FY 2021 LIABILITIES OF THE STATE EMPLOYEES' GROUP HEALTH INSURANCE PROGRAM

COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

MARCH 2020

Commission on Government Forecasting and Accountability

COMMISSION CO-CHAIRS

Senator Heather Steans
Representative C.D. Davidsmeyer

SENATE	*HOUSE*
Donald DeWitte	Thomas Bennett
David Koehler	Sonya Harper
Elgie Sims	Elizabeth Hernandez
Dave Syverson	Anna Moeller
Jil Tracy	Joe Sosnowski

EXECUTIVE DIRECTOR
Clayton Klenke

DEPUTY DIRECTOR
Laurie Eby

REVENUE MANAGER
Jim Muschinske

AUTHOR OF REPORT
Anthony Bolton

EXECUTIVE SECRETARY
Briana Jackson

TABLE OF CONTENTS

FY 2021 State Employees' Group Insurance Report
March, 2020

EXECUTIVE SUMMARY

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

- To estimate the 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.

CMS has provided information for the 2021 fiscal year indicating a continuation of the existing contracts in place as well as rate increases for group insurance participants. In addition to this, the Department will be starting a new High Deductible health insurance plan, the Consumer Driven Health Plan or CDHP (discussed in more detail further in the report), for current members and dependents. In conjunction with negotiations with public employee unions, current health insurance plan rates will increase/decrease depending on the specific plan chosen. This is a change from the historic similar rates charged to participants regardless of their choice of plan (within plan types, such as HMOs and PPOs). Existing funding and plan design components are largely unchanged.

According to CMS, for the 2021 fiscal year, the GRF appropriation is projected to be $2.022 billion for SEGIP, with total expected revenues projected at approximately $3.236 billion. CMS estimates the FY 2021 liability to be $3.249 billion, which is a 2.9% increase from the FY 2020 anticipated final liability of $3.178 billion. Noting these predictions, the Commission has presumed that liabilities and revenues will follow trends from FY 2020 and previous fiscal years and estimates a total SEGIP liability of $3.272 billion in FY 2021, $23.8 million more than CMS.

The FY 2020 and FY 2021 fiscal years have a number of noteworthy revenue and expenditure components. The revenue factors include increased member contributions (approximately $33 million), increased reimbursements, and slightly increased contributions from the Road Fund. Liability changes include continued reduction in projected Timely and Prompt Payment Interest, Teamsters Health insurance liability, HMO liability, and QCHP liability. However, increases are expected in OAP, Dental, and Medicare Advantage liability. The new CDHP is projected to have a liability totaling $113 million. These issues of revenue and liability are discussed later in this report.

Additionally, due in part to the stabilizing of revenues and expenditures into the SEGIP, projected hold times and delays in processing payments to healthcare vendors and insurance companies are expected to remain in line with FY 2020 timeframes. Most self-insured vendors are projected to have an approximate hold time of four months on their

bills while the QCHP and OAP are projected to have hold times of 131 and 130 days, respectively.

Finally, the Administration has proposed "reserving" a $400 million portion of the total state General Revenue contribution ($2.022 billion) towards the revenues of the SEGIP. This funding would be reduced from total group insurance funding contingent if PA 101-0008 (the Graduated Income Tax Amendment) does not take effect starting in January 2021. This additional funding is indicated by the Governor's Office of Management and Budget (GOMB) to be utilized for paying down existing accumulated held group insurance bills currently accruing interest.

GRF APPROPRIATION/REVENUE AND LIABILITY HISTORY FY 2014-2021
($ in Millions)

Fiscal Year	Appropriation Received	Revenues	CMS Liability
FY 2014	$1,697.0	$2,791.0	$2,614.4
FY 2015	$1,665.4	$2,674.3	$2,764.2
FY 2016*	$5.0	$876.9	$2,811.2
FY 2017*	$0.0	$1,082.1	$2,870.8
FY 2018	$1,340.0	$6,306.6	$3,130.7
FY 2019	$2,176.2	$3,198.0	$3,093.0
FY 2020**	$2,671.3	$3,708.8	$3,177.9
FY 2021**	$2,021.5	$3,235.4	$3,248.5

*FY 2016 and FY 2017 had no official appropriation. A small amount was appropriated in FY 2015 but not received until FY 2016.
**Estimated for FY 2020 and projected for FY 2021. FY 2018 included bond revenue to pay down held bills and FY 2020 currently includes interfund borrowing for the same purpose.

FY 2021 PROPOSED PLAN CHANGES

For FY 2021, the State is introducing significant changes to the existing health insurance plan arrangement. New in FY 2021 is a High Deductible Health Plan, the Consumer Driven Health Plan (CDHP). A High Deductible health plan is a type of health insurance plan that offers limited catastrophic coverage options and a high deductible to meet before benefits are applied in exchange for significantly lower premiums for participants. These types of health insurance plans are popular for participants who do not typically utilize health services such as hospital care. In addition, these plans are commonly utilized in conjunction with a Health Savings Account (HSA), wherein participants can utilize money deducted from their paycheck before taxes in order to save up for medical expenses, such as a deductible in the new CDHP.

In addition to the new CDHP, as a result of negotiations with public employee unions and the State, SEGIP participants will be able to choose from existing health insurance plan options with a more graduated set of rates. Unlike previous years, where participants were offered a variety of plans at similar prices based on the participant's salary, starting in FY 2021, plans will be priced based on the employee's salary and the individual plan itself. As a result, some plans will be significantly less expensive for employees to utilize than others that are currently at similar rates. For example, the FY 2021 median-salary individual rate for HMO/OAPs will vary between $127/month to $170/month depending on the type of plan chosen. Different types of plans (based on employee plan choice between individual and multiple dependent plans) will also have a variety of rates. These rates will be further detailed later in this report.

FY 2021 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) utilizes the CMS forecast for FY 2021 medical costs as the basis for estimating costs for FY 2021 along with information provided by the Segal Company in their annual report on State employee insurance trends. The CGFA State of Illinois liability cost projection uses the following assumptions based on historical claims data and anticipated cost changes.

Trend Factors	
Medical (QCHP plan)	-1.0%
Dental (QCHP and MC)	7.7%
HMO (Medical and Rx)	-2.1%
Prescription drugs (QCHP)	-2.2%
Open Access Plan	3.1%
Life Insurance	1.7%

As in the past, it is important to note that the trend percentages listed above relate only to the portion of total medical costs incurred by the State of Illinois. The shifting of eligible retirees and their dependents into Medicare Advantage plans along with negotiated increases in employee contributions and co-payments have caused overall cost projections to the State to decline historically. However, the yearly cost of providing healthcare for State employees, retirees and dependents continues to rise, though at a slower rate than otherwise, due to the aforementioned cost-controlling measures.

The medical trend inflation factors for the State consist of various components. These components include general medical cost 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 contributed historically to greater health care costs for the State. In addition to these factors, a gradual shift by employees to HMOs and OAPs from the Quality Care Health Program (QCHP) has resulted in more costly/higher risk employees remaining in the QCHP program, raising the per-member cost of that program. In terms of cost reduction, movement of Medicare-eligible retirees out of the QCHP/HMOs/OAPs

has reduced overall liability within the group insurance program in the past and continues to be a factor in the moderation of overall State costs.

In reference to individual liability components, CMS projects relatively small liability increases for the Open Access Plan, Medicare Advantage plans, and Dental plans. The OAP line is expected to rise to $921 million in FY 2021, a 2.3% increase from FY 2020 ($900 million) while Medicare Advantage plan liability is projected to rise 5.7% from $186 million in FY 2020 to $197 million in FY 2021. Dental plan liability is also projected to rise 5.7% from $128 million in FY 2020 to $135 million in FY 2021. Most of the other liabilities are projected to decrease, from -1.4% to as much as -21.2% in the case of Special Programs (this line includes interest paid on held bills which has decreased dramatically in the past few fiscal years). Other items of interest are the Life Insurance liability, which CMS projects to increase in FY 2021 by 1.7% to $92.6 million, and the Vision Insurance Liability, which is projected to increase $500 thousand total. The aforementioned savings are limited by the new inclusion of the Consumer Driven Health Plan liability, which is projected to total $112.9 million in its inception year.

In preparing this report, the Commission utilizes information from an annual cost trend survey report provided by the Segal Company. This report examines how large health plans are trending during the plan year. The following are some relevant findings of the 2020 Segal Health Plan Cost Trend Survey.

- For 2020, medical plan trends (insurance) are projected to be slightly lower than in the 2019 calendar year. Accordingly, while the overall rates are projected to increase, they are expected to increase at a lower rate than in 2019.

- For 2020, the largest component of increasing health care insurance cost trends is price inflation of goods and services, rather than utilization of services. Plainly stated, the goods and services utilized are increasing in price above and beyond the effects of increased demand for these goods and services.

- For 2020, most insurance plan trends are projected to be approximately equivalent compared to 2019 for active and retired members under age 65. However, prescription drug plan coverage is projected to increase at a lower trend than in 2019.

- Overall health plan trends are continuing to increase over user/consumer wages. In other words, the pace of health plan cost increases is increasing faster than increases in consumers' wages can keep up.

- Prescription drug coverage is expected to increase at a lower rate in 2020 than in 2019, though it is expected to increase sharply for specialty drugs and new "Biologics" (drugs derived from living organisms).

- Dental and vision plans are expected to have very little change in rates for 2020, with certain types of plans projected to increase at very slightly higher/lower rates than they experienced previously in 2019.

