FY 2023 LIABILITIES OF THE STATE EMPLOYEES' GROUP HEALTH INSURANCE PROGRAM

COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

MARCH 2022

Commission on Government Forecasting and Accountability

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March 2022

EXECUTIVE SUMMARY

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

- To estimate the 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.

CMS has provided information for the 2023 fiscal year indicating a continuation of the existing contracts in place as well as negotiated rate increases for group insurance participants. The Department is expected to continue the recently introduced high deductible health insurance plan, the Consumer Driven Health Plan or CDHP, for current members and dependents as well as a relatively new Open Access Plan from Blue Cross Blue Shield. In accordance with public employee union negotiations, current health insurance plan rates will differ depending on the specific plan chosen. This continues the change from historically similar rates charged to participants regardless of their choice of plan (within plan types, such as HMOs and PPOs). Existing funding and plan design components are largely unchanged.

According to CMS, for the 2023 fiscal year, the GRF appropriation is projected to be $1.841 billion for SEGIP, with total expected revenues projected at approximately $3.065 billion. CMS estimates the FY 2023 liability to be $3.065 billion, which is a 2% increase from the FY 2022 anticipated final liability of $3.064 billion. Noting these predictions, the Commission has presumed that liabilities and revenues will increase from FY 2022 and previous fiscal years and estimates a total SEGIP liability of $3.089 billion in FY 2023, $23.9 million more than CMS.

For FY 2023, expenditures are projected to increase by 2 percent, compared to a projected 3.7 percent decline in FY 2022 liabilities. FY 2023 revenues are projected to decrease compared to FY 2022, primarily due to an expected supplemental appropriation in FY 2022 to pay off existing held bills, which makes the overall revenues for that year outsized compared to most fiscal years. For FY 2023, member contributions are projected to total $551 million, compared to $520 million in FY 2022, a $31 million increase. Reimbursements are projected to remain unchanged, at $402 million in both FY 2022 and FY 2023. The Road Fund is projected to account for $110 million for FY 2023, a $21 million decrease, compared to $131 million in FY 2022 and $172 million in FY 2021. One major liability change is the projected elimination of all Prompt and Timely Payment Interest payments, which, if successful, would be the first time in over 20 years that the State has not had group insurance liability payments accruing interest beyond the 30 and 90 day

limits under current law. Additional projected liability changes include decreases in Quality Care Health Plan and HMO liabilities. However, increases are expected in OAP, CDHP, Dental, and Medicare Advantage liability.

In sync with the anticipated $898 million supplemental appropriation requested by the Governor in FY 2022 and (if the supplemental appropriation is approved through the budget process) subsequent payoff of existing held claims, projected hold times and delays on the part of CMS in processing payments to healthcare vendors and insurance companies are expected to be entirely eliminated. Self-insured vendors are projected to have no additional hold time on their bills at CMS while the QCHP and OAPs are also projected to have no additional hold time.

COVID-19 had an effect on the SEGIP in FY 2020-22, though not necessarily what might otherwise be expected. According to industry analysis by the Segal Trend Survey, the suspension of most non-essential care to prioritize COVID-19 care significantly offset costs for health plans. Many procedures and services which might otherwise have been performed and utilized were delayed or cancelled entirely, reducing overall costs for health insurers. For Illinois and the SEGIP, it may partially explain relatively level liabilities for the 2020-2023 fiscal years, though the impact of the Delta and Omicron COVID variants is uncertain in the context of overall liabilities for the SEGIP. It is yet to be determined whether certain delayed/cancelled services will be noticed in FY 2022 liabilities, especially in the context of a reoccurrence of COVID or similar health service constraining outbreak in the winter months.

GRF APPROPRIATION/REVENUE AND LIABILITY HISTORY FY 2016-2023
($ in Millions)

Fiscal Year	Appropriation Received	Revenues	CMS Liability
FY 2016*	$5.0	$876.9	$2,810.1
FY 2017*	$0.0	$1,082.1	$2,871.5
FY 2018	$1,340.0	$6,306.6	$3,157.9
FY 2019	$2,176.2	$3,201.8	$3,103.1
FY 2020	$2,440.2	$3,699.1	$3,089.8
FY 2021	$2,022.8	$3,208.5	$3,119.4
FY 2022**	$2,749.7	$3,967.0	$3,004.6
FY 2023**	$1,841.2	$3,064.9	$3,065.0

*FY 2016 and FY 2017 had no official GRF appropriation. A small amount was appropriated in FY 2015 but not received until FY 2016.
**Estimated for FY 2022 and projected for FY 2023. FY 2018 included bond revenue to pay down held bills and FY 2020 included interfund borrowing for the same purpose. FY 2022 includes a supplemental appropriation of $898 million.

FY 2023 PROPOSED PLAN CHANGES

For FY 2023, the State is not expected to introduce new changes to the existing health insurance plan arrangement utilized by employees, retirees, and dependents, though efforts to encourage healthy lifestyle options on the part of members and dependents are ongoing. Premiums are expected to increase in line with labor negotiations and the health plan premium graduation introduced in FY 2021. The Consumer Driven Health Plan (CDHP) is expected to continue and significantly increase in utilization in FY 2023, as the benefits for younger users continue to be attractive compared to more robust and costly plans. The new Blue Cross Blue Shield OAP plan option is also expected to draw participants from other, more expensive plans. Different types of plans (based on choices between individual and multiple dependent plans) will also continue to have a variety of rates, which will be detailed later in this report.

FY 2023 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) utilizes the CMS forecast for FY 2023 medical costs as the basis for estimating costs for FY 2023 along with information provided by the Segal Company in their annual report on State employee insurance trends. The CGFA State of Illinois liability cost projection uses the following assumptions based on historical claims data and anticipated cost changes.

