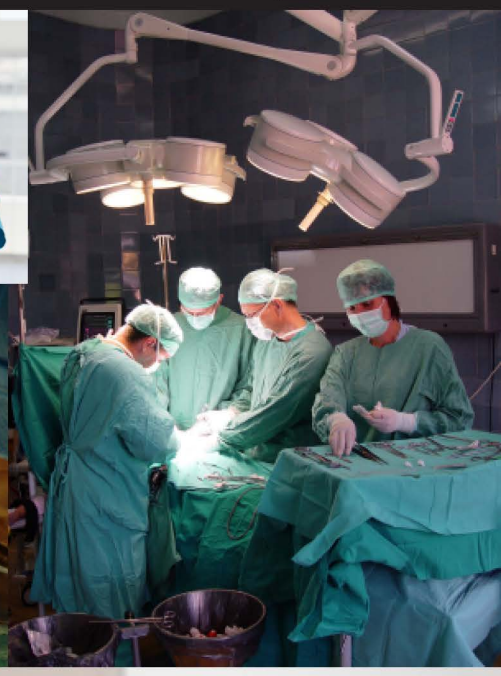
FY 2013

Liabilities of the: State Employees' Group Health Insurance Program

as projected by: Commission on Government Forecasting & Accountability



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Commission on Government Forecasting and Accountability

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March, 2012

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EXECUTIVE SUMMARY

The Commission on Government Forecasting and Accountability (CGFA) has several statutory requirements concerning the State Employees' Group Insurance Program.

- To estimate liabilities of the State Employees' Group Health Insurance Program.
- To meet with the Department of Central Management Services (CMS) and the Department of Healthcare and Family Services (HFS) to advise the departments on all matters relating to policy and administration of the Group Insurance Act.
- To review and approve contracts recommended by the Director of HFS related to the Group Insurance Program.

The Governor has requested that a total of $2,656.0 million be appropriated for the State Employees' Group Health and Life Insurance program for FY 2013. The requested FY 2012 appropriation request for the Group Health Insurance Program was $2,514.8 million. The following table represents historical appropriation and liability amounts, per HFS. The CGFA FY 2013 estimate of liability is $2,689.5 million, $39.6 million more than HFS.

Currently, the payment cycle for preferred providers and non-preferred providers is 218 days. In FY 2013, the cycle is expected to rise to 278 and 280 days for preferred and non-preferred providers respectively. The current amount of CIGNA claims being held is $338.7 million. HFS has calculated the amount of time it takes to make payments to managed care providers (HMO's) at approximately five months, growing to six months in FY 2013. The value of what is currently being held represents bills on hand of approximately $1.19 billion, and is estimated to be up to $1.38 billion by the end of FY 2013. Dental network claims are being held 90 days, while non-network providers are held 245 days. Rx claims, administrative service charges, and vision premiums are currently being paid in approximately 100-211 days.

According to HFS, the FY 2013 estimated liability for the Quality Care Health Plan (QCHP) is expected to increase 5.7% over the FY 2012 liability. The estimated liabilities for the State's managed care plans are expected to increase 6.8% over the FY 2012 cost. In comparison, the FY 2012 liability for the QCHP increased 4.1% over the FY 2011 cost. FY 2012 liability for the managed care plans decreased 15.3% over FY 2011 due to the migration towards Open Access Plans explained later in this report. The Department also projects prescription drug liability to increase 6.6% in FY 2013 from $209.8 million to $223.6 million.

APPROPRIATION AND LIABILITY HISTORY FY 2008-2013 ($ in Millions)			
Fiscal Year	Appropriation	HFS Liability	CGFA Liability
FY 2008	$1,983.0	$1,891.8	
FY 2009	$1,991.6	$2,041.8	
FY 2010	$2,163.3	$2,196.7	
FY 2011	$2,024.4	$2,364.4	
FY 2012*	$2,578.2	$2,475.0	
FY 2013*	$2,656.0	$2,649.9	$2,689.5
*Estimated for FY 2012 and FY 2013			

FY 2013 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2013 cost projection utilizes the HFS revised estimate for FY 2012 medical claims as the basis for estimating claims for FY 2013.

The CGFA cost estimate for FY 2013 uses the following assumptions based on historical claims data and anticipated cost increases:

TREND FACTORS	
Medical (QCHP plan)	5.95%
Dental (QCHP and MC)	5.65%
HMO (medical and Rx)	7.12%
Prescription drugs (QCHP)	7.03%
Administrative service charges (QCHP)	1.75%
Life insurance	3.35%

The medical trend inflation factors consist of various components. These components include cost-shifting due to Medicare/Medicaid reimbursement reduction, general inflation and leveraging (lower impact of coinsurance limits, level deductibles, etc.). In addition to these, the impact of a gradual shift by employees to HMOs and PPOs has resulted in more costly/higher risk employees remaining in the QCHP program. Also, advances in technological innovation, increased use of care for psychiatric/substance abuse, more use of equipment/services and the continued "greying" (aging and extended living) of the population have all contributed to greater health care costs.

The Segal Company compiles a cost trend survey annually that gives data as to how large health plans are trending during the plan year. The following are some of the key findings of the 2012 Segal study.

- All medical plan types are projected to experience lower cost trends for 2012, with managed care costs trending from 9.6 to 10.4 percent compared to 2011, which ranged from 10.2 to 11.7 percent.
- In 2012, prescription drug trends are forecast to be 2 percentage points lower from 2011 projected trend rates (7.2 percent in 2012). 73 percent of respondents to the Segal survey reported prescription drug ranges of less than 10 percent.
- Medicare Advantage HMO trend rates are expected to decrease to 6.6 percent from the 2011 forecast of 7.0 percent.
- Vision plan trend rates are projected to increase slightly.
- The lowest trend rates are expected in the South and Midwest regions, at 8.8 and 8.9 percent, with the Northeast forecast at 9.8 percent and the West region expected to trend at 10.8 percent.
- 75 percent of survey participants expect the extension of adult coverage to dependents up to age 26 to cause 2011 plan costs to increase, but only by less than 1 percent.

Table 1 below highlights national trending data and compares it to estimates by HFS and CGFA.

TABLE 1

NATIONAL HEALTH CARE TRENDING 2011

Component	National Trend	HFS Increase	COGFA Increase
PPO's	9.5%	11.2%	13.43%
HMO's	9.2%	6.8%	7.12%
Rx	7.2%	6.6%	7.03%
Dental	4.8%	4.2%	5.65%
Vision	3.8%	5.2%	7.36%

Source: Segal 2012 Health Plan Cost Trend Survey

Usually, there is a strong correlation between trend rates and actual costs. However, trend and the net annual change in plan costs are not the same. Trend rates allow the Commission to benchmark health plan components to analyze and estimate claims data. Changes in the costs to plan sponsors can be very different from projected cost trends. Such factors as program design changes, employee contribution rate increases, and group demographics can significantly influence total costs.

