

FY 2015

Liabilities of the State Employees' Group Health Insurance Program



Commission on Government Forecasting & Accountability

March 2014

*Commission on Government
Forecasting and Accountability*

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EXECUTIVE SUMMARY

Under the State Employees' Group Insurance Act of 1971 (5 ILCS 375), the Commission on Government Forecasting and Accountability (CGFA) has several statutory requirements.

- To estimate liabilities of the State Employees' Group Health Insurance Program.
- To meet with the Department of Central Management Services (CMS) to advise the department on all matters relating to policy and administration of the Group Insurance Act.
- To review contracts recommended by the Director of CMS related to the Group Insurance Program.
- To give “advice and consent” when CMS determines it would be in the best interest of the state and employees to administer benefits with the state as a self-insurer.

The Governor has requested that a total of \$2.790 billion be appropriated for the State Employees' Group Health and Life Insurance program for FY 2015. The requested FY 2014 appropriation request for the Group Health Insurance Program was \$2.828 billion. The following table represents historical appropriation and liability amounts, per CMS. CMS estimates the FY 2015 liability to be \$2.648 billion, a 0.9% increase from FY 2014. The CGFA FY 2015 estimate of liability is \$2.692 billion, \$44 million more than CMS. The CMS estimate reflects recently concluded negotiations with state employee unions. Additional information regarding health insurance negotiations is contained later in this report. The CGFA FY 15 estimate is reflective of the figures provided by CMS.

Currently, for CIGNA, the delay for preferred providers and non-preferred providers is 294 and 420 days. In FY 2015, the cycle is expected stay the same. The current (as of February 19, 2014) amount of SEGIP FY 2014 claims on hand is \$1.464 billion. CMS has calculated the amount of time it takes to make payments to managed care providers at approximately seven months, which is expected to stay the same in FY 2015. The value of bills on hand is estimated to be approximately \$1.500 billion by the end of FY 2014. For FY 2015, the bills on hand value is not expected to differ significantly from the FY 2014 numbers. Dental network claims are expected to be held 77 days, while non-network providers would be held 175 days in FY 2015. Using the figures provided by CMS, the FY 2015 estimated liability for the Quality Care Health Plan (QCHP) is expected to decrease by 5.2% over the FY 2014 liability. This follows actions taken by the state to reduce liability by moving retirees and dependents over to Medicare Advantage HMO/PPO plans. The estimated liabilities for the State's HMO plans are expected to increase 10.8% over the FY 2014 cost with OAP liabilities increasing 3.3%. FY 2014 liability for the HMO plans increased 8.5% from FY 2013. However, the Department projects prescription drug liability to decrease significantly by 39.0% in FY 2014 from \$170.2 million to \$103.8 million due to savings from Medicare Advantage and union contract negotiations.

APPROPRIATION/REVENUE AND LIABILITY HISTORY				
FY 2010-2015				
(\$ in Millions)				
Fiscal Year	Appropriation	Revenues	CMS Liability	CGFA Liability
FY 2010	\$2,044.2	\$2,163.3	\$2,187.9	
FY 2011	\$2,132.7	\$2,024.4	\$2,343.8	
FY 2012	\$2,418.4	\$2,567.8	\$2,434.1	
FY 2013	\$2,560.1	\$2,088.5	\$2,620.6	
FY 2014	\$2,843.0	\$2,828.4	\$2,624.3	
FY 2015	\$2,973.0	\$2,790.3	\$2,648.7	\$2,692.3
*Estimated for FY 2015				

FY 2015 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2015 cost projection utilizes the CMS estimate for FY 2014 medical claims as the basis for estimating claims for FY 2015 along with information provided by the Segal Company in their annual report on state employee insurance trends.

The CGFA State of Illinois liability cost estimate for FY 2015 uses the following assumptions based on historical claims data and anticipated cost changes:

TREND FACTORS	
Medical (QCHP plan)	1.3%
Dental (QCHP and MC)	-1.5%
HMO (Medical and Rx)	7.3%
Prescription drugs (QCHP)	5.0%
Administrative service charges (QCHP)	4.5%
Life Insurance	4.2%

It is necessary to note that these figures only relate to the portion of total medical costs borne by the State of Illinois. While State costs are declining in certain areas for FY 2015 due to the shift of retirees towards Medicare Advantage and negotiated increases in employee contributions, co-payments, etc., the overall costs of providing healthcare for State employees, retirees and dependents is rising. The medical trend inflation factors for the State consist of various components. These components include cost-shifting due to Medicare/Medicaid reimbursement reduction, general inflation and leveraging (lower impact of coinsurance limits, level deductibles, etc.). Also, advances in technological innovation, more use of equipment/services, and the continued “greying” (aging and extended living) of the population have all contributed to greater health care costs. In addition to these, the impact of a gradual shift by employees to

HMOs and OAPs has resulted in more costly/higher risk employees remaining in the QCHP program. In recent years, some of these employees have been moving to HMOs and OAPs.

Of particular interest is the movement downward in QCHP costs. In part, this is due to negotiated increases in health care contributions towards premiums, copayments, and other expenses by employees as a result of union contract negotiations. A recent factor, however, is the movement of retirees into Medicare Advantage HMO/PPO plans from existing QCHP/HMO/OAP options. This movement away from traditional state plans utilized by retirees and their dependents has resulted in lower QCHP medical and prescription drug costs. It is possible that this movement will help the entire group insurance program to reduce liabilities and limit growth. CMS estimates overall liability to rise by only 0.9 percent in FY 2015 after rising 0.1 percent in FY 2014, compared to increases of at least 7 percent in four of the previous five fiscal years.

The Segal Company compiles an annual cost trend survey that provides data as to how large health plans are trending during the plan year. The following are some of the key findings of the 2014 Segal study.

- All medical plan types surveyed are projected to experience declines in their trend rates in the coming year. This does not mean that costs will be lower, but the rate of increase in plan costs is expected to be less than in the previous year.
- HMO trend rates are significantly lower than just three years ago.
- Medicare Advantage trend rates are expected to decline for MA Preferred Provider Organizations (PPOs) as well as HMOs and Medicare Supplement plans. However, prescription drug coverage trends are likely to be higher than medical trends.

Table 1 below highlights national trending data and compares it to estimates by CMS and CGFA for State liability.

TABLE 1			
NATIONAL HEALTH CARE TRENDING 2014			
Component	National Trend	CMS Increase	CGFA Increase
HMOs	7.2%	10.8%	11.9%
Rx	6.3%	-39.0%	-31.4%
Dental	4.0%	-3.8%	-3.8%
Vision	2.9%	-0.4%	0.0%
Source: Segal 2014 Health Plan Cost Trend Survey			

Usually, there is a strong correlation between trend rates and actual costs. However, 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. With Illinois' situation, the trend factors cited by Segal are limited in their use this year. The massive movement of retirees alone makes a large difference in liabilities in certain program lines such as the QCHP.

