ILLINOIS ECONOMIC
AND
FISCAL COMMISSION

FISCAL YEAR 2002
REPORT ON THE LIABILITIES OF THE STATE EMPLOYEES' GROUP INSURANCE PROGRAM

MARCH 2001
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Report On The Liabilities
Of The
State Employees' Group Insurance Program

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EXECUTIVE SUMMARY

The Illinois Economic and Fiscal Commission 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 recommended by the Director of CMS related to the Group Insurance Program.

The Governor has requested that $1.213 billion be appropriated for the State Employees' Group Health and Life Insurance Program for FY 2002. The requested FY 2001 appropriation for the Group Health Insurance Program was $1.085 billion, which includes a $20 million dollar supplemental request from both the General Revenue Fund and the Health Insurance Reserve Fund. While the total supplemental appropriation needed is $20 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 2002 estimate of liability is approximately $1.202 billion, $25.2 million more than CMS.

The monthly cost of an employee in the indemnity plan is expected to increase 8.3% over the FY 2001 cost. The monthly cost of an employee in the managed care plan is expected to increase 12.6% over the FY 2001 cost.

APPROPRIATION AND LIABILITY HISTORY
($ in Millions)

FY 1998-FY 2002	Appropriation	CMS Liability	IEFC Liability
FY 1998	$801.3	$802.8	-
FY 1999	$852.0	$866.5*	-
FY 2000	$1,003.0	$965.8*	-
FY 2001	$1,085.0	$1,073.0*	-
FY 2002	$1,213.0	$1,177.0*	$1,202.2

*Estimated

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

FY 2002 IEFC COST ESTIMATE

The Illinois Economic and Fiscal Commission's (IEFC) FY 2002 cost projection utilizes the CMS revised estimate for FY 2001 medical claims as the basis for estimating claims for FY 2002. This revision is based on actual claims to date.

The IEFC cost estimate for FY 2002 uses the following assumptions based on historical claims data and anticipated cost increases:

- the medical trend factor for the indemnity plan is 8.09%;
- the dental trend factor is 6.89%;
- the HMO trend factor is 17.53%;
- the prescription drug trend factor is 18.92%;
- the administrative service charges trend factor is 3.80%;
- the life insurance trend factor is 5.45%;
- the special programs trend factor is 3.62%.

Each of the trend factors (except special programs) listed above is slightly higher than the percentage increases estimated by CMS. 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 2002 liability of approximately $1.202 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 2002.

TABLE 1: FY 2002 GROUP HEALTH INSURANCE LIABILITY
($ in Millions)

Liability Component	FY 2001 CMS Estimate	FY 2002 CMS Estimate	FY 2002 IEFC Estimate
Medical Indemnity	$402.4	$428.7	$435.0
Prescriptions	130.6	151.3	155.3
Dental	50.4	52.2	53.9
HMO	353.3	402.6	415.2
POS	11.7	13.6	13.5
Mental Health	11.0	10.1	11.0
Vision	10.6	11.0	10.6
Administrative Services	16.6	17.2	17.2
Life	72.3	76.0	76.2
Special Programs	13.8	14.3	14.3
TOTAL	**$1,072.7**	**$1,177.0**	**$1,202.2**
% Increase over FY 2001 CMS Estimate		10%	12%

The Commission's FY 2002 estimate is $25.2 million higher than the FY 2002 estimate from CMS. Of the major lines, IEFC's 2002 HMO liability estimate is $12.6 million higher than CMS, IEFC's indemnity estimate is $6.3 million higher than CMS, and IEFC's Dental estimate is $1.7 million higher than CMS. CMS' liability estimate does not reflect their projection of HMO premiums increasing 12.6% from FY 2001 to FY 2002. It was calculated before managed care contract negotiations were complete, and reflects their initial estimate of a 12.0% increase in HMO premiums. IEFC's FY 2002 estimate for prescriptions is $4.0 million higher than the CMS estimate. As mentioned before, HMO liabilities are expected to have an inflation factor of 17.53%.

