

FY 2022 LIABILITIES OF THE STATE EMPLOYEES' GROUP HEALTH INSURANCE PROGRAM



COMMISSION ON GOVERNMENT
FORECASTING & ACCOUNTABILITY

MARCH 2021

*Commission on Government
Forecasting and Accountability*

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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 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 2022 fiscal year indicating a continuation of the existing contracts in place as well as negotiated rate increases for group insurance participants. The Department is expected to continue the recently introduced 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 accordance with public employee union negotiations, current health insurance plan rates will differ depending on the specific plan chosen. This continues the change from historically 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 2022 fiscal year, the GRF appropriation is projected to be \$1.851 billion for SEGIP, with total expected revenues projected at approximately \$3.083 billion. CMS estimates the FY 2022 liability to be \$3.070 billion, which is a 0.8% increase from the FY 2021 anticipated final liability of \$3.046 billion. Noting these predictions, the Commission has presumed that liabilities and revenues will follow trends from FY 2021 and previous fiscal years and estimates a total SEGIP liability of \$3.092 billion in FY 2022, \$21.3 million more than CMS.

For FY 2022, revenues and expenditures are projected to continue trends from FY 2021 in most categories. Member contributions are projected to increase to \$547 million, compared to \$500 million in FY 2021, a \$47 million increase. Reimbursements are also projected to increase slightly, from \$391 million in FY 2021 to \$398 million for FY 2022. This is partially offset by a lower appropriation from the Road Fund of \$131 million for FY 2022 compared to \$172 million in FY 2021. Projected liability changes include continued reduction in Prompt Payment Interest (with a projected increase in Timely Payment Interest offsetting the reduction) and HMO liability. However, increases are expected in QCHP, OAP, CDHP, Dental, and Medicare Advantage liability. Most of these increases are relatively small and will be discussed along with revenue later in this report.

Continuing the welcomed trend (compared to only a few years ago), projected hold times and delays in processing payments to healthcare vendors and insurance companies are expected to increase only slightly compared to FY 2021. Most self-insured vendors are projected to have an approximate hold time of five months on their bills at CMS while the QCHP and OAP are projected to have hold times of 156 and 160 days, respectively.

As with all sectors of the economy, including personal health decisions, COVID-19 had an effect on the SEGIP in FY 2021, though not necessarily what might otherwise be expected. According to industry analysis by the Segal Trend Survey, the suspension of most non-essential care to prioritize COVID-19 care significantly offset costs for health plans. Many procedures and services which might otherwise have been performed and utilized were delayed or cancelled entirely, reducing overall costs for health insurers. For Illinois and the SEGIP, it is yet to be determined whether those delayed/cancelled services are simply pushed into FY 2022, absent a reoccurrence of COVID or similar health service constraining outbreak.

GRF APPROPRIATION/REVENUE AND LIABILITY HISTORY FY 2015-2022			
(\$ in Millions)			
Fiscal Year	Appropriation		
	Received	Revenues	CMS Liability
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	\$2,872.0
FY 2018	\$1,340.0	\$6,306.6	\$3,149.8
FY 2019	\$2,176.2	\$3,198.0	\$3,108.6
FY 2020	\$2,440.2	\$3,699.1	\$3,078.6
FY 2021**	\$1,856.5	\$3,070.6	\$3,045.6
FY 2022**	\$1,851.5	\$3,082.6	\$3,070.6

*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 2021 and projected for FY 2022. FY 2018 included bond revenue to pay down held bills and FY 2020 included interfund borrowing for the same purpose.

FY 2022 PROPOSED PLAN CHANGES

For FY 2022, the State is not expected to introduce new changes to the existing health insurance plan arrangement utilized by employees, retirees, and dependents. Premiums are expected to increase in line with labor negotiations and the health plan premium graduation introduced in FY 2021. The Consumer Driven Health Plan (CDHP) is expected to continue and increase in utilization in FY 2022, as the benefits for younger users continue to be attractive compared to more robust and costly plans. Different types

of plans (based on choices between individual and multiple dependent plans) will also continue to have a variety of rates. These rates will be detailed later in this report.

FY 2022 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) utilizes the CMS forecast for FY 2022 medical costs as the basis for estimating costs for FY 2022 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)	1.8%
Dental (QCHP and MC)	3.4%
HMO (Medical and Rx)	-5.4%
Prescription drugs (QCHP)	-0.2%
Open Access Plan	7.8%
Life Insurance	3.4%

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, negotiated increases in employee contributions and co-payments, and the creation of the CDHP 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, OAPs, and (more recently) the CDHP, 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 liability increases for the Open Access Plan, QCHP, CDHP, and Dental plans. The OAP line is expected to rise to \$954 million in FY 2022, a 7.0% increase from FY 2021 (\$891 million) while QCHP plan liability is projected to rise 0.6% from \$513 million in FY 2021 to \$516 million in FY 2022. The new CDHP is projected to rise from \$10.5 million in FY 2021 to \$20.5

million in FY 2022, though this is partly due to the program starting up and projected migration from other plans increasing liabilities. Dental plan liability is also projected to rise 2.6% from \$114 million in FY 2021 to \$117 million in FY 2022. HMO liability is projected to decrease \$60 million, from \$1.08 billion in FY 2021 to \$1.02 billion in FY 2022, which is the lowest it would be in the past five fiscal years. Medicare Advantage liabilities are projected to decrease also, from \$175 million in FY 2021 to \$161 million in FY 2022.

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 2021 Segal Health Plan Cost Trend Survey.

- For 2021, health plan cost increases are expected to outpace inflation and wage increases as price increases on the part of providers continue to be the primary driver for medical and pharmaceutical trends. In other words, the pace of health plan cost increases is increasing faster than increases in consumers' wages can keep up
- Vision and dental coverage options are projected to be lower or stay the same for the 2021 calendar year.
- For 2021, health plans are projected to increase over 2020 by 6.6% to 7.7% depending on plan type, with HMO-style plans on the lower end of the scale and PPO-style open access plans on the upper end.
- Prescription drug coverage is expected to increase in 2021, with specialty drugs expected to increase by as much as 11.5%.
- Medicare Advantage plans and prescription coverage options are projected to increase in 2021 between 3.9% and as much as 7.0%.
- Projected trends historically have been higher than actual results, though in recent years, the gap between both has been shrinking significantly.

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 2021			
Component	National Trend	CMS Estimate	COGFA Estimate
HMOs	6.6%	-5.7%	-5.4%
Rx	7.3%	-1.2%	-0.2%
Dental	2.6%	3.1%	3.4%
Vision	2.1%	1.2%	1.2%

Source: Segal 2021 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 usually tend to be lower in the aggregate.

The difference between national trends and state-level healthcare insurance trends can be seen in Table 1. 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, including the dispersal of Illinois HMO costs between traditional HMOs, the new CDHP, and Medicare Advantage (MA) HMOs. This 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. Combined with the movement of individuals into the CDHP, Illinois state employees/dependents/retirees have more and less expensive options than in previous years which has translated to much lower overall cost increases to the State than might otherwise be expected from the aforementioned medical plan trends in the Segal survey.

In addition, CMS and CGFA trend estimates include programmatic effects that likely affect estimates beyond normal market trends. For example, HMO liability continues to decrease for both CGFA and CMS projections for FY 2022 while increasing on the national level. This contradiction is due to expectations for migration to the Consumer Driven Health Plan and other factors independent of national trends but specific to Illinois. In addition, the CDHP has been available for state employees for only one year and is expected to become better known and utilized in the future. This utilization is expected to help lower overall liabilities for existing non-CDHP plans.

