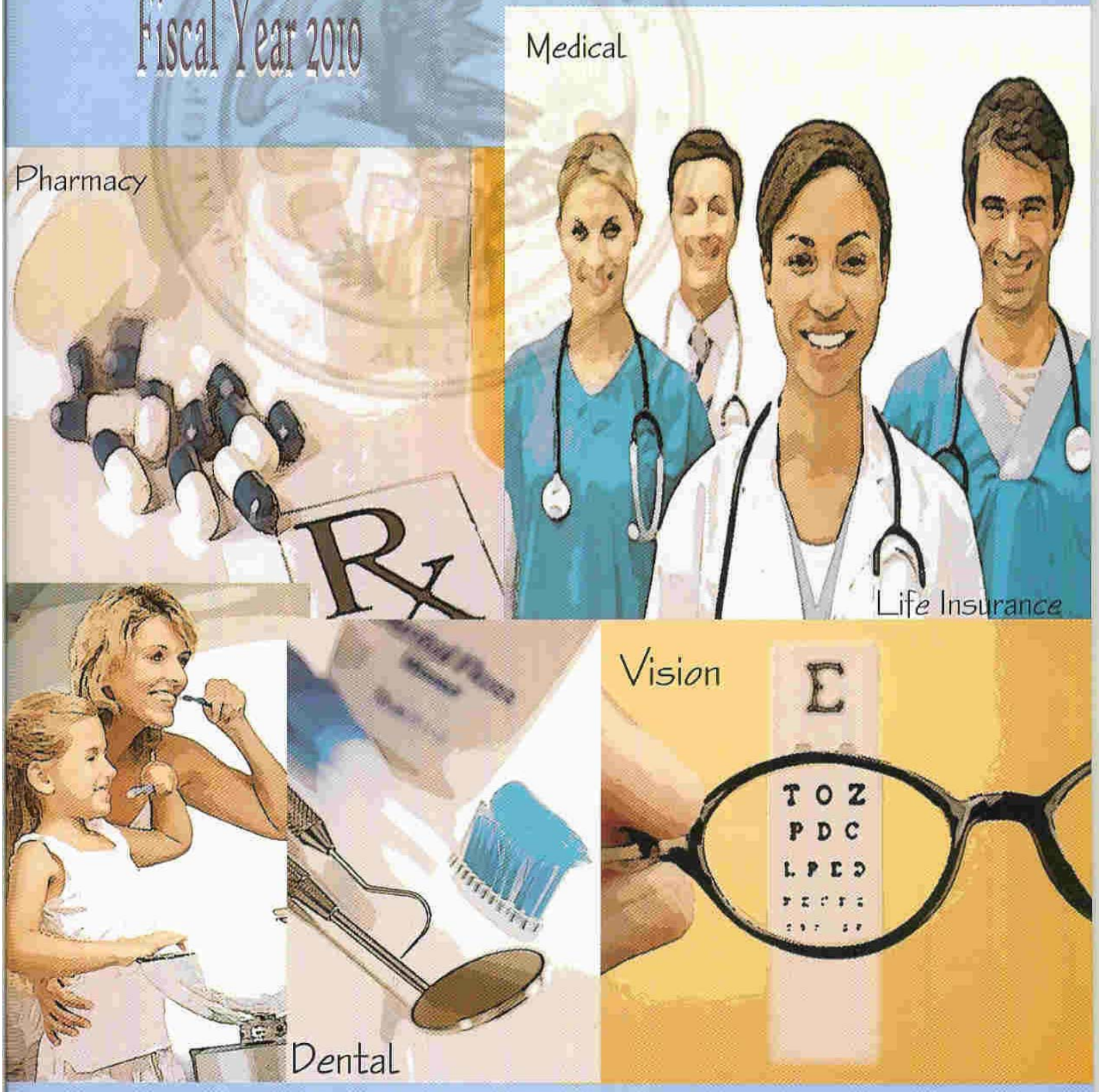
Commission on Government Forecasting & Accountability

Liabilities of the State Employees' Group Health Insurance Program

Fiscal Year 2010



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Commission on Government Forecasting and Accountability

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FY 2010 Liabilities of the State Employee's Group Insurance Program

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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 the Director of HFS related to the Group Insurance Program.

The Governor has requested that a total of $2,163.3 million be appropriated for the State Employees' Group Health and Life Insurance program for FY 2010. The requested FY 2009 appropriation for the Group Health Insurance Program was $1,991.6 million. The following table represents historical appropriation and liability amounts, per HFS. The CGFA FY 2010 estimate of liability is $2,124.0 million, $29 million more than HFS.

Currently, the payment cycles for preferred providers is 137 days, while non-preferred providers have a payment cycle of 158 days. The estimated ending claims hold cycle for FY 2009 for preferred and non providers is 102 days. In FY 2010, the claims hold cycle for both preferred and non-preferred providers is expected to be 91 days. On a cash basis, HFS projects processed claims on hand of approximately $178.6 million and $163.6 million for FY 2009 and FY 2010, respectively.

