
nurse [3] - 56:13, 57:3, 59:2
nurses [2] - 57:8, 59:18

O

o'clock [1] - 3:6
O'Rourke [3] - 7:22, 7:24, 8:18
O'ROURKE [5] - 2:7, 7:21, 8:2, 8:5, 8:19
oath [1] - 71:7
obtain [1] - 37:9
obtaining [1] - 38:12
Ochalla [1] - 8:22
OCHALLA [2] - 2:6, 8:23
October [3] - 10:4, 10:9, 10:15
OF [4] - 1:3, 1:11, 71:1, 71:2

offers [1] - 24:17
offset [4] - 17:7, 17:20, 64:1, 66:11
Offsets [1] - 17:3
offsets [1] - 17:9
offsetting [1] - 47:5
often [6] - 20:11, 22:9, 26:10, 39:10, 58:4, 58:22
old [1] - 69:3
older [2] - 36:12, 36:21
omitted [1] - 9:4
once [2] - 5:12, 42:17
Oncology [1] - 41:4
oncology [3] - 36:13, 41:6, 59:18
one [29] - 9:24, 13:4, 18:22, 20:22, 21:12, 21:14, 23:11, 24:7, 25:8, 25:18, 25:20, 26:9, 26:11, 37:21, 42:11, 42:18, 45:24, 46:5, 47:22, 50:19, 52:7, 52:17, 53:17, 55:3, 55:14, 60:13, 62:14, 63:9, 68:23
One [1] - 26:9
One-Touch [1] - 26:9
onus [1] - 38:24
onward [1] - 13:1
open [2] - 7:2, 63:8
opens [1] - 39:1
opportunities [1] - 57:12
opportunity [8] - 9:13, 10:5, 27:12, 39:1, 42:24, 44:11, 48:23, 59:3
opposed [2] - 10:19, 69:12
opt [1] - 56:21
option [6] - 19:18, 19:23, 20:4, 20:8, 22:1, 22:6
Optum [1] - 45:13
OR [1] - 2:8
order [4] - 3:15, 4:6, 4:19, 42:24
Order [3] - 3:4, 3:20, 4:7
orders [1] - 3:16
osteoarthritis [1] - 54:10
Osteoarthritis [1] - 54:12
otherwise [1] - 39:2
outlayers [1] - 19:9
outline [1] - 3:13
outlook [1] - 25:6
outreach [1] - 57:8
outs [1] - 25:4
overall [11] - 14:17, 16:11, 17:24, 25:11, 33:16, 37:19, 41:21, 49:8, 49:11, 50:14, 52:7
overview [2] - 21:11, 45:18
own [3] - 22:24, 23:22, 26:14

