FISCAL YEAR 2007
LIABILITIES OF THE STATE EMPLOYEES' GROUP INSURANCE PROGRAM

Commission on Government
Forecasting and Accountability
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Commission on Government Forecasting and Accountability

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EXECUTIVE SUMMARY

The Commission on Government Forecasting and Accountability (CGFA) 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 the Department of Healthcare and Family Services (HFS) to advise the departments on all matters relating to policy and administration of the Group Insurance Act.
- To review and approve contracts recommended by HFS and CMS related to the Group Insurance Program.

The Governor has requested that a total of $1.885 billion be appropriated for the State Employees' Group Health and Life Insurance program for FY 2007. The requested FY 2006 appropriation for the Group Health Insurance Program was $1.780 billion. The table below represents historical appropriation and liability amounts, per HFS. The CGFA FY 2007 estimate of liability is $1.895 billion, $37.9 million more than HFS.

According to HFS, the Group Insurance Program will fall $13.9 million short in the payment of FY 2006 claims, and expects a shortfall in FY 2007 of $24.4 million. Currently, the payment cycles for preferred providers is 28 days, while non-preferred providers also have a payment cycle of 28 days.

The FY 2007 annual cost of an enrollee in the indemnity plan is expected to increase 10.6% over the FY 2006 cost. The FY 2007 annual cost of an enrollee in the managed care plan is expected to increase 7.2% over the FY 2006 cost. In comparison, the FY 2006 annual cost for an enrollee in the indemnity plan increased 7.0% over the FY 2005 cost. FY 2006 annual costs for an enrollee in the managed care plan increased 8.5% over FY 2005.

APPROPRIATION AND LIABILITY HISTORY
FY 2002-2007
($ in Millions)

Fiscal Year	Appropriation	HFS Liability	CGFA Liability
FY 2002	$1,262.7	$1,176.4	
FY 2003	$1,390.9	$1,303.6*	
FY 2004	$1,609.8	$1,491.3*	
FY 2005	$1,720.0	$1,635.2*	
FY 2006	$1,780.3	$1,725.4*	
FY 2007	$1,885.3	$1,857.4*	**$1,895.3***

*Estimated

FY 2007 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2007 cost projection utilizes the HFS revised estimate for FY 2006 medical claims as the basis for estimating claims for FY 2007. This revision is based on actual claims to date.

The CGFA cost estimate for FY 2007 uses the following assumptions based on historical claims data and anticipated cost increases:

TREND FACTORS	
Medical (indemnity plan/QCHP)	8.21%
Dental (QCHP and MC)	8.85%
HMO (medical and Rx)	12.08%
Prescription drugs (QCHP)	10.35%
Administrative service charges (QCHP)	0.00%
Life insurance	1.69%
Special programs (QCHP)	0.00%

The medical trend inflation factor consists of several components. These include inflation; leveraging (the reduced impact of level deductibles and coinsurance limits), and cost shifting due to reductions in Medicare and Medicaid reimbursements. Other components of the medical trend inflation factor include 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. Trending information for national indemnity plans show an average increase of 14.3%. In addition, HMO's nationally are expected to increase an average around 12%.

Based on these assumptions and inflation factors, the CGFA estimates a FY 2007 liability of approximately $1.895 billion for the State Employee's Group Health Insurance Program. The table below shows a detailed comparison of the CGFA estimate for the various cost components and the HFS projection for FY 2007.

TABLE 1: FY 2007 GROUP HEALTH INSURANCE LIABILITY
($ in Millions)

Liability Component	FY 2006 HFS Estimate	FY 2007 HFS Estimate	FY 2007 CGFA Estimate
QCHP Medical	$516.2	$546.4	$558.6
QCHP Prescriptions	$197.7	$217.0	$218.2
Dental (QCHP/MC)	$81.7	$86.6	$88.9
HMO	$660.1	$724.2	$739.8
Open Access Plan	$123.1	$136.7	$142.3
POS	$0	$0	$0
Mental Health	$8.9	$8.6	$8.5
Vision	$8.3	$8.3	$8.3
Administrative Services (QCHP)	$22.0	$20.8	$22.0
Life	$74.8	$75.9	$76.1
Special Programs (Admin/Int/Other)	$32.5	$32.9	$32.5
TOTAL	**$1,725.3**	**$1,857.4**	**$1,895.3**
% Increase over FY 2006 HFS Estimate		7.7%	9.9%