The FY 2010 estimated liability for the Quality Care Health Plan (QCHP) is expected to increase $25.1 million, or 4.8% over the FY 2009 liability. The estimated liabilities for the State's managed care plans are expected to increase $68.6 million, or 8.2% over the FY 2009 cost. In comparison, the FY 2009 liability for the QCHP increased 4.2% over the FY 2008 cost. FY 2009 liability for the managed care plans increased 7.5% over FY 2008. The Department also projects prescription drug liability to decrease -1.7% from $200.2 million to $196.7 million.

APPROPRIATION AND LIABILITY HISTORY
FY 2005-2010
($ in Millions)

Fiscal Year	Appropriation	HFS Liability	CGFA Liability
FY 2005	$1,718.9	$1,618.5	
FY 2006	$1,779.8	$1,689.9	
FY 2007	$1,884.9	$1,779.3	
FY 2008	$1,983.0	$1,862.9	
FY 2009	$1,991.6	$1,989.3	
FY 2010	$2,163.3	$2,095.0	$2,124.0
Estimated			

FY 2010 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2010 cost projection utilizes the HFS revised estimate for FY 2009 medical claims as the basis for estimating claims for FY 2010. CGFA also used health trend survey data from The Segal Company. This revision is based on actual claims to date.

The CGFA cost estimate for FY 2010 uses the following assumptions based on historical claims data and anticipated cost increases:

TREND FACTORS	
Medical (indemnity plan/QCHP)	6.43%
Dental (QCHP and MC)	1.54%
HMO (medical and Rx)	9.06%
Prescription drugs (QCHP)	3.85%
Administrative service charges (QCHP)	1.29%
Life insurance	5.40%
Special programs (QCHP)	-18.10%

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 anti-selection or the impact of employees shifting to HMOs and PPOs, which retains sicker, more costly employees in the QCHP; technological advances; social shifts including the aging population and greater acceptance of psychiatric and substance abuse care; and, increased utilization of equipment and services.

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 2009 survey shows that Illinois is actually trending better than national assumptions. The following are some of the key findings of the Segal study.

- Prescription drug trends have declined dramatically, by nearly nine percentage points, since their high of 19.5% in CY 2003. For CY 2009 the prescription drug trend is estimated to be 9.6%
- Similar 2009 trends are forecasted for all managed care plan types, ranging from 10.0 to 10.4 percent.
- Although brand drug utilization is rapidly shifting to generic drugs due to patent expiration and PBM efforts, brand drug inflation continues to be a major driver due to ongoing focus on development and marketing of biotechnology or specialty drugs.

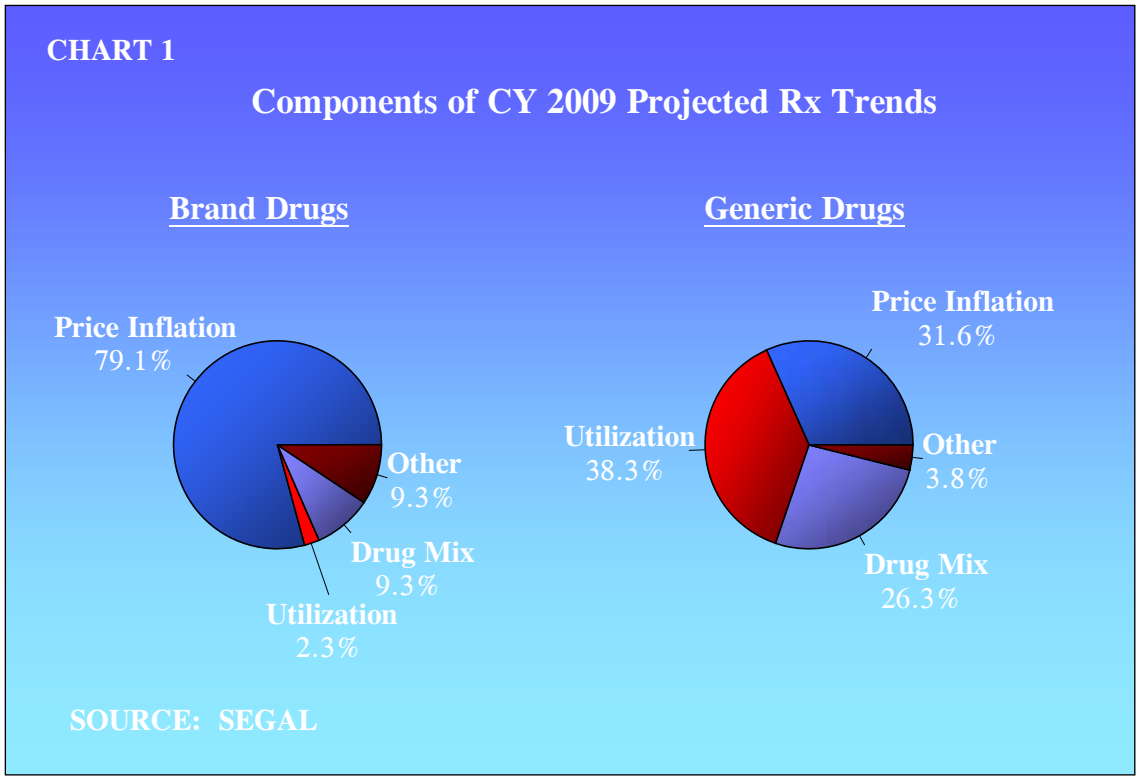
Table 1 below highlights national trending data and compares it to estimates by HFS and CGFA.