P

Page [17] - 13:6, 27:21, 29:23, 35:1, 37:2, 37:15, 38:6, 40:8, 45:18, 46:13, 48:20, 49:4, 50:17, 60:2, 65:9, 67:10
page [12] - 29:23, 31:6, 43:10, 46:15, 50:22, 52:13, 53:16, 54:9, 55:23, 60:6, 61:1, 64:6
PAGE [1] - 71:2
pages [2] - 37:5, 63:14
paid [2] - 51:7, 51:8
Paid [1] - 51:8
pain [2] - 54:8, 54:9
pandemic [1] - 68:18
pardon [1] - 7:21
pared [1] - 4:8
Park [1] - 65:21
Parkinson's [1] - 43:21
part [1] - 15:20
Part [1] - 14:15
participant's [1] - 65:22
participate [2] - 4:6, 56:20
participating [3] - 4:23, 11:1, 69:22
particular [16] - 25:14, 40:7, 40:21, 41:1, 41:11, 41:18, 42:1, 42:12, 42:20, 43:2, 43:13, 44:10, 52:8, 60:20, 61:6, 61:12
parties [1] - 14:24
parts [1] - 31:5
pass [1] - 15:7
passes [1] - 69:13
past [1] - 48:16
Pat [3] - 3:11, 43:23, 68:19
Pat's [1] - 8:4
PATRICIA [1] - 2:11
PATRICK [1] - 2:4
pattern [2] - 30:19, 37:22
pay [3] - 39:11, 65:23
paying [1] - 16:9
payment [1] - 46:1
pays [1] - 28:24
peer [2] - 21:22, 30:11
Peers [2] - 14:7, 16:15
peers [2] - 19:8, 21:6
peggy [1] - 8:7
Pension [26] - 12:7, 12:9, 13:4, 15:5, 15:7, 16:7, 17:16, 18:1, 18:12, 19:8, 19:9, 19:24, 20:7, 20:18, 21:14, 22:5, 22:17, 23:20, 24:21, 25:13, 26:6, 34:8, 38:8, 38:18, 45:6, 63:10
pension [1] - 19:17
people [9] - 5:1, 13:18, 37:23, 38:20, 41:6, 44:2, 53:6, 53:16, 62:3
Per [32] - 18:4, 18:9, 18:11, 30:5, 36:4, 41:24, 46:16, 46:24, 47:1, 47:13, 47:14, 50:24, 51:1, 51:13, 51:14, 51:17, 52:8, 53:11, 53:12, 54:2, 55:10
per [7] - 23:19, 40:15, 42:23, 55:10, 64:13, 65:7, 65:11
percent [82] - 14:3, 14:20, 15:8, 15:20, 16:1, 16:12, 16:16, 16:24, 17:11, 17:15, 17:24, 18:15, 19:10, 20:2, 20:7, 20:13, 21:23, 22:4, 22:12, 23:10, 28:17, 28:21, 29:3, 29:4, 29:5, 29:8, 29:17, 29:21, 30:7, 30:11, 31:10, 31:19, 31:23, 32:7, 32:17, 33:17, 34:21, 34:23, 38:10, 38:11, 42:2, 47:14, 47:18, 47:24, 48:9, 48:11, 49:13, 50:5, 50:8, 50:13, 50:15, 51:2, 51:14, 52:6, 52:9, 52:11, 53:11, 53:12, 54:1, 54:4, 54:5, 54:20, 54:22, 54:24, 55:9, 55:11, 55:13, 56:11, 57:4, 58:14, 60:20, 65:4, 65:8, 66:3, 66:8, 66:15, 66:20, 66:21, 66:23, 67:1, 67:10
percentage [7] - 16:10, 16:11, 29:2, 30:10, 34:20, 34:22, 40:16
percentile [3] - 38:14, 39:6, 39:14
Performance [1] - 45:6
performance [1] - 11:12
performing [1] - 39:17
period [12] - 45:22, 47:12, 47:15, 47:18, 49:14, 50:6, 50:10, 50:14, 51:3, 51:12, 51:15, 51:19
PERSON [1] - 2:8
Person [1] - 55:10
person [4] - 5:20, 11:5, 68:10, 68:16
personal [1] - 59:5
perspective [1] - 36:4
PETER [1] - 2:20
Peter [1] - 62:8
pharmaceutical [2] - 15:6, 15:13
pharmacist [1] - 27:15
pharmacy [6] - 11:17, 27:4, 37:18, 39:3, 57:21, 62:6
phone [5] - 5:6, 7:12, 12:12, 28:5, 59:7
Phone [1] - 28:2
phones [3] - 7:13, 13:19, 28:4
physically [2] - 3:23, 4:18
physician [1] - 38:13
picture [1] - 61:16
PINELLI [1] - 2:11
place [2] - 38:18, 56:4
plan [22] - 11:11, 16:17, 24:15, 24:17, 30:9, 30:20, 30:21, 31:15, 31:20, 32:7, 33:20, 37:18, 37:23, 38:17, 41:13, 49:12, 51:7, 51:8, 61:16, 62:20, 67:6, 67:15
Plan [8] - 11:18, 12:5, 13:5, 15:9, 45:6, 66:3, 66:9
plan's [1] - 37:22
Plans [1] - 66:8
plans [5] - 24:14, 38:16, 39:8, 64:22, 68:7
plaque [1] - 53:7
Plus [3] - 66:3, 66:8, 67:7
plus [1] - 5:9
PMPM [10] - 18:4, 31:14, 31:23, 33:16, 35:8, 35:11, 35:22, 51:5, 51:8, 51:11
PMPMs [1] - 46:17
point [4] - 9:12, 31:23, 34:3, 66:7
points [2] - 63:4, 63:17
Poisoning [1] - 55:8
population [49] - 12:11, 12:18, 12:21, 13:11, 14:2, 17:7, 21:7, 25:14, 26:23, 31:17, 32:18, 36:8, 36:12, 36:21, 37:20, 41:15, 41:18, 42:3, 47:11, 47:13, 47:17, 47:19, 48:1, 48:16, 48:21, 49:6, 49:8, 49:9, 49:18, 49:24, 50:4, 50:5, 50:10, 50:12, 50:21, 50:23, 51:1, 51:16, 51:24, 52:6, 53:20, 53:22, 55:1, 56:15, 56:18, 58:16, 60:11, 60:22, 61:13
Population [1] - 46:24
Population" [1] - 40:9
populations [2] - 46:17, 60:12
portion [3] - 26:17, 65:21, 65:23
positive [2] - 17:13, 32:15
possibly [2] - 57:18, 58:3
pre [3] - 12:11, 12:20, 26:23
pre-Medicare [3] - 12:11, 12:20, 26:23
predicate [1] - 6:13
prefer [1] - 33:8
preferred [1] - 33:12
preliminary [5] - 62:18, 62:22, 65:12, 65:14, 65:24
Preliminary [1] - 63:12
preparation [1] - 3:12
prepare [2] - 5:17, 63:22
prepared [2] - 63:8, 63:9
prescribed [2] - 37:24,