Based on these assumptions and inflation factors, the CGFA estimates a FY 2015 liability of approximately \$2.692 billion for the State Employee's Group Health Insurance Program. The table below shows a detailed comparison of the CGFA estimate for the various cost components and the CMS projection for FY 2015.

TABLE 2: FY 2015 GROUP HEALTH INSURANCE LIABILITY			
(\$ in Millions)			
Liability Component	FY 2014 CMS Estimate	FY 2015 CMS Estimate	FY 2015 CGFA Estimate
QCHP Medical	\$487.4	\$462.0	\$470.2
QCHP Prescriptions	\$170.2	\$103.8	\$116.8
Dental (QCHP/MC)	\$124.8	\$120.0	\$120.1
HMO	\$970.8	\$1,076.1	\$1,086.5
Open Access Plan	\$636.9	\$657.8	\$665.9
Mental Health	\$7.9	\$7.2	\$7.6
Vision	\$10.7	\$10.6	\$10.7
Administrative Services (QCHP)	\$22.2	\$18.2	\$20.3
Life	\$86.4	\$88.1	\$88.1
Special Programs (Admin/Int./Other)	\$107.2	\$104.5	\$106.1
TOTAL	\$2,624.5	\$2,648.3	\$2,692.3
% increase over prior year	0.1%	0.9%	2.6%
*Rounding may cause slight differences. FY 2014 and FY 2015 Special Programs line includes Prompt Payment Interest.			

ESTIMATE COMPARISON

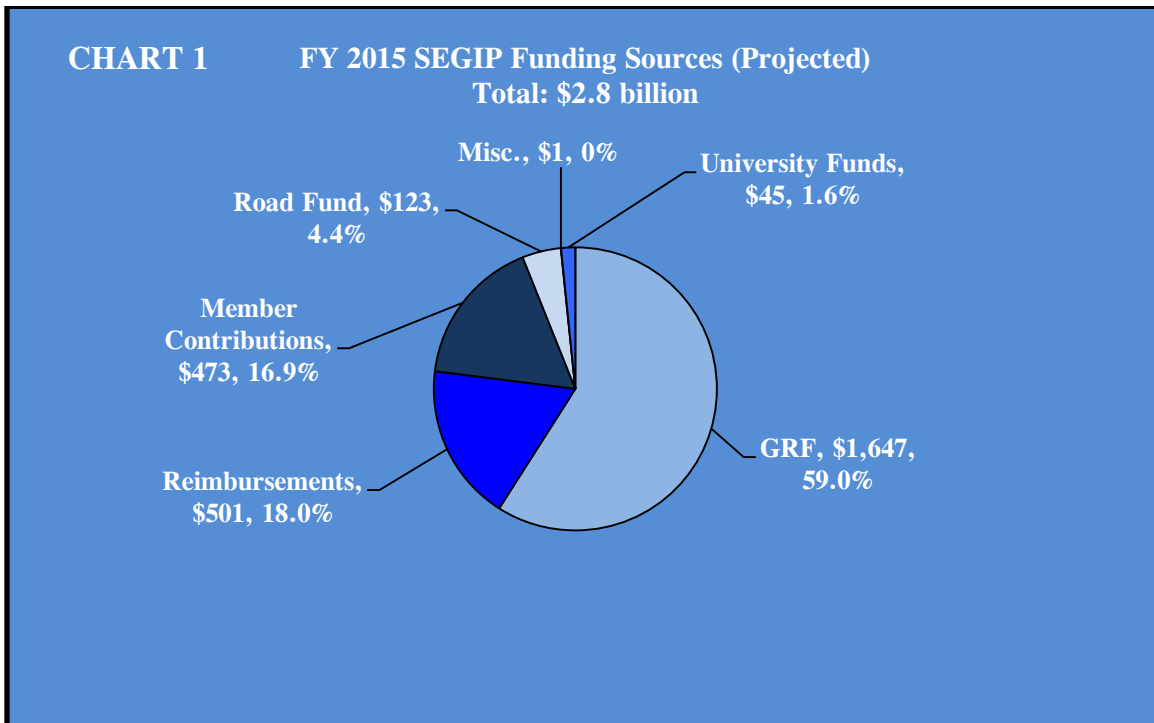
Overall, the Commission's FY 2015 estimate is \$44.1 million higher than the FY 2015 estimate from CMS. CGFA's FY 2015 HMO and Open Access Plan liabilities estimates are \$10.4 million and \$8.1 million higher than CMS, respectively. CGFA's FY 2015 estimates for prescriptions and dental coverage are \$13.0 million and \$0.2 million higher than the CMS estimate, respectively.

CGFA estimates that approximately \$2.700 billion would be required to fully fund the FY 2015 liabilities of the Group Health Insurance Program. This estimate is \$67.9 million or 2.6% more than the FY 2014 estimated liability of \$2.624 billion.

APPROPRIATION/FUNDING SOURCES

Funding for the State Employees’ Group Insurance plans originates from two funds, the Health Insurance Reserve Fund (HIRF), and the Group Insurance Premium Fund (GIPF). Contributions and payment for health coverage benefits are deposited into HIRF, and contributions for life insurance are deposited into GIPF.

HIRF is the fund mainly used to administer the group insurance program. 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, Member Contributions, Reimbursements, University Funds, and Miscellaneous Funds. Estimated cash flow into HIRF for FY 2015 is \$2.790 billion. A breakdown in the various funding sources is shown in the pie chart below.



The FY 2015 fiscal data provided by CMS shows the Group Health Insurance Program receiving \$1.647 billion in GRF funds. This represents a \$301 million or a 22.7% increase from the FY 2014 GRF component of \$1.346 billion, but \$55 million less than

the composite FY 2014 GRF figure of \$1.702 billion. This also includes General Revenue funding of \$356 million received in the lapse period. The estimated FY 2015 Road Fund request of \$123 million is \$2.3 million higher than the FY 2014 appropriation level. Member contributions continue to rise as well, with \$423.7 million in FY 2014 compared to \$473.5 million in FY 2015, an 11.8% increase, due to the agreement between the State of Illinois and AFSCME.

