ILLINOIS ECONOMIC
AND
FISCAL COMMISSION

OVERVIEW OF HEALTH CARE PROGRAMS IN THE STATE OF ILLINOIS

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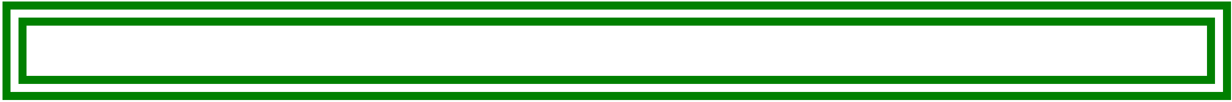

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Overview of Health Care Programs
In the
State of Illinois

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EXECUTIVE SUMMARY

Even prior to the tragic events on September 11, 2001, many state governments were already experiencing budgetary problems. Not only had revenues begun to slow as a result of the sluggish economy, but spending pressures were compounding the problem. In particular, states were feeling the effects of several years of higher than usual medical program growth.

Unfortunately, while the economy has turned further downward, health care program pressures continue to grow. HMO premiums, skyrocketing prescription drug costs, and other components of health care are putting pressure on state and private sector budgets throughout the nation. Over the last several years, medical inflation has significantly outpaced general consumer prices.

While Illinois may be better positioned than some states, we are certainly not immune to these pressures. Health benefit payments have been the fastest growing component of total benefit payments. As the cost of health care rises, employer-provided health insurance is becoming an increasingly valuable employee benefit, as well as an increasingly costly benefit for an employer to provide.

The following report examines the largest health care programs in Illinois. It provides background information for each program, as well as enrollment and eligibility information. In addition, funding sources and cash flow data is provided. The report looks at the following programs: Medicaid/KidCare, State Employees' Group Insurance, the Teachers' Retirement Insurance Program, Pharmaceutical Assistance (Circuit Breaker), the Local Government Health Plan, the College Insurance Program, and the Comprehensive Health Insurance Plan.

Total enrollment in these programs is estimated to be 2,060,135 in FY 2002 and resulting program liabilities are estimated to be approximately $7.6 billion. While Medicaid/KidCare and Group Insurance dominate both the enrollment and liability figures, all of the programs can be expected to experience continued pressure as they provide services to their respective populations.

The following table compares projected enrollment, anticipated funding sources, and liability among the eight health care programs reviewed in this report. The table also lists the start date for each program. They are listed in descending order, by FY 2002 estimated liability.

Executive Summary Table				
PROGRAM	Date Program Began	FY 02 Estimated Enrollment	FY 02 Estimated Funding Sources *$ in millions*	FY 02 Estimated Liability *$ in millions*
Medicaid	Became law in 1965	1,485,267	$5,788.0	$5,959.1
Group Insurance	1971	344,201	1,160.9	1,177.0
TRIP (CMS Projections)	January 1, 1996	42,174	149.8	180.5
Rx Assistance	1985	145,632	132.4	165.6
LGHP	December 15, 1989	27,700	101.7	97.4
CIP	July 1, 1999	2,897	14.3	12.5
CHIP	May 1989	12,774	106.7	N/A
KidCare	January 5, 1998	N/A	N/A	N/A
TOTAL		**2,060,135**	**$7,453.8**	**$7,592.1**

- Total KidCare estimated enrollment, funding sources, and liability is included in Medicaid estimates for FY 2002.

NOTE: The FY 2002 CMS liability estimate for the State Employees' Group Insurance Program is from March 2001. As of late October 2001, CMS had predicted a $110 million GRF shortfall for the program in FY 2002. This would indicate that their current estimate of liability is much higher.

Medicaid

BACKGROUND

According to the U.S. Department of Health and Human Services website, "Medicaid is a jointly-funded, Federal-State health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments."

In Illinois, Medicaid is a State government insurance program for low-income mothers and children and other indigent people who are disabled or 65 and older. The State of Illinois and federal government jointly fund the program, with each paying approximately 50% of the cost. The Medicaid program in Illinois operates under the Illinois Public Aid Code and Titles XIX and XXI of the Social Security Act.

The Medicaid program became law in 1965.