Trend Factors	
Medical (QCHP plan)	-2.0%
Dental (QCHP and MC)	3.0%
HMO (Medical and Rx)	-0.8%
Prescription drugs (QCHP)	-5.4%
Open Access Plan	7.2%
Life Insurance	3.1%

As in the past, it is important to note that the trend percentages listed above relate only to the portion of total medical costs incurred by the State of Illinois. The shifting of eligible retirees and their dependents into Medicare Advantage plans, negotiated increases in employee contributions and co-payments, and the creation of the CDHP have caused overall cost projections to the State to decline or remain level in recent years. However, the yearly cost of providing healthcare for State employees, retirees and dependents historically has risen compared to rates 10, 15 or more years ago.

The medical trend inflation factors for the State consist of various components. These components include general medical cost 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 contributed historically to greater health care costs for the State. In addition to these factors, a gradual shift by employees to HMOs, OAPs, and (more

recently) the CDHP, from the Quality Care Health Program (QCHP) has resulted in more costly/higher risk employees remaining in the QCHP program, raising the per-member cost of that program. In terms of cost reduction, movement of Medicare-eligible retirees out of the QCHP/HMOs/OAPs has reduced overall liability within the group insurance program in the past and continues to be a factor in the moderation of overall State costs.

In reference to individual liability components, CMS projects liability increases for the Open Access Plan, CDHP, Medicare Advantage, and Dental plans. The OAP line is expected to rise to $1.06 billion in FY 2023, a 6.8% increase from FY 2022 ($997 million) while the CDHP is projected to rise from $16.2 million in FY 2022 to $20.1 million in FY 2023, though this is partly due to the program ramping up and projected migration from other plans increasing liabilities. Medicare Advantage liability is projected to total $167 million in FY 2023, a 5.9% increase, compared to $158 million in FY 2022, in part reflecting increases in population across the various MA plans. Dental plan liability is also projected to rise 3.0% from $134 million in FY 2022 to $138 million in FY 2023. HMO liability is projected to decrease $15 million, from $985 million in FY 2022 to $970 million in FY 2023, continuing a decline that started in FY 2020.

In preparing this report, the Commission utilizes information from an annual cost trend survey report provided by the Segal Company. This report examines how large health plans are trending during the plan year. The following are some relevant findings of the 2022 Segal Health Plan Cost Trend Survey.

- For 2022, health plan cost increases are expected to be similar to pre-pandemic rates.

- Depending on various factors, including changes to health care provision and access from the pandemic, medical plan cost increases may be lower, especially in the utilization of telehealth and other cost-cutting options. However, costs associated with COVID surges, new tests/therapies, etc. may have an upward pressure on health care costs.

- For 2022, health plans are projected to increase over 2021 by 4.8% to 7.8% depending on plan type, with HMO-style plans on the lower end of the scale and PPO-style open access plans on the upper end.

- Prescription drug coverage is expected to increase in 2022, with specialty drugs expected to increase by as much as 13.4%.

- Medicare Advantage plans and prescription coverage options are projected to increase in 2021 by 4.8%.

- Dental and vision plans are expected to have increases of 1.7% to 3.4%, depending on plan type.

- These increases across various plans are due to normal development of new therapies/technologies, cost shifting, new regulations, and increased demand for services due to aging populations as well as obesity concerns.

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 2022

Component	National Trend	CMS Estimate	COGFA Estimate
HMOs	7.0%	-1.6%	-0.8%
Rx	8.4%	-6.2%	-5.4%
Dental	3.1%	3.0%	3.0%
Vision	1.7%	0.0%	0.0%

Source: Segal 2022 Health Plan Cost Trend Survey

National trend rates demonstrate the general direction and scale of healthcare insurance rates, though individual state plan data points may differ significantly due to actions on the state level. 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. To the extent that it can be measured, national trend data can be reflective of trends in various geographical regions of the US. While trends may be higher in the Northeast and West, for the Midwest, trends usually tend to be lower in the aggregate.

The difference between national trends and state-level healthcare insurance trends can be seen in the comparison of trends between traditional health cost drivers listed in Table 1. While CMS and CGFA projections reflect the direction of national trends, the scale (or intensity) of these trends is muted. This lower scaling can be attributed to various causes, including the dispersal of Illinois HMO costs between traditional HMOs, the CDHP, and Medicare Advantage (MA) HMOs. This continues to present an interesting contrast in terms of cost containment. As older individuals who are demographically more likely to utilize healthcare services have moved into MA HMO plans, the inflationary pressure on traditional HMO plan rates has been reduced. Combined with the movement of (primarily younger) individuals into the CDHP, Illinois state employees/dependents/retirees have more and less expensive options than in previous years which has translated to much lower overall cost increases to the State than might otherwise be expected from the aforementioned medical plan trends in the Segal survey.

In addition, CMS and CGFA trend estimates include programmatic effects that likely affect estimates beyond normal market trends. For example, HMO liability continues to decrease for both CGFA and CMS projections for FY 2023 while increasing on the national level. This contradiction is due to expectations for migration to the Consumer Driven

Health Plan and other factors independent of national trends but specific to Illinois. In addition, the CDHP is expected to become better known and utilized in the future. This utilization is expected to help lower overall liabilities for existing non-CDHP plans.

In reference to dental and vision plan costs in Table 1, for Illinois, these costs tend to remain relatively stable year to year, with dental liability projected to increase $4 million between FY 2022 and FY 2023. Vision liability is projected to remain steady in that same time period, with a projected decrease of $11,000 total. One practical note to keep in mind is that on a percentage basis, due to the relatively small amount of liability associated with these two categories, small increases in liability still have a significant percentage increase, depending on the years examined. **Based on these assumptions, trends, and inflation factors, CGFA estimates a FY 2023 liability of approximately $3.089 billion for the State Employee's Group Health Insurance Program.** Table 2 shows a detailed comparison of the CGFA estimate for the various cost components and the CMS projection for FY 2023, though minor program component lines have been combined for easier viewing and analysis.

