FY 2014
Liabilities of the State Employees' Group Health Insurance Program

Commission on Government Forecasting & Accountability

May 2013

Commission on Government Forecasting and Accountability

COMMISSION CO-CHAIRS

Senator Michael Frerichs
Representative Jil Tracy

SENATE	*HOUSE*
David Koehler	Kelly Burke
Matt Murphy	Elaine Nekritz
Chapin Rose	Raymond Poe
Dave Syverson	Al Riley
Donne Trotter	Michael Tryon

EXECUTIVE DIRECTOR
Dan R. Long

DEPUTY DIRECTOR
Laurie L. Eby

REVENUE MANAGER
Jim Muschinske

AUTHOR OF REPORT
Anthony Bolton

EXECUTIVE SECRETARY
Donna K. Belknap

TABLE OF CONTENTS

FY 2014 State Employees' Group Insurance Report
May, 2013

	PAGE
Executive Summary	1
FY 2014 CGFA Cost Estimate	2
Estimate Comparison	4
Appropriation/Funding Sources	5
Benefits	6
Membership	7
Enrollment Trends	8
Liability	9
Annual Cost Per Participant	9
Member Contributions	11
Employee/Retiree Cost Comparison	13
Managed Care Plans	14
Monthly Premiums	15
Table 1: National Health Care Trending 2013	3
Table 2: FY 2014 Group Health Insurance Liability	4
Table 3: Group Insurance Funding Sources: FY 2013-FY 2014	6
Table 4: State Employees' Group Health Insurance Liability: FY 2005-FY 2014	9
Table 5: Average Annual Cost Per Participant	10
Table 6: Member Contributions and ACPP	11
Table 7: Member/Retiree Costs and Contributions	13
Table 8: Managed Care Plans: FY 2012-2014 Actual Membership	14
Table 9: Monthly Premiums: Managed Care vs. Indemnity Plan	16
Table 10: Projected Costs: FY 2007-FY 2014	17
Table 11: Monthly Premiums Across All Plans	17
Chart 1: FY 2014 SEGIP Funding Sources	5
Chart 2: Total Membership	7
Chart 3: Health Plan Membership by Health Plan Category	8
Chart 4: Cost Per Participant	10
Chart 5: Group Insurance Components	12
APPENDIX I	18
APPENDIX II	19
APPENDIX III	20
APPENDIX IV (Negotiated Benefit Changes)	24

EXECUTIVE SUMMARY

The Commission on Government Forecasting and Accountability (CGFA) has several statutory requirements under the State Employees' Group Insurance Act of 1971 (5 ILCS 375).

- To estimate liabilities of the State Employees' Group Health Insurance Program.
- To meet with the Department of Central Management Services (CMS) to advise the department on all matters relating to policy and administration of the Group Insurance Act.
- To review contracts recommended by the Director of CMS related to the Group Insurance Program.
- To give "advice and consent" when CMS determines it would be in the best interest of the state and employees to administer benefits with the state as a self-insurer.

The Governor has requested that a total of $2.84 billion be appropriated for the State Employees' Group Health and Life Insurance program for FY 2014. The requested FY 2013 appropriation request for the Group Health Insurance Program was $2.66 billion. A subsequent supplemental appropriation request was passed for an additional $500 million in General Revenue. The following table represents historical appropriation and liability amounts, per CMS. CMS estimates the FY 2014 liability to be $2.75 billion. The CGFA FY 2014 estimate of liability is $2.78 billion, $36.10 million more than CMS. The CMS estimate reflects recently concluded negotiations with state employee unions. Additional information regarding health insurance negotiations is contained later in this report. The CGFA FY 14 estimate is reflective of the figures provided by CMS.

The final estimate of total liability from CMS is unavailable at this time due to a variety of factors, including the delay in ratifying a contract with state employee unions. The numbers provided by CMS are accurate as of May 1, 2013. However, final numbers will be included in an online addendum to this report at a later date.

Currently, the payment cycle for preferred providers and non-preferred providers is 336 and 385 days. In FY 2014, the cycle is expected to rise to 357 and 413 days for preferred and non-preferred providers respectively. The current amount of CIGNA claims being held is $474.7 million. CMS has calculated the amount of time it takes to make payments to managed care providers at approximately seven months, growing to nine to ten months in FY 2014. The value of bills on hand is estimated to be $1.38 billion by the end of FY 2013 and $1.75 billion by the end of FY 2014. Dental network claims are expected to be held 90 days, while non-network providers would be held 315 days in FY 2014

Using the figures provided by CMS, the FY 2014 estimated liability for the Quality Care Health Plan (QCHP) is expected to increase 3.7% over the FY 2013 liability.

The estimated liabilities for the State's HMO plans are expected to increase 6.0% over the FY 2013 cost with OAP liabilities increasing 9.3%. In comparison, the FY 2013 liability for the QCHP increased over the FY 2012 cost by 2.2%. FY 2013 liability for the HMO plans increased 5.4% from FY 2012. The Department also projects prescription drug liability to increase 3.5% in FY 2014 from $220.2 million to $227.8 million.

APPROPRIATION AND LIABILITY HISTORY FY 2009-2014 ($ in Millions)			
Fiscal Year	Appropriation	CMS Liability	CGFA Liability
FY 2009	$1,991.6	$2,041.8	
FY 2010	$2,163.3	$2,196.7	
FY 2011	$2,024.4	$2,364.4	
FY 2012	$2,418.4	$2,475.0	
FY 2013	$2,560.1	$2,649.9	
FY 2014	$2,843.0	$2,747.6	$2,783.7
*Estimated for FY 2013 and FY 2014			

FY 2014 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2014 cost projection utilizes the CMS revised estimate for FY 2013 medical claims as the basis for estimating claims for FY 2014.

The CGFA cost estimate for FY 2014 uses the following assumptions based on historical claims data and anticipated cost increases:

Trend Factors	
Medical (QCHP plan)	1.3%
Dental (QCHP and MC)	-1.5%
HMO (Medical and Rx)	7.3%
Prescription drugs (QCHP)	5.0%
Administrative service charges (QCHP)	-4.5%
Life Insurance	4.2%

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 OAPs has resulted in more costly/higher risk employees remaining in the QCHP program. In recent years, some of these employees have been moving over to OAPs. 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.