ENROLLMENT/ELIGIBILITY

The numbers below represent the "number of unduplicated individuals enrolled in the medical assistance programs administered by the Department of Public Aid during the course of" each fiscal year:

TABLE 1: Enrollment in IDPA Medical Assistance Programs

Fiscal Year	Average Monthly Enrollment	Change from Prior Year Avg. Monthly Enrollment
1999	1,305,264	(44,633)
2000	1,368,170	62,906
2001	1,436,886	68,716
2002 (Estimated)	1,485,267	48,381

Source: Bureau of the Budget (9/21/01)

FUNDING SOURCES

TABLE 2: Historical Funding Sources for DPA Medical Assistance Program
$ in millions

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002 (Est.)
GRF Approp.	$3,897	$4,297	$4,696	$5,193	$5,088
ATF Spending	$402	$265	$240	$396	$700
TOTAL Resources	$4,299	$4,562	$4,936	$5,589	$5,788

Source: Bureau of the Budget (9/21/01)

CASH FLOW

TABLE 3: Medical Assistance Spending $ in millions			
	FY 2000	FY 2001	FY 2002 (proj)
Bills on Hand	$ 202,035	$ 379,902	$ 340,917
Liability	5,145,529	5,561,898	5,959,152
Cash Flow	(4,945,192)	(5,600,883)	(5,805,776)
Bills on Hand	$ 379,902*	$ 340,917	$ 494,293

* Bills on Hand changed after adjustments were made. This was done after liability was figured
Source: Bureau of the Budget (9/21/01)

KidCare

BACKGROUND

In 1997, Congress passed the Children's Health Insurance Program (CHIP). Over a ten-year period, Congress will award $48 billion in grants to the states to provide free or low-cost health insurance to children 18 and under. KidCare, the Children's Health Insurance Program for the State of Illinois, was implemented on January 5, 1998. It is administered by the Illinois Department of Public Aid, and is part of the Medical Assistance Budget.

ENROLLMENT/ELIGIBILITY

KidCare provides health insurance to children 18 and under and pregnant women who do not qualify for Medicaid, whose family income is at or below 185% of the federal poverty level, and who are uninsured.

There are several different plans offered under KidCare, and a wide variety of services are available. Eligibility is based upon family income.

The five KidCare plans include KidCare Assist, KidCare Moms and Babies, KidCare Share, KidCare Premium, and KidCare Rebate. As of July 1, 1999, enrollment in all five plans totaled 40,675. As of July 1, 2000, enrollment in all five plans totaled 109,028. Enrollment as of July 1, 2001, after nearly three and a half years of KidCare, totaled 162,739.

TABLE 4: Total KidCare Enrollment					
		New Plans (Title XXI-SCHIP)			
	KidCare Assist, Moms and Babies*	KidCare Share	KidCare Premium	KidCare Rebate	TOTAL
July 1, 1999	33,540	2,905	2,937	1,293	40,675
July 1, 2000	92,513	6,245	6,378	3,892	109,028
July 1, 2001	141,790	7,011	8,406	5,532	162,739

*This category includes children, pregnant women, and infants eligible through KidCare initiatives and KidCare expansion
SOURCE: IDPA Division of Medical Programs, 10/19/01

According to State Government News, February 2001, "35 states promote CHIP (Children's Health Insurance Program) and Medicaid jointly, and 31 states have developed outreach programs targeted at hard-to-reach populations." Outreach efforts may attempt to reach "not only children eligible for CHIP, but also children eligible for Medicaid who were not enrolled."

FUNDING SOURCES

KidCare does not have a specific, all-inclusive, appropriation in the Department of Public Aid appropriation bill. The federal government and the State of Illinois jointly fund KidCare, the State Children's Health Insurance Program. For the Kid Care Share and KidCare Premium programs, (under SCHIP) 65% of KidCare funding comes from the federal government, while the State of Illinois funds the remaining 35%. The Medicaid expansion plans, KidCare Assist and KidCare Moms and Babies, are each funded 50% by the federal government and 50% by the State of Illinois. The KidCare Rebate program is 100% funded by the state. Federal funds for the KidCare program come to the State of Illinois by way of Titles XIX and XXI of the Social Security Act. Title XXI is a specific allotment for those elements of KidCare eligible for enhanced (65%) match. **All other KidCare medical costs are appropriated with Medicaid costs by provider category.**

Information on the cash flow of the KidCare program cannot be presented because there is not a separate appropriation for the KidCare program. The KidCare program is just one aspect of the appropriation to the Department of Public Aid for the medical assistance program. Therefore, a beginning balance, total estimated funding, estimated program costs, and an ending balance for a given fiscal year cannot be identified.

