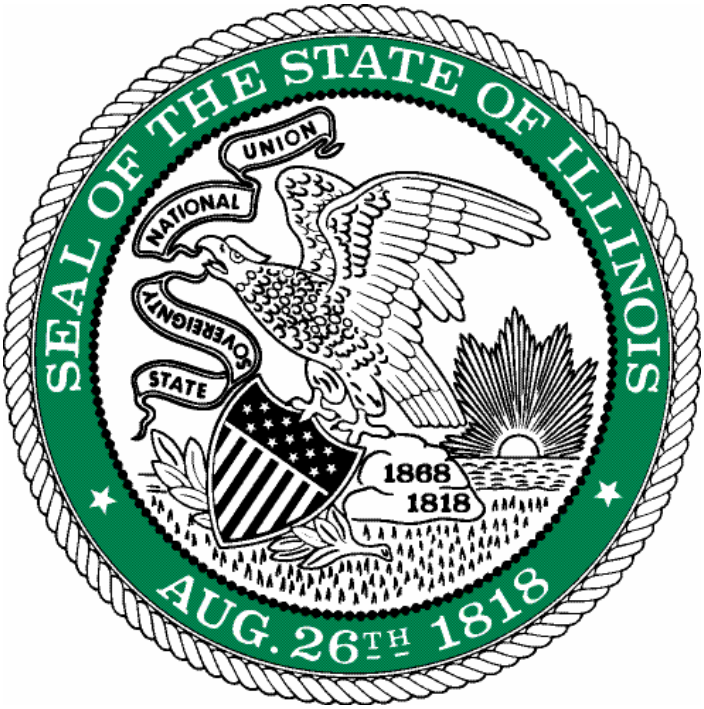

FISCAL YEAR 2008
LIABILITIES OF THE STATE EMPLOYEES' GROUP INSURANCE PROGRAM

Commission on Government
Forecasting and Accountability
703 Stratton Office Building
Springfield, Illinois 62706

March 2007

Commission on Government Forecasting and Accountability

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EXECUTIVE SUMMARY

The Commission on Government Forecasting and Accountability (CGFA) 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 the Department of Healthcare and Family Services (HFS) to advise the departments on all matters relating to policy and administration of the Group Insurance Act.
- To review and approve contracts recommended by the Directors of HFS and CMS related to the Group Insurance Program.

The Governor has requested that a total of $1,984.1 million be appropriated for the State Employees' Group Health and Life Insurance program for FY 2008. The requested FY 2007 appropriation for the Group Health Insurance Program was $1,886.6 million. The following table represents historical appropriation and liability amounts, per HFS. The CGFA FY 2008 estimate of liability is $1,984.7 million, $27.3 million more than the HFS estimate of $1,957.4 million.

According to HFS, the Group Insurance Program will fall $24.5 million short in the payment of FY 2007 claims, and expects a shortfall in FY 2008 of $24.5 million. Currently, the payment cycles for preferred providers is 28 days, while non-preferred providers also have a payment cycle of 28 days. Dental claims have a hold cycle of 28 days.

The Department's FY 2008 estimated liability for the indemnity plan is expected to increase 3.3% over the FY 2007 liability. The estimated liabilities for the State managed care plans is expected to increase 11.7% over the FY 2007 cost. In comparison, the FY 2007 liability for the indemnity plan decreased -1.9% below the FY 2006 cost. FY 2007 liability for the managed care plans increased 7.3% over FY 2006. The Department also projects prescription drug liability to increase 5.1% from $185.3 million to $194.8 million.

APPROPRIATION AND LIABILITY HISTORY
FY 2003-2008
($ in Millions)

Fiscal Year	Appropriation	HFS Liability	CGFA Liability
FY 2003	$1,390.9	$1,300.6	
FY 2004	$1,609.8	$1,490.3*	
FY 2005	$1,720.0	$1,645.0*	
FY 2006	$1,781.1	$1,717.8*	
FY 2007	$1,886.6	$1,821.9*	
FY 2008	$1,984.1	$1,957.4*	$1,984.7*

*Estimated

FY 2008 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2008 cost projection utilizes the HFS revised estimate for FY 2007 medical claims as the basis for estimating claims for FY 2008. This revision is based on actual claims to date.

The CGFA cost estimate for FY 2008 uses the following assumptions based on historical claims data and anticipated cost increases:

TREND FACTORS	
Medical (indemnity plan/QCHP)	4.29%
Dental (QCDP)	4.43%
HMO (medical and Rx)	12.17%
Prescription drugs (QCHP)	9.61%
Administrative service charges (QCHP)	0%
Life insurance	6.20%
Special programs (QCHP)	1.30%

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. The Commission also reviewed literature regarding nationwide trends to examine what other government entities were experiencing. The following is a review of national findings that the Commission felt relevant in determining our trending analysis.

Based on these assumptions and inflation factors, the CGFA estimates a FY 2008 liability of approximately $1,984.7 million for the State Employee's Group Health Insurance Program, $27.3 million more than HFS. The table on the following page shows a detailed comparison of the CGFA estimate for the various cost components and the HFS projection for FY 2008.

TABLE 1: FY 2008 GROUP HEALTH INSURANCE LIABILITY ($ in Millions)			
Liability Component	**FY 2007 HFS Estimate**	**FY 2008 HFS Estimate**	**FY 2008 CGFA Estimate**
QCHP Medical	$505.8	$522.4	$527.5
QCHP Prescriptions	$185.3	$194.8	$203.1
Dental (QCDP)	$107.0	$108.7	$111.7
HMO	$710.2	$793.5	$796.6
Open Access Plan	$153.2	$172.9	$180.1
POS	$0	$0	$0
Mental Health	$8.9	$8.6	$8.9
Vision	$8.2	$8.2	$8.2
Administrative Services (QCHP)	$28.1	$27.8	$28.1
Life	$76.7	$81.4	$81.5
Special Programs (Admin/Int/Other)	$38.4	$38.9	$38.9
TOTAL	**$1,821.9**	**$1,957.4**	**$1,984.7**
% Increase over FY 2007 HFS Estimate		7.4%	8.9%
Rounding may cause slight differences			

The Segal Company compiles a cost trend survey annually that gives data as to how large health plans are trending during the plan year. The 2007 survey shows that Illinois is actually trending better than national assumptions. The following are some of the key findings of the Segal study.

- All medical plan types are forecasted to see cost increases in 2007 that are more than twice the consumer price index and the annual increase in real average weekly earnings.

- For the first time in several years, trends for prescription drug coverage are projected to decelerate in 2007 to levels that are close to trends for medical coverage.

- Compared to trend rates for retail prescription drug coverage, prescription drug mail order trend rates are projected to decrease at least three percentage points for both actives and retirees in 2007.

- Very similar 2007 trend rates are forecasted for preferred provider organizations (PPOs) and health maintenance organizations (HMOs): 11.6 percent and 11.1 percent, respectively. However, projected increases for high-deductible PPOs are expected to be higher: 12.0 percent.

