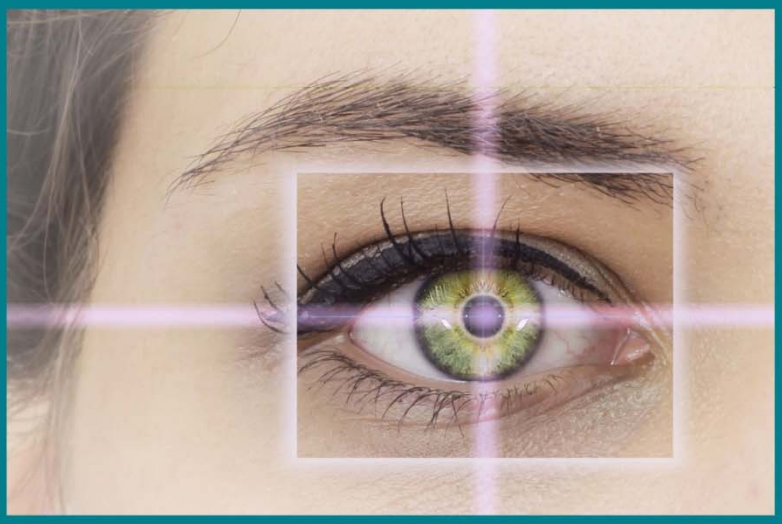
FY 2017

Liabilities of the State Employees' Group Health Insurance Program



Commission on Government Forecasting & Accountability

March 2016

Commission on Government Forecasting and Accountability

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FY 2017 State Employees' Group Insurance Report
March, 2016

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 $1.365 billion in General Revenue Funds (GRF) be appropriated for the State Employees' Group Health and Life Insurance program for FY 2017. The total expected revenues for the Group Insurance Program in FY 2017 is $2.307 billion. The FY 2016 GRF appropriation for the Group Health Insurance Program was $1.650 billion with total expected revenues of $2.678 billion. The table on page 2 represents historical appropriation and liability amounts. CMS estimates the FY 2017 liability to be $2.865 billion, a 4.1% increase from FY 2016. The CGFA FY 2017 estimate of liability is $2.884 billion, $18.4 million more than CMS. The CGFA FY 2017 estimate is reflective of the figures provided by CMS. It is possible that certain information utilized in this report may change depending on the outcome of ongoing collective bargaining negotiations. This is a continuation of the situation in FY 2016, as negotiations have not yet been completed as of the date of this report.

In regards to payment cycles, the situation is much worse than the last fiscal year. As of February 29, 2016, the amount of SEGIP claims on hand is $2.895 billion and growing approximately $200 million per month. The current FY 2016 payment cycles are:

- CIGNA claims: 446 days for preferred providers, 523 days for non-preferred (CMS projects 363 days and 440 days for FY 2017)
- Managed Care claims: Approximately 16 months (CMS projects 11 months for FY 17)
- Prescription/OAP claims: 478 days for Prescriptions, 392 days for OAPs (Similar estimates as Managed Care for FY 17)
- Dental claims: 253 days for network claims, 351 days for non-network claims (CMS projects (167 and 265 days for FY 17)

Using the figures provided by CMS, the FY 2017 estimated liability for the Quality Care Health Plan (QCHP) is expected to increase by 5.5% over the FY 2016 liability.

The estimated liabilities for the State's HMO plans are expected to increase 7.6% over the FY 2016 cost while OAP liabilities are actually expected to decrease 2.3%. FY 2016 liability for the HMO plans increased 2.8% from FY 2015, a significantly smaller percentage increase from FY 2014. CMS projects prescription drug liability to increase by 3.5% in FY 2017 from $105.0 million to $108.7 million. This follows a decrease in FY 2016 of 3.8% ($4.1 million) from FY 2015.

GRF APPROPRIATION/REVENUE AND LIABILITY HISTORY FY 2012-2017 ($ in Millions)				
Fiscal Year	Appropriation	Revenues	CMS Liability	CGFA Liability
FY 2012	$1,619.8	$2,567.8	$2,459.1	
FY 2013	$1,103.0	$2,088.5	$2,561.2	
FY 2014	$1,697.0	$2,791.3	$2,596.2	
FY 2015	$1,682.3	$2,689.9	$2,620.1	
FY 2016	$1,650.0	$2,677.5	$2,753.5	
FY 2017	$1,365.0	$2,306.6	$2,865.4	$2,883.8
*Estimated for FY 2017				

FY 2017 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2017 cost projection utilizes the CMS estimate for FY 2016 medical claims as the basis for estimating claims for FY 2017 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 2017 uses the following assumptions based on historical claims data and anticipated cost changes:

Trend Factors	
Medical (QCHP plan)	6.2%
Dental (QCHP and MC)	2.7%
HMO (Medical and Rx)	8.2%
Prescription drugs (QCHP)	4.6%
Life Insurance	3.8%

It is necessary to note that these figures only relate to the portion of total medical costs borne by the State of Illinois. The shifting of retirees towards Medicare Advantage and negotiated increases in employee contributions and co-payments have caused State costs to decline from where they might be otherwise. However, the overall cost of providing healthcare for State employees, retirees and dependents continues to rise. The medical trend inflation factors for the State consist of various components. These components include 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, though movement of Medicare-eligible retirees out of the QCHP/HMOs/OAPs has reduced overall liability within the group insurance program.

Of particular interest is the shift 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, though these costs are expected to rise over time. It is possible that this movement will help the entire group insurance program to reduce liabilities and limit expensive growth in the long run. However, the upcoming fiscal year shows continuing increases in costs to the state. CMS estimates overall liability to rise by 4.1 percent in FY 2017. This is in part due to limited savings potential from negotiated medical insurance changes, general medical cost inflationary rises, and rapidly rising year-to-year interest payments on SEGIP delayed bill payments.

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 2015 (Calendar Year) Segal study.