According to the FY 2002 Illinois State Budget Book, the FY 2001 appropriation for the Group Health Insurance Program was $1.085 billion, which includes a $20 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 $1.213 billion be appropriated for the State Employee Group Health and Life Insurance Program for FY 2002. 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 FY 2001 and FY 2002 funding sources for the Group Health Insurance Program are broken down as follows:

GROUP INSURANCE FUNDING SOURCES
FY 2001 – FY 2002
($ in Millions)

	FY 2001	FY 2002	Increase	% Increase
GRF*	$650.367	$710.367	$60.0	9.2%
Road	79.551	79.551	0	0%
Employee Contributions, Reimbursements and Misc.	342.921	370.944	28.023	8.2%
TOTAL	**$1,072.839**	**$1,160.862**	**$88.023**	**8.2%**

*FY 2001 includes $20 M supplemental, and in FY 2002, GRF includes an appropriation of $23 M to IBHE from GRF, the CMS appropriation from GRF would be $687.3 M.

The FY 2002 budget request for the Group Health Insurance Program is $710.4 million in GRF funds. This represents a 9.2% ($60 million) increase from the FY 2001 GRF appropriation of $650.4 million (which also includes a $20 million supplemental appropriation request). The FY 2002 Road Fund request of $79.5 million is equal to the FY 2001 appropriation level.

The IEFC estimates approximately $1.202 billion would be required to fully fund the FY 2002 liabilities of the Group Health Insurance Program. This estimate is $129.5 million or 12% more than the FY 2001 estimated liability of $1.073 billion. The difference between the FY 2002 IEFC and CMS liability estimates is $25.2 million.

According to CMS, the number of days that an employee's unassigned claim is held is 9 days. Claims from preferred hospitals (hospitals that have contracts with the State) are held 15 days. Dental claims, assigned claims, and claims from non-preferred hospitals (hospitals that do not have contracts with the State) are also held 15 days. Each of these claims hold periods is contingent upon CMS' receipt of the $20 million supplemental in FY 2001.

The FY 2002 appropriation level of $1.213 billion is $36 million higher than the CMS liability estimate for FY 2002, and $10.8 million higher than the IEFC liability estimate for FY 2002. Appropriations usually exceed liabilities due to the requirement of a cash balance for the State Group Insurance Program.

The Department of Central Management Services sets target end-of-year fund balances for both the HIRF and the GIPF. The historical budget target balance for the Group Insurance Program is $11 million. For the GIPF, that target balance is $4 million, and the target HIRF balance is $7 million.

The $20,000,000 FY 2001 supplemental appropriation for the Group Insurance Program is necessary to end FY 2001 with the target claims hold of approximately 9 days for Unassigned Claims and 15 days for PPO, Non-PPO, and Assigned Claims. Without the supplemental, CMS would end FY 2001 with holds of approximately 9 days for Unassigned Claims, 28 days for PPO claims, and 53 days for Non-PPO/Assigned claims.

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.

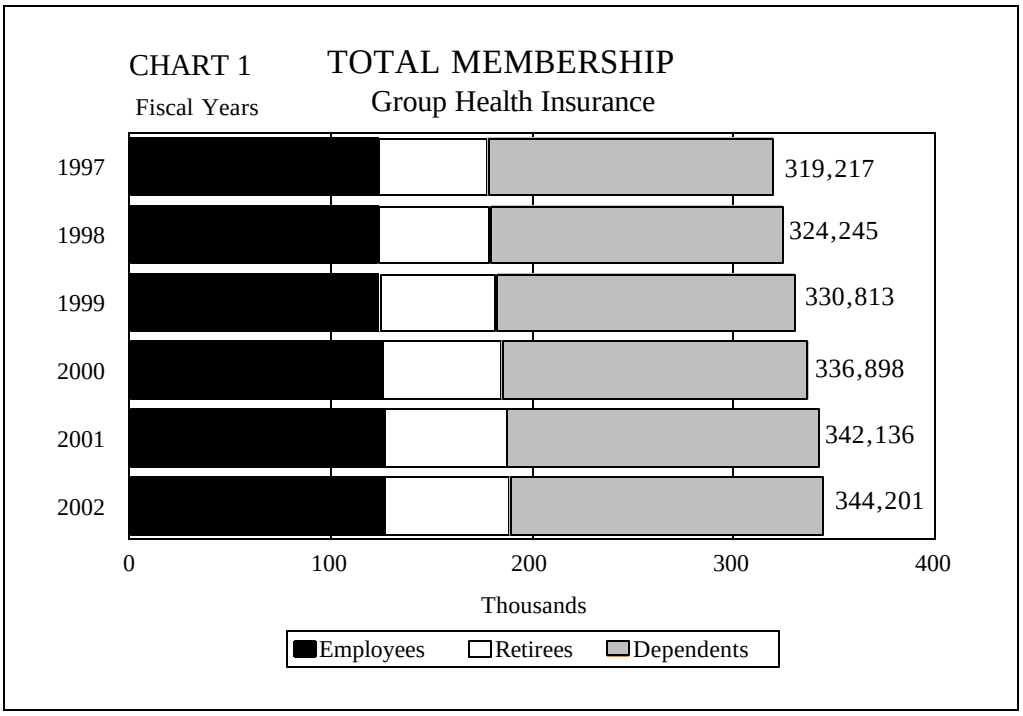
Public Act 90-0065 (HB 110) provided a new flat rate pension formula for individuals retiring on or after January 1, 1998. This change increased the liability of the State Employees' Retirement System.