Based on these assumptions and inflation factors, the CGFA estimates a FY 2013 liability of approximately $2,689.5 million for the State Employee's Group Health Insurance Program. The table on the following page shows a detailed comparison of the CGFA estimate for the various cost components and the HFS projection for FY 2013.

TABLE 2: FY 2013 GROUP HEALTH INSURANCE LIABILITY ($ in Millions)			
Liability Component	**FY 2012 HFS Estimate**	**FY 2013 HFS Estimate**	**FY 2013 CGFA Estimate**
QCHP Medical	$573.7	$606.7	$618.7
QCHP Prescriptions	$209.8	$223.6	$227.5
Dental (QCHP/MC)	$120.1	$125.1	$126.9
HMO	$853.0	$911.2	$913.7
Open Access Plan	$510.0	$567.3	$578.5
Mental Health	$8.0	$8.1	$8.1
Vision	$10.9	$11.5	$11.8
Administrative Services (QCHP)	$31.9	$32.3	$32.8
Life	$80.5	$83.2	$87.9
Special Programs (Admin/Int./Other)	$77.2	$81.0	$83.6
TOTAL	**$2,475.1**	**$2,649.9**	**$2,689.5**
% increase over prior year		7.1%	8.7%
*Rounding may cause slight differences. FY 2013 Special Programs line includes Prompt Payment Interest.			

ESTIMATE COMPARISON

Overall, the Commission's FY 2013 estimate is $39.6 million higher than the FY 2013 estimate from HFS. CGFA's FY 2013 HMO liability estimate is $2.5 million higher than HFS, CGFA's Open Access Plan medical estimate is $12.4 million more than HFS, and CGFA's FY 2013 estimate for prescriptions is $3.9 million higher than the HFS estimate. CGFA's dental estimate is $1.8 million more than HFS.

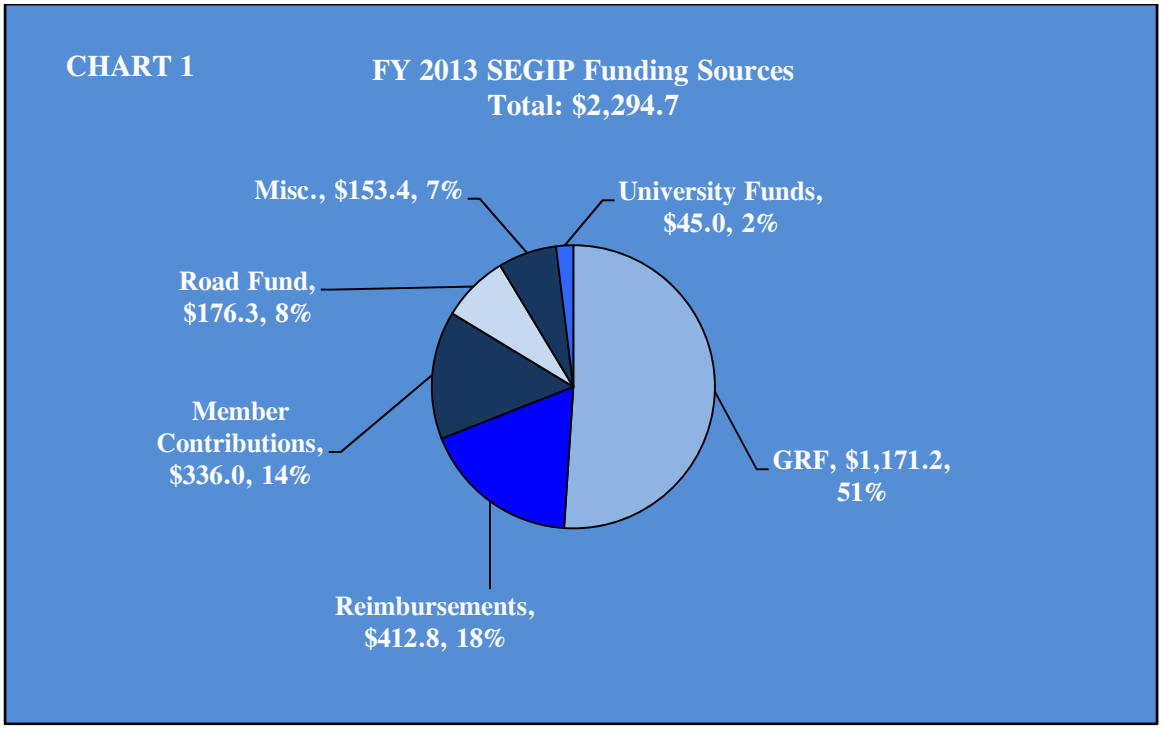
The CGFA estimates approximately $2,689.5 million would be required to fully fund the FY 2013 liabilities of the Group Health Insurance Program. This estimate is $214.4 million or 8.7% more than the FY 2012 estimated liability of $2,475.1 million.

APPROPRIATION/FUNDING SOURCES

Funding for the State Employees' Group Insurance plans originates from two funds, the Health Insurance Reserve Fund (HIRF), and the Group Insurance Premium Fund (GIPF). Contributions and payment for health coverage benefits are deposited into HIRF, and contributions for life insurance are deposited into GIPF.

HIRF is the fund mainly used to administer the group insurance program. 5 ILCS 375/13.1 states "All contributions, appropriations, interest, and other dividend payments to fund the program of health benefits shall be deposited into the Health

Insurance Reserve Fund. Funding for HIRF comes from several different revenue sources, the General Revenue Fund (GRF), Road Fund, reimbursements, university funds, and miscellaneous funds. Estimated cash flow into HIRF for FY 2013 is $2,294.7 billion. A breakdown in the various funding sources is shown in the pie chart below.



- Dollar amounts in Millions $

The FY 2013 budget request for the Group Health Insurance Program is $1,171.2 million in GRF funds. This represents a -$264.33 million or a -18.40% decrease from the FY 2012 GRF approximation of $1,435.53 million. The estimated FY 2013 Road Fund request of $176.30 million is $11.01 million or 6.66% higher than the FY 2012 appropriation level.