TABLE 1			
NATIONAL HEALTH CARE TRENDING CY 2009			
Component	**National Trend**	**HFS Trend**	**COGFA Trend**
PPO's	10.3%	4.76%	6.43%
HMO's	10.0%	8.23%	9.06%
Rx	9.6%	-1.75%	3.85%
Dental	4.6%	1.48%	1.54%
Vision	3.6%	0.0%	0.0%
SOURCE: Segal 2009 Health Plan Cost Trend Survey			

Although there is usually a strong correlation between trend rates and actual costs, 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.

Historically, Illinois liability estimates are driven by three major components of the group insurance program. The State's QCHP, Managed Care, and prescription drug coverage account for a large portion, (89.9%) of the states overall health plan liability. In their study, Segal, focused on PPO and HMO networks, as well as, prescription drug trends.

The State has negotiated higher employee co-pays and instituted a mail order prescription drug program for participants in the Quality Care Program. Prescription drug trending for persons under 65 years of age are estimated by Segal to be increasing in 2009 by approximately 9.8% at the retail level and 9.4% at the mail order level. Inflation, not surprisingly, is a key component of the upward prescription drug trend. Generic drug components are increasing mostly because of increased utilization. Many plan sponsors require employees to use a generic drug if one is available. The State of Illinois encourages employees to utilize prescription drugs through mail order and by the State's tiered co-pay structure. Chart 1, on the following page, shows the main components of the prescription drug trend as reported by Segal.



Based on these assumptions and inflation factors, the CGFA estimates a FY 2010 liability of approximately $2,124.0 million for the State Employee's Group Health Insurance Program. The following table shows a detailed comparison of the CGFA estimate for the various cost components and the HFS projection for FY 2010.

TABLE 2: FY 2010 GROUP HEALTH INSURANCE LIABILITY
($ in Million)

Liability Component	FY 2009 HFS Estimate	FY 2010 HFS Estimate	FY 2010 CGFA Estimate
QCHP Medical	$527.1	$552.2	$561.0
QCHP Prescriptions	$200.2	$196.7	$207.9
Dental (QCHP/MC)	$108.3	$109.9	$110.0
HMO	$833.1	$901.7	$908.6
Open Access Plan	$169.1	$182.4	$184.5
POS	$0.0	$0.0	$0.0
Mental Health	$8.3	$8.4	$8.3
Vision	$8.3	$8.2	$8.3
Administrative Services (QCHP)	$30.9	$31.3	$31.3
Life	$81.8	$86.1	$86.1
Special Programs (Admin/Int/Other)	$22.1	$18.1	$18.1
TOTAL	**$1,989.2**	**$2,095.0**	**$2,124.0**
% Increase over FY 2009 HFS Estimate		5.3%	6.8%

Rounding may cause slight differences

ESTIMATE COMPARISON

Overall, the Commission's FY 2010 estimate is $29 million higher than the FY 2010 estimate from HFS. CGFA's FY 2010 HMO liability estimate is $6.9 million higher than HFS, CGFA's QCHP medical estimate is $8.8 million more than HFS, and CGFA's dental estimate is $100 thousand higher than HFS. CGFA's FY 2010 estimate for prescriptions is $11.2 million higher than the HFS estimate.

The CGFA estimates approximately $2,124.0 million would be required to fully fund the FY 2010 liabilities of the Group Health Insurance Program. This estimate is $134.8 million or 6.8% more than the FY 2009 estimated liability of $1,989.2 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. More specifically, GIPF receives contributions by members for optional life insurance or health benefit coverage, or from any other source from which the State is reasonably and properly entitled to as a result of the group health benefits program.

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.

The FY 2010 budget request for the Group Health Insurance Program is $1,084.7 million in GRF funds. This represents a $2.0 million or a 0.2% increase from the FY 2009 GRF appropriation of $1,082.7 million. The estimated FY 2010 Road Fund request of $150.2 million is $7.2 million or 5.0% higher than the FY 2009 appropriation level.

