FY 2016
Liabilities of the State Employees' Group Health Insurance Program

Commission on Government Forecasting & Accountability

March 2015

Commission on Government Forecasting and Accountability

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March, 2015

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EXECUTIVE SUMMARY

Under the State Employees' Group Insurance Act of 1971 (5 ILCS 375), the Commission on Government Forecasting and Accountability (CGFA) has several statutory requirements.

- To estimate liabilities of the State Employees' Group Health Insurance Program.
- To meet with the Department of Central Management Services (CMS) to advise the department on all matters relating to policy and administration of the Group Insurance Act.
- To review contracts recommended by the Director of CMS related to the Group Insurance Program.
- To give "advice and consent" when CMS determines it would be in the best interest of the state and employees to administer benefits with the state as a self-insurer.

The Governor has requested that a total of $2.025 billion be appropriated for the State Employees' Group Health and Life Insurance program for FY 2016. The requested FY 2015 appropriation request for the Group Health Insurance Program was $2.790 billion. The table on page 2 represents historical appropriation and liability amounts. CMS estimates the FY 2016 liability to be $2.777 billion, a 6.8% increase from FY 2015. The CGFA FY 2016 estimate of liability is $2.803 billion, $25.9 million more than CMS. The CGFA FY 16 estimate is reflective of the figures provided by CMS. It is possible that certain information utilized in this report may change depending on the outcome of ongoing collective bargaining negotiations, which will be addressed later in a supplemental addendum to this report when the negotiations are concluded.

Currently, for the Quality Care Health Plan (CIGNA), the delay for preferred providers and non-preferred providers is 273 and 350 days. In FY 2016, the cycle is expected to be extended significantly. The current (as of February 5, 2015) amount of SEGIP FY 2014 claims on hand is $1.500 billion. CMS has calculated the amount of time it takes to make payments to managed care providers (HMOs and OAPs) at approximately seven months, which is expected to increase to 14 months in FY 2016. The value of bills on hand is estimated to be approximately $1.500 billion by the end of FY 2015. For FY 2016, the bills on hand value is expected to rise in comparison to FY 2015 numbers, though exact figures are not available. PPO claims would be held up to 360 days in FY 2016, above the 273 days utilized in FY 2015. Out-of-network PPO claims would rise from 350 days currently to 380 in FY 2016. Using the figures provided by CMS, the FY 2016 estimated liability for the QCHP is expected to increase by 6.4% over the FY 2015 liability. This follows actions taken by the state to reduce liability by moving retirees and dependents over to Medicare Advantage HMO/PPO plans. The estimated liabilities for the State's HMO plans are expected to increase 7.2% over the FY 2015 cost with OAP liabilities increasing 9.2%. FY 2015 liability for the HMO plans increased 10.6% from FY 2014, due in large part to the classification of Medicare Advantage plans (HMOs/PPOs) under Managed Care. However, the Department projects prescription drug liability to only increase by 2.2% in FY 2016 from $99.4 million to $101.6 million. This follows a large decrease in FY 2015 of

40.9% ($68.8 million) from FY 2014. Dental network claims are expected to be held 140 days, while non-network providers would be held 360 days in FY 2016.

GRF APPROPRIATION/REVENUE AND LIABILITY HISTORY FY 2011-2016 ($ in Millions)				
Fiscal Year	Appropriation	Revenues	CMS Liability	CGFA Liability
FY 2011	$1,204.8	$2,013.2	$2,343.8	
FY 2012	$1,619.8	$2,567.8	$2,434.1	
FY 2013	$1,103.0	$2,088.5	$2,620.6	
FY 2014	$1,697.0	$2,791.3	$2,624.3	
FY 2015	$1,665.4	$2,637.2	$2,648.7	
FY 2016	$1,195.5	$2,035.6	$2,777.5	$2,803.4
*Estimated for FY 2016				

FY 2016 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2016 cost projection utilizes the CMS estimate for FY 2015 medical claims as the basis for estimating claims for FY 2016 along with information provided by the Segal company in their annual report on state employee insurance trends.

The CGFA State of Illinois liability cost estimate for FY 2016 uses the following assumptions based on historical claims data and anticipated cost changes:

Trend Factors	
Medical (QCHP plan)	7.7%
Dental (QCHP and MC)	4.6%
HMO (Medical and Rx)	8.0%
Prescription drugs (QCHP)	3.3%
Administrative service charges (QCHP)	1.1%
Life Insurance	3.9%

It is necessary to note that these figures only relate to the portion of total medical costs borne by the State of Illinois. State costs have declined in part due to the shifting of retirees towards Medicare Advantage and negotiated increases in employee contributions, co-payments, etc. However, the overall cost of providing healthcare for State employees, retirees and dependents continues to rise. The medical trend inflation factors for the State consist of various components. These components include general inflation and leveraging (lower impact of coinsurance limits, level deductibles, etc.). Also, advances in technological innovation, more use of equipment/services, and the continued "greying" (aging and extended living) of the population have all contributed to greater health care costs. In addition to these, the impact of a gradual shift by employees to HMOs and OAPs has resulted in more costly/higher risk employees

remaining in the QCHP program, though movement of retirees out of the QCHP has reduced overall liability within the program. In recent years, some of these employees have been moving to HMOs and OAPs.

Of particular interest is the movement downward in QCHP costs. The largest factor in this decline is the shift of retirees into Medicare Advantage HMO/PPO plans from existing QCHP/HMO/OAP options. This movement away from traditional state plans utilized by retirees and their dependents has resulted in lower QCHP medical and prescription drug costs than since before the early 2000s (except for FY 2015). It is possible that this movement will help the entire group insurance program to reduce liabilities and limit growth in the long run. However, the upcoming fiscal year does not show significant decreases in costs to the state. Rather, CMS estimates overall liability to rise by 6.8 percent in FY 2016, a larger percentage increase than the previous four fiscal years, in part due to limited savings potential from negotiated medical insurance changes and general medical cost inflationary rises.

The Segal Company compiles an annual cost trend survey that provides data as to how large health plans are trending during the plan year. The following are some of the key findings of the 2015 Segal study.

- Most medical and prescription drug plans for active employees and non-Medicare retirees are expected to have a lower rate of increase than the previous year. Note that this does not mean that rates are not expected to increase, but rather, the rates are anticipated to be lower than previous year increases. Prescription Drug Carve-Out plans (separate prescription plans with a Pharmacy benefits Manager dedicated to that plan only) are anticipated to move against this trend, and are anticipated to be significantly higher than in 2014, at an 8.6% rise compared to 6.3%.

