ILLINOIS ECONOMIC
AND
FISCAL COMMISSION

FISCAL YEAR 2003
LIABILITIES OF THE STATE
EMPLOYEES' GROUP INSURANCE PROGRAM

MARCH 2002
703 STRATTON OFFICE BUILDING
SPRINGFIELD, ILLINOIS 62706

Illinois Economic and Fiscal Commission

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FISCAL YEAR 2003

Liabilities Of The
State Employees' Group Insurance Program

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EXECUTIVE SUMMARY

The Illinois Economic and Fiscal Commission has several statutory requirements concerning the State Employees' Group Insurance Program.

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

The Governor has requested that a total of $1.396 billion be appropriated for the State Employees' Group Health and Life Insurance Program for FY 2003. The requested FY 2002 appropriation for the Group Health Insurance Program was $1.263 billion. A $58.8 million supplemental appropriation for FY 2002 is pending approval by the General Assembly. The following table illustrates historical appropriation and liability amounts for the group insurance program, per CMS. The IEFC's FY 2003 estimate of liability is approximately $1.435 billion, $24.0 million more than CMS.

The liability estimates do not address the budgetary shortfall that the Group Insurance Program will experience in both FY 2002 and FY 2003. According to recent testimony from CMS, the Group Insurance Program will fall $61 million short in the payment of FY 2002 claims, and expects a shortfall of $100 million to $110 million for FY 2003. Currently, the payment cycles for preferred providers is 42 days, while non-preferred providers have a payment cycle of 60 to 70 days. For FY 2003, these payment cycles are expected to increase to 40 to 50 days for preferred providers, and 100 to 110 days for non-preferred providers.

The FY 2003 monthly cost of an employee in the indemnity plan is expected to increase 13.8% over the FY 2002 cost. The monthly cost of an employee in the managed care plan is expected to increase 13.0% over the FY 2002 cost.

APPROPRIATION AND LIABILITY HISTORY
FY 1999-2003
($ in Millions)

Fiscal Year	Appropriation	CMS Liability	IEFC Liability
FY 1999	$852.0	$866.7	-
FY 2000	$1,003.0	$978.7*	-
FY 2001	$1,085.0	$1,099.2*	-
FY 2002	$1,262.7	$1,242.6*	-
FY 2003	$1,395.9	$1,411.0*	$1,435.0*

*Estimated

NOTE: In FY 2002, the total appropriation for the Group Insurance Program includes a supplemental appropriation of $58,769,000 to the Health Insurance Reserve Fund. Expenditures from the Health Insurance Reserve Fund cannot exceed its appropriation; this amount represents additional expenditure authority.

This report provides further details on both our estimate and the Governor's request.

FY 2003 IEFC COST ESTIMATE

The Illinois Economic and Fiscal Commission's (IEFC) FY 2003 cost projection utilizes the CMS revised estimate for FY 2002 medical claims as the basis for estimating claims for FY 2003. This revision is based on actual claims to date.

The IEFC cost estimate for FY 2003 uses the following assumptions based on historical claims data and anticipated cost increases:

TREND FACTORS	
Medical (indemnity plan/QCHP)	13.15%
Dental (QCHP and MC)	17.25%
HMO (medical and Rx)	18.30%
Prescription drugs (QCHP)	17.45%
Administrative service charges (QCHP)	40.0%*
Life insurance	5.43%
Special programs (QCHP)	10.70%
***CMS received assistance from consultants during the contract renewal process for QCHP medical and prescription claims administration and for utilization management. The assumption of the consultants was that the fees associated with these contracts would increase precipitously in FY 2003.	

Each of the trend factors listed above is slightly higher than the percentage increases estimated by CMS. The medical trend inflation factor consists of several components. These include inflation; leveraging (the reduced impact of level deductibles and coinsurance limits), and cost shifting due to reductions in Medicare and Medicaid reimbursements. Other components of the medical trend inflation factor include anti-selection or the impact of employees shifting to HMOs and PPOs, which retains sicker, more costly employees in the indemnity plan; technological advances; social shifts including the aging population and greater acceptance of psychiatric and substance abuse care; and, increased utilization of equipment and services.

Based on these assumptions and inflation factors, the IEFC estimates a FY 2003 liability of approximately $1.435 billion for the State Employee's Group Health Insurance Program. The table on the following page shows a detailed comparison of the IEFC estimate for the various cost components and the CMS projection for FY 2003.

