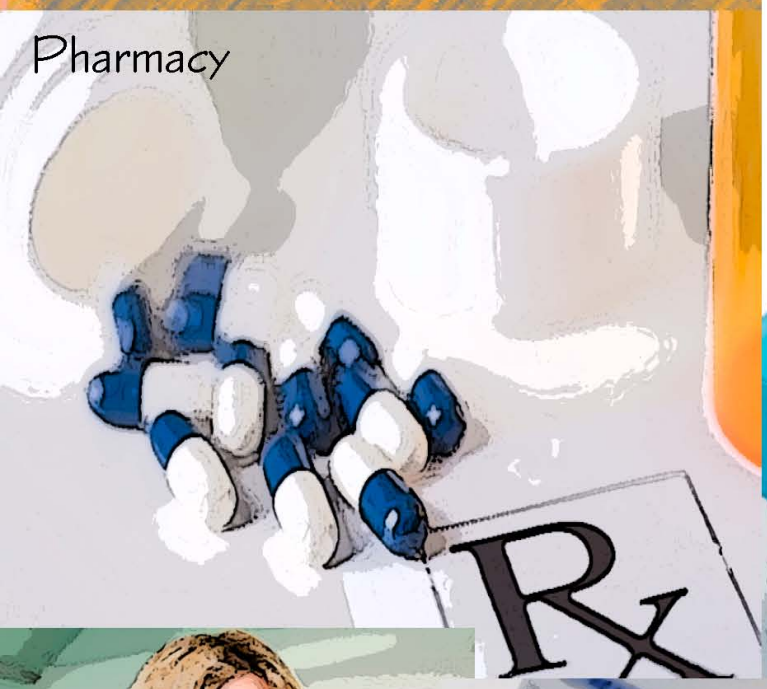
Commission on Government Forecasting & Accountability

Liabilities of the State Employees' Group Health Insurance Program

Fiscal Year 2012



March 2011

Commission on Government Forecasting and Accountability

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FY 2012 State Employees' Group Insurance Report
March, 2012

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 the Director of HFS related to the Group Insurance Program.

The Governor has requested that a total of $2,514.8 million be appropriated for the State Employees' Group Health and Life Insurance program for FY 2012. The requested FY 2011 appropriation request for the Group Health Insurance Program was $2,224.0 million. The table below represents historical appropriation and liability amounts, per HFS. The CGFA FY 2012 estimate of liability is $2,460.8 million, $72 million more than HFS.

Currently, the payment cycle for preferred providers is 231 days, while non-preferred providers have a payment cycle of 287 days. The current amount of CIGNA claims being held is $332.5 million. HFS has calculated the amount of time it takes to make payments to managed care providers (HMO's) at approximately 3.5 months. The value of what is currently being held for managed care providers is approximately $420 million. Dental claims, Rx claims, administrative service charges, and vision premiums are being paid in 161, 131, 90, and 90 days respectively.

According to HFS, the FY 2012 estimated liability for the Quality Care Health Plan (QCHP) is expected to increase 2.42% over the FY 2011 liability. The estimated liabilities for the State's managed care plans are expected to increase 4.75% over the FY 2011 cost. In comparison, the FY 2011 liability for the QCHP increased 2.75% over the FY 2010 cost. FY 2011 liability for the managed care plans increased 10.57% over FY 2010. The Department also projects prescription drug liability to increase 0.54% in FY 2012 from $194.2 million to $195.2 million.

APPROPRIATION AND LIABILITY HISTORY
FY 2007-2012
($ in Millions)

Fiscal Year	Appropriation	HFS Liability	CGFA Liability
FY 2007	$1,884.9	$1,789.5	
FY 2008	$1,983.0	$1,892.4	
FY 2009	$1,991.6	$2,044.3	
FY 2010	$2,163.3	$2,178.7	
FY 2011*	$3,329.0	$2,334.8	
FY 2012*	$2,514.8	$2,388.7	$2,460.4

*Estimated for FY 2011 and 2012. Also assumes a supplemental $1,100.0 appropriation in FY 2011

FY 2012 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2012 cost projection utilizes the HFS revised estimate for FY 2011 medical claims as the basis for estimating claims for FY 2012.

The CGFA cost estimate for FY 2012 uses the following assumptions based on historical claims data and anticipated cost increases:

TREND FACTORS	
Medical (QCHP plan)	2.61%
Dental (QCHP and MC)	1.23%
HMO (medical and Rx)	8.91%
Prescription drugs (QCHP)	1.12%
Administrative service charges (QCHP)	6.01%
Life insurance	3.21%

The medical trend inflation factors consist of various components. These components include cost-shifting due to Medicare/Medicaid reimbursement reduction, general inflation and leveraging (lower impact of coinsurance limits, level deductibles, etc.). In addition to these, the impact of a gradual shift by employees to HMOs and PPOs has resulted in more costly/higher risk employees remaining in the QCHP program. Also, advances in technological innovation, increased use of care for psychiatric/substance abuse, more use of equipment/services and the continued "greying" (aging and extended living) of the population have all contributed to greater health care costs.