State Employees’ Group Insurance Program

BACKGROUND

As reported in the March 2001 “*Report on the Liabilities of the State Employees’ Group Insurance Program*”, the HMO trend factor used for the FY 2002 estimate was approximately 17.5%, and the prescription drug trend factor used for the same estimate was almost 19%. HMO premium increases and rising prescription drug costs have an impact on most health care programs offered by the State of Illinois, due to the nature of the programs. This report examines the rising costs to the State of Illinois for Illinois residents of all ages and backgrounds.

In Illinois, HMO’s are anticipating premium increases of 15 percent or higher in order to keep profitable. “The biggest factor (in premium increases) seems to be an increase in the expense of providing prescription drugs,” according to David Dring, spokesman for the Illinois Association of Health Plans. Gordon Salm, Chief Financial Officer of Health Alliance Medical Plans agrees: “We’re seeing a trend in increases in drug prices alone of 18 percent to 20 percent.” (“Drug costs drive up HMO premiums,” The State Journal Register, August 21, 2001)

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. 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.

ENROLLMENT/ELIGIBILITY

As of March 2001, the State Employees’ Group Health Insurance Program had 342,136 participants. This figure includes employees, retirees, and dependents. FY 2002 enrollment is projected to be 344,201, a 0.6% increase over FY 01 enrollment.

TABLE 5: Total Membership: Group Health Insurance

Type of Enrollee	FY 1999	FY 2000	FY 2001	FY 2002 (Projected)
Employees	124,349	125,917	126,463	126,578
Retirees	57,650	58,985	60,710	62,221
Dependents	148,814	151,996	154,963	155,402
TOTAL	**330,813**	**336,898**	**342,136**	**344,201**

Source: Illinois Department of Central Management Services

All members are either enrolled in a managed care plan or the indemnity plan. In FY 2001, the percentage of enrollees in the HMO plans (54%) remained at the same level as FY 2000. The percentage of FY 2001 enrollees in the indemnity plan (46%) also remained constant from FY 2000.

Another factor that drives medical costs is the cost of indemnity plan coverage for employees, retirees, and their dependents. "Indemnity plans, unlike their managed care counterparts, pay the 'full' retail price of health care services. In contrast, managed care plans pay health care providers the 'wholesale' (discounted) price for services, and, depending on the type of managed-care plan, place controls on an individual's utilization of health care services." Forces that may increase the cost of indemnity plans include medical price inflation, the aging of the work force, longer life expectancy, and advances in medical technology. ("Post-Retirement Health Care Benefits: Key Issues for Decision Makers in the Public Sector," Kalman, Robert and Thomas Anderson, July 1997).

FUNDING SOURCES

TABLE 6: Group Insurance Funding Sources

$ in millions

	FY 2001	FY 2002	Increase	% Increase
GRF*	$650.367	$710.367	$60.0	9.2%
Road Fund	79.551	79.551	0	0%
Employee Contributions, Reimbursements and Misc.	342.921	370.944	28.0	8.2%
TOTAL	**$1,072.839**	**$1,160.862**	**$88.023**	**8.2%**

*FY 2001 includes $20 M supplemental, and in FY 2002, GRF includes an appropriation of $23 M to IBHE from GRF. The CMS appropriation from GRF would be $687.3 M.
Source: Illinois Department of Central Management Services

LIABILITY

The following table shows the increasing liability of the group insurance program in recent years:

TABLE 7: State Employees' Group Health Insurance Liability Estimates

$ in millions

	FY 1999	FY 2000	FY 2001	FY 2002
Liability Component				
QCHP	$426.0	$487.0	$533.0	$580.0
HMO	269.9	300.6	353.3	402.6
Life Insurance	59.8	68.1	72.3	76.0
Dental Claims	39.7	39.6	50.4	52.2
Administrative	18.2	18.6	16.6	17.2
Special Programs	10.5	12.4	13.8	14.3
POS	23.0	20.9	11.7	13.6
Vision	8.5	7.5	10.6	11.0
Mental Health	10.8	11.1	11.0	10.1
TOTAL	**$866.5**	**$965.8**	**$1,072.7**	**$1,177.0**
% change from py	8%	11%	11%	10%