TABLE 3: GROUP INSURANCE FUNDING SOURCES FY 2012 - FY 2013 ($ in Millions)				
	FY 2012	FY 2013	$ Change	% Change
GRF Appropriation	$1,435.53	$1,171.19	($264.34)	-18.41%
GRF Appropriation/Lapse Period	$194.31	N/A	N/A	N/A
Road Fund	$165.29	$176.32	$11.03	6.67%
University Cont.	$45.00	$45.00	$0.00	0.00%
University Cont./Lapse Period	$30.64	N/A	N/A	N/A
Member Cont.	$329.97	$335.99	$6.02	1.82%
Other Funds	$282.11	$412.79	$130.68	46.32%
Rebates/Interest/Other.	$95.33	$153.36	$58.03	60.87%
TOTAL Appropriations	**$2,578.18**	**$2,294.65**	**($283.53)**	**-11.00%**
Source: CMS. N/A indicates numbers not yet determined. Percent and $ change reflect this status.				

HFS sets target end-of-year fund balances for both the Health Insurance Reserve Fund and the Group Insurance Premium Fund. The historical budget target balance for the Group Insurance Program is $10 million. For FY 2013, the GIPF target balance is $4 million, and the target HIRF balance is $6 million.

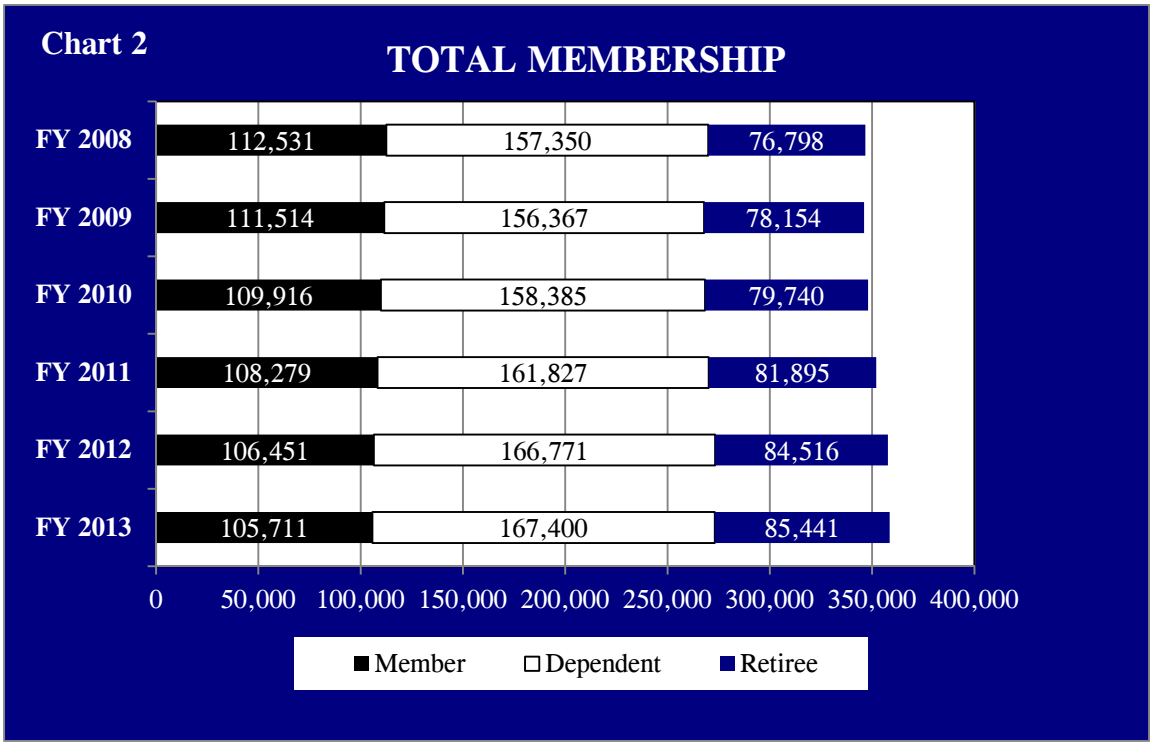
BENEFITS

The State Employees' Group Insurance Program provides medical, dental, vision, and life insurance coverage to State employees, retirees and their dependents. Medical coverage is provided separately to members in their choice of: QCHP plan, and various types of managed care plans such as Health Maintenance Organizations (HMO). Vision coverage, which includes savings on exams, glasses, and contacts, is provided at no additional premium costs. Appendix II describes the types of health and dental plans offered by the State.

Basic life insurance is provided at no cost to employees, retirees and annuitants. Full-time employees receive coverage equal to their annual salary. Retirees and annuitants receive coverage equal to the annual salary as of the last day of employment until the age of 60, at which time the benefit amount becomes $5,000. Employees are allowed to purchase optional term life insurance up to eight times their annual salary, as well as spouse and child term life insurance at group rates. Beginning January 1, 1995, CMS added a portability feature to the optional life program, thereby allowing employees leaving State service to continue optional term life insurance coverage indefinitely at group rates without being required to provide evidence of insurability. Group rates are based on age with an administration fee added.

MEMBERSHIP

According to CMS, the State Employees' Group Health Insurance Program has an estimated 357,738 participants for FY 2012, of which 158,582 are in a HMO, 81,485 are in an Open Access Plan, and 117,671 are in the Quality Care Health Plan. The QCHP is estimated to have 22,469 employees, 39,010 dependents, and 55,473 retirees in FY 2013. HMO plans are estimated to have 54,271 employees, 83,694 dependents, and 20,801 retirees in FY 2013. OAPs are expected to have 28,971 employees, 44,696 dependents, and 9,167 retirees in FY 2013.



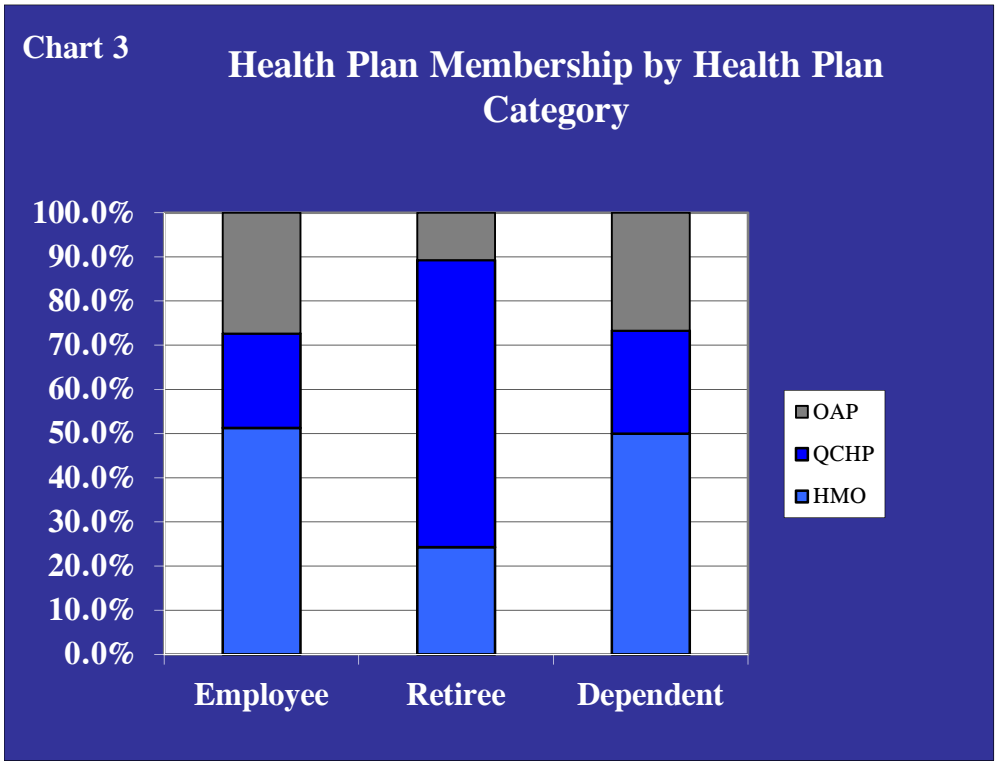
- **Membership is estimated for FY 2012 and FY 2013.**