TABLE 1: FY 2003 GROUP HEALTH INSURANCE LIABILITY ($ in Millions)			
Liability Component	FY 2002 CMS Estimate	FY 2003 CMS Estimate	FY 2003 IEFC Estimate
QCHP Medical	$477.2	$535.4	$539.9
QCHP Prescriptions	$145.4	$159.5	$170.8
Dental (QCHP/MC)	$57.1	$63.5	$66.9
HMO	$402.1	$473.1	$475.7
Open Access Plan	$39.6	$46.6	$46.7
POS	$7.5	$7.4	$7.5
Mental Health	$9.3	$9.5	$9.6
Vision	$10.9	$11.3	$12.0
Administrative Services (QCHP)	$19.0	$26.2	$26.6
Life	$60.3	$63.5	$63.6
Special Programs (Admin/Int/Other)	$14.2	$15.0	$15.7
TOTAL	**$1,242.6**	**$1,411.0**	**$1,435.0**
% Increase over FY 2002 CMS Estimate		13.5%	15.5%

ESTIMATE COMPARISON

The Commission's FY 2003 estimate is $24.0 million higher than the FY 2003 estimate from CMS. IEFC's 2003 HMO liability estimate is $2.6 million higher than CMS, IEFC's indemnity medical estimate is $4.5 million higher than CMS, and IEFC's Dental estimate is $3.4 million higher than CMS. IEFC's FY 2003 estimate for prescriptions is $11.3 million higher than the CMS estimate. As mentioned before, HMO liabilities are expected to have an inflation factor of 18.3%.

The IEFC estimates approximately $1.435 billion would be required to fully fund the FY 2003 liabilities of the Group Health Insurance Program. This estimate is $192.4 million or 15.4% more than the FY 2002 estimated liability of $1.2426 billion. The difference between the FY 2003 IEFC and CMS liability estimates is $24.0 million.

APPROPRIATION

According to the FY 2003 Illinois State Budget Book, the FY 2002 appropriation for the Group Health Insurance Program was $1.204 billion ($1.1175 billion to the Health Insurance Reserve Fund and $86.476 million to the Group Insurance Premium Fund). However, the total appropriation for FY 2002 was $1.2627 billion, reflecting a supplemental appropriation to the Health Insurance Reserve Fund of $58.77 million.

The Governor has requested that $1.396 billion be appropriated for the State Employee Group Health and Life Insurance Program for FY 2003. These appropriations reflect the combined authority appropriated to the Health Insurance Reserve Fund (HIRF) and the Group Insurance Premium Fund (GIPF). The sources of revenue that comprise these two funds include General Revenue Fund and Road Fund appropriations, as well as employee contributions and reimbursements from Federal and other State funds. The actual appropriation authorities in HIRF and GIPF are greater than the identifiable funding

sources to allow for unexpected events such as supplemental appropriations or unexpected increases in employee contributions or reimbursements.

The FY 2003 budget request for the Group Health Insurance Program is $827.7 million in GRF funds. This represents an 18.3% ($127.9 million) increase from the FY 2002 GRF appropriation of $699.8 million. The FY 2003 Road Fund request of $92.2 million is $6.3 million higher than the FY 2002 appropriation level.

FUNDING SOURCES

TABLE 2: GROUP INSURANCE FUNDING SOURCES
FY 2002 – FY 2003
($ in Millions)

	FY 2002	FY 2003	Increase	% Increase
GRF	$699.8	$827.7	$127.9	18.3%
Road	85.9	92.2	6.3	7.3%
Other Sources	407.45	429.35	21.9	5.4%
TOTAL	**$1,193.15**	**$1,349.25**	**$156.1**	**13.1%**

Additional Funding for the Group Insurance Program			
Funding Source	***Type of Funding***	***FY 2002***	***FY 2003***
GRF Approp	***IBHE Approp***	***$14,753,800***	***$14,753,800***
Road Fund Approp	***CMS Supplemental Approp***	***$ 6,319,400***	***$ 0***
Other Sources	***University payments***	***$45,000,000***	***$45,000,000***
TOTAL		***$66,073,200***	***$59,753,800***

Historically, appropriations usually exceed liabilities due to the requirement of a cash balance for the State Group Insurance Program. However, the FY 2003 appropriation level of $1.396 billion is $15 million lower than the CMS liability estimate for FY 2003, and $39 million lower than the IEFC liability estimate for FY 2003.

The Department of Central Management Services sets target end-of-year fund balances for both the HIRF and the GIPF. The historical budget target balance for the Group Insurance Program is $11 million. For the GIPF, that target balance is $4 million, and the target HIRF balance is $7 million.