TABLE 3: GROUP INSURANCE FUNDING SOURCES				
FY 2014 - FY 2015				
(\$ in Millions)				
	<u>FY 2014</u>	<u>FY 2015</u>	<u>\$ Change</u>	<u>% Change</u>
GRF Appropriation	\$1,702.0	\$1,647.0	-\$55.0	-3.2%
Road Fund	\$120.8	\$123.1	\$2.3	1.9%
University Cont.	\$45.0	\$45.0	\$0.0	0.0%
Member Cont.	\$423.7	\$473.5	\$49.8	11.8%
Other Funds	\$500.3	\$501.1	\$0.8	0.2%
Medicare Part D rebate	\$35.9	\$0.0	-\$35.9	-100.0%
Rebates/Interest/Other.	\$0.7	\$0.7	\$0.0	0.0%
TOTAL Appropriations	\$2,828.4	\$2,790.4	-\$38.0	-1.3%
Source: CMS. The FY 2014 GRF figure includes \$356 million received in the lapse period.				

CMS 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 FY 2015, the GIPF target balance is \$4 million, and the target HIRF balance is \$6 million.

BENEFITS

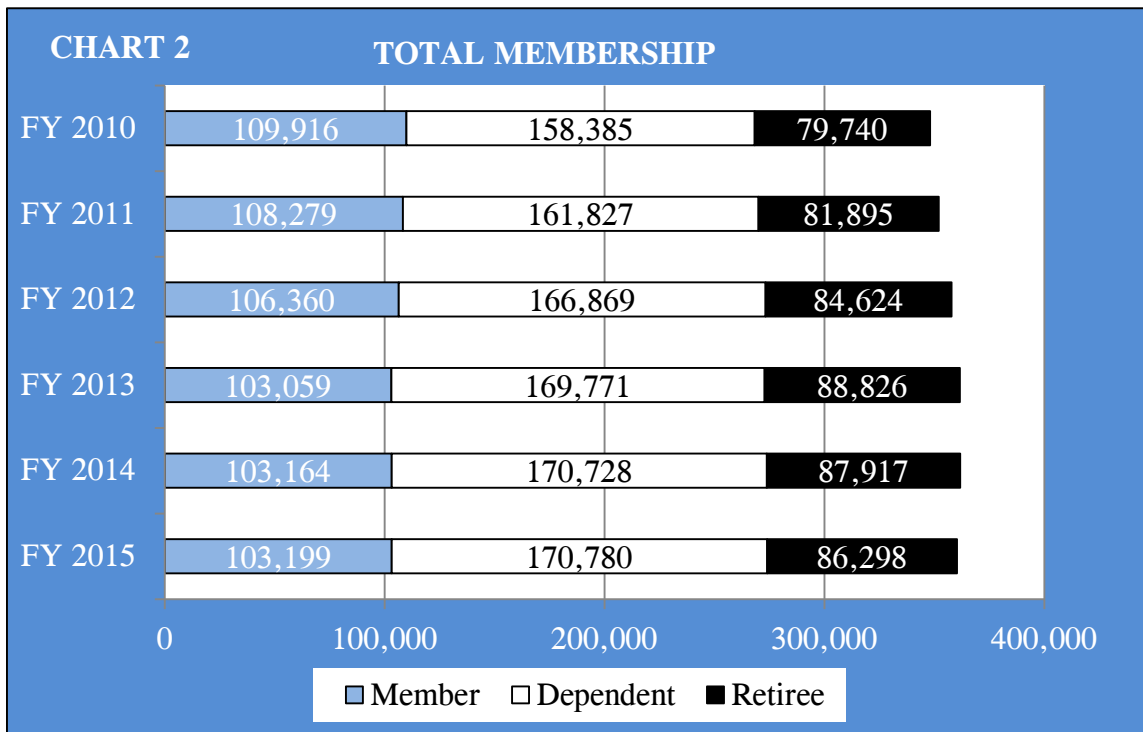
The State Employees' Group Insurance Program provides medical, dental, vision, and life insurance coverage to State employees, retirees and their dependents. Medical coverage is provided separately to members in their choice of: QCHP plan, and various types of managed care plans such as Health Maintenance 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. Appendix IV includes a brief outline of benefit changes resulting from the recently concluded labor negotiations between labor unions and the State of Illinois.

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.

Starting in FY 2014, Medicare-eligible retirees and their Medicare-eligible dependents were moved towards Medicare Advantage (MA) plans. Individual retirees and dependents had the choice of four different plans that ranged from MA HMO plans to a MA PPO plan. These plans became effective as of February 1, 2014. The retirees and dependents can still access benefits from the same dental, vision and life insurance plans that current state employees and dependents enjoy.

MEMBERSHIP

According to CMS, the State Employees' Group Health Insurance Program has an estimated 361,809 participants for FY 2014, of which 180,882 are in a HMO, 92,280 are in an Open Access Plan, and 88,647 are in the Quality Care Health Plan. The QCHP is estimated to have 19,111 employees, 31,484 dependents, and 38,052 retirees in FY 2014. HMO plans are estimated to have 52,118 employees, 88,873 dependents, and 39,891 retirees in FY 2014. The HMO numbers include Medicare Advantage HMO/PPO plans as categorized by CMS. OAPs are expected to have 31,935 employees, 50,371 dependents, and 9,974 retirees in FY 2013. For FY 2015, the QCHP is estimated to have 18,968 employees, 25,355 dependents and 15,404 retirees (as most retirees move towards Medicare Advantage HMO and PPO plans). HMO Plans are estimated to have 52,130 employees, 95,638 dependents and 63,147 retirees. OAPs are expected to have 32,101 employees, 49,787 dependents, and 7,747 retirees in FY 2015.



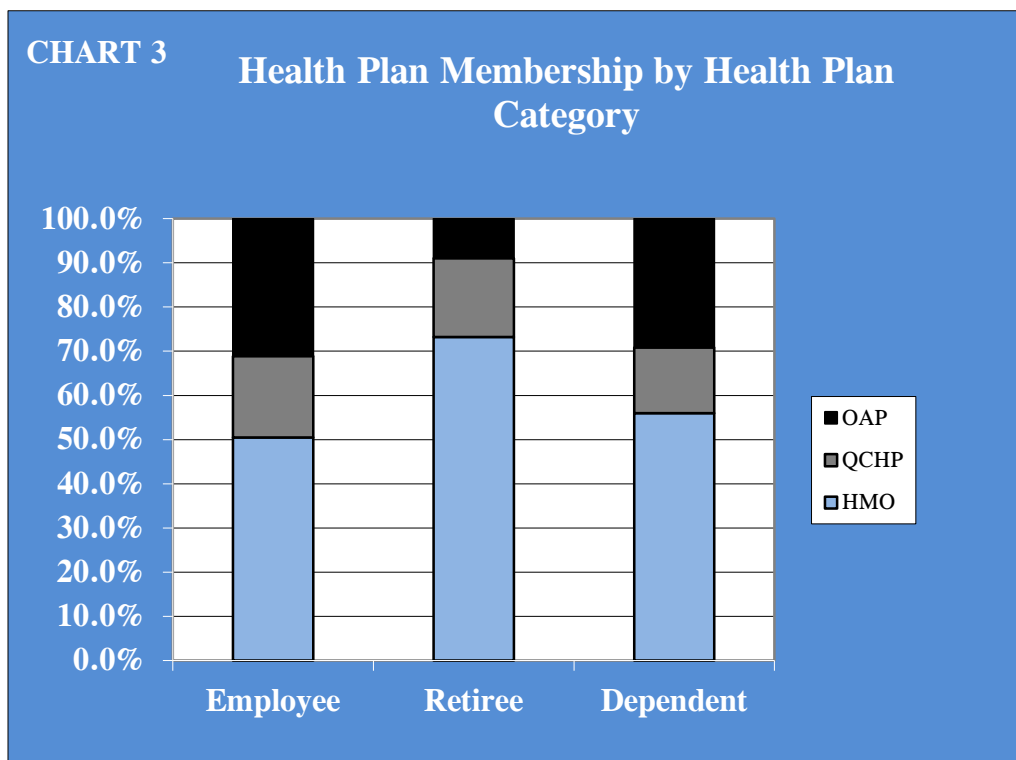
- Membership is estimated for FY 2014 and FY 2015.

