FY 2018 LIABILITIES OF THE STATE EMPLOYEES' GROUP HEALTH INSURANCE PROGRAM

COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

MARCH 2017

Commission on Government Forecasting and Accountability

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March, 2017

EXECUTIVE SUMMARY

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

- 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.

For the 2018 fiscal year, there are two possible options for the State Employees' Group Health and Life Insurance Program (SEGIP) in regards to liabilities and revenues. The State has sought to enact a new system of tiered benefits for state employees in an effort to save money on liabilities and increase overall revenues from employee contributions. This effort is currently paused as legal action has been undertaken it and it is currently being adjudicated. As part of this process, the State has been blocked against enacting changes while the litigation is pending in court. Accordingly, while CMS has provided the Commission with their customary data regarding projected liabilities, revenues, and insurance rates, this information is predicated on the assumption that the State will be victorious in court. Notably, the data provided by CMS makes specific assumptions of liability savings and increased revenues due to increased employee contributions that dramatically affect overall liability and revenues for FY 2018.

The Commission believes that it is prudent to analyze two scenarios: one where the State succeeds in its legal actions **(Scenario 1)** and is able to impose its best and final insurance rates and changes and one where the State is not successful in its legal efforts **(Scenario 2)** and is only able to maintain the status quo for FY 2018. In regards to Scenario 2, CMS has provided a supplementary set of data (Scenario 2) in which it is presumed that the current status of the health insurance program, including revenues, liabilities, population trends, and rates will remain in line with historic trends. Accordingly, the Commission has undertaken an effort to project an additional estimate of liability and revenues for FY 2018 based on Scenario 2.

Scenario 1 – Proposed Changes to Group Insurance Plans for FY 2018

For Scenario 1, the Governor has requested that a total of $1.415 billion in General Revenue Funds (GRF) be appropriated for the State Employees' Group Health and Life Insurance program for FY 2018. The total expected revenues for the Group Insurance Program in FY 2018 is $2.4 billion. The FY 2017 GRF appropriation request for the Group Health Insurance Program was $1.810 billion with total expected revenues of $2.933 billion. However, due to continuing budget negotiations, no GRF appropriation

for FY 2017 has been made for the Group Insurance Program. The table on page 3 represents historical appropriation and liability amounts. CMS estimates the FY 2018 liability for Scenario 1 to be $2.993 billion, a 9.0% decrease from FY 2017. This is due to assumed projected savings from a plan to have a tiered system and increased contributions from employees. This plan will be discussed in further detail later in the report. The CGFA FY 2018 estimate of liability for Scenario 1 is $3.028 billion, $34.6 million more than CMS. The CGFA FY 2018 estimate is reflective of the figures provided by CMS along with general trends as reported by the Segal company. It is likely that certain information utilized in this report may change depending on the outcome of ongoing collective bargaining negotiations and pending legal actions. This is a continuation of the situation in FY 2016, as neither negotiations nor legal confirmation of either the State's position or that taken by the state employee unions have yet been completed as of the date of this report.

Using the figures provided by CMS, the FY 2018 Scenario 1 estimated liability for the Quality Care Health Plan (QCHP) is expected to decrease by 9.4% over the FY 2017 liability, primarily due to projected employee migration to health plans with lower liability impact. The estimated liabilities for the State's HMO plans are expected to decrease 15.5% over the FY 2017 cost. FY 2017 liability for the HMO plans increased 4.8% from FY 2016. CMS projects prescription drug liability to increase by 1.7% in FY 2018 from $113.7 million to $115.6 million. This follows a decrease in FY 2017 of 7.3% ($7.7 million) from FY 2016. These figures presume a significant appropriation of General Revenue Funding for FY 2017 and FY 2018, though no such funding has yet been approved.

Scenario 2 – Status Quo for FY 2018

For Scenario 2, the expected GRF appropriation will continue to be $1.415 billion for SEGIP. In addition, total expected revenues would also be approximately $2.4 billion. In the case of Scenario 2, CMS estimates the FY 2018 liability to be $3.424 billion, a 4.1% increase from FY 2017. Accordingly, the Commission has presumed that liabilities and revenues will follow trends from FY 2017 and previous fiscal years in this scenario and estimates a liability for Scenario 2 of $3.452 billion, $28.4 million more than CMS.

Scenario 2 envisions a significant increase in liability overall, especially for the QCHP and HMO components of the Group Insurance Program. The estimated liability for the QCHP would increase by 7.8% while estimated liabilities for the State's HMO plans would increase by 7.6% over FY 2017. In addition, while the projected increase in the Special Programs line (Interest, etc.) over FY 2017 would only be 1.6% according to the State's estimate, this indicates a continuing lengthy claims hold period and high interest rates on group insurance debts.

GRF APPROPRIATION/REVENUE AND LIABILITY HISTORY FY 2012-2017 ($ in Millions)				
Fiscal Year	**Appropriation**	**Revenues**	**CMS Liability**	**CGFA Liability**
FY 2012	$1,435.5	$2,350.5	$2,439.6	
FY 2013	$1,451.0	$2,088.6	$2,565.8	
FY 2014	$1,446.0	$2,791.0	$2,653.7	
FY 2015	$1,565.4	$2,674.3	$2,651.8	
FY 2016*	$0.0	$876.9	$2,637.0	
FY 2017**	$1,810.0	$2,933.0	$3,288.4	
FY 2018 (1)**	$1,415.0	$2,400.4	$2,992.9	$3,027.5
FY 2018(2)**	$1,415.0	$2,381.7	$3,423.7	$3,451.7
*FY 2016 had no official appropriation. A small amount was appropriated in FY 2015 but received until FY 2016. **Estimated for FY 2017 and FY 2018. (1) and (2) signify Scenarios 1 and 2				

In regards to payment cycles, the situation continues to worsen over the last fiscal year. As of February 28, 2017, the amount of SEGIP claims on hand is $4.2 billion and growing approximately $200 million per month. The current FY 2017 payment cycles are:

- CIGNA claims: 615 days for preferred providers, 692 days for non-preferred (CMS projects 450 days and 525 days for FY 18)
- Managed Care claims: Approximately 12 to 19 months, depending on the provider (CMS projects 17 to 28 months for FY 18)
- Prescription/OAP claims: up to 529 days for Prescriptions, 329-362 days for OAPs (CMS projects 465 days for Prescriptions and up to 480 days for OAPs in FY 18)
- Dental claims: 220 days for network claims, 383 days for non-network claims (CMS projects (250 and 450 days for FY 18)

FY 2018 PROPOSED PLAN CHANGES

For FY 2018, the State has proposed numerous changes to the existing system of insurance plans and employee options. These changes would create a multi-tiered system of "metal" plans for the existing QCHP, HMOs and OAPs. However, these changes would not affect the Medicare Advantage HMO plans currently utilized by retirees. For the standard HMO/OAP/QCHP plans, four tiers would be set up for each plan. These tiers would be defined by a balance between premiums and co-payments/deductibles/etc.

The current FY 2017 insurance plan benefits would be the new "Platinum" plan, which would increase monthly plan premiums by 120%. This is only a minimum increase, as most Platinum plans will have a higher increase as a percentage of the FY 2017 monthly premium. A "Silver" plan would allow a member to keep their current insurance premium in exchange for higher deductibles/co-payments/etc. A "Gold" plan would split the difference between "Platinum" and "Silver" plans, in which participants would have higher premiums (though not as high as the "Platinum" plan) and higher deductibles/co-payments/etc. (though not as high as on the "Silver" plan). A new "Bronze" plan would be available to members with no monthly premiums, but much higher deductibles/co-payments/etc.

All of these plans, whether by higher premiums, deductibles, co-payments, or some other component, represent an effort to increase current participant contributions towards a 60/40 split. This split is intended to have the employee responsible for 40% of their applicable healthcare costs and the employer responsible for 60% of applicable healthcare costs.

It is important to note that according to CMS, while plan rates may change, depending on the plan chosen by participants, overall physician/provider access should remain the same. Regardless of the plan chosen, members would be able to keep their existing doctors and other providers. The table on the following page describes the contributions

Proposed Monthly Premium Comparison (Employee Only)					
Quality Care Health Plan					
FY 2017		FY 2018			
Current		Platinum	Gold	Silver	Bronze
$30,000	$93	$205	$149	$93	$0
$45,000	$111	$246	$179	$111	$0
$60,000	$127	$270	$199	$127	$0
$75,000	$144	$318	$231	$144	$0
$100,000	$162	$358	$260	$162	$0
$115,000	$211	$466	$339	$211	$0
$130,000	$211	$477	$347	$216	$0
$145,000	$211	$489	$355	$221	$0
$160,000	$211	$501	$364	$226	$0
$160,000+	$211	$512	$372	$231	$0
HMO/OAP					
FY 2017		FY 2018			
Current		Platinum	Gold	Silver	Bronze
$30,000	$68	$151	$110	$68	$0
$45,000	$86	$190	$138	$86	$0
$60,000	$103	$227	$165	$103	$0
$75,000	$119	$263	$191	$119	$0
$100,000	$137	$302	$220	$137	$0
$115,000	$186	$411	$299	$186	$0
$130,000	$186	$420	$305	$190	$0
$145,000	$186	$430	$312	$194	$0
$160,000	$186	$441	$320	$199	$0
$160,000+	$186	$451	$328	$204	$0

* For more details and dependent rates, see Appendix III.

As a result of these changes, CMS believes that members and their dependents will likely move to different plans based on their personal evaluation of the costs and likelihood of utilizing medical services. Correspondingly, while many may keep their current plan, despite increased premiums, many are likely to change to a lower-tier plan depending on their own circumstances. As an example, a young, single state employee who rarely uses medical providers will likely choose a lower-tier plan compared to older employees with dependents that use more medical services on a yearly basis.

Furthermore, these changes are expected to produce specific savings to the state and are included in their liability and revenue projections. According to CMS, approximately $419 million in reduced liabilities is expected due to employee movement to different plans along with an anticipated $100 million in increased employee contributions from

those who choose to keep their existing plan despite the increased premiums for FY 2018. In conjunction with this, CMS has estimated that approximately 3% (or 6,500 participants) of existing state employees and dependents will choose to drop their state insurance entirely in favor of their spouse's insurance plan, further reducing liabilities to the State.

For the purposes of this report, it is necessary to note that the liability, revenue, and plan rate data is utilized with the implementation of the CMS insurance plan changes as a given. Various elements of the liability estimate, for example, would be radically different if no plan or employee contribution changes were implemented. If the changes planned by CMS are altered due to court-mandated action/negotiation or implemented within the fiscal year, the data used by the Commission and the estimates contained within this report would have to be adjusted.

FY 2018 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2018 cost projection for Scenarios 1 and 2 utilizes the CMS estimate for FY 2017 medical claims as the basis for estimating claims for FY 2018 along with information provided by the Segal company in their annual report on state employee insurance trends. In addition, for FY 2018 Scenario 1, the Commission notes the anticipated plan changes by the State and their corresponding liability predictions. In this particular scenario, while expenses may rise in certain cases, CMS projects of an overall drop in total liability. It is necessary to note that pending legal action may adversely affect these predictions if the State is unable to pursue its changes in insurance plans for FY 2018.

The CGFA State of Illinois liability cost estimate for FY 2018 Scenarios 1 and 2 uses the following assumptions based on historical claims data and anticipated cost changes:

Trend Factors	Scenario 1	Scenario 2
Medical (QCHP plan)	-10.8%	8.7%
Dental (QCHP and MC)	-1.2%	4.3%
HMO (Medical and Rx)	-14.8%	8.0%
Prescription drugs (QCHP)	3.5%	14.3%
Open Access Plan	-9.4%	0.6%
Life Insurance	0.0%	0.0%

It is necessary to note that these figures only relate to the portion of total medical costs borne by the State of Illinois. The shifting of retirees towards Medicare Advantage and negotiated increases in employee contributions and co-payments have caused State costs to decline from where they might be otherwise. However, the overall cost of providing healthcare for State employees, retirees and dependents continues to rise. The medical trend inflation factors for the State consist of various components. These components include general inflation and leveraging (lower impact of coinsurance limits, level deductibles, etc.). Also, advances in technological innovation, more use of

equipment/services, and the continued "greying" (aging and extended living) of the population have all contributed to greater health care costs. 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, though movement of Medicare-eligible retirees out of the QCHP/HMOs/OAPs has reduced overall liability within the group insurance program. For Scenario 1, the projected migration of many employees and dependents into proposed lower-tier plans in FY 18 is also a major part of anticipated trends for FY 2018.