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

TABLE 1			
NATIONAL HEALTH CARE TRENDING 2020			
Component	**National Trend**	**CMS Estimate**	**COGFA Estimate**
HMOs	6.3%	-2.7%	-2.1%
Rx	7.1%	-3.9%	-2.2%
Dental	3.0%	5.7%	7.7%
Vision	2.0%	6.2%	6.2%
Source: Segal 2020 Health Plan Cost Trend Survey			

National trend rates demonstrate the general direction and scale of healthcare insurance rates, though individual state plan data points may differ significantly due to actions on the state level. 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. To the extent that it can be measured, national trend data can be reflective of trends in various geographical regions of the US. While trends may be higher in the Northeast and West, for the Midwest, trends tend to be lower in the aggregate.

The difference between national trends and state-level healthcare insurance trends can be seen in Table 1 above. While CMS and CGFA projections reflect the direction of national trends, the scale (or intensity) of these trends is muted. This lower scaling can be attributed to various causes, though the continued bifurcation of Illinois HMO costs between traditional HMOs and Medicare Advantage (MA) HMOs presents an interesting contrast in terms of cost containment. As older individuals who are demographically more likely to utilize healthcare services have moved into MA HMO plans, the inflationary pressure on traditional HMO plan rates has been reduced.

In addition, CMS and CGFA trend estimates include programmatic effects that may affect estimates beyond normal market trends. For example, HMO liability is decreasing in both CGFA and CMS projections for FY 2021 while increasing on the national level.

This is due to expectations for migration to the Consumer Driven Health Plan and other factors independent of national trends.

In reference to dental and vision plan costs, for Illinois, these costs tend to remain relatively stable year to year, with dental liability projected to increase $7 million between FY 2020 and FY 2021. Vision liability is projected to increase $500 thousand in that same time period. On a percentage basis, however, due to the relatively small amount of liability associated with these two categories, small increases in liability still have a significant percentage increase, as can be seen above. **Based on these assumptions, trends, and inflation factors, CGFA estimates a FY 2021 liability of approximately $3.272 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 2021.

TABLE 2: FY 2021 GROUP HEALTH INSURANCE LIABILITY
($ in Millions)

Liability Component	FY 2020 CMS Estimate	FY 2021 CMS Projection	FY 2021 CGFA Projection
QCHP Medical	$412.3	$406.7	$408.1
QCHP Prescriptions	$132.4	$127.2	$129.5
Dental (QCHP/MC)	$127.9	$135.2	$137.8
HMO	$1,092.6	$1,063.5	$1,070.2
Medicare Advantage HMO/PPO	$186.4	$197.1	$198.0
Open Access Plan	$900.3	$921.4	$928.5
Consumer Driven Health Plan (HDHP)	$0.0	$112.9	$110.0
Mental Health	$6.0	$6.0	$6.0
Vision	$8.1	$8.6	$8.6
Administrative Services (QC)	$17.8	$17.3	$17.5
Life	$91.1	$92.6	$92.6
Special Programs (Admin/Int./Other)	$203.0	$160.0	$165.5
TOTAL	**$3,177.9**	**$3,248.5**	**$3,272.3**
% increase over prior year	2.7%	2.2%	3.0%

*Rounding may cause slight differences. FY 2020 and FY 2021 Special Programs line includes Prompt Payment and Timely Payment Interest.

ESTIMATE COMPARISON

Overall, the Commission's FY 2021 estimate is $23.8 million higher than the FY 2021 estimate from CMS. CGFA's FY 2021 HMO and Open Access Plan liabilities estimates are $6.7 million and $7.1 million higher than CMS, respectively. CGFA's FY 2021 estimate for the Quality Care Health Plan Medical line is $1.4 million higher than the CMS estimate. The Commission's estimate for Special Programs (Interest, Admin, etc.) is $5.5 million higher than CMS.

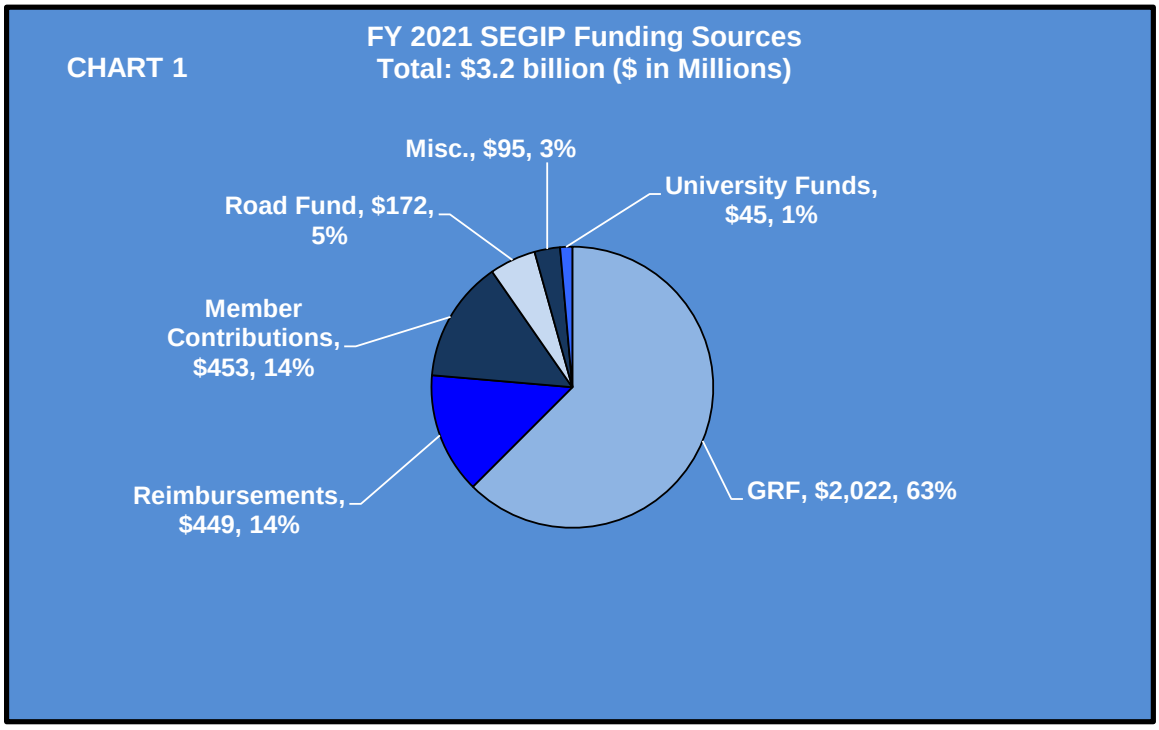
It is important to note that the FY 2021 group insurance liability estimates between CMS and CGFA are very close to each other, with less than a one percent total difference between them. This similarity in estimates is reflective of the general trends in healthcare insurance and the relative stability in overall plan design changes anticipated for FY 2021. Future (and larger) differences in liability projections may occur depending on various factors, including possible changes in plan design and applicability as a result of labor negotiations and/or changes on the federal level.

CGFA estimates that approximately $3.272 billion would be required to fully fund the FY 2021 liabilities of the Group Health Insurance Program. This estimate is $94.4 million or 3% higher than the FY 2020 estimated liability of $3.178 billion. CMS estimates that the FY 2021 liability will be $3.249 billion, approximately $71 million, or 2.2% higher than FY 2020.

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 payments 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. Pursuant to 5 ILCS 375/13.1, "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, which include the General Revenue Fund (GRF), Road Fund, Member Contributions, Reimbursements, University Funds, and Miscellaneous Funds. The department's estimated revenues for FY 2021 total $3.235 billion. This is a large decrease from the 2020 fiscal year estimated revenue of $3.709 billion, which was higher in part due to an extra $412 million in General Revenue received in FY 2020 that was originally appropriated in FY 2019 along with a $231 million General Revenue transfer into the SEGIP. A similar augmentation of resources is not expected to occur in FY 2021. The change in funding includes a projected increase of $10 million in Road Fund appropriation from FY 2020, as well as increases in employee contributions ($32.9 million) and reimbursements ($134.2 million) from the prior fiscal year. A breakdown in the various funding sources is shown in the following chart.



For FY 2021, the fiscal data provided by CMS shows the Group Health Insurance Program receiving $2.022 billion in GRF funds. As previously noted, this represents a very small $6 million (0.3%) decrease from the FY 2020 GRF component of $2.028 billion. The FY 2021 GRF appropriation request is in line with previous year GRF requests, though no prior fiscal year funding is anticipated to be received in FY 2021. As previously mentioned, approximately $400 million of the GRF component is to be held in "reserve" contingent on passage of the adoption of the proposed Progressive Income Tax constitutional amendment (PA 101-0008). This portion would revert back to GRF for non-specific use in the event of the proposed constitutional amendment failing to be passed into law.

In FY 2018 and FY 2019, bond revenues counted as part of GRF for the purposes of funding, making their totals artificially higher than the actual GRF budget request in those years. For FY 2020, additional GRF was transferred in and further GRF was received as part of the prior fiscal year appropriation, though this situation is not expected to occur in FY 2021. As noted above, the FY 2021 Road Fund request of $171.5 million is $10 million higher than the projected FY 2020 appropriation level of $161.5 million and $53.5 million greater than FY 2019.

Member contributions are also anticipated to increase in FY 2021 to $452.6 million, compared to $419.7 million in FY 2020, as a result of negotiated rate increases, new plan options, and plan price differentiation changes. Depending on employee plan choices, member contributions may increase or decrease as employees migrate to preferred plans based on the new premium rate structure. For example, if fewer employees choose to move to the High Deductible Health Plan, employee contributions may be higher as they will pay higher premiums depending on their preferred plan choice.