In reference to dental and vision plan costs in Table 1, for Illinois, these costs tend to remain relatively stable year to year, with dental liability projected to increase \$3 million between FY 2021 and FY 2022. Vision liability is projected to increase less than \$100 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, depending on the years examined. **Based on these assumptions, trends, and inflation factors, CGFA estimates a FY 2021 liability of approximately \$3.092 billion for the State Employee’s Group Health Insurance Program.** Table 2 shows a detailed comparison of the CGFA estimate for the various cost components and the CMS projection for FY 2021, though minor program component lines have been combined for easier viewing and analysis.

TABLE 2: FY 2022 GROUP HEALTH INSURANCE LIABILITY			
(\$ in Millions)			
Liability Component	FY 2021 CMS Estimate	FY 2022 CMS Projection	FY 2022 CGFA Projection
QCHP Medical	\$366.5	\$371.2	\$373.2
QCHP Prescriptions	\$126.6	\$125.1	\$126.3
Dental (QCHP/MC)	\$110.3	\$113.8	\$114.0
HMO	\$1,081.8	\$1,019.7	\$1,023.7
Medicare Advantage HMO/PPO	\$174.6	\$161.4	\$162.4
Open Access Plan	\$891.3	\$954.2	\$961.1
Consumer Driven Health Plan (HDHP)	\$10.5	\$20.5	\$20.9
Mental Health	\$5.5	\$5.6	\$5.7
Vision	\$8.5	\$8.6	\$8.6
Administrative Services (QC)	\$17.6	\$17.0	\$17.4
Life	\$95.0	\$98.2	\$98.2
Special Programs (Admin/Int./Other)	\$157.4	\$175.4	\$180.5
TOTAL	\$3,045.6	\$3,070.7	\$3,092.0
% increase over prior year	-1.1%	0.8%	1.5%
*Rounding may cause slight differences. FY 2021 and FY 2022 Special Programs line includes Prompt Payment and Timely Payment Interest.			

ESTIMATE COMPARISON

Overall, the Commission’s FY 2022 estimate is \$21.3 million higher than the FY 2022 estimate from CMS. CGFA’s FY 2022 HMO and Open Access Plan liabilities estimates are \$4.0 million and \$6.9 million higher than CMS, respectively. CGFA’s FY 2022 estimate for the Quality Care Health Plan Medical line is \$2 million higher than the CMS estimate. The Commission’s estimate for Special Programs (Interest, Admin, etc.) is \$5.1 million higher than CMS.

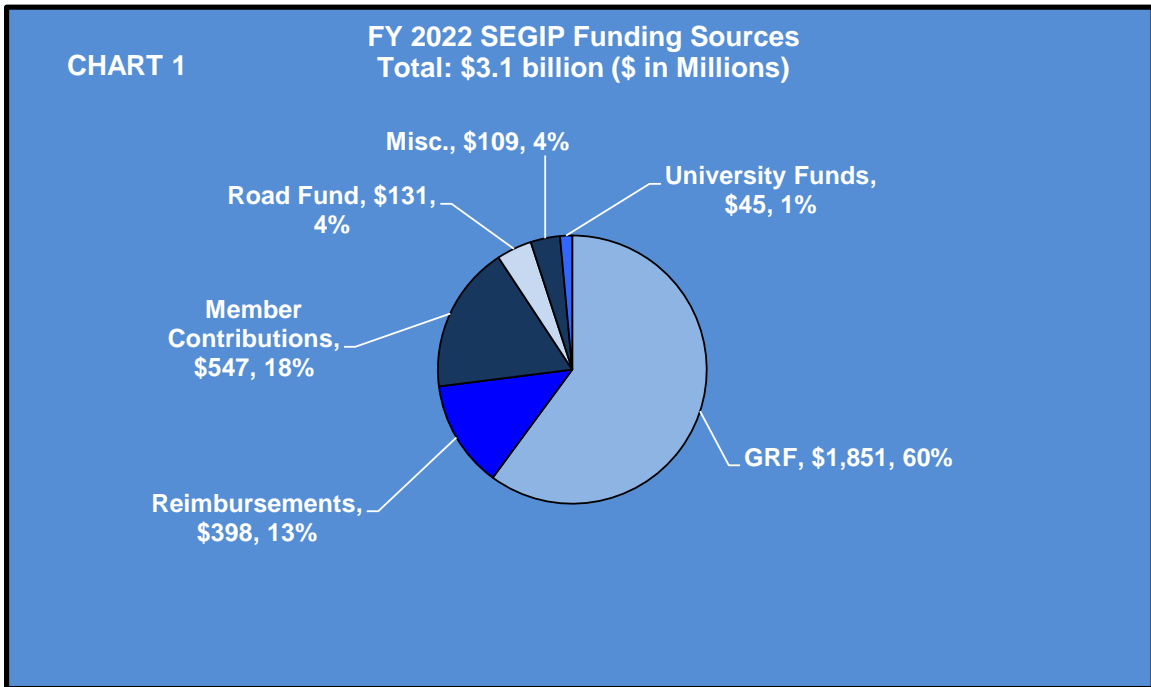
It is important to note that the FY 2022 group insurance liability estimates between CMS and CGFA are very similar to each other, with less than a one-percent total difference between them. This consistency in estimates is reflective of the general trends in healthcare insurance and the relative stability in overall plan design changes anticipated for FY 2022. 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 at the federal level.

CGFA estimates that approximately \$3.092 billion would be required to fully fund the FY 2022 liabilities of the Group Health Insurance Program. This estimate is \$46.4 million or 1.5% higher than the FY 2021 estimated liability of \$3.046 billion. CMS estimates that the FY 2022 liability will be \$3.071 billion, approximately \$25 million, or 0.8% higher than FY 2021.

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 2022 total \$3.083 billion. This is a minor increase from the 2021 fiscal year estimated revenue of \$3.071 billion, with the majority of the difference taken up by increased member contributions offsetting a lower Road Fund appropriation. The change in funding includes a projected decrease of \$41 million in the Road Fund appropriation from FY 2021, as well as increases in employee contributions (\$47 million) and smaller increases in reimbursements and miscellaneous funding components from the prior fiscal year. A breakdown in the various funding sources is shown in the following chart.



For FY 2022, the fiscal data provided by CMS shows the Group Health Insurance Program receiving \$1.851 billion in GRF funds. This represents a very small \$6 million (0.3%) decrease from the FY 2021 GRF component of \$1.857 billion. The FY 2022 GRF appropriation request is in line with the previous year GRF request, though lower than FY 2019 and FY 2020. This difference is largely due to the imposition of significantly higher employee contribution requirements starting in FY 2021, when total contributions rose from approximately \$400 million in FY 2020 to \$500 million in FY 2021 (a 20% increase). In addition, reimbursements rose from \$321 million to \$391 million (a \$70 million or 22% increase).

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. This did not occur in FY 2021 and is not expected to occur in FY 2022. As noted above, the FY 2022 Road Fund request of \$131 million is \$41.5 million lower than the projected FY 2021 appropriation level of \$171.5 million and \$30.5 million lower than FY 2020.

Member contributions are also anticipated to increase in FY 2022 to \$547.2 million, compared to \$499.9 million in FY 2021, 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 CDHP (a 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 increase by just \$7.3 million in FY 2022, to \$398.4 million compared to \$391.1 million in FY 2021. University contributions are projected to be flat compared to the 2021 fiscal year, as the Administration has proposed keeping contributions at \$45.0 million in FY 2022.