Despite lower overall projected liability, in Scenario 1, CMS projects an increase in prescription drug liability and continued large interest payments on bills held by the State. Interest payments on bills continues to be a significant concern for the State, as $493 million in Timely and Prompt payment interest is expected to be incurred in FY 18. This is less than the $516 million in anticipated liability for FY 17. It should be noted that the interest for FY 17 and FY 18 is partly a function of interest pushed past FY 16 ($25 million) into later years. However, as bills continue to await payment for almost two years in many cases, the overall amount of interest to be paid out will continue to be a significant factor in overall SEGIP liability.

For Scenario 2, liabilities are expected to increase, with a large increase in Prescription Drugs in the QCHP leading the trends at 14%. The medical component of the QCHP and the HMO lines of the estimate make up the other large percentage increase from FY 2017. However, certain components, such as the Medicare Advantage HMO/PPO line, are projected to remain unchanged. These liabilities are discussed in more detail later in this report.

The Segal Company compiles an annual cost trend survey 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 2017 Segal Health Plan Cost Trend Survey.

- Most medical and prescription drug plans for active employees and under-65 retirees are expected to continue to increase in cost at double digit rates, though the rates for retirees are expected to be slightly lower than the previous year. Prescription Drug Carve-Out plans (separate prescription plans with a Pharmacy benefits Manager dedicated to that plan only) are anticipated to increase even more than last year, and are anticipated to be significantly higher than in 2016, at an 11.6% rise compared to 11.3%. This is expected to decline slightly for Prescription Drug plans for Retirees (9.9% compared to 10.9%).

- HMO trend rates are expected to decrease slightly from 2016 at 6.7% compared to 6.8%.

- Medicare Advantage trend rates are expected to decrease for MA Preferred Provider Organizations (PPOs such as UnitedHealthCare) and MA HMOs. Medicare Supplemental plans trends are expected to stay the same.

- Dental and Vision plans trends are expected to decrease in most cases (including the State of Illinois plan), except Dental Indemnity Plans (3.5% to 4.2%), Dental Provider Organizations (3.5% to 4.1%), and Dental Maintenance Organizations (3.2% to 4%).

- Prescription drug cost increases are driven in large part by rises in specialty drug/biotechnology costs, which are expected to compose approximately 35% of the "total projected prescription drug cost trends for 2017."

- On a regional basis, the Midwest is expected have slightly below average increases compared to most of the country, with PPO/Point of Service plans expected to rise 7.4% compared to the South (7.9%) and West (9.2%).

Table 1 below highlights national trend data and compares it to estimates by CMS and CGFA for State liability.

TABLE 1

NATIONAL HEALTH CARE TRENDING 2017

Component	National Trend	CMS Estimate Scenario 1	CMS Estimate Scenario 2	COGFA Estimate Scenario 1	COGFA Estimate Scenario 2
HMOs	6.7%	-15.5%	7.6%	-14.8%	8.0%
Rx	11.6%	1.7%	11.4%	3.5%	14.3%
Dental	3.8%	-1.5%	3.5%	-1.2%	4.3%
Vision	2.5%	-1.9%	0.0%	-1.3%	0.0%

Source: Segal 2017 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. Within Scenario 1, such factors as program design changes, employee contribution rate increases, and group demographics can significantly influence total costs. With Illinois' situation, the trend factors cited by Segal are limited in their use for Scenario 1, especially as the proposed plan changes by CMS would affect HMO, Dental, and Vision liability. Prescription drug trending is expected to be significantly lower for SEGIP members and the State compared to the national average. For Scenario 2, the trends are much closer to projected values, as the large increase in prescription costs and significant increases in HMO and Dental costs are reflected in the estimates by both CMS and the Commission.

Based on these assumptions, trends, and inflation factors, CGFA estimates a FY 2018 liability of approximately $3.028 billion for the State Employee's Group Health Insurance Program under Scenario 1 (Proposed) and $3.451 billion under Scenario 2 (Status Quo). The following table shows a detailed comparison of the CGFA estimate for the various cost components and the CMS projection for FY 2018.

TABLE 2: FY 2018 GROUP HEALTH INSURANCE LIABILITY ($ in Millions)					
Liability Component	**FY 2017 CMS Estimate**	**FY 2018 CMS Projection Scenario 1**	**FY 2018 CGFA Projection Scenario 1**	**FY 2018 CMS Projection Scenario 2**	**FY 2018 CGFA Projection Scenario 2**
QCHP Medical	$429.1	$375.2	$382.7	$462.5	$466.2
QCHP Prescriptions	$113.7	$115.6	$117.7	$126.6	$129.9
Dental (QCHP/MC)	$131.7	$129.7	$130.1	$136.3	$137.3
HMO	$978.6	$826.8	$833.6	$1,053.1	$1,057.2
Medicare Advantage HMO/PPO	$182.6	$182.6	$183.6	$182.6	$182.6
Open Access Plan	$713.3	$640.2	$646.4	$713.1	$717.5
Mental Health	$5.7	$4.8	$4.9	$6.1	$6.1
Vision	$7.9	$7.8	$7.8	$7.9	$7.9
Administrative Services (QC)	$17.1	$17.1	$17.1	$17.5	$17.5
Life	$90.1	$89.9	$90.1	$89.5	$90.1
Special Programs (Admin/Int./Other)	$618.5	$603.2	$613.5	$628.1	$638.8
TOTAL	**$3,288.3**	**$2,992.9**	**$3,027.5**	**$3,423.3**	**$3,451.1**
% increase over prior year	4.1%	-9.0%	-7.9%	4.1%	5.0%

*Rounding may cause slight differences. FY 2017 and FY 2018 Special Programs line includes Prompt Payment and Timely Payment Interest.

ESTIMATE COMPARISON

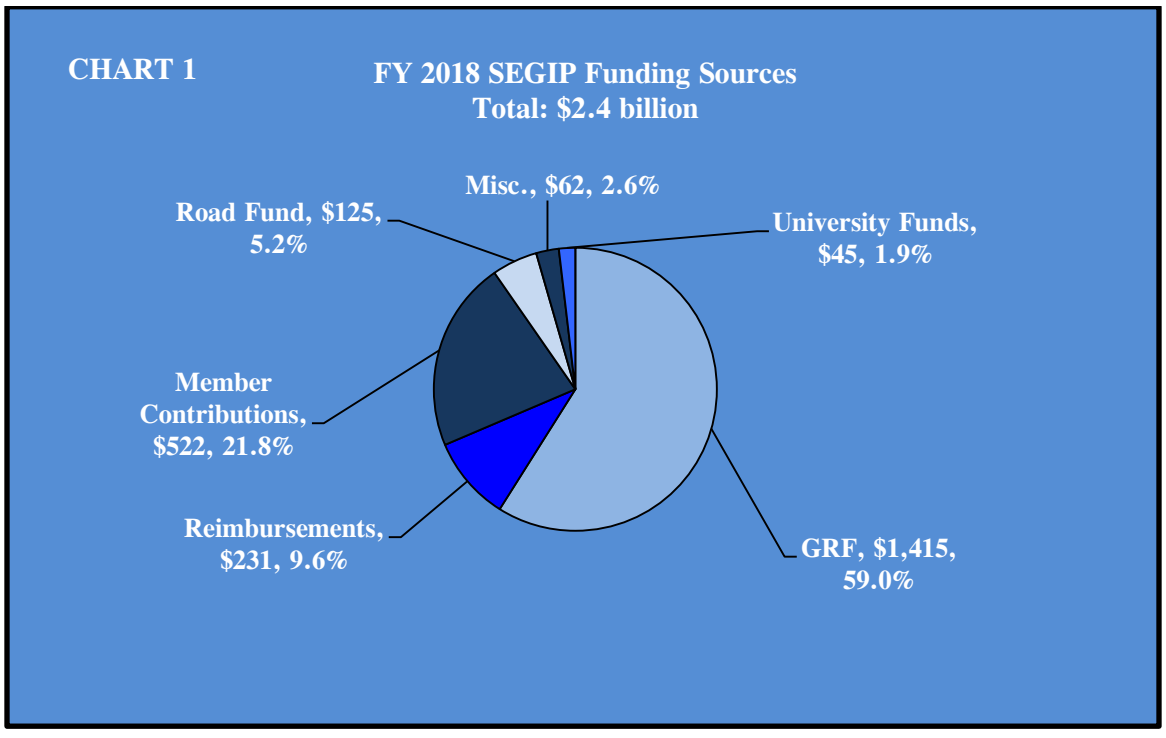
Overall, the Commission's FY 2018 Scenario 1 estimate is $34.6 million higher than the FY 2018 estimate from CMS. CGFA's FY 2018 HMO and Open Access Plan liabilities estimates are $6.8 million and $6.2 million higher than CMS, respectively. CGFA's FY 2018 estimate for the Quality Care Health Plan Medical line is $7.5 million higher than the CMS estimates. For Scenario 2, the Commission's estimate is $27.8 million higher than the Scenario 2 estimate provided by CMS. CGFA's FY 2018 HMO and OAP Liabilities are $4.1 and $4.4 million higher than CMS, respectively. Notably, the Commission's estimate for Special Programs (Interest, Admin, etc.) is $10.7 million higher than CMS.

CGFA estimates that approximately $3.028 billion would be required to fully fund the FY 2018 Scenario 1 liabilities of the Group Health Insurance Program and $3.451 billion would be required to fully fund the Scenario 2 liabilities. The Scenario 1 estimate is $78 million or 2.5% down from the FY 2017 estimated liability of $3.106 billion. The Scenario 2 estimate is $345.4 million or 11.1% above the FY 2017 estimated liability. CMS estimates that the FY 2018 Scenario 1 liability will be $2.993 billion, approximately $113 million below FY 2017. In the case of Scenario 2, CMS estimates that liability at $3.423 billion, approximately $317.6 million above FY 2017.

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, which include the General Revenue Fund (GRF), Road Fund, Member Contributions, Reimbursements, University Funds, and Miscellaneous Funds. Estimated revenues for FY 2018 Scenario 1 total $2.401 billion. This is a large decrease from the 2017 fiscal year estimated revenue of $2.933 billion due mostly to a $395 million decrease in GRF proposed in the Governor's FY 2018 budget. As of the drafting of this report, it is uncertain what sources of funding or changes in plan design will be used to cover the additional unfunded liability. A breakdown in the various funding sources is shown in the pie chart below.



The FY 2018 fiscal data provided by CMS shows the Group Health Insurance Program receiving $1.415 billion in GRF funds. As previously noted, this represents a $395 million or a 21.8% decrease from the FY 2017 GRF component of $1.810 billion and is lower than any previous fiscal year GRF allocation since FY 2011 (except for the FY 2016 GRF appropriation of $0). For FY 2018, the Road Fund request of $125 million

is $13.2 million higher than the projected FY 2017 appropriation level of $111.8 million. However, the expected receipt of Road Fund funding from FY 2016 of $120.1 million in FY 2017 will put the total expected Road Fund funding at $243.9 million for that fiscal year. Member contributions are anticipated to be significantly higher in FY 2018, at $521.9 million, compared to $419 million in FY 2017 (due in large part to the anticipated increased contributions from plan changes). Other Funds reimbursements are anticipated to be significantly lower in FY 2018, at $231.2 million compared to $346.6 million in FY 2017. University contributions are expected to be lower in the 2018 fiscal year, with a $6.3 million drop from $51.3 million to $45 million. The Medicare Part D rebate is expected to drop slightly compared to FY 2017 as well, from $5.4 million to $4.9 million.

For Scenario 2, the total funding level is approximately the same, at $2.38 billion. The only significant changes are a $100 million drop in anticipated member contributions ($422 million instead of $522 million) and an $82 million increase in reimbursements ($313 million instead of $231 million). The other funding sources remain untouched, included GRF, which remains at $1.415 billion regardless of Scenario 1 or 2.

TABLE 3: GROUP INSURANCE FUNDING SOURCES
FY 2017 - FY 2018
($ in Millions)

	FY 2017	FY 2018 Scenario 1	$ Change from FY17	% Change from FY17	FY 2018 Scenario 2	$ Change from FY17	% Change from FY17
GRF Appropriation	$1,810.0	$1,415.0	($395.0)	-21.8%	$1,415.0	($395.0)	-21.8%
Road Fund	$243.9	$125.0	($118.9)	-48.8%	$125.0	($118.9)	-48.7%
University Cont.	$51.3	$45.0	($6.3)	-12.3%	$45.0	($6.3)	-12.3%
Member Cont.	$419.0	$521.9	$102.9	24.6%	$421.5	$2.5	0.6%
Other Funds	$346.6	$231.2	($115.5)	-33.3%	$312.9	($33.7)	-9.7%
Medicare Part D rebate	$5.4	$4.9	($0.5)	-9.3%	$4.9	($0.5)	-9.3%
Rebates/Interest/Other.	$56.8	$57.4	$0.6	1.1%	$57.4	$0.6	1.1%
TOTAL	**$2,933.0**	**$2,400.3**	**-$532.7**	**-18.2%**	**$2,381.7**	**-$551.3**	**-18.8%**

Source: CMS. The FY 2017 Road Fund total includes the FY 2016 appropriation, which was not received until FY 2017.