Other Funds reimbursements are anticipated to significantly increase by $134.2 million in FY 2021, to $449.3 million compared to $315.1 million in FY 2020. University contributions are projected to be flat compared to the 2020 fiscal year, as the Administration has proposed keeping contributions at $45.0 million in FY 2021.

TABLE 3: GROUP INSURANCE FUNDING SOURCES
FY 2020 - FY 2021
($ in Millions)

	FY 2020	FY 2021	$ Change from FY20	% Change from FY20
GRF Appropriation	$2,028.0	$2,021.5	($6.5)	-0.3%
Prior Year GRF	$412.3	$0.0	($412.3)	N/A
GRF Transfer In	$231.0	$0.0	($231.0)	N/A
Road Fund	$161.5	$171.5	$10.0	5.8%
University Cont.	$45.0	$45.0	$0.0	0.0%
Prior Year Univ. Cont.	$0.1	$0.0	($0.1)	N/A
Member Cont.	$419.7	$452.6	$32.9	7.3%
Other Funds	$315.1	$449.3	$134.2	29.9%
Medicare Part D rebate	$6.2	$4.6	($1.6)	-34.8%
Rebates/Interest/Other.	$89.8	$90.9	$1.1	1.2%
TOTAL	**$3,708.8**	**$3,235.4**	**-$473.3**	**-14.6%**

Source: CMS

CMS sets target end-of-year fund balances for both the Health Insurance Reserve Fund and the Group Insurance Premium Fund. The FY 2021 budget target balance for the Group Insurance Program is $30.0 million. For FY 2021, as in previous years, the GIPF target balance is $8.0 million, and the target HIRF balance is $22.0 million.

BENEFITS

The State Employees' Group Insurance Program has traditionally provided 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 Health Maintenance Organizations (HMO), and the new Consumer Driven Health Plan (CDHP). Vision coverage, which includes savings on exams, glasses, and contacts, is provided at no additional premium costs.

One item of interest in FY 2021 is that CMS has indicated that increased telemedicine options and its utilization is expected in FY 2021 and future fiscal years. Telemedicine is the practice wherein patients will have the option to consult physicians via telephone

regarding standard medical needs and obtain information, prescriptions, and referrals rather than the patient being required to physically travel and consult a healthcare provider. While this option does not preclude emergency care or physician-supervised actions that require a clinical setting to perform, telemedicine is expected to be an attractive option for users in rural areas, or with significant travel issues, or other health/etc. related issues. Additionally, the copayment for telemedicine services is anticipated to be one-half the current charge for a physical physician's consultation copayment, providing fiscal savings for consumers.

New for FY 2021, the state will offer a High Deductible Health Plan, the Consumer Driven health Plan (CDHP), similar to other states such as Kansas and Texas. This plan offers a low-premium option for employees who prefer to minimize their health insurance deductions from their paychecks. Additionally, this plan is beneficial to the State as it is expected to be less difficult to administer with smaller overall liability compared to the other available plans. Specifically, while more information will be available in the yearly Employee Benefits Choice Handbook, the CDHP features a $1,500 deductible for employees to reach before primary health insurance benefits would be administered. For employees anticipating few health insurance needs, the savings from choosing this plan would potentially outweigh any routine health costs incurred over the course of the year.

According to CMS and actuarial analysis, it is expected that primarily younger members will choose this plan as their option, as those individuals tend to have fewer health-related expenses and overall needs compared to older employees. Older employees tend to utilize more health insurance options as they are more likely to have health-related needs (and require services covered by higher premium plan options) and have families who also would utilize benefits covered under higher premium plan alternatives. As such, this plan is open specifically to only active employees and their dependents. As of the drafting of this report, CMS projects approximately 17,000 active members and dependents will utilize this plan in FY 2021. Additional information on this new insurance option will be available in the annual Employee Benefits Handbook expected in April 2020.

When retirees reach the age of eligibility, they are enrolled in a Medicare Advantage plan of their choice (PPO or HMO). Starting in FY 2014, Medicare-eligible retirees and their Medicare-eligible dependents were moved into Medicare Advantage (MA) plans. Individual retirees and dependents have the choice of five different plans that range from MA HMO plans to a MA PPO plan. These plans became effective February 1, 2014 (Health Alliance MA HMO - 2015).

Retirees and dependents can still access benefits from the same dental, vision and life insurance plans that current State employees and dependents utilize. For FY 2021, CMS does not anticipate that the current benefits will be altered by the State. Proposed amendments to existing health insurance plan contracts are not anticipated to substantially affect the benefits received under the SEGIP. Appendix I provides further details regarding the types of health and dental plans offered by the State.

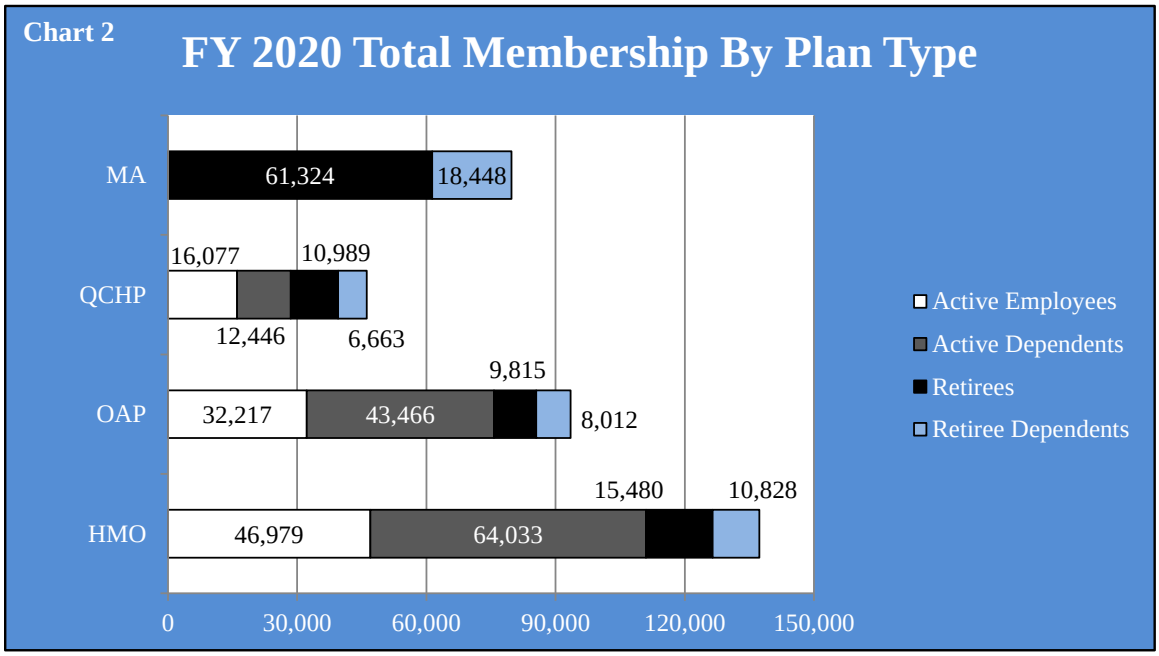
Basic life insurance is provided at no cost to employees, retirees and annuitants. Full-time employees receive coverage equal to their annual salary. Retirees and annuitants receive coverage equal to the annual salary as of the last day of employment until the age of 60, at which time the benefit amount 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.