TABLE 3: GROUP INSURANCE FUNDING SOURCES				
FY 2021 - FY 2022				
(\$ in Millions)				
	<u>FY 2021</u>	<u>FY 2022</u>	<u>\$ Change</u> <u>from FY21</u>	<u>% Change</u> <u>from FY21</u>
GRF Appropriation	\$1,921.5	\$1,851.5	(\$70.0)	-3.6%
GRF Not Received/Reserve	(\$65.0)	\$0.0	\$65.0	0.0%
Road Fund	\$171.5	\$131.0	(\$40.5)	-23.6%
University Cont.	\$45.0	\$45.0	\$0.0	0.0%
Prior Year Univ. Cont.	\$2.9	\$0.0	(\$2.9)	-100.0%
Member Cont.	\$499.9	\$547.2	\$47.3	9.5%
Other Funds	\$391.1	\$398.4	\$7.3	1.9%
Medicare Part D rebate	\$6.2	\$5.9	(\$0.3)	-4.8%
Rebates/Interest/Other.	\$97.5	\$103.6	\$6.1	6.3%
TOTAL	\$3,070.6	\$3,082.6	\$12.0	0.4%
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 2022 budget target balance for the Group Insurance Program is \$30.0 million. For FY 2022, 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 2022 is the increased appeal of telemedicine options in the wake of the COVID-19 pandemic. 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. While it is likely to be used in future years as a source of easing congestion at medical provider locations and providing a triage opportunity in administering care, telemedicine may be useful in maintaining social distancing and assisting other palliative options for medical providers.

Continuing in FY 2022, 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, 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 their 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 3,000 active members and dependents will utilize this plan in FY 2022, doubling the utilization from FY 2021 (1,557).

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) and are expected to be negotiated for the 2022 calendar year.

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 2022, 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.

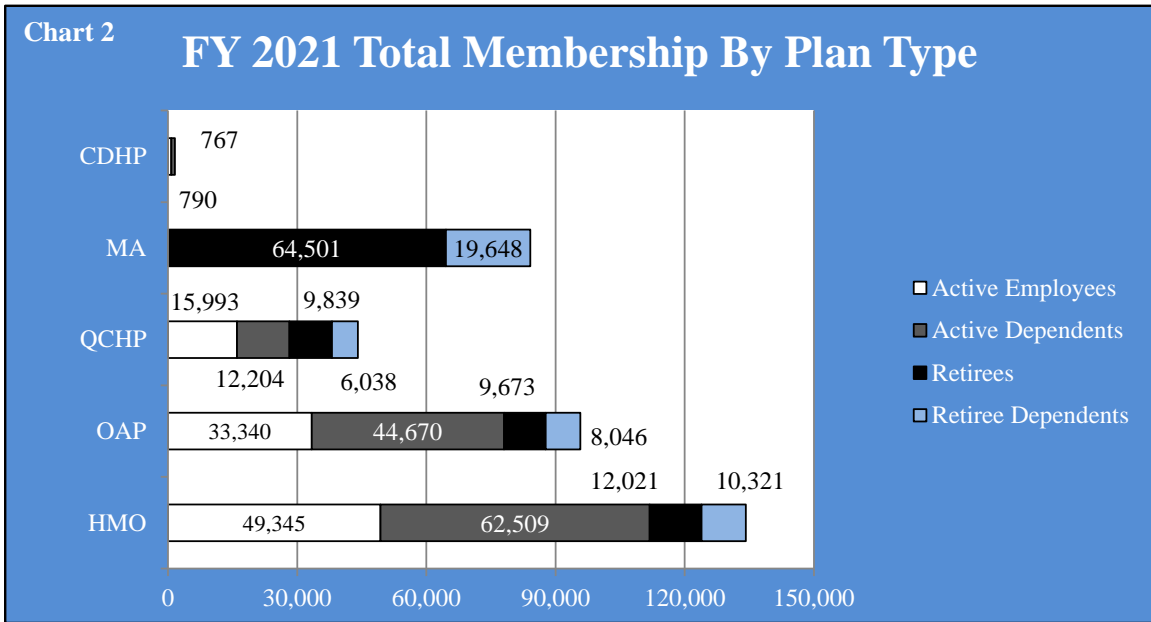
Basic life insurance is provided at no cost to employees, retirees and annuitants. Full-time employees receive coverage equal to their annual salary. Retirees and annuitants receive coverage equal to the annual salary as of the last day of employment until the age of 60, at which time the benefit amount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