- Most medical and prescription drug plans for active employees and under-65 retirees are expected to increase in cost at a higher trend than the previous year. Prescription Drug Carve-Out plans (separate prescription plans with a Pharmacy benefits Manager dedicated to that plan only) are anticipated to increase even more than last year, and are anticipated to be significantly higher than in 2016, at an 11.3% rise compared to 8.6%. This is expected to continue for Prescription Drug plans for Retirees as well (10.9% compared to 7.5%).

- HMO trend rates are expected to increase over 2016 at 6.8% compared to 6.2%.

- Medicare Advantage trend rates are expected to decrease for MA Preferred Provider Organizations (PPOs such as UnitedHealthCare) and MA HMOs. Medicare Supplemental plans trends are expected to stay the same.

- Dental and Vision plans trends are expected to decrease in most cases (including the State of Illinois plan), except Dental Schedule of Allowance plans and Vision Reasonable and Customary Plans.

- On a regional basis, the Midwest is expected to again have lower increases than most of the country, with PPO/Point of Service plans expected to rise 6.1% compared to the South (7.1%) and Northeast (7.5%).

- According to Segal, price inflation is the largest driver of cost increases, specifically price inflation for hospital services and brand-name medications.

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

TABLE 1

NATIONAL HEALTH CARE TRENDING 2016

Component	National Trend	CMS Trend	CGFA Trend
HMOs	6.8%	7.6%	8.2%
Rx	11.3%	3.5%	4.6%
Dental	4.2%	1.8%	2.7%
Vision	2.7%	-1.2%	-1.2%

Source: Segal 2016 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, though HMO and Dental rates are predicted to be similar to CGFA and CMS estimates. Prescription drug trending is expected to be significantly lower for SEGIP members and the State compared to the national average.

Based on these assumptions, trends, and inflation factors, CGFA estimates a FY 2017 liability of approximately $2.884 billion for the State Employee's Group Health Insurance Program. The table on the next page shows a detailed comparison of the CGFA estimate for the various cost components and the CMS projection for FY 2017.

TABLE 2: FY 2017 GROUP HEALTH INSURANCE LIABILITY ($ in Millions)			
Liability Component	**FY 2016 CMS Estimate**	**FY 2017 CMS Estimate**	**FY 2017 CGFA Estimate**
QCHP Medical	$391.5	$413.2	$415.9
QCHP Prescriptions	$105.0	$108.7	$109.8
Dental (QCHP/MC)	$125.9	$128.2	$129.3
HMO	$1,103.2	$1,186.7	$1,194.0
Open Access Plan	$662.7	$647.7	$649.7
Mental Health	$6.5	$6.5	$6.5
Vision	$8.1	$8.0	$8.0
Administrative Services (QCHP)	$17.4	$17.4	$17.4
Life	$88.5	$90.9	$91.9
Special Programs (Admin/Int./Other)	$244.7	$258.1	$261.3
TOTAL	**$2,753.5**	**$2,865.4**	**$2,883.8**
% increase over prior year	5.1%	4.1%	4.7%
*Rounding may cause slight differences. FY 2016 and FY 2017 Special Programs line includes Prompt Payment and Timely Payment Interest.			

ESTIMATE COMPARISON

Overall, the Commission's FY 2017 estimate is $18.4 million higher than the FY 2017 estimate from CMS. CGFA's FY 2017 HMO and Open Access Plan liabilities estimates are $7.3 million and $2.0 million higher than CMS, respectively. CGFA's FY 2017 estimates for prescriptions and dental coverage are $1.1 million higher than the CMS estimates.

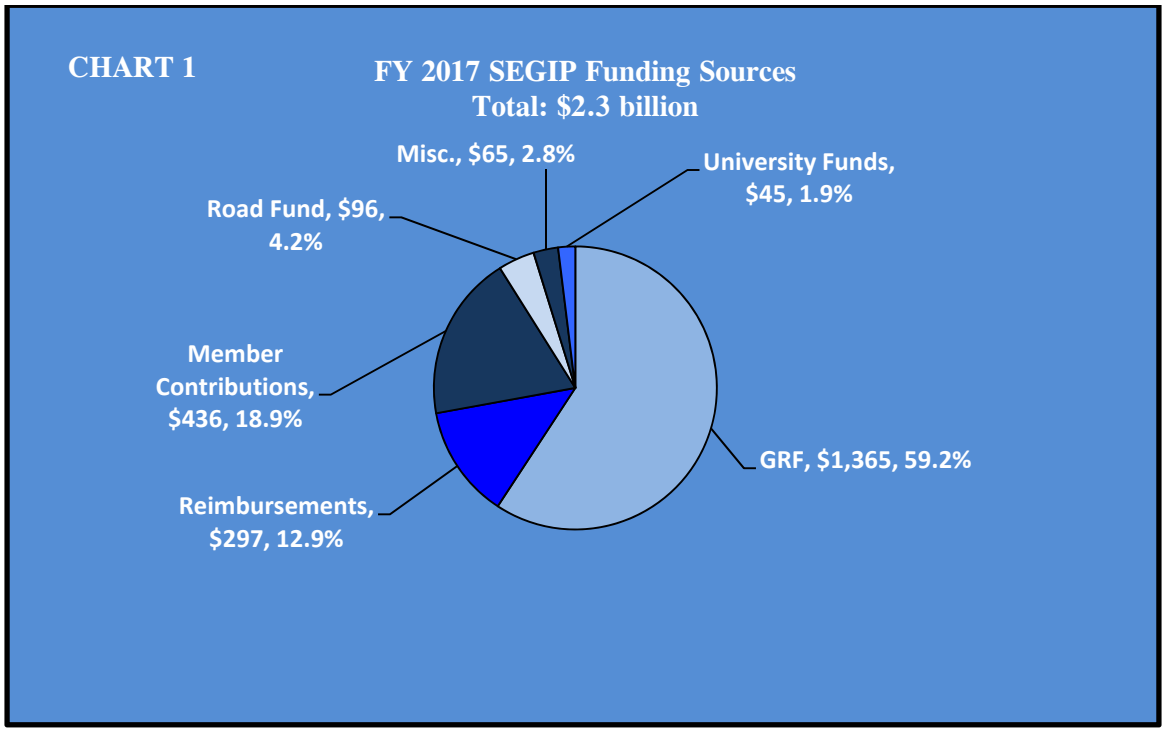
CGFA estimates that approximately $2.884 billion would be required to fully fund the FY 2017 liabilities of the Group Health Insurance Program. This estimate is $81 million or 2.9% more than the FY 2016 estimated liability of $2.803 billion. CMS estimates that the FY 2017 liability will be $2.865 billion, approximately $111 million above FY 2016.