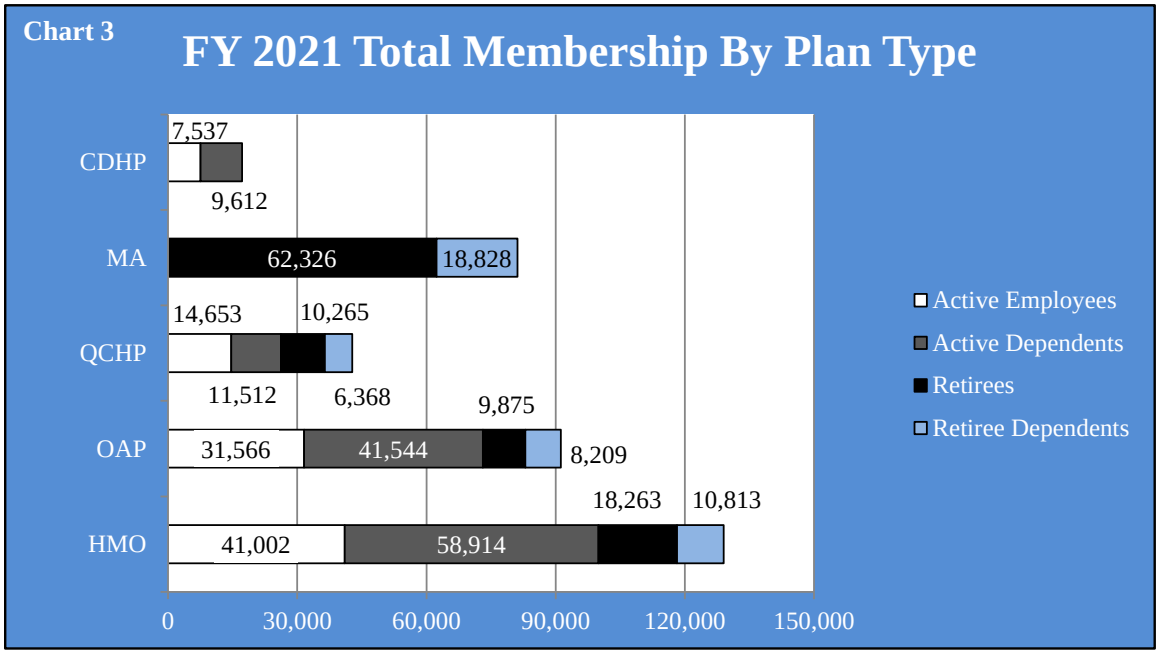
MEMBERSHIP

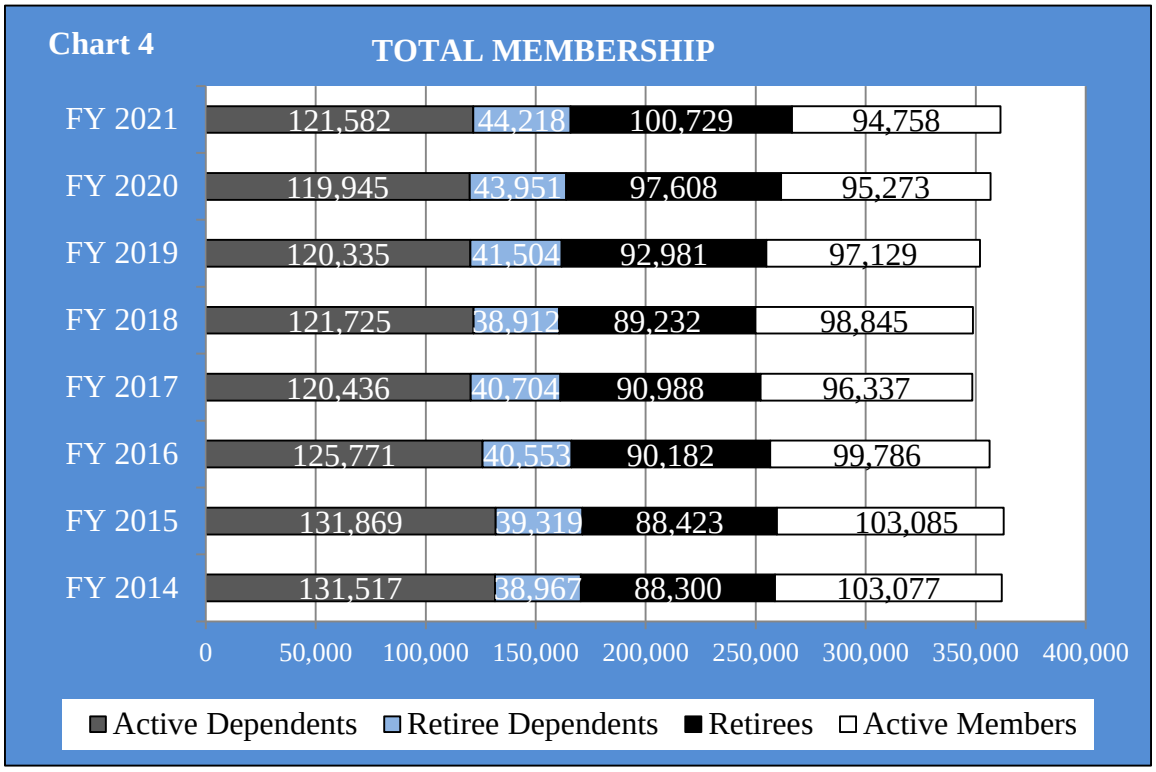
According to CMS, the State Employees' Group Health Insurance Program has an estimated 356,777 participants for FY 2020, of which 137,320 are in a non-Medicare Advantage HMO, 79,772 are in a Medicare Advantage HMO/PPO, 93,510 are in an Open Access Plan, and 46,175 are in the Quality Care Health Plan. The QCHP is estimated to have 16,077 employees, 12,446 active employee dependents, 6,663 retiree dependents, and 10,989 retirees in FY 2020.

HMO plans are estimated to have 46,979 employees, 64,033 active employee dependents, 10,828 retiree dependents, and 15,480 retirees in FY 2020. Medicare Advantage plans in FY 2020 include 18,448 dependents and 61,324 retirees. OAPs are anticipated to have 32,217 employees, 43,466 active employee dependents, 8,012 retiree dependents, and 9,815 retirees in FY 2020. This information is displayed in the chart on the next page.



For FY 2021, the QCHP is estimated to have 14,653 employees, 11,512 active employee dependents, 6,368 retiree dependents, and 10,265 retirees. Medicare advantage HMO/PPO plans are expected to have 18,828 dependents and 62,326 retirees. Non-Medicare Advantage HMO Plans are expected to have 41,002 employees, 58,914 active dependent lives, 10,813 retiree dependents, and 18,263 retirees. OAPs are expected to have 31,566 employees, 41,544 active dependents, 8,209 retiree dependents, and 9,875 retirees in FY 2021. The new Consumer Driven Health plan is projected to have 7,537 employees and 9,612 active employee dependents, which are primarily assumed to come from existing HMO plans. Total FY 2021 membership is expected to increase 1.3% from 356,777 to 361,287. This information is displayed in the following chart.





- **Membership (including CIP, TRIP, etc.) is estimated for FY 2021.**

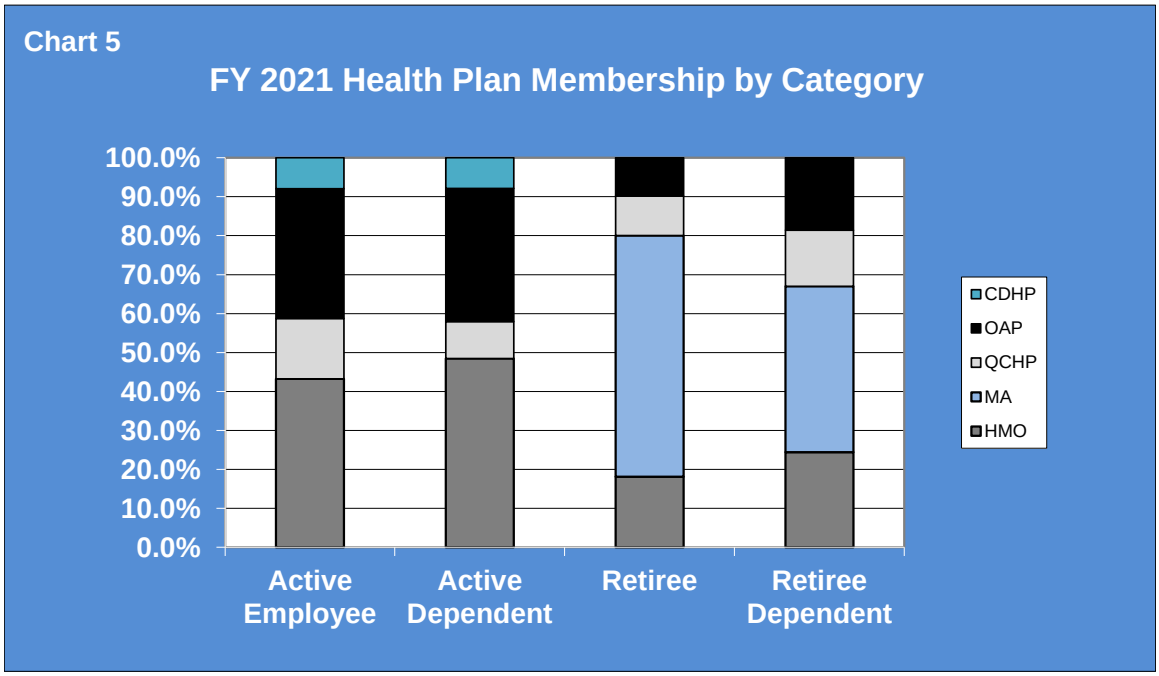
ENROLLMENT TRENDS

Membership in the Quality Care 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 transitioned away from traditional managed care (HMOs) to alternatives such as the Open Access Plan (OAP). This trend has stabilized and is reflected in FY 2020-FY 2021 membership projections by CMS. In recent years, the movement of retirees/dependents to Medicare Advantage plans has resulted in lower enrollment for both HMOs and OAPs.

For FY 2021, membership in HMOs is broken down by standard HMO membership and Medicare Advantage HMO/PPO membership. Though it has fluctuated over time, standard HMO membership is expected to continue to remain the highest population category among those measured (QCHP, OAP, etc.). Medicare Advantage HMO/PPO plans are expected to rise from 79,772 in FY 2020 to 81,154 for FY 2021. Membership is expected to grow in future years as retirees continue to qualify for Medicare Advantage.

Chart 5 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 less utilized among employees as a whole, especially retirees. In FY 2021, 61.9% of retirees are expected to enroll in a Medicare Advantage HMO/PPO. Chart 5 demonstrates that employees, retirees, and dependents from both

groups are moving towards managed care and Open Access Plans, though some are moving to the new CDHP.



LIABILITY

The Department's estimate of liability for FY 2021 represents a 2.1 percent increase from FY 2020, partly due to increases in OAP and Medicare Advantage liability, but also due in part to the inclusion of the new Consumer Driven Health Plan. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2011 through FY 2021 and demonstrates how several components make up 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, the majority of liability has been contained within the HMO, OAP, and QCHP sections. The Open Access Plan is anticipated to continue to have more liability for the State of Illinois than the QCHP and prescription components as a whole in FY 2021 ($921 million compared to $533 million).

The Interest Payments category has continued to decline in recent fiscal years due to large payments made in FY 2018/FY 2019, and is projected to amount to $33 million in FY 2021. However, the Administration/Other category has risen significantly over the past few fiscal years, primarily due to the rapidly increasing health insurance expenses for the Teamsters, who negotiated a health insurance arrangement outside of the rest of the participants in the group insurance program. The liability for this "opt-out" has risen from $6 million in FY 2015 to $125 million in FY 2020, though it is projected to decline to $102 million for FY 2021.