For FY 2014, recent labor agreements between workers' unions and the State of Illinois may result in significant group insurance savings for the state. These savings come in the form of agreed increases in state employee contributions to health insurance premiums, co-payments and other expenses. This report contains the CMS FY 2014 calculations as of March/April 2013 for revenues for the State Employees Group Insurance Program.

The Segal Company compiles a cost trend survey annually that provides data as to how large health plans are trending during the plan year. The following are some of the key findings of the 2013 Segal study.

- Most medical plan types are projected to experience cost increases under 10 percent for 2013, with managed care costs trending from 8.2 to 9.3 percent compared to 2012, which ranged from 9.6 to 10.4 percent.
- In 2013, prescription drug trends are forecast to be almost 1 percentage point lower from 2012 projected trend rates (7.2 percent in 2012). The forecasted trend of 6.4 percent is a drop of more than 13 percentage points from 10 years ago.
- Vision plan trend rates are projected to increase slightly (2.8 percent), but less than in 2012 (3.8 percent).
- Many survey participants have experienced cost increases due to the Affordable Care Act in non-grandfathered plans and anticipate placing restrictions on various aspects of existing plans to limit costs.

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

TABLE 1

NATIONAL HEALTH CARE TRENDING 2013

Component	National Trend	CMS Increase	CGFA Increase
HMO's	8.2%	6.0%	7.3%
Rx	6.4%	3.5%	5.0%
Dental	4.0%	-4.6%	-1.5%
Vision	2.8%	-6.9%	4.8%

Source: Segal 2013 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 2014 liability of approximately $2.78 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 CMS projection for FY 2014.

TABLE 2: FY 2014 GROUP HEALTH INSURANCE LIABILITY
($ in Millions)

Liability Component	FY 2013 CMS Estimate	FY 2014 CMS Estimate	FY 2014 CGFA Estimate
QCHP Medical	$560.7	$561.7	$567.7
QCHP Prescriptions	$220.2	$227.8	$231.3
Dental (QCHP/MC)	$129.8	$123.8	$127.9
HMO	$898.6	$952.8	$964.2
Open Access Plan	$597.7	$653.2	$659.6
Mental Health	$8.2	$8.0	$8.0
Vision	$11.5	$10.7	$12.0
Administrative Services (QCHP)	$31.3	$28.3	$29.9
Life	$83.3	$86.5	$86.8
Special Programs (Admin/Int./Other)	$65.5	$94.8	$96.2
TOTAL	**$2,606.8**	**$2,747.6**	**$2,783.6**
% increase over prior year		5.4%	6.8%

*Rounding may cause slight differences. FY 2013 and FY 2014 Special Programs line includes Prompt Payment Interest.

ESTIMATE COMPARISON

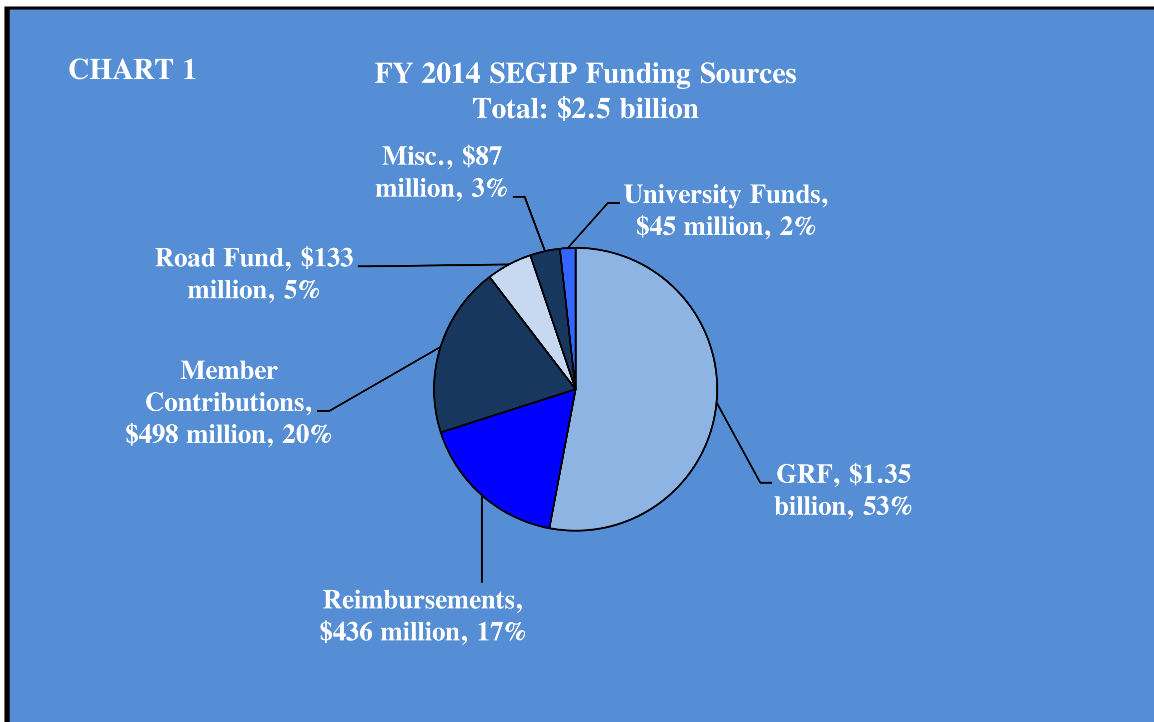
Overall, the Commission's FY 2014 estimate is $36.1 million higher than the FY 2014 estimate from CMS. CGFA's FY 2014 HMO and Open Access Plan liabilities estimates are $11.4 million and $6.4 million higher than CMS, respectively. CGFA's FY 2014 estimates for prescriptions and dental coverage are $3.5 million and $4.1 million higher than the CMS estimate, respectively.

CGFA estimates that approximately $2.8 billion would be required to fully fund the FY 2014 liabilities of the Group Health Insurance Program. This estimate is $176.9 million or 6.78% more than the FY 2013 estimated liability of $2.6 billion.

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, Member Contributions, reimbursements, university funds, and miscellaneous funds. Estimated cash flow into HIRF for FY 2014 is $2.5 billion. A breakdown in the various funding sources is shown in the pie chart below.