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, which include the General Revenue Fund (GRF), Road Fund, Member Contributions, Reimbursements, University Funds, and Miscellaneous Funds. Estimated revenues for FY 2017 total $2.307 billion. This is a large decrease from the 2016 fiscal year estimated revenue of $2.678 billion due to a $285 million decrease in GRF proposed in the Governor's FY 2017 budget. As of the drafting of this report, it is uncertain what sources of funding or changes in plan design will be used to cover the additional unfunded liability. A breakdown in the various funding sources is shown in the pie chart below.



The FY 2017 fiscal data provided by CMS shows the Group Health Insurance Program receiving $1.365 billion in GRF funds. As previously noted, this represents a $285 million or a 17.2% decrease from the FY 2016 GRF component of $1.650 billion and is lower than any previous fiscal year GRF allocation since FY 2013. For FY 2017, the estimated Road Fund request of $95.624 million is $24.5 million lower than the FY 2016 appropriation level. Member contributions are anticipated to be higher in FY 2017, at $436.1 million, compared to $427.6 million in FY 2016. Other Funds reimbursements are anticipated to be significantly lower in FY 2017, at $296.8 million compared to $368.7 million in FY 2016. University contributions and miscellaneous minor components are expected to remain mostly steady for the 2017 fiscal year, with a $2 million rise in miscellaneous revenues expected. The Medicare Part D rebate is expected to remain steady compared to FY 2016 as well.

TABLE 3: GROUP INSURANCE FUNDING SOURCES FY 2016 - FY 2017 ($ in Millions)				
	FY 2016	FY 2017	$ Change	% Change
GRF Appropriation	$1,650.0	$1,365.0	($285.0)	-17.3%
Road Fund	$120.1	$95.6	($24.5)	-20.4%
University Cont.	$45.0	$45.0	$0.0	0.0%
Member Cont.	$427.6	$436.1	$8.5	2.0%
Other Funds	$368.7	$296.8	($71.9)	-19.5%
Medicare Part D rebate	$3.5	$3.5	$0.0	0.0%
Rebates/Interest/Other.	$62.7	$64.6	$1.9	3.0%
TOTAL	**$2,677.6**	**$2,306.6**	**-$371.0**	**-13.9%**
Source: CMS.				

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 2017, as in previous years, 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 the 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.

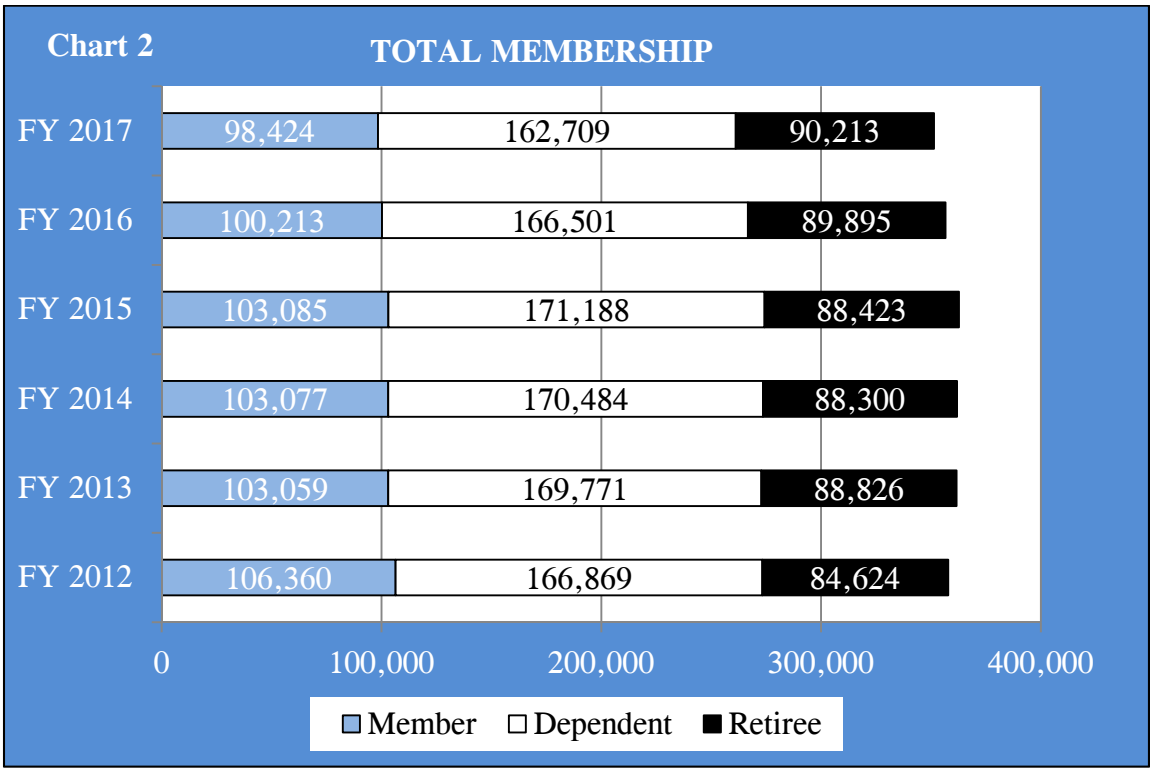
Basic life insurance is provided at no cost to employees, retirees and annuitants. Full-time employees receive coverage equal to their annual salary. Retirees and annuitants receive coverage equal to the annual salary as of the last day of employment until the age of 60, at which time the benefit amount 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 into Medicare Advantage (MA) plans. Individual retirees and dependents

have the choice of five different plans that range from MA HMO plans to a MA PPO plan. These plans became effective February 1, 2014 (Health Alliance MA HMO - 2015). The retirees and dependents can still access benefits from the same dental, vision and life insurance plans that current state employees and dependents utilize.