ENROLLMENT TRENDS

Membership in the Quality Care Plan has been decreasing since FY 2005 while membership in the States' managed care offerings had been increasing since FY 2004. However, in recent years, many participants have switched away from traditional managed care (HMOs) to alternatives such as the Open Access Plan (OAP). This move has moderated significantly in the past year due to a jump in HMO enrollment in FY 2014-2015 from retirees and dependents moving out of the QCHP.

For FY 2015, membership in HMOs is expected to increase significantly to 210,915, in large part due to the classification of Medicare Advantage HMO/PPO plans under this category (16.6%) while membership in OAPs is expected to decrease slightly to 89,635 (-2.9%).

Chart 3 below shows the breakdown of employee, dependent and retiree enrollment in the overall group insurance program. Due to the shift towards MA HMO/PPO plans by retirees, the QCHP has become much less utilized among employees as a whole, especially retirees. In FY 2015, 73.2% of retirees are expected to enroll in a HMO (MA HMO/PPO), a massive shift from the 62.8% QCHP enrollment in FY 2013. Chart 3 shows that employees, retirees, and dependents from both groups are gravitating towards managed care and Open Access Plans.



LIABILITY

The Department's estimate of liability for FY 2015 represents a 0.9% growth rate over FY 2014. This increase in estimated liability is much lower than the increase from FY 2012 to FY 2013, when liability increased 7.66%, but it is higher than the increase from FY 2013 to FY 2014 of just 0.2%. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2006 through FY 2015.

Table 4 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. However, in recent years, HMOs, OAPs and the QCHP have claimed the majority of group insurance liability. Retirees and their dependents have shifted away from QCHP towards MA HMO/PPO plans. As a partial result of the shift away from QCHP, the Open Access Plan is anticipated to have significantly more liability for the State of Illinois than the QCHP and prescription components as a whole.

TABLE 4: STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY										
(FY 2006-FY 2015)										
\$ in (millions)										
Liability Component	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
QCHP Medical/Rx	\$691	\$695	\$689	\$726	\$729	\$730	\$742	\$756	\$658	\$566
HMO Medical	\$662	\$711	\$781	\$844	\$911	\$1,007	\$853	\$895	\$971	\$1,076
Dental	\$85	\$96	\$102	\$110	\$115	\$129	\$133	\$129	\$125	\$120
Open Access Plan	\$125	\$154	\$178	\$213	\$252	\$285	\$511	\$602	\$637	\$658
QC Mental Health	\$9	\$9	\$9	\$8	\$11	\$8	\$8	\$8	\$8	\$7
Vision	\$8	\$8	\$8	\$8	\$8	\$10	\$11	\$12	\$11	\$11
Life Insurance	\$76	\$76	\$78	\$81	\$84	\$82	\$81	\$83	\$86	\$88
QC ASC	\$29	\$28	\$30	\$31	\$32	\$32	\$32	\$31	\$25	\$18
Admin/Int/Other	\$17	\$13	\$17	\$18	\$46	\$62	\$64	\$105	\$104	\$105
Total	\$1,702	\$1,790	\$1,892	\$2,039	\$2,188	\$2,344	\$2,434	\$2,621	\$2,624	\$2,649
% change over py	4.8%	5.2%	5.7%	7.8%	7.3%	7.1%	3.9%	7.7%	0.1%	0.9%
Rounding causes slight differences in totals.										

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 4 shows the steady increase each year in cost per participant. This increase can be attributed in part to medical inflation, though recent negotiations between the State and organized labor and the move of retirees towards MA plans have appeared to slow the rise in cost per participant. In FY 2006, the annual cost per participant in the group health insurance program was \$4,919. **According to CMS, the estimated cost per participant for FY 2015 is \$7,352. That represents a 57.4% increase over a ten year period.** The cost per participant increased 1.36% from FY 2014 to FY 2015.