- HMO trend rates are expected to increase more slowly than 2014 at 6.2% compared to 7.2%.

- Medicare Advantage trend rates are expected to hold steady for MA Preferred Provider Organizations (PPOs such as UnitedHealthcare) and be lower in the case of Medicare Supplement plans. However, Medicare Advantage HMOs (such as Health Alliance, Aetna, and Humana) and prescription drug coverage trends are likely to be higher than the previous year.

- Dental plan rates are expected to rise more than the previous year while vision plan rates are expected to rise less quickly.

- On a regional basis, the Midwest is set to have lower increases than most of the country, with PPO/Point of Service plans expected to rise only 6.6% compared to the Northeast (7.9%) and West (9.2%).

- Various new approaches are being considered to help moderate the continuing increase in health care costs, including emphasizing early detection, consumer literacy, and wellness initiatives.

Table 1 below highlights national trending data and compares it to estimates by CMS and CGFA for State liability.

TABLE 1

NATIONAL HEALTH CARE TRENDING 2015

Component	National Trend	CMS Trend	COGFA Trend
HMOs	6.2%	7.2%	8.0%
Rx	8.6%	2.2%	3.3%
Dental	4.0%	4.2%	4.6%
Vision	2.7%	-27.8%	-27.8%

Source: Segal 2015 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. With Illinois' situation, the trend factors cited by Segal are limited in their use, though HMO and Dental rates are comparable to COGFA and CMS trend predictions. The movement of Medicare-eligible retirees to Medicare advantage plans alone makes a large difference in total liabilities in certain program lines such as the QCHP, though the total liabilities for that line are expected to rise in FY 2016.

Based on these assumptions and inflation factors, CGFA estimates a FY 2016 liability of approximately $2.803 billion for the State Employee's Group Health Insurance Program. The following table shows a detailed comparison of the CGFA estimate for the various cost components and the CMS projection for FY 2016.

TABLE 2: FY 2016 GROUP HEALTH INSURANCE LIABILITY ($ in Millions)			
Liability Component	**FY 2015 CMS Estimate**	**FY 2016 CMS Estimate**	**FY 2016 CGFA Estimate**
QCHP Medical	$399.5	$425.0	$430.2
QCHP Prescriptions	$99.4	$101.6	$102.7
Dental (QCHP/MC)	$123.0	$128.2	$128.7
HMO	$1,073.9	$1,150.9	$1,160.1
Open Access Plan	$662.4	$723.6	$727.0
Mental Health	$6.2	$7.3	$7.3
Vision	$11.5	$8.3	$8.3
Administrative Services (QCHP)	$17.7	$17.9	$17.9
Life	$86.9	$89.1	$90.3
Special Programs (Admin/Int./Other)	$119.9	$125.6	$130.9
TOTAL	**$2,600.4**	**$2,777.5**	**$2,803.4**
% increase over prior year	**0.9%**	**6.8%**	**7.8%**
*Rounding may cause slight differences. FY 2015 and FY 2016 Special Programs line includes Prompt Payment Interest.			

ESTIMATE COMPARISON

Overall, the Commission's FY 2016 estimate is $25.9 million higher than the FY 2016 estimate from CMS. CGFA's FY 2016 HMO and Open Access Plan liabilities estimates are $9.2 million and $3.4 million higher than CMS, respectively. CGFA's FY 2016 estimates for prescriptions and dental coverage are $1.1 million and $0.5 million higher than the CMS estimate, respectively.

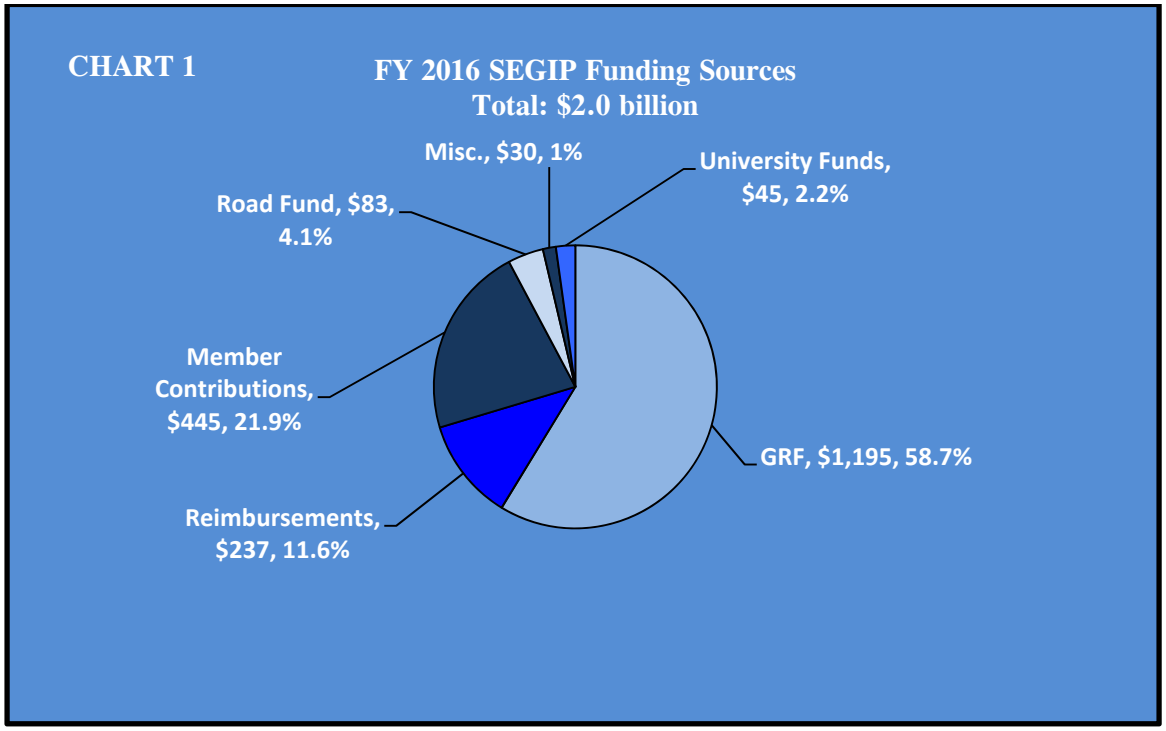
CGFA estimates that approximately $2.803 billion would be required to fully fund the FY 2016 liabilities of the State Employees' Group Health Insurance Program. This estimate is $202.9 million or 7.8% more than the FY 2015 estimated liability of $2.600 billion. CMS estimates that the FY 2016 liability will be $2.777 billion, approximately $177 million above FY 2015.