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

- Projected prescription drug trends, which remain under 10 percent for the second consecutive year, continue to decline (9.2 percent this year).
- In 2011, medical plan projections for most managed care plans are similar to those found in 2010, ranging from 10.2 percent to 11.0 percent. In contrast, high-deductible health plans are projected to decrease by two tenths of a percentage point to 11.7 percent.
- Forecasted Medicare medical plan trend rates for retirees age 65 and older are expected to increase, but are still projected to be lower than comparable medical plan trend rates for active participants and early retirees.
- The lowest trend rates are expected in the Midwest, and the highest trend rates are expected in the Northeast and the West for preferred provider organizations and point-of-service plans combined.
- Hospital stay claims are expected to be the largest component of the overall medical plan cost trend.

- For 2011, dental QCHP plans and dental provider organization plans are expected to decrease by almost one full percentage point over 2010 trend levels.

Table 1 below highlights national trending data and compares it to estimates by HFS and CGFA.

TABLE 1

NATIONAL HEALTH CARE TRENDING 2011

Component	National Trend	HFS Increase	COGFA Increase
PPO's	9.8%	2.42%	4.72%
HMO's	7.7%	4.75%	8.91%
Rx	9.2%	0.54%	1.12%
Dental	4.3%	-4.50%	12.3%
Vision	2.7%	4.13%	0.23%

Source: Segal 2011 Health Plan Cost Trend Survey

Usually, there is a strong correlation between trend rates and actual costs. However, trend and the net annual change in plan costs are not the same. Trend rates allow the Commission to benchmark health plan components to analyze and estimate claims data. Changes in the costs to plan sponsors can be very different from projected cost trends. Such factors as program design changes, employee contribution rate increases, and group demographics can significantly influence total costs.

Based on these assumptions and inflation factors, the CGFA estimates a FY 2012 liability of approximately $2,460.5 million for the State Employee's Group Health Insurance Program. The table on the following page shows a detailed comparison of the CGFA estimate for the various cost components and the HFS projection for FY 2012.

TABLE 2: FY 2012 GROUP HEALTH INSURANCE LIABILITY

($ in Millions)

Liability Component	FY 2011 HFS Estimate	FY 2012 HFS Estimate	FY 2012 CGFA Estimate
QCHP Medical	$529.9	$542.7	$543.0
QCHP Prescriptions	$208.8	$195.2	$213.5
Dental (QCHP/MC)	$125.7	$120.0	$126.0
HMO	$1,007.4	$1,055.2	$1,080.7
Open Access Plan	$288.1	$303.0	$315.4
POS	$0.0	$0.0	$0.0
Mental Health	$7.6	$9.2	$10.3
Vision	$10.2	$10.6	$10.6
Administrative Services (QCHP)	$31.6	$31.7	$33.5
Life	$82.1	$84.7	$89.2
Special Programs (Admin/Int./Other)	$32.3	$36.3	$38.3
TOTAL	**$2,334.8**	**$2,388.7**	**$2,460.5**
% increase over prior year		2.3%	5.4%

Rounding may cause slight differences

ESTIMATE COMPARISON

Overall, the Commission's FY 2012 estimate is $72.0 million higher than the FY 2012 estimate from HFS. CGFA's FY 2012 HMO liability estimate is $25.5 million higher than HFS, CGFA's Open Access Plan medical estimate is $12.4 million more than HFS, and CGFA's FY 2012 estimate for prescriptions is $18.3 million higher than the HFS estimate. CGFA's dental estimate is $6 million more than HFS.

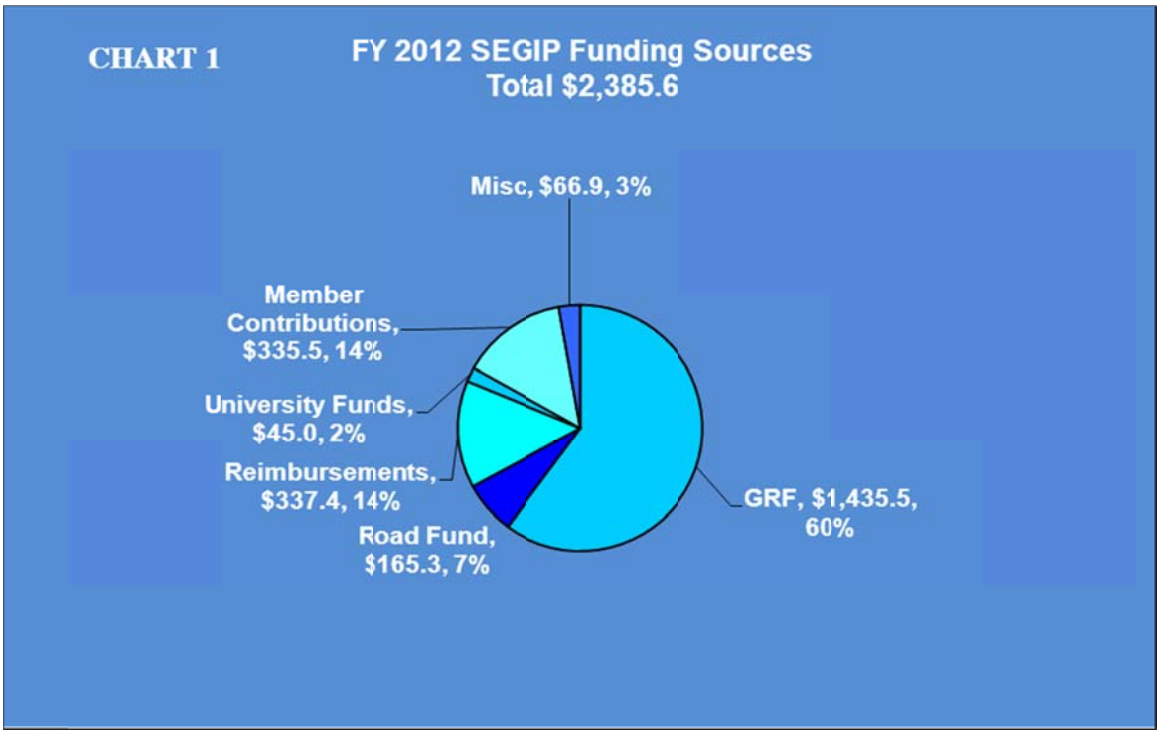
The CGFA estimates approximately $2,460.5 million would be required to fully fund the FY 2012 liabilities of the Group Health Insurance Program. This estimate is $125.7 million or 5.4% more than the FY 2011 estimated liability of $2,334.8 million.