ENROLLMENT TRENDS

Membership in the group insurance program is expected to increase slightly in FY 2013, adding 814 participants. Membership in the Quality Care Plan has been decreasing since FY 2005; HFS estimates that QCHP membership will decline -0.61% from 117,671 in FY 2012 to an estimated 116,952 in FY 2013. Membership in the States' managed care offerings has been increasing since FY 2004 except for an adjustment in 2012 as many participants switched away from managed care (traditional HMO) to alternatives such as the Open Access Plan. This adjustment came as a result of a process of awarding new health insurance contracts to vendors. This situation has achieved some stability, but overall enrollment in HMOs has decreased from 2011,

with 158,582 participants forecasted for FY 2012 and 158,766 for FY 2013 (a 0.12 % increase) compared to 188,653 in FY 2011. The State also offers an Open Access Plan. Membership in the OAP increased in 2012 as a result of the contract bidding process, from 44,251 in FY 2011 to an estimated 81,485 in FY 2012 (an 84.1 % increase). In FY 2013, this number is expected to rise by 1.66 %, for an estimated total of 82,834.

Chart 3, below, shows the breakdown of employee, dependent and retiree enrollment in the overall group insurance program. The QCHP continues to be the most popular plan for retirees. Retirees favor the QCHP because of provider access and other issues. In FY 2012, 64.9% of retirees were enrolled in the QCHP a slight drop from the 66.6% enrolled in FY 2011. Chart 3 shows that while retirees overwhelmingly choose the QCHP, dependents and employees prefer managed care and Open Access Plans.



LIABILITY

The Department's estimate of liability for FY 2013 represents a 7.1% growth rate over FY 2012. This increase in estimated liability is higher than the increase from FY 2011 to FY 2012, when liability increased 4.7%, but it is lower than the increase from FY 2010 to FY 2011 of 7.6%. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2004 through FY 2013.

Table 4, on the following page, demonstrates how several components make up for the majority of the State's total liability. Historically, the Quality Care Health Plan, Prescription Drugs, and HMO's have made up the largest segment of total liability. The dental plan and the Open Access Plan are also large components of the total insurance obligation. Increasingly, the Open Access Plan is being chosen at higher rates than traditional HMOs or the Quality Care Health Plan, though its overall insurance liability is still well below the two main alternatives. After the issues experienced with new contracts in 2011, the Open Access Plan has taken on a large share of liability that brings it closer to the Quality Care Health Plan and HMO liabilities than before.

Table 4 STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY
FY 2004-FY 2013
$ in (millions)

Liability Component	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
QCHP Medical/Rx	$663.3	$697.5	$690.8	$695.2	$689.2	$728.9	$738.6	$749.8	$783.5	$830.3
HMO Medical	$546.6	$607.2	$662.1	$711.4	$780.6	$843.9	$911.3	$1,006.6	$853.0	$911.2
Dental	$69.9	$88.9	$84.9	$95.6	$102.3	$109.8	$115.0	$129.3	$120.1	$125.1
Open Access Plan	$69.9	$102.0	$125.3	$153.9	$178.3	$212.9	$251.5	$284.7	$510.0	$567.3
QC Mental Health	$9.5	$9.2	$8.9	$8.8	$8.6	$8.3	$10.6	$7.7	$8.0	$8.1
Vision	$11.5	$11.7	$8.2	$8.2	$8.2	$8.2	$8.3	$10.2	$10.9	$11.5
Life Insurance	$65.0	$68.8	$75.6	$75.8	$78.4	$80.9	$83.7	$82.3	$80.5	$83.2
QC ASC	$22.8	$23.7	$29.2	$27.9	$29.6	$30.8	$32.2	$31.7	$31.9	$32.3
Admin/Int/Other	$15.8	$14.9	$17.3	$13.2	$16.5	$18.3	$45.5	$61.9	$77.2	$81.0
Total	**$1,474.4**	**$1,623.9**	**$1,702.3**	**$1,789.9**	**$1,891.8**	**$2,041.8**	**$2,196.7**	**$2,364.4**	**$2,475.0**	**$2,649.9**
% change over py		10.14%	4.83%	5.15%	5.69%	7.93%	7.59%	7.63%	4.68%	7.07%

Rounding causes slight differences in totals

ANNUAL COST PER PARTICIPANT

The cost per participant in the State Employees' Group Insurance Program is the total of the State's cost and the employee's contribution each month. Chart 4 shows the steady increase each year in cost per participant. This increase can be attributed to medical inflation as evidenced in Table 4 on the previous page. In FY 2004, the annual cost per participant in the group health insurance program was $4,235. **According to CMS/DHFS, the estimated cost per participant for FY 2012 is $6,918, a 63.4% increase from the FY 2004 cost per participant**. The cost per participant increased 3.0% from FY 2011 to FY 2012. The FY 2013 cost per participant is estimated to increase 6.8% over FY 2012 to $7,388.