38:12
prescription [7] - 23:19, 28:1, 28:8, 29:3, 63:24, 64:22, 67:18
Prescription [1] - 27:22
prescriptions [4] - 14:5, 20:3, 21:24, 23:17
present [11] - 3:24, 4:18, 7:14, 8:12, 8:14, 8:17, 8:19, 8:21, 9:1, 9:5, 27:12
PRESENT [2] - 2:2, 2:8
presentation [23] - 5:5, 11:16, 11:21, 11:24, 26:2, 26:17, 26:21, 27:1, 27:3, 27:16, 28:23, 36:2, 39:19, 43:6, 44:8, 44:21, 45:3, 45:5, 45:15, 47:10, 61:23, 62:14, 63:8
presentations [5] - 10:23, 11:15, 62:8, 68:3
presented [1] - 27:18
presenting [1] - 5:8
PRESERVE [1] - 1:1
Preserve [1] - 3:8
President [2] - 2:3, 2:4
pressure [4] - 48:3, 52:3, 52:19, 53:1
pretty [5] - 19:4, 33:17, 33:20, 49:19, 69:16
Prevalence [1] - 60:14
prevalence [2] - 41:5, 60:17
prevalent [1] - 41:17
previews [1] - 25:21
previous [4] - 23:1, 23:24, 37:5, 50:22
previously [3] - 29:13, 31:12, 43:22
pricing [1] - 15:21
primarily [3] - 34:7, 38:20, 58:16
primary [2] - 56:22, 57:24
printer [1] - 45:19
Pritzker's [1] - 3:20
procedures [1] - 3:13
proceed [3] - 7:19, 10:1, 12:24
PROCEEDINGS [2] - 1:11, 70:2
proceedings [2] - 71:10, 71:13
program [3] - 11:17, 57:2, 59:17
Program [1] - 59:17
programs [4] - 56:4, 56:16, 56:19, 59:4
project [1] - 65:12
Projected [1] - 63:12
projected [8] - 63:24, 64:15, 64:21, 65:3, 65:4, 65:8, 66:5, 66:18
projection [3] - 63:21, 64:9, 65:13
Projections [1] - 61:19
projections [2] - 63:23, 64:3
prone [1] - 36:8
prospective [9] - 14:18, 16:17, 19:2, 21:12, 25:12, 31:21, 31:24, 33:13, 46:21
provide [6] - 40:15, 44:13, 44:24, 68:8, 68:14
provided [5] - 3:21, 4:3, 4:5, 40:24, 42:7
provider [1] - 58:1
providers [2] - 57:24, 58:4
provides [3] - 24:21, 63:13, 63:14
providing [2] - 40:19, 48:17
Psoriasis [1] - 41:23
Public [1] - 9:14
public [10] - 4:5, 4:18, 6:14, 7:2, 7:3, 9:13, 9:18, 9:21, 9:22, 9:24
publicly [1] - 4:4
pull [1] - 25:4
purpose [1] - 62:14
purposes [1] - 65:15
pursuant [2] - 3:3, 3:19
put [1] - 4:4
putting [1] - 61:15