APPROPRIATION/FUNDING SOURCES

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

HIRF is the fund mainly used to administer the group insurance program. 5 ILCS 375/13.1 states "All contributions, appropriations, interest, and other dividend payments to fund the program of health benefits shall be deposited into the Health

Insurance Reserve Fund. Funding for HIRF comes from several different revenue sources, the General Revenue Fund (GRF), Road Fund, reimbursements, university funds, and miscellaneous funds. Estimated cash flow into HIRF for FY 2012 is $2.385.6 billion. A breakdown in the various funding sources is shown in the pie chart below.



- Dollar amounts in Millions $

The FY 2012 budget request for the Group Health Insurance Program is $1,435.53 million in GRF funds. This represents a -$355.5 million or a -19.85% decrease from the FY 2011 GRF appropriation of $1,791.1 million. The estimated FY 2012 Road Fund request of $165.29 million is $5.33 million or 3.33% higher than the FY 2011 appropriation level.

TABLE 3: GROUP INSURANCE FUNDING SOURCES FY 2011 – FY 2012 ($ in Millions)				
	FY 2011	FY 2012	$ Change	% Change
HFS GRF Appropriation	$1,791.06	$1,435.53	$(355.53)	(19.85)%
Road	$159.96	$165.29	$5.33	3.33%
University Cont.	$45.00	$45.0	$0.0	0.0%
Member Cont.	$330.72	$335.46	$4.74	1.43%
Other Funds	$283.22	$337.44	$54.22	19.14%
Rebates/Interest/Med D	$75.49	$66.88	$(8.62)	(11.42)%
TOTAL Appropriations	**$2,685.45**	**$2,385.6**	**$(299.85)**	**(11.17)%**
Source: CMS - FY 2011 Appropriation assumes a FY 2011 Supplemental Request of $1.1 Billion				

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 FY 2012, the GIPF target balance is $4 million, and the target HIRF balance is $6 million.