Source: Illinois Department of Central Management Services

At the most recent meeting of the Illinois Economic and Fiscal Commission on October 23, the Department of Central Management Services projected a $110 million GRF shortfall for the Group Insurance Program for FY 2002. CMS could be required to hold Quality Care Health Plan claims as early as March 2002 unless additional funding is directed to the State Employees' Group Insurance Program. (Claims are "held" when program funding is not sufficient to pay claims in a timely manner. This generally occurs near the end of a fiscal year if revenues do not keep pace with expenditures; the payment cycle for claims has to be extended.) The estimated GRF shortfall for FY 2003, as of August 2001, is in the range of $290 to $340 million. This number includes the FY 2002 shortfall. CMS expects the Governor's recent State employee hiring freeze to have an impact on the group insurance program; it should reduce costs for the group insurance program.

<u>Teachers' Retirement Insurance Program</u>

<u>BACKGROUND</u>

The Teachers' Retirement Insurance Program (TRIP) is a health insurance plan for retired Illinois teachers. It was introduced on January 1, 1996, and is administered by the Department of Central Management Services (CMS). The predecessor to the Teachers' Retirement Insurance Program, the TRS Health Insurance Plan, was operated and funded by the Teachers' Retirement System. The Teachers' Retirement Insurance Program is currently administered by the State because of previous fiscal problems the program experienced.

Members of the Teachers' Retirement System are downstate, public schoolteachers. While there are both active and inactive teachers in the Teachers' Retirement System, only active teachers contribute to the Teachers' Retirement Insurance Program through their paychecks. Teachers may not enroll in the Teachers' Retirement Insurance Program unless they have at least eight years of service upon retirement.

Few school districts in the State of Illinois provide health insurance for their retired teachers. Enrollment in TRIP is voluntary, but it is available to all TRS members who are eligible upon retirement. In a teachers' retirement package, there is a TRIP enrollment application and a TRIP highlights brochure. Once a teacher enrolls, he or she receives a packet that includes an acknowledgement letter, a benefit handbook, and a benefit choice book. The TRIP benefit choice period that preceded FY 2002 enrollment was June 1, 2001 through July 2, 2001.

<u>ENROLLMENT/ELIGIBILITY</u>

As of July 2001, there were approximately 62,200 TRS benefit recipients <u>eligible</u> for TRIP, an increase of 4.2% over July 2000. These benefit recipients include TRS retirees, their survivors, and "disabilitants." Each of these benefit recipients receives a monthly benefit or retirement annuity under Article 16 of the Illinois Pension Code. 34,986 TRS benefit recipients were enrolled in TRIP as of July 2001, an increase of 5.9% over July 2000 (33,042). There were also 6,920 dependents enrolled in TRIP (for the FY 2002 benefit year) as of July 2001, an 8.3% increase over July 2000 (6,390).

Approximately 55.3% of eligible TRS benefit recipients were enrolled in the Teachers' Retirement Insurance Program as of July 2000, and 56.2% of eligible TRS benefit recipients had enrolled as of July 2001. The remaining eligible TRS benefit recipients may not have enrolled in TRIP for several reasons. Enrollment in TRIP may be cost-prohibitive, or benefit recipients may have health insurance coverage through their spouse, a current employer, or the local school district from which they retired.

The table below shows historical enrollment for TRIP:

TABLE 8: ENROLLMENT IN TEACHERS' RETIREMENT INSURANCE PROGRAM						
	Annuitants	% Change	Dependents	% Change	TOTAL	% Change
January 1996	31,699	N/A	6,242	N/A	37,941	N/A
FY 1997 *(8/96)*	31,436	-0.83%	6,102	-2.24%	37,538	-1.06%
FY 1998 *(8/97)*	31,293	-0.45%	6,008	-1.54%	37,301	-0.63%
FY 1999 *(8/98)*	31,462	0.54%	5,940	-1.13%	37,402	0.27%
FY 2000 *(8/99)*	32,217	2.40%	6,090	2.53%	38,307	2.42%
FY 2001 *(7/00)*	33,042	2.60%	6,390	4.9%	39,432	2.9%
FY 2002 *(7/01)*	34,986	5.90%	6,920	8.3%	41,906	6.3%

Source: CMS 9/5/00, 9/5/01

FUNDING SOURCES

There are currently three funding sources for TRIP: active teacher payroll contributions, contributions from the General Revenue Fund, and premiums paid by retired teachers who enroll in the program.