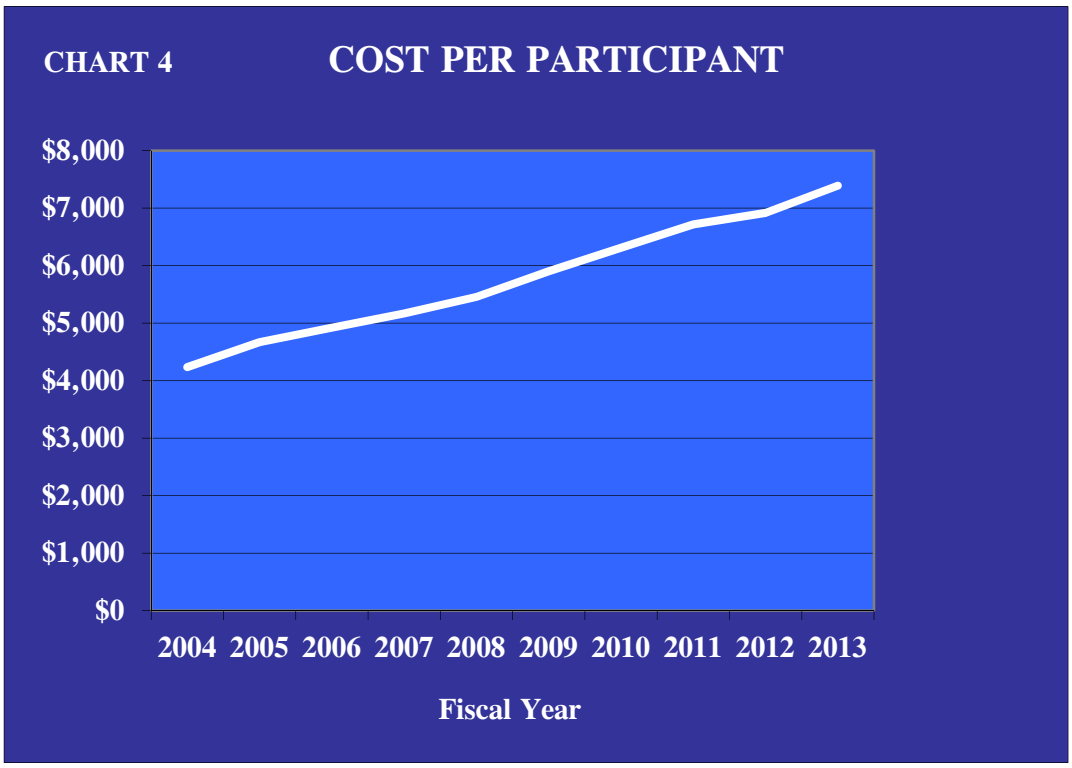


TABLE 5: AVERAGE ANNUAL COST PER PARTICIPANT				
	FY 2012 Total Participants	FY 2013 Total Participants	FY 2012 Average Cost Per Participant	FY 2013 Average Cost Per Participant
QCHP	117,671	116,952	$6,658	$7,099
HMO	158,582	158,766	$5,379	$5,739
OAP	81,485	82,834	$6,259	$6,849
	357,738	358,552		
OAP is the Open Access Plan. FY 2012 takes the mass migration into OAPs from HMOs into account. ACPP does not include dental, vision, admin/int/other, or life insurance. Numbers are not adjusted for risk.				

When comparing average cost per participant (ACPP) in Table 5, the average cost for FY 2013 is lowest for members in a HMO plan and highest for those in the PPO. **The FY 2013 ACPP in the QCHP is approximately 23.7% higher than managed care. The average cost per enrollee in the QCHP is estimated to be $7,099 in FY 2013.** The total participants in the QCHP has also declined for many years as people have steadily migrated to HMOs and OAPs.

MEMBER CONTRIBUTIONS

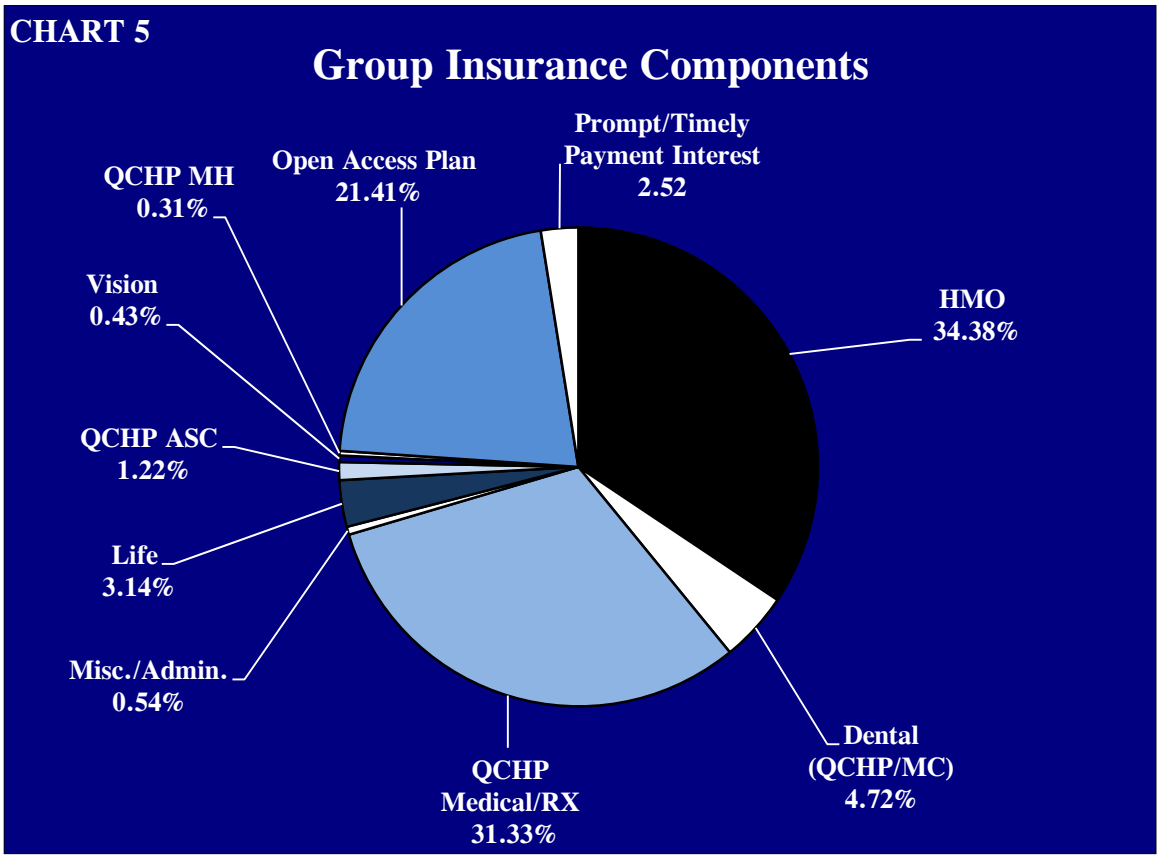
An important factor in the examination of cost per participant is the amount paid by the State versus the member. The ACPP per enrollee in the QCHP is $6,658 in FY 2012. Total member contributions for QCHP enrollees totaled $92.5 million. This means that of the total cost per participant ($6,658), $786 of that cost is covered by member contributions. Table 6 below examines the relationship between overall cost, and the offset by member contributions.