- The survey found some slight regional variances that suggest regional providers may be able to negotiate deeper discounts in their local markets than can national providers.

Table 2 below highlights national trending data and compares it to estimates by HFS and CGFA.

TABLE 2
NATIONAL HEALTH CARE TRENDING CY 2007

Component	National Trend	HFS Increase	COGFA Increase
PPO's	11.6%	3.28%	4.29%
HMO's	11.1%	11.73%	12.17%
Rx	11.5%	5.13%	9.61%
Dental	6.2%	1.59%	4.43%
Vision	5.1%	0%	0%

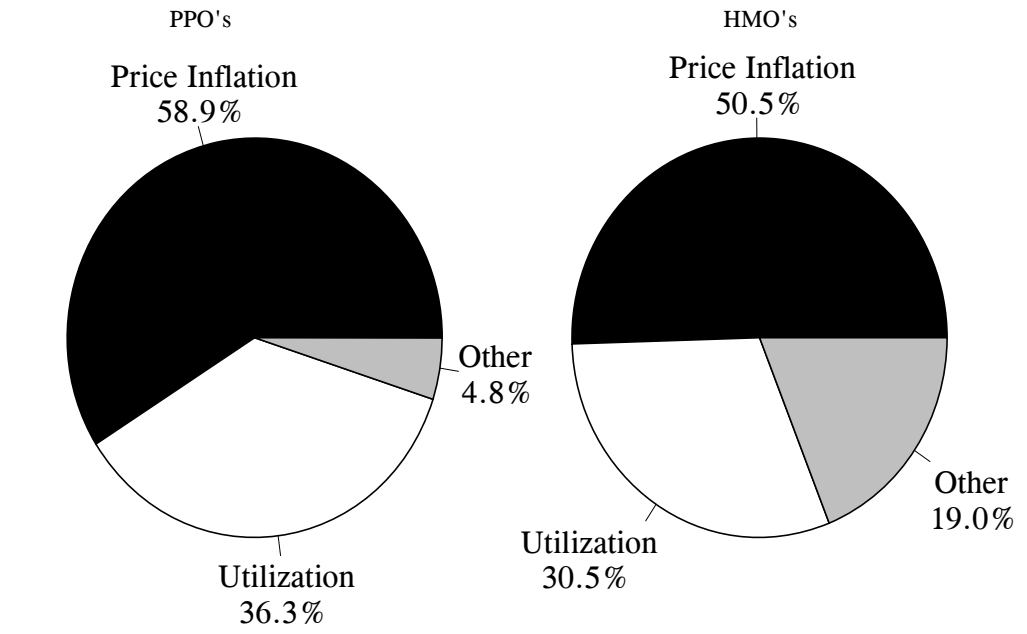
Source: Segal 2007 Health Plan Cost Trend Survey

Although there is usually a strong correlation between trend rates and actual costs, trend and the net annual change in plan costs are not the same. Trend rates allow the Commission to benchmark health plan components to analyze and estimate claims data. Changes in the costs to plan sponsors can be very different from projected cost trends. Such factors as program design changes, employee contribution rate increases, and group demographics can significantly influence total costs.

Historically, Illinois liability estimates are driven by three major components of the group insurance program. The State's indemnity plan, HMO's, and Prescription drug coverage account for a large portion, (77.2%) of the states overall health plan liability. In their study, Segal focused on PPO and HMO networks, as well as, prescription drug trends. Inflation, according to the Segal study, accounts for over 50% in the upward trend in PPO and HMO health plans. Chart 1 on the following page examines the overall components of the current projected trends for PPO's and HMO's.

CHART 1

Components of 2007 Projected PPO & HMO Trends

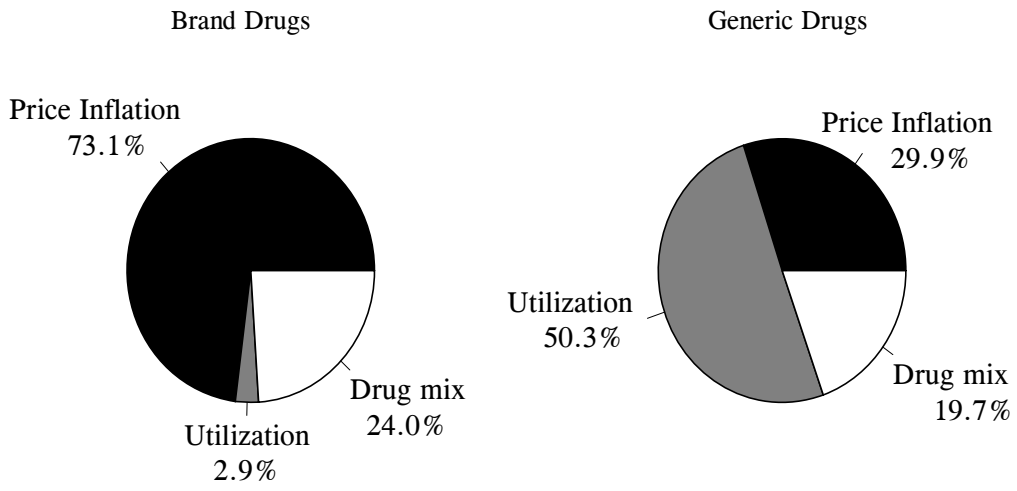


Source: Segal

The State has been dealing with double digit increases in prescription drug costs for some time. The State has negotiated higher employee co-pays and instituted a mail order prescription drug program for participants in the Quality Care Program. Prescription drug trending for persons under 65 years of age are estimated by Segal to be increasing in 2007 approximately 11.9% at the retail level and 11.5% at the mail order level. Inflation, not surprisingly, is a key component of the upward prescription drug trend. Generic drugs components are increasing mostly because of increased utilization. Many plan sponsors require employees to use a generic drug if one is available. The State of Illinois encourages employees to utilize prescription drugs through mail order and by the State's three tiered co-payment structure. Chart 2 shows the main components of the prescription drug trend as reported by Segal.

CHART 2

Components of 2007 Projected Rx Trends



Source: Segal

ESTIMATE COMPARISON

The Commission's FY 2008 estimate is $27.3 million higher than the FY 2008 estimate from HFS. CGFA's 2008 HMO liability estimate is $3.1 million higher than HFS, CGFA's indemnity medical estimate is $5.1 million higher than HFS, and CGFA's Dental estimate is $3.0 million higher than HFS. CGFA's FY 2008 estimate for prescriptions is $8.3 million higher than the HFS estimate.

The CGFA estimates approximately $1,984.7 million would be required to fully fund the FY 2008 liabilities of the Group Health Insurance Program. This estimate is $162.9 million or 8.9% more than the HFS's FY 2007 estimated liability of $1,821.9 million.