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 2001 and FY 2002 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

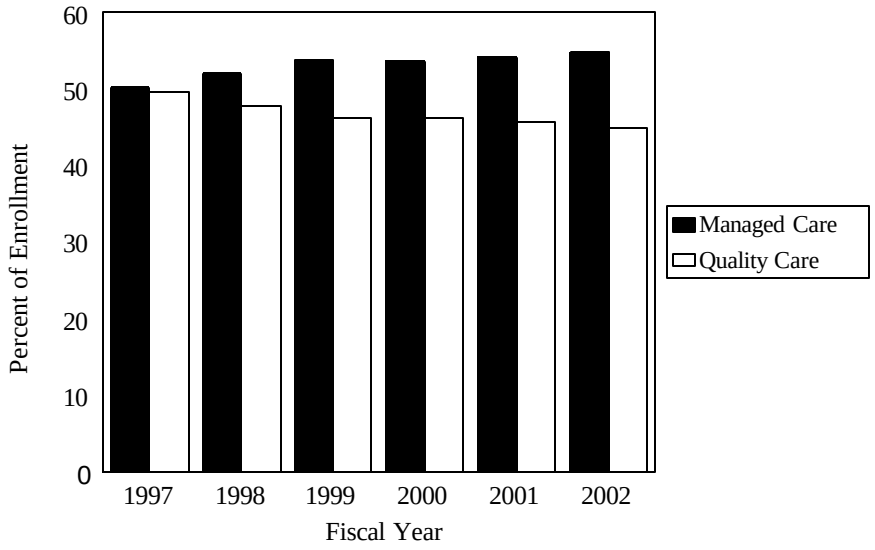
The State Employees' Group Health Insurance Program currently has 342,136 participants. The number of participants has increased steadily over the years as evidenced in Chart 1.



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 1997 and FY 2001, membership in the Quality Care Plan has gradually decreased, while membership in the HMO plans has consistently increased. In FY 2001, the percentage of enrollees in HMO plans (54%) remained at the same level as FY 2000. The percentage of FY 2001 enrollees in the indemnity plan, 46%, also remained constant from FY 2000. The FY 1999 – FY 2001 enrollment trends seem to indicate that the State's effort to encourage its members to move from the indemnity plan to managed care has leveled off. For the past three years, the enrollment split has remained the same.

CHART 2 QUALITY CARE/MANAGED CARE ENROLLMENT
FY 1997 – FY 2002



While the mid-1990's saw health care cost increases slow, recently costs have again started to climb. The Department's estimate of liability for FY 2001 represents an 11% growth rate over FY 2000. This increase in estimated liability is slightly lower than the increase from FY 1999 to FY 2000, when liability increased 11.5% over FY 1999. Table 2 illustrates the cost components for the Group Health Insurance Program from FY 1992 through FY 2002.