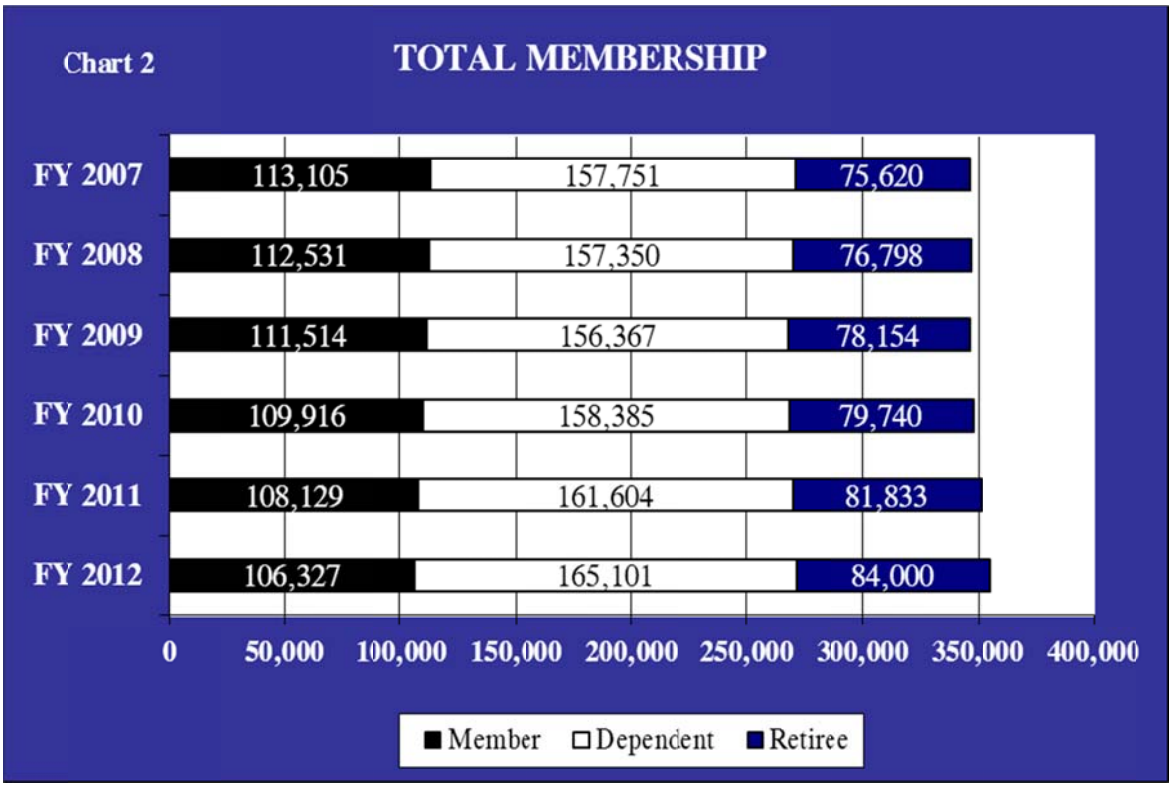
BENEFITS

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

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

According to HFS, the State Employees' Group Health Insurance Program currently has an estimated 351,566 participants, of which 232,710 are in managed care, and 118,856 are in the Quality Care Health Plan. The QCHP is estimated to have 23,604 employees; 39,238 dependents; and 54,312 retirees in FY 2012. Managed care plans are estimated to have 82,723 employees; 125,863 dependents; and 29,688 retirees in FY 2012. Membership in the Group Health Insurance Plan is projected to increase slightly in FY 2012, as evidenced in Chart 2 below.

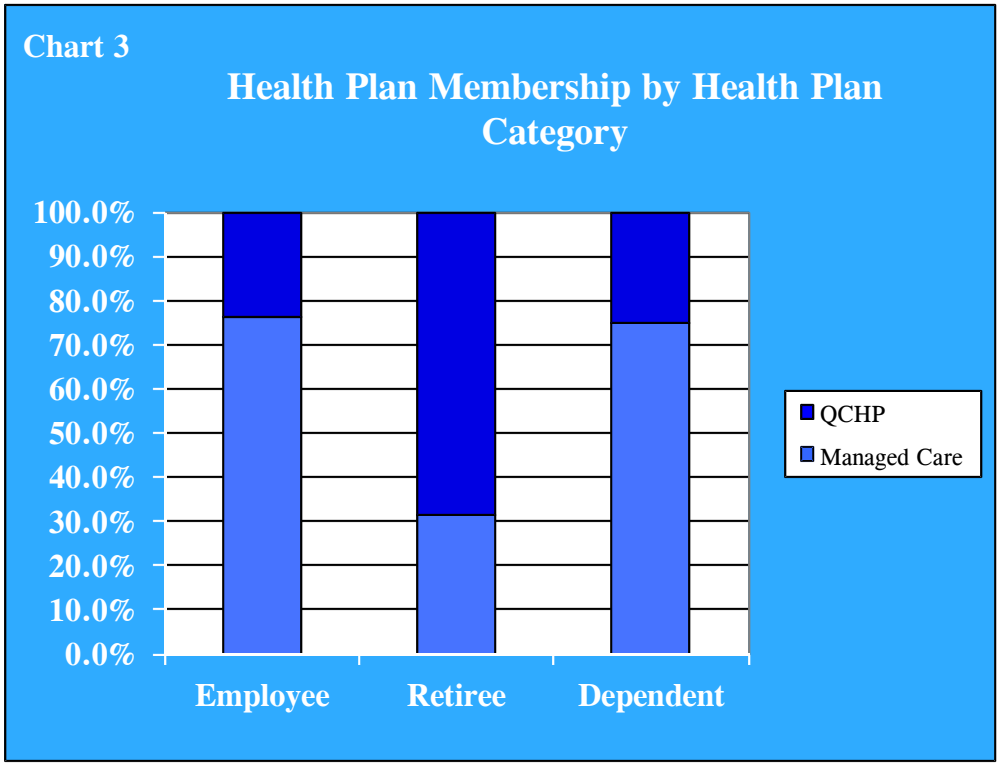


- **Membership is estimated for FY 2011 and FY 2012.**

ENROLLMENT TRENDS

Membership in the group insurance program is expected to increase moderately in FY 2012, adding 3,862 participants. Membership in the Quality Care Plan has been decreasing since FY 2005; HFS estimates that QCHP membership will decline -1.4% from 118,856 in FY 2011 to an estimated 117,154 in FY 2012. Membership in the States' managed care offerings has been increasing since FY 2004. Membership enrollment in managed care will increase 2.3% in FY 2012, going from 188,625 to 193,038. The State also offers an Open Access Plan. Membership in the OAP is expected to increase in FY 2011 by 2.6%.