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 Health 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, Member Contributions, Reimbursements, University Funds, and Miscellaneous Funds. Estimated cash flow into HIRF for FY 2016 is $2.035 billion. This is a significant decrease from the 2015 fiscal year estimated cash flow of $2.637 billion. As of the drafting of this report, it is uncertain what sources of funding will be used to cover the additional unfunded liability. A breakdown in the various funding sources is shown in the pie chart below.



The FY 2016 fiscal data provided by CMS shows the Group Health Insurance Program receiving $1.195 billion in GRF funds. This represents a $370 million or a 23.6% decrease from the FY 2015 GRF component of $1.565 billion and is lower than any previous fiscal year GRF allocation after FY 2011. For FY 2016, the estimated Road Fund request of $83.3 million is $40.1 million lower than the FY 2015 appropriation level. Member contributions are anticipated to be slightly lower in FY 2016, at $444.5 million, compared to $447 million in FY 2015. Other Funds reimbursements are anticipated to be significantly lower in FY 2016 as well, at $237.3 million compared to $326.4 million in FY 2015. University contributions and miscellaneous minor components are expected to remain steady for the 2016 fiscal year, along with the Medicare Part D rebate.

TABLE 3: GROUP INSURANCE FUNDING SOURCES FY 2015 - FY 2016 ($ in Millions)				
	FY 2015	FY 2016	$ Change	% Change
GRF Appropriation	$1,665.4	$1,195.5	($469.9)	-28.2%
Road Fund	$123.4	$83.3	($40.1)	-32.5%
University Cont.	$45.0	$45.0	$0.0	0.0%
Member Cont.	$447.0	$444.5	($2.5)	-0.6%
Other Funds	$326.4	$237.3	($89.1)	-27.3%
Medicare Part D rebate	$5.0	$5.0	$0.0	0.0%
Rebates/Interest/Other.	$25.1	$25.1	$0.0	0.0%
TOTAL Appropriations	**$2,637.3**	**$2,035.7**	**-$601.6**	**-22.8%**
Source: CMS. The FY 2015 GRF figure includes $100 million received in the lapse period.				

CMS 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 2016, as in previous years, the GIPF target balance is $4 million, and the target HIRF balance is $6 million.

BENEFITS

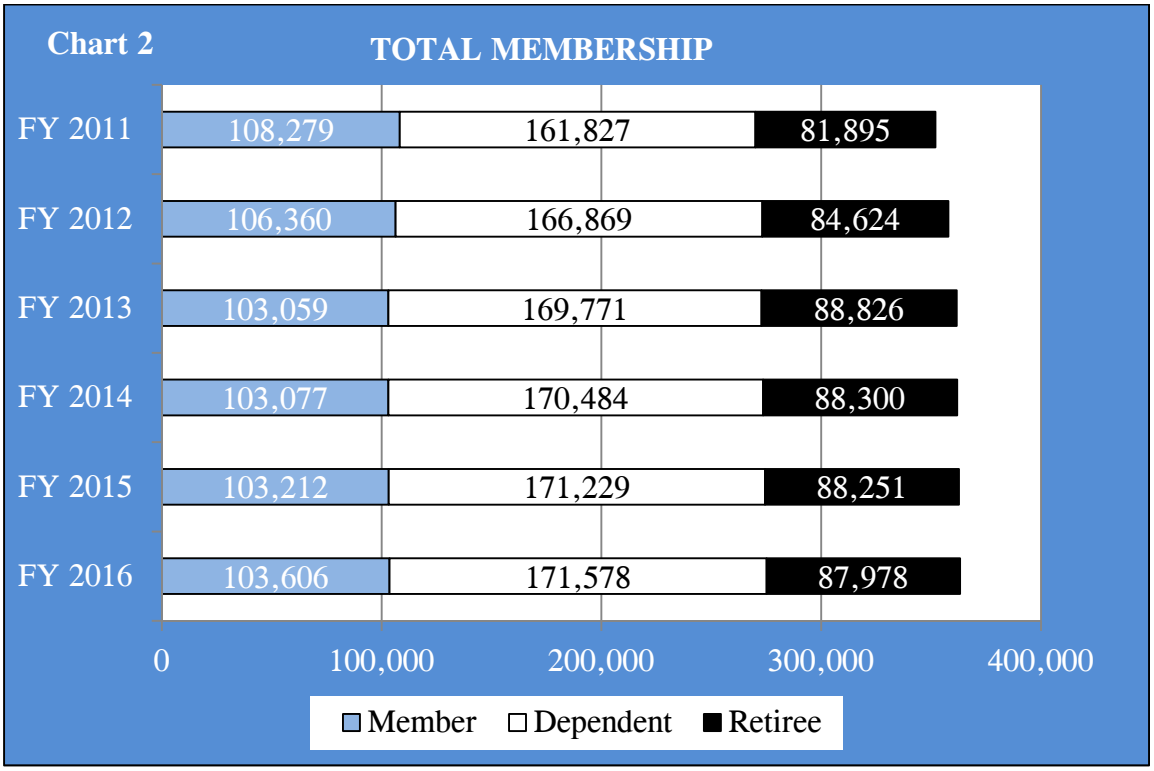
The State Employees' Group Insurance Program provides medical, dental, vision, and life insurance coverage to State employees, retirees and their dependents. Medical coverage is provided separately to members in their choice of the QCHP plan and various types of managed care plans such as HMOs and OAPs. 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 basic life insurance coverage equal to their annual salary. Retirees and annuitants receive basic life insurance coverage equal to the annual salary as of the last day of employment until the age of 60, at which time the benefit amount is reduced to $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.

Starting in FY 2014, Medicare-eligible retirees and their Medicare-eligible dependents were moved into Medicare Advantage (MA) plans. Individual retirees and dependents had the choice of four different plans that ranged from MA HMO plans to a MA PPO plan. These plans became effective as of February 1, 2014. The retirees and dependents can still access benefits from the same dental, vision and life insurance plans that current state employees and dependents utilize.

