ILLINOIS ECONOMIC
and
FISCAL COMMISSION

FY 2004 LIABILITIES OF THE STATE EMPLOYEES' GROUP INSURANCE PROGRAM

MARCH 2003
703 STRATTON BUILDING
SPRINGFIELD, ILLINOIS 62706

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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 on all matters relating to policy and administration of the Group Insurance Act.
- To review and approve contracts recommended by the Director of CMS related to the Group Insurance Program.

Due to the Governor's extended deadline for presenting the FY 2004 budget, at the time this report was written there was no appropriation information available. The table below illustrates historical appropriation and liability amounts for the group insurance program, per CMS. The IEFC FY 2004 estimate of liability is approximately $1,588.4 billion, $14.7 million more than CMS.

According to CMS, the Group Insurance Program will fall $65 million short in the payment of FY 2003 claims. Currently, the payment cycle for preferred providers is 70 days, while non-preferred providers have a payment cycle of 105 days. At this time it is not possible to project FY 2004 payment cycles.

The FY 2004 monthly cost of an employee in the indemnity plan is expected to increase 13.0% over the FY 2003 cost. The monthly cost of an employee in the managed care plan is expected to increase 16.3% over the FY 2003 cost.

APPROPRIATION AND LIABILITY HISTORY
FY 1999-2004
($ in Millions)

Fiscal Year	Appropriation	CMS Liability	IEFC Liability
FY 1999	$852.0	$865.9	-
FY 2000	$1,003.0	$973.4*	-
FY 2001	$1,085.0	$1,081.5*	-
FY 2002	$1,262.7	$1,229.0*	-
FY 2003	$1,355.9	$1,378.1*	-
FY 2004	N/A	$1,573.7*	$1,588.4*

*Estimated

FY 2004 IEFC COST ESTIMATE

The Illinois Economic and Fiscal Commission's (IEFC) FY 2004 cost projection utilizes the CMS revised estimate for FY 2003 medical claims as the basis for estimating claims for FY 2004. This revision is based on actual claims to date.

The IEFC cost estimate for FY 2004 uses the following assumptions based on historical claims data and anticipated cost increases:

TREND FACTORS	
Medical (indemnity plan/QCHP)	11.44%
Dental (QCHP and MC)	15.74%
HMO (medical and Rx)	18.37%
Prescription drugs (QCHP)	24.97%
Administrative service charges (QCHP)	0%
Life insurance	3.26%
Special programs (QCHP)	25.83%

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 2004 liability of approximately $1,588.4 billion for the State Employee's Group Health Insurance Program. The table below shows a detailed comparison of the IEFC estimate for the various cost components and the CMS projection for FY 2004.

TABLE 1: FY 2004 GROUP HEALTH INSURANCE LIABILITY ($ in Millions)			
Liability Component	FY 2003 CMS Estimate	FY 2004 CMS Estimate	FY 2004 IEFC Estimate
QCHP Medical	$505.2	$558.7	$563.0
QCHP Prescriptions	$146.7	$176.3	$183.3
Dental (QCHP/MC)	$70.1	$79.4	$81.1
HMO	$469.0	$554.9	$555.2
Open Access Plan	$56.9	$67.2	$68.3
POS	$8.4	$9.8	$9.3
Mental Health	$9.8	$10.0	$10.3
Vision	$11.1	$11.4	$11.5
Administrative Services (QCHP)	$24.3	$23.2	$24.3
Life	$63.3	65.8	$65.4
Special Programs (Admin/Int/Other)	$13.3	$17.0	$16.7
TOTAL	**$1,378.1**	**$1,573.7**	**1,588.4**
% Increase over FY 2003 CMS Estimate		14.2%	15.3%

ESTIMATE COMPARISON

The Commission's FY 2004 estimate is $14.7 million higher than the FY 2004 estimate from CMS. IEFC's 2004 HMO liability estimate is $300.0 thousand higher than CMS, IEFC's indemnity medical estimate is $4.3 million higher than CMS, and IEFC's Dental estimate is $1.7 million higher than CMS. IEFC's FY 2004 estimate for prescriptions is $7.0 million higher than the CMS estimate.

The IEFC estimates approximately $1,588.4 billion would be required to fully fund the FY 2004 liabilities of the Group Health Insurance Program. This estimate is $210.3 million or 15.3% more than the FY 2003 estimated liability of $1,378.1 billion. The difference between the FY 2004 IEFC and CMS liability estimates is $14.7 million. An additional $65 million would be needed to cover the shortfall in the Group Health Insurance Program for FY 2003.

