ILLINOIS ECONOMIC
AND
FISCAL COMMISSION

FISCAL YEAR 2001
REPORT ON THE LIABILITIES OF THE STATE EMPLOYEES' GROUP INSURANCE PROGRAM

MARCH 2000
703 STRATTON OFFICE BUILDING
SPRINGFIELD, ILLINOIS 62706

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FISCAL YEAR 2001

Report On The Liabilities
Of The
State Employees' Group Insurance Program

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March, 2000

The Honorable James "Pate" Philip
President of the Senate

The Honorable Michael Madigan
Speaker of the House

The Honorable Emil Jones, Jr.
Minority Leader of the Senate

The Honorable Lee Daniels
Minority Leader of the House

I am pleased to submit the Illinois Economic and Fiscal Commission's Fiscal Year 2001 Report on the State Employees' Group Insurance Plan. The IEFC has several statutory requirements concerning the State Employees' Group Insurance Program.

- To estimate liabilities of the State Employees' Group Health Insurance Program.
- To meet with the Department of Central Management Services (CMS) and advise the Department of Central Management Services on all matters relating to policy and administration of the Group Insurance Act.
- To approve the renewal of contracts by the Director of CMS related to the Group Insurance Program.

The Governor has requested that $1.095 billion be appropriated for the State Employees' Group Health and Life Insurance Program for FY 2001. The requested FY 2000 appropriation for the Group Health Insurance Program is $1.003 billion, which includes a $65.0 million dollar supplemental request from both the General Revenue Fund and the Health Insurance Reserve Fund. While the total supplemental appropriation needed is $65 million, it is necessary to request this amount from both GRF and HIRF. The supplemental appropriation is pending approval by the General Assembly. The following table illustrates historical appropriation and liability amounts for the group insurance program, per CMS. The IEFC's FY 2001 estimate of liability is approximately $1.078 billion, $16.4 million more than CMS.

The monthly cost of a member in the indemnity plan is expected to increase 12.0% over the FY 2000 cost. This is almost equal to the estimated 12.2% weighted average increase from FY 2000 to FY 2001 for members in HMOs. The projected 12.2% increase is much higher than it has been in recent fiscal years, but is in line with national HMO premium increases.

APPROPRIATION and LIABILITY HISTORY
($ in Millions)

FY 1997 - FY 2001	Appropriation	CMS Liability	IEFC Liability
FY 1997	$834.3	$757.2	-
FY 1998	$801.3	$796.4 *	-
FY 1999	$852.0	$869.0 *	-
FY 2000	$1,003.0	$959.3 *	-
FY 2001	$1,095.0 *	$1,061.7 *	$1,078.1 *

* Estimated

This report provides further details on both our estimate and the Governor's request.

Dan R. Long
Executive Director

DRL:dkb

FY 2001 IEFC COST ESTIMATE

The Illinois Economic and Fiscal Commission's (IEFC) FY 2001 cost projection utilizes the CMS revised estimate for FY 2000 medical claims as the basis for estimating claims for FY 2001. This revision is based on actual claims to date.

The IEFC cost estimate for FY 2001 uses the following assumptions based on historical claims data and anticipated cost increases:

- the medical trend factor for the indemnity plan is 9.09%;
- the dental trend factor is 0.69%;
- the HMO trend factor is 17.98%;
- the prescription drug trend factor is 21.13%;
- the administrative service charges trend factor is 2.20%;
- the life insurance trend factor is 4.09%;
- the special programs trend factor is 0%.

The medical trend inflation factor consists of several components such as inflation; leveraging or the reduced impact of level deductibles and coinsurance limits; cost shifting due to reductions in Medicare and Medicaid reimbursements; anti-selection or the impact of employees shifting to HMOs and PPOs, which retains sicker, more costly employees in the indemnity plan; technological advances; social shifts including the aging population and greater acceptance of psychiatric and substance abuse care; and, increased utilization of equipment and services.

Based on these assumptions and inflation factors, the IEFC estimates a FY 2001 liability of approximately $1.078 billion for the State Employee's Group Health Insurance Program. The table below shows a detailed comparison of the IEFC estimate for the various cost components and the CMS projection for FY 2001.

TABLE 1: FY 2001 GROUP HEALTH INSURANCE LIABILITY
(millions)

	FY 2000 Est. Liability	FY 2001 CMS Estimate	FY 2001 IEFC Estimate
Medical Indemnity	$372.0	$404.6	$405.8
Prescriptions	115.0	138.8	139.3
Dental	40.3	41.6	40.6
HMOs	297.5	335.5	351.0
POS	19.4	23.1	23.1
Mental Health	11.2	11.0	11.2
Vision	7.5	7.8	7.8
Administrative Services	18.6	19.5	19.0
Life	66.3	68.6	69.0
Special Programs	11.3	11.3	11.3
TOTAL	**$959.3**	**$1,061.7**	**$1,078.1**

The Commission's FY 2001 estimate is $16.4 million higher than the FY 2001 estimate from CMS. Of the major lines, IEFC's 2001 HMO liability estimate is $15.5 million higher than CMS, IEFC's indemnity estimate is $1.2 million higher than CMS, but IEFC's Dental estimate is $1.0 million lower than CMS. CMS' liability estimate does not reflect their projection of HMO premiums increasing 12.2% from FY 2000 to FY 2001. It was calculated before managed care contract negotiations were complete. IEFC's FY 2001 estimate for prescriptions is $0.5 million higher than the CMS estimate.