The FY 2014 budget request for the Group Health Insurance Program is $1.35 billion in GRF funds. This represents a $250 million or a 22.7% increase from the FY 2013

GRF appropriation of $1.1 billion (including the $500 million supplemental). The estimated FY 2014 Road Fund request of $133 million is $12.2 million or 10% higher than the FY 2013 appropriation level. Member contributions are significantly higher as well ($336 million in FY 2013 compared to $498 million in FY 2014), due to the concluded negotiations between the State of Illinois and AFSCME.

TABLE 3: GROUP INSURANCE FUNDING SOURCES
FY 2013 - FY 2014
($ in Millions)

	FY 2013	FY 2014	$ Change	% Change
GRF Appropriation	$1,100.0	$1,346.0	$246.0	22.7%
Road Fund	$120.8	$133.0	$12.2	10.1%
University Cont.	$45.0	$45.0	$0.0	0.0%
Member Cont.	$332.6	$497.9	$165.3	49.7%
Other Funds	$380.8	$436.1	$55.4	14.5%
Rebates/Interest/Other.	$81.3	$87.0	$5.7	7.0%
TOTAL Revenues	**$2,060.4**	**$2,549.0**	**$488.61**	**23.71%**

Source: CMS

CMS 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 2014, the GIPF target balance is $4 million, and the target HIRF balance is $6 million.

BENEFITS

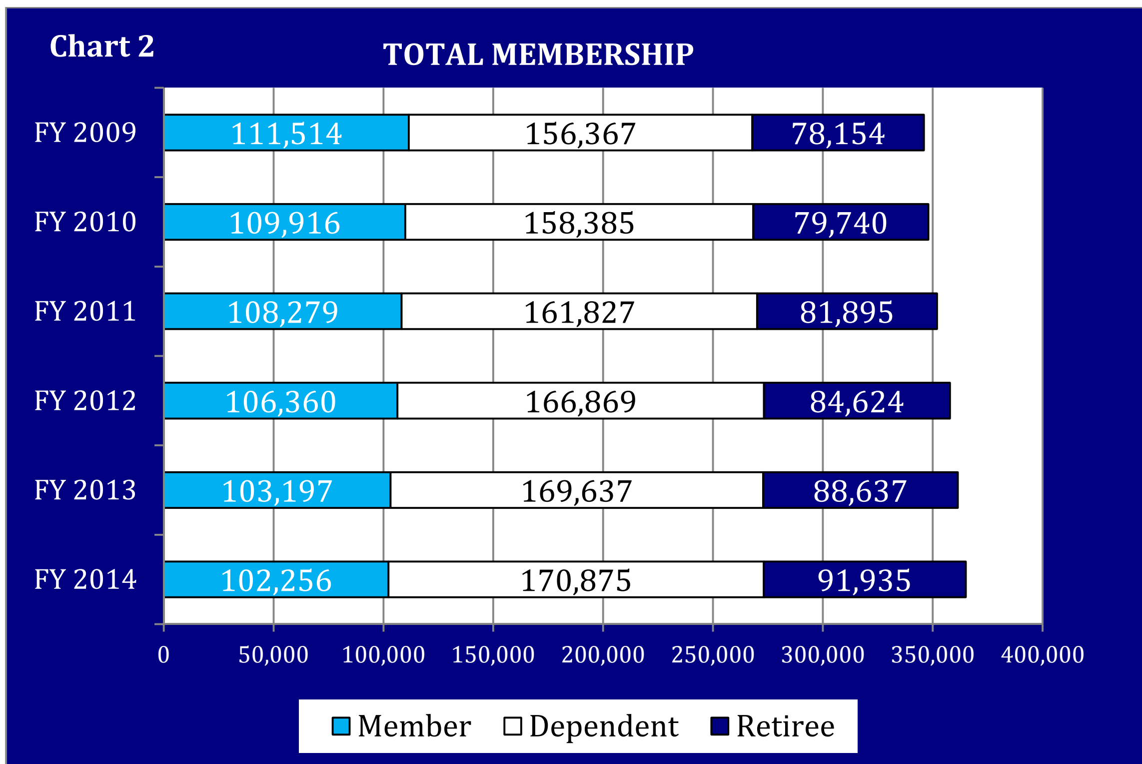
The State Employees' Group Insurance Program provides medical, dental, vision, and life insurance coverage to State employees, retirees and their dependents. Medical coverage is provided separately to members in their choice of: QCHP plan, and various types of managed care plans such as Health Maintenance 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. Appendix IV includes a brief outline of benefit changes resulting from the recently concluded labor negotiations between labor unions and the State of Illinois.

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 CMS, the State Employees' Group Health Insurance Program has an estimated 361,471 participants for FY 2013, of which 159,050 are in a HMO, 87,571 are in an Open Access Plan, and 114,850 are in the Quality Care Health Plan. The QCHP is estimated to have 20,894 employees, 38,288 dependents, and 55,668 retirees in FY 2013. HMO plans are estimated to have 52,505 employees, 84,063 dependents, and 22,482 retirees in FY 2013. OAPs are expected to have 29,798 employees, 47,286 dependents, and 10,487 retirees in FY 2013. For FY 2014, the QCHP is estimated to have 19,473 employees, 37,063 dependents and 56,002 retirees. HMO Plans are estimated to have 51,196 employees, 83,123 dependents and 23,789 retirees. OAPs are expected to have 31,586 employees, 50,690 dependents, and 12,144 retirees in FY 2014.