APPROPRIATION/FUNDING SOURCES

Expenditures for the State Employees' Group Insurance plans originate from two funds, the Health Insurance Reserve Fund (HIRF), and the Group Insurance Premium Fund (GIPF). Revenues related to health coverage are deposited into HIRF, and revenue related to life insurance are deposited into GIPF. More specifically, GIPF receives contributions by members for optional life insurance or health benefit coverage, or from any other source from which the State is reasonably and properly entitled to as a result of the group health benefits program.

HIRF is the fund mainly used to administer the group insurance program. 5 ILCS 375/13.1 states "All contributions, appropriations, interest, and other dividend payments to fund the program of health benefits shall be deposited into the Health Insurance Reserve Fund. Funding for HIRF comes from several different revenue sources, the General Revenue Fund (GRF), Road Fund, reimbursements, university funds, and member contributions.

The FY 2008 budget request for the Group Health Insurance Program is $1,164.4 million in GRF funds. This represents a $67 million or a 6.1% increase from the FY 2007 GRF appropriation of $1,097.4 million. The FY 2008 Road Fund request of $135.6 million is $5.1 million or 3.9% higher than the FY 2007 Road Fund appropriation level.

TABLE 3: GROUP INSURANCE FUNDING SOURCES
FY 2007 – FY 2008
($ in Millions)

	FY 2007	FY 2008	Increase	% Increase
GRF	$1,097.4	$1,164.4	$67.0	6.1%
Road	$130.5	$135.6	$5.1	3.9%
Other Sources	$576.6	$597.1	$20.6	3.6%
TOTAL	**$1,804.5**	**$1,897.1**	**$92.7**	**5.1%**

HFS sets target end-of-year fund balances for both the Health Insurance Reserve Fund and the Group Insurance Premium Fund. The historical budget target balance for the Group Insurance Program is $10 million. For the GIPF, that target balance is $4 million, and the target HIRF balance is $6 million.

BENEFITS

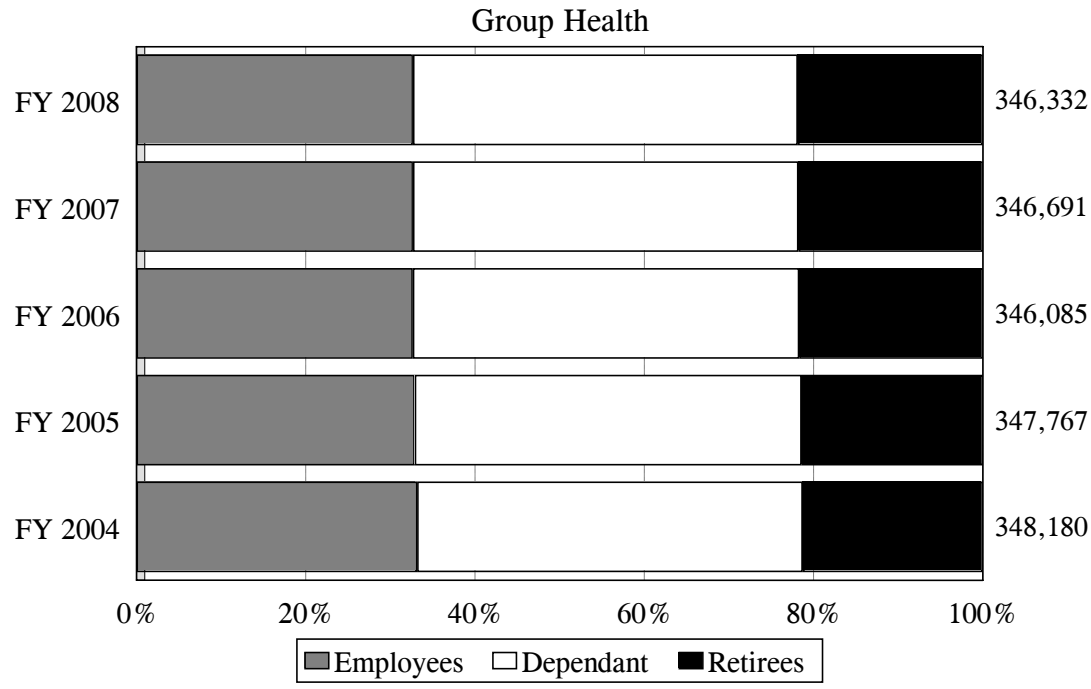
The State Employees' Group Insurance Program provides medical, dental, vision, and life insurance coverage to State employees, retirees and their dependents. Medical coverage is provided separately to members in their choice of: indemnity plan, and various types of managed care plans such as Health Maintenance Organizations (HMO). Vision coverage, which includes savings on exams, glasses, and contacts is provided at no additional premium costs. Appendix II describes the types of health and dental plans offered by the State.

Basic life insurance is provided at no cost to employees, retirees and annuitants. Full-time employees receive 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

The State Employees' Group Health Insurance Program currently has an estimated 346,691 participants, 216,093 in managed care, and 130,598 in the Quality Care Health Plan. Membership in the Group Health Insurance Plan is projected to decrease slightly FY 2008, as evidenced in Chart 3 on the following page.

CHART 3



Membership is estimated for FY 2007 and FY 2008

COST SAVINGS

The State 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

Overall membership in the State Employees' Group Insurance Program has declined since the beginning of FY 2005. Since FY 2003, total membership has decreased from 348,909 to an estimated 346,332 in FY 2008. Membership in the Quality Care Plan has been decreasing since FY 1997. DHS estimated that QCHP membership will decline -4.3% from 130,598 in FY 2007 to an estimated 125,000 in FY 2008. During the same time frame membership in the States' HMO plans has increased. Since FY 2003, membership in the States' HMO plans has increased 10.3%. Many of these

members joined the Open Access Plan over the past several years. HMO plan membership is expected to increase 2.4% from 216,093 in FY 2007 to an estimated 221,332 in FY 2008.

LIABILITY

The Department's estimate of liability for FY 2008 represents a 7.4% growth rate over FY 2007. This increase in estimated liability is higher than the increase from FY 2006 to FY 2007, when liability increased 5.9%. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 1999 through FY 2008.