As mentioned before, HMO liabilities are expected to have an inflation factor of 17.98%. According to the California Public Employees' Retirement System (CalPERS), HMO's significant increase is greatly due to the fact that HMOs will pass along much of their increased costs to physician groups, which have been struggling with unprecedented cost pressures. Nationally, according to the 2000 Segal Heath Plan Cost Trend Survey, HMO plans' cost trends are projected to be 8.9%, while POS is projected to be 9.6%. Segal is also expecting national prescription drug costs in 2000 to see a high trend rate as well – just over 18 % for retail purchases and 16.5% for mail order coverage.

According to the FY 2001 Illinois State Budget Book, the FY 2000 appropriation for the Group Health Insurance Program was $1,003.0 million, which includes a $65 million supplemental request. The supplemental appropriation, which is pending approval by the General Assembly, would be made from the Health Insurance Reserve Fund. The Governor has requested that $1,095.0 million be appropriated for the State Employee Group Health and Life Insurance Program for FY 2001. These appropriations reflect the combined authority appropriated to the Health Insurance Reserve Fund (HIRF) and the Group Insurance Premium Fund (GIPF). The sources of revenue that comprise these two funds include General Revenue Fund and Road Fund appropriations, as well as employee contributions and reimbursements from Federal and other State funds. The actual appropriation authorities in HIRF and GIPF are greater than the identifiable funding sources to allow for unexpected events such as supplemental appropriations or unexpected increases in employee contributions or reimbursements.

The funding sources for the Group Health Insurance Program are broken down as follows:

General Revenue Fund (GRF)	$660.4 M
Road Fund	79.5 M
Employee Contributions & Reimbursements*	314.6 M
TOTAL	**$1,054.5 M**
*Estimated	

The FY 2001 budget request for the Group Health Insurance Program (which is contingent on a $65 million supplemental appropriation from GRF in FY 2000) is $660.4 million in GRF funds. This represents a 12.1% ($71.3 million) increase from the FY 2000 GRF appropriation of $589.1 million (which also includes a $65 million supplemental appropriation request). The FY 2001 Road Fund request of $79.5 million represents an 8.4% ($6.1 million) increase over FY 2000 funding.

The IEFC estimates $1,078.1 million would be required to fully fund the FY 2001 liabilities of the Group Health Insurance Program. This estimate is $119 million or 12.4% more than the FY 2000 estimated liability of $959.1 million. The difference between the IEFC and the CMS liability estimates is $16.4 million.

According to CMS, reimbursements to employees are made within 9 days. Payments to preferred hospitals (hospitals that have contracts with the State) are made within 21 days. Payments made to dentists, doctors, and non-preferred hospitals (hospitals that do not have contracts with the State) are made within 35 days.

The FY 2001 appropriation level of $1,095.0 million is $33.2 million higher than the CMS liability estimate for FY 2001, and $16.9 million higher than the IEFC liability estimate for FY 2001. Appropriations usually exceed liabilities due to the requirement of a cash balance for the State Group Insurance Program.

STATE EMPLOYEES' GROUP INSURANCE PROGRAM

Overview

Employee benefits add to the total compensation package of workers and serve several important purposes. For instance, pension plans and savings plans, such as deferred compensation, help employees prepare for the future; whereas health, disability and life insurance provide economic security and protect against unforeseeable losses. Employer-sponsored group health plans play a major role in providing active and retired workers and their dependents access to needed medical services. Through group health plans, workers and their dependents may obtain hospitalization, physician, and other health services at less cost than they could purchase them individually.

In addition to assuring access to health care for employees and their families, health insurance is viewed by many as a substantial source of protection, since without adequate health coverage, an employee's financial well-being could be jeopardized by unanticipated medical expenses. Retiree health plans serve similar purposes. This coverage is especially important to retirees under age 65, most of whom are ineligible for Medicare, as it becomes increasingly difficult to purchase health insurance outside of a group as one ages. Therefore, the value of the benefit package may exceed that of a pension.

Health benefit payments have been the fastest growing component of total benefit payments. As the cost of health care rises, employer-provided health insurance is becoming an increasingly valuable employee benefit, as well as an increasingly costly benefit for an employer to provide. Therefore, it is important to examine the costs associated with providing employee benefits to determine if costs can be lowered, or if the rate of growth of such costs at least can be slowed.

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

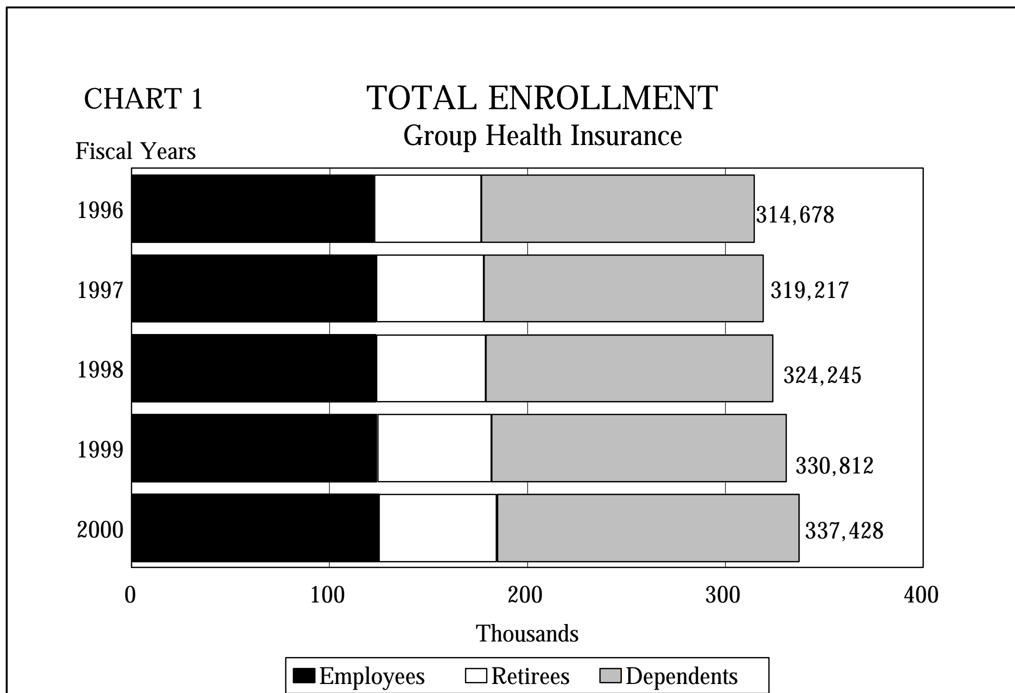
Public Act 90-0065 (HB 110) provided a new flat rate pension formula for individuals retiring on or after January 1, 1998. This change increased the liability of the State Employees' Retirement System.