BENEFITS

The State Employees' Group Insurance Program provides medical, dental, vision, and life insurance coverage to State employees, retirees and their dependents. Medical and dental coverage is provided separately to members in their choice of: indemnity plan, various types of managed care plans such as Health Maintenance Organizations (HMO), and Point of Service (POS). Vision coverage, which includes savings on exams, glasses, and

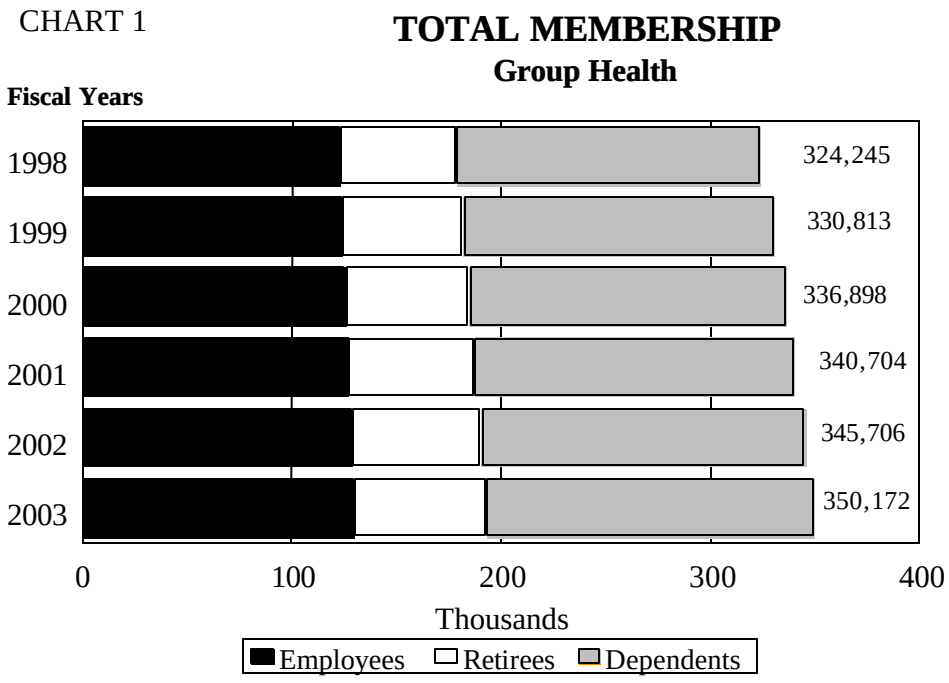
contacts is provided at no additional premium costs. Appendix I describes the types of health and dental plans offered by the State.

Basic life insurance is provided at no cost to employees, retirees and annuitants. Full-time employees receive coverage equal to their annual salary. Retirees and annuitants receive coverage equal to the annual salary as of the last day of employment until the age of 60, at which time the benefit amount becomes $5,000. Employees are allowed to purchase optional term life insurance up to four 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

The State Employees' Group Health Insurance Program currently has 350,172 participants. 200,922 in managed care, and 149,250 in the Quality Care Health Plan. The number of participants has increased steadily over the years as evidenced in Chart 1.

CHART 1



The Department of Central Management Services (CMS) has been attempting to reduce the cost of the medical indemnity program for the past several years. The Department has implemented various cost containment measures and has encouraged members to participate in managed care plans. Some of the cost containment measures include the establishment

of preferred provider networks, medical case management, pre-admission review, hospital bill audit, retail pharmacy network and a mental health/chemical dependency program. Managed care remains the preferred method for cost containment nationwide.

ENROLLMENT TRENDS

Between FY 2000 and FY 2002, membership in the Quality Care Plan has gradually decreased, and enrollment in this indemnity plan is expected to be slightly lower in FY 2003. At the same time, membership in managed care plans has consistently increased. In FY 2002, the percentage of enrollees in managed care (56%) was slightly higher than the FY 2001 level of 54.4 %. The percentage of FY 2002 enrollees in the indemnity plan, (44%), was slightly lower than FY 2001 enrollment of 45.6%. Recent enrollment trends seem to indicate that the State's effort to encourage its members to move from the indemnity plan to managed care has leveled off.

LIABILITY

While the mid-1990's saw health care cost increases slow, recent years have experienced steady increases, ranging from 12.3% to 13.6% over prior years. The Department's estimate of liability for FY 2003 represents a 13.6% growth rate over FY 2002. This increase in estimated liability is slightly higher than the increase from FY 2001 to FY 2002, when liability increased 13.0%. Table 3 illustrates the cost components for the Group Health Insurance Program from FY 1994 through FY 2003.