(Rounding may cause slight differences)

ESTIMATE COMPARISON

The Commission's FY 2007 estimate is $37.9 million higher than the FY 2007 estimate from HFS. CGFA's 2007 HMO liability estimate is $15.6 million higher than HFS, CGFA's indemnity medical estimate is $12.2 million higher than HFS, and CGFA's Dental estimate is $2.3 million higher than HFS. CGFA's FY 2007 estimate for prescriptions is $1.2 million higher than the HFS estimate.

The CGFA estimates approximately $1.895 billion would be required to fully fund the FY 2007 liabilities of the Group Health Insurance Program. This estimate is $170.0 million or 9.9% more than the FY 2006 estimated liability of $1.725 billion.

APPROPRIATION/FUNDING SOURCES

The FY 2007 budget request for the Group Health Insurance Program is $1.112 billion in GRF funds. This represents a $49.9 million or a 4.7% increase from the FY 2006 GRF appropriation of $1.062 billion. The FY 2007 Road Fund request of $130.5 million is $4.4 million or 3.5% higher than the FY 2006 appropriation level of $126.1 million.

TABLE 2: GROUP INSURANCE FUNDING SOURCES
FY 2006 – FY 2007
($ in Millions)

	FY 2006	FY 2007	Increase	% Increase
GRF	$1,062.3	$1,112.2	$49.9	4.7%
Road	$126.1	$130.5	$4.4	3.5%
Other Sources	$557.8	$607.6	$49.8	8.9%
TOTAL	**$1,746.2**	**$1,850.3**	**$104.1**	**6.0%**

Additional Funding for the Group Insurance Program

Funding Source	*Type of Funding*	*FY 2006*	*FY 2007*
GRF Approp	*IBHE Approp*	*0*	*0*
Road Fund Approp	*CMS Supplemental Approp*	*0*	*0*
Other Sources	*University payments*	*45,000,000*	*45,000,000*
TOTAL		*45,000,000*	*45,000,000*

HFS 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 the GIPF, that target balance is $4 million, and the target HIRF balance is $6 million.

Executive Order 2005-03 created a major shift in the administration of the State Employees' Group Insurance. The Department of Healthcare and Family Services (formerly the Department of Public Aid) assumed responsibility for the procurement, vendor negotiations and all other non-administrative functions. The Department of Central Management Services maintains an administrative role overseeing some aspects of the program including, group life insurance, deferred compensation, and the flexible spending program. The Group Insurance Program has a recommended $1.885

billion appropriation in the FY 2007 budget book. The State Employees' Group Insurance Program is slated to receive $1.112 billion in GRF and $130.5 million in Road Fund to administer the program. The State Employee's Group Insurance Program will receive a GRF appropriation of $33.2 million to administer the program.