One change in benefits expected to partially offset the increase in liability to the SERS is the requirement for retirees and their survivors (with less than 20 years of creditable service) to pay a portion of their health care costs. The remainder will be paid by the State. The State liability for the State Employees' Group Insurance Program for FY 2000 and FY 2001 continues to reflect the impact of P.A. 90-0065.

Basic life insurance is provided at no cost to employees, retirees and annuitants. Full-time employees receive coverage equal to their annual salary. Retirees and annuitants receive coverage equal to the annual salary as of the last day of employment until the age of 60, at which time the benefit amount becomes $5,000. Employees are allowed to purchase optional term life insurance up to four times their annual salary, as well as spouse and child term life insurance at group rates. Beginning January 1, 1995, CMS added a portability feature to the optional life program, thereby allowing employees leaving State service to continue optional term life insurance coverage indefinitely at group rates without being required to provide evidence of insurability. Group rates are based on age with an administration fee added.

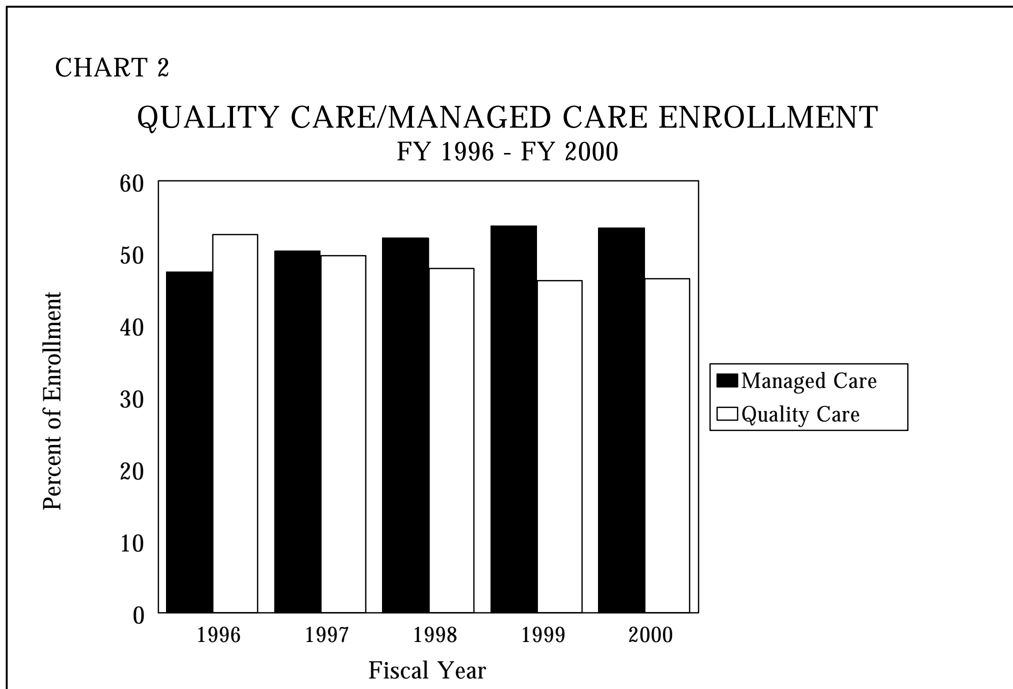
STATE EMPLOYEES' GROUP HEALTH INSURANCE PROGRAM

The State Employees' Group Health Insurance Program currently has 337,428 participants. The number of participants has increased steadily over the years as evidenced in Chart 1.



The Department of Central Management Services (CMS) has been attempting to reduce the cost of the medical indemnity program for the past several years. The Department has implemented various cost containment measures and has encouraged members to participate in managed care plans. Some of the cost containment measures include the establishment of preferred provider networks, medical case management, pre-admission review, hospital bill audit, retail pharmacy network and a mental health/chemical dependency program. It would appear that the nationwide trend for cutting health costs continues to be managed care.

Chart 2 reflects the migration of participants in the State Employees' Group Insurance Program towards HMO plans. Between FY 1996 and FY 1999, membership in the Quality Care Plan has gradually decreased, while membership in the HMO plans has consistently increased. In FY 2000, the percentage of enrollees in HMO plans, almost 54%, remained at the same level as FY 1999. The percentage of FY 2000 enrollees in the indemnity plan, 47%, also remained constant from FY 1999.