TABLE 6: MEMBER CONTRIBUTIONS AND ACPP				
	FY 2012 Average cost per participant	FY 2012 Member Contributions	Member contribution per year	State cost minus member contributions
QCHP	$6,658	$92,485,738	$786	$5,872
HMO + OAP	$6,159	$154,999,893	$646	$5,513
Dental	$342	$32,596,004	$93	$249
Source: HFS				

The table above shows that QCHP members contribute approximately 11.8% of the overall annual cost of providing their insurance. HMO members contribute 10.5% of the overall liability cost. Members that participate in the State's dental offering pay 27.2% percent of the overall liability cost.

Retirees and their survivors (with less than 20 years of creditable service) are required to pay a portion of their health care costs (P.A. 90-0065). The remainder is paid by the

State. The following chart includes the various components of the FY 2013 HFS liability estimate of $2,649.9 million. The largest component of the State Group Insurance Program is the State's managed care plans (HMO and OAP) which represent (55.8%) of FY 2013 liability, while dental care, life insurance, vision care, and other charges comprise (8.8%) of total liability. The QCHP component (32.9%) includes medical/prescriptions, mental health coverage, and administrative service charges.



EMPLOYEE/RETIREE COST COMPARISON

A subject of interest to legislators and other parties in recent years is the breakdown of costs for active employees and their dependents and retirees and their dependents. Table 7 below displays a comparison of the costs for these groups taken from data obtained from DHFS current as of March 2012.

TABLE 7: RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS			
Category	**Cost**	**Category**	**Cost**
Retiree Cost	$710.07	Active Employee Cost	$972.96
Retiree Contribution	$25.75	Active Employee Contribution	$100.73
Net State Cost	$684.32	Net State Cost	$872.23
Retiree Dependent Cost	$245.44	Active Employee Dependent Cost	$672.52
Retiree Dependent Contribution	$52.56	Active Employee Dependent Contribution	$105.33
Net State Cost	$192.87	Net State Cost	$567.19
Total Retiree Cost	$955.50	Total Active Cost	$1,645.48
Total Retiree Contribution	$78.71	Total Active Contribution	$206.06
Net State Cost	**$879.79**	**Net State Cost**	**$1,439.42**
Source: HFS All numbers in Millions			

A number of points can be observed from this table. In regards to retiree/active employee costs and contributions, retirees contribute approximately $25.75 million, or 3.6 percent towards the cost of their health insurance, while active employees contribute $100.73 million, or 10.3 percent. Retiree dependents contribute $52.56 million, or 21.4 percent, while active employee dependents contribute $105.33 million, or 15.7 percent.

CHANGES IN PLAN MEMBERSHIP FROM FY 2011 TO FY 2012

The largest age group switching to a managed care plan from the QCHP in FY 2011 was the 0-39 age group. Predominately, the members joining a managed care plan tend to be under the age of 55. Persons in this age group typically include parents and their dependents. While dependent care coverage is less expensive in a managed care plan than in the QCHP, members over the age of 55 have shown a reluctance to switch to a managed care plan. These members have higher medical utilization and may fear being

denied access to specialists. Members over the age of 55 may also be unwilling to change primary physicians. For members on Medicare, the coordination of benefits with a managed care plan may be confusing and/or disadvantageous.

The FY 2012 year was extraordinarily complicated for plan members as the 10 year contract period for most health insurance plans with the state had ended with a new long-term contract not finalized due to litigation over the process and court orders complicating matters for plan participants. All participants of Humana health insurance products were required to change their carrier, resulting in 11,683 members and dependents moving to new plans. In addition, with the Health Alliance contract with the state in question, 11,021 members and dependents moved from Health Alliance HMO and Health Alliance Illinois between the end of April and the end of July 2011. Many of these individuals moved to an Open Access Plan such as Personal Care or HealthLink. A special enrollment period was conducted in October of 2011, resulting in a migration of thousands of members back to Health Alliance from other carriers.

Addendum IV to this report (available online only) details the complicated migration situation for FY 2012, as multiple enrollment periods resulted in many changes in specific plan enrollment but a small net change across State of Illinois Group Insurance options.

MANAGED CARE PLANS

HMO-style plans require participants to choose a doctor from the HMO network to become their primary care physician. All routine medical care, hospitalization and referrals for specialized medical care must then be coordinated under the direction of the primary care physician who acts as a gatekeeper for medical services. Managed care plans have restricted service areas. Generally, HMOs cover preventive health care, such as regular checkups and immunizations, while QCHP plans typically do not. However, the State's QCHP plan provides several preventive health services, such as well-baby care, routine physicals, mammograms, school health physical exams, and annual pap smears. All these additions to the QCHP are in accordance with the current collective bargaining agreement with the American Federation of State, County and Municipal Employees (AFSCME).

The Open Access Plan, first offered for the FY 2002 benefit year, is a managed care plan that is a combination of an HMO and a PPO. Members have access to a wide range of care, with three benefit levels from which to choose. (*Members in an HMO have one level of benefits*). Tier I of the Open Access Plan provides the richest benefit and the lowest co-payments. Tier II, like Tier I, is considered in-network. A higher level of co-payment applies to Tier II providers. Tier III providers are out-of-network. Primary Care Physicians (PCPs) in the Open Access Plan do not perform the "gatekeeper" function. Therefore, patients may see specialists without referral from

the Primary Care Physician. Greater detail about FY 2012 and FY 2013 plan enrollment is listed in Table 8 below.

TABLE 8: MANAGED CARE PLANS FY 2011-2013 Actual Membership					
HMO/OAP	FY11 # of Participants	FY12 # of Participants	% Change 2011-2012	FY13 # of Participants	% Change 2012-2013
Health Alliance HMO	81,323	74,817	-8.00%	77,061	2.91%
Health Alliance Illinois	8,335	6,787	-18.57%	6,809	0.32%
HMO Illinois	61,041	63,449	3.94%	63,156	-0.46%
Blue Advantage	0	2,053	N/A	2,199	6.64%
Humana of Illinois	10,125	0	-100.00%	0	0.00%
Coventry Health Care HMO	27,161	11,476	-57.75%	9,541	-20.28%
Humana Winnebago	1,558	0	-100.00%	0	0.00%
Coventry Health Care OAP	0	18,108	N/A	17,972	-0.76%
Health Link OAP	44,964	63,377	40.95%	64,862	2.29%
TOTALS	**234,507**	**240,067**	**2.37%**	**241,600**	**0.63%**
Source HFS. FY11 numbers as of 4/29/2011. Estimated for FY 2012 and FY 2013.					