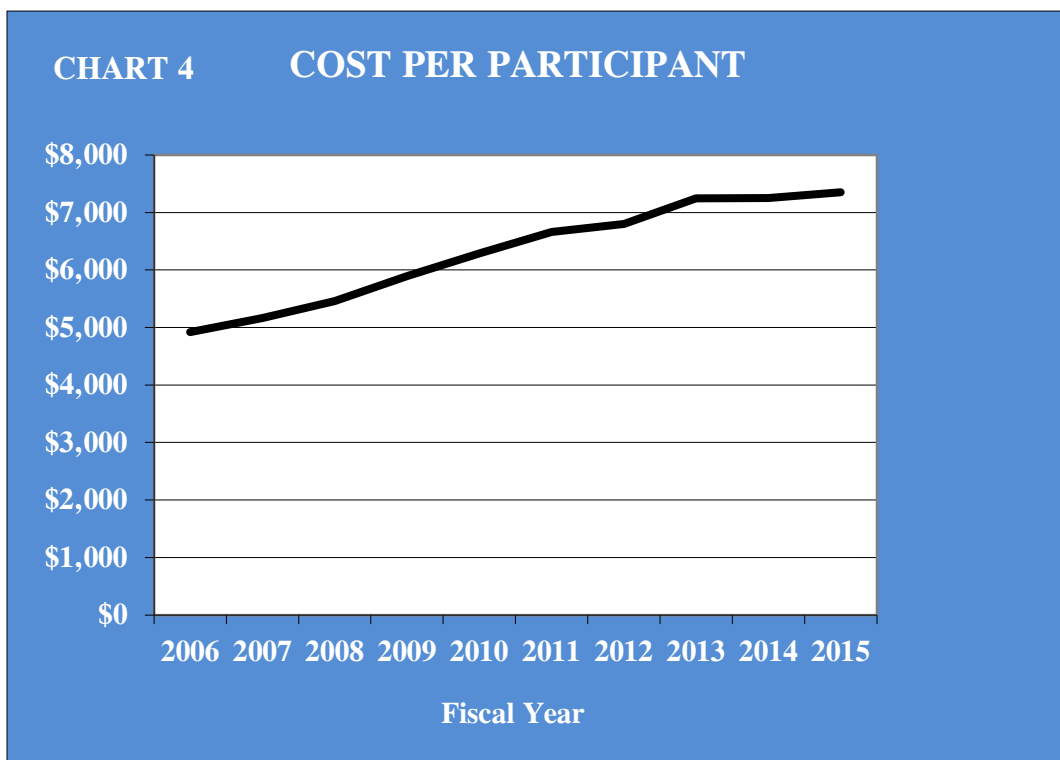


TABLE 5: AVERAGE ANNUAL COST PER PARTICIPANT				
	FY 2014	FY 2015	FY 2014	FY 2015
	Total Participants	Total Participants	Average Cost Per Participant	Average Cost Per Participant
QCHP	88,647	59,727	\$7,418	\$9,474
HMO	180,882	210,915	\$5,367	\$5,102
OAP	92,280	89,635	\$6,901	\$7,339
Totals	361,809	360,277		

OAP is the Open Access Plan. ACPP does not include dental, vision, admin/interest/other, or life insurance. Numbers are not adjusted for risk.

When comparing average cost per participant (ACPP) in Table 5, the average cost for FY 2014 is lowest for members in the HMO and highest for members in the QCHP. The total number of participants in the QCHP has declined for many years as people have steadily migrated to HMOs and OAPs. This trend was accelerated in FY 2014, as most retirees (over 90 percent) were moved from QCHP to a Medicare Advantage HMO/PPO plan, which boosted the number of participants in the HMO portion of Table 5. This massive shift has resulted in a huge increase in average cost for remaining QCHP participants, as those who remain, including non-Medicare eligible retirees and dependents are predominantly the more expensive to cover (requiring more treatment, medicines, etc.).

MEMBER CONTRIBUTIONS

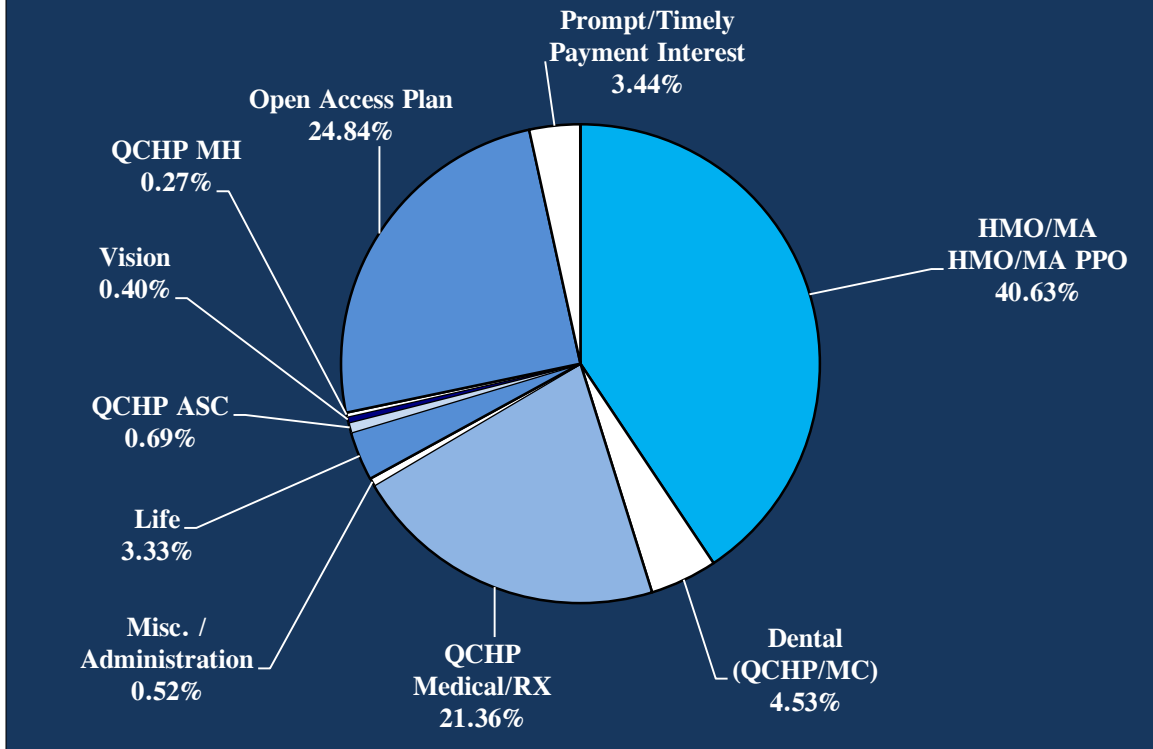
An important factor in the examination of cost per participant is the amount paid by the State versus the member. The ACPP per enrollee in the QCHP is \$7,418 in FY 2014. Total member contributions for QCHP enrollees totaled \$118 million. This means that of the total cost per participant, \$1334 of that cost is covered by member contributions. This is a significant change from previous years, as retirees are now contributing towards their coverage. In addition, many retirees have been moved out of QCHP towards a Medicare Advantage HMO/PPO plan. This causes more people to be added to the composite HMO/OAP line in Table 6 and leaves fewer people (who are still quite expensive accordingly to cover) in the QCHP, causing the cost per participant for that program to rise. Table 6 examines the relationship between overall cost and the offset by member contributions.

TABLE 6: MEMBER CONTRIBUTIONS AND AVERAGE COST PER PARTICIPANT (ACPP)						
	FY 2014 ACPP	FY 2014 Member Contributions	FY 2014 Member/ State Cost	FY 2015 ACPP	FY 2015 Member Contributions	FY 2015 Member/ State Cost
QCHP	\$7,418	\$118,297,571	\$1,334/ \$6,084	\$9,474	\$109,483,833	\$1,833 / \$7,641
HMO/OAP/MA HMO/PPO	\$5,885	\$272,471,012	\$997 / \$4,888	\$5,769	\$325,640,865	\$1,083/ \$4,686
Dental	\$350	\$32,871,506	\$92 / \$258	\$337	\$32,900,666	\$92/ \$245
Source: CMS. All FY 2015 numbers are estimates.						