MEMBERSHIP

According to CMS, the State Employees' Group Health Insurance Program has an estimated 356,609 participants for FY 2016, of which 141,614 are in a non-Medicare Advantage HMO, 69,920 are in a Medicare Advantage HMO/PPO, 91,908 are in an Open Access Plan, and 53,167 are in the Quality Care Health Plan. The QCHP is estimated to have 17,164 employees, 22,394 dependents, and 13,609 retirees in FY 2016. HMO plans are estimated to have 50,540 employees, 77,629 dependents, and 13,445 retirees in FY 2016. Medicare Advantage plans in FY 2016 include 15,713 dependents and 54,207 retirees. OAPs are anticipated to have 32,509 employees, 50,765 dependents, and 8,634 retirees in FY 2016. For FY 2017, the QCHP is estimated to have 16,894 employees, 21,688 dependents and 12,862 retirees. Medicare advantage HMO/PPO plans are expected to have 16,324 dependents and 55,860 retirees. Non-Medicare Advantage HMO Plans are expected to have 49,784 employees, 75,599 dependents and 13,062 retirees. OAPs are expected to have 31,746 employees, 49,098 dependents, and 8,429 retirees in FY 2017. Total FY 2017 membership is expected to decline to 351,346 in part due to the results of the Dependent Verification Audit (Appendix 3).



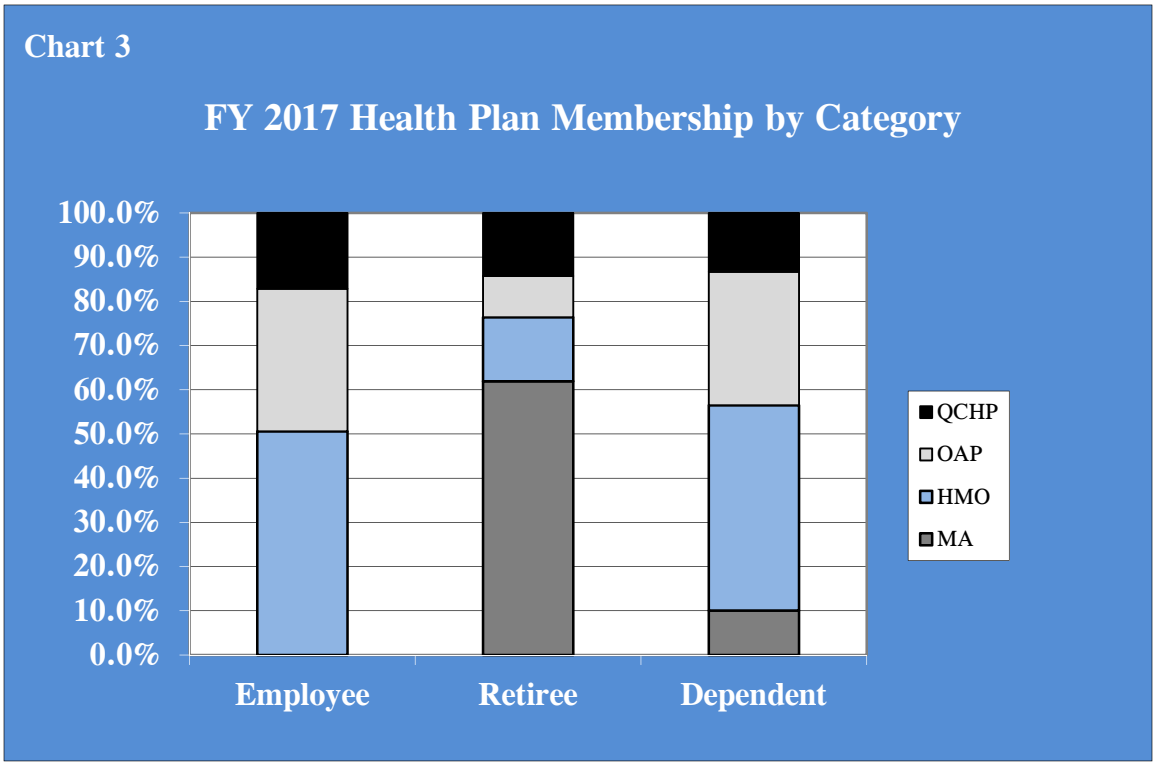
- Membership (including CIP, TRIP, etc.) is estimated for FY 2016 and FY 2017.

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. Since FY 2012, many participants have switched away from traditional managed care (HMOs) to alternatives such as the Open Access Plan (OAP). This trend appears to have stabilized the past few years, and is reflected in FY 2017 membership projections by CMS. In recent years, the movement of retirees/dependents to Medicare Advantage plans has resulted in lower enrollment for both HMOs and OAPs.

For FY 2017, membership in HMOs is broken down by standard HMO membership and Medicare Advantage HMO/PPO membership. Standard HMO membership is expected to decline from FY 2016, though it is anticipated to remain the highest population category among those measured (QCHP, OAP, etc.). Medicare Advantage HMO/PPO plans are expected to increase by approximately 3.2%, from 69,920 in FY 2016 to 72,184 for FY 2017, as retirees continue to qualify for MA plans and move out of the QCHP, HMO, and OAP plans.

Chart 3 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 2017, 61.9% of retirees are expected to enroll in a Medicare Advantage HMO/PPO, as required by the State of Illinois. 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 2017 represents a 4.1% growth rate over FY 2016. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2008 through FY 2017. 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 segments of total liability. However, in recent years, HMOs, OAPs and the QCHP have claimed the majority of group insurance liability. As a partial result of the shift away from QCHP, the Open Access Plan is anticipated to continue to have more liability for the State of Illinois than the QCHP and prescription components as a whole in FY 2017, with $648 million compared to $522 million.