Q

qualified [1] - 56:18
qualify [2] - 57:3, 59:20
questions [23] - 4:19, 5:13, 5:15, 5:18, 5:24, 6:4, 6:6, 6:7, 11:4, 11:5, 11:6, 11:8, 12:14, 24:2, 26:4, 26:15, 26:19, 26:21, 44:12, 44:23, 68:13, 68:22
quite [6] - 26:10, 34:4, 34:21, 36:13, 39:17, 40:23
quorum [1] - 8:24

R

radiation [2] - 53:17, 59:19
raise [2] - 13:22, 68:24
raised [1] - 14:18
rank [2] - 21:5, 21:9
Rank [6] - 21:8, 21:9, 43:14, 43:15, 43:20
ranking [2] - 21:12, 24:24
ranks [3] - 21:12, 21:14
Raoul [1] - 3:22
rate [11] - 18:5, 18:15, 32:13, 32:17, 37:15, 38:6, 38:13, 56:14, 58:14, 65:10, 67:6
Rates [1] - 63:12
rates [11] - 6:21, 65:14, 65:24, 66:2, 66:6, 66:10, 66:19, 66:20, 66:22, 66:24, 68:10
reach [3] - 56:8, 58:5, 59:1
ready [1] - 7:18
real [1] - 21:16
realize [1] - 59:1
really [14] - 17:15, 19:22, 20:8, 22:6, 25:4, 25:12, 33:8, 39:20, 47:6, 47:9, 51:5, 51:22, 57:7, 59:7
reason [2] - 5:22, 48:6
reasonable [1] - 9:15
reasons [2] - 5:1, 23:11
rebate [2] - 15:1, 36:18
Rebate [2] - 31:3, 32:2
rebates [16] - 15:17, 15:21, 15:23, 15:24, 16:21, 17:18, 18:10, 29:7, 29:12, 31:11, 33:13, 35:20, 35:23, 64:1, 66:12, 67:17
Rebates [2] - 31:10, 31:14
Rebates" [1] - 14:23
receive [2] - 4:16, 17:5
received [2] - 17:17, 58:5
receives [2] - 15:4, 15:5
receiving [2] - 5:14, 15:15
recently [1] - 67:14
recognizing [1] - 30:17
recommend [1] - 25:15
recommendations [1] - 6:20
recommending [2] - 3:14, 42:8
reconvene [1] - 67:21
record [1] - 9:23
recorded [2] - 3:3, 7:4
recording [1] - 3:1
reduce [1] - 48:23
reduction [7] - 28:17, 29:4, 29:7, 30:6, 31:10, 31:11, 31:17
refer [2] - 12:6, 63:19
reference [2] - 22:24, 23:23
referenced [1] - 28:22
references [3] - 13:4, 45:21, 46:6
referral [1] - 59:8
referred [1] - 11:18
refill [2] - 38:3, 38:24
refills [2] - 38:1, 39:2
reflected [4] - 17:15, 18:4, 18:17, 23:2
refresh [1] - 62:23
refresher [1] - 15:1
regarding [2] - 5:14, 6:20
REGINA [1] - 2:9
regular [1] - 69:19
reimbursements [1] - 46:12
reiterate [1] - 68:20
relate [1] - 63:18
related [6] - 12:15, 26:9, 34:7, 54:10, 54:19, 54:21
relation [1] - 32:5
Relationship [2] - 62:9, 62:10
relatively [7] - 28:10, 30:9, 31:7, 31:18, 47:7, 49:22
relevant [1] - 9:20
remain [1] - 28:24
remind [4] - 6:13, 7:2, 10:24, 59:10
reminder [2] - 58:11, 58:12
reminders [1] - 58:15
Renal [1] - 61:2
repair [2] - 54:16, 54:17
repairs [1] - 55:19
replacement [2] - 54:11, 60:8
report [3] - 18:2, 18:19, 67:2
REPORT [1] - 1:11
reported [1] - 71:9
Reporter [1] - 71:7
reporter [1] - 71:7
represent [1] - 57:4
representatives [1] - 44:18
request [4] - 5:10, 7:10, 9:19
requests [1] - 9:21
respect [2] - 5:2, 11:16
respectful [1] - 4:21
response [2] - 35:16, 68:14
rest [3] - 7:15, 26:13, 47:10
result [2] - 58:20, 59:3
resulting [1] - 29:5
results [1] - 53:8
retail [2] - 19:16, 19:20
retiree [2] - 66:2, 66:10
retirees [3] - 12:6, 64:22, 66:7
Review [2] - 40:8, 45:7
review [3] - 20:24, 26:18, 34:1
Review" [2] - 20:23, 24:8
reviewed [1] - 37:5
Revlimid [2] - 23:6, 23:12
right-hand [8] - 14:6, 16:14, 18:17, 20:6, 22:3, 23:7, 23:15, 30:14
rise [1] - 34:23
risk [4] - 56:10, 56:17, 57:13, 57:14
road [1] - 6:18
roll [1] - 8:7
Room [3] - 48:13, 48:22, 48:24
routine [1] - 55:5
row [8] - 14:3, 14:22, 16:3, 30:4, 30:23, 32:2, 32:16, 33:6
run [1] - 46:5