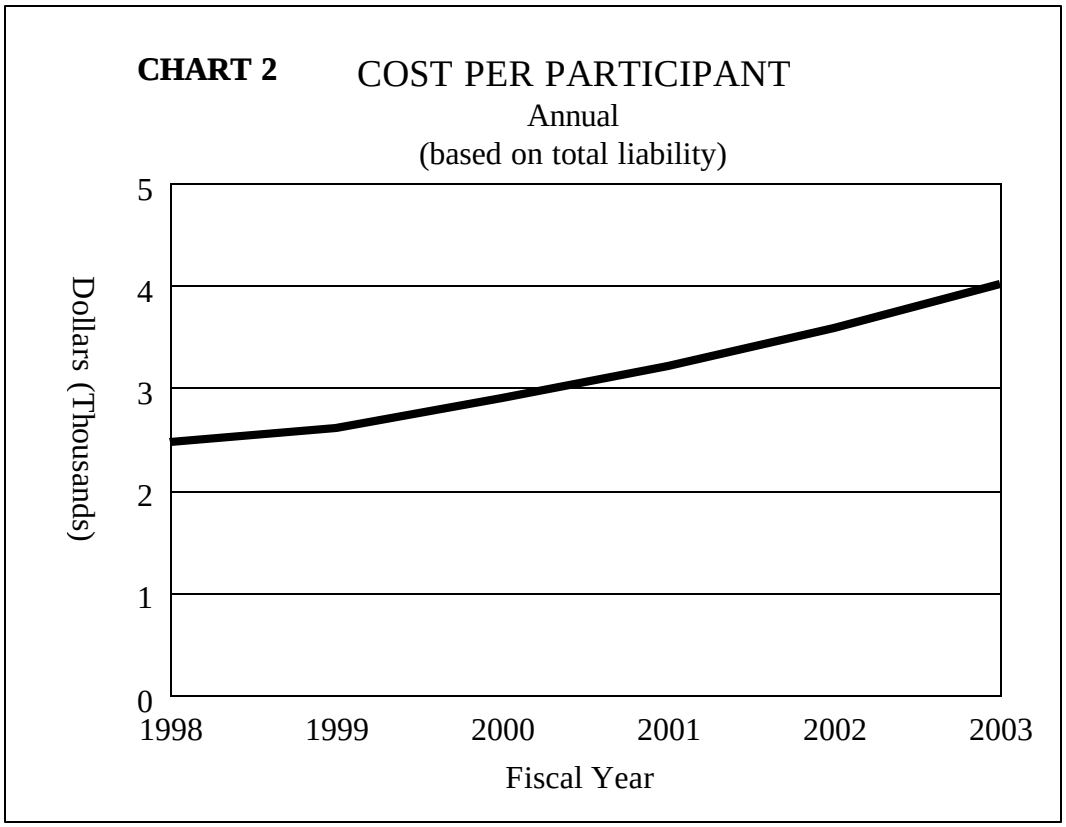
TABLE 3: STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY
FY 1994 to FY 2003
($ in Millions)

	1994	1995	1996	1997	1998	1999	2000*	2001*	2002*	2003*
Liability Component										
QCHP Medical/Rx	325.2	317.3	326.7	356.8	381.7	426.3	499.1	557.2	622.6	694.9
HMO Medical	136.8	184.3	219.1	238.0	250.2	269.9	305.5	361.4	402.1	473.1
Dental	30.3	31.7	30.2	39.5	39.0	39.6	40.3	48.7	57.1	63.5
POS	21.9	28.3	24.7	19.1	20.8	23.0	16.0	7.9	7.5	7.4
Open Access Plan									39.6	46.6
QC Mental Health	23.8	19.2	13.1	11.3	11.0	10.8	11.1	11.0	9.3	9.5
Vision		4.3	6.3	6.9	7.7	8.5	7.5	10.4	10.9	11.3
Life Insurance	55.3	55.9	58.8	58.8	57.7	59.8	68.1	71.8	60.3	63.5
QC ASC	18.9	18.3	21.3	19.3	23.9	18.2	18.6	18.8	19.0	26.2
Admin/Int/Other	3.9	5.5	9.6	7.5	10.9	10.6	12.4	12.0	14.2	15.0
TOTAL	**616.1**	**664.8**	**709.8**	**757.2**	**802.9**	**866.7**	**978.6**	**1,099.2**	**1,242.6**	**1.411.0**
% Inc over py	8.6%	7.9%	6.8%	6.7%	6.0%	7.9%	12.9%	12.3%	13.0%	13.6%