TABLE 3: GROUP INSURANCE FUNDING SOURCES
FY 2009 – FY 2010
($ in Millions)

	FY 2009	FY 2010	$ Increase	% Increase
DHFS GRF Appropriation	$1,082.7	$1,084.7	$2.0	0.2%
Road	$143.0	$150.2	$7.2	5.0%
TOTAL Appropriations	**$1,225.7**	**$1,234.9**	**$9.2**	**.01%**
Other Sources	$658.1	$868.1	$210.0	31.9%
Source: HFS				

The Governor, in the FY 2010 Budget Book, proposes that QCHP premiums for members and retirees be increased. The 31.9% increase in "other sources" reflects the anticipated $200 million in increased member and retiree contributions the department anticipates should this proposal become law. However, any change in employee benefits would likely require negotiations with of AFSCME and other collective bargaining units. Requiring retirees to contribute towards their healthcare would require the State Employee Group Insurance Act of 1971 to be amended, (5 ILCS 375/10) (from Ch. 127, par. 530).

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.

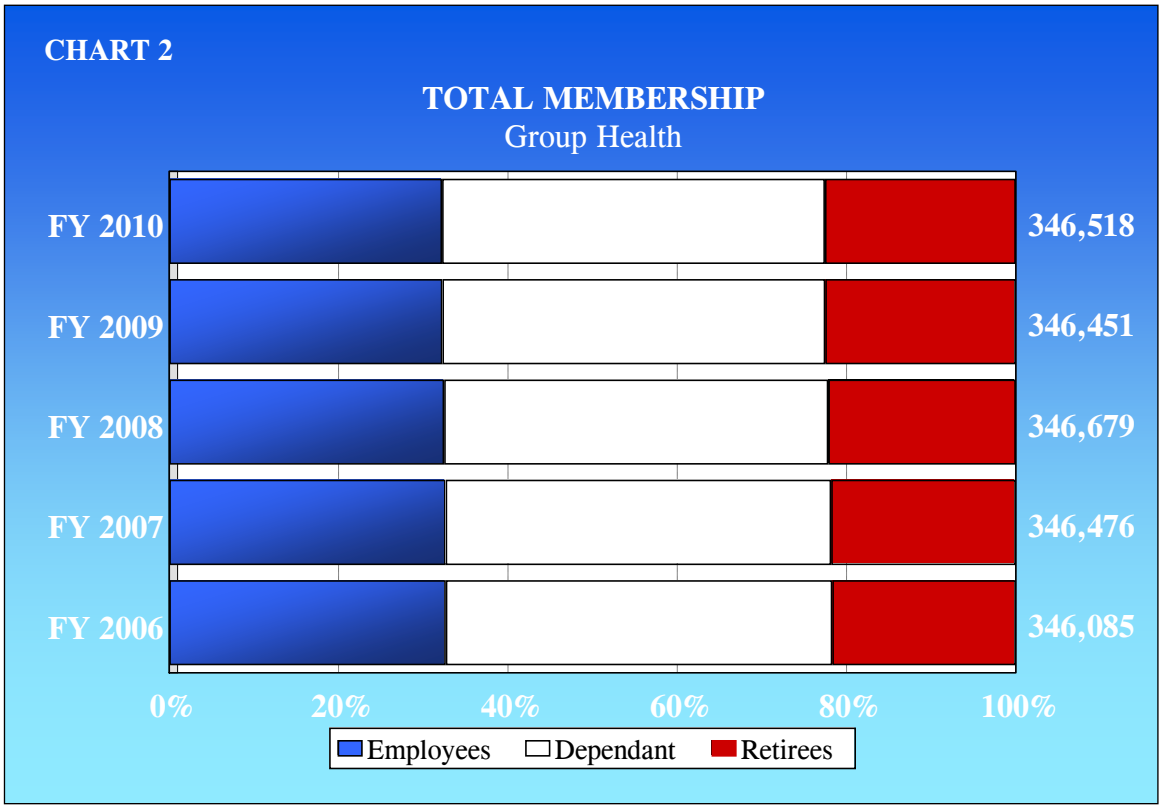
BENEFITS

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 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 their 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 an estimated 346,451 participants for FY 2009, of which 222,771 are in managed care, and 123,680 are in the Quality Care Health Plan. Membership in the Group Health Insurance Plan is projected to increase slightly in FY 2010, as evidenced in Chart 2 on the following page.