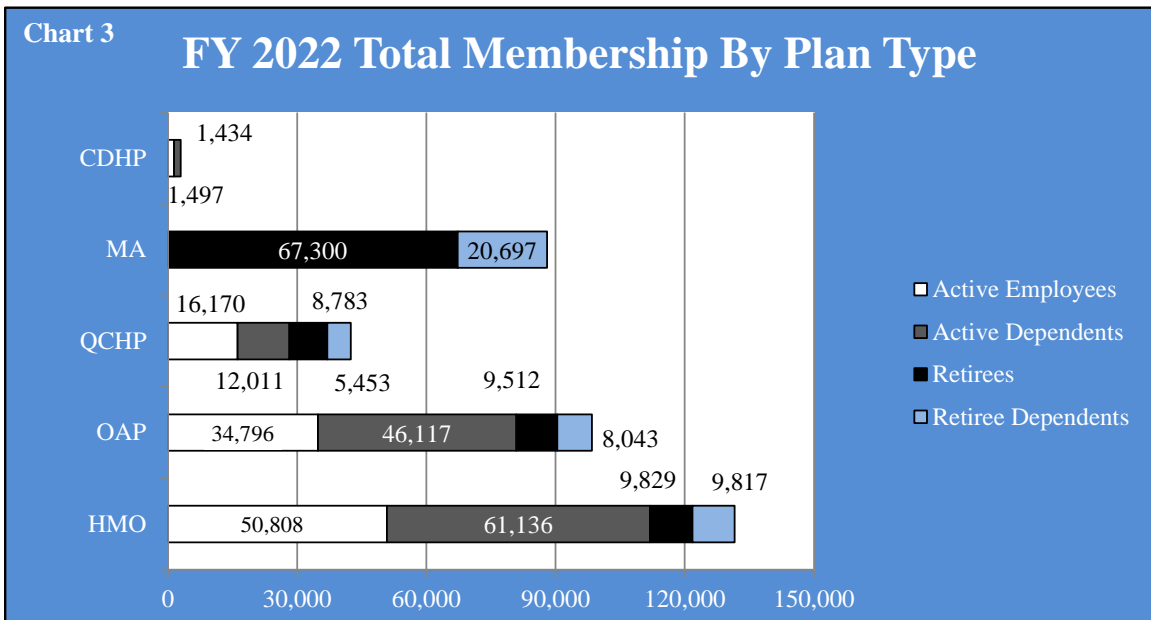
MEMBERSHIP

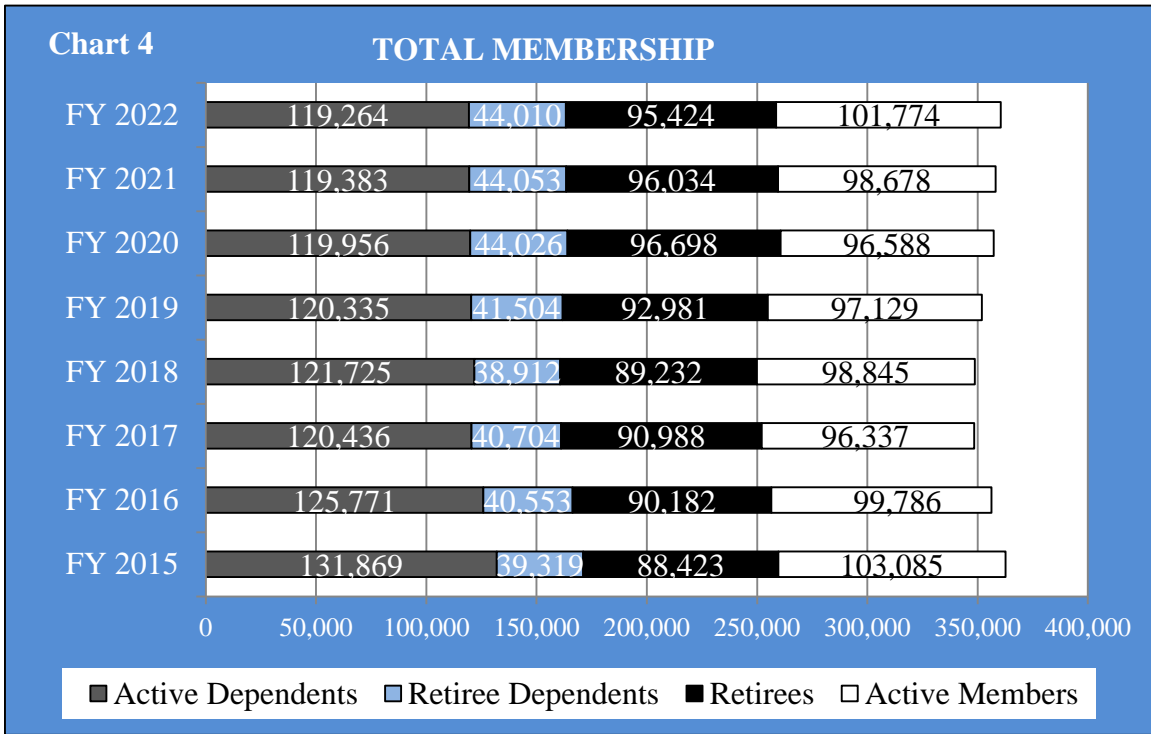
According to CMS, the State Employees' Group Health Insurance Program has an estimated 359,705 participants for FY 2021, of which 134,196 are in a non-Medicare Advantage HMO, 84,149 are in a Medicare Advantage HMO/PPO, 95,729 are in an Open Access Plan, and 44,074 are in the Quality Care Health Plan. The QCHP is estimated to have 15,993 employees, 12,204 active employee dependents, 6,038 retiree dependents, and 9,839 retirees in FY 2021.

Traditional HMO plans are estimated to have 49,345 employees, 62,509 active employee dependents, 10,321 retiree dependents, and 12,021 retirees in FY 2021. The CDHP is estimated to have 767 active employees and 790 active employee dependents. Medicare Advantage plans in FY 2021 include 19,443 dependents and 64,501 retirees. OAPs are anticipated to have 33,340 employees, 44,670 active employee dependents, 8,046 retiree dependents, and 9,673 retirees in FY 2021. This information is displayed in the chart on the next page.



For FY 2022, the QCHP is estimated to have 16,170 employees, 12,011 active employee dependents, 5,453 retiree dependents, and 8,783 retirees. Medicare advantage HMO/PPO plans are expected to have 20,697 dependents and 67,300 retirees. Non-Medicare Advantage HMO Plans are expected to have 50,808 employees, 61,136 active dependent lives, 9,817 retiree dependents, and 9,829 retirees. OAPs are expected to have 34,796 employees, 46,117 active dependents, 8,043 retiree dependents, and 9,512 retirees in FY 2022. The new Consumer Driven Health plan is projected to have 1,434 employees and 1,497 active employee dependents, which are primarily assumed to come from existing HMO plans. Total FY 2022 membership is expected to increase 1.0% from 359,705 to 363,403. This information is displayed in Chart 4.





- Membership (including CIP, TRIP, etc.) is projected for FY 2022.

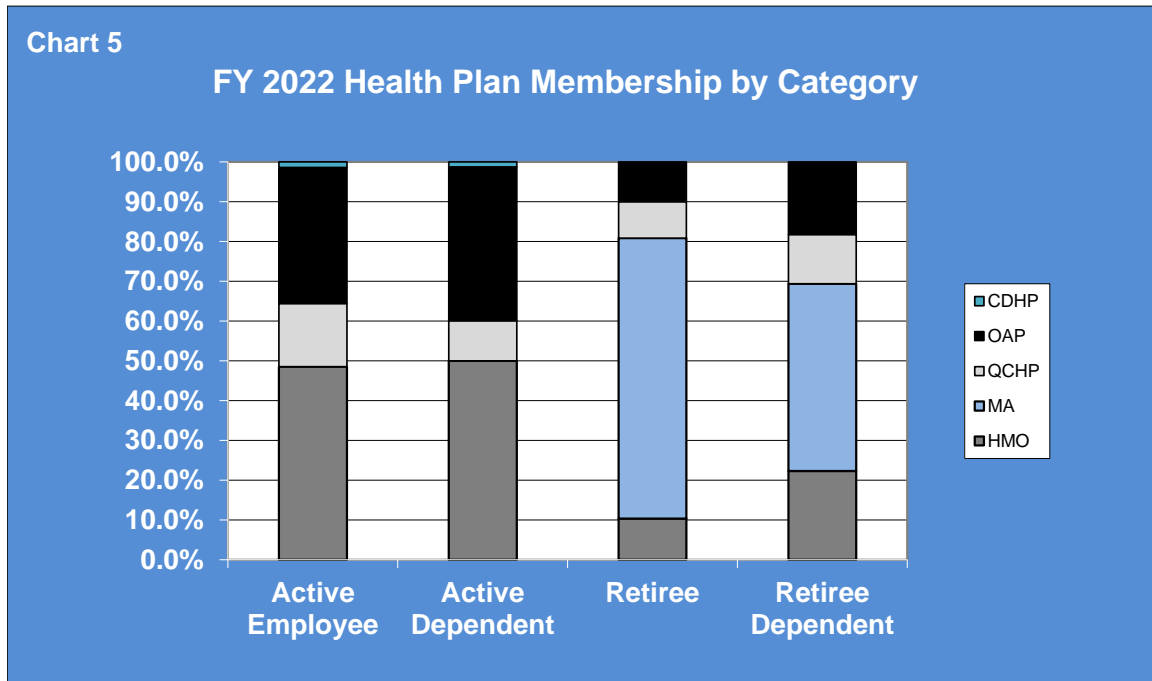
ENROLLMENT TRENDS

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) and the CDHP (since FY 2021). This trend has stabilized and is reflected in FY 2021-FY 2022 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 2022, 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 participant category among those measured (QCHP, OAP, etc.). Medicare Advantage HMO/PPO plans are expected to rise from 84,149 in FY 2021 to 87,997 for FY 2022. 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 2022, 70.5% of retirees and 47% of their dependents 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 2022 represents a 0.8 percent increase from FY 2021, partly due to a significant increase in OAP liability and smaller increases in other liability components (the CDHP, Timely Payment Interest, etc.). Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2012 through FY 2022 and demonstrates how several areas 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 lines. The Open Access Plan is anticipated to continue the trend of composing a larger liability for the State of Illinois than the QCHP and prescription components as a whole in FY 2022 (\$954 million compared to \$516 million).

The Interest Payments category has continued to decline in recent fiscal years due to large payments made in FY 2018/FY 2019, though it is projected to increase from \$26 million in FY 2021 to approximately \$40 million in FY 2022. The Administration/Other category continues to rise, sustaining the trend over the past few fiscal years, primarily due to the 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 \$126 million in FY 2020, though it is expected to decline to \$98 million for FY 2021. A subsequent rise to \$111 million is anticipated in FY 2022.

Other components of liability such as Vision, Dental, and Life Insurance are projected to mostly hold steady or change slightly from FY 2021 to FY 2022. These components are only a minor portion 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 over time, though it is only projected to amount to \$20 million in FY 2022. 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.