MEMBERSHIP

According to CMS, the State Employees' Group Health Insurance Program has an estimated 362,692 participants for FY 2015, of which 146,486 are in a non-Medicare Advantage HMO, 66,893 are in a Medicare Advantage HMO/PPO, 92,433 are in an Open Access Plan, and 56,880 are in the Quality Care Health Plan. The QCHP is estimated to have 18,046 employees, 23,985 dependents, and 14,849 retirees in FY 2015. HMO plans are estimated to have 52,124 employees, 81,027 dependents, and 13,335 retirees in FY 2015. Medicare Advantage plans in FY 2015 include 14,972 dependents and 51,921 retirees. OAPs are anticipated to have 33,042 employees, 51,245 dependents, and 8,146 retirees in FY 2015. For FY 2016, the QCHP is estimated to have 18,053 employees, 23,518 dependents and 13,376 retirees. Medicare Advantage HMO/PPO plans are expected to have 15,779 dependents and 54,200 retirees. Non-Medicare Advantage HMO Plans are expected to have 52,328 employees, 80,975 dependents and 12,640 retirees. OAPs are expected to have 33,225 employees, 51,306 dependents, and 7,762 retirees in FY 2016.



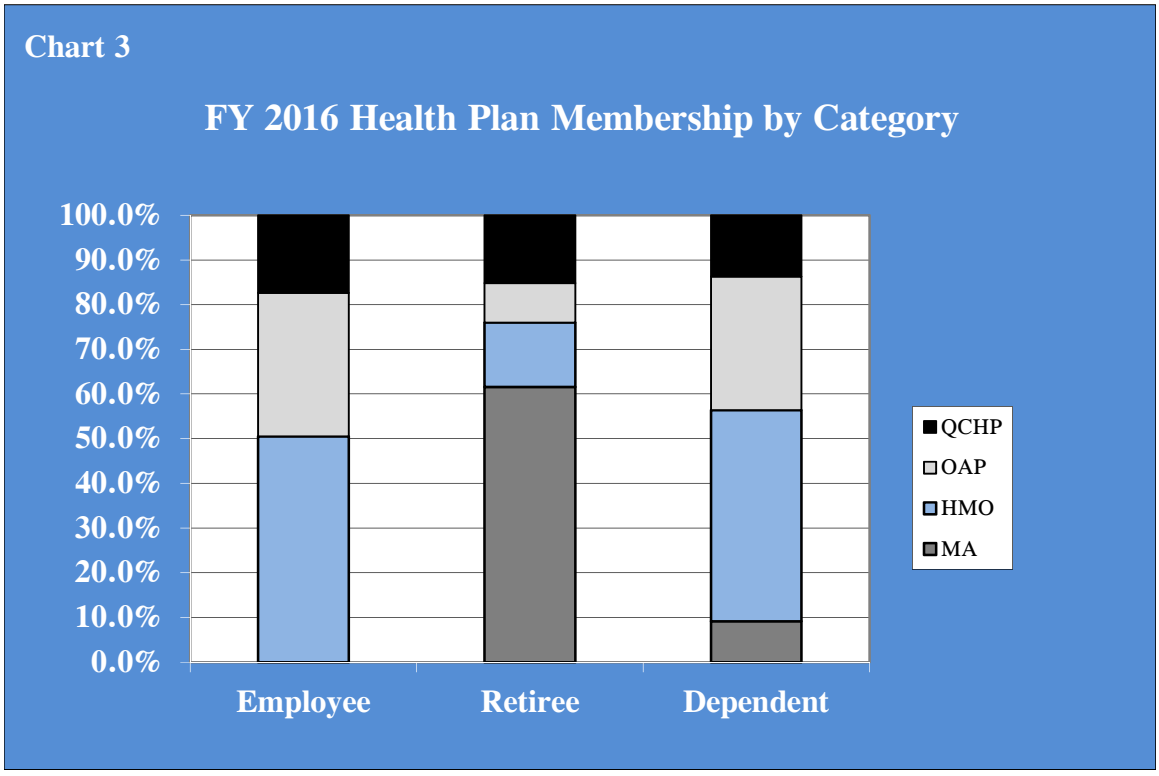
- **Membership (including CIP, TRIP, etc.) is estimated for FY 2015 and FY 2016.**

ENROLLMENT TRENDS

Membership in the Quality Care Health Plan has been decreasing since FY 2005 while membership in the states' managed care offerings has been increasing since FY 2004. Since FY 2012, many participants have switched away from traditional managed care (HMOs) to alternatives such as Open Access Plans (OAPs). This trend appears to have stabilized the past few years, and is reflected in FY 2016 membership projections by CMS.

For FY 2016, membership in HMOs is broken down by standard HMO membership and Medicare Advantage HMO/PPO membership. Standard HMO membership is expected to decline slightly from FY 2015, though it is anticipated to remain the highest population category among those measured (QCHP, OAP, etc.). Medicare Advantage HMO/PPO plans are expected to increase by approximately 4.4%, from 66,893 in FY 2015 to 69,979 for FY 2016, as retirees continue to qualify for MA plans and move out of the QCHP, HMO, and OAP plans.

Chart 3 shows the breakdown of employee, dependent and retiree enrollment in the overall Group Insurance Program. Due to the shift towards MA HMO/PPO plans by retirees, the QCHP has become much less utilized among employees as a whole, especially retirees. In FY 2016, 61.6% of retirees are expected to enroll in a Medicare Advantage HMO/PPO, as required by the State of Illinois, a massive shift from the 62.8% retiree QCHP enrollment in FY 2013. Chart 3 shows that employees, retirees, and dependents from both groups are gravitating towards HMOs and Open Access Plans.



LIABILITY

The Department's estimate of liability for FY 2016 represents a 6.8% growth rate over FY 2015. This increase in estimated liability is a stark contrast from previous years, especially FY 2014 to FY 2015, when liability actually decreased by 1.2%, but it is lower than increases in FY 2010 and FY 2011 of 7.4% and 7.1%. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2007 through FY 2016. Table 4 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 segments of total liability. However, in recent years, HMOs, OAPs and the QCHP have claimed the majority of group insurance liability. As a partial result of the shift away from QCHP, the Open Access Plan line is anticipated to have more liability for the State of Illinois than the QCHP and prescription components as a whole in FY 2016, with $724 million compared to $527 million.

Other components of liability, such as Mental Health, Vision, and Life Insurance are mostly holding steady or increasing slightly year-to-year. These components are only a small fraction of total liability as a whole, and are expected to remain in that position in years to come, as QCHP/HMO/OAP plans are utilized more by most state employees, retirees, and dependents. The dental plan is expected to decrease in liability for the 2016 fiscal year, though it is uncertain how permanent that decrease may be. Interest on payments remains a significant liability for the state ($58 million in Timely Payment Interest and $45 million in Prompt Payment Interest in FY 2016), and is the largest component of the Admin/Int/Other category. With the anticipated delays in payments to vendors increasing for FY 2016, this component is unlikely to decrease.