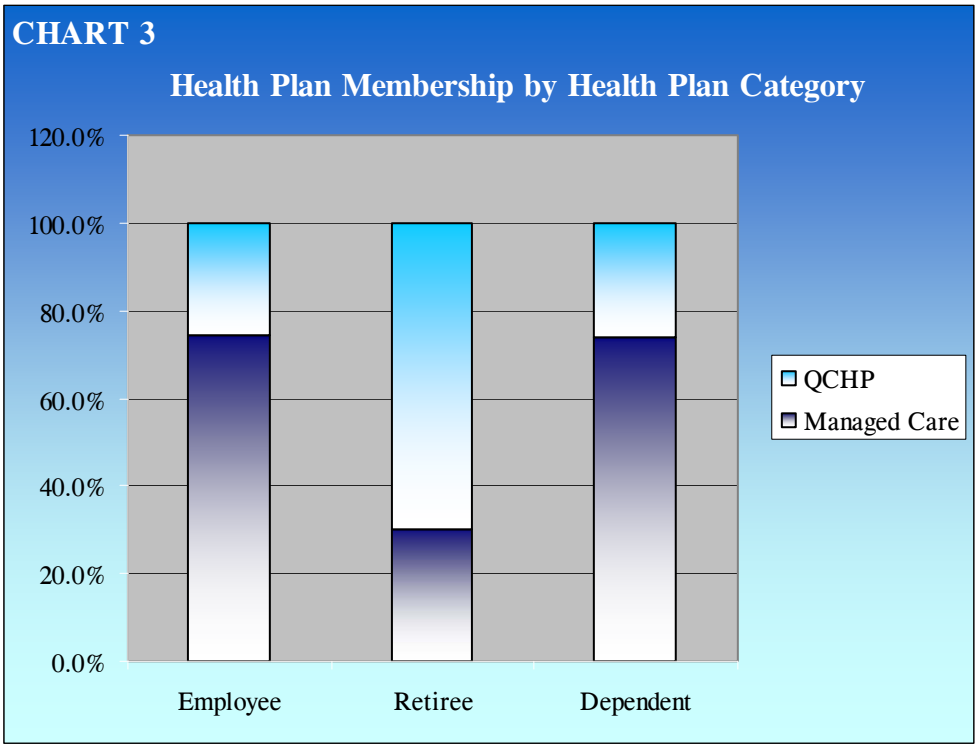


Membership is estimated for FY 2009 and FY 2010.

ENTROLLMENT TRENDS

Overall membership in the State Employees' Group Insurance Program has remained fairly stable ever since FY 2006. Membership in the group insurance program is expected to increase in FY 2010, adding only 67 members. Membership in the Quality Care Plan has been decreasing since FY 2005; HFS estimates that QCHP membership will decline -1.9% from 123,680 in FY 2009 to an estimated 121,297 in FY 2010. Membership in the States' managed care offerings has been increasing since FY 2004. Since FY 2004, membership in the States' HMO plans has increased 3.2%. The State also offers an Open Access Plan. Membership in the OAP is expected to increase in FY 2009 by 1.9%. Since its inception in FY 2002, membership in this plan has increased 154%.

Chart 3 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 2009, 69.7% of retirees were enrolled in the QCHP. Chart 3 shows that while retirees overwhelmingly choose the QCHP, dependents and employees prefer the managed care options.



LIABILITY

The Department's estimate of liability for FY 2010 represents a 5.3% growth rate over FY 2009. This increase in estimated liability is slightly lower than the increase from FY 2008 to FY 2009, when liability increased 6.8%. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2001 through FY 2010.

TABLE 4: STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY
FY 2001 - FY 2010
$ in (millions)