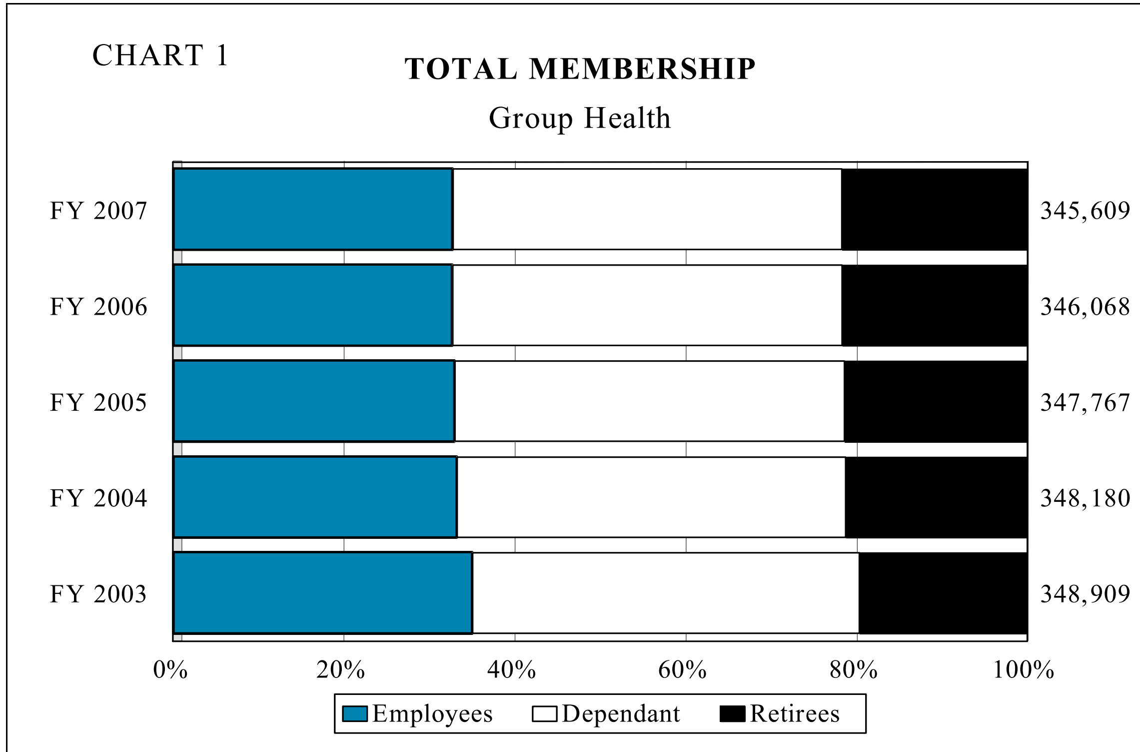
BENEFITS

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: indemnity plan, and two types of managed care plans such as Health Maintenance Organizations (HMO) and the Open Access Plans. 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. The program no longer includes a managed care option for dental benefits.

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.

MEMBERSHIP

The State Employees' Group Health Insurance Program currently has a projected membership of 346,068 participants. 210,923 in managed care, and 135,145 in the Quality Care Health Plan. Membership in the Group Health Insurance Plan is projected to decrease slightly in FY 2007 as evidenced in Chart 1.



- Membership for FY 2006 and FY 2007 is estimated.

COST SAVINGS

The State 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. Managed care remains the preferred method for cost containment nationwide.

ENROLLMENT TRENDS

Between FY 2001 and FY 2003, membership in the Quality Care Plan generally decreased. However, there was a slight increase in enrollment in the Quality Care Plan between FY 2003 and FY 2004. New data from HFS projects a further decrease of –4.6% for FY 2006 and an additional decrease in FY 2007 of -4.3%. In FY 2006, the

percentage of enrollees in managed care (60.9%) is slightly higher than the FY 2005 level of (59.2%). The percentage of FY 2006 enrollees in the indemnity plan, (39.1%), was slightly lower than FY 2005 enrollment of (40.8%). From FY 2004 to FY 2006 there was a decrease in enrollment in the indemnity plan, and a increase in enrollment in managed care plans. As a means of cost control it has been the objective of HFS to encourage group insurance members to enroll in managed care plans. It should be noted that 73.4% of retirees are enrolled in the indemnity plan.

LIABILITY

While the mid-1990's saw health care cost increases slow, recent years have experienced steady increases, ranging from 9.0% to 14.4% over prior years. The Department's estimate of liability for FY 2007 represents a 7.7% growth rate over FY 2006. This increase in estimated liability is higher than the forecasted 5.5% increase from FY 2005. Table 3 illustrates the cost components for the Group Health Insurance Program from FY 1998 through FY 2007.