APPROPRIATION/FUNDING SOURCES

At the time this report was written the FY 2004 budget recommendations had not been released. However, appropriations usually exceed liabilities due to the requirement of a cash balance for the State Group Insurance Program. Funds for the Group Health Insurance Program are 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.

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

	FY 2002	FY 2003	Increase	% Increase
GRF	$699.8	$769.9	$70.1	10.0%
Road	85.9	92.2	$6.3	7.3%
Other Sources	416.60	420.02	$3.4	.01%
TOTAL	**$1,202.3**	**$1,282.1**	**$79.8**	**6.6%**

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***

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 $10 million. For the GIPF, that target balance is $4 million, and the target HIRF balance is $6 million.

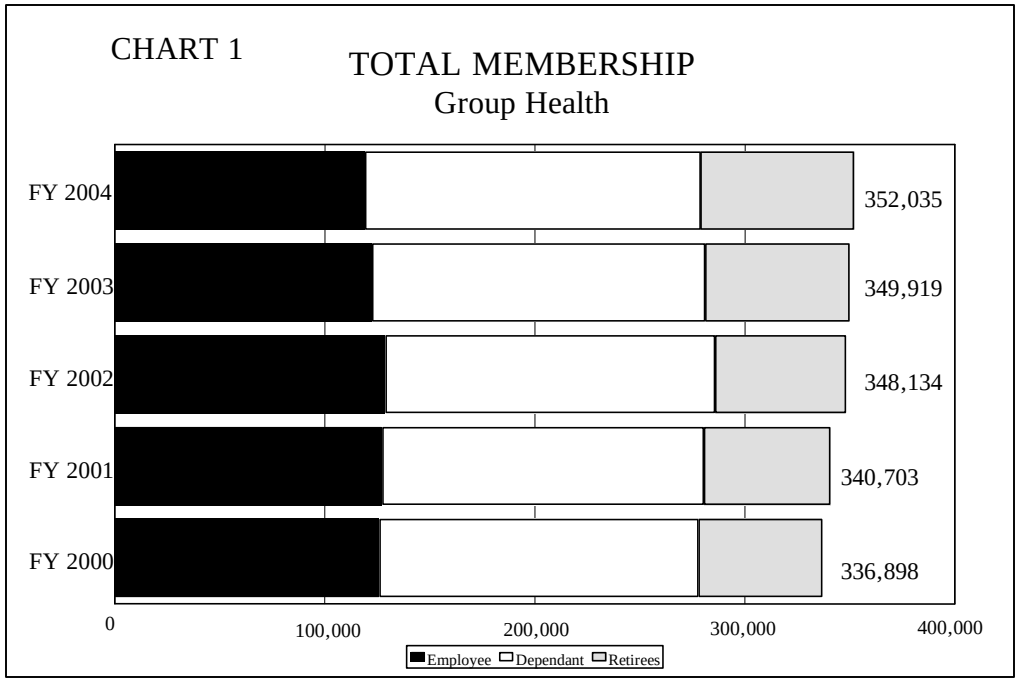
BENEFITS

The State Employees' Group Insurance Program provides medical, dental, vision, and life insurance coverage to State employees, retirees and their dependents. Medical 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 are 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 is projected to have 352,035 participants; 204,122 in managed care, and 147,923 in the Quality Care Health Plan. The number of participants has increased steadily over the years as evidenced in 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 2003, membership in the Quality Care Plan has gradually decreased, and enrollment in this indemnity plan is expected to be slightly lower in FY 2004. At the same time, membership in managed care plans has experienced marginal increases. In FY 2003, the percentage of enrollees in managed care (57.3%) was slightly higher than the FY 2002 level of 56.1%. The percentage of FY 2003 enrollees in the indemnity plan, (42.7%), was slightly lower than FY 2002 enrollment of 43.9%. 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 14.2% over prior years. The Department's estimate of liability for FY 2004 represents a 14.2% growth rate over FY 2003. This increase in estimated liability is slightly higher than the increase from FY 2002 to FY 2003, when liability increased 12.1%. Table 3 illustrates the cost components for the Group Health Insurance Program from FY 1995 through FY 2004.