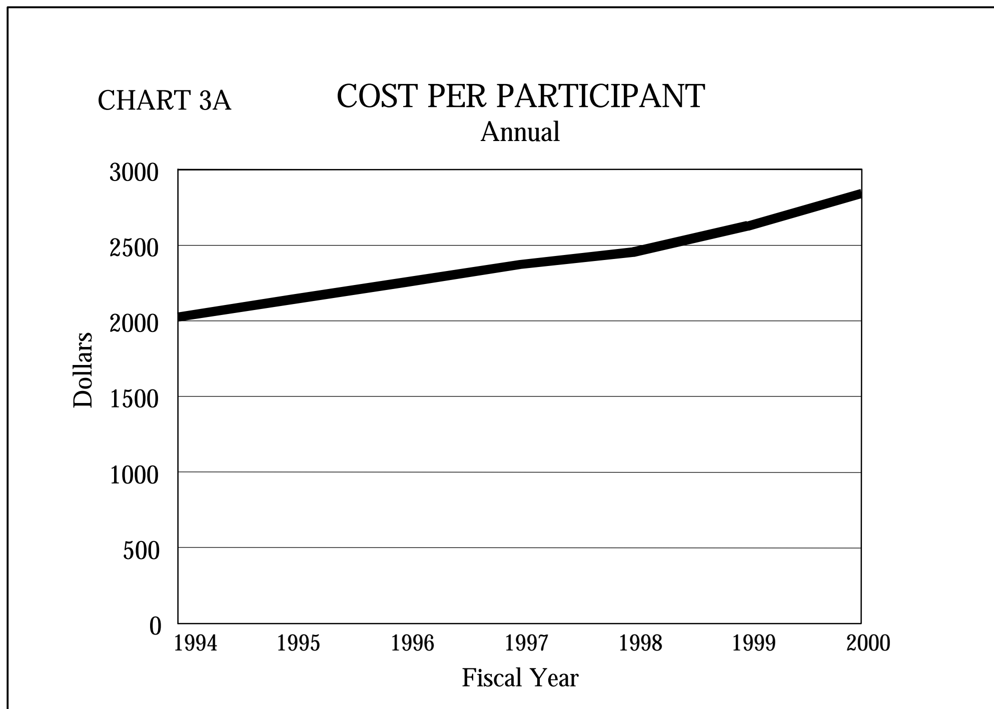
Since FY 1990, health care costs have continued to rise, but at a slower rate. The Department's estimate of liability for FY 2000 represents a 10% growth rate over FY 1999. This increase in estimated liability is the highest since FY 1992, when liability increased 12% over FY 1991. Table 2 illustrates the cost components for the Group Health Insurance Program from FY 1991 through FY 2000.

TABLE 2: State Employees' Group Health Insurance Liability
FY 1991 to FY 2000
($ in Millions)

Fiscal Year	1991	1992	1993	1994	1995	1996	1997	1998*	1999*	2000*
Liability Component										
QCHP (Health and Rx)	310.6	334.0	329.7	325.2	316.6	326.7	356.8	384.0	425.5	487.0
Dental Claims	29.6	27.4	29.2	30.3	31.6	30.2	39.5	38.7	39.2	40.3
HMO	78.2	92.2	110.0	136.8	184.2	219.1	238.0	244.7	264.8	297.5
POS			1.2	21.9	28.3	24.7	19.1	20.8	28.1	19.4
Mental Health (QCHP)			22.0	23.8	19.2	13.1	11.3	9.9	10.8	11.2
Vision					4.3	6.3	6.9	6.9	8.5	7.5
Life Insurance	36.9	51.1	50.9	55.3	55.9	58.8	58.8	60.2	63.5	66.3
Administrative Service Charge (QCHP)	10.5	16.7	18.5	18.9	18.3	21.3	19.3	20.1	18.2	18.6
Special Programs		1.0	5.7	3.9	5.5	9.6	7.5	10.9	10.6	11.3
TOTAL	**465.8**	**522.4**	**567.2**	**616.1**	**663.9**	**709.8**	**757.2**	**796.4**	**869.0**	**959.3**
% Inc./Dec.	15%	12%	9%	9%	8%	7%	7%	5%	9%	10%

***1998-2000 figures are estimates**

Chart 3A below shows the steady increase each year in cost per participant. In FY 1994, the annual cost per participant in the group health insurance program was $2,025.93. The estimated cost per participant for FY 2000 is $2,842.38, a 40% increase from the FY 1994 cost per participant. According to Chart 3B (page 8), although the dollars spent per participant have consistently increased, they increased at a slower rate each year from FY 1994 until FY 1998. From FY 1998 to FY 1999, the cost per participant increased 7%. From FY 1999 to FY 2000, this cost is estimated to increase more than 8%.