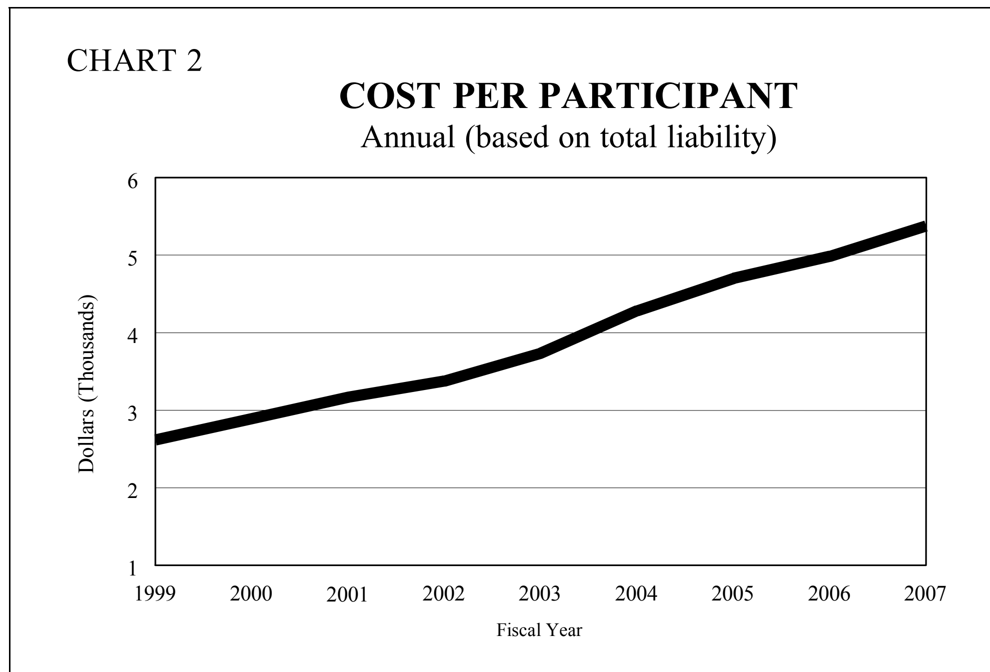
TABLE 3: STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY
FY 1998 to FY 2007
($ in Millions)

Liability Component	1998	1999	2000	2001	2002*	2003*	2004*	2005*	2006*	2007*
QCHP Medical/Rx	381.7	425.1	496.5	536.9	558.5	584.2	664.5	700.4	713.9	763.4
HMO Medical	250.2	269.9	307.0	364.1	402.1	469.3	544.5	602.8	660.1	724.2
Dental	39.0	39.6	42.4	51.1	58.7	65.8	72.2	91.4	81.7	86.6
POS	20.8	23.0	16.1	7.8	7.6	8.6	-	-	-	-
Open Access Plan	-	-	-	-	36.8	54.9	69.9	102.4	123.1	136.7
QC Mental Health	11.0	10.8	11.1	11.0	9.3	9.2	9.5	9.2	8.9	8.6
Vision	7.7	8.5	7.5	10.4	10.9	11.4	11.7	11.7	8.3	8.3
Life Insurance	57.7	59.8	64.8	70.1	61.3	63.6	65.9	68.8	74.8	75.9
QC ASC	23.9	18.2	15.8	16.0	19.1	22.4	21.2	21.4	22.1	20.8
Admin/Int/Other	10.9	10.6	12.8	11.4	12.2	14.3	31.8	27.2	32.5	32.9
TOTAL	**802.8**	**865.5**	**974.0**	**1,079.0**	**1,176.3**	**1,303.6**	**1,491.3**	**1,635.2**	**1,725.4**	**1,857.4**
% Increase over PY	6.0%	7.8%	12.5%	10.8%	9.0%	10.8%	14.4%	9.6%	5.5%	7.7%