CMS sets target end-of-year fund balances for both the Health Insurance Reserve Fund and the Group Insurance Premium Fund. The FY 2018 budget target balance for the Group Insurance Program is $30 million. For FY 2018, as in previous years, the GIPF target balance is $8 million, and the target HIRF balance is $22 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 the 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 I 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.

Starting in FY 2014, Medicare-eligible retirees and their Medicare-eligible dependents were moved into Medicare Advantage (MA) plans. Individual retirees and dependents have the choice of five different plans that range from MA HMO plans to a MA PPO plan. These plans became effective February 1, 2014 (Health Alliance MA HMO - 2015). The retirees and dependents can still access benefits from the same dental, vision and life insurance plans that current state employees and dependents utilize.

For FY 2018, CMS does not anticipate that the current benefits will be altered by the proposed changes to insurance plan rates, co-payments, deductibles, etc. While employees will pay different amounts depending on plan choice, the overall availability of benefits is not expected to be impinged. Employees, retirees, and their dependents should still be able to access their services and providers.

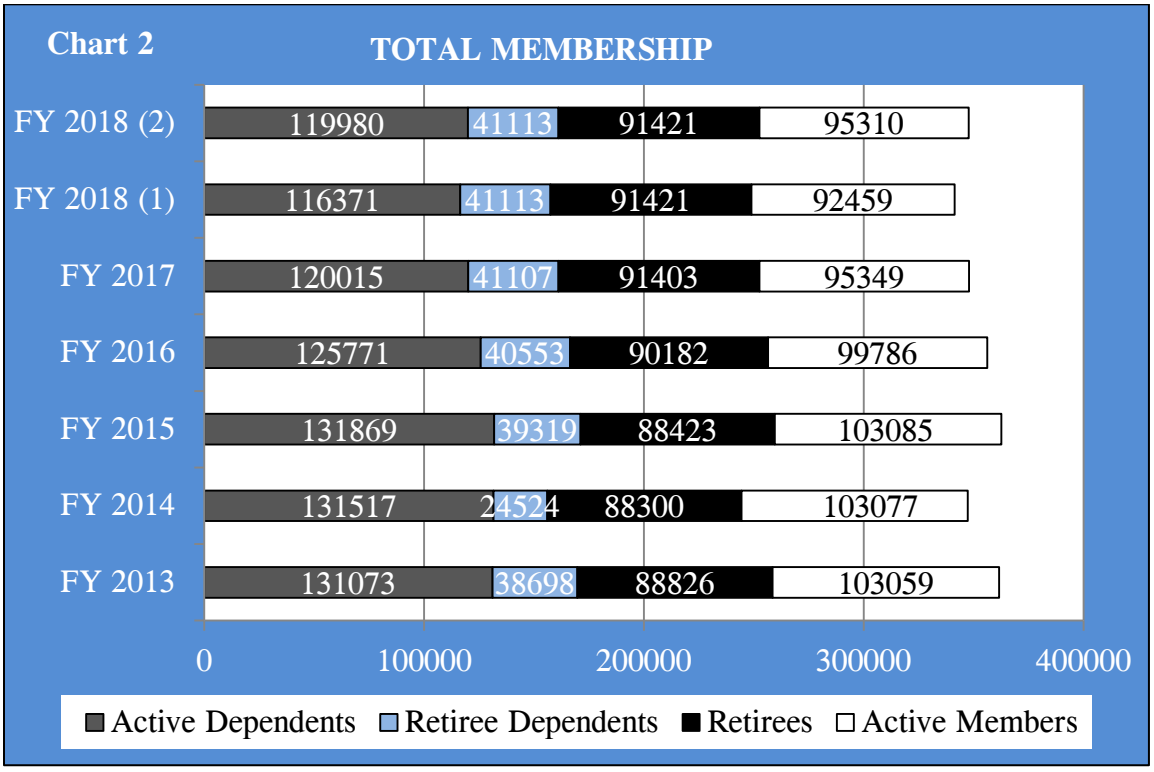
MEMBERSHIP

According to CMS, the State Employees' Group Health Insurance Program has an estimated 347,874 participants for FY 2017, of which 138,433 are in a non-Medicare Advantage HMO, 70,612 are in a Medicare Advantage HMO/PPO, 87,915 are in an Open Access Plan, and 50,914 are in the Quality Care Health Plan. The QCHP is estimated to have 16,111 employees, 13,554 active employee dependents, 7,675 retiree dependents, and 13,574 retirees in FY 2017. HMO plans are estimated to have 48,735 employees, 65,360 active employee dependents, 10,291 retiree dependents, and 14,047 retirees in FY 2017. Medicare Advantage plans in FY 2017 include 15,978 dependents

and 54,632 retirees. OAPs are anticipated to have 30,500 employees, 41,102 active employee dependents, 7,163 retiree dependents, and 9,150 retirees in FY 2017.

For FY 2018 (Scenario 1), the QCHP is estimated to have 15,624 employees, 13,144 active employee dependents, 7,676 retiree dependents, and 13,583 retirees. Medicare advantage HMO/PPO plans are expected to have 15,971 dependents and 54,616 retirees. Non-Medicare Advantage HMO Plans are expected to have 47,258 employees, 63,376 active dependent lives, 10,296 retiree dependents, and 14,062 retirees. OAPs are expected to have 29,573 employees, 39,852 active dependents, 7,170 retiree dependents, and 9,160 retirees in FY 2018. Total FY 2018 membership is expected to decline from 347,874 to 341,364 in part due to projected migration away from state group health insurance.

For Scenario 2, there is minimal change from FY 2017 to FY 2018, as total overall enrollment is projected to be only down by 50 individuals, from 347,874 to 347,824. Accordingly, only slight changes are expected to FY 2017 populations in existing plans. In addition, no significant migrations of actives or retirees (or their dependents) are anticipated.



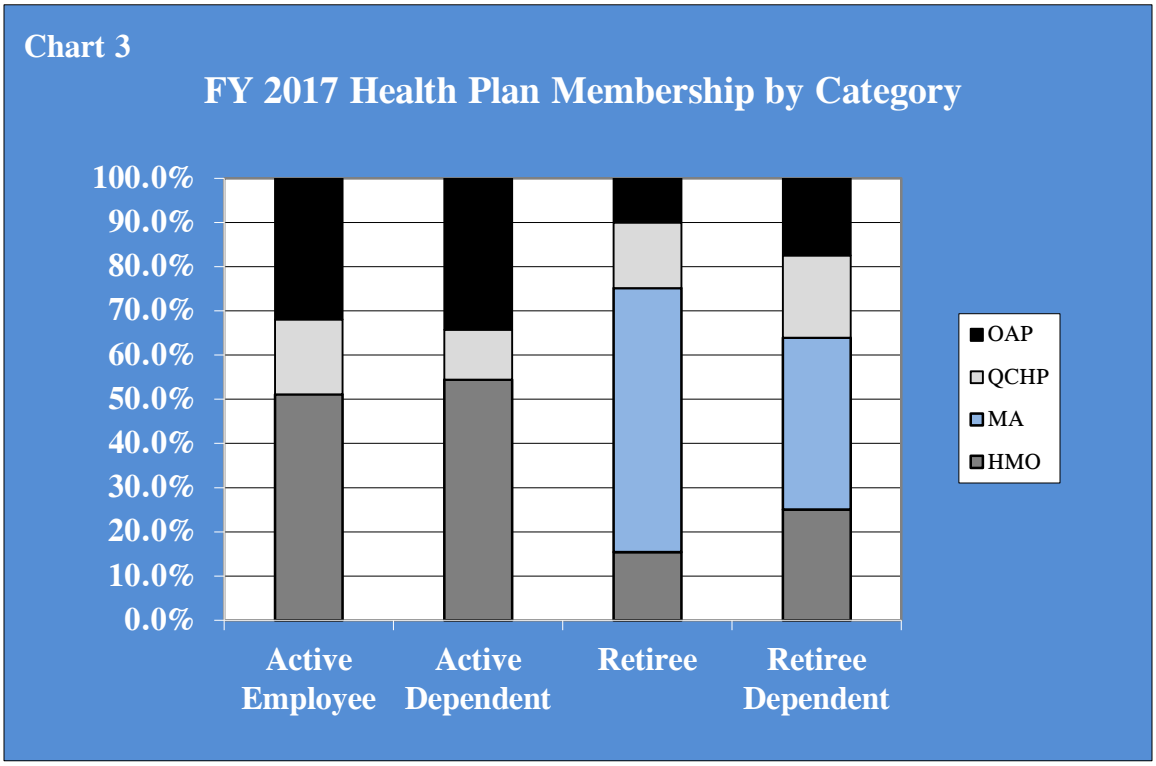
- **Membership (including CIP, TRIP, etc.) is estimated for FY 2018. 1 and 2 refer to Scenarios 1 and 2**

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. Since FY 2012, many participants have switched away from traditional managed care (HMOs) to alternatives such as the Open Access Plan (OAP). This trend appears to have stabilized the past few years, and is reflected in FY 2017 membership projections by CMS. In recent years, the movement of retirees/dependents to Medicare Advantage plans has resulted in lower enrollment for both HMOs and OAPs.

For FY 2018, membership in HMOs is broken down by standard HMO membership and Medicare Advantage HMO/PPO membership. Standard HMO membership is expected to continue its decline over the last several fiscal years, though it is anticipated to remain the highest population category among those measured (QCHP, OAP, etc.). For Scenario 1, Medicare Advantage HMO/PPO plans are expected to stay mostly steady, dropping only slightly from 70,612 in FY 2017 to 70,589 for FY 2018. Membership is expected to stay steady or grow in future years as retirees continue to qualify for Medicare Advantage.

Chart 3 shows the breakdown of employee, dependent and retiree enrollment in the overall group insurance program in Scenario 1. Due to the shift towards MA HMO/PPO plans by retirees, the QCHP has become much less utilized among employees as a whole, especially retirees. In FY 2018, 59.7% of retirees are expected to enroll in a Medicare Advantage HMO/PPO, as required by the State of Illinois. Chart 3 shows that employees, retirees, and dependents from both groups are gravitating towards managed care and Open Access Plans.



LIABILITY

The Department's estimate of liability in Scenario 1 for FY 2018 represents a 9.0% drop from FY 2017. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2009 through FY 2018 and 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 segments of total liability. However, in recent years, HMOs, OAPs and the QCHP have claimed the majority of group insurance liability. While the Open Access Plan is anticipated to continue to have more liability for the State of Illinois than the QCHP and prescription components as a whole in FY 2018 ($640 million compared to $491 million), the Interest Payments category has grown to the extent that it is expected to compose $516 million in FY 2017 and $493 million in FY 2018.

Other components of liability in Scenario 1, such as Mental Health, Vision, Dental, and Life Insurance are mostly holding steady or decreasing slightly from FY 2017 to FY 2018. These components are only a small fraction of total liability as a whole, and are expected to remain in that position in years to come, as QCHP/HMO/OAP plans are utilized more by most state employees, retirees, and dependents. In recent years, interest on payments has become a major issue for the State of Illinois, and with the anticipated delays in payments to vendors expected to continue in FY 2018, this component is unlikely to decrease absent major action. Scenario 2 keeps most of the existing liabilities in FY 2017 steady to slight increases, except for QCHP and HMOs, which are projected to rise by $46 million and $74 million respectively.