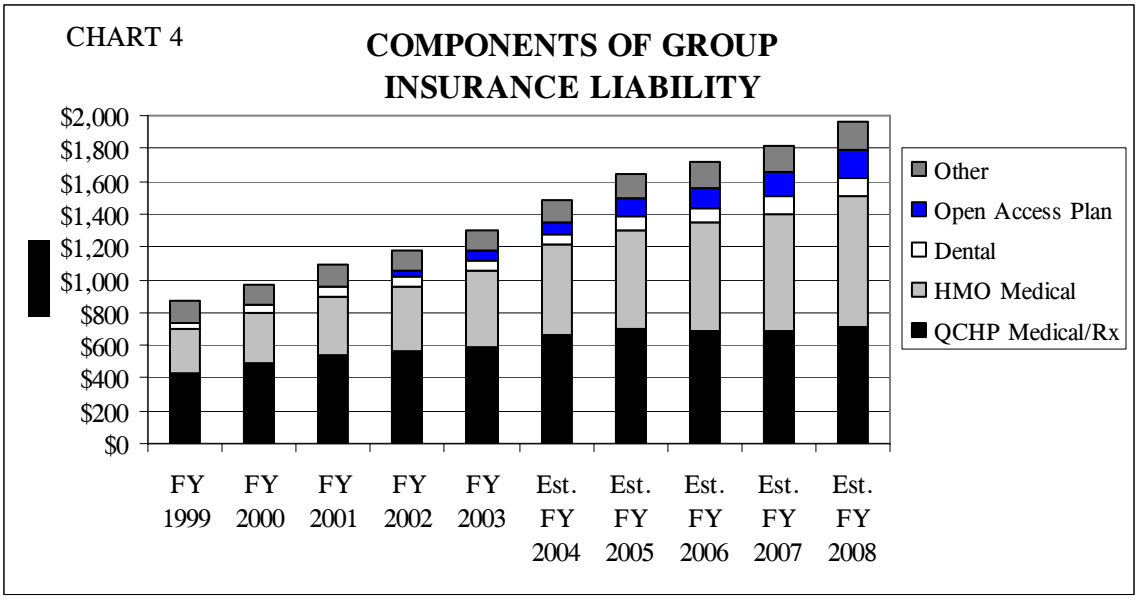
TABLE 4: STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY
FY 1999 to FY 2008
($ in Millions)

Liability Component	1999	2000	2001	2002	2003	2004*	2005*	2006*	2007*	2008*
QCHP Medical/Rx	425.1	496.5	536.9	558.5	584.2	664.1	699.0	693.1	691.1	717.2
HMO Medical	269.9	307.0	364.1	402.1	469.3	544.5	602.9	661.8	710.2	793.5
Dental	39.6	42.4	58.7	58.7	63.6	69.9	88.9	85.0	107.0	108.7
POS	23.0	16.1	7.8	7.6	8.6	-	-	-		
Open Access Plan				36.8	54.8	69.8	102.1	124.4	153.2	172.9
QC Mental Health	10.8	11.1	11.0	9.3	9.2	9.5	9.2	8.9	8.9	8.6
Vision	8.5	7.5	10.4	10.9	11.2	11.5	11.7	8.2	8.2	8.2
Life Insurance	59.8	64.8	70.1	60.4	61.0	65.9	68.8	75.1	76.7	81.4
QC ASC	18.2	15.8	16.0	19.1	24.4	23.2	24.0	29.4	28.1	27.8
Admin/Int/Other	10.6	12.88	11.4	11.8	14.3	31.8	38.5	33.8	38.4	38.9
TOTAL	**865.5**	**974.0**	**1,0790**	**1,175.0**	**1,300.6**	**1,490.3**	**1,645.0**	**1,717.8**	**1,821.9**	**1957.4**
% Inc over py	7.8%	12.5%	10.8%	8.9%	10.7%	14.6%	10.4%	4.5%	5.9%	7.4%

*Estimated
- FY 2004-2008 figures are estimates: Source-HFS
- Rounding causes slight differences in cumulative totals.

The table above demonstrates how several components make up for the majority of the state's total liability. Historically, the Quality Care Health Plan, Prescription Drugs, and HMO's have made up the largest segment of total liability. The groups dental plan and the Open Access Plan also are large components of the total insurance obligation. FY 2008 was the first year in which liabilities for HMO's were higher than the liability for the more costly QCHP. This is in due to a large part of migration of members into less costly managed care plans. Typically, older members in the state plan choose the QCHP in order to maintain physician choice, and enjoy the ease of seeing specialists without referral. Chart 4 on the following page shows the different components of the states group insurance liability.

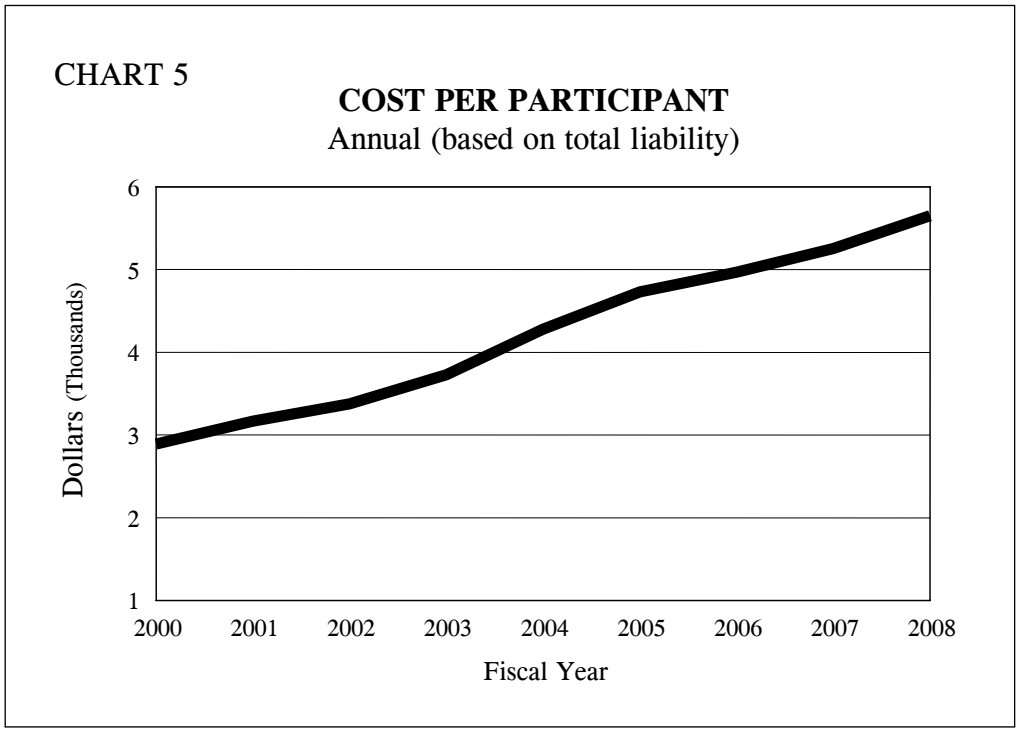
CHART 4



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 5 shows the steady increase each year in cost per participant. This increase can be attributed to medical inflation as evidenced in table 4. In FY 2003, the annual cost per participant in the group health insurance program was $3,728. **The estimated cost per participant for FY 2008 is $5,651, a 52% increase from the FY 2003 cost per participant**. The cost per participant increased 5.8% from FY 2006 to FY 2007. The FY 2008 cost per participant is estimated to increase 7.5% over FY 2007.