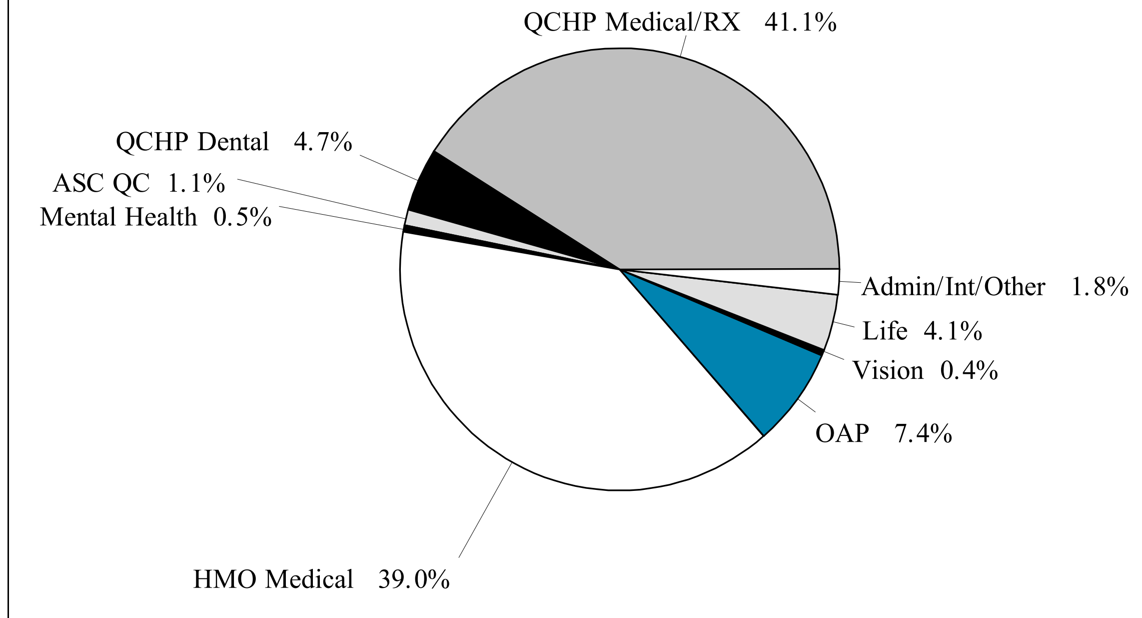
*Estimated
- FY 2002-2007 figures are estimates: Source: HFS
- Rounding causes slight differences in cumulative totals.

ANNUAL COST PER PARTICIPANT

The cost per participant in the State Employees' Group Insurance Program is the total of the State's cost and the employee's contribution each month. Chart 2 shows the steady increase each year in cost per participant. This increase can be attributed to medical inflation as evidenced in the previous table. In FY 1999, the annual cost per participant in the group health insurance program was $2,616. **The estimated cost per participant for FY 2007 is $5,374, a 105% increase from the FY 1999 cost per participant**. The cost per participant increased 6.0% from FY 2005 to FY 2006. The FY 2007 cost per participant is estimated to increase 7.8% over FY 2006.



P.A. 90-0065 requires State employees with less than 20 years credible service to pay a portion of their health care costs. State employees earn 5% every year of credible service towards their health care costs. Retirees with twenty or more years of credible service have 100% of their health care paid by the State. The chart on the following page includes the various components of the FY 2007 HFS liability estimate of $1,857.4 million. The largest component of the State Group Insurance Program is the State's managed care plans (HMO and OAP) which represent (46.4%) of FY 2007 liability, while dental care, life insurance, vision care, and other charges comprise (11.0%) of total liability. The indemnity component (42.7%) includes medical/prescriptions, mental health coverage, and administrative service charges.



CHANGE IN PLAN MEMBERSHIP FROM FY 2005 TO FY 2006

As of 7/29/05, the State Employees' Group Health Insurance Program saw 2.3% of its members (enrollees) changing their health carriers for the FY 2006 enrollment period. The indemnity plan experienced a 0.4% increase in membership, with 786 members migrating from managed care to the Quality Care Health Plan. Despite this overall increase in indemnity plan enrollment, 2,438 members moved from the indemnity plan to a managed care plan in FY 2006. In addition, 1,255 members went from one managed care plan to another.

Total enrollment (employees, retirees, and dependents) in the Quality Care Health Plan decreased 4.6% from 141,732 to 135,145. HMO plan membership increased from 206,035 to 210,923. Open Access Plan (managed care) membership increased 13.5% from 25,807 to 29,288.