Other components of liability, such as Mental Health, Vision, Dental, and Life Insurance are mostly holding steady or increasing slightly year-to-year. These components are only a small fraction of total liability as a whole, and are expected to remain in that position in years to come, as QCHP/HMO/OAP plans are utilized more by most state employees, retirees, and dependents. In recent years, interest on payments has become a major issue for the State of Illinois, and is expected to be a greater liability for the State than Dental and Life Insurance combined. With the anticipated delays in payments to vendors increasing for FY 2017, this component is unlikely to decrease absent major action.

Table 4 STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY (FY 2008-FY 2017)

$ in (millions)

Liability Component	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
QCHP Medical/Rx	$689	$726	$731	$731	$749	$730	$589	$502	$497	$522
HMO Medical	$781	$844	$911	$1,007	$853	$894	$971	$1,074	$1,103	$1,187
Dental	$102	$110	$115	$129	$133	$118	$118	$122	$126	$128
Open Access Plan	$178	$213	$252	$286	$528	$582	$615	$656	$663	$648
QC Mental Health	$9	$8	$11	$8	$8	$8	$7	$7	$6	$7
Vision	$8	$8	$8	$10	$11	$12	$11	$11	$8	$8
Life Insurance	$78	$81	$84	$83	$81	$81	$85	$88	$89	$91
QC ASC	$30	$31	$32	$32	$32	$31	$26	$19	$17	$17
Interest Payments	$0	$5	$33	$49	$50	$92	$161	$116	$221	$233
Admin/Other	$17	$13	$12	$13	$13	$12	$13	$26	$24	$25
Total	**$1,892**	**$2,039**	**$2,189**	**$2,347**	**$2,458**	**$2,560**	**$2,595**	**$2,620**	**$2,753**	**$2,865**
% change over PY	5.7%	7.8%	7.3%	7.2%	4.7%	4.1%	1.4%	1.0%	5.1%	4.0%

Rounding causes slight differences in totals.

GROUP INSURANCE INTEREST PAYMENTS

In recent years, SEGIP interest payments have grown at an alarming rate as the SEGIP has been forced to push payments for services further and further into the future. This is done by "holding" claims until the actual money is available for payment. As a result, these "held claims" accrue interest at rates of 9 or 12 percent annually depending on the criteria of the claim. Timely Pay Interest (9%), as cited in the Illinois Insurance Code, covers QCHP, OAP, Dental, and Mental Health claims payments. This interest is calculated at 9% annually after an initial 30 day period. Prompt Payment Interest (12%), as cited in the Prompt Payment Act, covers HMOs, Vision, Life Insurance, and administrative fees for the QCHP/OAP/Dental/Mental Health programs. This interest is calculated at 1% per month after an initial 90 day period.

For example, claims in the QCHP, are typically paid out under the 9 percent calculation, while claims from HMOs are paid out at 12 percent. Further exacerbating the issue is the inability of the State to pass a budget into law. Without spending authority, CMS is unable to pay down FY 2016 claims and must hold them as they accrue additional interest by the day. As of the end of February 2016, the State has approximately $2.9 billion in health insurance claims waiting to be paid out. Of that total, Managed Care claims account for $1.5 billion, Prescription/Open Access Plans/Mental Health claims account for $860 million, and CIGNA claims account for $434 million. This total is increasing by approximately $200 million per month. As of February 29, 2016, the State is obligated to pay $328 million in interest payments on bills that have been held beyond the 30 or 90 day grace period, to-date. This interest amount will continue to increase as the budget stalemate continues and the payment delays increase.

The current amount of accruing interest is especially remarkable in the context of current commercial interest rates. The Prime commercial interest rate as of the drafting of this report is 3.5%. Compared to rates of 9 and 12 percent, the state could be paying significantly less interest if the current Timely and Prompt Payment interest rates were adjusted. The table on the next page details the current claims hold situation with existing interest rates of 9 and 12 percent, as of February 2016.

Table 5 Claims Hold Data for SEGIP	
	February
Total Claims Hold	$2,894,865,955.16
Total Estimated Length of Claims Hold	Varies 253-523 days
CIGNA - PPO (and Member)	$433,719,379.40
Length of Claims Hold - PPO	446 days
CIGNA - Non-PPO	$29,687,780.69
Length of Claims Hold - Non-PPO	523 days
Total Managed Care Claims Hold	
HMO/ASC/Medicare Advantage Claims Hold	$1,471,827,678.32
Length of Claims Hold	479 days
Other Self-Insured Claims Held: Rx, OAP, Mental Health	$859,579,611.23
Length of Claims Hold	Rx=478, OAP=392 days
Dental Claims Hold - PPO and Premier	$67,974,536.94
Length of Dental Claims Hold - PPO & Premier	253 days
Dental - Non-PPO	$32,076,968.58
Length of Dental Claims Hold - Non-PPO	351 days

ANNUAL LIABILITY PER PARTICIPANT

The liability per participant in the State Employees' Group Insurance Program is the total of the State's liability across all participants. Chart 4 shows the steady increase each year in cost per participant, which can be attributed in part to medical inflation. As plan participants live increasingly longer lives, utilization of medical insurance plans (and thereby costs to the state) have tended to increase accordingly. In FY 2008, the annual cost per participant in the group health insurance program was $5,456. **According to CMS, the estimated cost per participant for FY 2017 is $8,156, which represents a 49.5% increase over a ten year period.** The cost per participant is projected to increase 5.6% from FY 2016 to FY 2017. It is important to note that this is only an aggregate cost representation, which is not itemized based on the types of plans used by participants or any other variables.

Table 6: ANNUAL LIABILITY PER PARTICIPANT

	FY 2016	FY 2017	FY 2016	FY 2017
	Total Participants	**Total Participants**	**Liability Per Participant**	**Liability Per Participant**
QCHP	53,167	51,444	$9,339	$10,144
MA HMO / PPO	69,920	72,184	$2,464	$2,556
HMO	141,614	138,445	$5,215	$5,634
OAP	91,908	89,273	$7,211	$7,255
Totals	356,609	351,346		

OAP is the Open Access Plan. ALPP does not include dental, vision, admin/interest/other, or life insurance. Numbers are not adjusted for risk. FY 2017 numbers are projections only.