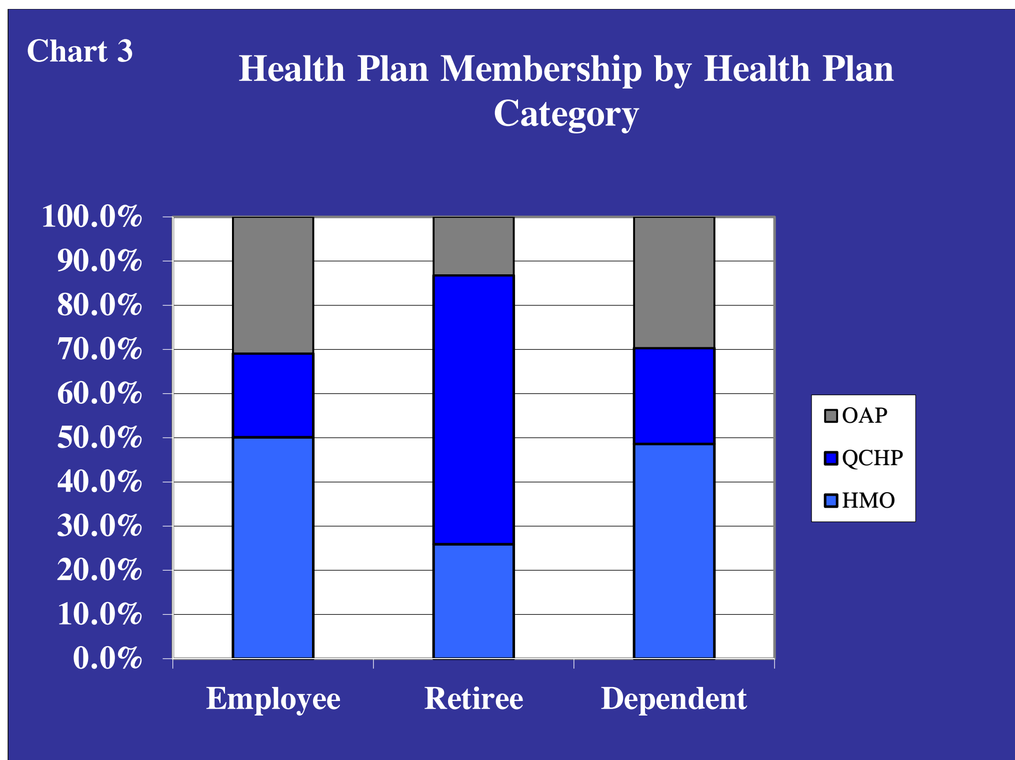


- **Membership is estimated for FY 2013 and FY 2014.**

ENROLLMENT TRENDS

Membership in the Quality Care Plan has been decreasing since FY 2005 while membership in the States' managed care offerings had been increasing since FY 2004. However, in 2012, many participants switched away from traditional managed care (HMOs) to alternatives such as the Open Access Plan (OAP). This adjustment came as a result of contract changes. This situation has achieved some stability, with overall enrollment in HMOs increasing from FY 2012. For FY 2012, 158,634 participants were forecasted and 159,050 were forecasted for FY 2013 (a 0.3% increase) compared to 188,653 in FY 2011. Membership in the OAP increased in 2013. 81,691 members in FY 2012 grew to an estimated 87,571 in FY 2013 (a 7.2% increase). For FY 2014, membership in HMOs is expected to decrease slightly to 158,108 (-0.59%) while membership in OAPs is expected to increase to 94,420 (7.8%).

Chart 3 below shows the breakdown of employee, dependent 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 2014, 60.9% of retirees are expected to enroll in the QCHP, a slight drop from the 62.8% enrolled in FY 2013. Chart 3 shows that while retirees overwhelmingly choose the QCHP, dependents and employees prefer managed care and Open Access Plans.



LIABILITY

The Department's estimate of liability for FY 2014 represents a 4.7% growth rate over FY 2013. This increase in estimated liability is lower than the increase from FY 2012 to FY 2013, when liability increased 6.8%, but it is higher than the increase from FY 2011 to FY 2012 of 4.5%. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2005 through FY 2014.

Table 4 below 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 Open Access Plan is also a large component 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, and its overall insurance liability is forecasted by CMS to surpass the QCHP medical component this year for the first time. However, if taken against the QCHP medical and prescription components as one unit, the OAP liability is still significantly smaller.

Table 4: STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILI
FY 2005-FY 2014
$ in (millions)

Liability Component	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
QCHP Medical/Rx	$697.5	$690.8	$695.2	$689.2	$726.3	$729.3	$722.1	$757.5	$780.9	$789.5
HMO Medical	$607.2	$662.1	$711.4	$780.6	$843.9	$911.3	$1,006.6	$853.0	$898.6	$952.8
Dental	$88.9	$84.9	$95.6	$102.3	$109.8	$115.2	$129.1	$123.7	$129.8	$123.8
Open Access Plan	$102.0	$125.3	$153.9	$178.3	$212.9	$251.5	$284.7	$510.9	$597.7	$653.2
QC Mental Health	$9.2	$8.9	$8.8	$8.6	$8.3	$10.6	$7.7	$8.4	$8.2	$8.0
Vision	$11.7	$8.2	$8.2	$8.2	$8.2	$8.3	$10.2	$10.9	$11.5	$10.7
Life Insurance	$68.8	$75.6	$75.8	$78.4	$80.9	$83.7	$82.3	$80.5	$83.3	$86.5
QC ASC	$23.7	$29.2	$27.9	$29.6	$30.8	$32.2	$31.7	$31.8	$31.3	$28.3
Admin/Int/Other	$14.9	$17.3	$13.2	$16.5	$18.3	$45.5	$61.9	$64.1	$65.5	$94.8
Total	**$1,623.9**	**$1,702.3**	**$1,790.0**	**$1,891.7**	**$2,039.4**	**$2,187.6**	**$2,336.3**	**$2,440.8**	**$2,606.8**	**$2,747.6**
% change over PY		4.83%	5.15%	5.68%	7.81%	7.27%	6.80%	4.47%	6.80%	5.40%

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 in part to medical inflation. In FY 2005, the annual cost per participant in the group health insurance program was $4,670. **According to CMS, the estimated cost per participant for FY 2014 is $7,475. That represents a 60.1% increase over a ten year period.** The cost per participant increased 4.68% from FY 2013 to FY 2014.