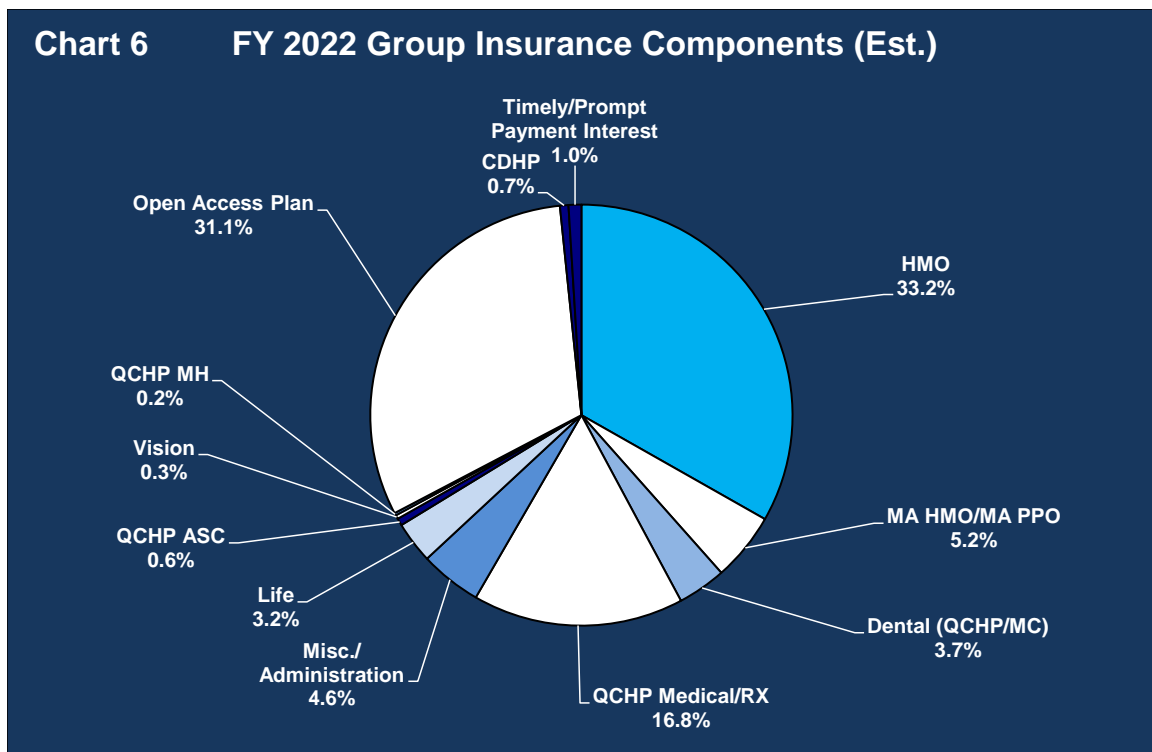
Table 4 STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY (CMS ESTIMATE) (FY 2013-FY 2022)										
§ in (millions)										
Liability Component	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022 (Estimated)
QCHP Medical/Rx	\$731	\$598	\$493	\$488	\$482	\$510	\$519	\$498	\$493	\$496
HMO Medical	\$894	\$910	\$917	\$934	\$975	\$1,036	\$1,067	\$1,088	\$1,082	\$1,020
Medicare Advantage	\$0	\$62	\$154	\$168	\$183	\$200	\$197	\$188	\$175	\$161
Dental	\$118	\$118	\$118	\$115	\$110	\$115	\$121	\$107	\$110	\$114
Open Access Plan	\$582	\$616	\$657	\$670	\$702	\$773	\$845	\$842	\$891	\$954
CDHP	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$10	\$20
QC Mental Health	\$7	\$7	\$5	\$5	\$5	\$6	\$6	\$6	\$6	\$6
Vision	\$12	\$11	\$11	\$8	\$8	\$8	\$8	\$8	\$9	\$9
Life Insurance	\$84	\$88	\$95	\$91	\$90	\$90	\$88	\$92	\$95	\$98
QC ASC	\$32	\$26	\$19	\$18	\$17	\$18	\$17	\$18	\$18	\$17
Interest Payments	\$112	\$130	\$221	\$262	\$195	\$274	\$105	\$73	\$25	\$30
Admin/Other	\$15	\$48	\$73	\$53	\$103	\$120	\$137	\$159	\$132	\$145
Total	\$2,587	\$2,614	\$2,764	\$2,812	\$2,870	\$3,150	\$3,110	\$3,079	\$3,046	\$3,070
% change over PY	6.0%	1.0%	5.7%	1.7%	2.1%	9.7%	-1.3%	-1.0%	-1.1%	0.8%

Source: CMS. Rounding causes slight differences in totals.

Chart 6 includes the various components of the FY 2022 CMS liability estimate of approximately \$3.070 billion. The largest component of the State Group Insurance Program continues to be the State’s Managed Care (HMO, OAP, and MA HMO/MA PPO) plans, which together have grown to represent 69.5% of FY 2022 liability. The new Consumer Driven Health Plan (CDHP) is projected to amount to just 0.7% of FY 2022 liability.

Dental care, life insurance, and vision care equal 7.2% of total liability, slightly down from 7.4% in FY 2021. The QCHP component (16.8%) is slightly lower than FY 2021 (17.1%) and includes medical/prescriptions, mental health coverage, and administrative service charges. For FY 22, interest payments are projected to continue to be a small fraction of the overall liability (1.0%) of the components of Group Insurance liability,

reflecting the massive reduction 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 over time.

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. 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. Standard HMO contracts have been awarded for the next five fiscal years as of this year.

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.

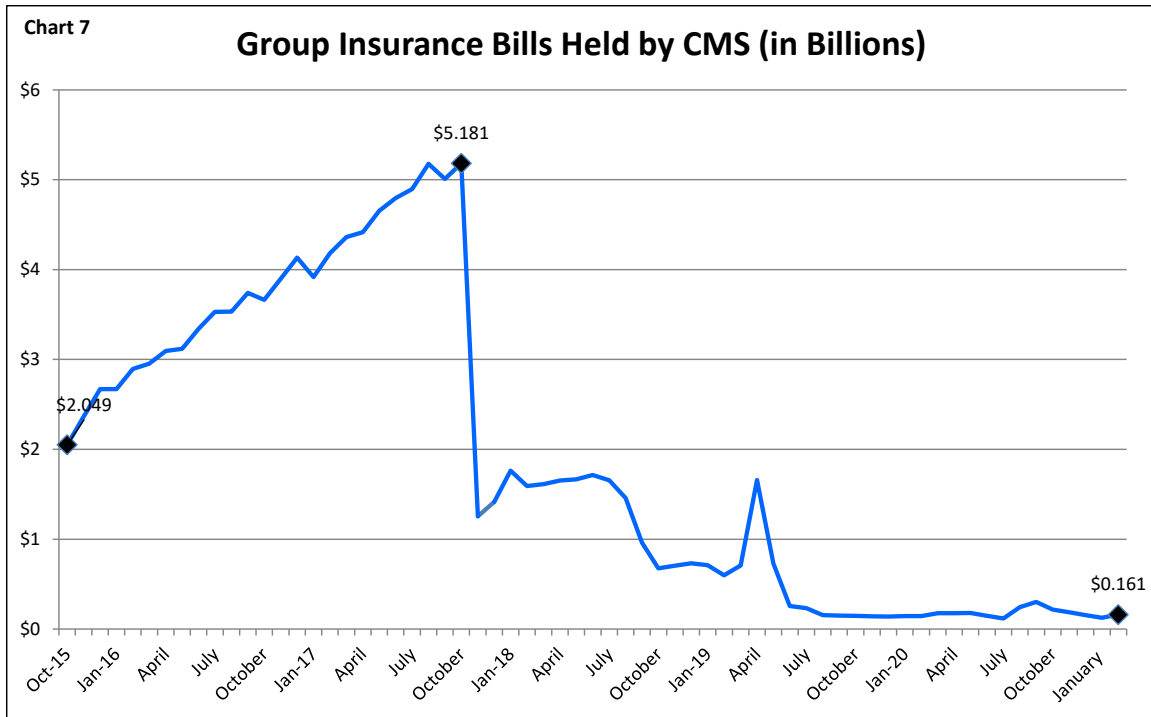
GROUP INSURANCE INTEREST AND BONDING

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. Various attempts have been made to lower this interest rate to save money for the State, but concerns have been raised as to the long-term effects for contracts with businesses that would have chosen to not work with the state if the interest on anticipated late payments was not available.