When comparing annual liability per participant (ALPP) in Table 6, the annual liability for FY 2016 is lowest for members in the Medicare Advantage HMO and highest for members in the QCHP. The total number of participants in the QCHP has declined in recent years as people have steadily migrated to HMOs and OAPs. This trend was accelerated in FY 2014 and FY 2015, as most retirees (over 90 percent) were moved from QCHP to a Medicare Advantage HMO/PPO plan. This shift has resulted in an 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 Average Liability Per Person (ALPP) per enrollee in the QCHP is $9,583 in FY 2016. Member contributions for QCHP enrollees are expected to total $78 million. This means that of the total cost per participant, $1,467 or 15% of that cost is covered by member contributions. Prior to the *Kanerva* decision by the Illinois Supreme Court, retirees were contributing part of their pension income towards their group insurance coverage. However, since that court decision, contributions from retirees have dropped sharply from the set of retirees with 20 years or more of service, who are exempt from health insurance contribution deductions from their pension income. In addition, many retirees have been moved out of QCHP towards a Medicare Advantage HMO/PPO plan. This leaves fewer people in the QCHP, causing the cost per participant for that program to rise (due to the generally increased expenses incurred by QCHP participants). Table 7 examines the relationship between overall cost and the offset by member contributions.

TABLE 7: MEMBER CONTRIBUTIONS AND AVERAGE LIABILITY PER PARTICIPANT (ALPP)

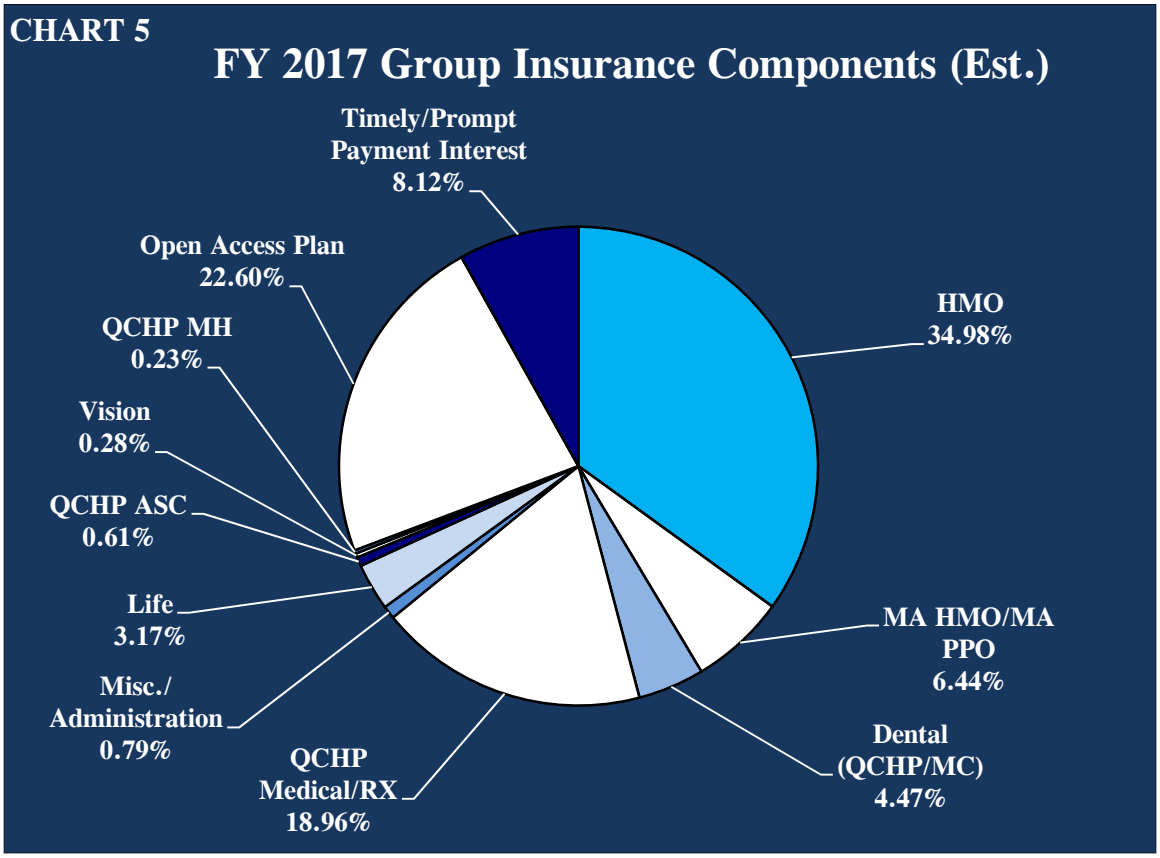
	FY 2016 ALPP	FY 2016 Member Contributions	FY 2016 State Liability	FY 2017 ALPP	FY 2017 Member Contributions	FY 2017 State Liability
QCHP	$9,339	$1,467	$7,872	$10,144	$1,487	$8,657
MA HMO/PPO	$2,464	$318	$2,146	$2,556	$320	$2,236
HMO	$5,215	$980	$4,235	$5,634	$983	$4,651
OAP	$7,211	$1,037	$6,174	$7,255	$1,039	$6,216
Dental	$356	$93	$263	$368	$94	$274

Source: CMS.

The table above shows that QCHP members are expected to contribute approximately 15.7% of the overall annual cost of providing their insurance in FY 2016. HMO/OAP/MA HMO (and PPO) members are expected to contribute 18.8%, 14.3%, and 12.9% of their overall liability cost in the same time period. Members that participate in the State's dental offering are expected to pay 26.1% 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. For FY 2016 and FY 2017, member contribution rates are not yet set due to ongoing labor negotiations by the State of Illinois. FY 2016 rates are currently the same as FY 2015 rates. Information on final rates and contributions will be provided in a supplement to this report when the information becomes available.