The table above shows that QCHP members contribute approximately 18.0% of the overall annual cost of providing their insurance in FY 2014. HMO/OAP/MA HMO/MA PPO members contribute 16.9% of their overall liability cost in the same time period. Members that participate in the State’s dental offering pay 26.3% percent of the overall liability cost. 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. These contribution levels in the Table above for FY 2014 and FY 2015 include agreed contribution increases for employees and retirees.

The following chart includes the various components of the FY 2015 CMS liability estimate of approximately \$2.648 billion. The largest component of the State Group Insurance Program continues to be the State’s managed care plans (HMO, OAP, MA HMO/MA PPO) which now represent 65.5% of FY 2015 liability. Dental care, life insurance, vision care, and all other components equal 11.7% of total liability. The QCHP component (22.3%) has dropped significantly in FY 2015, but still includes medical/prescriptions, mental health coverage, and administrative service charges.

CHART 5 FY 2015 Group Insurance Components (Est.)



Since the movement of retirees to MA HMO/PPO plans, it is unlikely that the QCHP will rise to the proportion of the total group insurance liability it had attained before FY 2014. At the same time, the availability and affordability of MA HMO plans for the State of Illinois indicates that this area of liability is not likely to shrink in size or proportion in the near future. In regards to Open Access Plans, they remain an option for state employees and non-Medicare eligible individuals who seek a middle ground between the affordability of HMOs and the options available to QCHP participants.

EMPLOYEE/RETIREE COST COMPARISON

A subject of interest in recent years is the breakdown of costs for active employees and their dependents and retirees and their dependents. As contributions from retirees have risen in recent years, the disproportion between actives/dependents and retirees/dependents has moderated somewhat. Table 7 below displays a comparison of the costs for these groups taken from data obtained from CMS as of March 2014.

TABLE 7: RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 2014			
Category	Cost	Category	Cost
Retiree Cost	\$570.1	Active Employee Cost	\$1,013.5
Retiree Contribution	\$105.7	Active Employee Contribution	\$174.1
Net State Cost	\$464.4	Net State Cost	\$839.4
Retiree Dependent Cost	\$209.3	Active Employee Dependent Cost	\$714.4
Retiree Dependent Contribution	\$65.5	Active Employee Dependent Contribution	\$122.8
Net State Cost	\$143.8	Net State Cost	\$591.6
Total Retiree Cost	\$779.4	Total Active Cost	\$1,727.9
Total Retiree Contribution	\$171.2	Total Active Contribution	\$296.9
Net State Cost	\$608.2	Net State Cost	\$1,431.0
Source: CMS			
All numbers in Millions			

A number of points can be observed from this table. Unlike previous years, retirees now pay a larger portion of their healthcare costs than active employees (18.5% to 17.2%). The trend of dependents of retirees and active employees paying more as a percentage of total costs than retirees or active employees by themselves has continued in FY 2014. In total, the net state cost of active employees and dependents remains significantly higher than retirees and retiree dependents. This cost difference results in part from retirees utilizing Medicare Advantage HMO and PPO plans and resulting savings for the State of Illinois. The trend may change in time as people continue to live longer lives and make use of medicinal technologies that were unavailable in past years.

MANAGED CARE PLANS

HMO-style plans require participants to choose a doctor from the HMO network to become their primary care physician. All routine medical care, hospitalization and referrals for specialized medical care must then be coordinated under the direction of the primary care physician who acts as a gatekeeper for medical services. Managed care plans have restricted service areas. Generally, HMOs cover preventive health care, such as regular checkups and immunizations, while QCHP plans typically do not. However, the State’s QCHP plan provides several preventive health services, such as well-baby care, routine physicals, mammograms, school health physical exams, and annual pap smears. All these additions to the QCHP are in accordance with the current collective bargaining agreement with the American Federation of State, County and Municipal Employees (AFSCME) Union.

The Open Access Plan, first offered for the FY 2002 benefit year, is a managed care plan that is a combination of an HMO and a PPO. Members have access to a wide range of care, with three benefit levels from which to choose. (*Members in an HMO have one level of benefits*). Tier I of the Open Access Plan provides the richest benefit and the lowest co-payments. Tier II, like Tier I, is considered in-network. A higher level of co-payment applies to Tier II providers. Tier III providers are out-of-network. Primary Care Physicians (PCPs) in the Open Access Plan do not perform the “gatekeeper” function. Therefore, patients may see specialists without referral from the Primary Care Physician. Greater detail about FY 2013 and FY 2014 plan enrollment is listed in Table 8 below.

TABLE 8: MANAGED CARE PLANS					
FY 2012-2014					
All Lives (Active Members/Dependents and non-MA Retirees/Dependents)					
HMO/OAP	FY12 # of Participants	FY13 # of Participants	% Change 2012-2013	FY14 # of Participants	% Change 2013- 2014
Health Alliance HMO	74,875	84,614	13.01%	86,178	1.85%
Health Alliance Illinois	6,782	0	-100.00%	0	N/A
HMO Illinois	63,426	61,214	-3.49%	60,445	-1.26%
Blue Advantage	2,109	3,394	60.93%	3,997	17.77%
Coventry Health Care HMO	11,442	8,850	-22.65%	8,610	-2.71%
Coventry Health Care OAP	18,210	20,688	13.61%	21,903	5.87%
Health Link OAP	63,481	69,380	9.29%	71,530	3.10%
TOTALS	240,325	248,140	3.25%	252,663	1.82%

Source CMS. FY 14 numbers as of February 2014.

MEDICARE ADVANTAGE

A new development in the 2014 fiscal year is the movement of eligible retirees and dependents into a system of Medicare Advantage plans. These plans were set forth in an effort to save the State money as well as to provide quality service and care for retirees and their dependents. As this program is in its infancy, there are only limited judgments to be made as to efficacy and overall quality of this decision. Table 9 below shows the population figures involved with this new program.

TABLE 9: MEDICARE ADVANTAGE PLANS FY 2014	
HMO/PPO	FY14 # of Participants
Aetna HMO	3,638
Humana Benefit Plan 1 HMO	162
Humana Benefit Plan 2 HMO	2,084
United HealthCare PPO	59,230
TOTALS	65,114

Source: CMS. FY 15 numbers not available at this time.

It is important to note that except for a limited number of retirees and dependents coming from a HMO or OAP program, almost all of the 65,114 people now covered by a MA HMO or PPO plan came from the QCHP. As a result of these people being removed from QCHP, it is forecasted to be significantly more expensive on a per-person basis in the 2015 fiscal year. In regards to MA, there are two different HMO benefit plans being offered by Humana as Humana Benefit Plan 1 is intended for Livingston and Knox counties while Humana Benefit Plan 2 is a traditional open area Medicare Advantage plan. The monthly rates for the State's Medicare Advantage plans are discussed in the Monthly Premiums section of this report.