NOTE: These numbers could change due to the HMO contracts being rebid for FY 2013. PersonalCare has become Coventry Health Care as of FY 2012. A major part of the change in participants is the decision by Humana of Illinois and Humana Winnebago to not participate in the FY 2012 managed care plan system, causing their members to choose other options.

MONTHLY PREMIUMS

Compared to managed care plans, the State of Illinois' QCHP is significantly more expensive than a traditional HMO or OAP. Historically, members in managed care plans cost the State less since the risk of providing health care is assumed by the HMO, and HMO plans typically have younger, healthier participants. OAPs are also less expensive for the state, as the consumer takes on more cost and the OAPs take on more risk than the QCHP.

According to the Department, the estimated monthly cost for a current employee in the QCHP for FY 2012 is $827.12 and will increase to $883.10 (6.3%) in FY 2013.

The monthly premium for a current employee in a managed care plan varies based on each plan's rates, but the FY 2013 estimated average cost for a member in a managed care plan will be $651.12 per month.

In FY 1998, a new approach for negotiating premium rates with managed care vendors was utilized. Previously, premium rates were negotiated based on four rate tiers; member only, one dependent, two or more dependents, and Medicare dependent. In FY 1998 and FY 1999, multipliers based on historical claims and enrollment experience were used for each of the dependent rate tiers. Thus, only the employee

rate is negotiated with each managed care provider, and then the appropriate multiplier is applied to that rate. Thus far, multipliers remain unchanged since FY 2001.

FY 2013 Managed Care Multipliers

Current Employee	1.00
Medicare Retiree	.65
Non-Medicare Retiree	1.48
1 Dependent	.84
2+ Dependents	1.44
Medicare Dependent	.65

Under current law, the term of any contract (group life insurance, health benefits, other employee benefits, and administrative services) authorized under the State Employees' Group Insurance Act (SEGIA) may not extend beyond 5 fiscal years. Upon recommendation of CGFA, the Director of CMS or HFS may exercise renewal options of the same contract for up to a period of 5 years. The State enters into contracts with the HMOs and pays them a dollar amount per individual enrolled in that particular HMO. The HMO then assumes the financial risk of providing services to its participants.

Table 9, on the following page, shows the FY 2013 weighted average monthly rates for managed care plans and the QCHP plans, as well as the State and member contributions. The State's contribution varies, depending on a member's salary.

TABLE 9: MONTHLY PREMIUMS
Managed Care vs. Indemnity Plan
Weighted Average
FY 2013 Rates (Projected)

	QCHP			HMO			OAP		
Membership	TOTAL	Member	State	TOTAL	Member	State	TOTAL	Member	State
Employee	$ 883.10	$ 83.52	$ 799.59	$ 623.61	$ 56.47	$ 567.14	$ 725.09	$ 56.47	$ 668.62
Medicare Retiree	$ 464.09	$ 12.84	$ 451.25	$ 409.58	$ 18.94	$ 390.64	$ 471.33	$ 18.94	$ 452.39
Non-Medicare Retiree	$ 1,120.39	$ 15.63	$ 1,104.76	$ 918.42	$ 13.86	$ 904.56	$ 1,075.22	$ 13.86	$1,061.36
1 Dependent	$ 948.57	$ 196.00	$ 752.57	$ 524.94	$ 89.53	$ 435.41	$ 608.86	$ 102.20	$ 506.66
2+ Dependents	$ 1,216.10	$ 226.00	$ 990.10	$ 914.45	$ 126.44	$ 788.01	$ 1,042.74	$ 144.81	$ 897.93
Medicare Dependent	$ 473.82	$ 142.00	$ 331.82	$ 411.79	$ 86.43	$ 325.36	$ 473.79	$ 99.43	$ 374.36

TABLE 10: PROJECTED COSTS
FY 2006 - FY 2013
Employee Only

	QCHP				HMO				OAP			
	TOTAL	% Increase	Member	State	TOTAL	% Increase	Member	State	TOTAL	% Increase	Member	State
FY 2006	$ 586.16	7.40%	$ 54.32	$ 531.84	$387.35	8.99%	$ 34.16	$ 353.19	$ 454.83	7.36%	$ 34.16	$ 420.67
FY 2007	$ 610.42	4.14%	$ 62.31	$ 548.11	$410.94	6.09%	$ 38.11	$ 372.83	$ 495.04	8.84%	$ 38.11	$ 456.93
FY 2008	$ 623.81	2.19%	$ 68.16	$ 555.65	$448.13	9.05%	$ 41.88	$ 406.25	$ 521.02	5.25%	$ 41.88	$ 479.14
FY 2009	$ 682.73	9.45%	$ 71.55	$ 611.18	$482.31	7.63%	$ 45.30	$ 437.01	$ 580.87	11.49%	$ 45.30	$ 535.57
FY 2010	$ 722.05	5.76%	$ 80.82	$ 641.23	$521.66	8.16%	$ 54.56	$ 467.10	$ 640.91	10.34%	$ 54.56	$ 586.35
FY 2011	$ 764.50	5.88%	$ 80.97	$ 683.53	$570.72	9.40%	$ 54.72	$ 516.00	$ 675.20	5.35%	$ 54.72	$ 620.48
FY 2012	$ 827.12	8.19%	$ 81.56	$ 745.56	$584.32	2.38%	$ 55.13	$ 529.19	$ 662.74	-1.85%	$ 55.13	$ 607.61
FY 2013	$ 883.10	6.33%	$ 83.52	$ 799.59	$623.61	6.72%	$ 56.47	$ 567.14	$ 725.09	9.41%	$ 56.47	$ 668.62

It is important to note that the comparisons made in Tables 9 and 10 are aggregate comparisons. As such, there are individual HMO and OAP plans that differ significantly from the average shown in these tables. Individual HMO and OAP plans may be significantly higher or lower than the averages shown. Therefore, it is necessary to show these plans individually in Table 11 on the following page.

TABLE 11: MONTHLY PREMIUMS ACROSS ALL PLANS
HMOs and OAPs
FY 2012 Rates (As of March 2012)

Membership	Health Alliance	Personal Care	Health Alliance Illinois	HMO Illinois	Blue Advantage	HealthLink OAP	Personal Care OAP
Employee	$596.11	$567.21	$791.56	$557.04	$532.55	$704.80	$564.87
Medicare Retiree	$389.77	$370.98	$516.80	$364.37	$348.45	$460.41	$369.46
Non-Medicare Retiree	$874.98	$832.21	$1,164.24	$817.16	$780.92	$1,035.84	$828.75
1 Dependent	$500.84	$476.56	$665.01	$468.02	$447.45	$592.14	$474.60
2 + Dependents	$869.98	$828.36	$1,151.42	$813.72	$778.45	$1,026.49	$824.99
Medicare Dependent	$389.77	$370.98	$516.80	$364.37	$348.45	$460.41	$369.46

As shown in this table, HMO plans are not necessarily less costly than OAPs. There are myriad factors involved in the rates submitted by health insurance providers, indicating that some plans may be better for participants based on their current status of active or retired, with or without dependents, and their status in regards to Medicare.