CHART 5

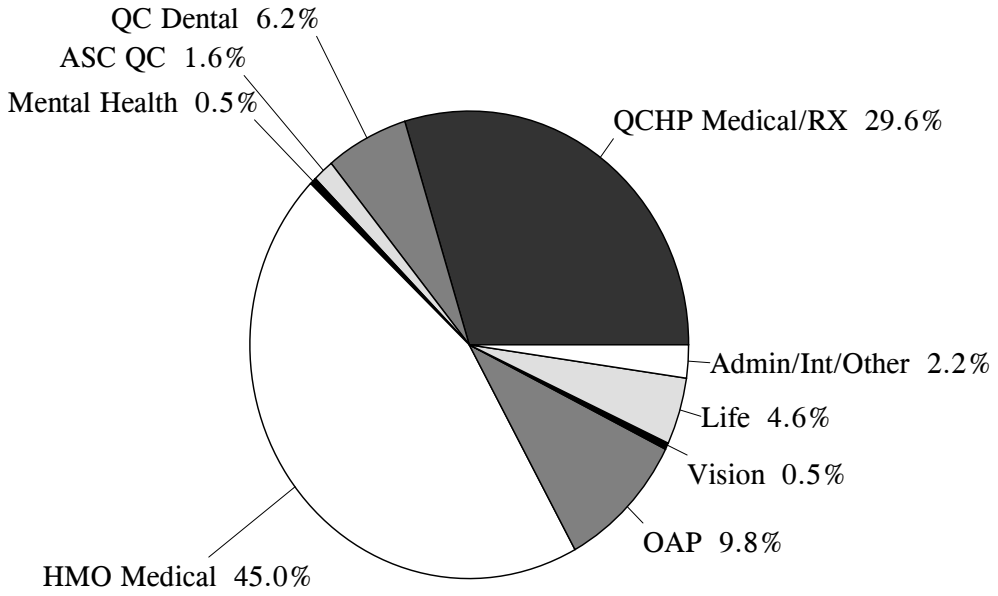


Retirees and their survivors (with less than 20 years of creditable service) are required to pay a portion of their health care costs (P.A. 90-0065). The remainder is paid by the State. The following chart includes the various components of the FY 2008 HFS liability estimate of $1,957.4 million. The largest component of the State Group Insurance Program is the State's managed care plans (HMO and OAP) which represent (54.8%) of FY 2008 liability, while dental care, life insurance, vision care, and other charges comprise (13.5%) of total liability. The indemnity component (31.7%) includes medical/prescriptions, mental health coverage, and administrative service charges.

CHART 6

GROUP INSURANCE COMPONENTS

FY 2008 Estimated Liability



CHANGES IN PLAN MEMBERSHIP FROM FY 2006 TO FY 2007

As of 7/28/06, the State Employees' Group Health Insurance Program saw 2.3% of its members (employees and retirees) changing their health carriers for the FY 2007 enrollment period. The indemnity plan experienced a 0.5% increase in membership, with 924 members migrating from managed care to the Quality Care Health Plan. Despite this overall increase in indemnity plan enrollment, 1,894 members moved from the indemnity plan to a managed care plan in FY 2007. In addition, 1,420 members went from one managed care plan to another.

Total enrollment (employees, retirees, and dependents) in the Quality Care Health Plan decreased 3.2% from 134,922 to 130,598. HMO plan membership increased from 181,775 to 182,224. Open Access Plan (managed care) membership increased 11.8% from 29,388 to 32,869.

The enrollment in the indemnity, HMO, OAP, and POS plans for FY 2006 and FY 2007 are shown in Table 5 on the following page. **FY 2008 enrollment has been estimated by DHS, but is not included in Table 5 because the enrollment period has not occurred yet.**

TABLE 5: Average Annual Cost per Participant Average Enrollment				
	FY 2007	FY 2006	FY 2007	FY 2006
	Average Cost Per Participant*	Average Cost Per Participant*	Total Participants	Total Participants
Indemnity (QCHP)	$5,554	$5,401	130,598	134,922
HMO	$3,876	$3,641	183,224	181,775
OAP	$4,660	$4,243	32,869	29,388
			346,691	346,085
• 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 5, the average cost for FY 2007 is lowest for members in a HMO plan and highest for those in the QCHP. **The FY 2007 ACPP in the QCHP is approximately 43.2% higher than managed care, and 19.2% higher than the ACPP in the OAP. The average cost per enrollee in the indemnity plan is estimated to be $6,007 in FY 2008.**

The largest age group switching to a managed care plan from an indemnity plan in FY 2007 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 Open Access Plan (Health Link), first offered for the FY 2002 plan 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.

The plan with the largest enrollment is Health Alliance HMO, and the plan with the smallest is OSF Winnebago. Greater detail about FY 2006 and FY 2007 plan enrollment, as well as the areas served by each plan, is listed in Table 6 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, and more members continue to migrate to HMO coverage. The long-term effect on costs as a result of implementing managed care, however, remains to be seen.

TABLE 6: MANAGED CARE PLANS
FY 2006 – FY 2007 Actual Membership

HMO/POS	FY06 # of Participants Thru Apr FY 06	FY07 # of Participants Thru July. FY 07	% Chg.	Areas Served
Health Alliance HMO	75,982	76,973	1.30%	Downstate Illinois
Health Alliance Illinois	7,498	7,733	3.13%	DeKalb County and Western, IL
HMO Illinois	48,330	48,647	0.07%	Chicago & Springfield areas
OSF Health Plans	10,036	10,198	1.61%	Northern & Central IL
Personal Care	25,142	25,020	-0.05%	Eastern & Central, IL
Unicare HMO	13,096	13,099	0.00%	Chicago area
OSF Winnebago	1,858	1,841	-0.09%	Winnebago County
Health Link OAP	29,761	32,436	9.00%	Central and Southern Illinois
TOTAL Members + Dependents	**211,703**	**215,947**	**2.00%**	
As of July 1, 2006, 8 plans were available to employees and their dependents.				

***FY 2007 is projected**

MONTHLY PREMIUMS

Historically, members in managed care plans cost the State less since the risk of providing health care is assumed by the HMO, in most cases. 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 2007 is $574.04 and will increase to $624.27 (8.8%) in FY 2008.

The monthly premium for a current employee in a managed care plan varies based on each plan's rates, but the FY 2008 estimated average cost for a member in a managed care plan will be $447.91 per month.

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. Thus far, multipliers remain unchanged since FY 2001.

FY 2008 Managed Care Multipliers

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

Under current law, the term of any contract (group life insurance, health benefits, other employee benefits, and administrative services) authorized under the State Employees' Group Insurance Act (SEGIA) may not extend beyond 5 fiscal years. Upon recommendation of CGFA, the Directors of CMS and HFS 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 7, shows the FY 2008 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. Some information is not yet available due to current negotiations with vendors.