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. Chart 7 displays the historical backlog of Group Insurance bills on the following page.



As of the end of February 2021, approximately \$161 million in Group Insurance bills are being held by CMS awaiting transmission to the Comptroller’s office for payment. Of that total, there are \$149 million in HMO claims (including Medicare Advantage) awaiting payment, and approximately \$3.6 million in interest payments has yet to be paid off on those claims. Open Access Plans claims account for \$0 currently in claims (but approximately \$573,000 in interest owed). Aetna PPO (QCHP) claims account for \$290,000 in interest owed.

Life Insurance (\$7.9 million) and Other Fees (\$3.4 million) make up the majority of the remaining claims held by Illinois. Interest due on these debts amounts to \$323,000 as of the end of February, 2021. Current projections by CMS estimate a total of \$4.9 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. Table 5 details the major portions of the current claims hold situation with existing interest rates of 9 and 12 percent, as of February 2021.

Table 5 Claims Hold Data for SEGIP			
(as of February 28, 2021)			
Vendor	Claims Hold	Length of Claims Hold (in days)	Interest Owed (Including Past Due Interest)
Aetna - PPO	\$0	84	\$268,925
Dental Claims Hold - PPO	\$0	42	\$29,924
Dental - Non-PPO	\$0	119	\$156,623
Magellan (Mental Health) Claims	\$0	35	\$1,274
Aetna HMO	\$7,113,014	3	\$179,802
Health Alliance HMO	\$87,037,513	34	\$1,135,177
HMO Illinois	\$32,997,775	95	\$1,221,776
Blue Advantage	\$8,363,156	3	\$414,141
HealthLink OAP	\$0	84	\$407,627
Aetna OAP	\$0	83	\$165,430
CVS/Caremark	\$0	0	\$150,936
Aetna MA	\$924,919	3	\$20,153
Health Alliance MA	\$331,050	3	\$8,198
Humana Benefit Plan MA	\$24,077	3	\$408
Humana Health Plan MA	\$569,111	3	\$10,062
United Healthcare MA	\$11,201,310	156	\$612,800
Eyemed (Vision)	\$710,997	3	\$21,243
Minnesota Life	\$7,858,019	3	\$0
Other (Fees/ASC/etc.)	\$3,391,975	3-156	\$184,214
Total	\$160,522,916	3-156	\$4,988,713

Source: CMS. MA stands for Medicare Advantage.

In regard to payment cycles, the 2022 fiscal year is projected to continue the hold cycle currently in place for the 2021 fiscal year at somewhat longer durations for bills in question. The projected FY 2022 claims hold cycles are:

- AETNA claims: 156 days
- Managed Care claims: Approximately 5 months
- OAP/Prescription claims: 160 days
- Dental claims: 156 days for network claims, 216 days for non-network claims

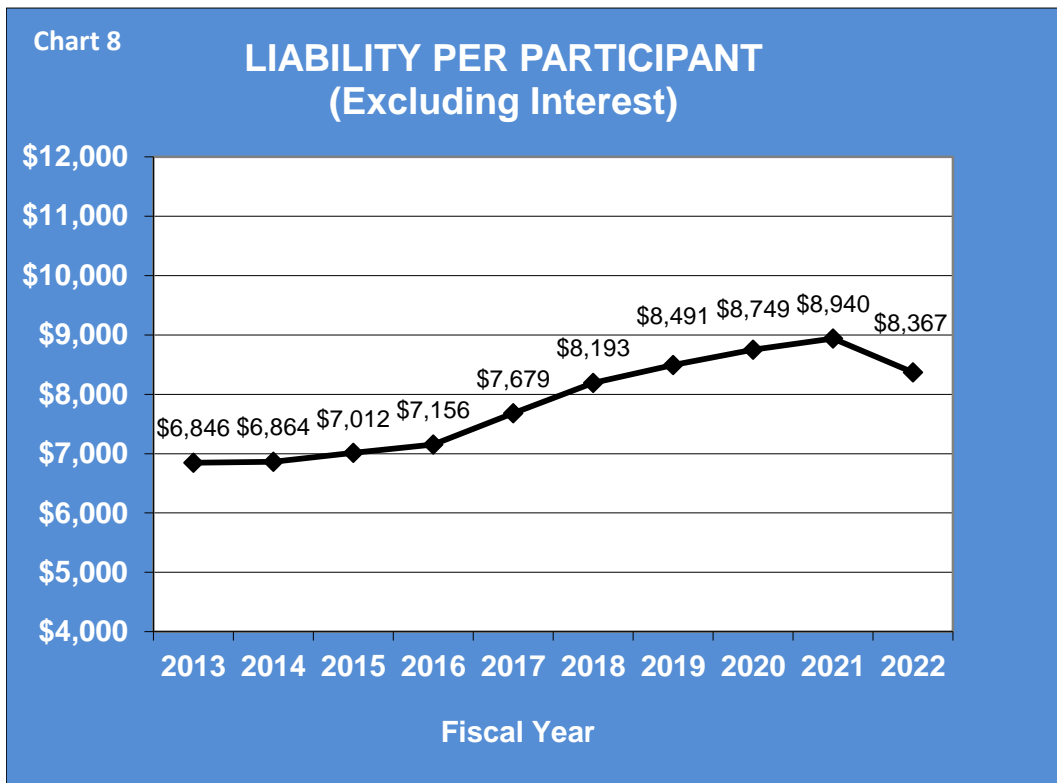
One important note on this subject is that this accounts only for the time for CMS to process claims and does not include time for the Comptroller to process and send out payment to the vendors in question. The Comptroller's timeliness depends on current cash flow needs and funds availability, which fluctuates daily. According to the Comptroller's office, as of the end of January 2021, they had approximately \$525 million in Health Insurance Reserve Fund vouchers awaiting payment as the cash flow becomes available. Regardless of the means utilized, stable fiscal commitment is required to ensure prompt payment of claims to vendors and avoid excessive interest payments that dramatically inhibited state health insurance spending priorities only a few years ago.

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 8 shows the steady increase each year in cost per participant, though FY 17 through FY 19 deviate 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 2013 – FY 2022 in Chart 8, 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 2013, the annual liability per participant in the group health insurance program was \$6,846.

According to CMS, the liability per participant for FY 2021 will increase to \$8,940, an increase of \$191 over FY 2020. For FY 2022, the estimated liability per participant is \$8,367, contrasting the increase since FY 2016. While this is a significant decrease from FY 2021, it also represents a 22.2% increase compared to FY 2013, demonstrating the long-term rise in overall liabilities for the SEGIP.



As such, the FY 2022 liability per participant is projected to decrease 6.4% from FY 2021. 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.

In the wake of the COVID-19 pandemic, it continues to be uncertain what the impact will be from the state introducing the Consumer Driven Health Plan (CDHP) for the 2021 fiscal year. While savings are expected for the state in the long run, as younger employees and dependents utilize this plan, the overall SEGIP liability may remain on an upward trajectory due to traditional 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, though the CDHP represents an attempt to address medical service utilization and demographics in a manner so as to save money for both individual participants and the State of Illinois.

For FY 2022, much will depend on how the State addresses COVID-related effects on the health industry. As discussed above, limiting service utilization in favor of leaving availability for COVID-related medical issues resulted in a degree of savings for health insurance providers. Depending on actions taken to deal with COVID and subsequent mutations and variant strains known to exist or expected to exist in the future, group health liabilities for Illinois will necessarily be affected.