Other components of liability such as Mental Health, Vision, Dental, and Life Insurance are projected to mostly hold steady or change slightly from FY 2020 to FY 2021. 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.

Depending on the participation rate by active members and their dependents, the CDHP may become a significant component of overall liability, though it is only projected to amount to $113 million in FY 2021. In recent years, interest on payments has become a major issue for the State of Illinois, though the bond sale revenues in FY 2018 and FY 2019 were utilized to pay down most of that component of liability. The issue of state interest payments and paying down those liabilities is addressed in the following section of this report.

Table 4 STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY (CMS ESTIMATE) (FY 2012-FY 2021)

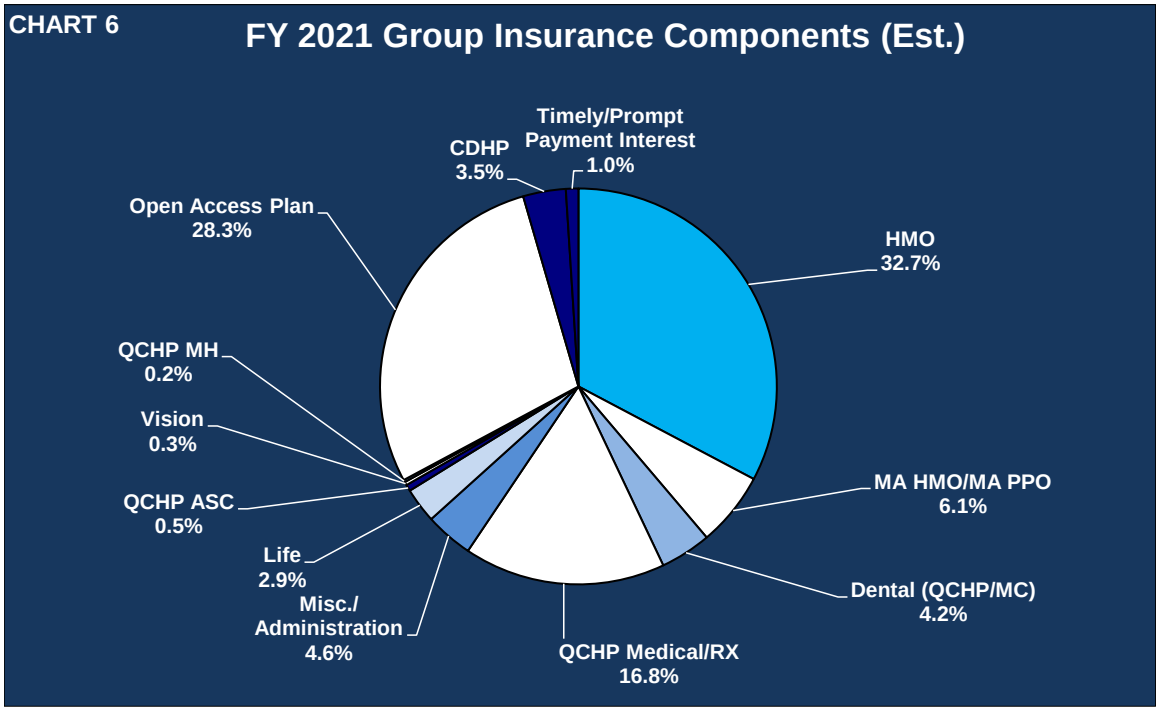
$ in (millions)

Liability Component	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021 (Proposed)
QCHP Medical/Rx	$750	$731	$598	$493	$488	$482	$496	$513	$545	$534
HMO Medical	$853	$894	$910	$917	$934	$975	$1,036	$1,067	$1,093	$1,064
Medicare Advantage	$0	$0	$62	$154	$168	$183	$200	$197	$186	$197
Dental	$115	$118	$118	$118	$115	$110	$115	$121	$128	$135
Open Access Plan	$528	$582	$616	$657	$670	$702	$768	$835	$900	$921
CDHP	$0	$0	$0	$0	$0	$0	$0	$0	$0	$113
QC Mental Health	$7	$7	$7	$5	$5	$5	$6	$6	$6	$6
Vision	$11	$12	$11	$11	$8	$8	$8	$8	$8	$9
Life Insurance	$83	$84	$88	$95	$91	$90	$90	$88	$91	$93
QC ASC	$30	$32	$26	$19	$18	$17	$18	$17	$18	$17
Interest Payments	$50	$112	$130	$221	$262	$195	$274	$105	$52	$33
Admin/Other	$12	$15	$48	$73	$53	$103	$120	$137	$151	$127
Total	**$2,440**	**$2,587**	**$2,614**	**$2,764**	**$2,812**	**$2,870**	**$3,131**	**$3,094**	**$3,178**	**$3,249**
% change over PY	**4.0%**	**6.0%**	**1.0%**	**5.7%**	**1.7%**	**2.1%**	**9.1%**	**-1.2%**	**2.7%**	**2.2%**

Source: CMS. Rounding causes slight differences in totals.

Chart 6 includes the various components of the FY 2021 CMS liability estimate of approximately $3.249 billion. The largest component of the State Group Insurance Program continues to be the State's HMO, OAP, and MA HMO/MA PPO plans, which have grown to represent 67.1% of FY 2021 liability. The new Consumer Driven Health Plan (CDHP) is projected to amount to 3.5% of FY 2021 liability.

Dental care, life insurance, and vision care equal 7.4% of total liability, slightly up from 7.0% in FY 2020. The QCHP component (17.1%) is slightly lower than FY 2020 (18.4%) and includes medical/prescriptions, mental health coverage, and administrative service charges. For FY 21, interest payments are projected to be a small fraction of the overall liability (1.0%) of the components of Group Insurance liability, reflecting the near elimination of payment interest as a major liability issue for the SEGIP.



As the movement of retirees to MA HMO/PPO plans continues, it is 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, affordability, and migration requirement of MA HMO/PPO plans for the State of Illinois indicates that this area of liability is not likely to shrink in consistent size or proportion in the near future, though the addition of the CDHP is projected to draw a sizable number of health insurance users from existing plans.

In regard to Open Access Plans, they remain a popular 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. However, their cost to the State is likely to grow if more people migrate to OAPs. Many of these contracts are up for renewal in the 2021 fiscal year and numerous contracts will be completed/rebid in the next few fiscal years, the results of which may be reflected in participant rates and utilization in the future.

One important note regarding liability is the attempt by the State to address interest payment liabilities and the issue of "lost money," i.e. money that could be spent on other liabilities within the SEGIP. An increased GRF commitment to cover increased year-to-year liabilities paid down significant health insurance bill interest in FY 2020. The long-term impact on overall State finances of using a bond to pay the held bill interest from prior years is yet to be determined, but for the purposes of the SEGIP in FY 2021 and beyond, steady fiscal commitment from the State that accounts for liabilities will presumably allow the State to avoid a similar situation with interest payments from occurring in the future. In the event of the "reserved" $400 million not being accessible

to the SEGIP, current held bills totals on hand at CMS will likely rise unless additional funding is made available through either State action or a reduction in liabilities elsewhere in the program.

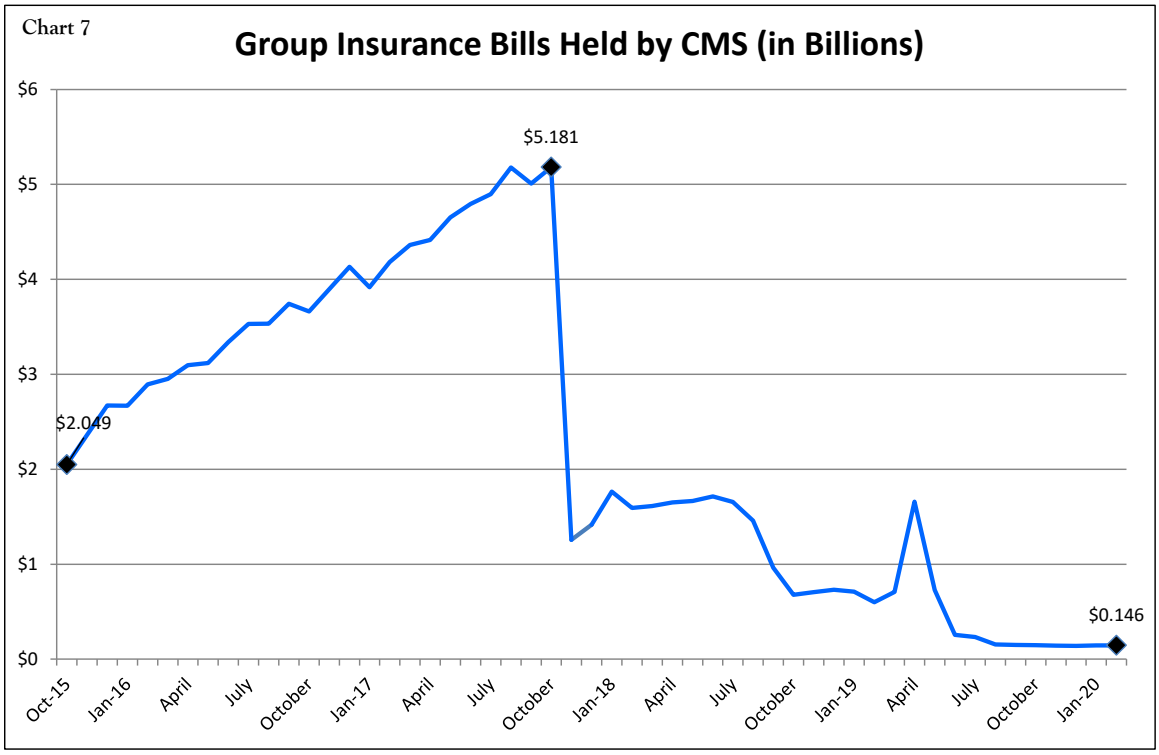
GROUP INSURANCE INTEREST AND BONDING

Since 2013, SEGIP interest payments have grown, sometimes at an alarming rate, as the State has been forced to push payments for services further and further into the future. This is done by "holding" claims until the actual money is available for payment. As a result, these "held claims" accrue interest at rates of 9 or 12 percent annually depending on the criteria of the claim. Timely Pay Interest (0.75% per month), as cited in the Illinois Insurance Code, covers QCHP, OAP, Dental, and Mental Health claims payments. This interest is calculated at 9.0% annually after an initial 30-day period.