TABLE 7: MONTHLY PREMIUMS Managed Care vs. Indemnity Plan Weighted Average FY 2008 Rates (Projected)						
	QCHP			Managed Care		
Membership	TOTAL	Member	State	TOTAL	Member	State
Employee	$624.27	$68.16	$556.12	$447.91	$41.93	$405.98
Medicare Retiree	$355.31	$8.39	$346.93	$287.64	$18.08	$296.56
Non-Medicare Retiree	$842.47	$10.41	$832.06	$673.80	$10.40	$663.40
1 Dependent	$644.47	$184.00	$460.47	$387.07	$80.75	$306.32
2+ Dependents	$913.70	$214.00	$699.70	$665.21	$118.91	$546.30
Medicare Dependent	$342.08	$130.00	$212.04	$299.89	$76.67	$223.22

TABLE 8: PROJECTED COSTS FY 2005 – FY 2008 Employee Only								
	QCHP				Managed Care			
	TOTAL	% Increase	Member	State	TOTAL	% Increase	Member	State
FY 2005	$553.85	12.96%	$43.92	$503.92	$370.52	11.14%	$33.76	$336.76
FY 2006	$589.47	6.43%	$54.32	$535.15	$397.67	7.33%	$34.16	$363.51
FY 2007	$574.04	-2.62%	$62.28	$511.73	$406.99	2.34%	$38.09	$368.90
FY 2008	$624.27	8.75%	$68.16	$556.12	$447.91	10.05%	$41.93	$405.98

CGFA estimate of group insurance liability for FY 2008 reflects a continued trend in prescription drug costs. Noteworthy trends used to estimate the growth in liability from FY 2007 to FY 2008 include the following:

- Prescription drug (QCHP) 9.61%
- HMO Medical/Rx 12.17%
- QC Medical 4.29%

HOW DOES ILLINOIS INSURANCE PREMIUMS COMPARE TO OTHER STATES?

In determining the comparable data to use, the Commission utilized a report by the National Conference of State Legislators to determine premium comparisons for state employee group coverage. For the purpose of this report, the premiums being compared are monthly premium costs for family coverage. The national average premium for family coverage for state employees in 2006 was $1,012.67 (this represents the total of employee and state contributions). Illinois state employees paid a total premium of $1,342.02 ($1,096 state contribution/$245.50 employee contribution) or 32.6% higher than the national average. Nationally, employees for state governments paid $193.93 for family health insurance while Illinois state employees paid $245.50. The table below highlights premium data for all 50 states for 2006.

TABLE 9: FAMILY HEALTHCARE PREMIUMS 2006

State	State Contribution	Employee Contribution	Total Premium	(Diff) % from Illinois
New Hampshire	$1,886.21	$0.00	$1,886.21	40.6%
Vermont	$1,200.55	$300.15	$1,500.70	11.8%
Maine	$1,117.44	$337.34	$1,454.78	8.4%
Nebraska	$1,141.64	$303.46	$1,445.10	7.7%
Massachussetts	$1,160.14	$204.73	$1,364.87	1.7%
Illinois	**$1,096.52**	**$245.50**	**$1,342.02**	**0.0%**
Wisconsin	$1,200.00	$55.00	$1,255.00	-6.5%
Michigan	$1,187.27	$62.49	$1,249.76	-6.9%
Missouri	$977.00	$258.00	$1,235.00	-8.0%
Iowa	$989.75	$222.08	$1,211.83	-9.7%
Indiana	$917.58	$291.66	$1,209.24	-9.9%
Conneticut	$995.38	$176.07	$1,171.45	-12.7%
Rhode Island	$1,098.01	$43.92	$1,141.93	-14.9%
Deleware	$1,053.52	$57.85	$1,111.37	-17.2%
Tennessee	$885.00	$221.40	$1,106.40	-17.6%
Oklahoma	$1,098.18	$0.00	$1,098.18	-18.2%
Minnesota	$976.84	$107.32	$1,084.16	-19.2%
Wyoming	$897.11	$158.31	$1,055.42	-21.4%
Louisianna	$645.90	$397.18	$1,043.08	-22.3%
Alaska	$763.00	$270.00	$1,033.00	-23.0%
Kentucky	$703.37	$320.14	$1,023.51	-23.7%
Virginia	$889.00	$127.00	$1,016.00	-24.3%
New York	$830.25	$185.20	$1,015.45	-24.3%
Oregon	$1,002.97	$0.00	$1,002.97	-25.3%
Washington	$953.00	$49.00	$1,002.00	-25.3%
Texas	$671.08	$327.60	$998.68	-25.6%
Ohio	$853.23	$128.50	$981.73	-26.8%
Kansas	$604.30	$357.08	$961.38	-28.4%
Utah	$882.70	$66.43	$949.13	-29.3%
California	$807.00	$141.81	$948.81	-29.3%
Arizona	$818.52	$125.00	$943.52	-29.7%
Florida	$715.92	$180.00	$895.92	-33.2%
Arkansas	$522.84	$346.90	$869.74	-35.2%
Maryland	$694.49	$151.72	$846.21	-36.9%
North Carolina	$321.14	$521.32	$842.46	-37.2%
New Jersey	$835.77	$0.00	$835.77	-37.7%
South Carolina	$529.00	$294.58	$823.58	-38.6%
Colorado	$460.26	$362.46	$822.72	-38.7%
Alabama	$650.00	$164.00	$814.00	-39.3%
Hawaii	$487.38	$322.34	$809.72	-39.7%
Georgia	$587.22	$217.16	$804.38	-40.1%
Nevada	$676.57	$114.54	$791.11	-41.1%
New Mexico	$550.87	$236.09	$786.96	-41.4%
Mississippi	$305.00	$477.00	$782.00	-41.7%
West Virginia	$649.00	$95.00	$744.00	-44.6%
South Dakota	$415.36	$297.68	$713.04	-46.9%
Pennsylvania	$595.83	$108.50	$704.33	-47.5%
Montana	$506.00	$187.00	$693.00	-48.4%
Idaho	$576.68	$80.00	$656.68	-51.1%
North Dakota	$553.94	$0.00	$553.94	-58.7%

Source: NCSL

As evident in Table 9, states vary widely in the amounts they require employees to pay for family health coverage premiums. Clearly, Illinois pays more than most states when it comes to family insurance coverage. The total premium Illinois pays is above the national premium average. In fact, only six states pay more in total premiums for family insurance coverage. The national average for family coverage employee share responsibility is 20.2%. Spelled out, this means that state employees nationwide are paying on average 20.2% of their total family health care premium. Illinois state employees actually pay less than the national average and our only responsible for 18.3% of the total family premium. States like North Carolina and Mississippi require employees to pay over 60%of the total family health care premium.

Not surprisingly, many states throughout the country are experiencing premium increases in their respective group insurance plans. Many states are facing budgetary challenges coping with double digit premium increases year after year. In the past several years, health care costs are receiving more attention for the following three reasons:

1. Rapidly rising commercial premiums are impacting state budgets;
2. State fiscal pressures are leading to more proposals to increase employee share of costs;
3. Co-payments and deductibles are on the rise in many places, separate from the established premiums.