* FY 2000-2003 figures are estimates: Source-CMS

ANNUAL COST PER PARTICIPANT

The cost per participant in the State Employees' Group Insurance Program is the total of the State's cost and the employee's contribution each month. Chart 2A below shows the steady increase each year in cost per participant. In FY 1998, the annual cost per participant in the group health insurance program was $2,475.90. **The estimated cost per participant for FY 2003 is $4,029.45, a 62.7% increase from the FY 1998 cost per participant**. The cost per participant increased 11.4% from FY 2001 to FY 2002. The FY 2003 cost per participant is estimated to increase more than 12% over FY 2002. The increase in cost per participant from FY 1998 to FY 1999 was 5.8%; each year thereafter the cost per participant has increased 11% or more.

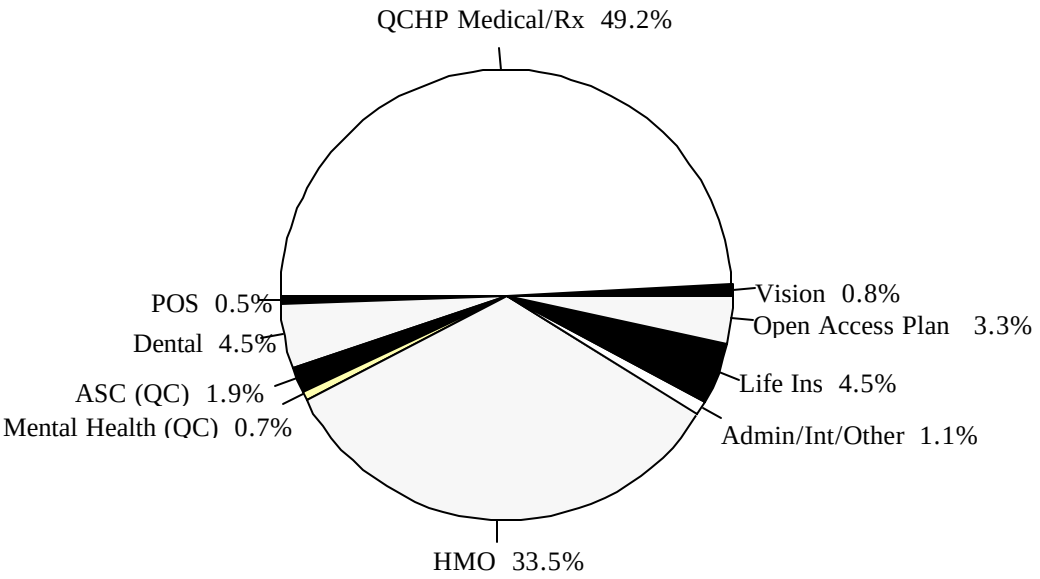


Retirees and their survivors (with less than 20 years of creditable service) are required to pay a portion of their health care costs (P.A. 90-0065). The remainder is paid by the State.

The following chart includes the various components of the FY 2003 CMS liability estimate of $1.411 billion. The largest component of the State Group Insurance Program is the indemnity plan, (Quality Care Health Plan) administered by UNICARE. The indemnity component (52%) includes medical/prescriptions, mental health coverage, and administrative service charges. Managed care plans (HMO, POS, OAP) represent 37% of FY 2003 liability, while dental care, life insurance, vision care, and other charges comprise 11% of total liability.

CHART 3 **GROUP INSURANCE COMPONENTS**

FY 2003 Estimated Liability



CHANGES IN PLAN MEMBERSHIP FROM FY 2001 TO FY 2002

The State Employees' Group Health Insurance Program saw 8.29% of its members (employees and retirees) changing their health carriers for the FY 2002 enrollment period. The indemnity plan experienced a 1.15% increase in membership, with 2,191 members migrating from managed care to the Quality Care Health Plan. Despite this overall increase in indemnity plan enrollment, 3,414 members moved from the indemnity plan to a managed care plan in FY 2002.

Total enrollment (employees, retirees, and dependents) in the Quality Care Health Plan decreased 2.1% from 155,340 to 152,085. HMO plan membership decreased 5,49 (3%), from 181,546 to 176,053. POS plan membership also decreased (12.8%) from 3,818 to 3,330. There was an overall increase in total membership of 1.5% with the addition of the Open Access Plan (managed care), which had 14, 238 members in FY 2002.