1. Active teachers pay ½ percent of their salaries through payroll contributions; it is collected by TRS and remitted to the State treasury.

2. The State contribution is a General Revenue Fund "match" equal to the ½ percent (estimated to be received) from active teachers, plus $11 million for benefit enhancements implemented in FY 2001. The ½ percent amount expected from teacher salaries is estimated by TRS, but is usually a little low. Therefore, the "match" from the General Revenue Fund is usually slightly less than what teachers actually contribute from their salaries.

3. Retired teachers who enroll in the Teachers' Retirement Insurance Program pay monthly premiums. These premiums are subsidized by the State from the Teacher Health Insurance Security Fund. The amount of the subsidy is not equal for all enrollees; it varies according to an enrollee's access to managed care and plan enrollment.

NOTE: At a local level, the teachers of Springfield's School District 186 recently ratified a one-year contract. Among the negotiated items is a requirement for the district to pay the ½% of teachers' salaries to the Teachers' Retirement System for TRIP. (State Journal Register, September 10, 2001).

CASH FLOW

TABLE 9: ESTIMATED TRIP CASH FLOW $ in millions (FY 2001 through FY 2005) *from TRIP 2001 Update, April 2001*					
	FY 2001	IEFC FY 2002	IEFC FY 2003	IEFC FY 2004	IEFC FY 2005
Beginning Balance	$29.9	$6.7	$-37.6	$-105.3	$-200.2
Program Costs	(150.0)	(177.0)	(208.9)	(246.5)	(290.8)
Member Contributions	52.6	55.7	59.6	64.4	70.2
Active Teacher Contributions	31.1	33.0	35.3	38.1	41.5
State Contributions: GRF	42.1	44.0	46.3	49.1	52.5
Interest/Other	1.0	0.0	0.0	0.0	0.0
ENDING BALANCE	**$6.7**	**$-37.6**	**$-105.3**	**$-200.2**	**$-334.8**

- From FY 2001 to FY 2005, State Contribution estimates include an additional $11 million for benefit enhancements. Program cost estimates are based on FY 2001 annualized expenditures; each year thereafter is increased 18%.

The estimated ending balances for the Teachers' Retirement Insurance Program reflect the maintenance of the status quo in program funding. **Member contributions, active teacher contributions, and State contributions do not keep pace with increasing program costs each year. While CMS has implemented several cost containment measures, it is likely that an additional funding source or increased funding will be necessary to prevent a negative balance for the Teachers' Retirement Insurance Program in the future.**

At the most recent meeting of the Illinois Economic and Fiscal Commission on October 23, the Department of Central Management Services projected a $29 million shortfall for the Teachers' Retirement Insurance Program for FY 2002. In April 2001, IEFC estimated a $37.6 million shortfall; this estimate was made before CMS implemented a 21% premium increase for FY 2002 monthly premiums. In addition to the 21% premium increase, CMS increased some deductibles and co-pay amounts for retired teachers as a cost-saving measure. CMS hopes that a legislative solution can be found during veto session in order to circumvent an 80% percent increase that may be necessary (beginning January 1, 2002) to avert a shortfall in the Teachers' Retirement Insurance Program. To illustrate the gravity of the situation, the table below compares the range of FY 2001, FY 2002, and proposed higher FY 2002 premiums for TRIP.

TABLE 10: Teachers' Retirement Insurance Program
Range of Monthly Premiums

	FY 2001	FY 2002 (current)	FY 2002 (proposed)
Benefit recipient	$36.56 to $272.41	$44.23 to $329.62	$79.61 to $593.32
Dependent	$146.22 to $544.82	$176.93 to $491.90	$318.47 to $885.42

- FY 2002 (current) premiums are 21% higher than FY 2001 premiums
- FY 2002 (proposed) premiums are 80% higher than current FY 2002 premiums

Circuit Breaker: Pharmaceutical Assistance Program

BACKGROUND

The Pharmaceutical Assistance Program was created in 1985. The program provides low-income seniors and disabled persons access to and cost savings on certain prescription drugs. Participants purchase coverage at nominal cost and receive approved prescription drugs through participating pharmacies. The program is operated under the Senior Citizens and Disabled Persons Property Tax Relief Act.