Table 4 STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY (CMS ESTIMATE) (FY 2009-FY 2018)

$ in (millions)

Liability Component	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018 Scenario 1 (Proposed)	2018 Scenario 2 (Status Quo)
QCHP Medical/Rx	$726	$731	$731	$749	$731	$639	$522	$524	$543	$491	$589
HMO Medical	$844	$911	$1,007	$853	$894	$910	$917	$934	$979	$827	$1,053
Medicare Advantage	$0	$0	$0	$0	$0	$62	$156	$173	$183	$183	$183
Dental	$110	$115	$129	$112	$118	$119	$123	$130	$132	$130	$136
Open Access Plan	$213	$252	$286	$528	$582	$615	$653	$685	$713	$640	$713
QC Mental Health	$8	$11	$8	$7	$7	$6	$5	$6	$6	$5	$6
Vision	$8	$8	$10	$11	$12	$11	$11	$8	$8	$8	$8
Life Insurance	$81	$84	$83	$83	$84	$88	$95	$91	$90	$90	$90
QC ASC	$31	$32	$32	$33	$33	$26	$19	$17	$17	$17	$18
Interest Payments	$5	$33	$49	$50	$92	$161	$116	$16	$516	$493	$518
Admin/Other	$13	$12	$13	$13	$14	$16	$35	$55	$103	$110	$110
Total	**$2,039**	**$2,189**	**$2,347**	**$2,439**	**$2,567**	**$2,653**	**$2,651**	**$2,639**	**$3,290**	**$2,994**	**$3,424**
% change over py	7.8%	7.3%	7.2%	3.9%	5.2%	3.4%	0.0%	-0.5%	24.7%	-9.0%	4.1%

Source: CMS. Rounding causes slight differences in totals.

GROUP INSURANCE INTEREST PAYMENTS

In recent years, SEGIP interest payments have grown at an alarming rate as the SEGIP has been forced to push payments for services further and further into the future. This is done by "holding" claims until the actual money is available for payment. As a result, these "held claims" accrue interest at rates of 9 or 12 percent annually depending on the criteria of the claim. Timely Pay Interest (0.75% per month), as cited in the Illinois Insurance Code, covers QCHP, OAP, Dental, and Mental Health claims payments. This interest is calculated at 9% annually after an initial 30 day period. Prompt Payment Interest (12%), as cited in the Prompt Payment Act, covers HMOs, Vision, Life Insurance, and administrative fees for the QCHP/OAP/Dental/Mental Health programs. This interest is calculated at 1% per month after an initial 90 day period.

For example, claims in the QCHP, are typically paid out under the 9 percent calculation, while claims from HMOs are paid out at 12 percent. Further exacerbating the issue is the inability of the State to pass a budget into law. Without spending authority, CMS is unable to pay down FY 2016 and later fiscal year claims and must hold them as they accrue additional interest by the day. CMS can use employee premium contributions to help defray some of these costs, but the vast majority of incurred claims continue to accrue interest, and in some cases, past due interest (interest on interest). As of the end of February 2017, the State has approximately $4.2 billion in health insurance claims waiting to be paid out. Of that total, HMO claims (excluding Medicare Advantage) account for $1.8 billion, Prescription/Open Access Plans/Mental Health claims account for $1.2 billion, and CIGNA claims account for $641 million. This does not include the interest due on these debts. This total is increasing by approximately $200 million per month on average. As of February 29, 2017, the State is obligated to pay $397 million in interest payments on bills that have been held beyond the 30 or 90 day grace period, to-date. This interest amount will continue to increase as the budget stalemate continues and the payment delays increase. Under the current projections of Scenario 1 (Projected Changes), the anticipated interest accumulated in FY 2018 will be $518 million, for a two year total of $1.01 billion in interest on the liabilities of the SEGIP. The table on the following page details the major portions of the current claims hold situation with existing interest rates of 9 and 12 percent, as of February 2017.

Table 5 Claims Hold Data for SEGIP (as of February 29, 2017)			
Company	Claims Hold	Length of Claims Hold (in days)	Interest Owed (Including Past Due Interest)
CIGNA - PPO (and Member)	$605,294,124	615	$44,554,354
CIGNA - Non-PPO	$35,630,747	692	$2,966,260
Dental Claims Hold – PPO	$88,628,396	450	$6,955,244
Dental - Non-PPO	$43,519,266	618	$4,954,501
Magellan (Mental Health) Claims	$5,126,631	275	$146,116
Coventry HMO	$64,742,996	309	$4,323,745
Health Alliance HMO	$1,048,035,125	734	$97,809,606
HMO Illinois	$615,545,162	706	$55,468,001
Blue Advantage	$87,075,771	675	$6,819,928
HealthLink OAP	$674,888,645	569	$43,525,106
Coventry OAP	$141,162,124	513	$7,980,228
Medco	$47,252,735	658	$58,142,382
CVS/Caremark	$367,919,735	593	$24,152,745
Coventry Medicare Advantage (MA)	$11,556,527	553	$1,030,293
Health Alliance MA	$2,179,206	614	$176,931
Humana Benefit Plan MA	$382,040	584	$43,572
Humana Health Plan MA	$7,561,378	584	$845,506
United Healthcare MA	$272,898,331	362	$30,563,696
Fidelity (Vision)	$11,131,156	369	$676,161
Other Fees (ASC/etc.)	$51,074,675	431-492	$5,788,687
Total	**$4,181,604,770**	**275-734**	**$396,923,062**

ANNUAL LIABILITY PER PARTICIPANT

The liability per participant in the State Employees' Group Insurance Program is the total of the State's liability across all participants. Chart 4 shows the steady increase each year in cost per participant, though FY 17 and FY 18 (Scenarios 1 and 2) deviate significantly from past fiscal years. As plan participants live increasingly longer lives, utilization of medical insurance plans (and thereby liabilities to the state) have tended to increase accordingly. In FY 2009, the annual liability per participant in the group health insurance program was $5,893.

According to CMS, the estimated liability per participant for FY 2017 will be $9,453, a large increase. This is in part due to much higher interest payment liabilities projected to total $493 million in FY 2018 under Scenario 1 ($518 million under Scenario 2), resulting from no budgeted appropriations to pay down existing liabilities. For FY 18 (Scenario 1), the estimated liability per participant is $8,767,

which represents a 48.8% increase over a ten year period. Scenario 2 envisions a moderate increase to $9,843.

Under Scenario 1, The FY 2018 liability per participant is projected to decrease 7.3% from FY 2017. Scenario 2 envisions a 4.1% increase from FY 2017. It is important to note that this is only an aggregate liability representation, which is not itemized based on the types of plans used by participants or any other variables. Furthermore, as mentioned previously, due to increased interest payment liabilities, the liabilities of FY 17 and FY 18 are significantly higher than FY 16, despite a projected drop in liability in FY 18 due to anticipated plan changes and participant migration.

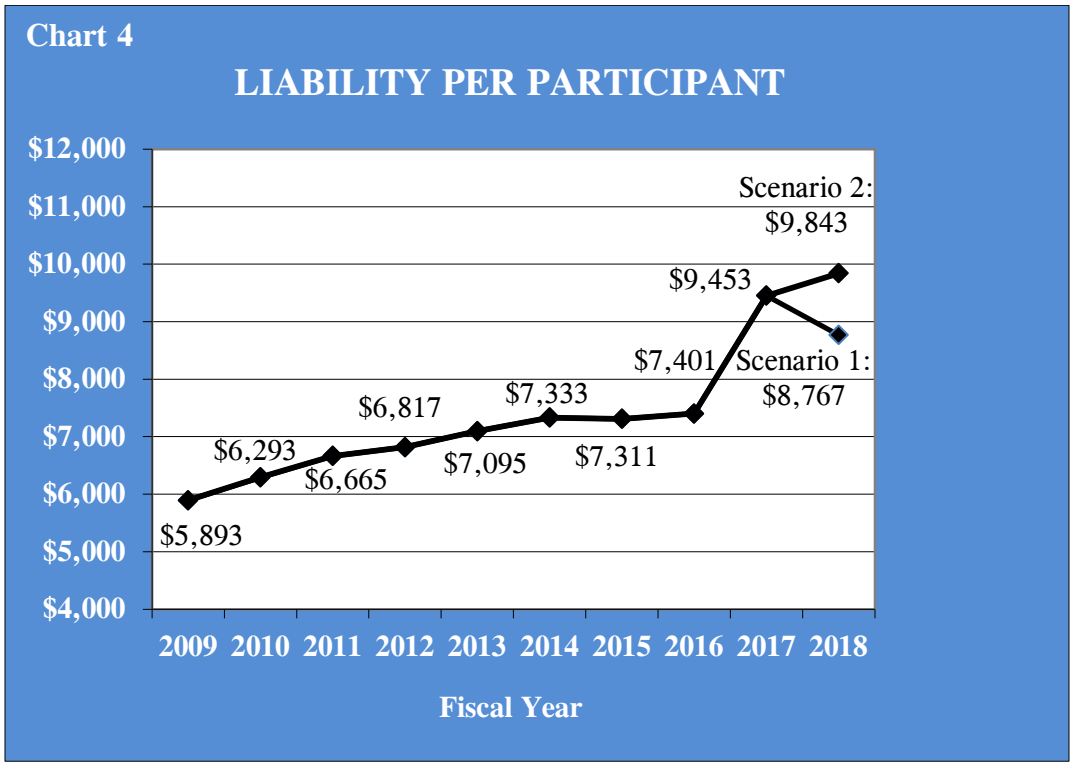


Table 6: ANNUAL LIABILITY PER PARTICIPANT						
	FY 2017	FY 2018 Scenario 1	FY 2018 Scenario 2	FY 2017	FY 2018 Scenario 1	FY 2018 Scenario 2
	Total Participants	Total Participants	Total Participants	Liability Per Participant	Liability Per Participant	Liability Per Participant
QCHP	50,914	50,027	50,916	$10,661	$9,811	$11,568
MA HMO / PPO	70,612	70,589	70,589	$2,587	$2,587	$2,587
HMO	138,433	134,992	138,414	$7,069	$6,125	$7,608
OAP	87,915	85,755	87,905	$8,113	$7,465	$8,113
Totals	347,874	341,363	347,824			
OAP is the Open Access Plan. ALPP does not include dental, vision, admin/interest/other, or life insurance. FY 2018 QCHP liability assumes more individual retirees and dependents not yet Medicare Advantage qualified, but still utilizing services, making it proportionately more expensive for remaining participants. Numbers are not adjusted for risk.						

When comparing annual liability per participant (ALPP) in Table 6, the annual liability for FY 2017 is lowest for members in the Medicare Advantage HMO and highest for members in the QCHP. The total number of participants in the QCHP has declined in recent years as people have steadily migrated to HMOs and OAPs. This trend was accelerated in FY 2014 and FY 2015, as most retirees (over 90 percent) were moved from QCHP to a Medicare Advantage HMO/PPO plan. This shift has resulted in an increase in average cost for remaining QCHP participants, as those who remain, including non-Medicare eligible retirees and dependents are predominantly the more expensive to cover (requiring more treatment, medicines, etc.).

In addition, the proposed plan changes by CMS are expected to exacerbate the situation. As many of the QCHP participants are retirees and their dependents, they are more likely to need and make use of medical services, thereby driving up the costs. They are also more likely to stay on QCHP, especially in the "Platinum" tier, as they are more likely to need services that would cost more to them in a lower tier. The QCHP is also the preferred plan for retirees and dependents who live or travel primarily out of Illinois, as traditional HMOs/OAPs have limited coverage outside the state. This results in the much higher projected liability for QCHP participants under Scenario 1 in FY 2018 (and an 88.8% increase compared to FY 2017). Scenario 2 envisions a much more moderate, though still significant, 8.5% increase for QCHP. Accordingly, Scenario 2 HMO liability is expected to increase 7.6% per participant relative to FY 2017, compared to the 13.3% drop projected under Scenario 1.

MEMBER CONTRIBUTIONS

An important factor in the examination of cost per participant is the amount paid by the State versus the member. The Average Liability Per Person (ALPP) per enrollee in the QCHP is $10,661 in FY 2017. Member contributions for QCHP enrollees are expected to total $74 million. This means that of the total cost per participant, $1,471 or 14% of that cost is covered by member contributions. Prior to the *Kanerva* decision by the Illinois Supreme Court, retirees were contributing part of their pension income towards their group insurance coverage. However, since that court decision, contributions from retirees have dropped sharply from the set of retirees with 20 years or more of service, who are exempt from health insurance contribution deductions from their pension income. In addition, many retirees have been moved out of QCHP towards a Medicare Advantage HMO/PPO plan. This leaves fewer people in the QCHP, causing the cost per participant for that program to rise (due to the generally increased expenses incurred by QCHP participants). Table 7 examines the relationship between overall cost and the offset by member contributions for Scenario 1.

TABLE 7: MEMBER CONTRIBUTIONS AND AVERAGE LIABILITY PER PARTICIPANT PER YEAR (ALPP)

	FY 2017 ALPP	FY 2017 Member Contributions	FY 2017 State Liability	FY 2018 Scenario 1 ALPP	FY 2018 Member Contributions	FY 2018 State Liability
QCHP	$10,661	$1,471	$9,190	$9,811	$1,919	$7,892
MA HMO/PPO	$2,587	$387	$2,200	$2,587	$391	$2,196
HMO	$7,069	$984	$6,085	$6,125	$1,208	$4,917
OAP	$8,113	$1,038	$7,075	$7,465	$1,283	$6,182
Dental	$382	$94	$288	$376	$197	$179

Source: CMS.