The enrollment in the indemnity, HMO, OAP, and POS plans for FY 2001 and FY 2002 are shown in Table 4 below. **FY 2003 enrollment has been estimated by CMS, but is not included in Table 4 because the enrollment period has not occurred yet, nor have the managed care contracts been approved for FY 2003.**

Prior to the FY 2002 benefit choice period, CMS terminated its contractual arrangements with three carriers, while adding one new managed care plan (the open access plan).

TABLE 4: Average Annual Cost per Participant
Average Enrollment

	FY 2002	FY 2001	FY 2002	FY 2001
	Average Cost Per Participant*	Average Cost Per Participant*	Total Participants	Total Participants
Indemnity (QCHP)	$4,267	$3,767	152,085	155,340
HMO	$2,284	$1,991	176,053	181,546
OAP	$2,784	N/A	14,238	N/A
POS	$2,240	$2,065	3,330	3,818
			345,706	340,704

* OAP is the Health Link Open Access Plan. ACPP does not include dental, vision, admin/int/other, or life insurance.

When comparing average cost per participant (ACPP) in Table 4, the average cost for FY 2002 is lowest for members in a POS plan and highest (almost twice as much) for those in the indemnity plan. **The FY 2002 ACPP in the indemnity plan is approximately 90% higher than in the POS plans, 87% higher than the ACPP in the HMO plans, and 53% higher than the ACPP in the Open Access Plan.**

The Department is continuing to encourage the trend toward managed care in order to further temper rising costs. Indemnity plan enrollment decreased 2.1 percent from FY 01 to FY 02, and is expected to decrease 1.9 percent from FY 2002 to FY 2003. Since FY 00, enrollment in the far more costly indemnity plan has steadily decreased.

The largest age group switching to a managed care plan from an indemnity plan in FY 2002 was the 0-39 age group. Predominately, the members joining a managed care plan tend to be under the age of 55. Persons in this age group typically include parents and their dependents. While dependent care coverage is less expensive in a managed care plan than in the indemnity plan, members over the age of 55 have shown a reluctance to switch to a managed care plan. These members have higher medical utilization and may fear being denied access to specialists. Members over the age of 55 may also be unwilling to change primary physicians. For members on Medicare, the coordination of benefits with a managed care plan may be confusing and/or disadvantageous.

MANAGED CARE PLANS

HMO-style plans differ from typical indemnity plans in several ways. Members are required 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 indemnity plans typically do not. However, the State's indemnity 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 indemnity plan are in accordance with the current collective bargaining agreement with the American Federation of State, County and Municipal Employees (AFSCME).

The Point of Service plan is a combination of traditional health coverage and HMO benefits. Participants may choose to go to a participating HMO physician and receive enhanced coverage, or go to any physician outside the network and receive benefits with applicable deductibles and coinsurances. Participants may choose the type of coverage meeting their needs each time they seek medical care.

Before FY 1997, the POS plan was self-funded. An administration fee was paid by the State as well as a fixed amount to the POS provider for each member. In addition, members paid a minimal premium, as well as a portion of the dependent care cost. The plan was then self-insured for the remaining benefits with the State covering all other medical costs. Currently, the POS plan is fully insured. A premium is paid by the members (and the State) to the insurance provider and the POS plan assumes all of the risk.

The Open Access Plan (Health Link), first offered for the FY 2002 benefit year, is a managed care plan that is neither an HMO nor a Point of Service plan. 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, while POS members have two*). 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.

The current network of managed care plans is the result of efforts by CMS to increase the concentration of State members into managed care plans statewide. Beginning July 1, 2001, one new managed care plan, Health Link Open Access Plan, was offered to State members. CMS also terminated contracts with three plans for FY 2002: Prudential HMO, Prudential POS, and Aetna US Healthcare HMO. In FY 2002 (as of 8/5/01), 192,354 state members and their dependents were participants in one of ten managed care plans, an increase of 3.2% over FY 2001 enrollment. In FY 2003, 11 plans will be available to members and their dependents.

The plan with the largest enrollment is Health Alliance HMO, and the plan with the smallest is OSF Winnebago. Greater detail about FY 2001 and FY 2002 plan enrollment, as well as the areas served by each plan, is listed in Table 5 on the following page.

The trend in health care nationwide indicates that managed care has peaked; however, PPO plans continue to expand. It is believed that one of the best ways to control medical costs is to institute managed care plans, which closely control the use of medical services to keep costs down. The State has realized some cost savings from implementing managed care plans. The long-term effect on costs as a result of implementing managed care, however, remains to be seen.