Chart 3, below, shows the breakdown of employee, dependant and retiree enrollment in the overall group insurance program. The QCHP continues to be the most popular plan for retirees. Retirees favor the QCHP because of provider access and other issues. In FY 2011, 66.6% of retirees were enrolled in the QCHP. Chart 3 shows that while retirees overwhelmingly choose the QCHP, dependents and employees prefer managed care.



LIABILITY

The Department's estimate of liability for FY 2012 represents a 2.3% growth rate over FY 2011. This increase in estimated liability is lower than the increase from FY 2010 to FY 2011, when liability increased 7.2%. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2003 through FY 2012.

Table 4, on the following page, demonstrates how several components make up for the majority of the State's total liability. Historically, the Quality Care Health Plan, Prescription Drugs, and HMO's have made up the largest segment of total liability. The dental plan and the Open Access Plan are also large components of the total insurance obligation. Increasingly, the Open Access Plan is being chosen at higher rates than traditional HMOs or the Quality Care Health Plan, though its overall insurance liability is still well below the two main alternatives.

Table 4	STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY FY 2002-FY 2011									
	$ in (millions)									
Liability Component	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
QCHP Medical/Rx	$584.0	$663.4	$697.6	$690.8	$694.7	$689.9	$731.2	$724.5	$724.0	$737.9
HMO Medical	$469.3	$544.5	$602.8	$662.1	$711.4	$780.6	$843.8	$911.1	$1,007.4	$1,055.2
Dental	$63.7	$69.9	$88.9	$84.9	$95.6	$102.3	$109.8	$111.6	$125.7	$120.0
POS	$8.6	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Open Access Plan	$54.9	$69.9	$102.0	$125.3	$153.9	$178.3	$213.0	$251.2	$288.1	$303.0
QC Mental Health	$9.2	$9.5	$9.2	$8.9	$8.8	$8.6	$8.3	$10.6	$7.6	$9.1
Vision	$11.2	$11.5	$11.7	$8.2	$8.2	$8.2	$8.2	$8.3	$10.2	$10.6
Life Insurance	$63.1	$65.0	$68.8	$75.6	$75.8	$78.4	$80.9	$83.7	$82.1	$84.7
QC ASC	$24.4	$22.8	$23.7	$29.2	$27.9	$29.6	$30.7	$32.2	$31.6	$31.7
Admin/Int/Other	$14.6	$15.9	$14.8	$17.3	$13.2	$16.5	$18.4	$45.5	$58.1	$36.5
Total	**$1,303.0**	**$1,472.4**	**$1,619.5**	**$1,702.3**	**$1,789.5**	**$1,892.4**	**$2,044.3**	**$2,178.7**	**$2,334.8**	**$2,388.7**
% change over py		13.00%	9.99%	5.11%	5.12%	5.75%	8.03%	6.57%	7.16%	2.31%
Rounding causes slight differences in totals										

ANNUAL COST PER PARTICIPANT

The cost per participant in the State Employees' Group Insurance Program is the total of the State's cost and the employee's contribution each month. Chart 4 shows the steady increase each year in cost per participant. This increase can be attributed to medical inflation as evidenced in Table 4. In FY 2003, the annual cost per participant in the group health insurance program was $3,735. **According to CMS, the estimated cost per participant for FY 2011 is $6,721, a 79.9% increase from the FY 2003 cost per participant**. The cost per participant increased 5.6% from FY 2010 to FY 2011. The FY 2012 cost per participant is estimated to increase 1.4% over FY 2011, a significant drop from previous rates of increase.