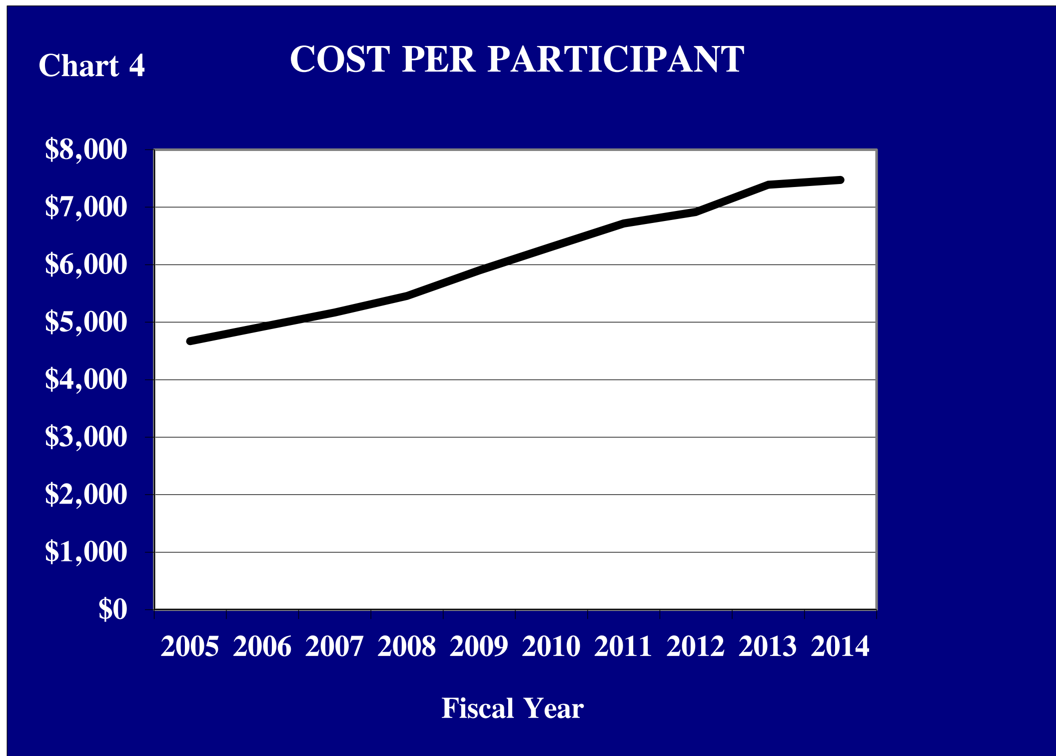


Table 5: AVERAGE ANNUAL COST PER PARTICIPANT

	FY 2013	FY 2014	FY 2013	FY 2014
	Total Participants	**Total Participants**	**Avg. Cost Per Participant**	**Avg. Cost Per Participant**
QCHP	114,850	112,538	$6,799	$7,326
HMO	159,050	158,108	$5,649	$5,882
OAP	87,571	94,420	$6,200-$6,800	$6,569
Totals	361,471	365,066		

OAP is the Open Access Plan. ACPP does not include dental, vision, admin/interest/other, or life insurance. Numbers are not adjusted for risk. **Numbers are lower than previous SEGIP report due to recalculation of cost per participant based on actual number of participants per plan.**

When comparing average cost per participant (ACPP) in Table 5, the average cost for FY 2013 is lowest for members in the HMO and highest for members in the QCHP. The total participants in the QCHP has also declined for many years as people have steadily migrated to HMOs and OAPs. FY 2014 is expected to continue this trend of HMOs having lower costs for participants, though the expected average annual cost per participant across HMOs, OAPs and QCHP is anticipated to rise from FY 2013.

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 $6,799 in FY 2013. Total member contributions for QCHP enrollees totaled $90 million. This means that of the total cost per participant ($6,799), $784 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

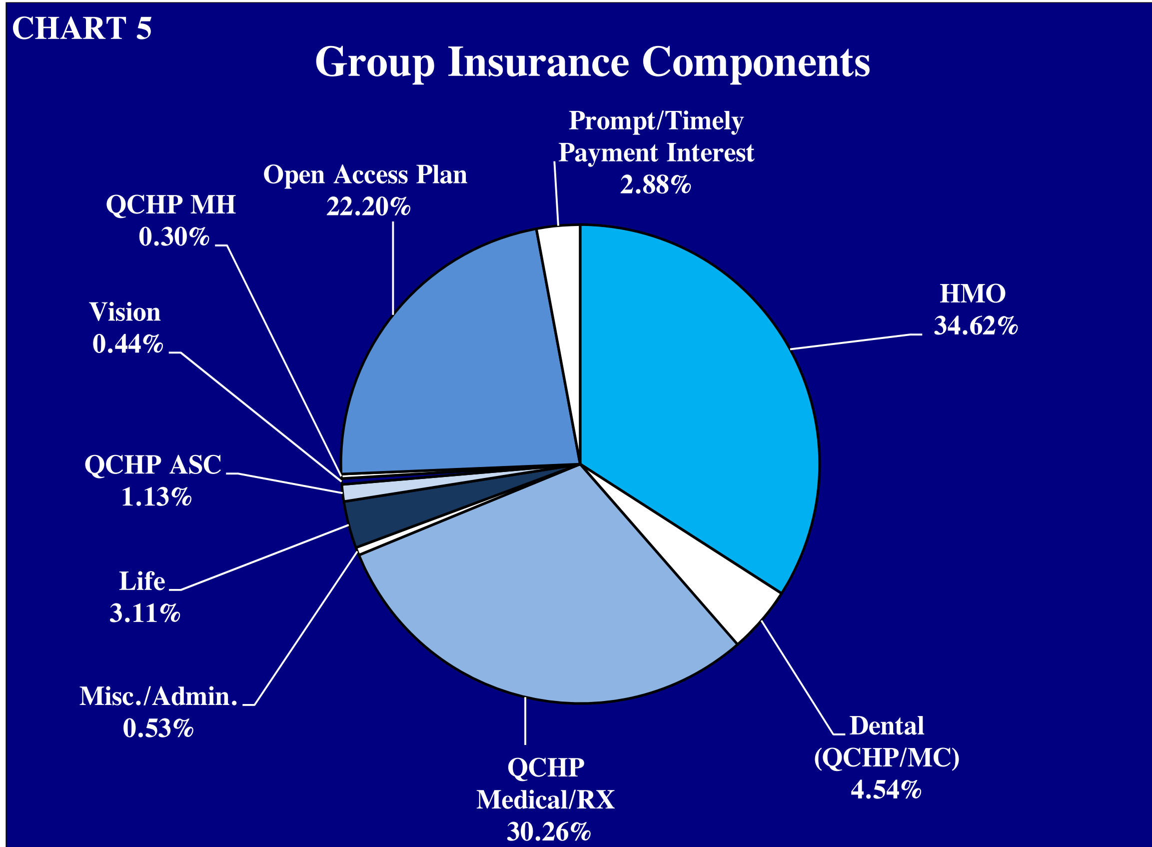
	FY 2013 Avg. cost per participant	FY 2013 Member Contributions	FY 2013 Member/ State Cost	FY 2014 Avg. cost per participant	FY 2014 Member Contributions	FY 2014 Member/ State Cost
QCHP	$6,799	$90,007,281	$784/$6,015	$7,326	$142,858,250	$1,269/$6,056
HMO + OAP	$6,067	$157,673,164	$639/$5,428	$6,139	$246,471,579	$976/$5,163
Dental	$366	$32,769,314	$92/$274	$336	$56,436,976	$156/$182

Source: CMS FY 14 values are estimated based on results from state labor negotiations for increased member contributions.