TABLE 2: STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY
FY 1992 to FY 2001
($ in Millions)

	1993	1994	1995	1996	1997	1998	1999*	2000*	2001*	2002*
Liability Component										
QCHP	329.7	325.2	317.3	326.7	356.8	381.7	426.0	487.0	533.0	580.0
Dental Claims	29.2	30.3	31.7	30.2	39.5	39.0	39.7	39.6	50.4	52.2
HMO	110.0	136.8	184.3	219.1	238.0	250.2	269.9	300.6	353.3	402.6
POS	1.2	21.9	28.3	24.7	19.1	20.8	23.0	20.9	11.7	13.6
Mental Health	22.0	23.8	19.2	13.1	11.3	11.0	10.8	11.1	11.0	10.1
Vision			4.3	6.3	6.9	7.7	8.5	7.5	10.6	11.0
Life Insurance	50.9	55.3	55.9	58.8	58.8	57.7	59.8	68.1	72.3	76.0
Administrative	18.5	18.9	18.3	21.3	19.3	23.9	18.2	18.6	16.6	17.2
Special Programs	5.7	3.9	5.5	9.6	7.5	10.9	10.5	12.4	13.8	14.3
TOTAL	**567.2**	**616.1**	**664.8**	**709.8**	**757.2**	**802.9**	**866.5**	**965.8**	**1,072.7**	**1,177.0**
% Increase/Decrease	9%	9%	8%	7%	7%	6%	8%	11%	11%	10%

* 1999-2002 figures are estimates

Chart 3A below shows the steady increase each year in cost per participant. In FY 1995, the annual cost per participant in the group health insurance program was $2,140.30. The estimated cost per participant for FY 2001 is $3,135.30, a 46.4% increase from the FY 1995 cost per participant. According to Chart 3B, although the dollars spent per participant have consistently increased, they increased at a slower rate each year from FY 1994 until FY 1998. The cost per participant increased 9.45% from FY 1999 to FY 2000. The FY 2001 and FY 2002 costs per participant are estimated to increase more than 9% each year over the prior year.

CHART 3A COST PER PARTICIPANT
Annual

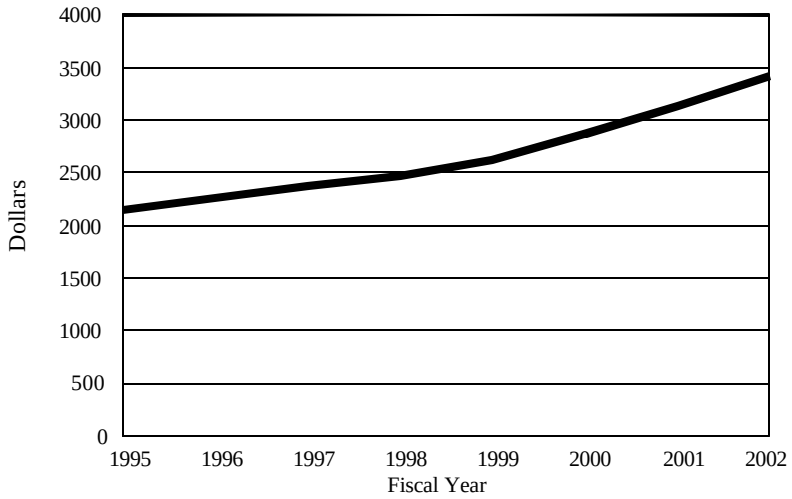
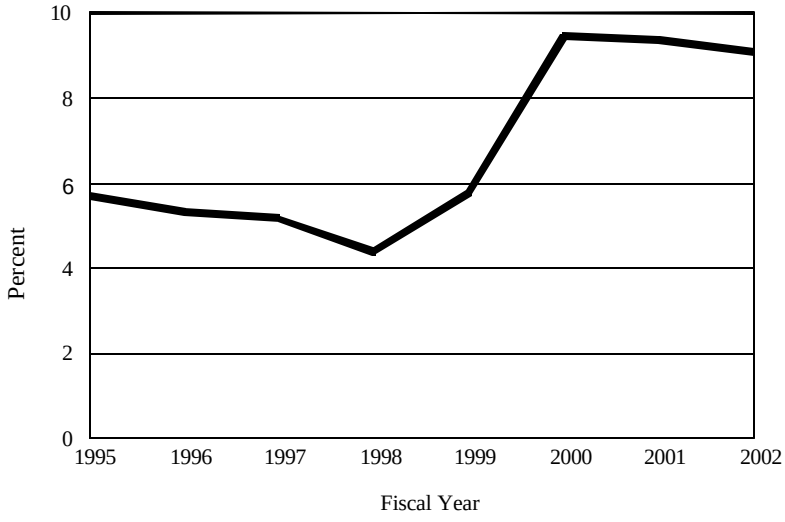
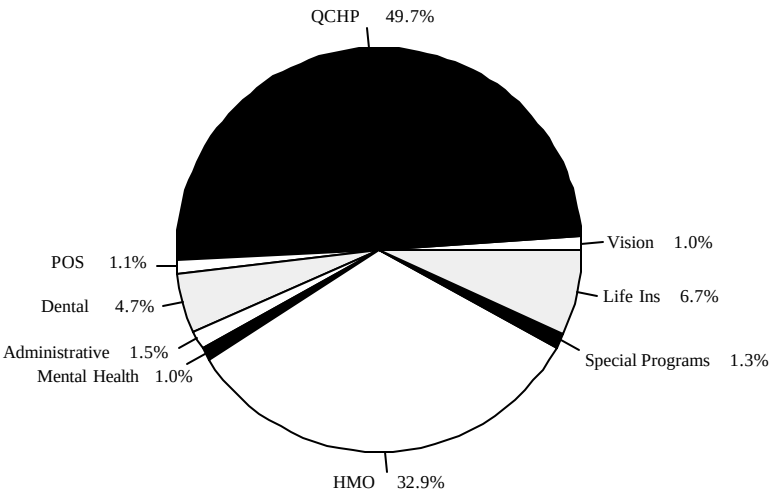