The table above shows that QCHP members are expected to contribute 19.6% of the overall annual cost of providing their insurance in FY 2018. HMO/OAP/MA HMO (and PPO) members are expected to contribute 19.7%, 17.2%, and 15.1% of their overall liability cost in the same time period. Members that participate in the State's dental offering are expected to pay 52% 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. For FY 2017 and FY 2018, member contribution rates are not yet set due to ongoing labor negotiations and legal actions involving the State of Illinois. FY 2017 rates are currently the same as FY 2016 rates. Information on final rates and contributions will be provided in a supplement to this report when the information becomes available. Though not shown, Scenario 2 member contributions are consistent with FY 2017 rates and have minimal change from the prior fiscal year.

Chart 5 includes the various components of the FY 2018 CMS Scenario 1 liability estimate of approximately $2.993 billion. The largest component of the State Group Insurance Program continues to be the State's managed care plans (HMO, OAP, MA HMO/MA PPO) which now represent 55.1% of FY 2018 liability, a decrease from 64.0% in FY 2017. Dental care, life insurance, and vision care equal 7.7% of total liability. The QCHP component (17.0%) is lower than FY 2017 (19.8) and includes medical/prescriptions, mental health coverage, and administrative service charges. For FY 18, interest payments are significantly higher than FY 17 (8.1%) as a total projected percentage of the components of Group Insurance liability at 16.5%.

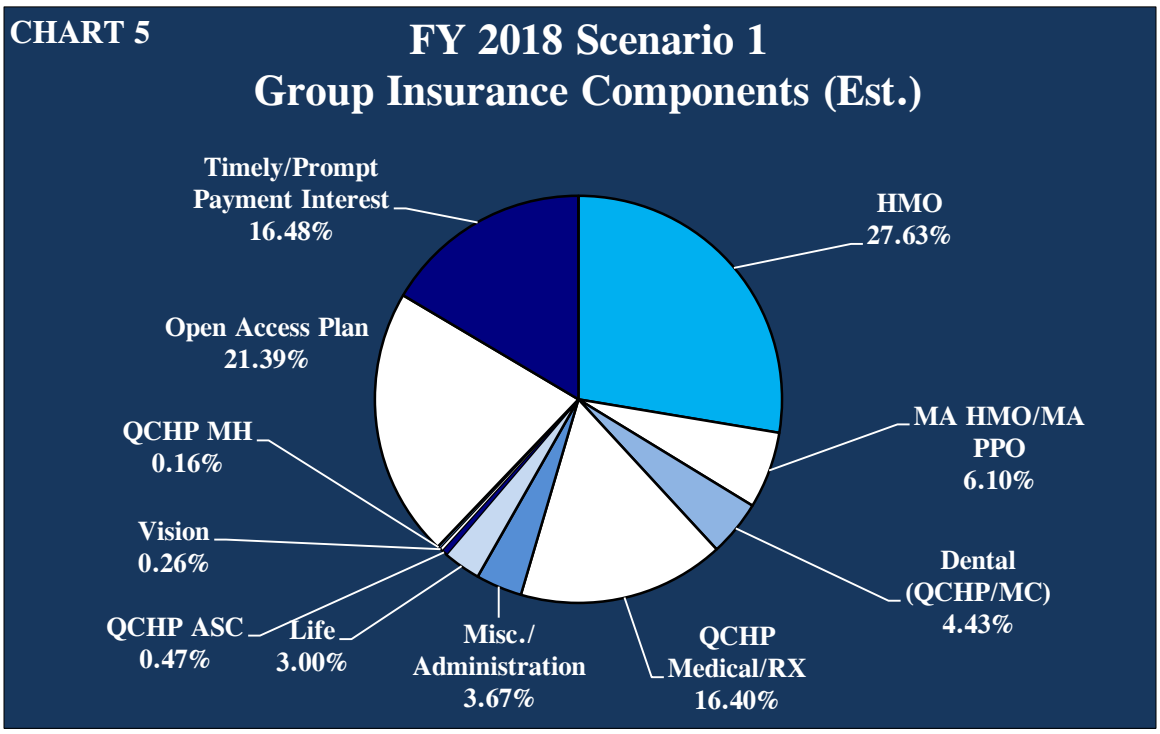
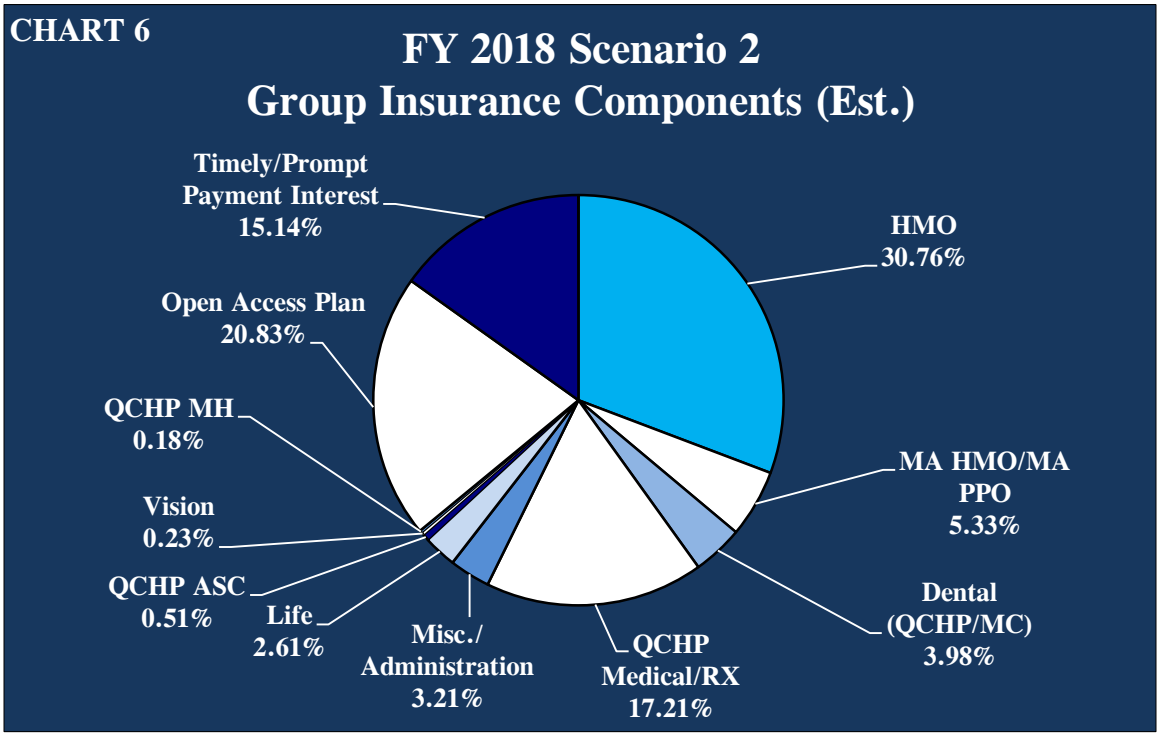


Chart 6 on the next page includes the components of the FY 2018 CMS Scenario 2 liability estimate of approximately $3.423 billion. As in Scenario 1, the largest components of the State Group Insurance Program are the managed care plans, which collectively represent 56.9% of FY 2018 liability, also decreasing from 64.0% in FY 2017. In this scenario, dental care, life insurance, and vision care equal 6.8% of total liability. Similar to Scenario 1, the QCHP component (17.9%) remains lower than FY 2017. In this scenario, interest payments are slightly lower as a percentage (15.1%) than in scenario 1, but only because the overall liability is significantly larger.



Regardless of Scenario 1 or 2, since the movement of retirees to MA HMO/PPO plans, it is extremely unlikely that the QCHP will rise to the proportion of the total group insurance liability it had attained before FY 2014. At the same time, the availability, affordability, and migration requirement of MA HMO/PPO plans for the State of Illinois indicates that this area of liability is not likely to shrink in size or proportion in the near future. In regards to Open Access Plans, they remain an option for state employees and non-Medicare eligible individuals who seek a middle ground between the affordability of HMOs and the options available to QCHP participants.

As detailed previously in this report, the rising growth of interest payments is a matter of concern for policymakers and budgeters, as these payments represent "lost money" that could be spent elsewhere within the program or in other areas of the state budget. Interest payments for Scenario 1 are projected to be 16.5% (or $493 million) in FY 2018 and $516 million in FY 2017 ($518 million in Scenario 2 for FY 2018). This area of the SEGIP budget represents a long-term fiscal problem, as the State of Illinois has been unable to make the contributions necessary to pay claims in a timely manner for many years. Without budgetary changes, this percentage will likely grow and further constrict state revenues along with limiting budgetary outcomes for the SEGIP.
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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. The Illinois Supreme Court decision in *Kanerva* has resulted in reduced contributions for many retirees. Table 8 displays a comparison of the costs in the case of Scenario 1 for these groups taken from data obtained from CMS as of February 2017. It is necessary to note that these costs (to active members, dependents, and retirees) are reflective of current labor contracts only and are likely to change given the results of ongoing labor discussions and court cases. Scenario 2 is not shown, as it is projected to be substantially the same as FY 2017.

TABLE 8: RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 18
(Numbers in Millions)

Category	Cost	Category	Cost
Retiree Cost	$807.6	Active Employee Cost	$1,242.9
Retiree Contribution	-$39.3	Active Employee Contribution	-$207.0
Other Revenues	-$15.1	Other Revenues	-$16.4
Net State Cost	**$753.2**	**Net State Cost**	**$1,019.5**
Retiree Dependent Cost	$324.8	Active Employee Dependent Cost	$913.1
Retiree Dependent Contribution	-$59.7	Active Employee Dependent Contribution	-$113.0
Other Revenues	-$8.3	Other Revenues	-$16.3
Net State Cost	**$256.8**	**Net State Cost**	**$783.8**
Total Retiree Cost	$1,132.4	Total Active Cost	$2,156.0
Total Retiree Contribution	-$99.0	Total Active Contribution	-$320.0
Other Revenues	-$23.4	Other Revenues	-$32.7
Total State Cost	**$1,010.1**	**Total State Cost**	**$1,803.2**

Source: CMS

A number of points can be observed from this table. As has been the trend in the past, retiree dependents and active employee dependents continue to pay a substantially larger portion of their total costs to the State in the form of contributions for their healthcare coverage. However, due to the Illinois Supreme Court decision in the *Kanerva* case, which rejected state of Illinois attempts to increase contributions from retirees and dependents, those contributions decreased. For FY 2018, retirees and retiree dependents are projected to pay 4.9% and 18.4% of their healthcare costs respectively. This contrasts with active employees and their dependents, who are

projected to pay 16.7% and 12.4% respectively. In total, the contributions of active employees and dependents (14.8%) remains significantly higher as a percentage than retirees and retiree dependents (8.7%). This cost difference results in part from retirees utilizing Medicare Advantage HMO and PPO plans and resulting savings for the State of Illinois.

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 2016, FY 2017, and FY 2018 plan enrollment is listed in Table 9 (Scenario 1). Scenario 2 is not shown, as the numbers are almost exactly the same as in FY 2017.

TABLE 9: MANAGED CARE PLANS
FY 2016-2018 All Lives (Active Members/Dependents and non-MA Retirees/Dependents)

HMO/OAP	FY16 # of Participants	FY17 # of Participants	% Change 2016-2017	FY18 # of Participants	% Change 2017-2018
Health Alliance HMO	76,909	75,435	-1.92%	73,587	-2.45%
HMO Illinois	49,765	47,607	-4.34%	46,406	-2.52%
Blue Advantage	7,701	8,437	9.56%	8,211	-2.68%
Coventry Health Care HMO	7,092	6,954	-1.95%	6,784	-2.44%
Coventry Health Care OAP	21,249	19,478	-8.33%	18,988	-2.52%
Health Link OAP	70,658	68,437	-3.14%	66,770	-2.44%
TOTALS	**233,374**	**226,348**	**-3.01%**	**220,746**	**-2.47%**

Source CMS. FY 18 numbers are projected as of February 2017.

MEDICARE ADVANTAGE

A continuing development from the 2014 fiscal year onward is the movement of eligible retirees and dependents into a system of Medicare Advantage (MA) plans. These plans were set forth in an effort to save the State money as well as to provide quality service and care for retirees and their dependents. Table 10 (Scenario 1) below shows the population figures involved with this new program.