APPENDIX I

STATE EMPLOYEES' GROUP INSURANCE OVERSIGHT

P.A 93-0839 strengthened the Commission's oversight role of the State Employees' Group Health Insurance Program. P.A 93-0839, clarified State policy for the administration of the Group Insurance Program, and requires CMS and DHS to administer the program within set policy parameters. Those key parameters are:

- Maintain stability and continuity of coverage, care, and services for members and their dependents.
- Members should have continued access, on substantially similar terms and condition, to trusted family health care providers with whom they have developed a long-term relationship.
- The Director (CMS) may consider affordability, cost of coverage and care, and competition among health insurers and providers in the contract review process.

The specific changes in oversight authority for the Economic and Fiscal Commission are listed below:

- By April 1st of each year, the Director (CMS/DHS) must report and provide information to the Commission concerning the status of the employee benefits program to be offered the next fiscal year.
- By the first of each month thereafter, the Director (CMS/DHS) must provide updated, and any new information to the Commission until the employee benefits program for the fiscal year has been determined.
- Requires CMS/DHS to promptly, but no later than 5 business days after receipt of a request, respond to a written request by the Commission for information.
- Within 30 days after notice of the awarding of a contract has appeared in the Illinois Procurement Bulletin, the Commission may request information about a contract. The Commission must receive information promptly and in no later than 5 business days.
- No contract may be entered into until the 30-day period has expired.
- Changes or modifications to proposed contracts must be reported to the Commission in accordance with the aforementioned points.
- CMS/DHS must provide to the Commission a final contract or agreement by the beginning of the annual benefit choice period.
- States that the benefits choice period must begin on May 1st unless interrupted by the collective bargaining process. In the case that the collective bargaining process is still pending on April 15, the benefit choice period will begin 15 days after the ratification of the agreement.
- Specifies the methods used to provide the Commission with requested information and discusses confidentiality.
- States that all contracts are subject to appropriation and must comply with the Illinois procurement code.

APPENDIX II

TYPES OF MEDICAL & DENTAL GROUP INSURANCE PLANS			
Type of Plan	Coverage	Characteristics	Geographic Location
QCHP Medical	Care related to the treatment of an illness or injury. Preventive care includes well-baby care, routine and school physicals, annual pap smears and mammograms.	Choice of physician and other medical care providers. Annual deductibles and employee contributions based on member salary. Dependent premiums do not vary.	No limitation; preferred hospital providers statewide.
QCHP Dental	Preventive, diagnostic, restorative, orthodontic, endodontic, and periodontic services as well as extractions and prosthetics.	Choice of dental care providers, reimbursement on a scheduled basis. No deductibles. Premiums for members and dependents.	No limitations.
HMO Medical	Comprehensive medical benefits including preventive care.	Prepaid benefits, primary care physician who coordinates all care chosen from HMO network. Co-payments vary by HMO plan. Employee premiums, based on salary, vary for dependents by plan.	Statewide coverage
OAP	Comprehensive medical benefits including preventive care.	Three tiers of benefit levels. Patients may see specialists without referral from the primary care physician. Co-payment levels vary.	Southern Illinois, St. Louis Metro-East area.

APPENDIX III

Contracts to be bid or renewed for FY 12 at DCMS	
Service	**Vendor**
Managed Care Health Plans	Health Alliance HMO/Health Alliance Illinois/Personal Care HMO (Bid) Personal Care OAP (New Contract) Healthlink OAP (New Contract) HMO Illinois/Blue Advantage (Renew)
Self-Insured Medical Plan Administration **(Bid)**	Cigna
Vision **(Renew)**	EyeMed
Behavioral Health/EAP**(Renew)**	Magellan AFSCME Personal Support Program
Subrogation**(Renew)**	ACS
Peer Review**(Renew)**	CIMRO
Flu Shots**(Renew)**	Varies each plan year
Consulting Contracts **(Two Renew)**	Willis of Illinois Blalock Consulting Mercer Consulting **(Bid)**
Life Insurance **(Renew)**	Minnesota Life
Flexible Spending **(Renew)**	FBMC
Commuter Savings Program **(Renew)**	FBMC

BACKGROUND

The Commission on Government Forecasting and Accountability (CGFA), a bipartisan, joint legislative commission, provides the General Assembly with information relevant to the Illinois economy, taxes and other sources of revenue and debt obligations of the State. The Commission's specific responsibilities include:

1) Preparation of annual revenue estimates with periodic updates;
2) Analysis of the fiscal impact of revenue bills;
3) Preparation of "State Debt Impact Notes" on legislation which would appropriate bond funds or increase bond authorization;
4) Periodic assessment of capital facility plans;
5) Annual estimates of public pension funding requirements and preparation of pension impact notes;
6) Annual estimates of the liabilities of the State's group health insurance program and approval of contract renewals promulgated by the Department of Central Management Services;
7) Administration of the State Facility Closure Act.

The Commission also has a mandate to report to the General Assembly ". . . on economic trends in relation to long-range planning and budgeting; and to study and make such recommendations as it deems appropriate on local and regional economic and fiscal policies and on federal fiscal policy as it may affect Illinois. . . ." This results in several reports on various economic issues throughout the year.

The Commission publishes several reports each year. In addition to a Monthly Briefing, the Commission publishes the "Revenue Estimate and Economic Outlook" which describes and projects economic conditions and their impact on State revenues. The “Bonded Indebtedness Report" examines the State's debt position as well as other issues directly related to conditions in the financial markets. The “Financial Conditions of the Illinois Public Retirement Systems” provides an overview of the funding condition of the State’s retirement systems. Also published are an Annual Fiscal Year Budget Summary; Report on the Liabilities of the State Employees’ Group Insurance Program; and Report of the Cost and Savings of the State Employees’ Early Retirement Incentive Program. The Commission also publishes each year special topic reports that have or could have an impact on the economic well-being of Illinois. All reports are available on the Commission’s website.

These reports are available from:

Commission on Government Forecasting and Accountability
703 Stratton Office Building
Springfield, Illinois 62706
(217) 782-5320
(217) 782-3513 (FAX)

http://www.ilga.gov/commission/cgfa2006/home.aspx