CHART 3B COST PER PARTICIPANT
% Increase over Prior Year



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 2001, these four components of the indemnity plan will account for almost 50% of the total program, while HMO and POS plans will comprise 34%. Dental and Vision Plan claims and other components, such as Life Insurance and the Employee Assistance Plan, make up the remaining 16% of the program. The FY 2001 estimated liability for the State Employees' Group Insurance Program is $1,072.7 million, which is broken down into its various components in Chart 4.

CHART 4 GROUP INSURANCE COMPONENTS
FY 2001 Estimated Liability



Managed Care

The State Employees' Group Health Insurance Program saw 8.61% of its participants changing their health carriers for the FY 2001 enrollment period. The indemnity plan experienced a 0.4% increase in membership, with an increase of 659 participants. Despite this overall increase in indemnity plan enrollment, 2,508 members and their dependents moved from the indemnity plan to a managed care plan in FY 2001. HMO plan membership increased by 8,640 (5%). POS plan membership showed a significant (50%) decrease in membership from 8,079 in FY 00 to 4,019 in FY 2001. The enrollment in the indemnity, HMO and POS plans for FY 2000 and FY 2001 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. The Department of Central Management Services terminated its contractual arrangements with American POS effective July 1, 2000.

TABLE 3: AVERAGE ENROLLMENT FY 2000 – FY 2001						
	Indemnity		***H M O***		***P O S***	
	FY 2000	FY 2001	FY 2000	FY 2001	FY 2000	FY 2001
Total Participants	155,927	156,586	172,892	181,532	8,079	4,019
Avg. Annual Cost/Participant*	$3,341	$3,691	$1,771	$1,977	$2,587	$2,911

Indemnity includes medical, prescriptions, and dental. HMO includes medical and dental; POS includes medical claims only.

*Estimated

NOTE: These enrollment figures are averages for FY 2000, and estimated averages for FY 2001.

When comparing average cost per participant (Table 3), the average cost for FY 2001 is lowest for members in an HMO and highest for those in the indemnity plan. The POS cost falls between these two. The FY 2001 average cost per participant in the indemnity plan is approximately 27% higher than in the POS plan and about 87% higher than the average cost per participant in HMO plans. (In FY 2000 the average cost per participant in the indemnity plan was approximately 29% higher than in the POS plan and about 89% higher than the average cost per participant in HMO plans.)

The Department is continuing to encourage the trend toward managed care in order to further temper rising costs. However, the indemnity plan gained 659 participants in FY 2001, a 0.4% increase in membership over FY 2000 enrollment. The indemnity plan had gained 3,931 participants in FY 2000. The cost per participant of the indemnity plan is almost twice the FY 2001 cost per participant for HMO members.

The largest age group switching to a managed care plan from an indemnity plan in FY 2001 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 provides several preventive health services, such as well-baby care, routine physicals, mammograms, school health physical exams, and annual pap smears. All these

additions to the indemnity plan are in accordance with the current collective bargaining agreement with the American Federation of State, County and Municipal Employees (AFSCME).