Prompt Payment Interest (12.0%), as cited in the Prompt Payment Act, covers HMOs, Vision, Life Insurance, and administrative fees for the QCHP/OAP/Dental/Mental Health programs. This interest is calculated at 1.0% per month after an initial 90-day period. For example, claims in the QCHP, are typically paid out under the 9 percent calculation, while claims from HMOs are paid out at 12 percent. The administration's proposed FY 2021 budget includes a recommendation to reduce the Prompt Payment interest rate to a lower rate similar to five-year U.S. Treasury Bond rates. This action, if successful, would potentially lower the current 12 percent rate to as low as 1.5 percent (as of January 2020).

Further exacerbating the issue was the inability of the State to pass a budget into law in recent years. Without spending authority, CMS was unable to pay down FY 2016 and FY 2017 year claims and held them as they accrued additional interest. CMS utilized employee premium contributions to help defray some of these costs (as this source of revenue was determined to be legally spendable outside traditional appropriations), but the vast majority of incurred claims remained unpaid and continued to accrue interest, including past-due interest (interest on interest) in some situations.

A State budget was eventually passed into law and provided funding for FY 2018, but no additional funding was provided to pay down the enormous amount of held bills. At the end of October 2017, the State had approximately $5.181 billion in health insurance claims waiting to be paid out. However, in November 2017, a bond sale was issued to pay down SEGIP and Medicaid bills. The bond proceeds were used to pay off approximately $3.982 billion in held group insurance bills, bringing the total bills held by Illinois to $1.256 billion at the end of November 2017. This total has fluctuated since that time, but has trended downward in recent months. A chart displaying the historical backlog of Group Insurance bills is provided.



As of the end of February 2020, approximately $146 million in Group Insurance bills are being held by CMS awaiting transmission to the Comptroller's office for payment. Of that total, there are $106 million in HMO claims (including Medicare Advantage) awaiting payment, and approximately $3.6 million in interest payments has yet to be paid off. Open Access Plans claims account for $0 currently in claims (but approximately $545,000 in interest owed) and Aetna PPO (QCHP) claims account for $279,000 in interest owed.

Dental ($2.4 million), Life Insurance ($7.6 million), Other Fees ($3.2 million), and Prescription claims ($25.3 million) make up the majority of the remaining claims held by Illinois. Interest due on these debts amounts to $3.5 million as of the end of February, 2020. Current projections by CMS estimate a total of $8.2 million in interest liability (not including amounts sent to the Comptroller awaiting payment to vendors) at this point, considerably smaller than the total of $335.0 million in interest awaiting payment as recently as FY 2018. The table below details the major portions of the current claims hold situation with existing interest rates of 9 and 12 percent, as of February 2020.

Table 5 Claims Hold Data for SEGIP (as of February 29, 2020)			
Vendor	Claims Hold	Length of Claims Hold (in days)	Interest Owed (Including Past Due Interest)
Aetna - PPO	$0	83	$279,096
Dental Claims Hold – PPO	$672,287	83	$104,439
Dental - Non-PPO	$1,750,713	167	$474,790
Magellan (Mental Health) Claims	$341,427	41	$220,463
Aetna HMO	$7,107,637	4	$203,601
Health Alliance HMO	$52,704,179	4	$1,831,771
HMO Illinois	$22,948,195	400	$822,958
Blue Advantage	$7,508,634	4	$255,953
HealthLink OAP	$0	83	$410,125
Aetna OAP	$0	82	$134,600
CVS/Caremark	$25,317,654	13	$1,997,326
Aetna/Coventry MA	$975,793	4	$10,180
Health Alliance MA	$273,702	4	$3,966
Humana Benefit Plan MA	$22,012	4	$233
Humana Health Plan MA	$542,693	4	$5,648
United Healthcare MA	$14,239,176	4	$440,515
Fidelity (Vision)	$679,568	4	$9,224
Minnesota Life	$7,613,333	4	$0
Other (Fees/ASC/etc.)	$3,157,979	4	$963,984
Total	**$145,854,982**	**4-400**	**$8,168,872**
Source: CMS. MA stands for Medicare Advantage. Aetna represents Coventry, unless indicated otherwise.			

In regard to payment cycles, the 2021 fiscal year is projected to continue the hold cycle currently in place for the 2020 fiscal year at roughly the same durations for bills in question. The projected FY 2021 claims hold cycles are:

- AETNA claims: 130 days
- Managed Care claims: Approximately 4 months
- OAP/Prescription claims: 130 days
- Dental claims: 131 days for network claims, 191 days for non-network claims

This accounts only for the time for CMS to process claims and does not include time for the Comptroller to process and send out payment to the vendors in question. The Comptroller's timeliness depends on current cash flow needs and funds availability, which fluctuates daily. According to the Comptroller's office, as of the end of February 2020, they had approximately $789 million in vouchers awaiting payment as the cash flow becomes available.

New for the 2021 fiscal year is a proposal by the Governor to "reserve" a $400 million portion of group insurance General Revenue funding. This funding is intended to pay down historical held bills balances. According to the Governor's Office of Management and Budget, the $400 million would be moved into the General Revenue Fund if the proposed Constitutional Amendment to create a graduated income tax structure in Illinois in place of the current flat tax rate structure is not adopted by voters in the November 2020 election. In this scenario, it is presumed that held bill times would consequently increase.

ANNUAL LIABILITY PER PARTICIPANT

The liability per participant in the State Employees' Group Insurance Program is the total of the State's liability across all participants. Chart 7 shows the steady increase each year in cost per participant, though FY 17 through FY 19 deviate significantly from past fiscal years, in part due to the accumulation of held bills that temporarily inflated overall liability. As plan participants live increasingly longer lives, utilization of medical insurance plans (and thereby liabilities to the state) have tended to increase accordingly.

For FY 2012 – FY 2021 in Chart 7, this information is displayed without including interest payments in order to illustrate general medical plan trends more accurately. In earlier years, interest payments composed a much smaller portion of total liability than in recent years. Therefore, in FY 2012, the annual liability per participant in the group health insurance program was $6,678.

According to CMS, the liability per participant for FY 2020 will increase to $8,761, an increase of $270 over FY 2019. For FY 2021, the estimated liability per participant is $8,900, which represents a 33.3% increase over a ten-year period, continuing a sharply increasing trend since FY 2016.

The FY 2021 liability per participant is projected to increase 1.6% from FY 2020. It is necessary to note that this is only an aggregate liability representation, which is not itemized based on the types of plans used by participants or any other variables. While it is informative of general liability trends, it is not necessarily indicative of all medical inflation factors.

It is uncertain what the impact will be from the state introducing the Consumer Driven Health Plan for the 2021 fiscal year. While savings are expected for the state, the overall liability may remain on an upward trajectory due to extraneous factors such as demographics and medical service utilization. It is likely that absent a major change in these areas, overall liability and liability per participant will rise from year to year.

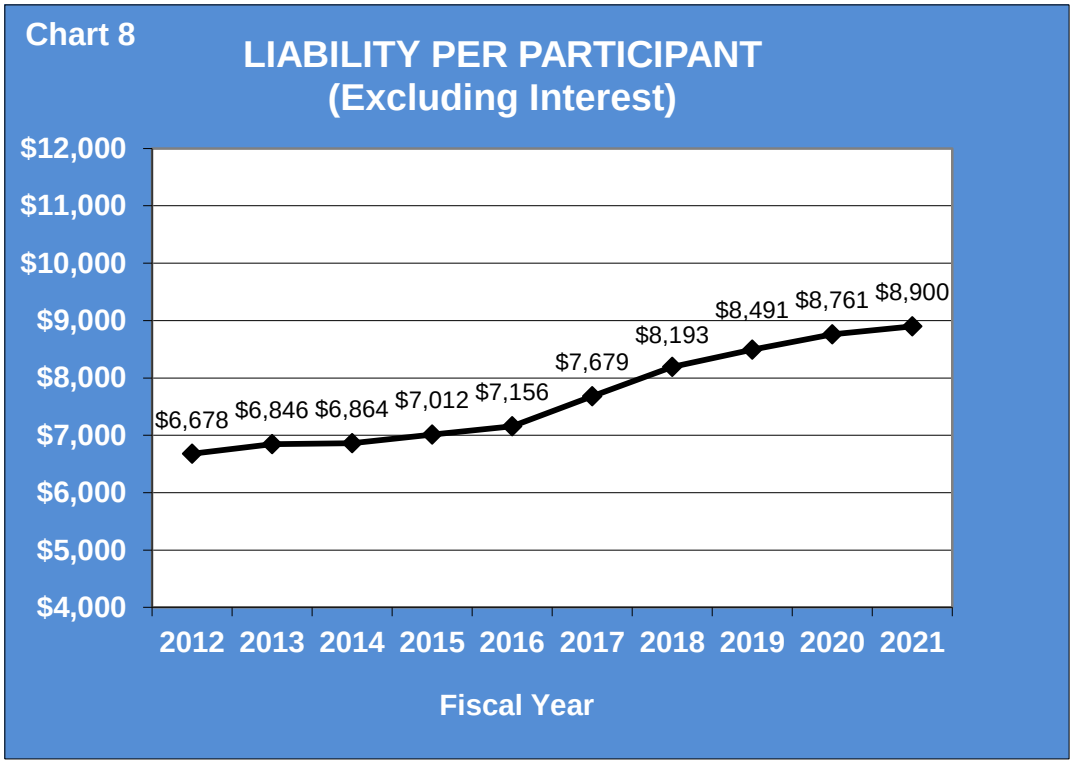


Table 6: ANNUAL LIABILITY PER PARTICIPANT

	FY 2020	FY 2021	FY 2020	FY 2021
	Total Participants	Total Participants	Liability Per Participant	Liability Per Participant
QCHP	46,175	42,798	$12,243	$12,938
MA HMO / PPO	79,772	81,154	$2,336	$2,429
HMO	137,320	128,992	$7,956	$8,245
OAP	93,510	91,194	$9,628	$10,104
CDHP	0	17,149	$0	$6,588
Totals	**356,777**	**361,287**		