S

save [2] - 32:21, 32:23
saw [18] - 16:8, 19:5, 31:6, 47:4, 47:11, 47:22, 48:7, 49:20, 49:23, 50:6, 50:9, 51:12, 51:15, 51:18, 52:7, 52:10, 54:4, 54:23
scene [1] - 24:14
schedule [1] - 59:12
scheduled [3] - 68:3, 69:19, 69:20
schedules [1] - 5:6
screening [1] - 58:17
screenings [1] - 58:15
Script [1] - 19:18
se [1] - 42:23
Sean [13] - 11:22, 12:2, 13:1, 26:24, 27:9, 27:14, 27:17, 28:22, 29:13, 33:4, 35:23, 36:1, 36:20
SEAN [1] - 2:14
second [6] - 10:13, 32:16, 33:7, 51:4, 53:10, 69:7
secondarily [1] - 53:19
secondary [3] - 53:2, 53:4, 55:5
seconded [1] - 10:11
seconds [1] - 69:8
Secretary [1] - 2:4
section [8] - 19:14, 20:17, 22:9, 30:24, 31:4, 32:3, 33:5, 33:23
see [72] - 13:12, 13:22, 14:2, 14:10, 14:17, 15:18, 16:1, 16:16, 17:14, 18:8, 18:13, 19:13, 20:2, 20:12, 21:21, 21:23, 22:11, 23:5, 23:6, 23:15, 25:1, 27:24, 28:8, 28:15, 28:16, 30:4, 30:15, 30:23, 31:16, 32:1, 32:15, 33:5, 33:21, 33:24, 34:2, 34:7, 34:19, 35:10, 35:21, 37:14, 37:18, 37:21, 38:2, 38:6, 38:8, 38:10, 39:14, 40:23, 41:19, 41:23, 42:18, 45:21, 48:10, 48:12, 49:12, 49:19, 50:3, 52:1, 52:5, 52:21, 52:23, 54:11, 54:13, 55:7, 55:14, 57:19, 61:11, 61:12, 64:23, 66:11
seeing [22] - 16:19, 20:15, 20:19, 22:15, 22:19, 22:22, 25:10, 38:5, 42:8, 46:21, 51:23, 52:15, 52:18, 52:20, 53:4, 53:14, 53:19, 53:21, 58:10, 60:22, 66:12, 66:14
seemingly [1] - 37:8
SEGAL [1] - 2:18
Segal [7] - 5:9, 15:3, 34:12, 61:17, 61:21, 62:16, 64:9
send [1] - 57:16
sending [1] - 57:23
sent [1] - 57:17
separately [2] - 67:7, 67:9
service [2] - 45:23, 46:4
set [7] - 4:24, 5:3, 12:22, 15:2, 15:3, 15:11, 15:14
setting [3] - 49:1, 49:2, 68:11
setup [2] - 40:10, 40:22
seven [3] - 21:13, 21:14, 21:16
several [2] - 39:15, 68:22
Share [4] - 16:10, 16:13, 32:3, 32:8
share [10] - 11:7, 16:22, 17:19, 28:23, 29:5, 29:10, 31:22, 33:14, 37:7, 39:10
shared [1] - 68:14
shift [1] - 25:1
shifts [2] - 19:6, 21:17
shortchange [1] - 44:2
shorter [1] - 18:23
Shorthand [1] - 71:6
shorthand [2] - 71:9, 71:12
showcase [1] - 40:3
showing [5] - 14:8, 17:24, 20:6, 21:11, 22:3
shown [3] - 23:2, 31:12, 67:10
shows [2] - 44:10, 64:7
shrunk [1] - 50:5
side [18] - 16:14, 17:23, 18:17, 20:6, 21:4, 21:21, 22:3, 23:7, 23:15, 35:24, 36:3, 39:16, 46:18, 56:8, 56:11, 61:1, 61:9, 67:15
sign [1] - 56:15
significant [2] - 18:20, 42:19
SilverScript [3] - 11:18, 12:3, 12:5