TABLE 2: FY 2023 GROUP HEALTH INSURANCE LIABILITY
($ in Millions)

Liability Component	FY 2022 CMS Estimate	FY 2023 CMS Projection	FY 2023 CGFA Projection
QCHP Medical	$347.3	$334.8	$340.4
QCHP Prescriptions	$123.3	$115.6	$116.7
Dental	$130.5	$134.4	$134.4
HMO	$985.4	$969.6	$977.2
Medicare Advantage HMO/PPO	$157.7	$167.0	$169.3
Open Access Plan	$996.9	$1,064.8	$1,068.8
Consumer Driven Health Plan (HDHP)	$16.2	$20.1	$20.4
Mental Health	$5.6	$5.6	$5.6
Vision	$8.4	$8.4	$8.4
Administrative Services (QC)	$15.8	$14.7	$14.7
Life	$83.2	$85.5	$85.8
Special Programs (Admin/Int./Other)	$134.2	$144.4	$147.1
TOTAL	**$3,004.5**	**$3,064.9**	**$3,088.8**
% increase over prior year	-3.7%	2.0%	2.8%

*Rounding may cause slight differences. FY 2022 and FY 2023 Special Programs line includes Prompt Payment and Timely Payment Interest.

ESTIMATE COMPARISON

Overall, the Commission's FY 2023 estimate is $23.9 million higher than the FY 2023 estimate from CMS. CGFA's FY 2023 HMO and Open Access Plan liabilities estimates are $7.6 million and $4.0 million higher than CMS, respectively. CGFA's FY 2023 estimate for the Quality Care Health Plan Medical line is $5.6 million higher than the CMS estimate.

The Commission's estimate for Special Programs (Interest, Admin, etc.) is $2.7 million higher than CMS.

It is important to note that the FY 2023 group insurance liability estimates between CMS and CGFA are very similar to each other, with less than a one-percent total difference between them. This consistency in estimates is reflective of the general trends in healthcare insurance and the relative stability in overall plan design changes anticipated for FY 2023. Future (and larger) differences in liability projections may occur depending on various factors, including possible changes in plan design and applicability as a result of labor negotiations and/or changes at the federal level.

CGFA estimates that approximately $3.089 billion would be required to fully fund the FY 2023 liabilities of the Group Health Insurance Program. This estimate is $84.3 million or 2.8% higher than the FY 2022 estimated liability of $3.005 billion. CMS estimates that the FY 2023 liability will be $3.065 billion, approximately $60 million, or 2.0% higher than FY 2022.

APPROPRIATION/FUNDING SOURCES

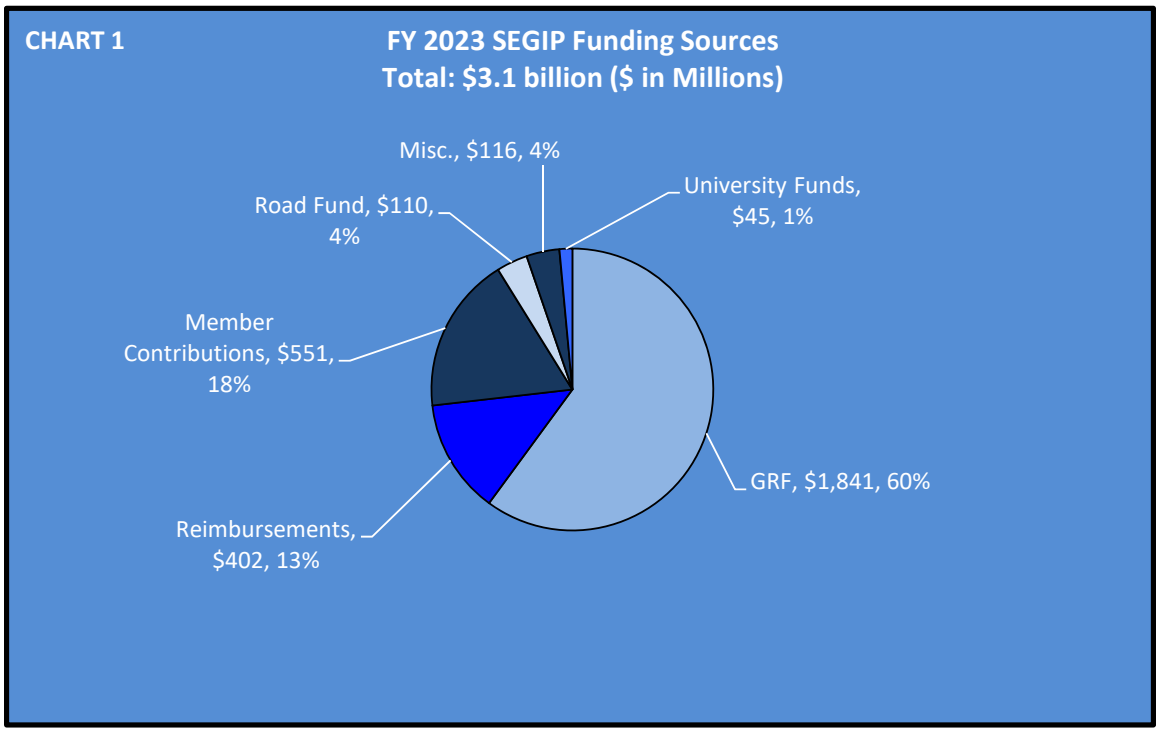
Funding for the State Employees' Group Insurance plans originates from two funds, the Health Insurance Reserve Fund (HIRF) and the Group Insurance Premium Fund (GIPF). Contributions and payments for health coverage benefits are deposited into HIRF, and contributions for life insurance are deposited into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

HIRF is the fund mainly used to administer the group insurance program. Pursuant to 5 ILCS 375/13.1, "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. The department's estimated revenues for FY 2023 total $3.065 billion. This is a decrease from the 2022 fiscal year estimated revenue of $3.967 billion, with the majority of the difference due to a supplemental appropriation of $898 million proposed by the Governor in FY 2022, but not anticipated for FY 2023.