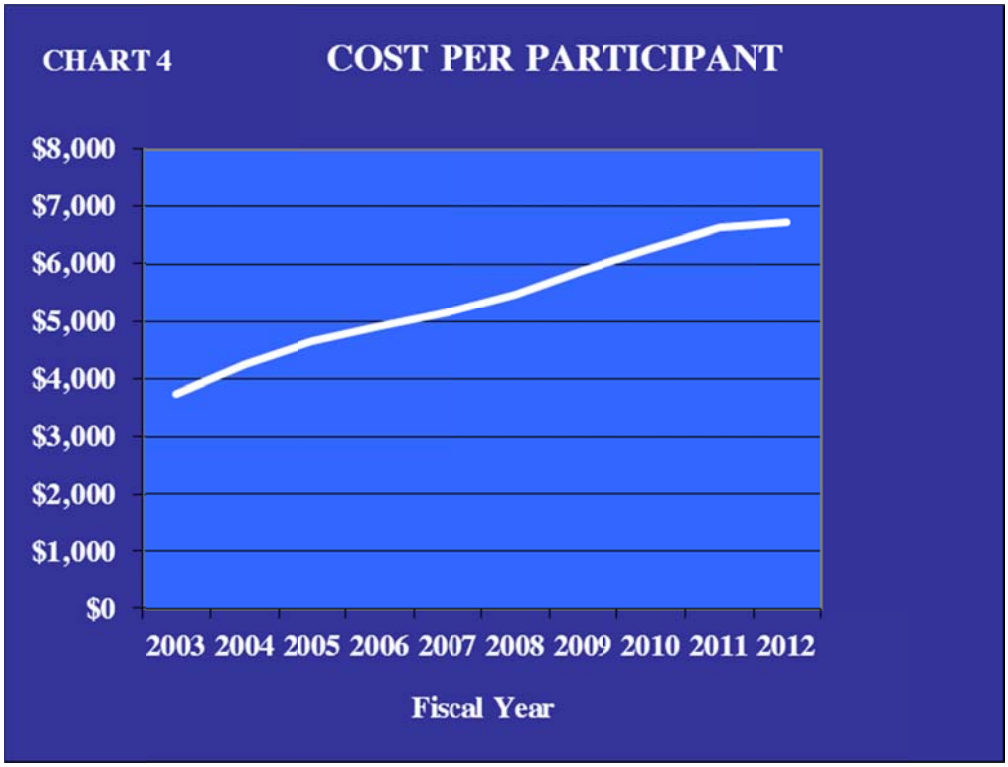


TABLE 5: AVERAGE ANNUAL COST PER PARTICIPANT				
	FY 2012 Average Cost Per Participant	FY 2011 Average Cost Per Participant	FY 2012 Total Participants	FY 2011 Total Participants
QCHP	$6,624	$6,399	117,154	118,856
HMO	$5,467	$5,341	193,038	186,669
OAP	$6,699	$6,534	45,236	44,085
			355,428	351,566
OAP is the Health Link Open Access Plan. ACPP does not include dental, vision, admin/int/other, or life insurance.				

When comparing average cost per participant (ACPP) in Table 5, the average cost for FY 2012 is lowest for members in a HMO plan and highest for those in the PPO. **The FY 2012 ACPP in the QCHP is approximately 21.2% higher than managed care. The average cost per enrollee in the QCHP is estimated to be $6,624 in FY 2012.**

MEMBER CONTRIBUTIONS

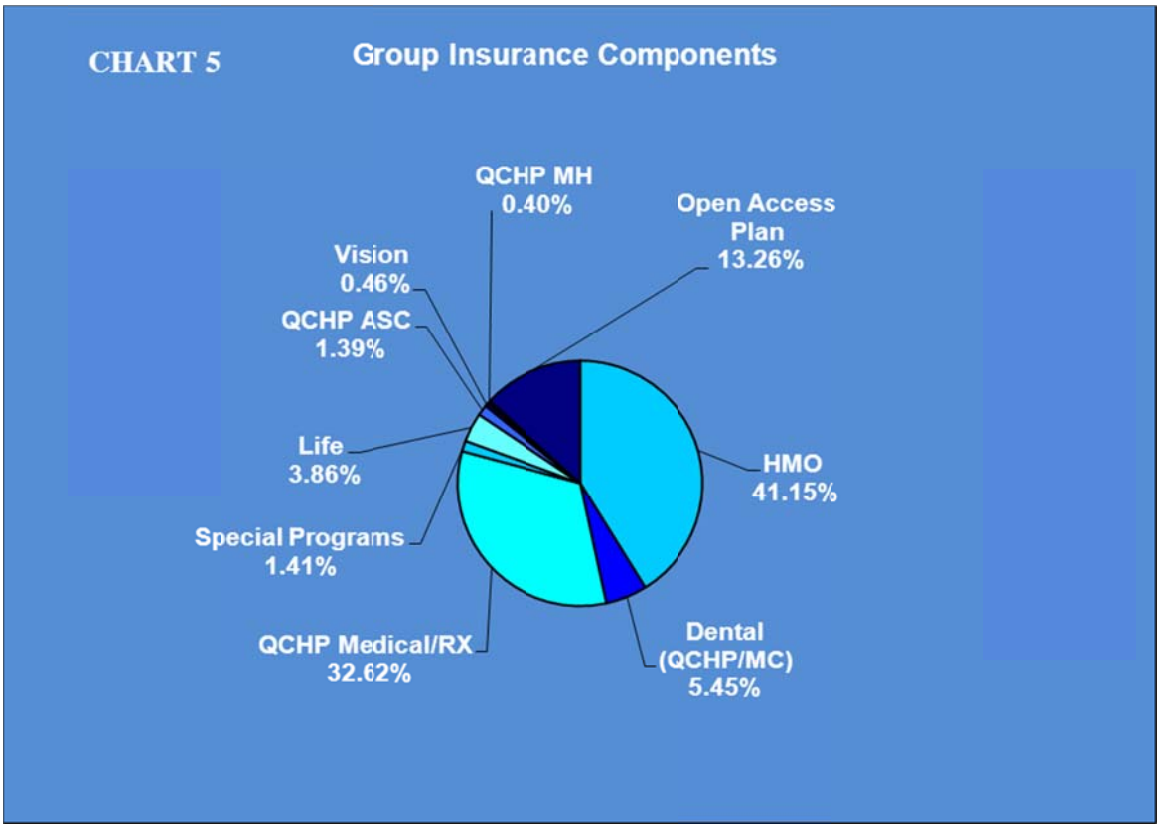
An important factor in the examination of cost per participant is the amount paid by the State versus the member. The ACPP per enrollee in the QCHP is $6,399 in FY 2011. Total member contributions for QCHP enrollees totaled $95.4 million. This means that of the total cost per participant ($6,399), $803 of that cost is covered by member contributions. Table 6 below examines the relationship between overall cost, and the offset by member contributions.