similar [9] - 22:19, 25:18, 27:17, 28:22, 33:4, 49:22, 50:18, 60:18, 61:8
simply [2] - 38:1, 42:8
single [1] - 32:12
size [2] - 31:17, 49:9
skip [3] - 58:18, 59:15, 63:16
Sleep [1] - 42:17
sleep [1] - 42:20
Slide [5] - 51:20, 56:6, 58:19, 59:15, 63:19
slide [34] - 13:3, 13:4, 13:8, 13:21, 14:10, 17:2, 18:21, 20:21, 21:11, 22:23, 23:1, 23:22, 23:24, 24:6, 24:19, 25:17, 25:18, 25:21, 26:13, 30:1, 35:2, 40:7, 40:10, 40:21, 41:1, 43:2, 43:13, 44:10, 51:20, 51:21, 58:19, 60:13, 60:14
slides [4] - 25:19, 34:1, 40:3, 63:7
slight [7] - 16:11, 28:16, 29:7, 30:6, 31:10, 31:11, 66:11
slightly [3] - 66:23, 66:24, 67:12
smaller [1] - 49:16
someone [1] - 10:6
sometimes [2] - 5:24, 15:12
sorry [3] - 13:16, 43:24, 44:5
sort [4] - 6:22, 23:1, 57:15, 60:19
source [2] - 32:12, 32:13
span [1] - 62:15
speaking [2] - 13:19, 28:5
speaks [1] - 24:19
SPECIAL [1] - 1:3
Special [1] - 3:7
special [1] - 59:16
specialty [15] - 20:17, 22:9, 22:19, 23:9, 34:6, 34:10, 34:15, 34:20, 34:22, 36:14, 39:20, 39:23, 40:24, 41:5, 42:6
Specialty [3] - 23:8, 33:23, 40:8
specific [7] - 12:15, 12:16, 20:17, 22:16, 24:3, 25:16, 55:10
specifically [4] - 23:14, 24:19, 24:23, 26:19
specifics [1] - 43:3
spend [7] - 46:9, 46:10, 47:20, 52:7, 54:1, 54:20, 55:9
spine [1] - 48:7
split [1] - 61:8
SS [1] - 71:1
staff [1] - 5:12
STAFF [1] - 2:8
stand [1] - 32:5
standard [2] - 24:17, 66:13
start [3] - 5:12, 30:2, 63:20
started [2] - 12:24, 45:14
STATE [1] - 71:1
State [2] - 1:14, 71:8
STENOGRAPHIC [1] - 1:11
STEPHEN [1] - 2:5
still [3] - 16:16, 16:18, 36:19
stop [1] - 46:12
strategic [1] - 25:6
stream [1] - 65:8
Street [1] - 1:13
strips [1] - 26:9
strokes [3] - 48:3, 52:3, 52:24
subsets [3] - 46:17, 47:20, 49:17
subsidiaries [1] - 66:12
Subsidies [1] - 17:3
subsidies [9] - 17:5, 17:9, 17:14, 17:20, 18:10, 35:19, 36:22, 64:21, 67:17
subsidy [1] - 64:1
suggest [1] - 27:5
suitable [1] - 30:16
Suite [1] - 1:13
summarized [2] - 27:2, 61:16
summarizes [1] - 64:11
Summary [6] - 37:3, 50:19, 52:11, 60:4, 63:11, 63:13
summary [1] - 7:5
Summary" [2] - 27:23, 46:14
supplies [3] - 33:9, 37:12, 38:20
supply [3] - 19:19, 26:8, 38:23
Supply [1] - 33:16
Support [1] - 59:17
support [4] - 27:15, 56:4, 56:24, 59:5
surgeries [4] - 48:8, 54:11, 60:7, 60:9
surgery [2] - 55:16, 59:19
surgical [1] - 55:17
surprise [1] - 41:9
sustainability [1] - 32:20
system [1] - 6:1