Increased member contributions of $551 million in FY 2023 (compared to $520 million in FY 2022) offset an anticipated lower Road Fund appropriation. The Road Fund appropriation of $110 million expected in FY 2023 would be the lowest appropriation since FY 2016, when there was no appropriation, and a decrease of $21 million from the $131 million expected in FY 2022. Other components of total revenues are expected to remain substantially similar between FY 2022 and FY 2023.

These revenue totals reflect lower total revenues than any year since FY 2015, though these lower revenues also correlate with lower expected expenses. Of note is the

increased funding from member contributions, as these totaled $400 million as recently as FY 2019 compared to current expectations of $551 million for FY 2023, an increase in program funding of $151 million in four fiscal years. A breakdown in the various funding sources is shown in Chart 1.



For FY 2023, the fiscal data provided by CMS shows the Group Health Insurance Program receiving $1.841 billion in GRF funds. This represents a small $10 million (0.5%) decrease from the FY 2022 GRF component of $1.851 billion. The FY 2023 GRF appropriation request is in line with the previous year GRF request, though lower than FY 2019 and FY 2020. This difference is largely due to the imposition of significantly higher employee contribution requirements along with a rise in reimbursements, which rose from $321 million in FY 2020 to $402 million projected in FY 2023 (an $81 million or 25% increase).

Member contributions are anticipated to increase in FY 2023 to $550.9 million, compared to $519.8 million in FY 2022, as a result of negotiated rate increases, new plan options, and plan price differentiation changes. Depending on employee plan choices, member contributions may increase or decrease as employees migrate to preferred plans based on the new premium rate structure. For example, if fewer employees choose to move to CDHP (a High Deductible Health Plan), employee contributions may be higher as they will pay higher premiums depending on their preferred plan choice.

Other Funds reimbursements are anticipated to decrease by less than $1 million in FY 2023, to $401.7 million compared to $402.4 million in FY 2022. University contributions are projected to be flat compared to the 2022 fiscal year, as the Administration has proposed keeping contributions at $45.0 million in FY 2023.

TABLE 3: GROUP INSURANCE FUNDING SOURCES FY 2022 - FY 2023 ($ in Millions)				
	FY 2022	FY 2023	$ Change from FY22	% Change from FY22
GRF Appropriation	$1,851.1	$1,841.2	($9.9)	-0.5%
Prior Year GRF	$898.3	$0.0	($898.3)	0.0%
Road Fund	$131.0	$110.3	($20.7)	-15.8%
University Cont.	$45.0	$45.0	$0.0	0.0%
Prior Year Univ. Cont.	$1.7	$0.0	($1.7)	-100.0%
Member Cont.	$519.8	$550.9	$31.1	6.0%
Other Funds	$402.4	$401.7	($0.7)	-0.2%
Medicare Part D rebate	$4.5	$4.2	($0.3)	-6.7%
Rebates/Interest/Other.	$112.9	$111.7	($1.2)	-1.1%
TOTAL	**$3,966.7**	**$3,065.0**	**-$901.7**	**-22.7%**
Source: CMS				

CMS sets target end-of-year fund balances for both the Health Insurance Reserve Fund and the Group Insurance Premium Fund. The FY 2023 budget target balance for the Group Insurance Program is $30.0 million. For FY 2023, as in previous years, the GIPF target balance is $8.0 million, and the target HIRF balance is $22.0 million.

BENEFITS

The State Employees' Group Insurance Program has traditionally provided 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), and the Consumer Driven Health Plan (CDHP). Vision coverage, which includes savings on exams, glasses, and contacts, is provided at no additional premium costs.

A continued item of interest in FY 2023 is the appeal of telemedicine options in the wake of the COVID-19 pandemic. Telemedicine is the practice wherein patients will have the option to consult physicians via telephone regarding standard medical needs and obtain information, prescriptions, and referrals rather than the patient being required to physically travel and consult a healthcare provider. While this option does not preclude emergency care or physician-supervised actions that require a clinical setting to perform, telemedicine is expected to be an attractive option for users in rural areas, or with significant travel issues, or other health/etc. related issues. Additionally, the copayment for telemedicine services is anticipated to be one-half the current charge for a physical physician's consultation copayment, providing fiscal savings for consumers. While it is

likely to be used in future years as a source of easing congestion at medical provider locations and providing a triage opportunity in administering care, telemedicine may be useful in maintaining social distancing and assisting other palliative options for medical providers.

As in FY 2021 and FY 2022, the state will offer a High Deductible Health Plan, the Consumer Driven Health Plan (CDHP), similar to other states such as Kansas and Texas. This plan offers a low-premium option for employees who prefer to minimize their health insurance deductions from their paychecks. Additionally, this plan is beneficial to the State as it is expected to be less difficult to administer with smaller overall liability compared to the other available plans. Specifically, the CDHP features a $1,500 deductible for employees to reach before primary health insurance benefits would be administered. For employees anticipating few health insurance needs, the savings from choosing this plan would potentially outweigh any routine health costs incurred over the course of the year.

According to CMS and their actuarial analysis, it is expected that primarily younger members will choose this plan as their option, as those individuals tend to have fewer health-related expenses and overall needs compared to older employees. Older employees tend to utilize more health insurance options as they are more likely to have health-related needs (and require services covered by higher premium plan options) and have families who also would utilize benefits covered under higher premium plan alternatives. As such, this plan is open specifically to only active employees and their dependents. As of the drafting of this report, CMS projects approximately 2,700 active members and dependents will utilize this plan in FY 2023, compared to the utilization from FY 2021 (1,618).