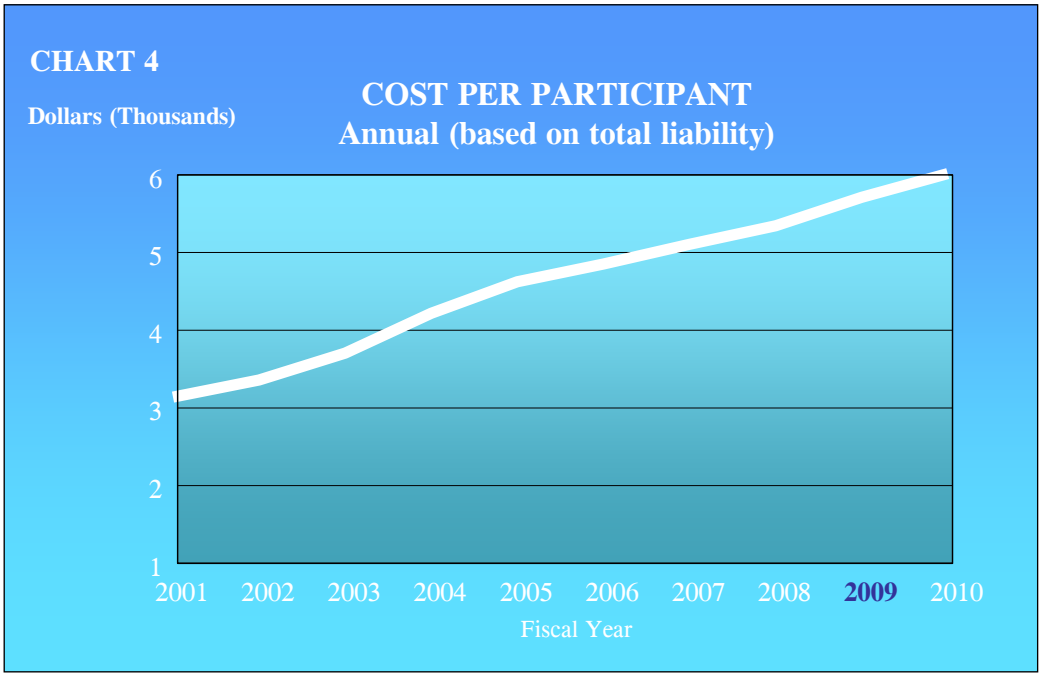
Liability Component	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
QCHP Medical/Rx	$536.9	$561.9	$584.0	$663.5	$697.8	$690.8	$695.7	$697.5	$727.3	$748.9
HMO Medical	$364.1	$402.1	$469.3	$539.9	$597.5	$655.0	$706.1	$775.0	$833.1	$901.7
Dental	$58.7	$58.7	$63.7	$69.9	$88.9	$84.9	$95.6	$99.6	$108.3	$109.9
POS	$7.8	$7.6	$8.6	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Open Access Plan	$0.0	$36.8	$54.9	$62.9	$81.6	$102.8	$127.0	$148.9	$169.1	$182.4
QC Mental Health	$11.0	$9.3	$9.2	$9.5	$9.2	$8.9	$8.8	$8.6	$8.3	$8.4
Vision	$10.4	$10.9	$11.2	$11.5	$11.7	$8.2	$8.3	$8.3	$8.3	$8.2
Life Insurance	$70.1	$61.7	$63.6	$66.8	$69.3	$76.1	$76.3	$79.0	$81.8	$86.1
QC ASC	$16.0	$19.6	$24.4	$23.2	$24.0	$29.4	$28.0	$29.8	$30.9	$31.3
Admin/Int/Other	$11.4	$11.8	$14.3	$31.8	$38.5	$33.8	$33.6	$16.3	$22.1	$18.1
Total	**$1,086.4**	**$1,180.4**	**$1,303.2**	**$1,479.0**	**$1,618.5**	**$1,689.9**	**$1,779.4**	**$1,863.0**	**$1,989.2**	**$2,095.0**
% change over PY		8.65%	10.40%	13.49%	9.43%	4.41%	5.30%	4.70%	6.77%	5.32%

Rounding causes slight differences in totals

The table above 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 Life Insurance Program also are large components of the total insurance obligation. FY 2007 was the first year in which liabilities for HMO's was higher than the liability for the more costly QCHP. This is due in large part because of the migration of members into less costly managed care plans. Typically, older members in the state plan choose the QCHP in order to maintain physician choice, and enjoy the ease of seeing specialists without referral.