The National Conference of State Legislators has compiled data from two national surveys that illustrate the top issues that are affecting state health care budgets. Below is a summary of their findings with general facts regarding state employee health care nationwide.

- States provided coverage for about 3.4 million state government employees and retirees.
- Nearly all full-time state workers were eligible for coverage (97%), and take-up was high across most plans, averaging 91%.
- 74 percent of part-time state employees had the option of electing health benefits (compared to 48% nationally.)
- 37 of the state plans experienced double-digit premium growth, averaging 12.8% (compared to 12.7% nationally.) The highest premium increase was in Wyoming at 38%, the lowest was Georgia, where premiums decreased by 1.3%.
- In state employee plans, 37% of workers were in HMOs, 42% in PPOs, 16% in POS plans and 5% were in conventional indemnity coverage. However, Indemnity plans enrolled a majority of *retirees* in the Midwest, Northeast and South.

In an effort to control costs many states our trying new ways to control costs of health care. In an effort to provide policy makers with new ideas to control costs, Table 1 below illustrates some of the major innovations that states throughout the country have been implementing to cut health care costs.

TABLE 10: INNOVATIONS TO CONTROL STATE EMPLOYEE HEALTH CARE COSTS	
State	Innovation
Alabama	The 2005 plan, adopted in a special session in (House Bill 2) November 2004, provides for: "Section 36-29-19.3. **Surcharge on smokers**; changes in contributions. A surcharge on smokers and users of tobacco products shall be added to the employee and retiree contribution by the Board to be effective October 1, 2005. For FY 2007 the surcharge for smokers was $22.
Florida	In May 2004 Governor Bush signed HB 1837, which established the state employees' prescription drug program. The new program "shall create a preferred drug list" and shall be subject to new copayments (effective 1/1/04) as follows: For generic drug with card….$10. For preferred brand name drug with card….$25. For nonpreferred brand name drug with card….$40. For generic mail order drug….$20. For preferred brand name mail order drug….$50. For nonpreferred brand name drug….$80.
Massachusetts	In 2003, Governor Romney proposed that for FY 2004 state employees would have to pay substantially more for their health insurance premiums-from 15 percent to 25 percent. This was not approved by the legislature.
South Dakota	The state has a carved-out prescription drug plan, emphasizing mail order and administered by Prescription Solutions. A mandatory generic drugs policy took effect on July 1, 2004. If enrollees choose a name brand drug, and could use a generic, they will pay the generic copayment plus the difference in cost between the generic drug and the cost of the name brand drug.
West Virginia	Created a program by law (W. Va. Code § 5-16-8). It requires the Public Employee Insurance Plan to provide wellness programs and activities which include benefit plan incentives to discourage tobacco, alcohol and chemical abuse and an educational program to encourage proper diet and exercise. The cost of the exercise program shall be paid by county boards of education, the public employee's insurance agency, or participating employees, their spouses or dependents. All exercise programs shall be made available to all employees, their spouses or dependents and shall not be limited to employees of county boards of education.
Indiana	Added a non-smoker rate incentive in 2006. For 2007, enrollees save up to $500 /year on annual deductible when the Tobacco Incentive is applied.

GASB 45

One issue also effecting state budgets is the new standards set by the Governmental Accounting Standards Board (GASB). GASB 45 is part of a push to lead governments toward accounting for long range financial obligations, especially for other post employment benefits. A report by the Rockefeller Institute found that when it came to health care liabilities for state and local governments, liabilities totaled around $1 trillion.

GASB 45 does not require the states or localities to do anything to close their reported liability gap. It does however require Government entities in the future to report the future liability gap in annual financial reports, and rating agencies will be watching to see how states deal with the new debt projections. Standard and Poor's, according to Governing Magazine, is not expecting miracle fixes. What they are looking for however, is a thoughtful plan to address the unfunded liability.

According to Associated Press data, Illinois will have an estimated OPEB liability projection of $43 to $53 billion.

Illinois, along with many other states face a daunting task to deal with unfunded OPEB liabilities. Some states are already taking action by looking at options related to the benefits themselves. Many government entities will have to boost co-pays, lengthen vesting periods completely cutting benefits for certain groups. One example is the San Diego County Board of Supervisors. The Board recently cut $50 million in subsidies for all retirees that retired after March 2002. North Carolina has extended from five to twenty years the time it will take for state employees to become fully vested for health care benefits.

According to Governing Magazine, states will soon have to come face to face with enormous numbers that will cause many leaders to take action. According to organizations that represent public employees, it's an issue that will have significant fiscal and political ramifications. States could be forced into cutting benefits in order to fund these liability obligations. While employees who have retired or planned to retire in the future feel that health benefits are a commitment from their employer.

FUTURE OF GROUP INSURNANCE LIABILITIES

Illinois will continue to see increases in liabilities for the group insurance program into the foreseeable future. The state should continue to examine areas where savings could be realized. The last AFSCME contract included higher co-pays for both physician office visits and prescription drug coverage. These costs to employees ramp up over the length of the agreement. It will likely be a continued effort to require that employees of the state will pay higher co-pays as the state attempts to slow the increasing cost of healthcare.

More bad news related to overall health care spending was released on February 21, 2007 by Health Affairs. A report by the National Health Expenditure Accounts Projection Team projects that health care spending will double in the next ten years. The report shows that health spending, as a proportion of the nations wealth is down very slightly, from an estimated 6.9 in 2005 to 6.8 percent of Gross Domestic Product in 2006. This "flat" trend has been steady for the last four years. Prior to the relatively flat growth in the four prior years, health care costs were increasing year after year. The authors of the report state that cost trends will begin to rise again to an estimated 19.6 percent of GDP in 2016.

APPENDIX I

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 and HFS 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 dependants.
- 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 Economic and Fiscal Commission are listed below:

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

APPENDIX II

TYPES OF MEDICAL & DENTAL GROUP INSURANCE PLANS

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 nationwide.
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
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 III