TABLE 6: MEMBER CONTRIBUTIONS AND ACPP				
	FY 2011 Average cost per participant	FY 2011 Member Contributions	Member contribution per year	State cost minus member contributions
QCHP	$6,399	$95,385,958	$803	$5,596
HMO + OAP	$5,567	$150,954,474	$654	$4,913
Dental	$372	$32,371,815	$94	$278
Source: HFS				

The table above shows that QCHP members contribute approximately 12.5% of the overall annual cost of providing their insurance. HMO members contribute 11.7% of the overall liability cost. Members that participate in the State's dental offering pay 25.3% percent of the overall liability cost.

Retirees and their survivors (with less than 20 years of creditable service) are required to pay a portion of their health care costs (P.A. 90-0065). The remainder is paid by the State. The following chart includes the various components of the FY 2012 HFS liability estimate of $2,388.7 million. The largest component of the State Group Insurance Program is the State's managed care plans (HMO and OAP) which represent

(57.7%) of FY 2012 liability, while dental care, life insurance, vision care, and other charges comprise (9.2%) of total liability. The QCHP component (33.1%) includes medical/prescriptions, mental health coverage, and administrative service charges.



CHANGES IN PLAN MEMBERSHIP FROM FY 2010 TO FY 2011

As of 08/13/2011, the State Employees' Group Health Insurance Program saw 0.89% of its members (employees and retirees) changing their health carriers for the FY 2011 enrollment period. The QCHP experienced a -1.36% decrease in membership, with 1,244 members migrating from the QCHP to a managed care plan. Despite the overall decrease in QCHP enrollment, 541 managed care participants moved to the QCHP. In addition, 1,508 members went from one managed care plan to another.

The largest age group switching to a managed care plan from the QCHP in FY 2011 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 QCHP, 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 require participants to choose a doctor from the HMO network to become their primary care physician. All routine medical care, hospitalization and referrals for specialized medical care must then be coordinated under the direction of the primary care physician who acts as a gatekeeper for medical services. Managed care plans have restricted service areas. Generally, HMOs cover preventive health care, such as regular checkups and immunizations, while QCHP plans typically do not. However, the State's QCHP plan provides several preventive health services, such as well-baby care, routine physicals, mammograms, school health physical exams, and annual pap smears. All these additions to the QCHP are in accordance with the current collective bargaining agreement with the American Federation of State, County and Municipal Employees (AFSCME).

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 2011 and FY 2012 plan enrollment is listed in Table 7 below.

TABLE 7: MANAGED CARE PLANS
FY 2011-2012 Actual Membership

HMO/OAP	FY11# of Participants	FY12 # of Participants	% Change
Health Alliance HMO	80,782	83,055	2.81%
Health Alliance Illinois	8,239	8,416	2.15%
HMO Illinois	60,928	61,893	1.58%
Humana of Illinois	10,116	10,350	2.31%
Personal Care	26,989	27,711	2.68%
Humana Winnebago	1,571	1,613	2.67%
Health Link OAP	44,085	45,236	2.61%
TOTALS	**232,710**	**238,274**	**2.39%**

Source: HFS. Estimated for FY 2011 and FY 2012

NOTE: These numbers could change significantly due to the HMO contracts being rebid for FY 2012.

MONTHLY PREMIUMS

Compared to managed care plans, the State of Illinois' QCHP is significantly more expensive than a traditional HMO. Historically, members in managed care plans cost the State less since the risk of providing health care is assumed by the HMO, and HMO plans typically have younger, healthier participants.

According to the Department, the estimated monthly cost for a current employee in the QCHP for FY 2011 is $719.04 and will increase to $742.24 (3.1%) in FY 2011.

The monthly premium for a current employee in a managed care plan varies based on each plan's rates, but the FY 2012 estimated average cost for a member in a managed care plan will be $569.67 per month.

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.

FY 2012 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 or 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 8, on the following page, shows the FY 2012 weighted average monthly rates for managed care plans and the QCHP plans, as well as the State and member contributions. The State's contribution varies, depending on a member's salary.

TABLE 8: MONTHLY PREMIUMS Managed Care vs. Indemnity Plan Weighted Average FY 2012 Rates (Projected)						
	QCHP			Managed Care		
Membership	TOTAL	Member	State	TOTAL	Member	State
Employee	$ 742.24	$ 89.80	$ 652.44	$ 613.91	$ 60.03	$ 553.88
Medicare Retiree	$ 337.06	$ 13.04	$ 324.02	$ 339.87	$ 18.92	$ 320.95
Non-Medicare Retiree	$ 938.79	$ 16.29	$ 922.50	$ 894.51	$ 13.85	$ 880.67
1 Dependent	$ 819.78	$ 197.72	$ 622.06	$ 510.12	$ 95.07	$ 415.05
2+Dependents	$ 1,008.39	$ 231.83	$ 776.56	$ 877.07	$ 135.59	$ 741.48
Medicare Dependent	$ 337.41	$ 142.03	$ 195.38	$ 344.79	$ 89.67	$ 255.12