TABLE 10: MEDICARE ADVANTAGE PLANS FY 2018

HMO/PPO	FY16 # of Participants	FY17 # of Participants	FY18 # of Participants
Aetna HMO	3823	3,891	3,890
Humana Benefit Plan HMO	122	124	124
Humana Health Plan HMO	2482	2,578	2,577
Health Alliance HMO	726	823	823
United HealthCare PPO	62610	63,196	63,175
TOTALS	**69,763**	**70,612**	**70,589**

Source: CMS. FY 18 numbers are projected as of February 2017

It is important to note that except for a limited number of retirees and dependents coming from a HMO or OAP program, almost all of the 70,612 people covered in FY 2017 by a MA HMO or PPO plan came from the QCHP. In regards to MA, there are two different HMO benefit plans being offered by Humana as Humana Benefit Plan is intended for Livingston and Knox counties while Humana Health Plan is a traditional open area Medicare Advantage plan. The Health Alliance HMO plan was first offered during the 2015 fiscal year. The monthly rates for the State's Medicare Advantage plans are discussed in the Monthly Premiums section of this report. Scenario 2 envisions this program having minimal population change from the 2017 fiscal year.

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. For FY 2018, the State has proposed a new system of premiums (and deductibles/co-payments/etc.) based on four separate options for each current health insurance plan (Scenario 1). The premium options range from as high as 142% above the FY 2017 premium (maximum salary range contribution for an HMO "Platinum" plan) to $0 (all "Bronze" plans).

According to CMS, the projected monthly premium for a current employee making $50,000/year in the QCHP for FY 2018 will be $270, compared to $127/month in FY 2017. Information regarding charges for dependents as well as rates for HMOs and OAPs is included in Table 12.

For the purposes of Tables 11 and 12, the CMS projections of rates are based on the current legal cases being decided in favor of the State. If the State is prevented from applying the projected premium rates for employees, retirees, and dependents, then the contractually agreed increases from year to year will likely be applied for FY 2018.

TABLE 11: PROJECTED MONTHLY COSTS
FY 2011 - FY 2018
Employee Only – Platinum Membership

	QCHP				HMO				OAP			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY11	$765	5.9%	$90	$684	$560	9.2%	$60	$516	$679	4.1%	$59	$620
FY12	$827	8.2%	$90	$746	$572	2.1%	$60	$529	$685	0.9%	$60	$625
FY13	$883	6.8%	$90	$800	$602	5.2%	$60	$567	$699	2.0%	$60	$639
FY14	$872	-1.3%	$166	$714	$631	4.8%	$122	$534	$707	1.1%	$120	$587
FY15	$884	1.4%	$168	$716	$661	4.8%	$125	$536	$745	5.4%	$124	$621
FY16	$969	9.6%	$170	$799	$692	4.7%	$126	$566	$784	5.2%	$125	$659
FY17	$969	0.0%	$170	$799	$740	6.9%	$126	$614	$850	8.4%	$125	$725
FY18	$950	-2.0%	$377	$573	$615	-16.9%	$279	$336	$751	-11.6%	$281	$470

TABLE 12: MONTHLY PREMIUMS
Managed Care vs. Indemnity Plan
Weighted Average
FY 2018 Rates (Projected for Median Salary)

	QCHP			HMO			OAP		
Platinum Membership	TOTAL	Member	State	TOTAL	Member	State	TOTAL	Member	State
Employee	$950	$377	$573	$615	$278	$337	$751	$276	$475
Medicare Retiree	$526	$15	$511	$231	$11	$220	$572	$11	$561
Non-Medicare Retiree	$1,392	$19	$1,373	$1,095	$15	$1,080	$1,309	$15	$1,294
1 Dependent	$1,077	$559	$518	$541	$253	$288	$658	$283	$375
2+ Dependents	$1,393	$653	$740	$903	$361	$542	$1,092	$400	$692
Medicare Dependent	$553	$161	$392	$237	$96	$141	$553	$114	$439

TABLE 13: MONTHLY PREMIUMS ACROSS ALL PLANS HMOs and OAPs FY 2018 Proposed Rates						
Platinum Membership - Median Salary	**Health Alliance**	**Coventry HMO**	**HMO Illinois**	**Blue Advantage**	**HealthLink OAP**	**Coventry OAP**
Employee	$277.99	$278.19	$281.91	$274.68	$275.85	$278.19
Medicare Retiree	$10.82	$10.82	$10.82	$10.82	$10.82	$10.82
Non-Medicare Retiree	$15.38	$15.38	$15.38	$15.38	$15.38	$15.38
1 Dependent	$253.28	$249.82	$225.40	$214.91	$282.97	$249.82
2 + Dependents	$361.04	$352.74	$318.80	$300.02	$400.42	$352.74
Medicare Dependent	$96.00	$95.00	$99.57	$81.00	$114.29	$95.00
Gold Membership - Median Salary	**Health Alliance**	**Coventry HMO**	**HMO Illinois**	**Blue Advantage**	**HealthLink OAP**	**Coventry OAP**
Employee	$202.11	$202.25	$204.96	$199.70	$200.55	$202.25
Medicare Retiree	$10.82	$10.82	$10.82	$10.82	$10.82	$10.82
Non-Medicare Retiree	$15.38	$15.38	$15.38	$15.38	$15.38	$15.38
1 Dependent	$184.11	$182.25	$163.93	$156.86	$206.35	$182.25
2 + Dependents	$263.05	$256.35	$232.33	$218.57	$291.68	$256.35
Medicare Dependent	$93.00	$92.00	$96.05	$78.00	$95.59	$92.00
Silver Membership - Median Salary	**Health Alliance**	**Coventry HMO**	**HMO Illinois**	**Blue Advantage**	**HealthLink OAP**	**Coventry OAP**
Employee	$125.92	$126.01	$127.70	$124.42	$124.95	$126.01
Medicare Retiree	$10.82	$10.82	$10.82	$10.82	$10.82	$10.82
Non-Medicare Retiree	$15.38	$15.38	$15.38	$15.38	$15.38	$15.38
1 Dependent	$114.94	$113.65	$102.46	$97.78	$128.72	$113.65
2 + Dependents	$164.02	$159.97	$144.81	$136.09	$181.92	$159.97
Medicare Dependent	$89.00	$88.00	$92.54	$75.00	$105.98	$88.00
Bronze Membership - Median Salary	**Health Alliance**	**Coventry HMO**	**HMO Illinois**	**Blue Advantage**	**HealthLink OAP**	**Coventry OAP**
Employee	$0	$0	$0	$0	$0	$0
Medicare Retiree	$0	$0	$0	$0	$0	$0
Non-Medicare Retiree	$0	$0	$0	$0	$0	$0
1 Dependent	$0	$0	$0	$0	$0	$0
2 + Dependents	$0	$0	$0	$0	$0	$0
Medicare Dependent	$0	$0	$0	$0	$0	$0
* Individuals whose salary is above or below the median may pay more or less in real dollars, but will pay a similar percentage increase from their FY 2017 premiums.						

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, etc. New for FY 2018 are the different proposed tiers of each health existing health plan (except for the Medicare Advantage plans). The premiums of these tiers are priced differently based on the prices of the deductibles/co-payments/etc. contained in each of these plans. For example, a Platinum-tier Health Alliance plan will have a lower deductible for yearly health expenses than a Silver-tier Health Alliance plan. However, the Silver tier of plans is designed to be roughly the same price as FY 2017 plan

premiums. For individuals valuing continuity in premium pricing above all other factors, this tier would be most attractive. However, the Silver tier plans have much higher costs outside of premiums.

This tier system is part of an effort by the State of Illinois to move closer to a market-based distribution of health costs. Outside of Illinois, most plans have a 60/40 split, where the employer pays approximately 60% of health insurance costs while the employee pays the remaining 40%. Illinois is unusual in that the split is much lower, as employees pay a much smaller portion of the total health insurance cost. Whether by increased premiums or increased co-payments/deductibles/etc., these plans would allow the State to adjust the proportion closer to the 60/40 distribution.

Table 14 shows a comparison between FY 2016 and projected FY 2018 MA rates for retirees and dependents. These rates are not expected to increase in the manner seen in FY 2018 rates for the other health plans.

TABLE 14: MONTHLY PREMIUMS FOR STATE MEDICARE ADVANTAGE PLANS
FY 2016-2018 Rates (As of February 2017)

Aetna HMO	FY 2016	FY 2017	FY 2018
Medicare Retiree	$10.01	$10.41	$10.82
Medicare Dependent	$89.00	$89.00	$89.00
Humana Benefit Plan HMO	FY 2016	FY 2017	FY 2018
Medicare Retiree	$10.01	$10.41	$10.82
Medicare Dependent	$89.00	$89.00	$89.00
Humana Health Plan HMO	FY 2016	FY 2017	FY 2018
Medicare Retiree	$10.01	$10.41	$10.82
Medicare Dependent	$89.00	$89.00	$89.00
United HealthCare	FY 2016	FY 2017	FY 2018
Medicare Retiree	$10.01	$10.41	$10.82
Medicare Dependent	$110.00	$110.00	$110.00
Health Alliance HMO	FY 2016	FY 2017	FY 2018
Medicare Retiree	$10.01	$10.41	$10.82
Medicare Dependent	$89.00	$89.00	$89.00

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 (and band selection – Scenario 1). 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 for preventative services. 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/coinsurance levels vary.	Statewide coverage
MA HMO	Comprehensive medical benefits including preventive care.	Prepaid benefits, primary care physician who coordinates all care chosen from HMO network.	Statewide coverage
MA PPO	Comprehensive medical benefits including preventive care.	Choice of physician and other medical care providers.	Statewide coverage

APPENDIX II

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.

Status of Contracts for FY 16 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	**Renew** - Term goes to June 30, 2017 with up to four 1-year renewals.
Medicare Advantage Health Plans	Aetna/Coventry HMO / Health Alliance HMO / Humana Benefits Plan HMO / Humana Health Plan HMO / UnitedHealthCare PPO	**Ongoing** - Term goes to December 30, 2017 with up to five 1-year renewals.
Self-Insured Medical Plan Administration	Cigna	**Ending** - Term goes to June 30, 2017. RFP in process.
Vision	EyeMed	**Ongoing** - Term goes to June 30, 2020 with up to five 1-year renewals.
Behavioral Health/EAP	Magellan	**Ongoing** - Term goes to June 30, 2021.
Flu Shots	Varies each plan year	**Ongoing -** Term goes to September 30, 2017 with 1-year renewal options.
Consulting Contracts	Segal / Deloitte	**Ongoing –** Segal ends 2018; Deloitte ends 2021.
Life Insurance	Minnesota Life	**Ongoing** - Term goes to June 30, 2021.
Flexible Spending	ConnectYourCare	**Ongoing -** Term goes to June 30, 2019 with up to five 1-year renewals
Administration of Dental Claims	Delta Dental	**Ongoing** - Term goes to June 30, 2021.
Prescription Drugs	CVS/Caremark	**Ongoing -**Term goes to June 30, 2018 with up to six 1-year renewals.
Commuter Savings Program	Endred Commuter Benefit Solutions	**Ongoing** - Term goes to June 30, 2020 with up to five 1-year renewals.