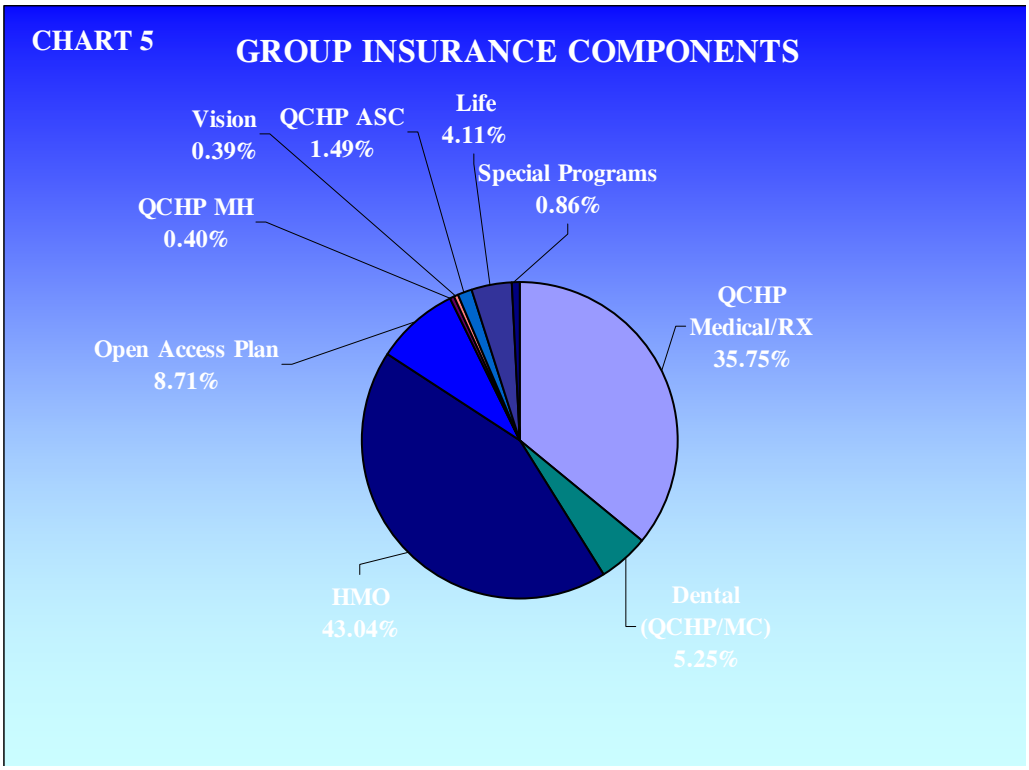
ANNUAL COST PER PARTICIPANT

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 2002, the annual cost per participant in the group health insurance program was $3,390. **The estimated cost per participant for FY 2010 is $6,046, a 78.3% increase from the FY 2002 cost per participant**. The cost per participant increased 6.8% from FY 2008 to FY 2009. The FY 2010 cost per participant is estimated to increase 5.3% over FY 2009.



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 chart on the following page includes the various components of the FY 2010 HFS liability estimate of $2,095 million. The largest component of the State Group Insurance Program is the State's managed care plans (HMO and OAP) which represent (51.7%) of FY 2010 liability, while dental care, life insurance, vision care, and other charges comprise (10.6%) of total liability. The QCHP component (37.6%) includes medical/prescriptions, mental health coverage, and administrative service charges.



CHANGES IN PLAN MEMBERSHIP FROM FY 2008 to FY 2009

As of 08/01/2008, the State Employees' Group Health Insurance Program saw 1.5 % of its members (employees and retirees) changing their health carriers for the FY 2009 enrollment period. The QCHP experienced a 0.4% increase in membership, with 799 members migrating from managed care to the Quality Care Health Plan. Despite this overall increase in QCHP enrollment, 920 members moved from the QCHP to a managed care plan in FY 2009. In addition, 1,040 members went from one managed care plan to another.

Total enrollment (employees, retirees, and dependents) in the Quality Care Health Plan decreased 2.1% from 126,303 to 123,680. HMO plan membership increased from 184,132 to 184,463. Open Access Plan (managed care) membership increased 9.6% from 36,244 to 38,308.

The enrollment in the indemnity, HMO, OAP, and POS plans for FY 2008 and FY 2009 are shown in Table 5 on the following page. **FY 2010 enrollment has been estimated by HFS, but is not included in Table 5 because the enrollment period has not occurred yet.**

TABLE 5: Average Annual Cost per Participant Average Enrollment				
	FY 2010	**FY 2009**	**FY 2010**	**FY 2009**
	Average Cost Per Participant	**Average Cost Per Participant**	**Total Participants**	**Total Participants**
QCHP	**$6,409**	**$6,108**	**121,297**	**123,680**
HMO	**$4,844**	**$4,517**	**186,170**	**184,463**
OAP	**$4,670**	**$4,415**	**39,051**	**38,308**
			346,518	**346,451**
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 (AACCP) in Table 5, the average projected cost for FY 2010 is lowest for members in the OAP and highest for those in the QCHP. **The FY 2010 AACCP in the QCHP will be approximately 32.3% higher than managed care, and 37.2% higher than the ACPP in the OAP.**

The largest age group switching to a managed care plan from an indemnity plan in FY 2009 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 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 2008 and FY 2009 plan enrollment, as well as the areas served by each plan, is listed in Table 6 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. The State has realized some cost savings from implementing managed care plans, and more members continue to migrate to HMO coverage. The long-term effect on costs as a result of implementing managed care, however, remains to be seen.

TABLE 6 MANAGED CARE PLANS FY 2008-2009 Actual Membership			
HMO/OAP	FY08 # of Participants	FY09 # of Participants	% Change
Health Alliance HMO	77,608	77,851	0.31%
Health Alliance Illinois	7,851	7,908	0.73%
HMO Illinois	49,649	49,887	0.48%
OSF Health Plans	11,773	10,168	-13.63%
Personal Care	25,097	25,304	0.82%
Unicare HMO	11,836	12,616	6.59%
OSF Winnebago	1,729	1,683	-2.66%
Health Link OAP	36,561	37,645	2.96%
TOTALS	**222,104**	**223,062**	**0.43%**
SOURCE: HFS			

MONTHLY PREMIUMS

Historically, members in managed care plans cost the State less since the risk of providing health care is assumed by the HMO, in most cases. The QCHP continues to be the significantly more expensive plan.

According to the Department, the estimated monthly cost for a current employee in the QCHP for FY 2009 is $661.10 and will increase to $697.09 (5.4%) in FY 2010.