The table above shows that QCHP members contribute approximately 11.5% of the overall annual cost of providing their insurance. HMO/OAP members contribute 10.5% of the overall liability cost. Members that participate in the State's dental offering pay 25.1% 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. These contribution levels in the Table above for FY 2014 include agreed contribution increases for employees and retirees.

The following chart includes the various components of the FY 2014 CMS liability estimate of approximately $2.8 billion. The largest component of the State Group Insurance Program is the State's managed care plans (HMO and OAP) which represent

56.8% of FY 2014 liability, while dental care, life insurance, vision care, and all other components equal 12.9% of total liability. The QCHP component (30.3%) includes medical/prescriptions, mental health coverage, and administrative service charges.



EMPLOYEE/RETIREE COST COMPARISON

A subject of interest in recent years is the breakdown of costs for active employees and their dependents and retirees and their dependents. Table 7 below displays a comparison of the costs for these groups taken from data obtained from DCMS as of March 2013.

TABLE 7: RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 14			
Category	**Cost**	**Category**	**Cost**
Retiree Cost	$757.7	Active Employee Cost	$939.7
Retiree Contribution	$77.9	Active Employee Contribution	$159.5
Net State Cost	$680.8	Net State Cost	$780.2
Retiree Dependent Cost	$266.6	Active Employee Dependent Cost	$689.0
Retiree Dependent Contribution	$63.8	Active Employee Dependent Contribution	$127.4
Net State Cost	$202.8	Net State Cost	$561.6
Total Retiree Cost	$1,025.3	Total Active Cost	$1,628.7
Total Retiree Contribution	$141.7	Total Active Contribution	$286.9
Net State Cost	$883.6	Net State Cost	$1,341.8
Source: CMS All numbers in Millions			

A number of points can be observed from this table. As in previous years, retirees pay a significantly lower portion of their healthcare costs than active employees. Dependents of retirees and active employees pay more as a percentage of total costs than retirees or active employees by themselves. In total, though, the net state cost of active employees and dependents is significantly higher than retirees and retiree dependents. This cost difference may change in time as people continue to live longer lives and make use of medicinal technologies that were unavailable in past years.

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) Union.

The Open Access Plan, 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. Greater detail about FY 2013 and FY 2014 plan enrollment is listed in Table 8 below.

TABLE 8: MANAGED CARE PLANS
FY 2011-2013 Actual Membership

HMO/OAP	FY12 # of Participants	FY13 # of Participants	% Change 2012-2013	FY14 # of Participants	% Change 2013-2014
Health Alliance HMO	74,875	78,716	5.13%	81,828	3.95%
Health Alliance Illinois	6,782	6,743	-0.58%	0	N/A
HMO Illinois	63,426	61,751	-2.64%	63,988	3.62%
Blue Advantage	2,109	2,965	N/A	3,059	3.17%
Coventry Health Care HMO	11,442	8,875	-22.43%	9,233	4.03%
Coventry Health Care OAP	18,210	19,675	N/A	21,195	7.73%
Health Link OAP	63,481	67,896	6.95%	73,226	7.85%
TOTALS	**240,325**	**246,621**	**2.62%**	**252,529**	**2.40%**

Source CMS. FY 13 numbers as of January 2013. FY 2014 numbers unavailable from CMS at this time.

MONTHLY PREMIUMS

Compared to managed care plans, the State of Illinois' QCHP is significantly more expensive for individuals than a traditional HMO or OAP. 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. OAPs are also less expensive for the state, as the consumer takes on more cost and the OAPs take on more risk than the QCHP.

According to the Department, the estimated monthly cost for a current employee in the QCHP for FY 2013 is $883 and will decrease slightly to $872 (1.2%) in FY 2014.

The monthly premium for a current employee in a managed care plan varies based on each plan's rates, but the FY 2014 estimated average cost for a member in a HMO plan will be $648 per month. The premium for a current employee in an OAP will average to $734.

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 2014 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 9 below shows the FY 2014 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 9: MONTHLY PREMIUMS Managed Care vs. Indemnity Plan Weighted Average FY 2014 Rates (Projected)									
	QCHP			HMO			OAP		
Membership	TOTAL	Member	State	TOTAL	Member	State	TOTAL	Member	State
Employee	$872	$158	$714	$648	$114	$534	$734	$112	$622
Medicare Retiree	$475	$48	$427	$433	$48	$385	$502	$48	$454
Non-Medicare Retiree	$1,169	$82	$1,087	$964	$82	$882	$1,127	$82	$1,045
1 Dependent	$906	$251	$655	$552	$109	$443	$644	$125	$519
2+ Dependents	$1,228	$294	$934	$967	$155	$812	$1,121	$176	$945
Medicare Dependent	$490	$142	$348	$434	$86	$348	$505	$99	$406

TABLE 10: PROJECTED COSTS FY 2007 - FY 2014 Employee Only												
	QCHP				HMO				OAP			
	TOTAL	% Increase	Member	State	TOTAL	% Increase	Member	State	TOTAL	% Increase	Member	State
FY 2007	$610.42		$62.31	$548.11	$410.94		$38.11	$372.83	$495.04		$38.11	$456.93
FY 2008	$623.81	2.20%	$68.16	$555.65	$448.13	9.00%	$41.88	$406.25	$521.02	5.20%	$41.88	$479.14
FY 2009	$682.73	9.40%	$71.55	$611.18	$482.31	7.60%	$45.30	$437.01	$580.87	11.50%	$45.30	$535.57
FY 2010	$722.05	5.80%	$80.82	$641.23	$521.66	8.20%	$54.56	$467.10	$640.91	10.30%	$54.56	$586.35
FY 2011	$764.50	5.90%	$80.97	$683.53	$570.72	9.40%	$54.72	$516.00	$675.20	5.40%	$54.72	$620.48
FY 2012	$827.12	8.20%	$81.56	$745.56	$584.32	2.40%	$55.13	$529.19	$662.74	-1.80%	$55.13	$607.61
FY 2013	$883.10	6.80%	$83.52	$799.59	$623.61	6.70%	$56.47	$567.14	$725.09	9.40%	$56.47	$668.62
FY 2014	$872.00	-1.30%	$158.00	$714.00	$648.00	3.90%	$114.00	$534.00	$734.00	1.20%	$112.00	$622.00

It is important to note that the comparisons made in Tables 9 and 10 are aggregate comparisons. As such, there are individual HMO and OAP plans that differ significantly from the average shown in these tables. Individual HMO and OAP plans may be significantly higher or lower than the averages shown. Therefore, it is necessary to show these plans individually in Table 11 below.