The current network of HMOs is the result of efforts by CMS to increase the concentration of State members into managed care plans statewide. Beginning July 1, 2000, OSF Winnebago became the newest managed care plan offered to State members. CMS terminated contracts with the following plans for FY 2001: American HMO and American POS in Chicago and central Illinois, and Community Health Plan of SBL in East central Illinois. In FY 2001 (as of 8/5/00), 183,736 state members and their dependents were participants in one of twelve HMO or POS plans. The increase in the number of managed care enrollees from FY99 to FY00 was 4.4%. The FY 2001 number of participants represents a 3.2% increase over the number of participants in managed care plans in FY 2000, which was 178,021 (as of 7/30/99). In FY 2002, ten plans will be available to members and their dependents.

Of the total participants in managed care, HMO enrollees increased 5% from FY00 to FY 2001, partly due to the termination of the American POS contract. Those enrolled with American POS were forced to choose another plan, and most chose Health Alliance or HMO Illinois. The estimated number of participants in the group insurance plan in FY 2001 is 342,136, which is 1.6% (5,238) higher than in FY 2000.

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.

Table 4 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 – FY 2001 Actual Membership

	HMO/POS	FY00 # of Participants As of 7/30/99	FY01 # of Participants As of 8/5/00	% Chg.	Areas Served
	Aetna U.S. Health Care	4,751	7,614	60.3	Chicago area
T	American HMO	11,776	0	-100.0	Cook, collar counties, NE IL, Southern IL, Peoria County
T	American POS	5,471	0	-100.0	Central & Northern IL
T	Community Health Plan of SBL	1,369	0	-100.0	East Central IL
	Health Alliance HMO	68,321	70,003	2.5	Cook & Downstate, throughout IL
	Health Alliance Illinois	1,878	3,554	89.2	Ogle & DeKalb Counties
	HMO Illinois	8,476	14,739	73.9	Chicago & Springfield areas
	Humana Premier HMO	22,426	23,801	6.1	Cook & Collar Counties
	Humana POS	1,725	2,532	46.8	Chicago area
	OSF Health Plans	11,600	12,455	7.4	Northern & Central IL
	Personal Care	22,914	25,566	11.6	Eastern IL
	Prudential HMO	8,982	9,477	5.5	St. Louis area
	Prudential POS	839	1,144	36.4	St. Louis area
	Unicare HMO (Rush Prudential)	7,493	10,888	45.3	Chicago area
N	OSF Winnebago	0	1,963		Winnebago County
TOTAL Members + Dependents		**178,021**	**183,736**	**3.2%**	

As of July 1, 2000, 12 plans were available to employees and their dependents.

N = New Plan

T = Terminated plan; no longer available to members in Illinois.

NOTE: Table 3 and Appendix II reflect average enrollment, while this table looks at actual enrollment from two different points in time.

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 2001 is $366 and will increase to $396 (8.3%) by FY 2002. (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 2002 estimated average cost for a member in an HMO will be $240 per month, an increase over the FY 2001 estimated cost of $213 (12.6%). Employees pay a minimal, graduated premium based on salary for HMO membership.

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 2002 multipliers remain the same as the FY 2001 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 IEFC, 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 5 below shows the FY 2002 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 2002 Rates (Projected)

	QCHP			**Managed Care**		
Membership	TOTAL	Member	State	TOTAL	Member	State
Employee	$396.45	$36.90	$359.55	$239.98	$28.90	$211.08
Medicare Retiree	$262.35	$4.13	$258.22	$157.11	$6.12	$150.99
Non-Medicare Retiree	$589.43	$4.13	$585.30	$358.69	$6.12	$352.57
1 Dependent	$433.24	$129.00	$304.24	$201.91	$56.21	$145.70
2+ Dependents	$503.54	$159.00	$344.54	$347.30	$93.38	$253.92
Medicare Dependent	$246.13	$75.00	$171.13	$159.24	$53.86	$105.38

It is evident from Table 5 that HMO programs have saved the State money by reducing the cost 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 on the next page (Chart 5) compares the percentage increases in rates for the HMOs and the Quality Care indemnity plan for FY 1999 to FY 2002.