Chart 5 includes the various components of the FY 2017 CMS liability estimate of approximately $2.865 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 64.0% of FY 2017 liability, a slight decrease from FY 2016. Dental care, life insurance, and vision care equal 7.9% of total liability. The QCHP component (19.8%) is roughly the same as in FY 2016 and includes medical/prescriptions, mental health coverage, and administrative service charges. As shown, interest payments are expected to comprise 8.1% of total liability.



Since the movement of retirees to MA HMO/PPO plans, it is extremely 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/PPO 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.

As detailed previously in this report, the rising growth of interest payments is a matter of concern for policymakers and budgeters, as these payments represent "lost money" that could be spent elsewhere within the program or in other areas of the state budget. Interest payments are projected to be 8.1% (or $233 million) in FY 2017 and $221 million in FY 2016. This area of the SEGIP budget represents a long-term fiscal problem, as the State of Illinois has been unable to make the contributions necessary to pay claims in a timely manner for many years. Without budgetary changes, this

percentage will likely grow and further constrict state revenues along with limiting budgetary outcomes for the SEGIP

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. The Illinois Supreme Court decision in *Kanerva* has resulted in reduced contributions for many retirees. Table 8 displays a comparison of the costs for these groups taken from data obtained from CMS as of February 2016. It is necessary to note that these costs (to active members, dependents, and retirees) are reflective of current labor contracts only and are likely to change given the results of ongoing labor discussions.

TABLE 8: RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 16 (Numbers in Millions)

Category	Cost	Category	Cost
Retiree Cost	$647.3	Active Employee Cost	$1,042.3
Retiree Contribution	-$19.4	Active Employee Contribution	-$173.5
Other Revenues	-$15.1	Other Revenues	-$26.4
Net State Cost	**$612.8**	**Net State Cost**	**$842.4**
Retiree Dependent Cost	$265.8	Active Employee Dependent Cost	$798.1
Retiree Dependent Contribution	-$58.1	Active Employee Dependent Contribution	-$116.7
Other Revenues	-$7.3	Other Revenues	-$15.1
Net State Cost	**$200.3**	**Net State Cost**	**$666.3**
Total Retiree Cost	$913.1	Total Active Cost	$1,840.4
Total Retiree Contribution	-$77.5	Total Active Contribution	-$290.2
Other Revenues	-$22.5	Other Revenues	-$41.5
Total State Cost	**$813.2**	**Total State Cost**	**$1,508.7**

Source: CMS

A number of points can be observed from this table. As has been the trend in the past, retiree dependents and active employee dependents continue to pay a substantially larger portion of their total costs to the State in the form of contributions for their healthcare coverage. However, due to the Illinois Supreme Court decision in the *Kanerva* case, which rejected state of Illinois attempts to increase contributions from retirees and dependents, those contributions decreased.

For FY 2016, retirees and retiree dependents pay 3.0% and 21.9% of their healthcare costs respectively. This contrasts with active employees and their dependents, who pay 16.6% and 14.6% respectively. In total, the net state cost of active employees and

dependents (15.8%) remains significantly higher than retirees and retiree dependents (8.5%). This cost difference results in part from retirees utilizing Medicare Advantage HMO and PPO plans and resulting savings for the State of Illinois.

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 2015 and FY 2016 plan enrollment is listed in Table 9.

TABLE 9: MANAGED CARE PLANS
FY 2014-2016 All Lives (Active Members/Dependents and non-MA Retirees/Dependents)

HMO/OAP	FY14 # of Participants	FY15 # of Participants	% Change 2014-2015	FY16 # of Participants	% Change 2015-2016
Health Alliance HMO	86,178	82,678	-4.06%	83,154	0.58%
HMO Illinois	60,445	58,799	-2.72%	56,236	-4.36%
Blue Advantage	3,997	6,467	61.80%	8,281	28.05%
Coventry Health Care HMO	8,610	8,268	-3.97%	8,053	-2.60%
Coventry Health Care OAP	21,903	24,429	11.53%	25,072	2.63%
Health Link OAP	71,530	78,400	9.60%	80,577	2.78%
TOTALS	**252,663**	**259,041**	**2.52%**	**261,373**	**0.90%**

Source CMS. FY 16 numbers as of February 2016.

MEDICARE ADVANTAGE

A continuing development from the 2014 fiscal year onward is the movement of eligible retirees and dependents into a system of Medicare Advantage (MA) 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 still relatively new, there are only limited judgments to be made as to efficacy and overall quality of this decision. Table 10 below shows the population figures involved with this new program.

TABLE 10: MEDICARE ADVANTAGE PLANS FY 2016		
HMO/PPO	FY15 # of Participants	FY16 # of Participants
Aetna HMO	3,829	3,977
Humana Benefit Plan HMO	127	126
Humana Health Plan HMO	2,431	2,635
Health Alliance HMO	442	828
United HealthCare PPO	63,093	64,745
TOTALS	**69,922**	**72,311**
Source: CMS. Humana Benefit Plan 2 now known as Humana Health Plan		

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 72,311 people now covered by a MA HMO or PPO plan came from the QCHP. In regards to MA, there are two different HMO benefit plans being offered by Humana as Humana Benefit Plan is intended for Livingston and Knox counties while Humana Health Plan is a traditional open area Medicare Advantage plan. The Health Alliance HMO plan was first offered during the 2015 fiscal year. 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 CMS, the projected monthly cost for a current employee in the QCHP for FY 2016 is $1,422. Due to ongoing State of Illinois labor negotiations, FY 2017 data is unavailable at this time, but will be provided in a supplemental publication upon its availability.