APPENDIX III

Medical Plan Summary	FY2018 QCHP Platinum Plan		FY2018 HMO Platinum Plans		FY2018 OAP Platinum Plans		
	In-Network	OON	In-Network	OON	Preferred Network	In-Network	OON
Annual Deductible							
* Single	$375 - $525 (Salary-Based)	$375 - $525 (Salary-Based)	$0	n/a	$0 Per Person	$250 Per Person	$350 Per Person
* Family	$937 - $1,312 (Salary-Based)	$937 - $1,312 (Salary-Based)	$0	n/a			
Annual Out of Pocket Maximum							
* Single	$1,500	$6,000	$3,000	n/a	$6,250 (Inlcudes eligible charges from Tier I and Tier II combined)		Unlimited
* Family	$3,750	$12,000	$6,000	n/a	$12,700 (Inlcudes eligible charges from Tier I and Tier II combined)		Unlimited
Covered Services							
Hospital Services							
Inpatient Hospital	$100 Per Admit Copay, Ded, 85%	$500 Per Admit Copay, Ded, 60%	$350 Per Admit Copay	n/a	$350 Per Admit Copay	$400 Per Admit Copay, Ded, 90%	$500 Per Admit Copay, Ded, 60%
Outpatient Hospital	85% Coinsurance after Deductible	60% Coinsurance after Deductible	$250 Copay (OP Surgery)	n/a	$250 Copay (OP Surgery)	$250 Copay (OP Surgery), 90%	$250 Copay (OP Surgery), 90%
Physician/Surgeon Fees	85% Coinsurance after Deductible	60% Coinsurance after Deductible	100% Coverage	n/a	100% Coinsurance	90% Coinsurance after Deductible	60% Coinsurance after Deductible
Emergency Room Services	$450 Copay; Deductible Applies	$450 Copay; Deductible Applies	$250 Copay	$250 Copay	$250 Copay	$250 Copay	$250 Copay
Physician Serivces							
Primary Care Visit	85% Coinsurance after Deductible	60% Coinsurance after Deductible	$20 Copay	n/a	$20 Copay	90% Coinsurance after Deductible	60% Coinsurance after Deductible
Specialist Visit	85% Coinsurance after Deductible	60% Coinsurance after Deductible	$30 Copay	n/a	$30 Copay	90% Coinsurance after Deductible	60% Coinsurance after Deductible
Home Health Care Visit	85% Coinsurance after Deductible	60% Coinsurance after Deductible	$30 Copay	n/a	$30 Copay	90% Coinsurance after Deductible	60% Coinsurance after Deductible
Preventive Care Screenings	No Charge	60% Coinsurance after Deductible	No Charge	n/a	No Charge	No Charge	Not Covered
Other Services							
Diagnostic Testing (x-ray, blood work)							
* At Doctor Office	85% Coinsurance after Deductible	60% Coinsurance after Deductible	100% Coverage	n/a	100% Coinsurance	90% Coinsurance after Deductible	60% Coinsurance after Deductible
* At OP Facility or Ind Lab	85% Coinsurance after Deductible	60% Coinsurance after Deductible	100% Coverage	n/a	100% Coinsurance	90% Coinsurance after Deductible	60% Coinsurance after Deductible
Complex Imaging (CT/Pet Scans, MRIs)	85% Coinsurance after Deductible	60% Coinsurance after Deductible	100% Coverage	n/a	100% Coinsurance	90% Coinsurance after Deductible	60% Coinsurance after Deductible
Durable Medical Equipment	85% Coinsurance after Deductible	60% Coinsurance after Deductible	80% Coverage	n/a	80% Coinsurance	80% Coinsurance after Deductible	60% Coinsurance after Deductible
Urgent Care Services	85% Coinsurance after Deductible	60% Coinsurance after Deductible	$20 Copay	n/a	$20 Copay	90% Coinsurance after Deductible	60% Coinsurance after Deductible
Prescription Drugs							
Retail	*Separate $125 Per Person Deductible Applies Regardless of Tier*		*Separate $100 Per Person Deductible Applies*		*Separate $100 Per Person Deductible Applies Regardless of Tier*		
Generic	$10 Copay	$10 Copay	$8 Copay	n/a	$8 Copay	$8 Copay	$8 Copay
Preferred Brand	$30 Copay	$30 Copay	$26 Copay	n/a	$26 Copay	$26 Copay	$26 Copay
Non-Preferred Brand	$60 Copay	$60 Copay	$50 Copay	n/a	$50 Copay	$50 Copay	$50 Copay
Mail Order	*90 Day Supply*	*90 Day Supply*	*90 Day Supply*		*90 Day Supply*	*90 Day Supply*	*90 Day Supply*
Generic	$25 Copay	$25 Copay	$20 Copay	n/a	$20 Copay	$20 Copay	$20 Copay
Preferred Brand	$75 Copay	$75 Copay	$65 Copay	n/a	$65 Copay	$65 Copay	$65 Copay
Non-Preferred Brand	$150 Copay	$150 Copay	$125 Copay	n/a	$125 Copay	$125 Copay	$125 Copay
Actuarial Value	0.9174		0.9402		0.9368		

Employee Contributions						
	Salary Range:		Salary Range:		Salary Range:	
	* $0 to $30,200	$205.00	* $0 to $30,200	$151.00	* $0 to $30,200	$151.00
	* $30,201 to $45,600	$246.00	* $30,201 to $45,600	$190.00	* $30,201 to $45,600	$190.00
	* $45,601 to $60,700	$270.00	* $45,601 to $60,700	$227.00	* $45,601 to $60,700	$227.00
	* $60,701 to $75,900	$318.00	* $60,701 to $75,900	$263.00	* $60,701 to $75,900	$263.00
	* $75,901 to $100,000	$358.00	* $75,901 to $100,000	$302.00	* $75,901 to $100,000	$302.00
	* $100,001 to $115,000	$466.00	* $100,001 to $115,000	$411.00	* $100,001 to $115,000	$411.00
	* $115,001 to $130,000	$477.00	* $115,001 to $130,000	$420.00	* $115,001 to $130,000	$420.00
	* $130,001 to $145,000	$489.00	* $130,001 to $145,000	$430.00	* $130,001 to $145,000	$430.00
	* $145,001 to $160,000	$501.00	* $145,001 to $160,000	$441.00	* $145,001 to $160,000	$441.00
	* $160,001 and Over	$512.00	* $160,001 and Over	$451.00	* $160,001 and Over	$451.00
Dependent Contributions						
	QCHP		Health Alliance		HealthLink Open Access Plan	
	* One Dependent	$550.00	* One Dependent	$249.00	* One Dependent	$277.00
	* Two Plus Dependents	$634.00	* Two Plus Dependents	$350.00	* Two Plus Dependents	$394.00
	* Medicare Dependent	$155.00	* Medicare Dependent	$96.00	* Medicare Dependent	$110.00
			Coventry		Coventry Open Access Plan	
			* One Dependent	$244.00	* One Dependent	$244.00
			* Two Plus Dependents	$344.00	* Two Plus Dependents	$344.00
			* Medicare Dependent	$95.00	* Medicare Dependent	$95.00
			HMO Illinois			
			* One Dependent	$220.00		
			* Two Plus Dependents	$306.00		
			* Medicare Dependent	$85.00		
			Blue Advantage			
			* One Dependent	$211.00		
			* Two Plus Dependents	$291.00		
			* Medicare Dependent	$81.00		

Medical Plan Summary	FY2018 QCHP Gold Plan		FY2018 HMO Gold Plans		FY2018 OAP Gold Plans		
	In-Network	OON	In-Network	OON	Preferred Network	In-Network	OON
Annual Deductible							
* Single	$4,465 Per Person	$4,465 Per Person	$1,030 Per Person	n/a	$2,025	$2,025	$2,025
* Family					$4,050	$4,050	$4,050
Annual Out of Pocket Maximum							
* Single	$6,850	$13,700	$6,850	n/a	$6,850 (Inlcudes eligible charges from Tier I and Tier II combined)		$13,700
* Family	$13,700	$27,400	$13,700	n/a	$13,700 (Inlcudes eligible charges from Tier I and Tier II combined)		$27,400
Covered Services							
Hospital Services							
Inpatient Hospital	$350 Per Admit Copay; Deductible	50% Coinsurance after ded	$350 Per Admit Copay; Deductible Applies	n/a	$350 Per Admit Copay; Deductible	$350 Per Admit Copay, Ded, 90%	50% Coinsurance after ded
Outpatient Hospital	$250 Copay (OP Surgery); Ded	50% Coinsurance after ded	$250 Copay (OP Surgery); Ded Applies	n/a	$250 Copay (OP Surgery); Ded	$250 Copay (OP Surgery) Ded 90%	50% Coinsurance after ded
Physician/Surgeon Fees	Deductible Applies	50% Coinsurance after ded	100% Coverage	n/a	Deductible Applies	90% Coinsurance after ded	50% Coinsurance after ded
Emergency Room Services	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies
Physician Serivces							
Primary Care Visit	$20 Copay	50% Coinsurance after ded	$20 Copay	n/a	$20 Copay	$20 Copay	50% Coinsurance after ded
Specialist Visit	$30 Copay	50% Coinsurance after ded	$30 Copay	n/a	$30 Copay	$30 Copay	50% Coinsurance after ded
Home Health Care Visit	$30 Copay	50% Coinsurance after ded	$30 Copay	n/a	$30 Copay	$30 Copay	50% Coinsurance after ded
Preventive Care Screenings	No Charge	50% Coinsurance after ded	No Charge	n/a	No Charge	No Charge	50% Coinsurance after ded
Other Services							
Diagnostic Testing (x-ray, blood work)							
* At Doctor Office	No Charge	50% Coinsurance after ded	No Charge	n/a	No Charge	90% Coinsurance after ded	50% Coinsurance after ded
* At OP Facility or Ind Lab	$20 Copay	50% Coinsurance after ded	100% Coverage	n/a	$20 Copay	90% Coinsurance after ded	50% Coinsurance after ded
Complex Imaging (CT/Pet Scans, MRIs)	Deductible Applies	50% Coinsurance after ded	100% Coverage	n/a	Deductible Applies	90% Coinsurance after ded	50% Coinsurance after ded
Durable Medical Equipment	80% Coinsurance after ded	50% Coinsurance after ded	90% Coinsurance after ded	n/a	Deductible Applies	90% Coinsurance after ded	50% Coinsurance after ded
Urgent Care Services	$20 Copay	50% Coinsurance after ded	$20 Copay	n/a	$20 Copay	$20 Copay	50% Coinsurance after ded
Prescription Drugs							
Retail	*Separate $250 Per Person Deductible Applies Regardless of Tier*		*Separate $250 Per Person Deductible Applies*		*Separate $250 Per Person Deductible Applies Regardless of Tier*		
Generic	$8 Copay	50% Coinsurance after ded	$8 Copay	n/a	$8 Copay	$8 Copay	50% Coinsurance after ded
Preferred Brand	$26 Copay	50% Coinsurance after ded	$26 Copay	n/a	$26 Copay	$26 Copay	50% Coinsurance after ded
Non-Preferred Brand	$50 Copay	50% Coinsurance after ded	$50 Copay	n/a	$50 Copay	$50 Copay	50% Coinsurance after ded
Mail Order	*90 Day Supply*	*90 Day Supply*	*90 Day Supply*		*90 Day Supply*	*90 Day Supply*	
Generic	$20 Copay	50% Coinsurance after ded	$20 Copay	n/a	$20 Copay	$20 Copay	50% Coinsurance after ded
Preferred Brand	$65 Copay	50% Coinsurance after ded	$65 Copay	n/a	$65 Copay	$65 Copay	50% Coinsurance after ded
Non-Preferred Brand	$125 Copay	50% Coinsurance after ded	$125 Copay	n/a	$125 Copay	$125 Copay	50% Coinsurance after ded
Actuarial Value	0.7789		0.8252			0.8152	

Employee Contributions						
	Salary Range:		Salary Range:		Salary Range:	
	* $0 to $30,200	$149.00	* $0 to $30,200	$110.00	* $0 to $30,200	$110.00
	* $30,201 to $45,600	$179.00	* $30,201 to $45,600	$138.00	* $30,201 to $45,600	$138.00
	* $45,601 to $60,700	$199.00	* $45,601 to $60,700	$165.00	* $45,601 to $60,700	$165.00
	* $60,701 to $75,900	$231.00	* $60,701 to $75,900	$191.00	* $60,701 to $75,900	$191.00
	* $75,901 to $100,000	$260.00	* $75,901 to $100,000	$220.00	* $75,901 to $100,000	$220.00
	* $100,001 to $115,000	$339.00	* $100,001 to $115,000	$299.00	* $100,001 to $115,000	$299.00
	* $115,001 to $130,000	$347.00	* $115,001 to $130,000	$305.00	* $115,001 to $130,000	$305.00
	* $130,001 to $145,000	$355.00	* $130,001 to $145,000	$312.00	* $130,001 to $145,000	$312.00
	* $145,001 to $160,000	$364.00	* $145,001 to $160,000	$320.00	* $145,001 to $160,000	$320.00
	* $160,001 and Over	$372.00	* $160,001 and Over	$328.00	* $160,001 and Over	$328.00
Dependent Contributions						
	QCHP		Health Alliance		HealthLink Open Access Plan	
	* One Dependent	$400.00	* One Dependent	$181.00	* One Dependent	$202.00
	* Two Plus Dependents	$461.00	* Two Plus Dependents	$255.00	* Two Plus Dependents	$287.00
	* Medicare Dependent	$179.00	* Medicare Dependent	$93.00	* Medicare Dependent	$106.00
			Coventry		Coventry Open Access Plan	
			* One Dependent	$178.00	* One Dependent	$178.00
			* Two Plus Dependents	$250.00	* Two Plus Dependents	$250.00
			* Medicare Dependent	$92.00	* Medicare Dependent	$92.00
			HMO Illinois			
			* One Dependent	$160.00		
			* Two Plus Dependents	$223.00		
			* Medicare Dependent	$82.00		
			Blue Advantage			
			* One Dependent	$154.00		
			* Two Plus Dependents	$212.00		
			* Medicare Dependent	$78.00		