Table 6: ANNUAL LIABILITY PER PARTICIPANT				
	FY 2021	FY 2022	FY 2021	FY 2022
	Total Participants	Total Participants	Liability Per Participant	Liability Per Participant
QCHP	44,074	42,417	\$11,638	\$12,154
MA HMO / PPO	84,149	87,997	\$2,075	\$1,834
HMO	134,196	131,590	\$8,062	\$7,749
OAP	95,729	98,468	\$9,310	\$9,690
CDHP	1,557	2,931	\$6,713	\$6,982
Totals	359,705	363,403		

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 2022, as in FY 2021, 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 2022. 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 \$11,638 in FY 2021. Member contributions for QCHP enrollees are expected to total \$74 million in FY 2021. 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 2021 and FY 2022.

TABLE 7: MEMBER CONTRIBUTIONS AND AVERAGE LIABILITY PER PARTICIPANT PER YEAR (ALPP)						
	FY 2021 ALPP	FY 2021 Member Contributions	FY 2021 State Liability	FY 2022 ALPP	FY 2022 Member Contributions	FY 2022 State Liability
QCHP	\$11,638	\$1,671	\$9,967	\$12,154	\$1,852	\$10,302
MA HMO/PPO	\$2,075	\$380	\$1,694	\$1,834	\$373	\$1,461
HMO	\$8,062	\$1,256	\$6,806	\$7,749	\$1,402	\$6,347
OAP	\$9,310	\$1,338	\$7,972	\$9,690	\$1,481	\$8,209
CDHP	\$6,713	\$1,345	\$5,369	\$6,982	\$1,465	\$5,517
Dental	\$318	\$104	\$214	\$326	\$114	\$212

Source: CMS.

Table 7 shows that QCHP members are expected to contribute 15.2% of the overall annual cost of providing their insurance in FY 2022. HMO/OAP/MA HMO (and PPO) members are expected to contribute 18.1%, 15.3%, and 20.3% of their overall liability cost in the same time period. Members of the Consumer Driven Health Plan are estimated to contribute 21.0% of the overall liability, a higher proportion than the other options. Members that participate in the State's dental offering are expected to pay 35.0% percent of the overall liability cost in FY 2022, an increase from 32.7% in FY 2021.

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 2021.

TABLE 8: RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 2022			
(Numbers in Millions)			
Category	Cost	Category	Cost
Retiree Cost	\$612.3	Active Employee Cost	\$1,285.2
Retiree Contribution	-\$44.9	Active Employee Contribution	-\$283.0
Other Revenues	-\$18.3	Other Revenues	-\$38.0
Net State Cost	\$549.1	Net State Cost	\$964.2
Retiree Dependent Costs			
Retiree Dependent Cost	\$274.6	Active Employee Dependent Cost	\$898.6
Retiree Dependent Contribution	-\$71.6	Active Employee Dependent Contribution	-\$147.8
Other Revenues	-\$11.7	Other Revenues	-\$38.8
Net State Cost	\$191.3	Net State Cost	\$712.0
Total Active Costs			
Total Retiree Cost	\$886.8	Total Active Cost	\$2,183.8
Total Retiree Contribution	-\$116.5	Total Active Contribution	-\$430.8
Other Revenues	-\$29.9	Other Revenues	-\$76.8
Total State Cost	\$740.4	Total State Cost	\$1,676.3
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 2022, retirees and retiree dependents are projected to pay 7.3% and 26.1% of their healthcare costs, an increase from 5.1% and 19.7% in FY 2021. This contrasts with active employees and their dependents, who are projected to pay 22.0% and 16.4% of their healthcare costs, a rise for active employees and active employee dependents compared to 19.3% and 12.7% respectively in FY 2021. In total, the aggregate contributions of active employees and dependents (19.7% for both groups combined in FY 2022 compared to 16.5% in FY 2021) remain significantly higher as a percentage than the aggregate contributions of retirees and retiree dependents (13.1% for both groups combined in FY 2022 compared to 9.2% in FY 2021). This difference is accounted for by retirees utilizing Medicare Advantage HMO and PPO plans (resulting in savings for the State of Illinois) along with increased contributions by active employees and their dependents expected in FY 2022.

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 2020, FY 2021, and FY 2022 plan enrollment is listed in Table 9.

TABLE 9: MANAGED CARE PLANS					
FY 2020-2022 All Lives (Active Members/Dependents and non-MA Retirees/Dependents)					
HMO/OAP	FY20 # of Participants	FY21 # of Participants	% Change 2020-2021	FY22 # of Participants	% Change 2021-2022
Health Alliance HMO	72,542	70,259	-3.15%	68,239	-2.88%
HMO Illinois	41,187	38,786	-5.83%	36,404	-6.14%
Blue Advantage	14,150	15,613	10.34%	17,121	9.66%
Aetna/Coventry Health Care HMO	9,491	9,538	0.50%	9,826	3.02%
Aetna/Coventry Health Care OAP	28,336	32,605	15.07%	37,112	13.82%
Health Link OAP	65,093	63,124	-3.02%	61,356	-2.80%
Consumer Driven Health Plan HDHP	0	1,557	N/A	2,931	88.25%
TOTALS	230,799	231,482	0.30%	232,989	0.65%

Source CMS. FY 22 numbers are projected as of February 2021.

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 to continue 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 2020-2022			
HMO/PPO	FY20 # of Participants	FY21 # of Participants	FY22 # of Participants
Aetna HMO	4,899	5,281	5,649
Humana Benefit Plan HMO	142	157	171
Humana Health Plan HMO	3,472	3,829	4,187
Health Alliance HMO	1,599	1,971	2,338
United HealthCare PPO	70,222	72,911	75,652
TOTALS	80,334	84,149	87,997

Source: CMS. FY 22 numbers are projected as of February 2021.

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 87,997 people projected to be covered in FY 2022 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. These plans are expected to be negotiated in the latter part of 2021.

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 2022 fiscal year, as a result of negotiations with public employee unions, premiums for HMO/OAP/QCHP options will continue to increase, with most plans experiencing an increase of between \$10 to \$40/month depending on plan coverage options and the specific plan provider 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 2015 - FY 2022								
Employee Only								
	OCHP				CDHP			
	TOTAL	% Inc.	Member	State	TOTAL	%Inc.	Member	State
FY 15	\$859		\$168	\$691	N/A	N/A	N/A	N/A
FY 16	\$895	4.2%	\$170	\$725	N/A	N/A	N/A	N/A
FY 17	\$921	2.9%	\$169	\$752	N/A	N/A	N/A	N/A
FY 18	\$939	2.0%	\$168	\$771	N/A	N/A	N/A	N/A
FY 19	\$1,019	8.5%	\$168	\$851	N/A	N/A	N/A	N/A
FY 20	\$1,001	-1.8%	\$168	\$833	N/A	N/A	N/A	N/A
FY 21	\$1,033	3.2%	\$195	\$838	\$740	N/A	\$153	\$587
FY 22	\$1,076	4.2%	\$213	\$863	\$773	4.4	\$167	\$606
	HMO				OAP			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY 15	\$671		\$125	\$546	\$761		\$124	\$637
FY 16	\$699	4.1%	\$126	\$573	\$774	1.7%	\$125	\$649
FY 17	\$749	7.2%	\$126	\$623	\$850	9.9%	\$125	\$725
FY 18	\$800	6.7%	\$126	\$674	\$940	10.5%	\$125	\$815
FY 19	\$822	2.8%	\$126	\$696	\$990	5.3%	\$125	\$865
FY 20	\$836	1.7%	\$127	\$709	\$951	-4.0%	\$128	\$823
FY 21	\$848	1.5%	\$155	\$693	\$979	3.0%	\$167	\$812
FY 22	\$817	-3.7%	\$168	\$649	\$1,017	3.9%	\$182	\$835