MONTHLY PREMIUMS

Compared to managed care plans, the State of Illinois' QCHP is significantly more expensive for individuals than a traditional HMO or OAP. Historically, members in managed care plans cost the State less since the risk of providing health care is assumed by the HMO, and HMO plans typically have younger, healthier participants. OAPs are also less expensive for the state, as the consumer takes on more cost and the OAPs take on more risk than the QCHP.

According to the Department, the estimated monthly cost for a current employee in the QCHP for FY 2014 is \$872 but will increase significantly to \$970 (11.2%) in FY 2015.

The monthly premium for a current employee in a managed care plan varies based on each plan's rates, but the FY 2015 estimated average cost for a member in a HMO plan will be \$693 per month. The premium for a current employee in an OAP will average to \$793.

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 experiences 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 2014 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 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 10 below shows the FY 2015 weighted average monthly rates for managed care plans and the QCHP plans, as well as the State and member contributions. The State's contribution varies, depending on a member's salary. Of particular interest is the cost involved with the new Medicare Advantage plan option for retirees and their dependents. This comparison is shown in Table 13, but can be summarized as a significant savings for both the State of Illinois and for retirees/dependents in terms of cost of monthly premiums.

TABLE 10: MONTHLY PREMIUMS Managed Care vs. Indemnity Plan Weighted Average FY 2015 Rates (Projected)									
Membership	QCHP			HMO			OAP		
	TOTAL	Member	State	TOTAL	Member	State	TOTAL	Member	State
Employee	\$970	\$166	\$804	\$693	\$114	\$579	\$793	\$112	\$681
Medicare Retiree	\$471	\$71	\$400	\$222	\$48	\$174	\$520	\$48	\$472
Non-Medicare Retiree	\$1,234	\$165	\$1,069	\$1,027	\$82	\$945	\$1,168	\$82	\$1,086
1 Dependent	\$1,060	\$251	\$809	\$585	\$109	\$476	\$668	\$125	\$543
2+ Dependents	\$1,400	\$294	\$1,106	\$976	\$155	\$821	\$1,163	\$176	\$987
Medicare Dependent	\$472	\$142	\$330	\$227	\$86	\$141	\$522	\$99	\$423

TABLE 11: PROJECTED COSTS FY 2008 - FY 2015 Employee Only												
	QCHP				HMO				OAP			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY08	\$624	2.20%	\$68	\$556	\$448	9.00%	\$42	\$406	\$521	5.20%	\$42	\$479
FY09	\$683	9.40%	\$72	\$611	\$482	7.60%	\$45	\$437	\$581	11.50%	\$45	\$536
FY10	\$722	5.80%	\$81	\$641	\$522	8.20%	\$55	\$467	\$641	10.30%	\$55	\$586
FY11	\$765	5.90%	\$81	\$684	\$571	9.40%	\$55	\$516	\$675	5.40%	\$55	\$620
FY12	\$827	8.20%	\$82	\$746	\$584	2.40%	\$55	\$529	\$663	-1.80%	\$55	\$608
FY13	\$883	6.80%	\$84	\$800	\$624	6.70%	\$56	\$567	\$725	9.40%	\$56	\$669
FY14	\$872	-1.30%	\$158	\$714	\$648	3.90%	\$114	\$534	\$734	1.20%	\$112	\$622
FY15	\$970	11.20%	\$166	\$804	\$693	6.90%	\$114	\$579	\$793	8.00%	\$112	\$681

It is important to note that the comparisons made in Tables 10 and 11 are aggregate comparisons. As such, there are individual HMO and OAP plans that differ significantly from the average shown in these tables. Individual HMO and OAP plans may be significantly higher or lower than the averages shown. Therefore, it is necessary to show these plans individually in Table 12.

TABLE 12: MONTHLY PREMIUMS ACROSS ALL PLANS HMOs and OAPs FY 2015 Rates (As of February 2014)						
Membership	Health Alliance	Coventry HMO	HMO Illinois	Blue Advantage	HealthLink OAP	Coventry OAP
Employee	\$714	\$662	\$635	\$607	\$789	\$688
Medicare Retiree	\$464	\$430	\$413	\$394	\$513	\$447
Non-Medicare Retiree	\$1,056	\$979	\$940	\$898	\$1,168	\$1,019
1 Dependent	\$599	\$556	\$534	\$510	\$663	\$578
2 + Dependents	\$1,027	\$953	\$915	\$874	\$1,136	\$991
Medicare Dependent	\$464	\$430	\$413	\$394	\$513	\$448

As shown in this table, HMO plans are not necessarily less costly than OAPs. There are numerous factors involved in the rates submitted by health insurance providers, indicating that some plans may be better for participants based on their current status of active or retired, with or without dependents, and their status in regards to Medicare.

Table 13 shows a comparison between FY 2014 and projected FY 15 MA rates for retirees and dependents. The significant rise in rates between the two years for retirees is a reflection of the negotiated increase in health care contributions for retirees from 1% to 2% of their pension. Rates for dependents are expected to remain steady.

TABLE 13: MONTHLY PREMIUMS FOR STATE MEDICARE ADVANTAGE PLANS FY 2014-2015 Rates (As of February 2014)		
Aetna HMO	FY 2014	FY 2015
Medicare Retiree	\$42.94	\$73.03
Medicare Dependent	\$89.91	\$89.91
Humana Benefit Plan 1 HMO	FY 2014	FY 2015
Medicare Retiree	\$42.94	\$73.03
Medicare Dependent	\$89.91	\$89.91
Humana Benefit Plan 2 HMO	FY 2014	FY 2015
Medicare Retiree	\$42.94	\$73.03
Medicare Dependent	\$89.91	\$89.91
United HealthCare	FY 2014	FY 2015
Medicare Retiree	\$42.94	\$73.03
Medicare Dependent	\$89.91	\$89.91

APPENDIX I

TYPES OF MEDICAL & DENTAL GROUP INSURANCE PLANS			
Type of Plan	Coverage	Characteristics	Geographic Location
QCHP Medical	Care related to the treatment of an illness or injury. Preventive care includes well-baby care, routine and school physicals, annual pap smears and mammograms.	Choice of physician and other medical care providers. Annual deductibles and employee contributions based on member salary. Dependent premiums do not vary.	No limitation; preferred hospital providers statewide.
QCHP Dental	Preventive, diagnostic, restorative, orthodontic, endodontic, and periodontic services as well as extractions and prosthetics.	Choice of dental care providers, reimbursement on a scheduled basis. No deductibles. 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.	Statewide coverage
MA HMO	Comprehensive medical benefits including preventive care.	Prepaid benefits, primary care physician who coordinates all care chosen from HMO network.	Statewide coverage
MA PPO	Comprehensive medical benefits including preventive care.	Choice of physician and other medical care providers.	Statewide coverage