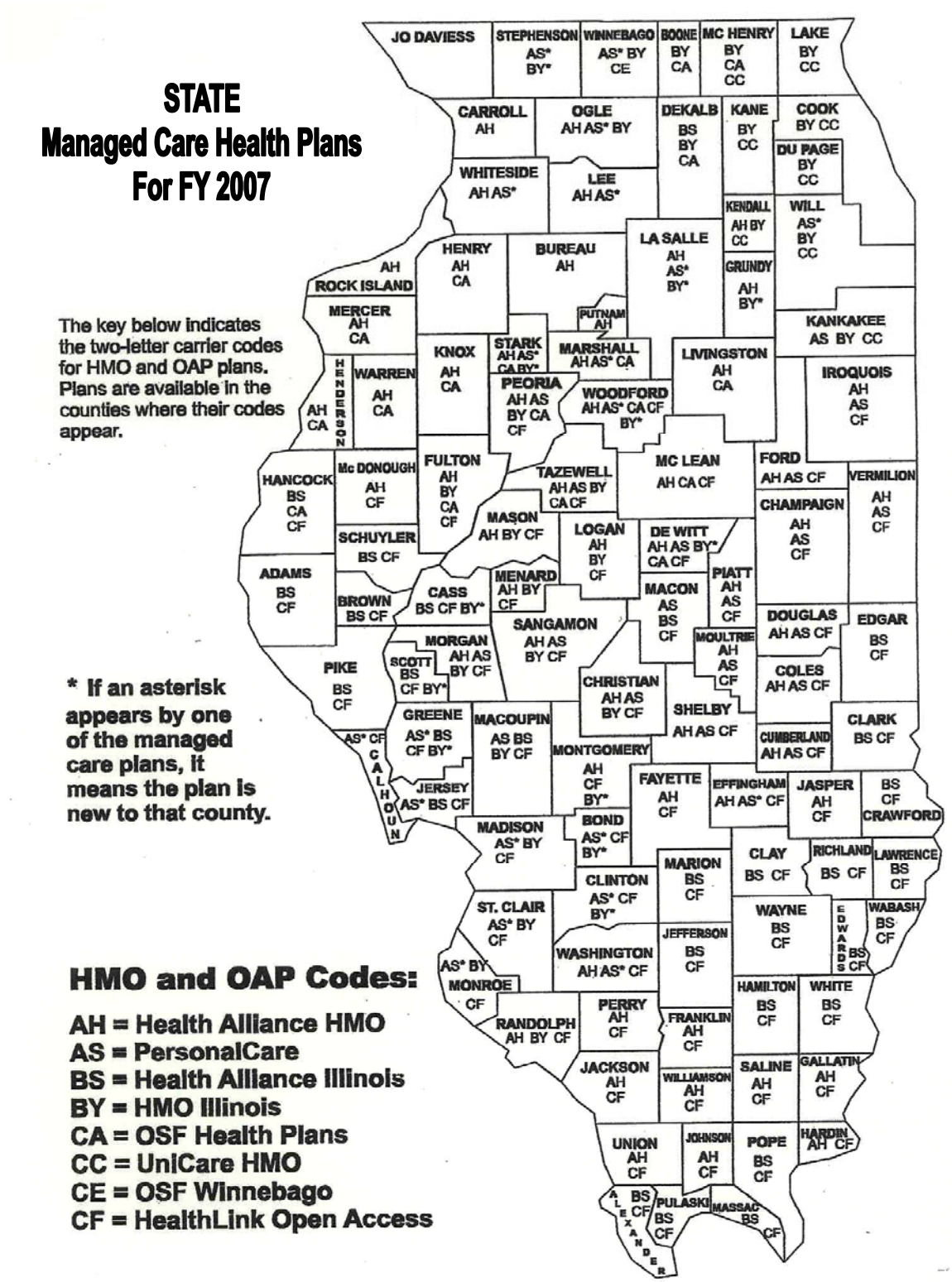
Group Insurance Contracts to be Awarded or Renewed for FY 2008		
Contract	***Type of Contract***	***Renewal/Competitively Selected***
Medco*	Rx benefit administrator (QCHP members)	Renewal/Amended at HFS
CIGNA	Claims administrator for health care benefits (QCHP members)	Renewal/Amended at HFS
CompDent	Dental (QCHP and managed care members)	Renewal/Amended atHFS
Fringe Benefit Management Company	Flexible Spending Administrator	Multi-year
Intracorp	Utilization review administrator (QCHP members)	Renewal/Amended at HFS
Magellan Behavioral Health	Mental health/substance abuse services (QCHP members)	Renewal/Amended at HFS
Medical Cost Management	Peer review	Multi-year
Minnesota Life Insurance Company	Term life insurance	Renewal/Amended at CMS
Primax	Subrogation	Multi-Year
Sykes Health Plan Services	Hospital bill auditing	Renewal/Amended at HFS
Vision Service Plan	Vision care (all members)	Multi-year
Wage Works	Qualified Transportation Benefit Administrator	Multi-year
Met Life	Long Term Care	Renewal/Amended at CMS

Managed Care Contracts thru FY 2008		
Health Alliance HMO		In initial term/Amended
Health Alliance Illinois		In initial term/Amended
Health Link OAP		In initial term/Amended
HMO Illinois		In initial term/Amended
OSF Health Plan		In initial term/Amended
OSF Winnebago		In initial term/Amended
Personal Care		In initial term/Amended
Unicare HMO		In initial term/Amended

HFS, in addition to the contracts listed above, also is renewing contracts for flu shots and consulting contracts. General Consulting Contracting is done by Willis of Illinois. Pharmacy General Consulting is done by Healthlinx. General Healthcare consulting is done by Mercer.

APPENDIX IV

Managed Care Plans in Illinois Counties



BACKGROUND

The Commission on Government Forecasting and Accountability (CGFA), a bipartisan, joint legislative commission, provides the General Assembly with information relevant to the Illinois economy, taxes and other sources of revenue and debt obligations of the State. The Commission's specific responsibilities include:

1) Preparation of annual revenue estimates with periodic updates;
2) Analysis of the fiscal impact of revenue bills;
3) Preparation of "State Debt Impact Notes" on legislation which would appropriate bond funds or increase bond authorization;
4) Periodic assessment of capital facility plans;
5) Annual estimates of public pension funding requirements and preparation of pension impact notes;
6) Annual estimates of the liabilities of the State's group health insurance program and approval of contract renewals promulgated by the Department of Central Management Services;
7) Administration of the State Facility Closure Act.

The Commission also has a mandate to report to the General Assembly ". . . on economic trends in relation to long-range planning and budgeting; and to study and make such recommendations as it deems appropriate on local and regional economic and fiscal policies and on federal fiscal policy as it may affect Illinois. . . ." This results in several reports on various economic issues throughout the year.

The Commission publishes several reports each year. In addition to a Monthly Briefing, the Commission publishes the "Revenue Estimate and Economic Outlook" which describes and projects economic conditions and their impact on State revenues. The "Bonded Indebtedness Report" examines the State's debt position as well as other issues directly related to conditions in the financial markets. The "Financial Conditions of the Illinois Public Retirement Systems" provides an overview of the funding condition of the State's retirement systems. Also published are an Annual Fiscal Year Budget Summary; Report on the Liabilities of the State Employees' Group Insurance Program; and Report of the Cost and Savings of the State Employees' Early Retirement Incentive Program. The Commission also publishes each year special topic reports that have or could have an impact on the economic well being of Illinois. All reports are available on the Commission's website.

These reports are available from:

Commission on Government Forecasting and Accountability
703 Stratton Office Building
Springfield, Illinois 62706
(217) 782-5320
(217) 782-3513 (FAX)

http://www.ilga.gov/commission/cgfa2006/home.aspx