Approximately 56% of those enrolled in the State Employees' Group Insurance Program are in managed care plans.

TABLE 5: MANAGED CARE PLANS
FY 2001 – FY 2002 Actual Membership

	HMO/POS	FY01 # of Participants As of 8/5/00	FY02 # of Participants As of 8/5/01	% Chg.	Areas Served
	Health Alliance HMO	70,003	70,880	1.3%	Cook & Downstate, throughout IL
	Health Alliance Illinois	3,554	4,039	13.6%	Ogle & DeKalb Counties
	HMO Illinois	14,739	23,376	58.6%	Chicago & Springfield areas
	Humana Premier HMO	23,801	23,784	-.1%	Cook & Collar Counties
	Humana POS	2,532	3,297	30.2%	Chicago area
	OSF Health Plans	12,455	13,345	7.1%	Northern & Central IL
	Personal Care	25,566	25,298	-1.0%	Eastern IL
	Unicare HMO (Rush Prudential)	10,888	11,823	8.6%	Chicago area
	OSF Winnebago	1,963	2,266	15.4%	Winnebago County
N	Health Link OAP		14,246		Central and Southern Illinois
T	Aetna U.S. Health Care HMO	7,614	0		Chicago area
T	Prudential HMO	9,477	0		St. Louis area
T	Prudential POS	1,144	0		St. Louis area
TOTAL Members + Dependents		**183,736**	**192,354**	**3.2%**	

As of July 1, 2001, 10 plans were available to employees and their dependents.
N = New Plan
T = Terminated plan; no longer available to members in Illinois.
NOTE: Table 4 reflects average enrollment, while this table looks at actual enrollment from two different points in time.

MONTHLY PREMIUMS

Typically, members in managed care plans cost the State less since the risk of providing health care is assumed by the HMO. The indemnity plan continues to be the significantly more expensive plan.

According to the Department, the estimated monthly cost for a current employee in the Quality Care indemnity plan for FY 2002 is $437 and will increase to $497 (13.7%) by FY 2003. The monthly cost includes both the State's portion ($457 in FY 03) and the employee's monthly contribution ($40 in FY 03).

The monthly premium for a current employee in a managed care plan varies based on each plan's rates, but the FY 2002 estimated average cost for a member in a managed care plan

will be $246 per month, and will increase to $278 by FY 2003. Employees pay a minimal, graduated premium based on salary for managed care plan membership-approximately $29 per month in FY 2002, and $31 per month in FY 2003.

In FY 1998, a new approach for negotiating premium rates with managed care vendors was utilized. Previously, premium rates were negotiated based on four rate tiers; member only, one dependent, two or more dependents, and Medicare dependent. In FY 1998 and FY 1999, multipliers based on historical claims and enrollment experience were used for each of the dependent rate tiers. Thus, only the employee rate is negotiated with each managed care provider, and then the appropriate multiplier is applied to that rate. The FY 2003 multipliers remain unchanged since FY 2001.

FY 2003 Managed Care Multipliers

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

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

Table 6 below shows the FY 2003 weighted average monthly rates for managed care plans and the indemnity plans, as well as the State and member contributions. The State's contribution varies, depending on a member's salary.

TABLE 6: MONTHLY PREMIUMS
Managed Care vs. Indemnity Plan
Weighted Average
FY 2003 Rates (Projected)

	QCHP			Managed Care		
Membership	TOTAL	Member	State	TOTAL	Member	State
Employee	**$497.13**	$40.16	$456.97	**$278.05**	$31.12	$246.97
Medicare Retiree	**$306.66**	$4.88	$301.78	**$179.96**	$6.53	$173.43
Non-Medicare Retiree	**$741.32**	$4.88	$736.44	**$412.26**	$6.53	$405.73
1 Dependent	**$547.05**	$139.00	$408.05	**$234.36**	$63.88	$170.48
2 + Dependents	**$621.98**	$169.00	$452.98	**$403.42**	$101.89	$301.53
Medicare Dependent	**$290.25**	$85.00	$205.25	**$182.43**	$60.49	$121.94

It is evident from Table 6 that managed care plans have saved the State money by reducing the cost of medical care. The State's contribution for indemnity plan coverage is higher in every instance than the average State contribution under an HMO.