The enrollment in the indemnity, HMO, OAP, and POS plans for FY 2005 and FY 2006 are shown in Table 4, on the following page.

TABLE 4: Average Annual Cost per Participant Average Enrollment				
	FY 2006	FY 2007	FY 2006	FY 2007
	Average Cost Per Participant*	Average Cost Per Participant*	Total Participants*	Total Participants*
Indemnity (QCHP)	$5,512	$6,128	135,145	129,382
HMO	$3,634	$3,893	181,635	186,029
OAP	$4,203	$4,527	29,288	30,198
			346,068	345,609

- OAP is the Health Link Open Access Plan. ACPP does not include dental, vision, admin/Int/Other, or life insurance.

*Estimated
SOURCE: HFS

When comparing average cost per participant (ACPP) in Table 4, the average cost for FY 2006 is lowest for members in a HMO plan and highest for those in the QCHP. **The FY 2006 ACPP in the QCHP is approximately 31.1% higher than in the OAP, and 51.3% higher than the ACPP in the HMO plans. The average cost per enrollee in the indemnity plan is estimated to be $6,128 in FY 2007, an increase of 11.2%. ACPP for HMO and OAP coverage will increase 7.1% and 7.7% respectively.**

The largest age group switching to a managed care plan from an indemnity plan in FY 2006 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.

MANAGED CARE PLANS

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 Open Access Plan (Health Link), 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.

The plan with the largest enrollment is Health Alliance HMO, and the plan with the smallest is OSF Winnebago. Greater detail about FY 2005 and FY 2006 plan enrollment, as well as the areas served by each plan, is listed in Table 5 below.

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. Based on information provided to the Commission, 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 5: MANAGED CARE PLANS
FY 2005 – FY 2006 Actual Membership

HMO/POS	FY05 # of Participants Thru April FY 2005	FY06 # of Participants Thru July FY 2006	% Chg.	Areas Served
Health Alliance HMO	74,989	75,864	1.17%	Downstate Illinois
Health Alliance Illinois	7,538	7,500	-0.51%	DeKalb County & Western, IL
HMO Illinois	48,101	48,198	0.20%	Chicago & Springfield areas
OSF Health Plans	9,981	10,099	1.20%	Northern & Central IL
Personal Care	23,943	25,084	4.77%	Eastern & Central, IL
Unicare HMO	13,135	13,177	0.32%	Chicago area
OSF Winnebago	2,034	1,909	-6.1%	Winnebago County
Health Link OAP	26,240	28,794	9.70%	Central & Southern Illinois
TOTAL Members + Dependents	**205,961**	**210,625**	**2.26%**	

As of July 1, 2005, 8 plans were available to employees and their dependents.

MONTHLY PREMIUMS

Historically, 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 2006 is $595 and will increase to $641 (7.7%) in FY 2007.

The monthly premium for a current employee in a managed care plan varies based on each plan's rates, but the FY 2006 estimated average cost for a member in a managed care plan will be $390 per month. Until HFS completes negotiating rates with Managed Care providers, the Department is unable to calculate the average amount paid by each member for FY 2007.

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 experience 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. HFS must wait for contract negotiations to conclude before releasing the FY 2007 multipliers. Below is the multipliers used for FY 2006.

FY 2006 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/HFS 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 6, shows the FY 2007 weighted average monthly rates for managed care plans and the indemnity plans, as well as the State and member contributions. The State's contribution varies, depending on a member's salary. Some information is not yet available due to current negotiations with vendors.

TABLE 6: MONTHLY PREMIUMS Managed Care vs. Indemnity Plan Weighted Average FY 2007 Rates (Projected)						
	QCHP			Managed Care		
Membership	TOTAL	Member	State	TOTAL	Member	State
Employee	$640.53	$64.77	$575.76	N/A	$38.56	N/A
Medicare Retiree	$371.97	$6.10	$365.87	N/A	$8.79	N/A
Non-Medicare Retiree	$846.65	$9.37	$837.28	N/A	$8.06	N/A
1 Dependent	$680.40	$174.00	$506.40	N/A	$76.50	N/A
2+ Dependents	$839.80	$204.00	$635.60	N/A	$117.00	N/A
Medicare Dependent	$393.27	$120.00	$273.27	N/A	$73.00	N/A

N/A: Managed Care contracts are currently being negotiated by HFS and total premiums have yet to be determined.