TABLE 9: PROJECTED COSTS FY 2005 - FY 2012 Employee Only								
	QCHP				Managed Care			
	TOTAL	% Increase	Member	State	TOTAL	% Increase	Member	State
FY 2005	$ 538.70		$ 48.59	$ 490.11	$ 362.40		$ 36.85	$ 325.54
FY 2006	$ 578.55	7.40%	$ 60.10	$ 518.45	$ 394.98	8.99%	$ 37.29	$ 357.69
FY 2007	$ 598.90	3.52%	$ 68.93	$ 529.97	$ 421.01	6.59%	$ 41.60	$ 379.41
FY 2008	$ 612.81	2.32%	$ 75.41	$ 537.40	$ 457.70	8.72%	$ 45.71	$ 411.99
FY 2009	$ 669.94	9.32%	$ 79.16	$ 590.78	$ 497.91	8.78%	$ 49.45	$ 448.45
FY 2010	$ 695.05	3.75%	$ 89.41	$ 605.64	$ 550.82	10.63%	$ 59.61	$ 491.20
FY 2011	$ 719.04	3.45%	$ 89.59	$ 629.45	$ 605.99	10.02%	$ 59.85	$ 546.14
FY 2012	$ 742.24	3.23%	$ 89.80	$ 652.44	$ 613.91	1.31%	$ 60.03	$ 553.88

TABLE 10: EMPLOYEE MONTHLY PREMIUM COMPARISON				
State	State Share	Employee Share	Total	Employee %
IL	**$412.13**	**$45.71**	**$457.84**	**11.09%**
CA	$382.00	$90.00	$472.00	23.56%
IN	$349.68	$66.06	$415.74	18.89%
IA	$398.49	$0.00	$398.49	0.00%
MO	$445.00	$31.00	$476.00	6.97%
NY	$343.41	$38.12	$381.53	11.10%
OH	$277.46	$49.38	$326.84	17.80%
TX	$360.54	$0.00	$360.54	0.00%
WI	$477.50	$31.00	$508.50	6.49%
Source: NCSL (Employee Only CY 2009)				

Illinois compares fairly well with other states when it comes to health insurance costs. In this multi-state comparison done by NCSL, Illinois has the 3rd highest cost for individual employee health coverage, behind Wisconsin and Missouri. Four state's, (CA, IN, OH, NY) require State employees to pay a higher portion of the overall premium. Texas and Iowa do not require employees to pay any portion for individual coverage.

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 DHS 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) 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 Economic and Fiscal Commission are listed below:

- By April 1st of each year, the Director (CMS/DHS) 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/DHS) must provide updated, and any new information to the Commission until the employee benefits program for the fiscal year has been determined.
- Requires CMS/DHS 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/DHS 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
QCHP Medical	Care related to the treatment of an illness or injury. Preventive care includes well-baby care, routine and school physicals, annual pap smears and mammograms.	Choice of physician and other medical care providers. Annual deductibles and employee contributions based on member salary. Dependent premiums do not vary.	No limitation; preferred hospital providers statewide.
QCHP Dental	Preventive, diagnostic, restorative, orthodontic, endodontic, and periodontic services as well as extractions and prosthetics.	Choice of dental care providers, reimbursement on a scheduled basis. No deductibles. Premiums for members and dependents.	No limitations.
HMO Medical	Comprehensive medical benefits including preventive care.	Prepaid benefits, primary care physician who coordinates all care chosen from HMO network. Co-payments vary by HMO plan. Employee premiums, based on salary, vary for dependents by plan.	Statewide coverage
OAP	Comprehensive medical benefits including preventive care.	Three tiers of benefit levels. Patients may see specialists without referral from the primary care physician. Co-payment levels vary.	Southern Illinois, St. Louis Metro-East area.

APPENDIX III

Contracts to be bid or renewed for FY 12 at DCMS	
Service	**Vendor**
Managed Care Health Plans **(HMO Contracts must be bid in FY 2011 for the FY 2012 plan year)**	Health Alliance HMO Health Alliance Illinois OSF Winnebago OSF Health Plans Personal Care Healthlink OAP HMO Illinois
Prescription Benefit Manager (PBM) for self-funded plans **(Renewed)**	Medco
Vision **(Renewed)**	EyeMed
Behavioral Health/EAP**(Renewed)**	Magellan
Dental **(Renewed)**	Delta Dental
Hospital Bill Audit**(Expiring)**	SHPS
Subrogation**(Renewed)**	ACS
Peer Review**(Renewed)**	CIMRO
Flu Shots**(Renewed)**	Varies each plan year
Consulting Contracts **(Renewed)**	Willis of Illinois Blalock Consulting Mercer Consulting Fairbanks
Life Insurance **(Bid)**	Minnesota Life
Long Term Care **(Expiring)**	Metropolitan Life
Flexible Spending **(Renewed)**	FBMC
Commuter Savings Program **(Renewed)**	FBMC
Claims Processing/Payments **(Renewed)**	CIGNA

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/cgfa2006/home.aspx