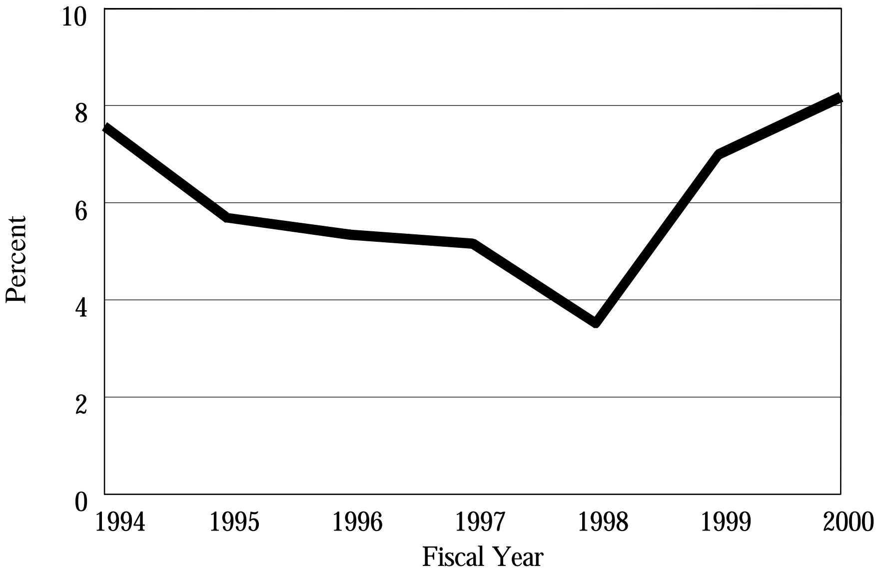
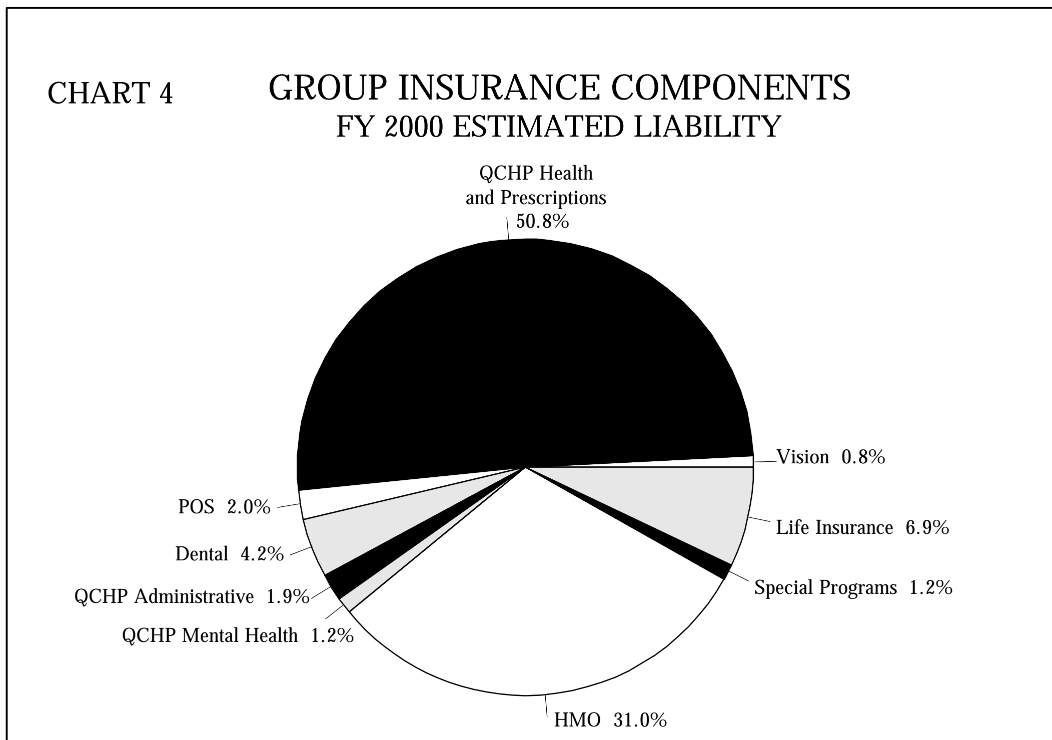


Chart 3B
COST PER PARTICIPANT
% Increase over Prior Year
10
8
6
4
2
0
Percent
1994
1995
1996
1997
1998
1999
2000
Fiscal Year

The largest portion of the State Group Insurance Program is the indemnity component administered by UNICARE. This indemnity component includes health, prescription drug, and mental health coverage, for those enrolled in the Quality Care Health Plan, and also includes the administrative service charges related to the Quality Care Health Plan. In FY 2000, these four components of the indemnity plan will account for almost 54% of the total program, while HMO and POS plans will comprise 33%. Dental and Vision Plan claims and other components, such as Life Insurance and the Employee Assistance Plan, make up the remaining 13% of the program. The FY 2000 estimated liability for the State Employees' Group Insurance Program is $959.3 million, which is broken down into its various components in Chart 4.



Managed Care

The State Employees' Group Health Insurance Program saw 14.45% of its participants changing their health carriers for the FY 2000 enrollment period. The indemnity plan experienced a 2.6% increase in membership, with an increase of 3,931 participants. Despite this overall increase in indemnity plan enrollment, 2,293 members and their dependents moved from the indemnity plan to a managed care plan in FY 2000. HMO plan membership increased by 7,256 (4.4%). POS plan membership showed a significant (36%) decrease in membership from 12,702 in FY 99 to 8,131 in FY 2000. The enrollment in the indemnity, HMO and POS plans for FY 1999 and FY 2000 are shown in Table 3 on the next page.

Much of the decrease in POS plan enrollment can be attributed to enrollees changing from American POS to another plan. According to the Department, "American HMO and POS discontinued arrangements with a substantial number of providers in the central (Illinois) and Chicago areas which resulted in a loss of over 3,600 members for their organization." Both of these plans are operated by American Health Care Providers, the seventh largest HMO in Illinois. According to a March 10th article from the State Journal Register, American Health Care Providers "has been operating under state control since February 2 (2000), with regulators approving all company spending." The Department of Central Management Services is currently reviewing its contract with American Health Care Providers. If it is determined that AHCP is not financially solvent, it is possible that the Department will terminate its contract with AHCP. Members currently enrolled in American HMO and American POS would need to enroll in another plan.