TABLE 7: PROJECTED COSTS FY 2004 – FY 2007 Employee Only								
	QCHP				Managed Care			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY 2004	$472.49	14.17%	$43.61	$446.86	$322.53	15.06%	$33.48	$288.70
FY 2005	$529.48	12.06%	$43.91	$498.74	$358.53	11.16%	$33.76	$333.48
FY 2006	$594.74	12.3%	$54.48	$540.26	$390.28	8.88%	$34.31	$356.07
FY 2007	$640.53	7.7%	$64.77	$575.76	N/A	N/A	$38.56	N/A

N/A: Managed Care contracts are currently being negotiated by HFS and total premiums have yet to be determined.

CGFA estimate of group insurance liability for FY 2007 reflects a continued trend in prescription drug costs. According to studies done by Segal, health plan trends will continue declining in 2006. Trends for prescription drug coverage will also slow in 2006. Noteworthy trends used to estimate the growth in liability from FY 2006 to FY 2007 include the following:

Prescription drug (QCHP)	10.35%
HMO Medical/Rx	12.08%
QC Medical	8.21%

APPENDIX I

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 and HFS 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 dependants.
- 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/HFS) 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/HFS) 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/HFS) must provide updated, and any new information to the Commission until the employee benefits program for the fiscal year has been determined.
- Requires CMS/HFS 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/HFS 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.

APPENDIX II

TYPES OF MEDICAL & DENTAL GROUP INSURANCE PLANS

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
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

APPENDIX III

Group Insurance Contracts to be Awarded or Renewed for FY 2007		
Contract	***Type of Contract***	***Renewal/Competitively Selected***
Medco	Rx benefit administrator (self-insured plans)	Multi-Year
CIGNA	Claims administrator for health care benefits (QCHP members)	Multi-Year
CompDent	Dental	Contract up for Renewal/Amendment HFS
Fringe Benefit Management Company	Flexible Spending Administrator	Multi-year/CMS
Intracorp	Utilization review administrator (QCHP members)	Multi-Year
Magellan Behavioral Health	Mental health/substance abuse services (QCHP members)	Contract up for Renewal/Amendment HFS
CIMRO	Peer review	Multi-year
Minnesota Life Insurance Company	Term life insurance	Contract up for Renewal/Amendment at CMS
Primax	Subrogation	Multi-Year
Sykes Health Plan Services	Hospital bill auditing	Contract up for Renewal/Amendment HFS
EyeMed	Vision care (all members)	Competitively selected
Wage Works	Qualified Transportation Benefit Administrator	Contract up for Renewal/Amendment at CMS
Met-Life	Long-Term Care	Contract up for Renewal/Amendment at CMS
PPO Hospital Network	Hospital Network	Multi-Year

Managed Care Contracts thru FY 2007		
Health Alliance HMO		Renewal/Amended
Health Alliance Illinois		Renewal/Amended
Health Link OAP		Renewal/Amended
HMO Illinois		Renewal/Amended
OSF Health Plan		Renewal/Amended
OSF Winnebago		Renewal/Amended
Personal Care		Renewal/Amended
Unicare HMO		Renewal/Amended