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 2015 to the projected values for members in FY 2022. 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. For FY 2022, 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 2022 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 2022 Rates (Projected for Median Salary)						
	QCHP			CDHP		
	TOTAL	Member	State	TOTAL	Member	State
Employee	\$1,076	\$213	\$863	\$773	\$167	\$606
Medicare Retiree	\$566	\$26	\$540	\$0	\$0	\$0
Non-Medicare Retiree	\$1,571	\$26	\$1,545	\$0	\$0	\$0
1 Dependent	\$1,426	\$277	\$1,148	\$717	\$155	\$562
2 +Dependents	\$1,697	\$321	\$1,376	\$1,116	\$202	\$914
Medicare Dependent	\$701	\$173	\$528	\$555	\$129	\$426
	HMO			OAP		
	TOTAL	Member	State	TOTAL	Member	State
Employee	\$817	\$168	\$649	\$1,017	\$182	\$835
Medicare Retiree	\$538	\$31	\$508	\$681	\$31	\$651
Non-Medicare Retiree	\$1,317	\$19	\$1,298	\$1,548	\$19	\$1,529
1 Dependent	\$696	\$166	\$529	\$863	\$185	\$679
2 +Dependents	\$1,207	\$213	\$994	\$1,481	\$235	\$1,246
Medicare Dependent	\$549	\$142	\$407	\$682	\$158	\$524

As with Employee-only premium projections and associated costs, premiums for all applicable active SEGIP member and dependent cohorts are expected to continue the rise started in FY 2021. 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 2022 Proposed Rates							
Median Salary	Health Alliance	Aetna HMO	HMO Illinois	Blue Advantage	HealthLink OAP	Aetna OAP	CDHP
Employee	\$178.94	\$167.55	\$165.41	\$140.40	\$187.62	\$174.98	\$167.23
Medicare Retiree	\$30.56	\$30.56	\$30.56	\$30.56	\$30.56	\$30.56	N/A
Non-Medicare Retiree	\$18.73	\$18.73	\$18.73	\$18.73	\$18.73	\$18.73	N/A
1 Dependent	\$180.04	\$181.22	\$147.54	\$142.60	\$191.03	\$173.03	\$154.82
2 +Dependents	\$230.04	\$227.64	\$190.66	\$181.46	\$243.91	\$219.44	\$202.08
Medicare Dependent	\$153.00	\$154.00	\$123.00	\$119.00	\$163.00	\$146.00	\$129.00

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.

Continuing the trend started last year in FY 2021, plan rates will 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 \$48-\$63/month spread between the most expensive and least expensive 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 2020, FY 2021, and projected FY 2022 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 2020-2022 Rates (As of February 2021)			
Aetna HMO	FY 2020	FY 2021	FY 2022
Medicare Retiree	\$9.05	\$8.96	\$8.64
Two of More Dependents	\$126.00	\$126.00	\$126.00
Medicare Dependent	\$89.91	\$89.91	\$89.91
Humana Benefit Plan HMO	FY 2020	FY 2021	FY 2022
Medicare Retiree	\$9.05	\$8.96	\$8.64
Two of More Dependents	\$126.00	\$126.00	\$126.00
Medicare Dependent	\$89.91	\$89.91	\$89.91
Humana Health Plan HMO	FY 2020	FY 2021	FY 2022
Medicare Retiree	\$9.05	\$8.96	\$8.64
Two of More Dependents	\$126.00	\$126.00	\$126.00
Medicare Dependent	\$89.91	\$89.91	\$89.91
United HealthCare	FY 2020	FY 2021	FY 2022
Medicare Retiree	\$10.00	\$8.75	\$7.64
Two of More Dependents	\$155.00	\$155.00	\$155.00
Medicare Dependent	\$110.00	\$110.00	\$110.00
Health Alliance HMO	FY 2020	FY 2021	FY 2022
Medicare Retiree	\$9.05	\$8.96	\$8.64
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 22 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	Ongoing - HMO Terms go to June 30, 2026 with five 1-year renewals. OAPs are pending Request for Proposal. (RFP)
Medicare Advantage Health Plans	Aetna/Coventry HMO / Health Alliance HMO / Humana Benefits Plan HMO / Humana Health Plan HMO / UnitedHealthCare PPO	Renewed - Terms go to December 30, 2021 with up to one 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	Ongoing - Term goes to June 30, 2023.
Behavioral Health/EAP	Magellan	Ending - Term goes to June 30, 2021. RFP is pending.
Life Insurance	Securian Life (formerly Minnesota Life)	Ongoing - Last year of contract, term goes to June 30, 2021. Currently pending RFP.
Flexible Spending	ConnectYourCare	Ongoing - Term goes to June 30, 2023
Administration of Dental Claims	Delta Dental	Ongoing - Term goes to June 30, 2026.
Prescription Drugs	CVS/Caremark	Ongoing -Term goes to June 30, 2021. Currently negotiating.
Commuter Savings Program	Edenred	Ongoing - Term goes to June 30, 2024.

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.

COMMISSION OVERVIEW

The Commission on Government Forecasting & Accountability is a bipartisan legislative support service agency responsible for advising the Illinois General Assembly on economic and fiscal policy issues and for providing objective policy research for legislators and legislative staff. The Commission's board is comprised of twelve legislators—split evenly between the House and Senate and between Democrats and Republicans. Effective December 10, 2018, pursuant to P.A. 100-1148 the former Legislative Research Unit was merged into the Commission.

The Commission has three internal units—Revenue, Pensions, and Research, each of which has a staff of analysts and researchers who analyze policy proposals, legislation, state revenues & expenditures, and benefit programs, and who provide research services to members and staff of the General Assembly. The Commission's staff fulfills the statutory obligations set forth in the Commission on Government Forecasting and Accountability Act (25 ILCS 155/), the State Debt Impact Note Act (25 ILCS 65/), the Illinois Pension Code (40 ILCS 5/), the Pension Impact Note Act (25 ILCS 55/), the State Facilities Closure Act (30 ILCS 608/), the State Employees Group Insurance Act of 1971 (5 ILCS 375/), the Public Safety Employee Benefits Act (820 ILCS 320/), the Legislative Commission Reorganization Act of 1984 (25 ILCS 130/), and the Reports to the Commission on Government Forecasting and Accountability Act (25 ILCS 110/).

- The **Revenue Unit** issues an annual revenue estimate, reports monthly on the state's financial and economic condition, and prepares bill analyses and debt impact notes on proposed legislation having a financial impact on the State. The Unit publishes a number of statutorily mandated reports, as well as on-demand reports, including the Monthly Briefing newsletter and annually, the Budget Summary, Capital Plan Analysis, Illinois Economic Forecast Report, Wagering in Illinois Update, and Liabilities of the State Employees' Group Insurance Program, among others. The Unit's staff also fulfills the agency's obligations set forth in the State Facilities Closure Act.
- The **Pension Unit** prepares pension impact notes on proposed pension legislation and publishes several statutorily mandated reports including the Financial Condition of the Illinois State Retirement Systems, the Financial Condition of Illinois Public Pension Systems and the Fiscal Analysis of the Downstate Police & Fire Pension Funds in Illinois. The Unit's staff also fulfills the statutory responsibilities set forth in the Public Safety Employee Benefits Act.
- The **Research Unit** primarily performs research and provides information as may be requested by members of the General Assembly or legislative staffs. Additionally, the Unit maintains a research library and, per statute, collects information concerning state government and the general welfare of the state, examines the effects of constitutional provisions and previously enacted statutes, and considers public policy issues and questions of state-wide interest. Additionally, the Unit publishes First Reading, a quarterly newsletter which includes abstracts of annual reports or special studies from other state agencies, the Illinois Tax Handbook for Legislators, Federal Funds to State Agencies, various reports detailing appointments to State Boards and Commissions, the 1970 Illinois Constitution Annotated for Legislators, the Roster of Illinois Legislators, and numerous special topic publications.

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