TABLE 3: ENROLLMENT MIGRATION
FY 1999 - FY 2000

	Indemnity		HMO		POS	
	FY99*	FY00*	FY99*	FY00*	FY99*	FY00
Total Participants	152,918	156,849	165,192	172,448	12,702	8,131
Average Annual Cost/Participant	$2,960	$3,283	$1,603	$1,725	$2,212	$2,386

Indemnity includes medical, prescriptions, mental health, and ASC. HMO and POS include medical claims and prescriptions.
*Estimated

When comparing average cost per participant (Table 3), the average cost for FY 2000 is lowest for members in an HMO and highest for those in the indemnity plan. The POS cost falls between these two. The FY 2000 average cost per participant in the indemnity plan is approximately 38% higher than in the POS plan and about 90% higher than the average cost per participant in HMO plans. (In FY 1999 the average cost per participant in the indemnity plan was approximately 34% higher than in the POS plan and about 85% higher than the average cost per participant in HMO plans.) While the Department is continuing to encourage the trend toward managed care in order to further temper rising costs, the indemnity plan gained 3,931 participants in FY 2000, a 2.6% increase in membership over FY99 enrollment. The cost per participant of the indemnity plan is almost twice the FY 2000 cost per participant for HMO members.

The largest age group switching to a managed care plan in FY 2000 was the 0-39 age group. Predominately, the members joining a managed care plan tend to be under the age of 55. Persons in this age group typically include parents and their dependents. While dependent care coverage is less expensive in a managed care plan than in the indemnity plan, members over the age of 55 have shown a reluctance to switch to a managed care plan. These members have higher medical utilization and may fear being denied access to specialists. Members over the age of 55 may also be unwilling to change primary physicians. For members on Medicare, the coordination of benefits with a managed care plan may be confusing and/or disadvantageous.

Health Maintenance Organizations (HMO)

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

The current network of HMOs is the result of efforts by CMS to increase the concentration of State members into managed care plans statewide. In FY 2000, NYLCare was acquired by Aetna U.S. Healthcare HMO, and Maxicare was bought out by American Health Plan. CMS terminated contracts with the following plans for FY 2000: Group Health Plan and John Deere/Heritage. In FY 2000 (as of 7/30/99), 178,021 state members and their dependents were participants in one of fourteen HMO or POS plans. The FY 2000 number of participants represents a 1.6% increase over the number of participants in managed care plans in FY 1999, which was 175,147 (as of 7/31/98).

The increase in the number of managed care enrollees from FY98 to FY99 was 5.6%. The smaller increase from FY99 to FY 2000 is partly due to a 2.1% increase (from 7/31/98 to 7/30/99) in indemnity plan enrollment from FY 1999 (153,138) to FY 2000 (156,342). The estimated number of participants in the group insurance plan in FY 2000, 337,428, is about 2% (6,616) higher than in FY 1999.

Two HMO plans were terminated prior to July 1, 1999; two more were acquired by other managed care plans. Table 4, on the following page, lists the HMO plans, the POS plans, the areas served, and the number of participants in each plan.

	TABLE 4: MANAGED CARE PLANS - FY 2000 Actual Membership			
	HMO/POS	FY99 # of Participants 7/31/98	FY00 # of Participants 7/30/99	Areas Served
N	Aetna U.S. Healthcare	0	4,751	Chicago area
	American HMO	12,049	11,776	Cook, collar counties, NE IL, Southern IL, Peoria County
	American POS	11,527	5,471	Central & Northern Illinois
	Community Health Plan of SBL	852	1,369	East Central Illinois
T	Group Health Plan	19,182	0	Southern & Central Illinois
	Health Alliance HMO	51,883	68,321	Cook & Downstate, throughout IL
	Health Alliance Illinois	1,770	1,878	Ogle & DuPage Counties
	HMO Illinois	3,638	8,476	Chicago & Springfield areas
	Humana Premier HMO	22,083	22,426	Cook & Collar Counties
	Humana POS	1,018	1,725	Chicago area
T	John Deere/Heritage	6,830	0	Northern & Central Illinois
A	Maxicare (American Health Plan)	6,649	0	North Central Illinois
A	NYLCare	7,327	0	Cook & Collar counties
	OSF Health Plans	6,417	11,600	Northern & Central Illinois
	Personal Care	15,708	22,914	Eastern Illinois
	Prudential HMO	3,978	8,982	St. Louis area
	Prudential POS	79	839	St. Louis area
	Rush Prudential	4,157	7,493	Chicago area
	TOTAL Members + Dependents	**175,147**	**178,021**	

As of July 1, 1999, 14 plans were available to employees and their dependents.
N New Plan **A** Acquired by another managed care plan
T Terminated Plan; no longer available to members in Illinois

The Department of Central Management Services has made and continues to make, a concerted effort to increase the concentration of State members into managed care plans. Typically, members in managed care plans cost the State less since the risk of providing health care is assumed by the HMO. The indemnity plan continues to be the significantly more expensive plan. According to the Department, the estimated monthly cost for a current employee in the Quality Care indemnity plan for FY 2000 is $332 and will increase to $369 by FY 2001. (The actual cost to the State is slightly lower because the employee contributes monthly for health insurance coverage.) The monthly premium for a current employee in an HMO varies based on each plan's rates, but the FY 2001 estimated average cost for a member in an HMO will be $214 per month, an increase over the FY 2000 estimated cost of $191. Employees pay a minimal, graduated premium based on salary for HMO membership. This premium is identical to the premium paid by members in the indemnity plan.

In FY 1998, a new approach for negotiating HMO premium rates with managed care vendors was utilized. Previously, premium rates were negotiated based on four rate tiers; member only, one dependent, two or more dependents, and Medicare dependent. In FY 1998 and FY 1999, multipliers based on historical claims and enrollment experience were used for each of the dependent rate tiers. Thus, only one rate is negotiated with the HMOs and then the appropriate multiplier is applied. The FY 2001 multipliers, revised since last year, are as follows:

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

Contract Extension and Renewal

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 may not extend beyond 5 fiscal years. Upon recommendation of IEFC, the Director of CMS may exercise renewal options of the same contract for up to a period of 5 years. Recently introduced legislation, SB 1652, would amend the SEGIA to allow the extension and renewal of contracts, for a period not to exceed 10 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.