CHART 5 MC/QUALITY CARE
FY 2000 – FY 2002 Rate Increase

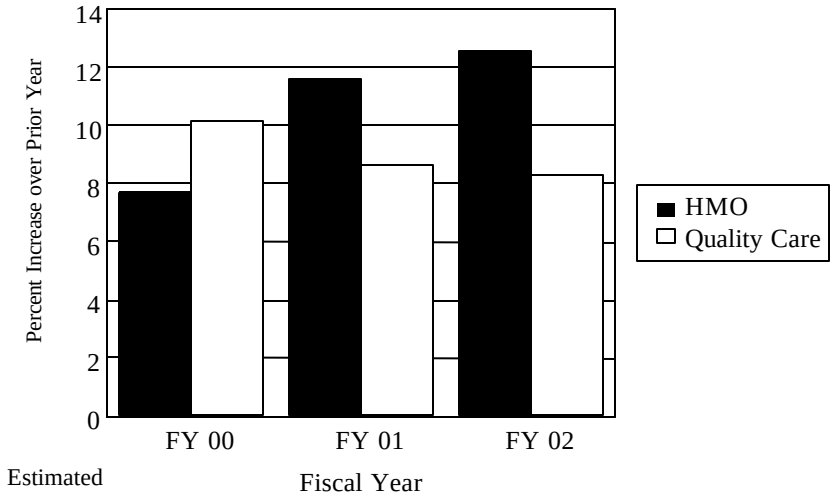


TABLE 6: PROJECTED COSTS
FY 1999 – FY 2001
Employee

	QCHP			Managed Care		
	TOTAL	Member	State	TOTAL	Member	State
FY 1999	$305.67	$20.99	$284.68	$177.23	$20.99	$156.24
FY 2000	$336.87	$21.06	$315.81	$190.93	$21.06	$169.87
FY 2001	$366.03	$33.90	$332.13	$213.13	$26.90	$186.23

IEFC's estimate of group insurance liability for FY 2002 reflects a trend in rising prescription drug costs. Noteworthy trends used to estimate the growth in liability from FY 2001 to FY 2002 include the following:

- Prescription drug inflation factor: 18.92%
- HMO trend inflation factor: 17.53%
- POS trend inflation factor: 15.00%

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 state-wide.
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 1999 - FY 2001

Enrollment	FY99	% of Total	FY00	% of Total	FY01	% of Total
Managed Care (HMO/POS)	177,895	53.8%	180,971	53.7%	185,551	54.2%
Members	84,984	47.8%	86,230	47.6%	87,665	47.2%
Dependents	92,911	52.2%	94,741	52.4%	97,886	52.8%
Indemnity	152,918	46.2%	155,927	46.3%	156,586	45.8%
Members	97,015	63.4%	98,672	63.3%	99,509	63.5%
Dependents	55,903	36.6%	57,255	36.7%	57,077	36.5%
TOTAL	**330,813**	**100.0%**	**336,898**	**100.0%**	**342,137**	**100.0%**
Members	181,999	55.0%	184,902	54.9%	187,174	54.7%
Dependents	148,814	45.0%	151,996	45.1%	154,963	45.3%

NOTE: Table 3 and Appendix II reflect average enrollment.

MEMBERSHIP TRENDS FROM FY 1999 to FY 2001

- Of the total enrollees in the State Employees Group Insurance Program, 54% were in managed care plans and 46% were in the indemnity plan.
- 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.

APPENDIX III

FY 2002 GROUP INSURANCE CONTRACTS	
CONTRACT	**TYPE OF CONTRACT**
Unicare	Claims administrator for health care benefits for QCHP members
Intracorp	Utilization review administrator for QCHP members
National Prescription Administrators	Prescription benefit administrator for QCHP members
Primax	Subrogation
Magellan Behavioral Health	Mental health/ Substance abuse services for QCHP members
CompDent	Indemnity and managed care Dental plans
Vision Service Plan	Vision care for all members
Medical Cost Management	Peer review
Health Alliance HMO	Managed care
Health Alliance Illinois	Managed care
Health Link	Managed care
HMO Illinois	Managed care
Humana HMO	Managed care
Humana POS	Managed care
OSF Health Plan	Managed care
OSF Winnebago	Managed care
Personal Care	Managed care
Unicare HMO	Managed care
Minnesota Life Insurance Company	Term life insurance

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