OAP is the Open Access Plan. CDHP is the Consumer Driven Health Plan. ALPP does not include dental, vision, admin/interest/other, or life insurance. Numbers are not adjusted for risk.

When comparing annual liability per participant (ALPP) in Table 6, the annual liability for FY 2021, as in FY 2020, is lowest for members in the Medicare Advantage HMO and highest for members in the QCHP. The total number of participants in the QCHP has declined in recent years, especially in FY 2014 – FY 2015 as people have steadily migrated to HMOs and OAPs. 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 more expensive to cover (requiring more treatment, medicines, etc.). The QCHP is also the preferred plan for retirees and dependents who live or travel primarily out of Illinois, as traditional HMOs/OAPs have limited coverage outside the state. This results in the higher projected liability for QCHP participants (compared to others) in FY 2021. OAPs remain higher than HMOs, but lower than the QCHP.

MEMBER CONTRIBUTIONS

An important factor in the examination of cost per participant is the amount paid by the State versus the member. The Average Liability per Person (ALPP) per enrollee in the QCHP is $11,860 in FY 2020. Member contributions for QCHP enrollees are expected to total $70 million. This means that of the total cost per participant, $1,520 or 12.8% of that cost is covered by member contributions. Prior to the *Kanerva* decision by the Illinois Supreme Court, retirees were contributing part of their pension income towards their group insurance coverage. However, since that court decision, contributions from retirees have dropped sharply from the set of retirees with 20 years or more of service, who are exempt from health insurance contribution deductions from their pension income. In addition, many retirees (starting in FY 2014) have been moved out of QCHP towards a Medicare Advantage HMO/PPO plan. This 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). While lower, the other medical plans (Traditional HMOs, Medicare Advantage HMOs, and Open Access Plans) also have significant average liabilities per participant which are only partially offset by member contributions. Table 7 examines the relationship between overall cost and the offset by member contributions for FY 2020 and FY 2021.

TABLE 7: MEMBER CONTRIBUTIONS AND AVERAGE LIABILITY PER PARTICIPANT PER YEAR (ALPP)

	FY 2020 ALPP	FY 2020 Member Contributions	FY 2020 State Liability	FY 2021 ALPP	FY 2021 Member Contributions	FY 2021 State Liability
QCHP	$12,243	$1,512	$10,731	$12,938	$1,711	$11,227
MA HMO/PPO	$2,336	$381	$1,956	$2,429	$385	$2,044
HMO	$7,956	$970	$6,986	$8,245	$1,240	$7,005
OAP	$9,628	$1,039	$8,589	$10,104	$1,463	$8,640
CDHP	$0	$0	$0	$6,588	$1,309	$5,279
Dental	$361	$94	$267	$376	$104	$272

Source: CMS.

The table above shows that QCHP members are expected to contribute 13.2% of the overall annual cost of providing their insurance in FY 2021. HMO/OAP/MA HMO (and PPO) members are expected to contribute 15.0%, 14.5%, and 15.9% of their overall liability cost in the same time period. New members of the Consumer Driven Health Plan are estimated to contribute 19.9% of the overall liability, a higher proportion than the other options. Members that participate in the State's dental offering are expected to pay 27.7% percent of the overall liability cost, a slight increase from 26.0% in FY 2020. 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. Liability may also change slightly year to year based on expenses incurred in a particular fiscal year from paying down held bills in a particular category (HMOs/etc.).

For example, the Dental line in Table 7 may be slightly higher due in part to extra dental liabilities being incurred/paid off in a particular fiscal year. A stable budget that promptly pays down these liabilities would help alleviate this issue, though some liabilities will always be incurred in future fiscal years due to the natural billing cycle between providers, CMS, and the Comptroller's office.

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. The Illinois Supreme Court decision in *Kanerva* resulted in reduced contributions for many retirees. Table 8 displays a comparison of the costs for these groups taken from data obtained from CMS as of February 2020.

TABLE 8: RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 21 (Numbers in Millions)

Category	Cost	Category	Cost
Retiree Cost	$822.4	Active Employee Cost	$1,209.4
Retiree Contribution	-$42.0	Active Employee Contribution	-$233.6
Other Revenues	-$17.0	Other Revenues	-$38.7
Net State Cost	**$763.4**	**Net State Cost**	**$937.0**
Retiree Dependent Cost	$320.0	Active Employee Dependent Cost	$896.8
Retiree Dependent Contribution	-$62.9	Active Employee Dependent Contribution	-$114.1
Other Revenues	-$10.7	Other Revenues	-$30.8
Net State Cost	**$246.4**	**Net State Cost**	**$751.9**
Total Retiree Cost	$1,142.4	Total Active Cost	$2,106.2
Total Retiree Contribution	-$104.9	Total Active Contribution	-$347.7
Other Revenues	-$27.7	Other Revenues	-$69.5
Total State Cost	**$1,009.8**	**Total State Cost**	**$1,688.9**

Source: CMS

Based on data provided by CMS, retiree dependents (but not 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 2021,

retirees and retiree dependents are projected to pay 5.1% and 19.7% of their healthcare costs, a decrease from 6.0% and 20.2% in FY 2020. This contrasts with active employees and their dependents, who are projected to pay 19.3% and 12.7% of their healthcare costs, a rise for active employees and a minimal increase for active employee dependents compared to 16.9% and 12.6% respectively in FY 2020. In total, the contributions of active employees and dependents (16.5%) remain significantly higher as a percentage than retirees and retiree dependents (9.2%). This cost difference results in part from retirees utilizing Medicare Advantage HMO and PPO plans and resulting savings for the State of Illinois and increased contributions for active employees and their dependents in FY 2021.

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 2019, FY 2020, and FY 2021 plan enrollment is listed in Table 9.

TABLE 9: MANAGED CARE PLANS FY 2019-2021 All Lives (Active Members/Dependents and non-MA Retirees/Dependents)					
HMO/OAP	FY19 # of Participants	FY20 # of Participants	% Change 2019-2020	FY21 # of Participants	% Change 2020-2021
Health Alliance HMO	73,501	72,495	-1.37%	65,781	-9.26%
HMO Illinois	43,082	41,175	-4.43%	38,533	-6.42%
Blue Advantage	12,405	14,127	13.88%	14,795	4.73%
Aetna/Coventry Health Care HMO	8,410	9,523	13.23%	9,883	3.78%
Aetna/Coventry Health Care OAP	24,852	28,380	14.20%	32,077	13.03%
Health Link OAP	65,505	65,130	-0.57%	59,117	-9.23%
Consumer Driven Health Plan HDHP	0	0	N/A	17,149	N/A
TOTALS	**227,755**	**230,830**	**1.35%**	**237,335**	**2.82%**
Source CMS. FY 21 numbers are projected as of February 2020.					

The Consumer Driven Health Plan is expected to draw some people out of existing plans, but migration is also expected towards HMOs and lower-priced options in general. Under the new contracts signed between the state and employee unions, rate increases are expected for existing plans with higher rates expected for more expensive plans rather than the traditional equivalency between HMO and OAP options. This is discussed in further detail in the Monthly Premiums section of this report.

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 (MA) 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. Table 10 shows the population figures involved with this new program.

TABLE 10: MEDICARE ADVANTAGE PLANS FY 2019-2021			
HMO/PPO	FY19 # of Participants	FY20 # of Participants	FY21 # of Participants
Aetna HMO	4,720	4,840	4,876
Humana Benefit Plan HMO	137	140	143
Humana Health Plan HMO	3,233	3,426	3,581
Health Alliance HMO	1,392	1,568	1,711
United HealthCare PPO	68,366	69,798	70,843
TOTALS	**77,848**	**79,772**	**81,154**
Source: CMS. FY 21 numbers are projected as of February 2020.			

It is important to note that except for a limited number of retirees and dependents coming from a HMO or OAP program, most of the 81,154 people projected to be covered in FY 2021 by a MA HMO or PPO plan will come from the QCHP. In regard to MA, there are

two different HMO benefit plans being offered by Humana as Humana Benefit Plan is intended for Livingston and Knox counties while Humana Health Plan is a traditional open area Medicare Advantage plan. The Health Alliance HMO plan was first offered during the 2015 fiscal year. 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.