The annual cost of coverage varies, depending upon household size and income level. During FY 2001, many changes were implemented for those eligible for the Pharmaceutical Assistance Program. Income eligibility limits were increased, allowing additional persons to qualify. The annual cost of coverage decreased; depending upon a participant's income, the annual cost now ranges from $5 to $25, with $0 to $3 co-payments, respectively. A beneficiary must pay 20% of all prescription drug costs incurred above a $2,000 cap; previously the beneficiary was responsible for 20% when he or she had incurred $800 in prescription drug costs.

The FY 2001 expansion of the Pharmaceutical Assistance Program was partially funded by Illinois' share of the tobacco settlement proceeds. The Illinois Department of Revenue received $35 million from the Tobacco Settlement Recovery Fund for this purpose. In FY 2002, the Pharmaceutical Assistance Program will receive $94.2 million from the Tobacco Settlement, including $1.7 million for expanded coverage of drugs to treat osteoporosis.

ENROLLMENT/ELIGIBILITY

TABLE 11: Pharmaceutical Assistance Cardholders

Type of Enrollee	FY 00	FY 01	FY 02
Senior Citizens	31,643	35,043	101,082
Disabled Persons (16-64)	18,156	17,088	44,550
TOTAL	**49,799**	**52,131**	**145,632**

Source: Illinois Department of Revenue, Budget and Planning, 9/24/01

FUNDING SOURCES

The Pharmaceutical Assistance Program is funded by a GRF appropriation to the Department of Revenue, and in recent years, money from the Tobacco Settlement Recovery Fund. While cardholders each pay an annual fee, this contribution is not considered a funding source for the program; it is deposited into the General Revenue Fund.

TABLE 12: Historical Funding Sources for Pharmaceutical Assistance Program
$ in millions

	FY 99	FY 00	FY 01	FY 02 (est)
GRF Approp.	$31.3	$37.3	$41.8	$38.2
Tobacco Settlement	$0	$0	$25.6	$94.2
TOTAL	**$31.3**	**$37.3**	**$67.4**	**$132.4**

Source: Illinois Department of Revenue, Budget and Planning 9/24/01

CASH FLOW

The following table shows the increasing program costs in recent years as the program has been expanded:

TABLE 13: Pharmaceutical Assistance Program Cash Flow
$ in millions

	FY 00	FY 01	FY 02 (est)
Funding Sources	$37.3	$67.4	$ 132.4
Program Costs	($37.3)	($72.4)*	($165.6)
Shortfall	$0	$(10.0)	$(33.2)

*While $72.4 m was the FY 01 liability, $5 m of this figure was paid out of the FY 02 appropriation
Source: Illinois Department of Revenue, Budget and Planning

Local Government Health Plan

BACKGROUND

The Local Government Health Plan (LGHP) is a program of health, dental, vision, and mental health benefits for certain eligible local government employees (and their dependent beneficiaries). There is no cost to the State for this program; the premium for members varies based on the type of local government unit enrolled. Some units pay 100% of this premium, while others pay a lesser percentage and have the employee also pay a percentage. The LGHP is a self-insured pool funded solely by the participants of the program. The Local Government Health Plan was mandated by Public Act 86-978 and became effective December 15, 1989. The LGHP members receive benefits comparable to those provided to State of Illinois group Insurance members. LGHP offers managed care or indemnity plan health coverage to enrollees. The Department of Central Management Services administers the program.

ENROLLMENT/ELIGIBILITY

Local government units enroll their employees in the Local Government Health Plan. There is not a specific enrollment period. A local government unit may join at any time during the fiscal year, but must enroll at least 85% of its full-time staff (excluding elected officials). School districts are allowed to enroll 85% of those employees currently covered through a health plan within that district.

Average FY 2001 enrollment was 27,699, only 1.5 % higher than FY 2000 average enrollment of 27,285. FY 2000 average enrollment, however, was 8.6% higher than FY 1999 enrollment of 25,125. In FY 2001, approximately 610 units of local government had enrolled employees in the Local Government Health Plan. For FY 2002, there are currently about 613 units enrolled. This number will fluctuate throughout FY 2002 as local government units are added to or dropped from the LGHP. FY 2002 LGHP enrollment is projected to remain flat (27,700).