TABLE 11: MONTHLY PREMIUMS ACROSS ALL PLANS HMOs and OAPs FY 2014 Rates (As of April 2014)						
Membership	Health Alliance	Coventry HMO	HMO Illinois	Blue Advantage	HealthLink OAP	Coventry OAP
Employee	$677	$645	$620	$593	$763	$632
Medicare Retiree	$444	$409	$419	$401	$522	$432
Non-Medicare Retiree	$991	$911	$934	$893	$1,167	$962
1 Dependent	$569	$524	$537	$514	$669	$553
2 + Dependents	$995	$917	$940	$900	$1,167	$968
Medicare Dependent	$444	$409	$419	$401	$522	$432

As shown in this table, HMO plans are not necessarily less costly than OAPs. There are numerous factors involved in the rates submitted by health insurance providers, indicating that some plans may be better for participants based on their current status of active or retired, with or without dependents, and their status in regards to Medicare.

APPENDIX I

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 II

Status of Contracts for FY 14 at DCMS		
Service	**Vendor**	**Contract Term Details**
Managed Care Health Plans	Health Alliance HMO / Coventry HMO / Coventry OAP / Healthlink OAP / BC HMO Illinois / BC Blue Advantage	**Ongoing** - Term goes to June 30, 2016 with up to five 1-year renewals.
Self-Insured Medical Plan Administration	Cigna	**Ongoing** - Term goes to June 30, 2015 with up to two 1-year renewals.
Vision	EyeMed	**Renew** - Currently in the 3rd year of up to 5 single year renewals. Renewal would extend contract to June 30, 2014.
Behavioral Health/EAP	Magellan	**Ongoing** - Term goes to June 30, 2016 with up to five 1-year renewals.
Flu Shots	Varies each plan year	**IFB being drafted**
Consulting Contracts	Willis of Illinois / Blalock Consulting	**Renew –** Contract finalization in progress.
Life Insurance	Minnesota Life	**Ongoing** - Term goes to June 30, 2016 with up to five 1-year renewals.
Flexible Spending	FBMC	**Renew** - Currently in the 4th year of up to five 1-year renewals. Renewal would extend contract to June 30, 2014.
Administration of Dental Claims	Delta Dental	**Ongoing** - Term goes to June 30, 2016 with up to five 1-year renewals.
Prescription Drugs	Medco	**Renew** - Currently in the 3rd year of up to 5 single year renewals. Renewal would extend contract to June 30, 2014.
Commuter Savings Program	FBMC	**Renew** - Currently in 2nd year of up to five 1-year renewals. Renewal would extend contract to June 30, 2014.

APPENDIX III

Settlement between AFSCME and State of Illinois

Recent negotiations with state employee unions have resulted in a framework for increased employee and retiree contributions to health insurance plans. The following chart shows the breakdown of contributions from the current insurance plans to the proposed plan rates.

QCHP MEDICAL	CURRENT	FY13	FY14	FY15
QCHP Plan Year Employee Deductible	$300 - $450	$300 - $450	$350 - $500	$375 - $525
QCHP Plan Year Dependent Deductible	$300	$300	$350	$375
QCHP Plan Year Retiree Deductible	$300	$300	$350	$375
QCHP Plan Year Family Deductible	2.5x Ed	2.5x Ed	2.5x Ed	2.5x Ed
QCHP In-Patient Hospitalization Member Deductible (In-Network)	$50	$50	$75	$100
QCHP In-Patient Hospitalization Dependent Deductible (In-Network)	$50	$50	$75	$100
QCHP In-Patient Hospitalization Member Deductible (Out-of-Network)	$300	$300	$400	$500
QCHP In-Patient Hospitalization Dependent Deductible (Out-of-Network)	$300	$300	$400	$500
QCHP Emergency Room Deductible	$400	$400	$425	$450
QCHP Co-Insurance (In-Network)	90%	90%	90%	85%
QCHP Co-Insurance (Out-of-Network)	70%	70%	60%	60%
QCHP Individual Out Of Pocket Maximum (In-Network)	$1,200	$1,200	$1,500	$1,500
QCHP Family Out Of Pocket Maximum (In-Network)	2.5x Ind	2.5x Ind	2.5x Ind	2.5x Ind
QCHP Individual Out Of Pocket Maximum (Out-of-Network)	$4,400	$4,400	$6,000	$6,000
QCHP Family Out Of Pocket Maximum (Out-of-Network)	2x Ind	2x Ind	2x Ind	2x Ind
QCHP Lab/X-Ray (In-Network)	90%	90%	90%	85%
QCHP Lab/X-Ray (Out-of-Network)	70%	70%	60%	60%

QCHP PRESCRIPTIONS	CURRENT	FY13	FY14	FY15
QCHP Rx Deductible	$75	$75	$100	$125
QCHP Rx Co-Pay Tiers	$11/$26/$52	$11/$26/$52	$10/$30/$60	$10/$30/$60
QCHP Rx Speciality Tier	N/A	N/A	N/A	N/A
QCHP Mail Multiplier	2x	2x	2.5x	2.5x

For individuals in the QCHP, this translates to graduated increases in deductibles, co-insurance, out of pocket maximums, and diagnostic services through FY 2015. An example of this is the QCHP employee/retiree deductibles, which are currently $300-$450. These numbers will rise to $350-$500 and $375-$525 in FY 2014 and FY 2015 respectively. In the Quality Care Dental Plan, costs will be higher in FY 15 compared to the current year. The annual deductible will rise to $175 and the annual max and Orthodontia max will be lowered from $2500 and $2000 to $2000 and $1500. Prescription deductibles and co-payments will increase also, along with a bump in the multiplier for mail-order prescriptions.