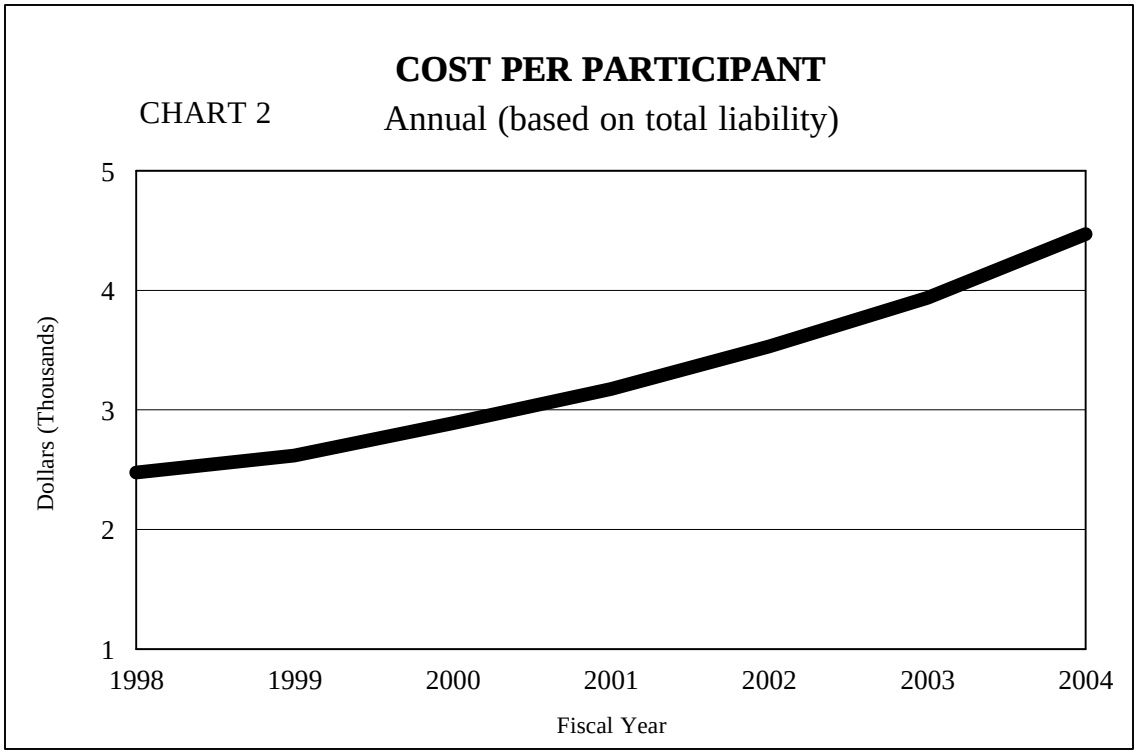
TABLE 3: STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY
FY 1995 to FY 2004
($ in Millions)

Liability Component	1995	1996	1997	1998	1999	2000*	2001*	2002*	2003*	2004*
QCHP Medical/Rx	317.3	326.7	356.8	381.7	425.9	497.1	541	600	651.9	735
HMO Medical	184.3	219.1	238.0	250.2	269.9	305.4	361.5	401.7	469	554.9
Dental	31.7	30.2	39.5	39.0	39.6	40.3	49.1	62	70.1	79.4
POS	28.3	24.7	19.1	20.8	23.0	16.1	7.8	7.5	8.4	9.8
Open Access Plan								42.2	56.9	67.2
QC Mental Health	19.2	13.1	11.3	11.0	10.8	11.1	11.0	9.3	9.8	10
Vision	4.3	6.3	6.9	7.7	8.5	7.5	10.4	10.9	11.1	11.4
Life Insurance	55.9	58.8	58.8	57.7	59.8	64.8	69.8	61.3	63.3	65.8
QC ASC	18.3	21.3	19.3	23.9	18.2	18.6	18.8	19.1	24.3	23.2
Admin/Int/Other	5.5	9.6	7.5	10.9	10.6	12.4	12.0	15.1	13.3	17
TOTAL	**664.8**	**709.8**	**757.2**	**802.9**	**866**	**973.3**	**1,081.5**	**1,229.1**	**1,378.1**	**1,573.7**
% Inc over PY	7.9%	6.8%	6.7%	6.0%	7.9%	12.4%	11.1%	13.7%	12.1%	14.2%

* FY 2000-2004 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 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 $2,476. The **CMS estimated cost per participant for FY 2004 is $4,470, a 80.5% increase from the FY 1998 cost per participant**. The cost per participant increased 11.6% from FY 2002 to FY 2003. The FY 2004 cost per participant is estimated to increase more than 13.5% over FY 2003. 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.