The monthly premium for a current employee in a managed care plan varies based on each plan's rates, but the FY 2010 estimated average cost for a member in a managed care plan will be $448.20 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 2010 Managed Care Multipliers

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

Under current law, the term of any contract (group life insurance, health benefits, other employee benefits, and administrative services) authorized under the State Employees' Group Insurance Act (SEGIA) may not extend beyond 5 fiscal years. Upon recommendation of CGFA, the Director of CMS may exercise renewal options of the same contract for up to a period of 5 years. The State enters into contracts with the HMOs and pays them a dollar amount per individual enrolled in that particular HMO. The HMO then assumes the financial risk of providing services to its participants.

Table 7, shows the FY 2010 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. Employees, under the Governor's FY 2010 budget proposal, would pay increased premiums if they participate in the QCHP. Currently, an employee in the QCHP pays an average of $89.57/month. If the Governor's proposals are implemented, as shown in Table 8, employee monthly premiums will rise to $309.56 a month or 245.5% and a non-Medicare retire would see their premiums increase from $12.98 a month on average to $582.71 a month on average or 4,389%.

TABLE 7: MONTHLY PREMIUMS
Managed Care vs. Indemnity Plan
Weighted Average
FY 2010 Rates (Projected)

	QCHP			Managed Care		
Membership	TOTAL	Member	State	TOTAL	Member	State
Employee	$697.09	$309.56	$387.53	$448.20	$59.86	$388.33
Medicare Retiree	$350.99	$5.04	$345.96	$293.86	$10.79	$283.06
Non-Medicare Retiree	$928.66	$582.71	$345.96	$688.01	$432.47	$255.54
1 Dependent	$709.65	$294.35	$415.30	$396.29	$94.69	$301.60
2+ Dependents	$949.79	$336.66	$613.13	$680.92	$135.09	$545.83
Medicare Dependent	$386.69	$142.01	$244.69	$311.21	$89.07	$222.14

TABLE 8: PROJECTED MONTHLY COSTS
FY 2004 – FY 2010
Employee Only

	QCHP				Managed Care			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY 2004	$490.16		$48.25	$441.91	$327.40		$36.59	$290.81
FY 2005	$553.47	12.91%	$48.59	$504.87	$357.93	9.32%	$36.89	$321.04
FY 2006	$590.25	6.65%	$60.10	$530.16	$384.49	7.42%	$37.33	$347.16
FY 2007	$595.74	0.93%	$68.93	$526.81	$388.25	0.98%	$41.65	$346.60
FY 2008	$613.20	2.93%	$75.41	$537.79	$414.83	6.85%	$45.76	$369.07
FY 2009	$661.10	7.81%	$79.15	$581.95	$448.20	8.04%	$49.50	$398.70
FY 2010	$697.09	5.44%	$309.56	$387.53	$477.15	6.46%	$59.86	$417.29

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
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.	Southern Illinois, St. Louis Metro-East area.

APPENDIX III

Group Insurance Contracts to be Bid or Renewed for FY 2010		
Contract	**Type of Contract**	**Renewal/Competitively Selected**
CIGNA	Claims administrator for health care benefits (QCHP members)	Will be bid/amended or renewed.
CompBenefits	Dental (QCHP and managed care members)	Will be bid/amended or renewed.
FBMC (CMS)	Flexible spending/commuter savings	Will be bid/amended or renewed.
Magellan Behavioral Health	Mental health/substance abuse services (QCHP members)	Will be bid/amended or renewed.
Minnesota Life Insurance Company (CMS)	Term life insurance	Will be bid/amended or renewed.
Sykes Health Plan Services	Hospital bill auditing	Will be bid/amended or renewed.
Flu Shots	Vendor varies each plan year	Will be bid/amended or renewed.
CIMRO	Peer Review	Will be bid/amended or renewed.
Met Life (CMS)	Long Term Care	Will be bid/amended or renewed.

Managed Care Contracts thru FY 2010		
Health Alliance HMO		Will be bid/amended or renewed.
Health Alliance Illinois		Will be bid/amended or renewed.
Health Link OAP		Will be bid/amended or renewed.
HMO Illinois		Will be bid/amended or renewed.
OSF Health Plan		Will be bid/amended or renewed.
OSF Winnebago		Will be bid/amended or renewed.
Personal Care		Will be bid/amended or renewed.
Unicare HMO		Will be bid/amended or renewed.

Ongoing Contracts for FY 2010		
Contract	**Type of Contract**	**Status**
Medco Health Solutions	Prescription Benefit Manager	Ongoing
EyeMed	Vision	Ongoing
ACS Recovery Services	Subrogation	Ongoing

General Consulting Contracting is done by Fairbanks and Mercer. Actuarial consulting is done by Willis of Illinois. LGHP rate setting is done by Blalock Consulting.

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