T

table [1] - 46:16
takeaways [1] - 63:15
Target [2] - 19:20, 33:9
team [7] - 11:20, 26:16, 27:8, 45:4, 57:11, 61:22, 62:1
tear [1] - 54:15
telephonic [1] - 56:16
telephonically [1] - 56:9
Ten [1] - 20:22
ten [2] - 20:24, 24:1
tend [1] - 52:21
term [1] - 55:7
terms [18] - 16:8, 16:17, 19:2, 21:17, 24:3, 24:13, 24:18, 24:24, 25:6, 25:9, 25:15, 26:11, 26:14, 26:18, 46:21, 50:7, 53:18, 67:23
test [2] - 26:9, 58:10
THE [5] - 1:3, 2:10, 10:6, 70:2, 70:3
themselves [1] - 67:6
Therapeutic [2] - 20:23, 43:16
therapeutic [4] - 21:1, 21:16, 24:1, 24:8
therapy [1] - 59:19
third [3] - 43:19, 50:2, 53:24
THIS [1] - 70:4

THOMAS [1] - 2:20
thousand [2] - 64:16, 64:18
three [4] - 11:19, 42:16, 63:7, 64:4
throughout [3] - 16:5, 21:2, 21:19
TIME [1] - 70:4
timeframe [1] - 27:18
timeframes [1] - 5:2
tissue [1] - 54:17
tissues [1] - 54:14
today [16] - 5:8, 5:15, 9:22, 10:1, 10:2, 11:1, 11:9, 12:8, 12:17, 14:13, 15:1, 27:12, 27:21, 45:20, 62:3, 62:13
today's [1] - 7:1
together [5] - 5:20, 11:4, 58:3, 61:15, 68:10
Tom [4] - 62:10, 63:4, 67:4, 68:1
top [23] - 13:7, 13:9, 13:11, 13:21, 14:7, 20:24, 21:4, 21:16, 23:5, 23:24, 25:18, 25:22, 27:24, 30:2, 30:4, 32:24, 39:15, 41:1, 46:15, 50:22, 53:14, 55:2, 64:7
Top [2] - 20:22, 43:11
topic [1] - 12:17
total [19] - 16:22, 17:8, 28:10, 28:14, 29:2, 29:6, 31:6, 31:14, 31:24, 33:16, 40:13, 46:9, 46:10, 49:6, 50:23, 51:6, 62:19, 65:10, 65:22
Total [2] - 14:15, 46:24
touch [1] - 60:14
Touch [1] - 26:9
towards [2] - 23:14, 58:7
track [2] - 43:5, 67:22
trade [2] - 19:8, 27:15
trained [1] - 59:18
transcript [3] - 7:5, 7:9, 71:11
treat [1] - 42:6
treatment [3] - 53:17, 59:5, 59:16
trend [7] - 18:19, 25:11, 31:18, 31:24, 66:14, 67:1, 67:16
trends [1] - 67:12
true [1] - 71:11
Trustee [19] - 7:22, 7:24, 8:8, 8:9, 8:11, 8:13, 8:15, 8:16, 8:18, 8:20, 8:22, 9:3, 9:7, 10:8, 10:12, 10:13, 35:7, 69:4, 69:8
trustee [1] - 6:12
TRUSTEE [18] - 7:21, 8:2, 8:10, 8:12, 8:14, 8:19, 8:21, 8:23, 9:5, 9:8, 9:11, 10:8, 10:12, 35:4, 36:16, 36:23, 69:4, 69:8
trustees [5] - 3:22, 3:23, 5:5, 6:2, 11:3
TRUSTEES [1] - 2:2
Trustees [8] - 6:14, 6:16, 6:17, 7:2, 9:16, 44:22, 68:6
try [2] - 43:7, 48:16
trying [2] - 35:5, 59:1
TUCZAK [10] - 2:9, 11:13, 12:23, 26:24, 43:4, 44:17, 59:9, 61:14, 67:24, 69:24
Tuesday [2] - 3:6, 3:9
turn [11] - 26:22, 27:6, 36:1, 40:4, 45:2, 45:15, 49:4, 55:21, 61:20, 63:3, 65:9
turning [2] - 45:18, 60:2
two [11] - 11:15, 11:23, 24:13, 49:21, 55:16, 59:10, 60:11, 62:14, 62:18, 63:14, 64:6
two-fold [1] - 62:14
type [1] - 23:7
types [3] - 21:18, 32:11, 68:8
typically [3] - 63:1, 65:18, 65:23
TYRRELL [2] - 71:6, 71:17