FUNDING SOURCES

As mentioned earlier, the LGHP is a self-insured pool funded solely by the participants of the program. The contribution level determined by the local government unit is between the unit and the employees. Some units pay 100% of the LGHP premium, while some pay a lesser percentage and have the employee pay a percentage. Premiums are paid to the State of Illinois directly by the units of local government.

CASH FLOW

TABLE 14: Local Government Health Plan Cash Flow		
	FY 2000	FY 2001 (est)
Beginning Balance	$641,000	$1,740,000
Total Income*	$73,700,000	$87,900,000
Program Costs	($72,600,000)	($86,100,000)
ENDING BALANCE	$1,740,000	$3,540,000

Source: CMS Response to LGHP questions 7/27/01

*Total Income includes insurance premiums, third party reimbursement, and investment income into the Fund 193, the Local Government Health Insurance Reserve Fund. In FY 2001, $86.1 million of total income was from insurance premiums.

CMS has estimated that the FY 2002 end-of-year balance for the Local Government Health Plan (Local Government Health Insurance Reserve Fund) will be $8.2 million. It does not appear that the LGHP is currently facing financial difficulties.

The College Insurance Program

BACKGROUND

The College Insurance Program is a program of health, dental, and vision benefits for certain eligible community college retirees (who are receiving an annuity) and their dependent beneficiaries. The College Insurance Program (CIP) was mandated by SB 423 (Public Act 90-0497) and became effective July 1, 1999. FY 2000 was the first full year of the CIP, which offers managed care or indemnity plan health coverage to enrollees. In addition, all participants have the same vision and dental coverage. The Department of Central Management Services and the State Universities Retirement System jointly administer the program.

ENROLLMENT/ELIGIBILITY

June 2001 enrollment (2,387) was almost 30% higher than June 2000 enrollment (1,842). 414 additional retirees enrolled in the College Insurance Program, along with 131 of their dependents. As of June 2001, 81% of enrollees were in the indemnity plan, while 19% were in managed care.

TABLE 15: College Insurance Program Enrollment

Enrollment Status	June 2000	June 2001
Annuitants	1,479	1,893
Dependents	363	494
Total Lives	1,842	2,387

Source: CMS Memorandum 9/5/2001

An eligible community college retiree may enroll in the College Insurance Program when he or she applies for annuity benefits. If the retiree does not enroll at this time, the retiree and his or her dependents may enroll upon turning 65; when other coverage is terminated; or during the annual Benefit Choice Period, which is from May 1 to May 31, with coverage effective July 1.

FUNDING SOURCES

There are four funding sources for the College Insurance Program: benefit recipient (retiree) premiums, eligible active public community college employee contributions, community college districts, and the State of Illinois. Monthly premiums vary by enrollment status and the type of health coverage that a participant selects. Eligible active employees contribute ½ % of their salary to the College Insurance Program. Community college districts match the employee contributions. (Community colleges in the City of Chicago do not contribute to the Community College Health Insurance Security Fund because they were excluded from the enabling legislation.) The employee salary contribution is collected by employers and paid to the State

Universities Retirement System; the contributions from community college districts are also paid to the State Universities Retirement System. The State contribution to the Community College Health Insurance Security Fund (CCHISF) is equal to the estimated employee contributions for a fiscal year. The State Universities Retirement System estimates what the employee contributions will be, an amount is appropriated to the State Comptroller for deposit into the CCHISF, and 1/12 of the appropriated amount is transferred on the first day of each month from the General Revenue Fund to the CCHISF.

CASH FLOW

TABLE 16: College Insurance Program Cash Flow

	FY 2000	FY 2001
Beginning Balance	$3,389,594	$8,727,564
Active Employee Contributions	2,739,363	2,860,825
Community College Districts	2,678,043	2,849,050
Member Premiums (Retirees)	2,360,786	3,145,253
State Contribution	2,652,000	2,786,500
Investment Income	315,694	703,181
Program Costs	(5,407,916)	(8,201,502)
ENDING BALANCE	$8,727,564	$12,870,871

Source: CMS CIP Cash Flow table (9/5/01)

Comprehensive Health Insurance Plan

BACKGROUND

The Illinois Comprehensive Health Insurance Plan (CHIP) differs from all of the previously mentioned State administered health insurance programs. The General Assembly created CHIP in May 1989 to provide access to health insurance coverage for certain eligible Illinois residents who have been denied major medical coverage (because of their health) by private insurers. CHIP also serves as an acceptable alternative mechanism for complying with the individual portability requirements of the federal Health Insurance Portability and Accountability Act (HIPAA).