In recent years, efforts have been made to increase member/employee contributions to pay for a larger portion of the costs of providing health coverage. For the 2021 fiscal year, after negotiations with public employee unions, premiums for HMO/OAP/QCHP options will increase substantially, with most plans experiencing an increase of between $10 to $40/month depending on demographic option and individual plan chosen. Under this arrangement, HMO premiums are generally substantially lower than OAP premiums, though individual demographic cohorts within specific plans may be more comparable.

TABLE 11: PROJECTED MONTHLY COSTS FY 2014 - FY 2021 Employee Only								
	QCHP				CDHP			
	TOTAL	% Inc.	Member	State	TOTAL	%Inc.	Member	State
FY14	$812	2.3%	$166	$646	N/A	N/A	N/A	N/A
FY15	$860	5.9%	$168	$692	N/A	N/A	N/A	N/A
FY16	$896	4.2%	$170	$726	N/A	N/A	N/A	N/A
FY17	$921	2.9%	$169	$753	N/A	N/A	N/A	N/A
FY18	$924	0.2%	$168	$756	N/A	N/A	N/A	N/A
FY19	$1,017	10.0%	$168	$848	N/A	N/A	N/A	N/A
FY20	$1,088	7.0%	$168	$920	N/A	N/A	N/A	N/A
FY 21	$1,150	5.7%	$215	$935	$736	N/A	$153	$584
	HMO				OAP			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY14	$679	5.8%	$121	$557	$597	2.0%	$121	$475
FY15	$671	4.5%	$125	$546	$761	5.8%	$124	$638
FY16	$699	4.1%	$126	$573	$774	1.7%	$125	$649
FY17	$749	7.3%	$126	$623	$850	9.8%	$125	$725
FY18	$800	6.7%	$126	$674	$933	9.8%	$125	$808
FY19	$822	2.8%	$126	$696	$977	4.7%	$125	$851
FY20	$837	1.8%	$127	$710	$1,015	3.9%	$128	$887
FY 21	$859	2.6%	$174	$685	$1,055	3.9%	$200	$855

Table 11 displays the gradual increases in total monthly costs to the State for providing the three main types of health insurance plans for members/dependents from FY 2014 to the significantly increased projected values for members in FY 2021. Whether members are in the QCHP, a traditional HMO, or an Open Access Plan, the monthly cost of such plans has steadily increased. Concurrently, the employee premiums for these plans have also increased, though at a much lower rate year-to-year until recently. Interestingly for FY 2021, the employee contributions are projected to cause the total cost of health insurance provision for HMO plans to the state to decrease somewhat. However, the total costs and projected member contributions of the proposed Consumer Driven Health Plan (a HDHP) are still lower than other alternatives.

Table 12 displays the projected monthly rates for the provision of health plans across the QCHP/HMO/OAP spectrum along with the projected State and member contributions expected for the 2021 fiscal year. As in previous years, members/dependents are expected to pay a relatively small portion of total monthly rates compared to the total cost of health insurance coverage, though the increased contributions agreed to as a result of labor negotiations may reduce that gap over time.

TABLE 12: MONTHLY PREMIUMS QCHP / CDHP / HMO / OAP Weighted Average FY 2021 Rates (Projected for Median Salary)						
	QCHP			CDHP		
	TOTAL	Member	State	TOTAL	Member	State
Employee	$1,150	$215	$935	$736	$153	$584
Medicare Retiree	$618	$19	$599	$0	$0	$0
Non-Medicare Retiree	$1,732	$24	$1,708	$0	$0	$0
1 Dependent	$1,452	$256	$1,196	$684	$138	$547
2+Dependents	$1,800	$299	$1,501	$1,059	$185	$875
Medicare Dependent	$733	$151	$582	$525	$112	$413
	HMO			OAP		
	TOTAL	Member	State	TOTAL	Member	State
Employee	$859	$174	$685	$1,055	$200	$855
Medicare Retiree	$555	$27	$528	$706	$27	$679
Non-Medicare Retiree	$1,222	$16	$1,206	$1,601	$16	$1,586
1 Dependent	$719	$148	$570	$897	$163	$734
2+Dependents	$1,244	$195	$1,049	$1,537	$214	$1,323
Medicare Dependent	$569	$125	$444	$707	$137	$570

As with Employee-only premium projections and concomitant costs, premiums for all applicable active SEGIP member and dependent cohorts are expected to rise at a higher rate for FY 2021 than in previous years. It is important to note that despite this increase and the traditional cost differential between plans, certain HMO/OAP/CDHP options may have a lower projected median premium than their traditionally less-expensive contemporaries.

TABLE 13: MONTHLY PREMIUMS ACROSS ALL PLANS HMOs / OAPs / CDHP FY 2021 Proposed Rates							
Median Salary	Health Alliance	Aetna HMO	HMO Illinois	Blue Advantage	HealthLink OAP	Aetna OAP	CDHP
Employee	$195.28	$148.79	$163.56	$135.15	$209.63	$184.97	$137.29
Medicare Retiree	$27.09	$27.09	$27.09	$27.09	$27.09	$27.09	N/A
Non-Medicare Retiree	$15.67	$15.67	$15.67	$15.67	$15.67	$15.67	N/A
1 Dependent	$160.72	$161.77	$132.17	$127.32	$167.53	$154.60	$137.50
2 +Dependents	$210.44	$208.16	$175.03	$165.99	$220.54	$200.98	$184.55
Medicare Dependent	$134.00	$135.00	$108.00	$104.00	$140.00	$128.00	N/A

Table 13 displays the average projected rates for employees, retirees, and dependents across all the HMO, OAP, and CDHP options. 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, etc. The new Consumer Driven

Health Plan (CDHP) option will have lower rates than most other options due to its unique characteristics, but it is limited to active employees and their dependents only.

Unlike previous years, for FY 2021, plan rates are anticipated to be set by the particular plan type and optional demographic option, rather than a generally similar rate across all HMOs and OAPs. Accordingly, there is an approximate $70/month spread between the different plans in Table 13, with different plans having lower rates than others depending on the particular demographic components of the plan being considered. For example, while the CDHP is projected to have lower rates than most other plans in the table, the average rate for Employee-only and 1 Dependent plans make other HMOs and OAPs potentially more desirable. It is expected that competition between the various health insurance vendors will lead to more competitive rates in future fiscal years.

Table 14 shows a comparison between FY 2019, FY 2020, and projected FY 2021 MA rates for retirees and dependents. Unlike non-Medicare Advantage plans, limited increases are expected for the rates in the Medicare Advantage SEGIP plans.

TABLE 14: MONTHLY PREMIUMS FOR STATE MEDICARE ADVANTAGE PLANS
FY 2019-2021 Rates (As of February 2020)

Aetna HMO	FY 2019	FY 2020	FY 2021
Medicare Retiree	$7.92	$8.37	$8.71
Two of More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91
Humana Benefit Plan HMO	FY 2019	FY 2020	FY 2021
Medicare Retiree	$7.92	$8.37	$8.71
Two of More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91
Humana Health Plan HMO	FY 2019	FY 2020	FY 2021
Medicare Retiree	$7.92	$8.37	$8.71
Two of More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91
United HealthCare	FY 2019	FY 2020	FY 2021
Medicare Retiree	$8.35	$9.12	$9.49
Two of More Dependents	$155.00	$155.00	$155.00
Medicare Dependent	$110.00	$110.00	$110.00
Health Alliance HMO	FY 2019	FY 2020	FY 2021
Medicare Retiree	$7.92	$8.37	$8.71
Two of More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91

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 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 for preventative services. 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 and plan choice, 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/coinsurance levels vary. Premiums vary based on salary and plan choice.	Statewide coverage
MA HMO	Comprehensive medical benefits including preventive care.	Prepaid benefits, primary care physician who coordinates all care chosen from HMO network.	Statewide coverage
MA PPO	Comprehensive medical benefits including preventive care.	Choice of physician and other medical care providers.	Statewide coverage
CDHP	High-deductible health plan. Significantly lower premiums compared to traditional HMO/PPO/etc. plans.	$1500 deductible required before health services are covered. Network providers and coverage options. Similar provisions to HMO plans.	Statewide coverage

APPENDIX II

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 5 one-year renewals. 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.

Status of Contracts for FY 21 at DCMS		
Service	**Vendor**	**Contract Term Details**
Managed Care Health Plans	Health Alliance HMO / Aetna HMO / Aetna OAP / Healthlink OAP / BC HMO Illinois / BC Blue Advantage	**Renew** - Term goes to June 30, 2020 with one 1-year renewal.
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, 2020 with up to two 1-year renewals.
Self-Insured Medical Plan Administration	Aetna	**Ongoing -** Term goes to June 30, 2021 with up to five 1-year renewals
Vision	EyeMed	**Renew** - Term goes to June 30, 2020 with up to five 1-year renewals.
Behavioral Health/EAP	Magellan	**Ongoing** - Term goes to June 30, 2021.
Life Insurance	Securian Life (formerlyMinnesota Life)	**Ongoing** - Term goes to June 30, 2021.
Flexible Spending	ConnectYourCare	**Ongoing -** Term goes to June 30, 2023
Administration of Dental Claims	Delta Dental	**Ongoing** - Term goes to June 30, 2021.
Prescription Drugs	CVS/Caremark	**Ongoing -**Term goes to June 30, 2024.
Commuter Savings Program	Edenred	**Renew** - Term goes to June 30, 2020 with up to five 1-year renewals.

APPENDIX III

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
Springfield, Illinois 62706
(217) 782-5320
(217) 782-3513 (FAX)
http://cgfa.ilga.gov