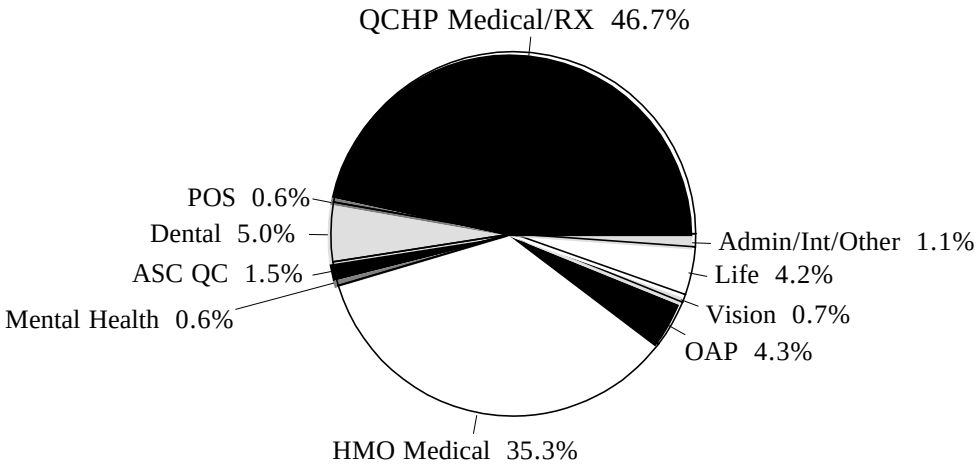
Retirees and their survivors (with less than 20 years of creditable service) are required to pay a portion of their health care costs (P.A. 90-0065). The remainder is paid by the State.

The following chart includes the various components of the FY 2004 CMS liability estimate of $1.573.7 billion. The largest component of the State Group Insurance Program is the indemnity plan, (Quality Care Health Plan) administered by CIGNA. The indemnity component (48.8%) includes medical/prescriptions, mental health coverage, and administrative service charges. Managed care plans (HMO, POS, OAP) represent 40.2% of FY 2004 liability, while dental care, life insurance, vision care, and other charges comprise 11% of total liability.

CHART 3

GROUP INSURANCE COMPONENTS

FY 2004 Estimated Liability



CHANGES IN PLAN MEMBERSHIP FROM FY 2002 TO FY 2003

The State Employees' Group Health Insurance Program saw 7.4% of its members (employees and retirees) changing their health carriers for the FY 2003 enrollment period. The indemnity plan experienced a 0.76% increase in membership, with 1,452 members migrating from managed care to the Quality Care Health Plan. Despite this overall increase in indemnity plan enrollment, 2,814 members moved from the indemnity plan to a managed care plan in FY 2003.

Total enrollment (employees, retirees, and dependents) in the Quality Care Health Plan decreased 2.4% from 152,832 to 149,254. HMO plan membership increased 1.5%, from 176,818 to 179,437. POS plan membership also increased 1.8% from 3,392 to 3,453. Open Access Plan (managed care) membership increased 17.8% from 15,091 to 17,776.

The enrollment in the indemnity, HMO, OAP, and POS plans for FY 2002 and FY 2003 are shown in Table 4 below. **FY 2004 enrollment has been estimated by CMS, but is not included in Table 4 because the enrollment period has not occurred yet.**

TABLE 4: AVERAGE ANNUAL COST PER PARTICIPANT Average Enrollment				
	FY 2003	FY 2002	FY 2003	FY 2002
	Average Cost Per Participant*	Average Cost Per Participant*	Total Participants	Total Participants
Indemnity (QCHP)	$4,582	$4,099	149,254	152,832
HMO	$2,614	$2,272	179,437	176,819
OAP	$3,199	$2,798	17,776	15,091
POS	$2,445	$2,229	3,453	3,392
			349,919	348,134
* 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 2003 is lowest for members in a POS plan and highest (almost twice as much) for those in the indemnity plan. **The FY 2003 ACPP in the indemnity plan is approximately 87.4% higher than in the POS plans, 75.3% higher than the ACPP in the HMO plans, and 43.2% 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 2.4% from FY 02 to FY 03, and is expected to decrease 0.9% from FY 2003 to FY 2004. 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 2003 (as of 8/5/02), 200,405 state members and their dependents were participants in one of eleven managed care plans, an increase of 4.2% over FY 2002 enrollment.

The plan with the largest enrollment is Health Alliance HMO, and the plan with the smallest is OSF Winnebago. Greater detail about FY 2002 and FY 2003 plan enrollment, as well as the areas served by each plan, is listed in Table 5 below.

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.