TABLE 7: PROJECTED COSTS
FY 2001 – FY 2003
Employee Only

	QCHP				Managed Care			
	TOTAL	% Increase	Member	State	TOTAL	% Increase	Member	State
FY 2001	$390.34		$34.16	$356.18	$213.15		$27.12	$186.03
FY 2002	$436.85	11.9%	$37.16	$399.69	$246.10	15.4%	$29.12	$216.98
FY 2003	$497.13	13.8%	$40.16	$456.97	$278.09	13.0%	$31.12	$246.97

IEFC's estimate of group insurance liability for FY 2003 reflects a trend in rising prescription drug costs. Noteworthy trends used to estimate the growth in liability from FY 2001 to FY 2002 include the following:

- Prescription drug (QCHP) 17.45%
- HMO Medical/Rx 18.30%
- QC Medical 13.15%

TYPES OF MEDICAL & DENTAL GROUP INSURANCE PLANS

APPENDIX I

Type of Plan	Coverage	Characteristics	Geographic Location
Indemnity 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.
Indemnity Dental	Preventive, diagnostic, restorative, orthodontic, endodontic, and periodontic services as well as extractions and prosthetics.	Choice of dental care providers, reimbursement on a scheduled basis. No deductibles. Premiums for members and dependents.	No limitations.
HMO Medical	Comprehensive medical benefits including preventive care.	Prepaid benefits, primary care physician who coordinates all care chosen from HMO network. Co-payments vary by HMO plan. Employee premiums, based on salary, vary for dependents by plan.	Statewide coverage
HMO Dental	Preventive and diagnostic services, and coverage for certain procedures not covered by indemnity dental plan.	No premiums, deductibles, or annual benefit limits; co-payments apply, dentists must be chosen from network of providers.	Statewide coverage
POS	Comprehensive medical benefits including preventive care.	Benefits prepaid, PCP physicians must be chosen from POS network who coordinates all in-network care at lower co-payments; may also use physicians not in the network and receive reduced benefits. Deductibles for out of network care vary by plan. Employee premiums, based on salary, vary for dependents by plan.	Statewide coverage
OAP	Comprehensive medical benefits including preventive care.	Three tiers of benefit levels. Patients may see specialists without referral from the primary care physician. Co-payment levels vary.	Southern Illinois, St. Louis Metro-East area.

APPENDIX II

Group Insurance Contracts to be Awarded or Renewed for FY 2003		
Contract	***Type of Contract***	***Renewal/Competitively Selected***
Caremark	Rx benefit administrator (QCHP members)	Competitively Selected
CIGNA	Claims administrator for health care benefits (QCHP members)	Competitively Selected
CompDent (2)	Dental (QCHP and managed care members)	Multi-year
Fringe Benefit Management Company	Flexible Spending Administrator	Renewal
Intracorp	Utilization review administrator (QCHP members)	Competitively Selected
Magellan Behavioral Health	Mental health/substance abuse services (QCHP members)	Multi-year
Medical Cost Management	Peer review	Renewal
Minnesota Life Insurance Company	Term life insurance	Multi-year
Primax	Subrogation	Renewal
Sykes Health Plan Services	Hospital bill auditing	Renewal
Vision Service Plan	Vision care (all members)	Renewal
Wage Works	Qualified Transportation Benefit Administrator	Competitively Selected

Managed Care Contracts for FY 2003		
Health Alliance HMO		Renewal
Health Alliance Illinois		Renewal
Health Link OAP		Renewal
HMO Illinois		Renewal
Humana HMO		Renewal
Humana POS		Renewal
OSF Health Plan		Renewal
OSF Winnebago		Renewal
Personal Care		Renewal
Personal Care East*****		Renewal
Unicare HMO		Renewal
***** Personal Care East is an expansion of Personal Care		

NEW		***TERMINATED***
Caremark	CIGNA	NPA
Intracorp	Wage Works	UNICARE

BACKGROUND

The Illinois Economic and Fiscal Commission, 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; and

5) 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.

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 two primary reports. The "Revenue Estimate and Economic Outlook" describes and projects economic conditions and their impact on State revenues. "The Illinois Bond Watcher" examines the State's debt position as well as other issues directly related to conditions in the financial markets. The Commission also periodically publishes special topic reports that have or could have an impact on the economic well being of Illinois.

These reports are available from:

Illinois Economic and Fiscal Commission
703 Stratton Office Building
Springfield, Illinois 62706
(217) 782-5320
(217) 782-3513 (FAX)

Reports can also be accessed from our Webpage:

http://www.legis.state.il.us/commission/ecfisc/ecfisc_home.html