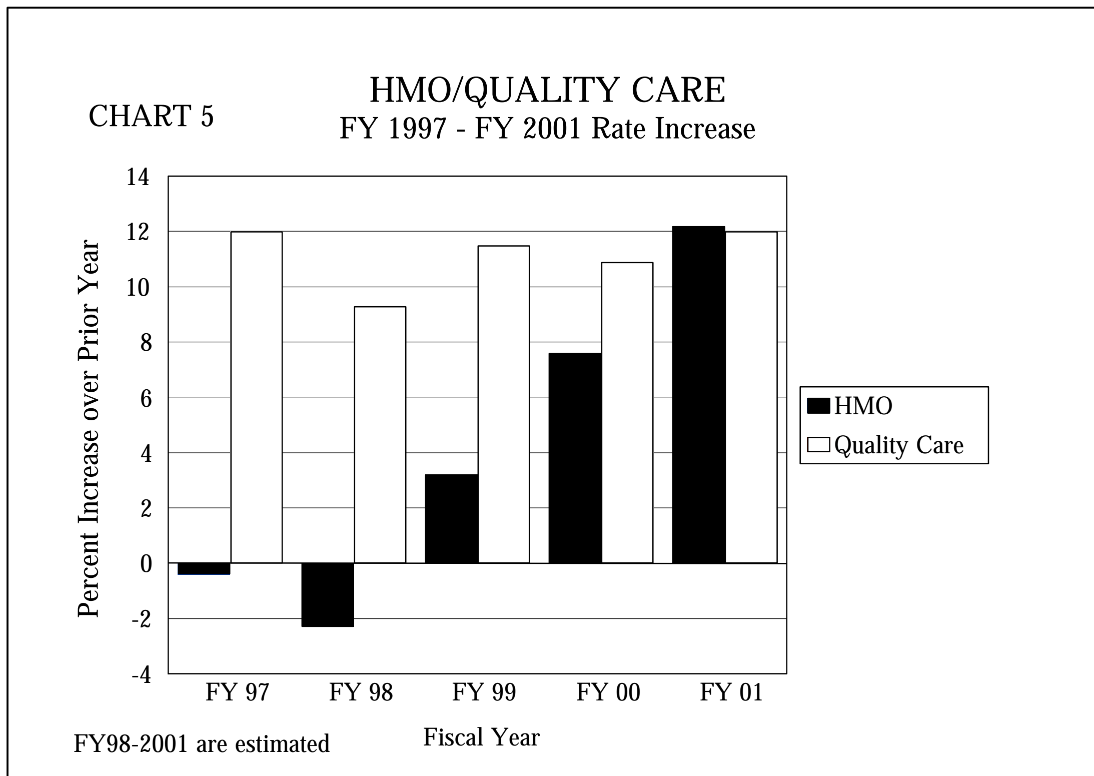
The State's contract with the AFSCME requires that the amount of the dependent-care premium paid by the member be held constant throughout the term of the contract. In FY 1998, CMS was responsible for 64% of the weighted average dependent premium. During FY 1999, the State paid 66% of the weighted average premium, and in FY2000 the State paid 68% of the weighted average premium. As the premium increased, the State had to contribute more, because the member's contribution for the dependent premium was frozen. The FY 2001-2003 contract between CMS and AFSCME is currently being negotiated; it has yet to be determined if a member's contribution for a dependent's premium will remain frozen.

Table 5 on the next page shows the FY 2001 weighted average monthly rate for the HMOs and the indemnity rate, as well as the State's contribution for each program. The State's contribution varies, depending on a member's salary.

TABLE 5: MONTHLY PREMIUMS HMO vs. Indemnity Plan Weighted Average FY 2001 Rates						
Membership	QCHP	State Portion	HMO	State Portion	Difference	Difference State Portion
Employee	$369	$348	$214	$193	$154	$154
Medicare Retiree	250	248	140	136	110	112
Non-Medicare Retiree	549	546	320	315	229	231
1 Dependent	411	296	180	129	230	167
2+ Dependents	482	337	310	222	172	115
Medicare Dependent	229	168	142	93	88	75

For HMO and QCHP premiums, the monthly member portion varies based on an employee's salary, from $15 to $27.50 beginning July 1, 1999 to June 30, 2000. This affects the State portion. The portion for dependents is based on the amount negotiated with AFSCME in FY 2000.

It is evident from Table 5 that HMO programs have saved the State money by reducing the costs of medical care. The State's contribution for indemnity plan coverage is higher in every instance than the average State contribution under an HMO. The following chart (Chart 5) compares the percentage increases in rates for the HMOs and the Quality Care indemnity plan for FY 1997 to FY 2001.



According to the Segal Health Plan Cost Trend Survey, the factors that may affect cost trends vary by type of member covered under a medical plan. "Increased federal and state regulations that are beginning to take effect" and "greater emphasis on open access networks" are just two examples of factors affecting costs trends for actives and retirees under 65. The survey also mentions several factors that affect the trend in rising prescription drug costs:

- Increased patient demand as a result of direct-to-consumer advertising
- Advent of new and expensive drug therapies
- Greater reliance on drug therapy by the physician community
- Increased utilization to address chronic illnesses and improve the quality of life for an aging population
- Erosion of enrollee cost sharing plans with flat co-payments

IEFC's estimate of group insurance liability for FY 2001 reflects this trend in rising prescription drug costs. Additional trends used to estimate the growth in liability from FY 2000 to FY 2001 include the following:

- HMO trend inflation factor: 17.98%
- POS trend inflation factor: 19.07%

Point of Service (POS)

The Point of Service plan is a combination of traditional health coverage and HMO benefits. Participants may choose to go to a participating HMO physician and receive enhanced coverage, or go to any physician outside the network and receive benefits with applicable deductibles and coinsurances. Participants may choose the type of coverage meeting their needs each time they seek medical care.