Table 4 STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY (FY 2007-FY 2016)

$ in (millions)

Liability Component	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
QCHP Medical/Rx	$695	$689	$726	$731	$730	$748	$722	$623	$499	$527
HMO Medical	$711	$781	$844	$911	$1,007	$853	$894	$971	$1,074	$1,151
Dental	$96	$102	$110	$115	$129	$133	$118	$119	$123	$128
Open Access Plan	$154	$178	$213	$252	$286	$528	$582	$615	$662	$724
QC Mental Health	$9	$9	$8	$11	$8	$8	$8	$7	$6	$7
Vision	$8	$8	$8	$8	$10	$11	$12	$11	$11	$8
Life Insurance	$76	$78	$81	$84	$82	$81	$81	$85	$87	$89
QC ASC	$28	$30	$31	$32	$32	$32	$31	$25	$18	$18
Admin/Int/Other	$13	$17	$18	$45	$62	$63	$105	$174	$120	$125
Total	**$1,790**	**$1,892**	**$2,039**	**$2,189**	**$2,345**	**$2,457**	**$2,552**	**$2,630**	**$2,600**	**$2,777**
% change over py	**5.2%**	**5.7%**	**7.8%**	**7.3%**	**7.1%**	**4.8%**	**3.9%**	**3.0%**	**-1.1%**	**6.8%**

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 in part to medical inflation, though as plan participants live increasingly longer lives, utilization of medical insurance plans (and thereby costs to the state) have tended to increase accordingly. In FY 2007, the annual cost per participant in the Group Health Insurance Program was $5,166. **According to CMS, the estimated cost per participant for FY 2016 is $7,648. That represents a 48.0% increase over a ten year period.** The cost per participant is projected to increase 6.3% from FY 2015 to FY 2016. It is important to note that this is only an aggregated cost representation, which is not itemized based on the types of plans used by participants or any other variables.

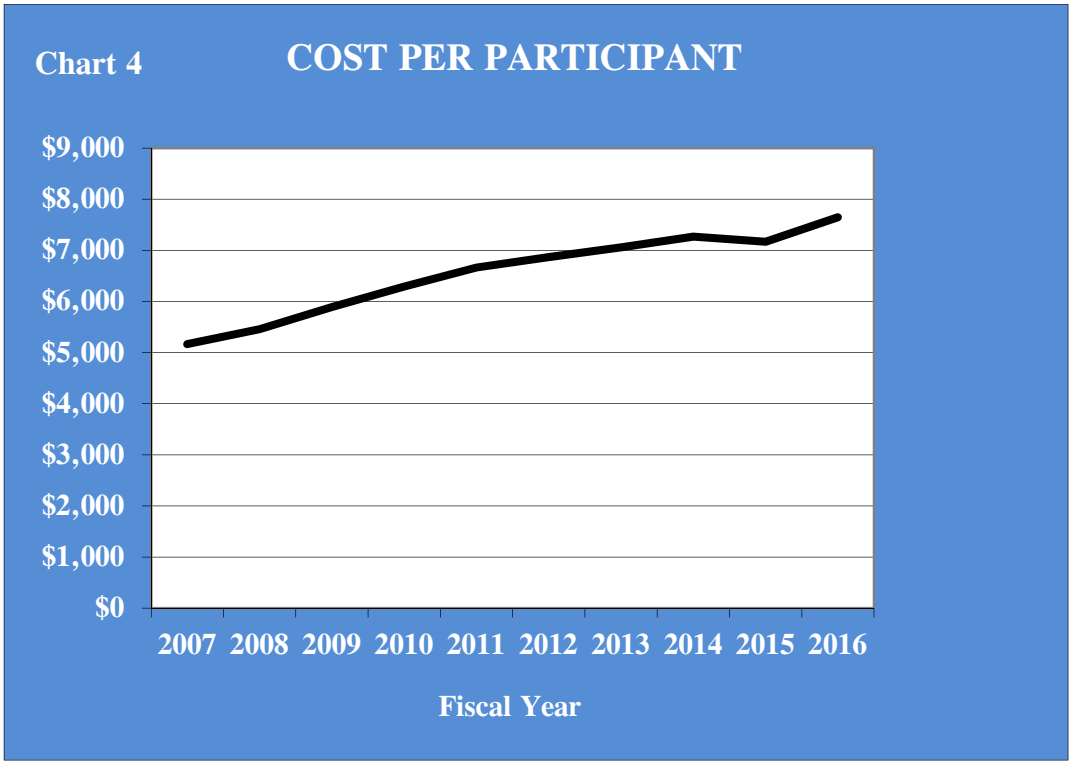


Table 5: AVERAGE ANNUAL COST PER PARTICIPANT				
	FY 2015	FY 2016	FY 2015	FY 2016
	Total Participants	Total Participants	Average Cost Per Participant	Average Cost Per Participant
QCHP	56,880	54,947	$8,771	$9,583
MA HMO / PPO	66,893	69,979	$2,117	$2,464
HMO	146,486	145,943	$6,379	$6,704
OAP	92,433	92,293	$7,167	$7,840
Totals	362,692	363,162	$2,299,773,320	$2,401,092,994
OAP is the Open Access Plan. ACPP does not include dental, vision, admin/interest/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 2015 is lowest for members in the HMO and highest for members in the QCHP. The total number of participants in the QCHP has declined in recent years as people have steadily migrated to HMOs and OAPs. This trend was accelerated in FY 2014 and FY 2015, as most retirees (over 90 percent) were moved from QCHP to a Medicare Advantage HMO/PPO plan. This shift has resulted in an increase in average cost for remaining QCHP participants, as those who remain, including non-Medicare eligible retirees and dependents are predominantly the more expensive to cover (requiring more treatment, medicines, etc.).