When retirees reach the age of eligibility, they are enrolled in a Medicare Advantage plan of their choice (PPO or HMO). 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 started effective February 1, 2014 (Health Alliance MA HMO - 2015) and are in the RFP process currently, with new plans expected to take effect January 2023.

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 2023, CMS does not anticipate that the current benefits will be altered by the State. Proposed amendments to existing health insurance plan contracts are not anticipated to substantially affect the benefits received under the SEGIP. Appendix I provides further details regarding the types of health and dental plans offered by the State.

Basic life insurance is provided at no cost to employees, retirees and annuitants. Full-time employees receive coverage equal to their annual salary. Retirees and annuitants receive coverage equal to the annual salary as of the last day of employment until the age of 60, at which time the benefit amount becomes $5,000. Employees are allowed to

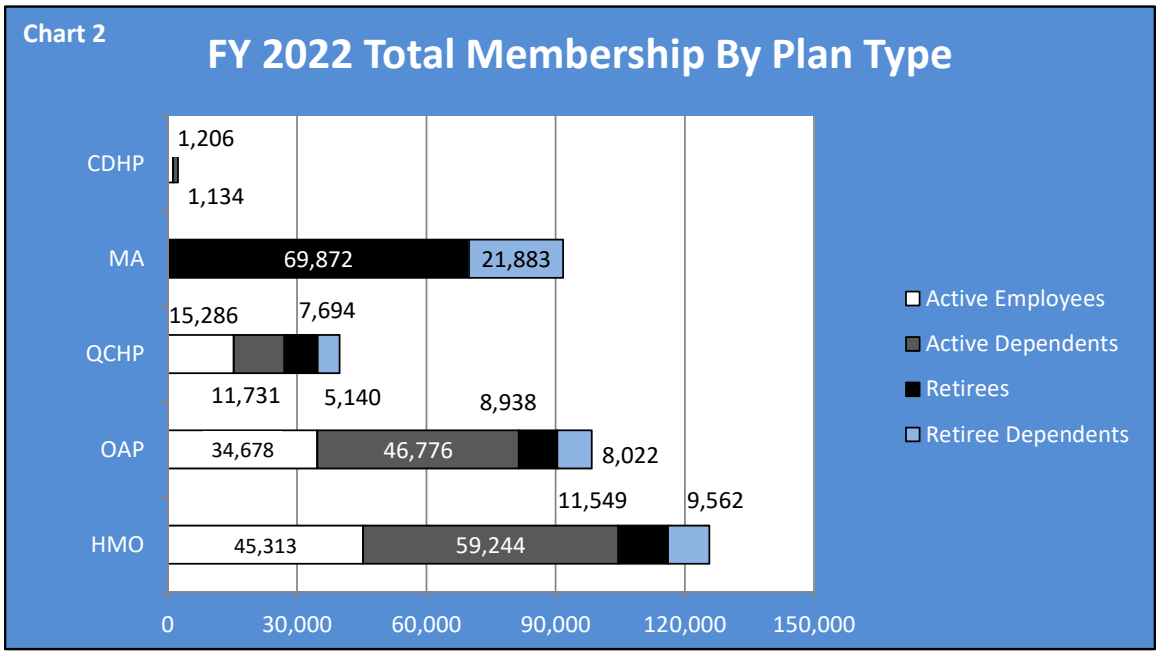
purchase optional term life insurance up to eight times their annual salary, as well as spouse and child term life insurance at group rates.

Beginning January 1, 1995, CMS added a portability feature to the optional life program, thereby allowing employees leaving State service to continue optional term life insurance coverage indefinitely at group rates without being required to provide evidence of insurability. Group rates are based on age with an administration fee added.