Before FY 1997, the POS plan was self-funded. An administration fee was paid by the State as well as a fixed amount to the POS provider for each member. In addition, members paid a minimal premium, as well as a portion of the dependent care cost. The plan was then self-insured for the remaining benefits with the State covering all other medical costs.

Currently, the POS plan is fully insured. A premium is paid by the members (and the State) to the insurance provider and the POS plan assumes all of the risk.

The trend in health care nationwide indicates that managed care has peaked; however, PPO plans continue to expand. It is believed that one of the best ways to control medical costs is to institute managed care plans, which closely control the use of medical services to keep costs down. The State has realized some cost savings from implementing managed care plans. The long-term effect on costs as a result of implementing managed care, however, remains to be seen.

TYPES OF MEDICAL & DENTAL GROUP INSURANCE PLANS

APPENDIX I

Type of Plan	Coverage	Characteristics	Geographic Location
Indemnity Medical	Care related to the treatment of an illness or injury. Preventive care includes well-baby care, routine and school physicals, annual pap smears and mammograms.	Choice of physician and other medical care providers. Annual deductibles and employee contributions based on member salary. Dependent premiums do not vary.	No limitation; preferred hospital providers statewide.
Indemnity Dental	Preventive, diagnostic, restorative, orthodontic, endodontic, and periodontic services as well as extractions and prosthetics.	Choice of dental care providers, reimbursement on a scheduled basis. No deductibles. Premiums for members and dependents.	No limitations.
HMO Medical	Comprehensive medical benefits including preventive care.	Prepaid benefits, primary care physician who coordinates all care chosen from HMO network. Co-payments vary by HMO plan. Employee premiums, based on salary, vary for dependents by plan.	Statewide coverage
HMO Dental	Preventive and diagnostic services, and coverage for certain procedures not covered by indemnity dental plan.	No premiums, deductibles, or annual benefit limits; copayments apply, dentists must be chosen from network of providers.	Statewide coverage
POS	Comprehensive medical benefits including preventive care.	Benefits prepaid, PCP physicians must be chosen from POS network who coordinates all in-network care at lower co-payments; may also use physicians not in the network and receive reduced benefits. Deductibles for out of network care vary by plan. Employee premiums, based on salary, vary for dependents by plan.	Statewide coverage

APPENDIX II

STATE EMPLOYEES' GROUP INSURANCE PROGRAM ENROLLMENT FY 1998 - FY 2000						
Enrollment	FY98	% of Total	FY99	% of Total	FY00	% of Total
Managed Care	165,861	51.6%	175,147	53.4%	178,021	53.2%
Members	79,641	48.0%	83,585	47.7%	84,770	47.6%
Dependents	86,220	52.0%	91,562	52.3%	93,251	52.4%
Indemnity	155,496	48.4%	153,138	46.6%	156,342	46.8%
Members	97,812	62.9%	96,869	63.3%	98,797	63.2%
Dependents	57,684	37.1%	56,269	36.7%	57,545	36.8%
TOTAL	**321,357**	**100.0%**	**328,285**	**100.0%**	**334,363**	**100.0%**
Members	177,453	55.2%	180,454	55.0%	183,567	54.9%
Dependents	143,904	44.8%	147,831	45.0%	150,796	45.1%

MEMBERSHIP TRENDS FROM FY 1998 to FY 2000

- Of the total enrollees in the State Employees Group Insurance Program, 55% were members, and 45% were their dependents.
- Of the enrollees in Managed Care Plans, about 48% are members and 52% were their dependents.
- Of the enrollees in the Indemnity Plan, 63% were members and 37% were their dependents.
- FY 1998 51.6% Managed Care
  48.4% Indemnity Plan

  FY 1999 53.4% Managed Care
  46.6% Indemnity Plan

  FY 2000 53.2% Managed Care
  46.8% Indemnity Plan

BACKGROUND

The Illinois Economic and Fiscal Commission, a bipartisan, joint legislative commission, provides the General Assembly with information relevant to the Illinois economy, taxes and other sources of revenue and debt obligations of the State. The Commission's specific responsibilities include:

1) Preparation of annual revenue estimates with periodic updates;

2) Analysis of the fiscal impact of revenue bills;

3) Preparation of "State Debt Impact Notes" on legislation which would appropriate bond funds or increase bond authorization;

4) Periodic assessment of capital facility plans; and

5) Annual estimates of the liabilities of the State's group health insurance program and approval of contract renewals promulgated by the Department of Central Management Services.

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

The Commission publishes two primary reports. The "Revenue Estimate and Economic Outlook" describes and projects economic conditions and their impact on State revenues. "The Illinois Bond Watcher" examines the State's debt position as well as other issues directly related to conditions in the financial markets. The Commission also periodically publishes special topic reports that have or could have an impact on the economic well being of Illinois.

These reports are available from:

Illinois Economic and Fiscal Commission
703 Stratton Office Building
Springfield, Illinois 62706
(217) 782-5320
(217) 782-3513 (FAX)

Reports can also be accessed from our Webpage:

http://www.legis.state.il.us/commission/ecfisc/ecfisc_home.html