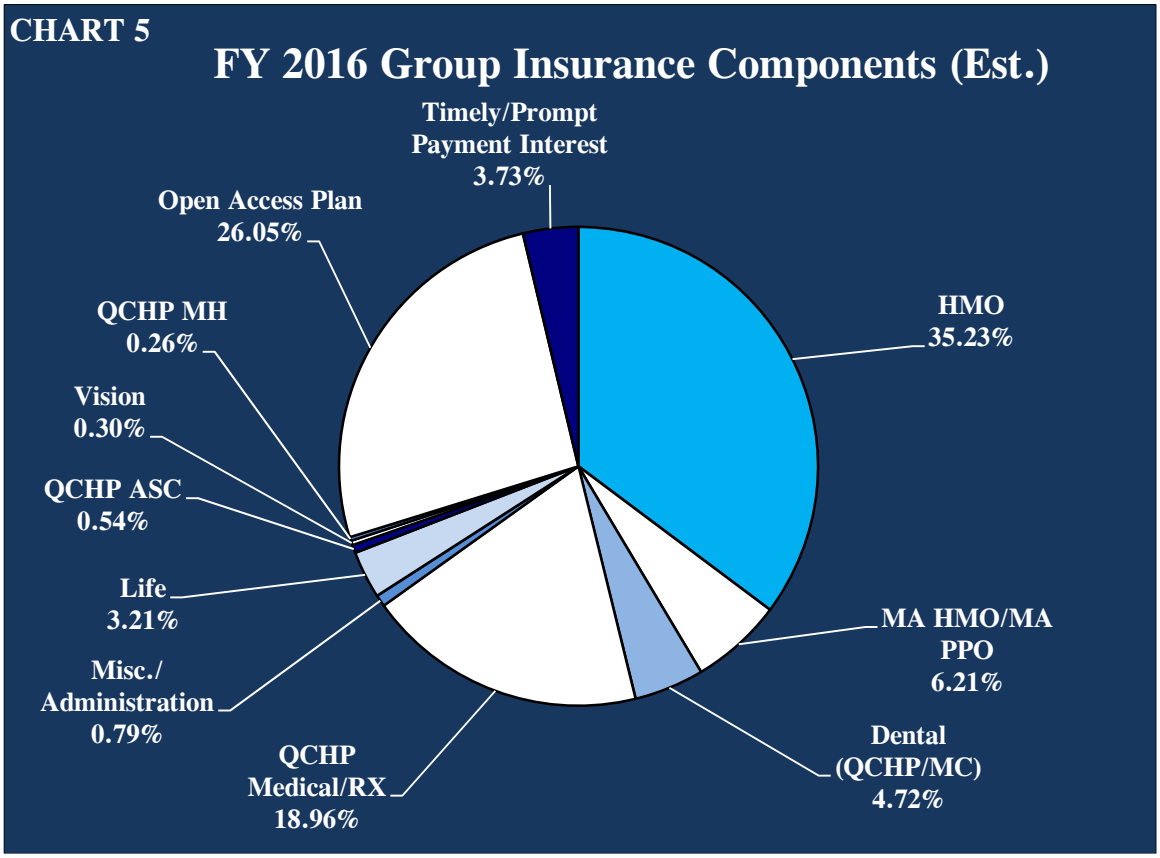
MEMBER CONTRIBUTIONS

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 $8,771 in FY 2015. Total member contributions for QCHP enrollees totaled $84 million. This means that of the total cost per participant, $1,468 of that cost is covered by member contributions. Prior to the *Kanerva* decision by the Illinois Supreme Court, retirees were contributing towards their coverage, which was a change from most previous years. However, since that court decision, which stopped the practice of taking a percentage of all retiree pension income as health insurance contributions, contributions from retirees have dropped sharply (especially from the set of retirees with 20 years or more of service, who are exempt from health insurance contribution deductions from their pension income, per *Kanerva*). In addition, many retirees have been moved out of QCHP towards a Medicare Advantage HMO/PPO plan. This causes more people to be added to the composite HMO/OAP line in Table 6 and leaves fewer people in the QCHP, causing the cost per participant for that program to rise (due to the generally increased expenses incurred by QCHP participants). Table 6 examines the relationship between overall cost and the offset by member contributions.

TABLE 6: MEMBER CONTRIBUTIONS AND AVERAGE COST PER PARTICIPANT (ACPP)						
	FY 2015 ACPP	FY 2015 Member Contributions	FY 2015 Member/ State Cost	FY 2016 ACPP	FY 2016 Member Contributions	FY 2016 Member/ State Cost
QCHP	$8,771	$83,501,519	$1,468/ $7,303	$9,583	N/A	N/A
MA HMO/PPO	$2,117	$28,971,164	$433/$1684	$2,464	N/A	N/A
HMO/OAP/MA HMO/PPO	$6,379	$239,143,064	$1001/$5378	$6,704	N/A	N/A
Dental	$343	$33,127,210	$92 / $251	$357	N/A	N/A
Source: CMS. FY 2016 numbers unavailable at this time due to collective bargaining discussions.						

The table above shows that QCHP members contribute approximately 16.7% of the overall annual cost of providing their insurance in FY 2015. HMO/OAP/MA HMO/MA PPO members contribute 15.4% of their overall liability cost in the same time period. Members that participate in the State's dental offering pay 26.8% percent of the overall liability cost. Retirees (with less than 20 years of creditable service) and their survivors are required to pay a portion of their health care costs (P.A. 90-0065). The remainder is paid by the State. These contribution levels in the Table above for FY 2015 include agreed contribution increases for employees and retirees. For FY 2016, member contribution rates are not yet set due to ongoing labor negotiations by the State of Illinois. This information will be provided in a supplement to this report when the information becomes available.

Chart 5 includes the various components of the FY 2016 CMS liability estimate of approximately $2.777 billion. The largest component of the State Employees' Group Insurance Program continues to be the State's managed care plans (HMO, OAP, MA HMO/MA PPO) which now represent 67.5% of FY 2016 liability, a slight increase from FY 2015. Dental care, life insurance, vision care, and all other components equal 12.8% of total liability. The QCHP component (19.8%) has dropped slightly in FY 2016 from FY 2015, but still includes medical/prescriptions, mental health coverage, and administrative service charges.



Since the movement of retirees to MA HMO/PPO plans, it is extremely unlikely that the QCHP will rise to the proportion of the total group insurance liability it had attained before FY 2014. At the same time, the availability and affordability of MA HMO/PPO plans for the State of Illinois indicates that this area of liability is not likely to shrink in size or proportion in the near future. In regards to Open Access Plans, they remain an option for state employees and non-Medicare eligible individuals who seek a middle ground between the affordability of HMOs and the options available to QCHP participants. As retirees and their dependents continue to live longer lives, it is likely that the proportion of the group insurance budget they currently compose will increase as well.