U

UHC [6] - 43:8, 45:3, 45:4, 61:15, 64:2, 67:13
under [7] - 14:1, 30:17, 43:20, 47:13, 49:19, 51:10, 55:3
undergoing [1] - 53:16
underneath [1] - 49:16
unique [1] - 34:7
UNITED [1] - 2:16
UnitedHealthcare [4] - 45:7, 45:11, 56:13, 58:6
up [26] - 5:3, 15:17, 16:5, 18:9, 23:10, 29:1, 29:18, 31:18, 31:23, 34:2, 34:21, 35:1, 39:1, 43:8, 44:3, 45:24, 47:2, 47:3, 48:6, 48:8, 48:11, 59:23, 63:8, 66:20, 66:23
upcoming [1] - 63:23
update [1] - 65:16
Urgent [4] - 48:10, 48:12, 48:18, 49:1
usage [1] - 26:12
Utilization [1] - 33:5
utilization [13] - 12:19, 21:17, 29:1, 30:10, 30:19, 33:11, 33:17, 34:15, 36:7, 37:22, 40:11, 41:20, 42:5
Utilization" [1] - 19:15
utilized [3] - 23:12, 32:11, 33:20
utilizer [2] - 41:10, 41:19
utilizers [7] - 23:17, 34:20, 40:18, 40:19, 41:11, 41:13, 43:17
utilizing [5] - 14:4, 19:16, 21:2, 26:7, 35:3

V

various [7] - 5:8, 19:3, 19:15, 23:2, 24:13, 44:10, 56:5
veins [1] - 52:22
vendors [7] - 4:22, 5:3, 5:4, 5:8, 7:3, 7:7, 7:14
versus [9] - 27:19, 28:9, 38:20, 40:14, 40:20, 48:13, 60:7, 60:9, 63:20
Versus [2] - 61:18, 63:11
Vice [1] - 2:4
Vice-President [1] - 2:4

W

Waiver [1] - 13:5
wakefulness [1] - 42:24
walk [5] - 11:20, 40:2, 45:16, 45:19, 46:6
WALL [3] - 2:17, 55:24, 59:14
Wall [2] - 45:13, 55:22
wants [1] - 9:22
ways [1] - 34:15
website [2] - 4:4, 7:6
Wednesday [1] - 1:15
welcome [2] - 9:10, 37:1
WERE [1] - 70:2
West [1] - 1:13
WHICH [1] - 70:2
White [1] - 45:12
WHITE [3] - 2:17, 45:17, 60:1
whole [4] - 17:10, 21:2, 48:1, 51:1
Wilson [5] - 8:20, 10:8, 35:7, 69:4
WILSON [7] - 2:3, 8:21, 10:8, 35:4, 36:16, 36:23, 69:4
Wilson's [1] - 10:13
win [2] - 19:23
win-win [1] - 19:23
wind [1] - 44:3
wondering [2] - 23:1, 23:23
Wrap [8] - 11:18, 24:10, 24:16, 24:23, 25:22, 25:23, 26:5, 26:6
wrap [2] - 24:20, 43:8
wraps [1] - 24:16
Wyszomirski [2] - 62:11, 63:4
WYSZOMIRSKI [2] - 2:20, 63:6

Y

year [35] - 6:21, 10:16, 11:12, 14:19, 16:5, 17:10, 18:1, 18:14, 18:15, 18:16, 20:13, 21:3, 21:19, 22:12, 23:10, 31:20, 39:1, 39:3, 40:14, 41:22, 58:14, 60:7, 60:9, 63:22, 63:23, 65:1, 65:19, 68:23
years [6] - 12:10, 25:7, 47:6, 49:15, 64:4, 65:2
young [1] - 30:21
yourself [2] - 5:21, 9:23