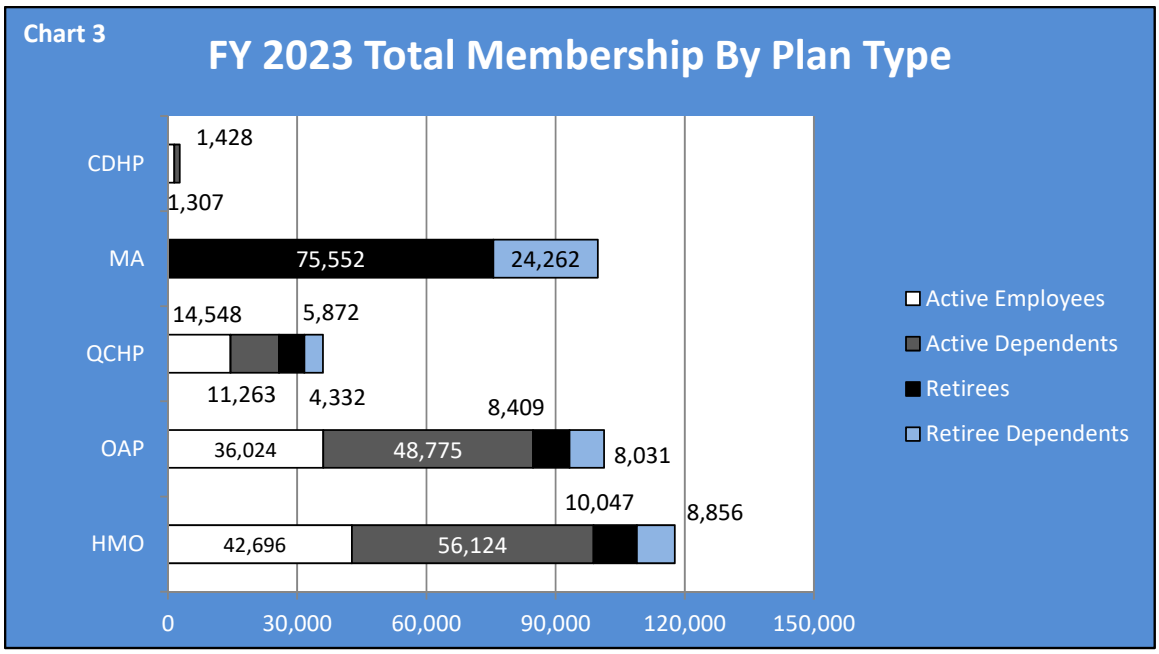
MEMBERSHIP

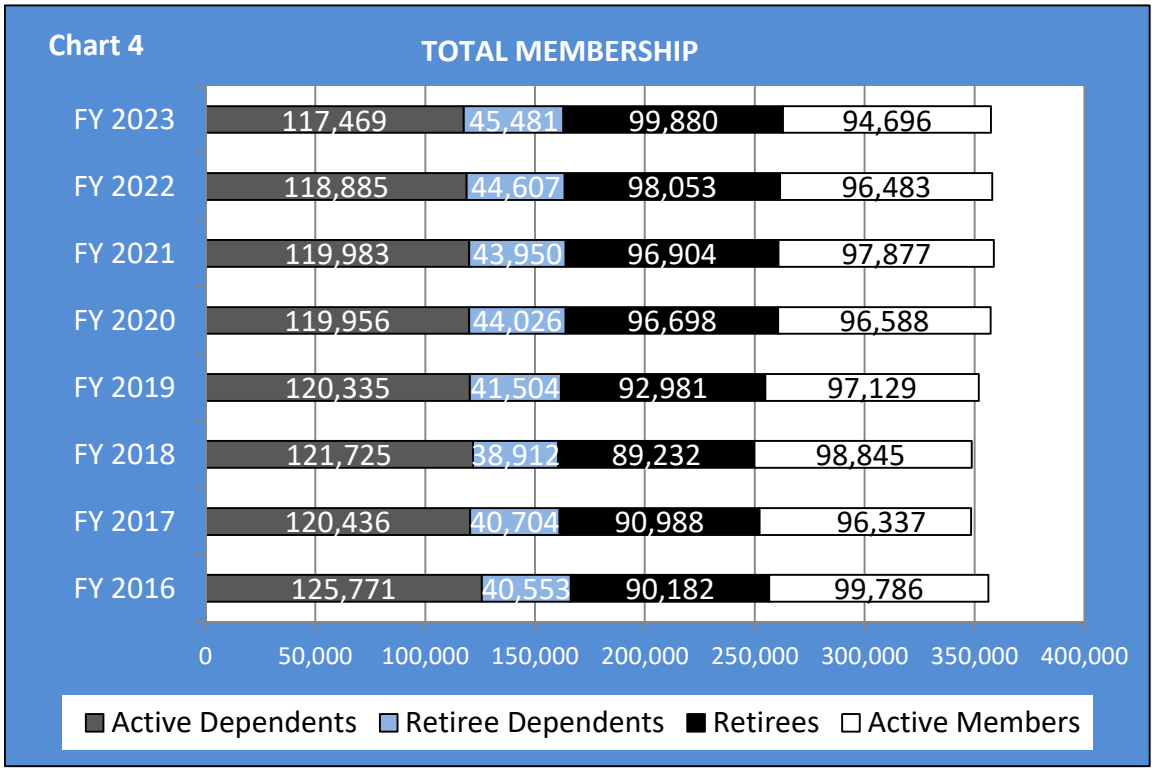
According to CMS, the State Employees' Group Health Insurance Program has an estimated 358,028 participants for FY 2022, of which 125,668 are in a non-Medicare Advantage HMO, 91,755 are in a Medicare Advantage HMO/PPO, 98,414 are in an Open Access Plan, and 39,851 are in the Quality Care Health Plan. The QCHP is estimated to have 15,286 employees, 11,731 active employee dependents, 5,140 retiree dependents, and 7,694 retirees in FY 2022.

Traditional HMO plans are estimated to have 45,313 employees, 59,244 active employee dependents, 9,562 retiree dependents, and 11,549 retirees in FY 2022. The CDHP is estimated to have 1,206 active employees and 1,134 active employee dependents. Medicare Advantage plans in FY 2022 include 21,883 dependents and 69,872 retirees. OAPs are anticipated to have 34,678 employees, 46,776 active employee dependents, 8,022 retiree dependents, and 8,938 retirees in FY 2022. This information is displayed in Chart 2.



For FY 2023, the QCHP is estimated to have 14,548 employees, 11,263 active employee dependents, 4,332 retiree dependents, and 5,872 retirees. Medicare advantage HMO/PPO plans are expected to have 24,262 dependents and 75,552 retirees. Non-Medicare Advantage HMO Plans are expected to have 42,696 employees, 56,124 active dependent lives, 8,856 retiree dependents, and 10,047 retirees. OAPs are expected to have 36,024 employees, 48,775 active dependents, 8,031 retiree dependents, and 8,409 retirees in FY 2023. The Consumer Driven Health Plan is projected to have 1,428 employees and 1,307 active employee dependents, which are primarily assumed to come from existing HMO plans. Total FY 2023 membership is expected to decrease 0.1% from 358,028 to 357,526. This information is displayed in Charts 3 and 4.