Medical Plan Summary	FY2018 QCHP Silver Plan		FY2018 HMO Silver Plans		FY2018 OAP Silver Plans		
	In-Network	OON	In-Network	OON	Preferred Network	In-Network	OON
Annual Deductible							
* Single	$7,150 Per Person	$7,150 Per Person	$2,780 Per Person	n/a	$4,110	$4,110	$4,110
* Family				n/a	$8,220	$8,220	$8,220
Annual Out of Pocket Maximum							
* Single	$7,150	$14,300	$6,850	n/a	$7,150 (Inlcudes eligible charges from Tier I and Tier II combined)		$14,300
* Family	$14,300	$28,600	$13,700	n/a	$14,300 (Inlcudes eligible charges from Tier I and Tier II combined)		$28,600
Covered Services							
Hospital Services							
Inpatient Hospital	$600 Per Admit Copay; Deductible	50% Coinsurance after ded	$500 Per Admit Copay; Deductible Applies	n/a	$500 Per Admit Copay; Deductible	$500 Per Admit Copay, Ded, 90%	50% Coinsurance after ded
Outpatient Hospital	$200 Copay (OP Surgery); Ded	50% Coinsurance after ded	$200 Copay (OP Surg); Deductible Applies	n/a	$200 Copay (OP Surg); Deductible	$200 Copay (OP Surgery) Ded 90%	50% Coinsurance after ded
Physician/Surgeon Fees	Deductible Applies	50% Coinsurance after ded	100% Coverage	n/a	Deductible Applies	90% Coinsurance after ded	50% Coinsurance after ded
Emergency Room Services	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies	$250 Copay; Deductible Applies
Physician Serivces							
Primary Care Visit	$35 Copay	50% Coinsurance after ded	$30 Copay	n/a	$30 Copay	$30 Copay	50% Coinsurance after ded
Specialist Visit	$55 Copay	50% Coinsurance after ded	$50 Copay	n/a	$50 Copay	$50 Copay	50% Coinsurance after ded
Home Health Care Visit	$35 Copay	50% Coinsurance after ded	$30 Copay	n/a	$30 Copay	$30 Copay	50% Coinsurance after ded
Preventive Care Screenings	No Charge	50% Coinsurance after ded	No Charge	n/a	No Charge	No Charge	50% Coinsurance after ded
Other Services							
Diagnostic Testing (x-ray, blood work)							
* At Doctor Office	No Charge	50% Coinsurance after ded	100% Coverage	n/a	No Charge	90% Coinsurance after ded	50% Coinsurance after ded
* At OP Facility or Ind Lab	$40 Copay	50% Coinsurance after ded	100% Coverage	n/a	$40 Copay	90% Coinsurance after ded	50% Coinsurance after ded
Complex Imaging (CT/Pet Scans, MRIs)	Deductible Applies	50% Coinsurance after ded	100% Coverage	n/a	Deductible Applies	90% Coinsurance after ded	50% Coinsurance after ded
Durable Medical Equipment	Deductible Applies	50% Coinsurance after ded	90% Coinsurance after ded	n/a	Deductible Applies	90% Coinsurance after ded	50% Coinsurance after ded
Urgent Care Services	$55 Copay	50% Coinsurance after ded	$50 Copay	n/a	$50 Copay	$50 Copay	50% Coinsurance after ded
Prescription Drugs							
Retail	*Separate $250 Per Person Deductible Applies Regardless of Tier*		*Separate $250 Per Person Deductible Applies*		*Separate $250 Per Person Deductible Applies Regardless of Tier*		
Generic	$15 Copay	50% Coinsurance after ded	$15 Copay	n/a	$15 Copay	$15 Copay	50% Coinsurance after ded
Preferred Brand	$40 Copay	50% Coinsurance after ded	$40 Copay	n/a	$40 Copay	$40 Copay	50% Coinsurance after ded
Non-Preferred Brand	$75 Copay	50% Coinsurance after ded	$75 Copay	n/a	$75 Copay	$75 Copay	50% Coinsurance after ded
Mail Order	*90 Day Supply*	*90 Day Supply*	*90 Day Supply*		*90 Day Supply*	*90 Day Supply*	
Generic	$30 Copay	50% Coinsurance after ded	$30 Copay	n/a	$30 Copay	$30 Copay	50% Coinsurance after ded
Preferred Brand	$80 Copay	50% Coinsurance after ded	$80 Copay	n/a	$80 Copay	$80 Copay	50% Coinsurance after ded
Non-Preferred Brand	$150 Copay	50% Coinsurance after ded	$150 Copay	n/a	$150 Copay	$150 Copay	50% Coinsurance after ded
Actuarial Value	0.6824		0.7355		0.7188		

Employee Contributions						
	Salary Range:		Salary Range:		Salary Range:	
	* $0 to $30,200	$93.00	* $0 to $30,200	$68.00	* $0 to $30,200	$68.00
	* $30,201 to $45,600	$111.00	* $30,201 to $45,600	$86.00	* $30,201 to $45,600	$86.00
	* $45,601 to $60,700	$127.00	* $45,601 to $60,700	$103.00	* $45,601 to $60,700	$103.00
	* $60,701 to $75,900	$144.00	* $60,701 to $75,900	$119.00	* $60,701 to $75,900	$119.00
	* $75,901 to $100,000	$162.00	* $75,901 to $100,000	$137.00	* $75,901 to $100,000	$137.00
	* $100,001 to $115,000	$211.00	* $100,001 to $115,000	$186.00	* $100,001 to $115,000	$186.00
	* $115,001 to $130,000	$216.00	* $115,001 to $130,000	$190.00	* $115,001 to $130,000	$190.00
	* $130,001 to $145,000	$221.00	* $130,001 to $145,000	$194.00	* $130,001 to $145,000	$194.00
	* $145,001 to $160,000	$226.00	* $145,001 to $160,000	$199.00	* $145,001 to $160,000	$199.00
	* $160,001 and Over	$231.00	* $160,001 and Over	$204.00	* $160,001 and Over	$204.00
Dependent Contributions						
	QCHP		Health Alliance		HealthLink Open Access Plan	
	* One Dependent	$249.00	* One Dependent	$113.00	* One Dependent	$126.00
	* Two Plus Dependents	$287.00	* Two Plus Dependents	$159.00	* Two Plus Dependents	$179.00
	* Medicare Dependent	$203.00	* Medicare Dependent	$89.00	* Medicare Dependent	$102.00
			Coventry		Coventry Open Access Plan	
			* One Dependent	$111.00	* One Dependent	$111.00
			* Two Plus Dependents	$156.00	* Two Plus Dependents	$156.00
			* Medicare Dependent	$88.00	* Medicare Dependent	$88.00
			HMO Illinois			
			* One Dependent	$100.00		
			* Two Plus Dependents	$139.00		
			* Medicare Dependent	$79.00		
			Blue Advantage			
			* One Dependent	$96.00		
			* Two Plus Dependents	$132.00		
			* Medicare Dependent	$75.00		

Medical Plan Summary	FY2018 QCHP Bronze Plan		FY2018 HMO Bronze Plans		FY2018 OAP Bronze Plans		
	In-Network	OON	In-Network	OON	Preferred Network	In-Network	OON
Annual Deductible							
* Single	$7,150 Per Person	$7,150 Per Person	$7,150 Per Person	n/a	$6,200 Per Person	$6,200 Per Person	$6,200 Per Person
* Family				n/a			
Annual Out of Pocket Maximum							
* Single	$7,150	$14,300	$7,150	n/a	$6,200 (Inlcudes eligible charges from Tier I and Tier II combined)		$12,400
* Family	$14,300	$28,600	$14,300	n/a	$12,400 (Inlcudes eligible charges from Tier I and Tier II combined)		$24,800
Covered Services							
Hospital Services							
Inpatient Hospital	Deductible Applies	50% Coinsurance after ded	Deductible Applies	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Outpatient Hospital	Deductible Applies	50% Coinsurance after ded	Deductible Applies	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Physician/Surgeon Fees	Deductible Applies	50% Coinsurance after ded	100% Coverage	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Emergency Room Services	Deductible Applies	50% Coinsurance after ded	Deductible Applies	Deductible Applies	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Physician Serivces							
Primary Care Visit	Deductible Applies	50% Coinsurance after ded	$80 Copay	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Specialist Visit	Deductible Applies	50% Coinsurance after ded	$100 Copay	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Home Health Care Visit	Deductible Applies	50% Coinsurance after ded	$100 Copay	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Preventive Care Screenings	No Charge	50% Coinsurance after ded	No Charge	n/a	No Charge	No Charge	50% Coinsurance after ded
Other Services							
Diagnostic Testing (x-ray, blood work)							
* At Doctor Office	Deductible Applies	50% Coinsurance after ded	100% Coverage	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
* At OP Facility or Ind Lab	Deductible Applies	50% Coinsurance after ded	100% Coverage	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Complex Imaging (CT/Pet Scans, MRIs)	Deductible Applies	50% Coinsurance after ded	100% Coverage	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Durable Medical Equipment	Deductible Applies	50% Coinsurance after ded	Deductible Applies	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Urgent Care Services	Deductible Applies	50% Coinsurance after ded	$100 Copay	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Prescription Drugs							
Retail	*Deductible Applies*		*Deductible Applies*			*Deductible Applies*	
Generic	Deductible Applies	50% Coinsurance after ded	Deductible Applies	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Preferred Brand	Deductible Applies	50% Coinsurance after ded	Deductible Applies	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Non-Preferred Brand	Deductible Applies	50% Coinsurance after ded	Deductible Applies	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Mail Order	*90 Day Supply*	*90 Day Supply*	*90 Day Supply*		*90 Day Supply*	*90 Day Supply*	*90 Day Supply*
Generic	Deductible Applies	50% Coinsurance after ded	Deductible Applies	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Preferred Brand	Deductible Applies	50% Coinsurance after ded	Deductible Applies	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Non-Preferred Brand	Deductible Applies	50% Coinsurance after ded	Deductible Applies	n/a	Deductible Applies	Deductible Applies	50% Coinsurance after ded
Actuarial Value	0.6395		0.5955			0.5828	

Employee Contributions						
	Salary Range:		Salary Range:		Salary Range:	
	* $0 to $30,200	$0.00	* $0 to $30,200	$0.00	* $0 to $30,200	$0.00
	* $30,201 to $45,600	$0.00	* $30,201 to $45,600	$0.00	* $30,201 to $45,600	$0.00
	* $45,601 to $60,700	$0.00	* $45,601 to $60,700	$0.00	* $45,601 to $60,700	$0.00
	* $60,701 to $75,900	$0.00	* $60,701 to $75,900	$0.00	* $60,701 to $75,900	$0.00
	* $75,901 to $100,000	$0.00	* $75,901 to $100,000	$0.00	* $75,901 to $100,000	$0.00
	* $100,001 to $115,000	$0.00	* $100,001 to $115,000	$0.00	* $100,001 to $115,000	$0.00
	* $115,001 to $130,000	$0.00	* $115,001 to $130,000	$0.00	* $115,001 to $130,000	$0.00
	* $130,001 to $145,000	$0.00	* $130,001 to $145,000	$0.00	* $130,001 to $145,000	$0.00
	* $145,001 to $160,000	$0.00	* $145,001 to $160,000	$0.00	* $145,001 to $160,000	$0.00
	* $160,001 and Over	$0.00	* $160,001 and Over	$0.00	* $160,001 and Over	$0.00
Dependent Contributions						
	QCHP		Health Alliance		HealthLink Open Access Plan	
	* One Dependent	$0.00	* One Dependent	$0.00	* One Dependent	$0.00
	* Two Plus Dependents	$0.00	* Two Plus Dependents	$0.00	* Two Plus Dependents	$0.00
	* Medicare Dependent	$0.00	* Medicare Dependent	$0.00	* Medicare Dependent	$0.00
			Coventry		Coventry Open Access Plan	
			* One Dependent	$0.00	* One Dependent	$0.00
			* Two Plus Dependents	$0.00	* Two Plus Dependents	$0.00
			* Medicare Dependent	$0.00	* Medicare Dependent	$0.00
			HMO Illinois			
			* One Dependent	$0.00		
			* Two Plus Dependents	$0.00		
			* Medicare Dependent	$0.00		
			Blue Advantage			
			* One Dependent	$0.00		
			* Two Plus Dependents	$0.00		
			* Medicare Dependent	$0.00		

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