EMPLOYEE/RETIREE COST COMPARISON

A subject of interest in recent years is the breakdown of costs for active employees and their dependents and retirees and their dependents. As contributions from retirees have risen in recent years, the disproportion between actives/dependents and retirees/dependents has moderated somewhat. The Illinois Supreme Court decision in *Kanerva* has resulted in reduced contributions for many retirees, and is reflected below. Table 7 below displays a comparison of the costs for these groups taken from data obtained from CMS as of February 2015.

TABLE 7: RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 2015			
Category	**Cost**	**Category**	**Cost**
Retiree Cost	$602.8	Active Employee Cost	$1,049.1
Retiree Contribution	$41.3	Active Employee Contribution	$218.6
Other Revenues	$9.3	Other Revenues	$9.8
Net State Cost	$552.2	Net State Cost	$820.7
Retiree Dependent Cost	$226.6	Active Employee Dependent Cost	$722.0
Retiree Dependent Contribution	$57.3	Active Employee Dependent Contribution	$122.2
Other Revenues	$4.2	Other Revenues	$10.7
Net State Cost	$165.1	Net State Cost	$589.0
Total Retiree Cost	$829.4	Total Active Cost	$1,771.1
Total Retiree Contribution	$98.6	Total Active Contribution	$340.9
Other Revenues	$13.5	Other Revenues	$20.5
Net State Cost	$717.3	Net State Cost	$1,409.7
Source: CMS **All numbers in Millions**			

A number of points can be observed from this table. As has been the trend in the past, retiree dependents and active employee dependents continue to pay a substantially larger portion of their total costs to the state in the form of contributions for their healthcare coverage. However, due to the Illinois Supreme Court decision in the *Kanerva* case, which rejected state of Illinois attempts to increase contributions from retirees and dependents, those contributions decreased.

For FY 2015, retirees and retiree dependents pay 6.9% and 25.3% of their healthcare costs respectively. This contrasts with active employees and their dependents, who pay 20.8% and 16.9% respectively. In total, the net state cost of active employees and dependents remains significantly higher than retirees and retiree dependents.

This cost difference results in part from retirees utilizing Medicare Advantage HMO and PPO plans and resulting savings for the State of Illinois. The trend may change in time as people continue to live longer lives and make use of medicinal technologies that were unavailable in past years.

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) Union.

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 2014 and FY 2015 plan enrollment is listed in Table 8 below.

TABLE 8: MANAGED CARE PLANS

FY 2013-2015 All Lives (Active Members/Dependents and non-MA Retirees/Dependents)

HMO/OAP	FY13 # of Participants	FY14 # of Participants	% Change 2013-2014	FY15 # of Participants	% Change 2014-2015
Health Alliance HMO	84,614	86,178	1.85%	82,678	-4.06%
HMO Illinois	61,214	60,445	-1.26%	58,799	-2.72%
Blue Advantage	3,394	3,997	17.77%	6,467	61.80%
Coventry Health Care HMO	8,850	8,610	-2.71%	8,268	-3.97%
Coventry Health Care OAP	20,688	21,903	5.87%	24,429	11.53%
Health Link OAP	69,380	71,530	3.10%	78,400	9.60%
TOTALS	**248,140**	**252,663**	**1.82%**	**259,041**	**2.52%**

Source CMS. FY 2015 numbers as of February 2015.

MEDICARE ADVANTAGE

A continuing development from the 2014 fiscal year onward is the movement of eligible retirees and dependents into a system of Medicare Advantage plans. These plans were set forth in an effort to save the State money as well as to provide quality service and care for retirees and their dependents. As this program is still relatively new, there are only limited judgments to be made as to efficacy and overall quality of this decision. Table 9 below shows the population figures involved with this new program.

TABLE 9: MEDICARE ADVANTAGE PLANS
FY 2015

HMO/PPO	FY14 # of Participants	FY15 # of Participants
Aetna HMO	3,638	3,829
Humana Benefit Plan 1 HMO	162	127
Humana Benefit Plan 2 HMO	2,084	2,431
Health Alliance HMO	0	442
United Healthcare PPO	59,230	63,093
TOTALS	**65,114**	**69,922**

Source: CMS. FY 16 numbers not available at this time.

It is important to note that except for a limited number of retirees and dependents coming from a HMO or OAP program, almost all of the 69,922 state retirees and dependents now covered by a MA HMO or PPO plan came from the QCHP. As a result of these people being removed from QCHP, it is forecasted to be significantly more expensive on a per-person basis in the 2015 fiscal year. In regards to MA, there are two different HMO benefit plans being offered by Humana as Humana Benefit Plan 1 is intended for Livingston and Knox counties while Humana Benefit Plan 2 is a traditional open area Medicare Advantage plan. The Health Alliance HMO plan is a new plan offered during the 2015 fiscal year going forward. The monthly rates for the State's Medicare Advantage plans are discussed in the Monthly Premiums section of this report.

MONTHLY PREMIUMS

Compared to managed care plans, the State of Illinois' QCHP is significantly more expensive for individuals 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 projected monthly cost for a current employee in the QCHP for FY 2015 is $970. Due to ongoing State of Illinois labor negotiations,

FY 2016 data is unavailable at this time, but will be provided in a supplemental publication upon its availability.

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 experiences 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 2015 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 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 10: MONTHLY PREMIUMS Managed Care vs. Indemnity Plan Weighted Average FY 2016 Rates (Projected)									
	QCHP			HMO			OAP		
Membership	TOTAL	Member	State	TOTAL	Member	State	TOTAL	Member	State
Employee	Not Available at this time due to ongoing Collective Bargaining negotiations.								
Medicare Retiree									
Non-Medicare Retiree									
1 Dependent									
2+ Dependents									
Medicare Dependent									

TABLE 11: PROJECTED MONTHLY COSTS FY 2009 - FY 2016 Employee Only												
	QCHP				HMO				OAP			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY09	$683	9.4%	$72	$611	$482	7.6%	$45	$437	$581	11.5%	$45	$536
FY10	$722	5.8%	$81	$641	$522	8.2%	$55	$467	$641	10.3%	$55	$586
FY11	$765	5.9%	$81	$684	$571	9.4%	$55	$516	$675	5.4%	$55	$620
FY12	$827	8.2%	$82	$746	$584	2.4%	$55	$529	$663	-1.8%	$55	$608
FY13	$883	6.8%	$84	$800	$624	6.7%	$56	$567	$725	9.4%	$56	$669
FY14	$872	-1.3%	$158	$714	$648	3.9%	$114	$534	$734	1.2%	$112	$622
FY15	$970	11.2%	$166	$804	$693	6.9%	$114	$579	$793	8.0%	$112	$681
FY16	Not Available at this time due to ongoing Collective Bargaining negotiations.											