- **Membership (including CIP, TRIP, etc.) is projected for FY 2023.**

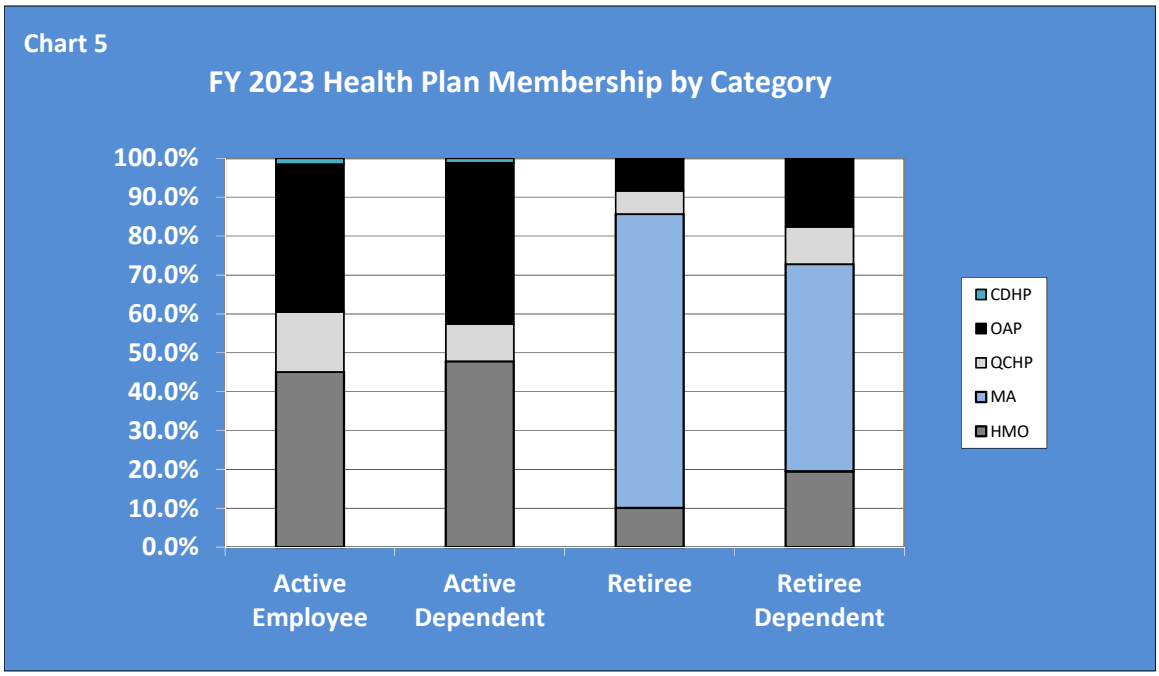
ENROLLMENT TRENDS

Membership in the Quality Care Plan has been decreasing since FY 2005, while membership in the States' managed care offerings has been increasing since FY 2004. Since FY 2012, many participants have transitioned away from traditional managed care (HMOs) to alternatives such as the Open Access Plan (OAP) and the CDHP (since FY 2021). This trend is reflected in FY 2022-FY 2023 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 2023, membership in HMOs is broken down by standard HMO membership, CDHP membership, and Medicare Advantage HMO/PPO membership. Though it has fluctuated over time, standard HMO membership is expected to continue to remain the highest participant category (for active employees and their dependents) among those measured (QCHP, OAP, etc.). Medicare Advantage HMO/PPO plans are expected to rise from 91,755 in FY 2022 to 99,814 for FY 2023. Membership is expected to grow in future years as retirees continue to qualify for Medicare Advantage.

Chart 5 shows the breakdown of employee, dependent, and retiree enrollment in the overall group insurance program. Due to the shift towards MA HMO/PPO plans by retirees, the QCHP has become less utilized among employees as a whole, especially retirees. In FY 2023, 76% of retirees and 53% of their dependents are expected to enroll in a Medicare Advantage HMO/PPO. Chart 5 demonstrates that employees, retirees, and

dependents from both groups are moving towards managed care and Open Access Plans, though some are moving to the new CDHP.



LIABILITY

The Department's estimate of liability for FY 2023 represents a 2.0 percent increase from FY 2022, partly due to a significant increase in OAP liability and smaller increases in other liability components (the CDHP, Dental, etc.). Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2014 through FY 2023 and demonstrates how several areas make up 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, the majority of liability has been contained within the HMO, OAP, and QCHP lines. The Open Access Plan is anticipated to compose the largest component of overall liability for FY 2023, with $1.06 billion out of a total group insurance liability (estimated) of $3.07 billion.

The Interest Payments category has continued to decline in recent fiscal years due to large payments made in FY 2018/FY 2019, and is projected to be zeroed out in FY 2023 due primarily to an expected supplemental appropriation in FY 2022. This would be the first time in over 20 years that Interest Payments was not a component of group insurance liability. The issue of state interest payments and paying down those liabilities is addressed in the following section of this report. The Administration/Other category continues to rise, sustaining the trend over the past few fiscal years, primarily due to the increasing health insurance expenses for the Teamsters, who negotiated a health insurance arrangement outside of the rest of the participants in the group insurance

program. Under this agreement, the Teamsters are allowed to opt-out of the SEGIP and enroll in a health plan administered by the Teamsters Health and Welfare Funds. According to the collective bargaining agreement signed with the state, the state pays a specific dollar amount for each person who opted-out and enrolled in the alternative plan. This plan will be renegotiated for FY 2024. The liability for this "opt-out" has risen from $6 million in FY 2015 to $104 million in FY 2022, and is expected to increase to $115 million in FY 2023. While a subsequent bargaining agreement has ensured that no new members will be permitted to opt-out, it is expected that rates will continue to increase through inflation and existing members becoming more expensive to insure over time, though negotiations for FY 2024 will affect any increases in future fiscal years.

Other components of liability such as Vision, Dental, and Life Insurance are projected to hold steady or increase slightly from FY 2022 to FY 2023. These components are only a minor portion 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. Depending on the participation rate by active members and their dependents, the CDHP may become a significant component of overall liability over time, though it is only projected to amount to $20 million in FY 2023, after totaling $16 million in FY 2022.