MCHP MEDICAL	CURRENT	FY13	FY14	FY15
MCHP Office Visit (PCP)	$15	$15	$18	$20
MCHP Office Visit (Specialist)	$20	$20	$25	$30
MCHP Home Health Visit	$20	$20	$25	$30
MCHP Inpatient Copay	$275	$275	$325	$350
MCHP Outpatient Copay	$175	$175	$225	$250
MCHP ER Copay	$200	$200	$225	$250
MCHP PRESCRIPTIONS	**CURRENT**	**FY13**	**FY14**	**FY15**
MCHP Rx Deductible	$50	$50	$75	$100
MCHP Rx Co-Pay Tiers	$10/$24/$48	$10/$24/$48	$8/$26/$50	$8/$26/$50
MCHP Rx Speciality Tier	N/A	N/A	N/A	N/A
MCHP Mail Multiplier	2x	2x	2.5x	2.5x
VISION	**CURRENT**	**FY13**	**FY14**	**FY15**
Vision Eye Exam	$10	$10	$20	$25
Vision Lenses	$10	$10	$20	$25
Vision Standard Frames	$10	$10	$20	$25
Offset from Union Proposal				
QCDP	**CURRENT**	**FY13**	**FY14**	**FY15**
QCDP Annual Deductible	$125	$125	$150	$175
QCDP AFSCME Annual Max (In-Network)	$2500	$2500	$2500	$2500
QCDP AFSCME Annual Max (Out-of-Network)	$2500	$2500	$2000	$2000
QCDP AFSCME Orthodontia Max (In-Network)	$2000	$2000	$2000	$2000

QCDP AFSCME Orthodontia Max (Out-of-Network)	$2000	$2000	$1500	$1500

For the MCHP, costs to employees will increase in the same graduated pattern as in the QCHP. Office visits will increase from $15 to $18 and $20 in FY 14 and FY 15, with specialist office visits rising to $30 by FY 15. Inpatient/Outpatient and ER Copays will rise to $350/$250/$250 by FY 15. In the vision program, costs will increase significantly, with eye exams, lenses and standard frames increasing in cost from $10/each to $25/each by FY 15.

LIFE INSURANCE	**CURRENT**	**FY13**	**FY14**	**FY15**
Employee Basic Life Insurance	1x Salary	1x Salary	1x Salary	1x Salary
Retiree Basic Life Insurance	Salary/$5000	Salary/$5000	Salary/$5000	Salary/$5000
QCDP Employee Contributions	$11.00	$11.00	$11.00	$11.00
QCDP Employee One Dependent Contributions	$6.00	$6.00	$6.00	$6.00
QCDP Employee Two Plus Dependent Contributions	$8.50	$8.50	$8.50	$8.50
QCDP Retiree Contributions	$11.00	$11.00	$11.00	$11.00
QCDP Retiree One Dependent Contributions	$6.00	$6.00	$6.00	$6.00
QCDP Retiree Two Plus Dependent Contributions	$8.50	$8.50	$8.50	$8.50

DEPENDENTS	**MC CURRENT**	**MC PROPOSED**	**QCHP CURRENT**	**QCHP PROPOSED**
One Dependent Plan	$93.93	$113.00	$196.00	$249.00
Two Plus Dependent Plan	$132.56	$159.00	$226.00	$287.00
Medicare Dependent Plan	$89.91	$89.91	$142.00	$142.00
(Based on percentage of medical cost, will increase with medical inflation.)				

ACTIVE MEMBERS	**MC CURRENT**	**MC PROPOSED**	**QCHP CURRENT**	**QCHP PROPOSED**
$30,200 and Under	$47.00	$68.00	$72.00	$93.00
$30,201 - $45,600	$52.00	$86.00	$77.00	$111.00
$45,601 - $60,700	$54.50	$103.00	$79.50	$127.00
$60,701 - $75,900	$57.00	$119.00	$82.00	$144.00
$75,901 - $100,000	$59.50	$137.00	$84.50	$162.00
$100,001 and Above	$59.50	$186.00	$84.50	$211.00
(Based on percentage of average salary, will increase with payroll inflation.)				

Other issues affecting retirees from the AFSCME agreement include:

Plan Design – Changes to co-pays, deductibles and co-insurance made to the Managed Care Health Plans (MCHP) and Quality Care Health Plan (QCHP) will also apply to retirees.

Premiums (Medicare Eligible Retirees) - Starting July 1, 2013, Medicare Eligible retirees will have 1% of their pension annuity deducted to pay for their share of the health care premium. Starting July 1, 2014, 2% of their pension annuity will be deducted.

Also starting on July 1, 2014, all Medicare eligible retirees will be enrolled in a Medicare plan that provides a comparable level of services and a comparable range of providers as the current health plans. Medicare eligible dependents enrolled in a MCHP plan will pay no more than $89.91/month and dependents in a QCHP plan will pay no more than $142/month through June 30, 2015 (the same rates they are currently paying).

Premiums (Pre-65 Non-Medicare Eligible Retirees) – Starting July 1, 2013, pre-65 Non-Medicare eligible retirees will be offered a $500/month subsidy if they opt out of the state's group health insurance plan to be covered in another health insurance plan. Starting on the same date, these retirees will have 2% of their pension annuity deducted to pay for their share of the health care premium. Starting July 1, 2014, an additional 2% will be deducted.

<u>QCHP:</u> Starting July 1, 2013, premium monthly rates for dependents in the Retiree +1 Dependent plan option will increase $53, from $196 to $249 while dependents in the Retiree +2 or more Dependent plan option will increase $61, from $226 to $287.

<u>MCHP:</u> Starting July 1, 2013, premium monthly rates for dependents in the Retiree +1 Dependent plan option will increase $19, from $94 to $113 while dependents in the Retiree +2 or more Dependent plan option will increase $26.50, from $132.50 to $159.

APPENDIX IV

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 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 dependents.
- 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 Commission on Government Forecasting and Accountability are listed below:

- By April 1st of each year, the Director (CMS) 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) must provide updated and any new information to the Commission until the employee benefits program for the fiscal year has been determined.
- Requires CMS 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 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.

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://cgfa.ilga.gov