APPENDIX II

Status of Contracts for FY 14 at DCMS		
Service	Vendor	Contract Term Details
Managed Care Health Plans	Health Alliance HMO / Coventry HMO / Coventry OAP / HealthLink OAP / BC HMO Illinois / BC Blue Advantage	Ongoing - Term goes to June 30, 2016 with up to five 1-year renewals.
Self-Insured Medical Plan Administration	Cigna	Ongoing - Term goes to June 30, 2015 with up to two 1-year renewals.
Medicare Advantage Payments	Humana Benefits Plan / Aetna-Coventry HMO / United HealthCare PPO	Ongoing - Term goes to December 31, 2016 with up to six renewal options.
Vision	EyeMed	Renew - Currently in the fourth year of up to five renewals. RFP in process.
Behavioral Health/EAP	Magellan	Ongoing - Term goes to June 30, 2016 with up to five 1-year renewals.
Flu Shots	Maxim	Ongoing - Term goes to September 30, 2016
Consulting Contracts	Blalock Consulting	Ending - Term ends June 30, 2014
Life Insurance	Minnesota Life	Ongoing - Term goes to June 30, 2016 with up to five 1-year renewals.
Flexible Spending	Wage Works	Renew - Currently in the last year of renewals. RFP in progress.
Dependent Eligibility Verification Audit	Health Management System	Ongoing - Term goes to June 30, 2018 with up to five 1-year renewals.
Administration of Dental Claims	Delta Dental	Ongoing - Term goes to June 30, 2016 with up to five 1-year renewals.
Prescription Drugs	Express Scripts	Ongoing - Term goes to June 30, 2015. RFP in progress.
Commuter Savings Program	Wage Works	Renew - Currently in 3rd year of up to five 1-year renewals. Renewal would extend contract to June 30, 2015.

APPENDIX III

SAVINGS UPDATE

In the FY 2014 State Employees Group Insurance Report, a section was included regarding the proposed savings estimated by CMS resulting from negotiations with public employee unions. As of March 2014, CMS has provided an update detailing the expected savings for the current fiscal year (2014) and for FY 2015. A chart with this information is shown below.

FY 2014 and FY 2015 Program Cost/Savings Estimates		
Initiative	FY 2014	FY 2015
Cost Savings:		
Plan Design Changes	\$51.9	\$85.9
Medicare Advantage	\$58.0	\$150.0
Maximum Reimbursement Charge	\$10.0	
Pharmacy Network	\$9.8	
Medicare Coordination of Benefits	\$34.0	
Insurance Committee (Dental)		\$55.0
Increased Revenues:		
Member Contribution	\$136.7	\$180.8
Decreased Revenues:		
Loss of Medicare D		(\$36.0)
Total	\$300.4	\$435.7
Source: CMS. All numbers in millions.		

Though significant savings are expected from the shift towards Medicare Advantage, a loss in Medicare Part D reimbursement funding is expected. However, this is more than offset by scheduled increases in Member Contributions as well as general savings from changes in plan design and the shifting of retirees and dependents towards Medicare Advantage. For FY 2014, the expected savings amount to \$300.4 million, while in FY 2015, savings are expected to reach \$435.7 million. This contrasts with previous CMS estimates, which assumed a \$214 million savings in FY 2014 (including offsets from additional wages paid out to employees) and \$429 in FY 2015 as a result of collective bargaining agreements.

DEPENDENT AUDIT

CMS has also undertaken an audit of all listed dependents of current members and retirees of the health plans under its purview. This includes State Employees, State University Employees, College Insurance Program enrollees, TRS members, and Local Government Health Plan members. The status of the audit for each group is listed in the chart below.

DEPENDENT ELIGIBILITY AUDIT	
Group	Status
1 - Local Government Health Plan / College Insurance Program Enrollees	1,835 dependents audited - 42 terminations processed as of 3/1/2014
2 - State Employee Retirees/TRS Retirees	51,441 dependents audited - As of 2/7/2014: 45,802 dependents verified; 228 dependents voluntarily terminated by member; 1,317 dependents updated (terminated/approved/other) by the State; 4,094 dependents unverified
3 - Active State Employees	Audit start date postponed until at least 7/1/2014
4 - Active University Employees	Audit start date postponed until at least 8/1/2014

Given the cost of providing coverage to dependents, the number of terminations of dependents from employee/retiree plans could result in significant savings for the State of Illinois. The largest number of dependents, however, remains in the State Employee and University Employee groups, which are not targeted for auditing until July 2014 at the earliest (in the case of State Employees).

APPENDIX IV

STATE EMPLOYEES' GROUP INSURANCE OVERSIGHT

P.A 93-0839 strengthened the Commission's oversight role of the State Employees' Group Health Insurance Program. P.A 93-0839, clarified State policy for the administration of the Group Insurance Program, and requires CMS to administer the program within set policy parameters. Those key parameters are:

- Maintain stability and continuity of coverage, care, and services for members and their dependents.
- Members should have continued access, on substantially similar terms and condition, to trusted family health care providers with whom they have developed a long-term relationship.
- The Director (CMS) may consider affordability, cost of coverage and care, and competition among health insurers and providers in the contract review process.

The specific changes in oversight authority for the Commission on Government Forecasting and Accountability are listed below:

- By April 1st of each year, the Director (CMS) must report and provide information to the Commission concerning the status of the employee benefits program to be offered the next fiscal year.
- By the first of each month thereafter, the Director (CMS) must provide updated, and any new information to the Commission until the employee benefits program for the fiscal year has been determined.
- Requires CMS to promptly, but no later than 5 business days after receipt of a request, respond to a written request by the Commission for information.
- Within 30 days after notice of the awarding of a contract has appeared in the Illinois Procurement Bulletin, the Commission may request information about a contract. The Commission must receive information promptly and in no later than 5 business days.
- No contract may be entered into until the 30-day period has expired.
- Changes or modifications to proposed contracts must be reported to the Commission in accordance with the aforementioned points.
- CMS must provide to the Commission a final contract or agreement by the beginning of the annual benefit choice period.
- States that the benefits choice period must begin on May 1st unless interrupted by the collective bargaining process. In the case that the collective bargaining process is still pending on April 15, the benefit choice period will begin 15 days after the ratification of the agreement.
- Specifies the methods used to provide the Commission with requested information and discusses confidentiality.

States that all contracts are subject to appropriation and must comply with the Illinois procurement code.

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
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