TABLE 12: MONTHLY PREMIUMS ACROSS ALL PLANS HMOs and OAPs FY 2016 Rates						
Membership	Health Alliance	Coventry HMO	HMO Illinois	Blue Advantage	HealthLink OAP	Coventry OAP
Employee	Not available at this time due to Collective Bargaining negotiations.					
Medicare Retiree						
Non-Medicare Retiree						
1 Dependent						
2 + Dependents						
Medicare Dependent						

HMO plans are not necessarily less costly than OAPs. There are numerous 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.

Table 13 shows a comparison of MA member contributions between FY 2014 and FY 2015 for retirees and dependents. Retiree contributions reflect the average contribution of retirees as a result of COBRA or having less than 20 years of service to the State of Illinois. The dependent rate is negotiated. These rates reflect the eliminated contributions from retirees with 20+ years of service as per the *Kanerva* decision. FY 2016 rates will be supplied when they are available, due to State of Illinois labor negotiations.

TABLE 13: MONTHLY PREMIUMS FOR STATE MEDICARE ADVANTAGE PLANS
FY 2014-2016 Rates (As of February 2015)

Aetna HMO	FY 2014	FY 2015	FY 2016
Medicare Retiree	$13.45	$15.53	N/A
Medicare Dependent	$89.91	$89.91	N/A
Humana Benefit Plan 1 HMO	FY 2014	FY 2015	FY 2016
Medicare Retiree	$13.45	$15.53	N/A
Medicare Dependent	$89.91	$89.91	N/A
Humana Benefit Plan 2 HMO	FY 2014	FY 2015	FY 2016
Medicare Retiree	$13.45	$15.53	N/A
Medicare Dependent	$89.91	$89.91	N/A
United HealthCare	FY 2014	FY 2015	FY 2016
Medicare Retiree	$13.45	$15.53	N/A
Medicare Dependent	$110.00	$110.00	N/A
Health Alliance HMO	FY 2014	FY 2015	FY 2016
Medicare Retiree	N/A	$15.53	N/A
Medicare Dependent	N/A	$89.91	N/A

APPENDIX I

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 nationwide.
QCHP Dental	Preventive, diagnostic, restorative, orthodontic, endodontic, and periodontic services as well as extractions and prosthetics.	Choice of dental care providers, in and out-of-network benefits; out-of-network benefits are reimbursed on a scheduled basis. Premiums for members and dependents.	No limitations.
HMO Medical	Comprehensive medical benefits including preventive care.	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. Deductibles, co-payments, and coinsurance levels vary.	Statewide coverage
MA HMO	Comprehensive medical benefits including preventive care.	Primary care physician who coordinates all care chosen from HMO network.	Statewide coverage
MA PPO	Comprehensive medical benefits including preventive care.	Choice of Medicare physician and other Medicare providers.	Statewide coverage

APPENDIX II

Status of Contracts for FY 16 at DCMS		
Service	**Vendor**	**Contract Term Details**
Managed Care Health Plans	Health Alliance HMO / Coventry HMO / Coventry OAP / Healthlink OAP / BC HMO Illinois / BC Blue Advantage	**Ongoing** - Term goes to June 30, 2016 with up to five 1-year renewals.
Medicare Advantage Health Plans	Aetna/Coventry HMO / Health Alliance HMO / Humana Benefits Plan HMO / Humana Health Plan HMO / UnitedHealthCare PPO	**Ongoing** - Term goes to December 30, 2016 with up to six 1-year renewals.
Self-Insured Medical Plan Administration	Cigna	**Renew** - Term goes to June 30, 2015 with up to two 1-year renewals.
Vision	EyeMed	**Bid** - Currently in the last year of single year renewals. RFP process is ongoing.
Behavioral Health/EAP	Magellan	**Ongoing** - Term goes to June 30, 2016 with up to five 1-year renewals.
Flu Shots	Varies each plan year	**Ongoing -** Term goes to September 30, 2016 (earliest) with 1-year renewal options.
Consulting Contracts	Blalock / Segal / Deloitte	**Ongoing -** Blalock ends 12/31/2016, Segal and Deloitte end 2018 with up to five one-year renewal options
Life Insurance	Minnesota Life	**Ongoing** - Term goes to June 30, 2016 with up to five 1-year renewals.
Flexible Spending	ConnectYourCare	**Ongoing -** Term goes to June 30, 2019 with up to five 1-year renewals
Administration of Dental Claims	Delta Dental	**Ongoing** - Term goes to June 30, 2016 with up to five 1-year renewals.
Prescription Drugs	Express Scripts	**Bid -** Currently in the last year of single year renewals. RFP process is ongoing.
Commuter Savings Program	Wage Works	**Bid** - Currently in last year of 1-year renewals. RFP process is ongoing.

APPENDIX III

DEPENDENT AUDIT

CMS has undertaken an audit of all covered dependents of current members and retirees of the health plans under its purview. This includes State Employees, State University Employees, College Insurance Program members, Teachers' Retirement Insurance Program members, and Local Government Health Plan members. The status of the audit for each group is listed in the chart below.

Dependent Eligibility Audit	
Group	**Status**
1 - Local Government Health Plan / College Insurance Program Enrollees	1,835 dependents audited - 16 dependents terminated on 3/1/2014
2 - SEGIP/TRS Retirees	51,441 dependents audited - 805 dependents terminated; non-Medicare retiree dependents terminated on 5/1/2014, Medicare Advantage retiree dependents terminated on 6/1/2014
3 - Active State Employees	Proposed start date of audit, July 1, 2015
4 - Active University Employees	Proposed start date of audit, September 1, 2015

Given the cost of providing coverage to dependents, the number of terminations of dependents from employee/retiree plans could result in significant savings for the State of Illinois. The largest number of dependents, however, remains in the State Employee and University Employee groups, which are not targeted for auditing until July 2015 at the earliest (in the case of State Employees). This audit program was previously suspended in 2014.

APPENDIX IV

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 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 Commission on Government Forecasting and Accountability are listed below:

- By April 1st of each year, the Director (CMS) 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) must provide updated and any new information to the Commission until the employee benefits program for the fiscal year has been determined.
- Requires CMS 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 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.

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
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(217) 782-5320
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