CHIP currently provides coverage to more than 5,600 otherwise uninsurable Illinois residents under Section 7 of the CHIP Act. This portion of the program is also known as the Traditional CHIP or Section 7 pool.

1. Illinois residents can generally qualify for CHIP, unless otherwise ineligible under Section 7 of the CHIP Act, if they meet ONE of the following criteria:

- if they have applied for individual health insurance and have been rejected because of a pre-existing condition;
- if they have an individual policy that is substantially similar to CHIP which costs them more than they would pay for CHIP coverage, OR
- if they have one of 31 presumptive medical conditions, i.e. conditions presumed to result in automatic rejection by an insurance company.

As of July 1, 1997, CHIP began to offer coverage to Illinois residents who qualify as federally eligible individuals under Section 15 of the CHIP Act. In FY 2002, it is estimated that over 7,000 Illinoisans will enroll under Section 15, also known as the HIPAA-CHIP pool. Coverage is similar to the traditional PPO option, except there is no pre-existing conditions limitation, and benefits for inpatient treatment of mental health are limited to 45 days per calendar year for all hospitals.

2. To qualify for HIPAA-CHIP, Illinois residents must satisfy ALL of the following requirements:

- they must have accrued a total of 18 months of prior creditable coverage, and have no more than a 90-day break between periods of creditable coverage;
- their most recent creditable coverage must have been provided under a group health plan, governmental plan, or church plan;
- they must not be eligible for coverage under a group health plan, Medicare due to age or Medicaid, and must not have any other health insurance coverage;
- their most recent coverage must not have been terminated due to nonpayment of premium or fraud; and
- if offered continuation of coverage under federal COBRA or state continuation laws, they must have elected and exhausted such continuation coverage.

CHIP is not an insurance company. CHIP is a State program which is subject to its own enabling act, the Comprehensive Health Insurance Plan Act (215 ILCS 105/1 et seq.). It is neither an entitlement nor a welfare program.

Due to the limited amount of state money available to subsidize the Comprehensive Health Insurance Plan, enrollment is limited in the Traditional CHIP pool. However, there is no enrollment limitation for the aforementioned federally eligible individuals in the HIPAA-CHIP pool.

ENROLLMENT/ELIGIBILITY

TABLE 17: CHIP Enrollment

Type of Participant	FY 99	FY 00	FY 01	FY 02 Projected
State Eligible	5,120	5,466	5,540	5,698
Federally Eligible	2,079	3,633	5,572	7,076
TOTAL Participants	7,199	9,099	11,112	12,774

Source: Illinois CHIP memo, 9/14/01

FUNDING SOURCES

The Illinois Comprehensive Health Insurance Plan has three primary funding sources:

1. premiums paid by its members;
2. an appropriation from the State's General Revenue Fund for State eligible persons (Section 7 of the CHIP Act);
3. an assessment of all health insurers doing business in the State of Illinois for federally eligible individuals (Section 15 of the CHIP Act)

TABLE 18: Historical Funding Sources for CHIP
$ in millions

	FY 1999	FY 2000	FY 2001 (Est)	FY 2002 (Proj.)
Premiums: (State eligibles)	$18.7	$19.3	$21.1	$25.3
Premiums (Fed eligibles)	6.3	11.4	21.3	30.9
GRF App. (State eligibles)	15.3	17.3	27.3	32.0
Assessment (Fed eligibles)	6.7	5.4	18.5	18.5
TOTAL Resources	**$47.0**	**$53.4**	**$88.2**	**$106.7**

Source: Illinois CHIP memo, 9/14/01

The coverage provided to State eligible participants is funded in part by the premiums paid by those participants. The remainder of the cost of Traditional CHIP is funded by an annual appropriation from the General Revenue Fund. The coverage provided to federally eligible participants is also funded in part by those participants. The remainder of the cost of this HIPAA-CHIP pool is funded by an assessment levied on all health insurers doing business in Illinois.

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