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 2015 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 11: MONTHLY PREMIUMS
Managed Care vs. Indemnity Plan
Weighted Average
FY 2017 Rates (Projected)

Membership	QCHP			HMO			OAP		
	TOTAL	Member	State	TOTAL	Member	State	TOTAL	Member	State
Employee	Not Available at this time due to ongoing Collective Bargaining negotiations.								
Medicare Retiree									
Non-Medicare Retiree									
1 Dependent									
2+ Dependents									
Medicare Dependent									

TABLE 12: PROJECTED COSTS FY 2010 - FY 2017 Employee Only												
	QCHP				HMO				OAP			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY10	$722	5.8%	$89	$641	$513	8.2%	$60	$467	$652	10.3%	$59	$593
FY11	$765	5.9%	$90	$684	$560	9.2%	$60	$516	$679	4.1%	$59	$620
FY12	$827	8.2%	$90	$746	$572	2.1%	$60	$529	$685	0.9%	$60	$625
FY13	$883	6.8%	$90	$800	$602	5.2%	$60	$567	$700	2.2%	$60	$640
FY14	$872	-1.3%	$166	$714	$631	4.8%	$122	$534	$707	1.0%	$120	$587
FY15	$884	1.4%	$168	$716	$661	4.8%	$125	$536	$749	5.9%	$124	$625
FY16	$969	9.6%	$170	$799	$692	4.7%	$126	$566	$765	2.1%	$125	$640
FY17	Not Available at this time due to ongoing Collective Bargaining negotiations.											

TABLE 13: MONTHLY PREMIUMS ACROSS ALL PLANS HMOs and OAPs FY 2017 Rates						
Membership	Health Alliance	Coventry HMO	HMO Illinois	Blue Advantage	HealthLink OAP	Coventry OAP
Employee Medicare Retiree Non-Medicare Retiree 1 Dependent 2 + Dependents Medicare Dependent	Not available at this time due to Collective Bargaining negotiations.					

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, etc.

Table 14 shows a comparison between FY 2015 and projected FY 2017 MA rates for retirees and dependents. Final FY 2017 rates will be supplied when they are available, due to State of Illinois labor negotiations.

TABLE 14: MONTHLY PREMIUMS FOR STATE MEDICARE ADVANTAGE PLANS FY 2015-2017 Rates (As of February 2016)			
Aetna HMO	FY 2015	FY 2016	FY 2017
Medicare Retiree	$2.74	$2.74	$2.74
Medicare Dependent	$89.00	$89.00	$89.00
Humana Benefit Plan 1 HMO	FY 2015	FY 2016	FY 2017
Medicare Retiree	$2.74	$2.74	$2.74
Medicare Dependent	$89.00	$89.00	$89.00
Humana Health Plan HMO	FY 2015	FY 2016	FY 2017
Medicare Retiree	$2.74	$2.74	$2.74
Medicare Dependent	$89.00	$89.00	$89.00
United HealthCare	FY 2015	FY 2016	FY 2017
Medicare Retiree	$2.74	$2.74	$2.74
Medicare Dependent	$110.00	$110.00	$110.00
Health Alliance HMO	FY 2015	FY 2016	FY 2017
Medicare Retiree	$2.74	$2.74	$2.74
Medicare Dependent	$89.00	$89.00	$89.00

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 16 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	**Renew** - Term goes to June 30, 2016 with up to five 1-year renewals.
Medicare Advantage Health Plans	Aetna/Coventry HMO / Health Alliance HMO / Humana Benefits Plan HMO / Humana Health Plan HMO / UnitedHealthCare PPO	**Ongoing** - Term goes to December 30, 2016 with up to six 1-year renewals.
Self-Insured Medical Plan Administration	Cigna	**Renew** - Term goes to June 30, 2016 with one 1-year renewals.
Vision	EyeMed	**Ongoing** – Term goes to June 30, 2020 with up to five 1-year renewals.
Behavioral Health/EAP	Magellan	**Renew** - Term goes to June 30, 2016 with up to five 1-year renewals.
Flu Shots	Varies each plan year	**Ongoing -** Term goes to September 30, 2016 (earliest) with 1-year renewal options.
Consulting Contracts	Blalock / Segal / Deloitte	**Ongoing -** Blalock ends 12/31/2016, Segal and Deloitte end 2018 with up to five one-year renewal options
Life Insurance	Minnesota Life	**Renew** - Term goes to June 30, 2016 with up to five 1-year renewals.
Flexible Spending	ConnectYourCare	**Ongoing -** Term goes to June 30, 2019 with up to five 1-year renewals
Administration of Dental Claims	Delta Dental	**Renew** - Term goes to June 30, 2016 with up to five 1-year renewals.
Prescription Drugs	CVS/Caremark	**Ongoing –** Term goes to June 30, 2018 with up to six 1-year renewals.
Commuter Savings Program	Endred Commuter Solutions	**Ongoing** – Term goes to June 30, 2020 with up to five 1-year renewals.

APPENDIX III

DEPENDENT AUDIT

CMS has finished 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, TRIP members, and Local Government Health Plan members. The results of the audit for each group are listed in the chart below along with the projected savings for the State of Illinois.

Dependent Eligibility Audit Results					
	Local Government Health Plan / College Insurance Program Enrollees	Teachers Retirement Insurance Program / SEGIP Retirees	Active State Employees	State University Employees / Retiree "Cleanup"	Total
Members Audited	1,261	44,394	36,074	29,116	110,845
Dependents Audited	1,835	51,441	79,796	57,562	190,634
Dependents Terminated	16	766	3,470	2,202	6,454
Voluntary Terminations	11	231	698	456	1,396
Annual Savings	$112,639	$3,942,686	$16,338,088	$12,042,145	$32,435,558

As shown above, the audit has resulted in numerous individuals who had been erroneously receiving benefits to be terminated from the Group Insurance Program. In total, 6,454 individuals were terminated from the program. This is expected to result in a savings of approximately $22.6 million in FY 2016 and $32.4 million in FY 2017. The difference is due to only partial savings from the State and University employees groups, as these occurred during the 2016 Fiscal Year. According to CMS, the cost recovery strategy for the audit is primarily prospective and aimed at future savings. They noted that attempts to recover claim payments would be quite difficult and burdensome on an administrative basis, not to mention the up-front legal costs.

One item of further interest has come out of this audit. Starting in the fall of calendar year 2016, the Bureau of Benefits will require members to certify their marriages or civil unions every three years (on a rolling basis). This is partly an attempt to forestall future issues of long-term dependent ineligibility.

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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