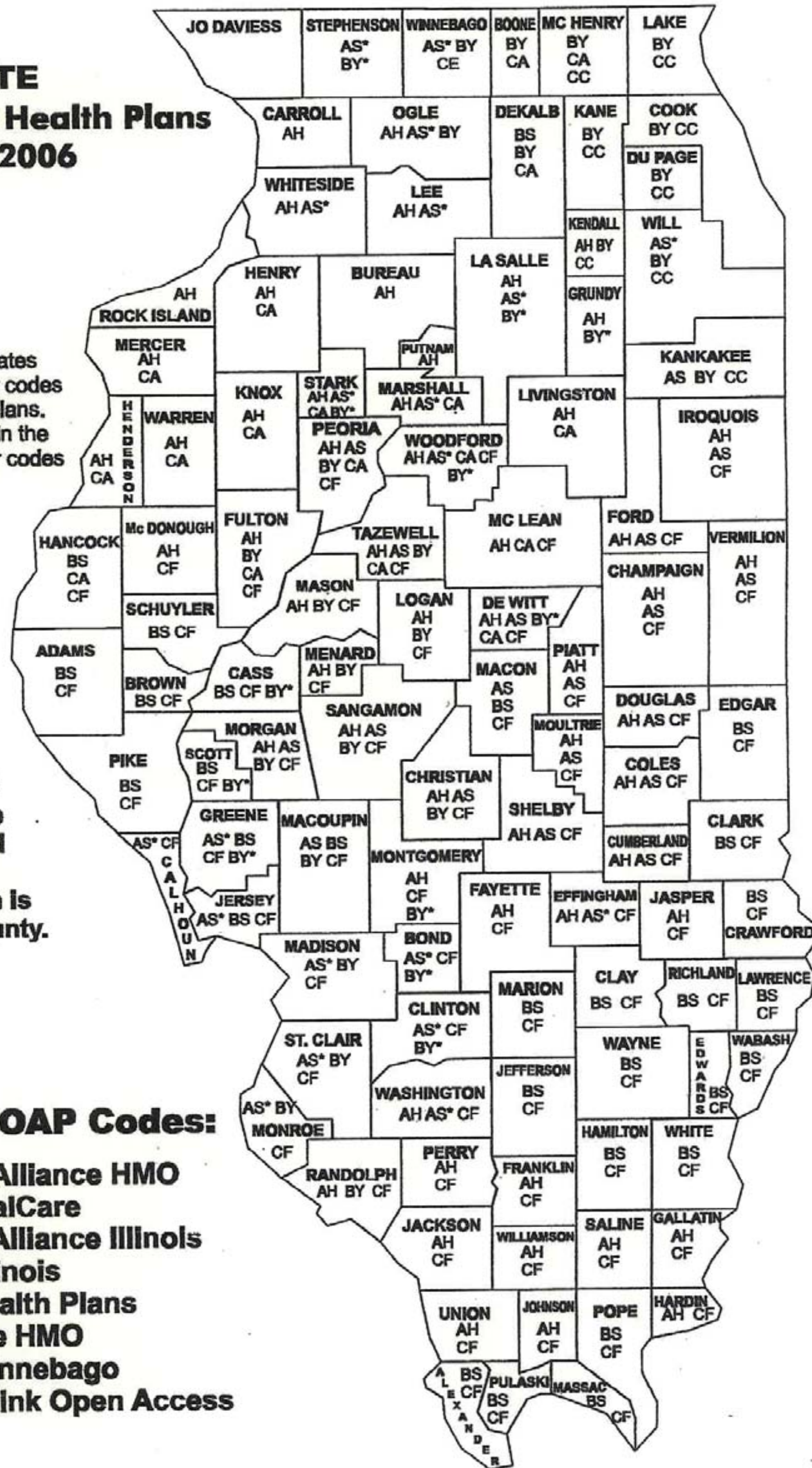
HFS, in addition to the contracts listed above, also is renewing contracts for flu shots and consulting contracts. General Consulting Contracting is done by Willis of Illinois. Prescription Consulting is done by HealthLinx.

APPENDIX IV

Managed Care Plans in Illinois Counties

STATE
Managed Care Health Plans
For FY 2006

The key below indicates the two-letter carrier codes for HMO and OAP plans. Plans are available in the counties where their codes appear.



*** If an asterisk appears by one of the managed care plans, it means the plan is new to that county.**

HMO and OAP Codes:

AH = Health Alliance HMO
AS = PersonalCare
BS = Health Alliance Illinois
BY = HMO Illinois
CA = OSF Health Plans
CC = UniCare HMO
CE = OSF Winnebago
CF = HealthLink Open Access

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

http://www.ilga.gov/commission/cgfa/cgfa_home.html