TABLE 5: MANAGED CARE PLANS
FY 2002 – FY 2003 Actual Membership

	FY02 # of Participants As of 8/5/01	FY03 # of Participants As of 8/5/02	% Change	Areas Served
Health Alliance HMO	70,880	70,770	-0.16%	Cook & Downstate, throughout IL
Health Alliance Illinois	4,039	6,790	68.1%	Ogle & DeKalb Counties
HMO Illinois	23,376	26,630	13.9%	Chicago & Springfield areas
Humana HMO	23,784	22,625	-4.87%	Cook & Collar Counties
Humana POS	3,297	3,463	5.03%	Chicago area
OSF Health Plans	13,345	14,192	6.35%	Northern & Central IL
Personal Care	25,298	11,082	-56.19%	Eastern IL
Unicare HMO (Rush Prudential)	11,823	10,883	-7.95%	Chicago area
OSF Winnebago	2,266	2,176	-3.97%	Winnebago County
Health Link OAP	14,246	17,862	25.38%	Central and Southern Illinois
N Personal Care East*	0	13,932	100.0%	Extension of Personal Care
TOTAL Members + Dependents	**192,354**	**200,405**	**4.19%**	

As of July 1, 2002, 11 plans were available to employees and their dependents.
N = New Plan
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 2003 is $467 and will increase to $534 (14.3%) by FY 2004. The monthly cost includes both the State's portion ($490 in FY04) and the employee's monthly contribution ($43 in FY 04).

The monthly premium for a current employee in a managed care plan varies based on each plan's rates, but the FY 2003 estimated average cost for a member in a managed care plan will be $283 per month, and will increase to $325 by FY 2004. Employees pay a minimal, graduated premium based on salary for managed care plan membership-approximately $31 per month in FY 2003, and $33 per month in FY 2004.

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 2004 multipliers remain unchanged since FY 2001.

FY 2004 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, on the next page shows the FY 2004 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 2004 Rates (Projected)

	QCHP			MANAGED CARE		
Membership	TOTAL	Member	State	TOTAL	Member	State
Employee	$533.61	$43.43	$490.18	$325.10	$33.30	$291.80
Medicare Retiree	$319.01	$6.00	$313.01	$210.60	$7.18	$203.42
Non-Medicare Retiree	$782.27	$6.00	$776.27	$484.80	$7.18	$477.62
1 Dependent	$593.50	$150.00	$443.50	$274.53	$71.32	$203.21
2 + Dependents	$671.30	$180.00	$491.30	$472.17	$109.54	$362.63
Medicare Dependents	$300.91	$96.00	$204.91	$214.77	$67.94	$146.83

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 2004 Employee Only								
	QCHP				Managed Care			
	TOTAL	% Increase	Member	State	TOTAL	% Increase	Member	State
FY 2001	$381.76		$34.16	$347.60	$213.15		$27.12	$186.03
FY 2002	$421.55	11.9%	$37.30	$384.25	$246.10	15.4%	$29.12	$216.98
FY 2003	$466.72	13.8%	$40.43	$426.29	$278.09	13.0%	$31.12	$246.97
FY2004	$533.61	14.3%	$43.43	$490.18	$325.10	16.9%	$33.30	$291.80

IEFC's estimate of group insurance liability for FY 2004 reflects a trend in rising prescription drug costs. Noteworthy trends used to estimate the growth in liability from FY 2003 to FY 2004 include the following:

- Prescription drug (QCHP) 24.97%
- HMO Medical/Rx 18.37%
- QC Medical 11.44%

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 2004		
Contract	***Type of Contract***	***Renewal/Competitively Selected***
Caremark	Rx benefit administrator (QCHP members)	Multi-Year
CIGNA	Claims administrator for health care benefits (QCHP members)	Multi-Year
CompDent (2)	Dental (QCHP and managed care members)	Multi-year
Fringe Benefit Management Company	Flexible Spending Administrator	Renewal
Intracorp	Utilization review administrator (QCHP members)	Multi-Year
Magellan Behavioral Health	Mental health/substance abuse services (QCHP members)	Multi-year
Medical Cost Management	Peer review	Competitively Selected
Minnesota Life Insurance Company	Term life insurance	Multi-year
Primax	Subrogation	Renewal
Sykes Health Plan Services	Hospital bill auditing	Multi-Year
Vision Service Plan	Vision care (all members)	Renewal
Wage Works	Qualified Transportation Benefit Administrator	Renewal

Managed Care Contracts for FY 2004		
Health Alliance HMO		Still Negotiating
Health Alliance Illinois		Still Negotiating
Health Link OAP		Still Negotiating
HMO Illinois		Still Negotiating
Humana HMO		Still Negotiating
Humana POS		Still Negotiating
OSF Health Plan		Still Negotiating
OSF Winnebago		Still Negotiating
Personal Care		Still Negotiating
Personal Care East*****		Still Negotiating
Unicare HMO		Still Negotiating
***** 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