Table 4 STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY (CMS ESTIMATE) (FY 2014-FY 2023)

$ in (millions)

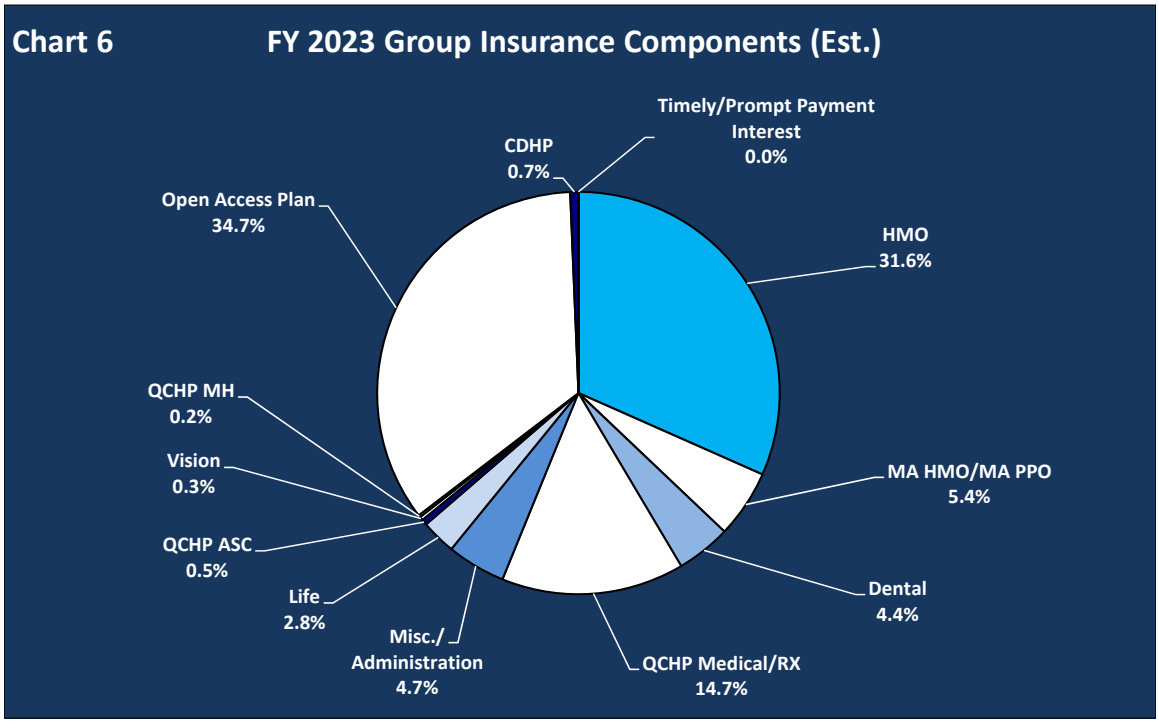
Liability Component	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023 (Estimated)
QCHP Medical/Rx	$598	$493	$488	$482	$512	$516	$495	$488	$471	$450
CDHP	$0	$0	$0	$0	$0	$0	$0	$8	$16	$20
HMO Medical	$910	$917	$934	$976	$1,037	$1,067	$1,088	$1,083	$985	$970
Medicare Advantage	$62	$154	$168	$183	$200	$197	$188	$175	$158	$167
Dental	$118	$118	$118	$113	$117	$124	$107	$130	$134	$138
Open Access Plan	$616	$657	$669	$703	$779	$842	$859	$965	$997	$1,065
QC Mental Health	$7	$5	$5	$6	$5	$6	$6	$6	$6	$6
Vision	$11	$11	$8	$8	$8	$8	$8	$9	$8	$8
Life Insurance	$88	$95	$91	$90	$90	$88	$92	$94	$83	$86
QC ASC	$26	$19	$15	$14	$15	$14	$15	$14	$12	$11
Interest Payments	$130	$221	$262	$195	$274	$104	$73	$23	$1	$0
Admin/Other	$48	$73	$53	$103	$120	$137	$159	$126	$133	$144
Total	**$2,614**	**$2,764**	**$2,810**	**$2,871**	**$3,158**	**$3,103**	**$3,090**	**$3,119**	**$3,005**	**$3,065**
% change over PY	**1.0%**	**5.7%**	**1.7%**	**2.2%**	**10.0%**	**-1.7%**	**-0.4%**	**1.0%**	**-3.7%**	**2.0%**

Source: CMS. Rounding causes slight differences in totals.

Chart 6 includes the various components of the FY 2023 CMS liability estimate of approximately $3.065 billion. The largest component of the State Group Insurance Program continues to be the State's Managed Care (HMO, OAP, and MA HMO/MA PPO)

plans, which together have grown to represent 71.7% of FY 2023 liability. The Consumer Driven Health Plan (CDHP) is projected to amount to 0.7% of FY 2023 liability.

Dental care, life insurance, and vision care equal 7.5% of total liability, slightly up from 7.2% in FY 2022. The QCHP component (15.4%) is slightly lower than FY 2022 (16.8%) and includes medical/prescriptions, mental health coverage, and administrative service charges. As mentioned previously, for FY 23, interest payments are projected to not contribute to Group Insurance liability, reflecting the proposed elimination of payment interest as a liability issue for the SEGIP.



As the movement of retirees to MA HMO/PPO plans continues, it is 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 consistent size or proportion in the near future, though the addition of the CDHP is projected to draw a sizable number of health insurance users from existing plans over time.

In regard to Open Access Plans, they remain a popular 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. However, their cost to the State has grown as more people migrate to OAPs. A new OAP option from Blue Cross Blue Shield started in FY 2022. This new OAP utilizes existing BCBS network provider access to offer lower participant costs (and potentially, lower costs to the State over time), though

it will take at least a few years before enough participants utilize the BCBS option to make a difference in overall State OAP liabilities.

One important note regarding liability is the attempt by the State to address interest payment liabilities and the issue of "lost money," i.e. money that could be spent on other liabilities within the SEGIP. An increased GRF commitment to cover increased year-to-year liabilities paid down significant health insurance bill interest in FY 2020 and the proposed supplemental appropriation for FY 2022 is expected to pay down the remainder of existing held bills. If the state is able to keep bills paid on a timely basis in FY 2023, the saved money that would otherwise be paid out in interest payments could be used for a variety of purposes.

GROUP INSURANCE INTEREST AND BONDING

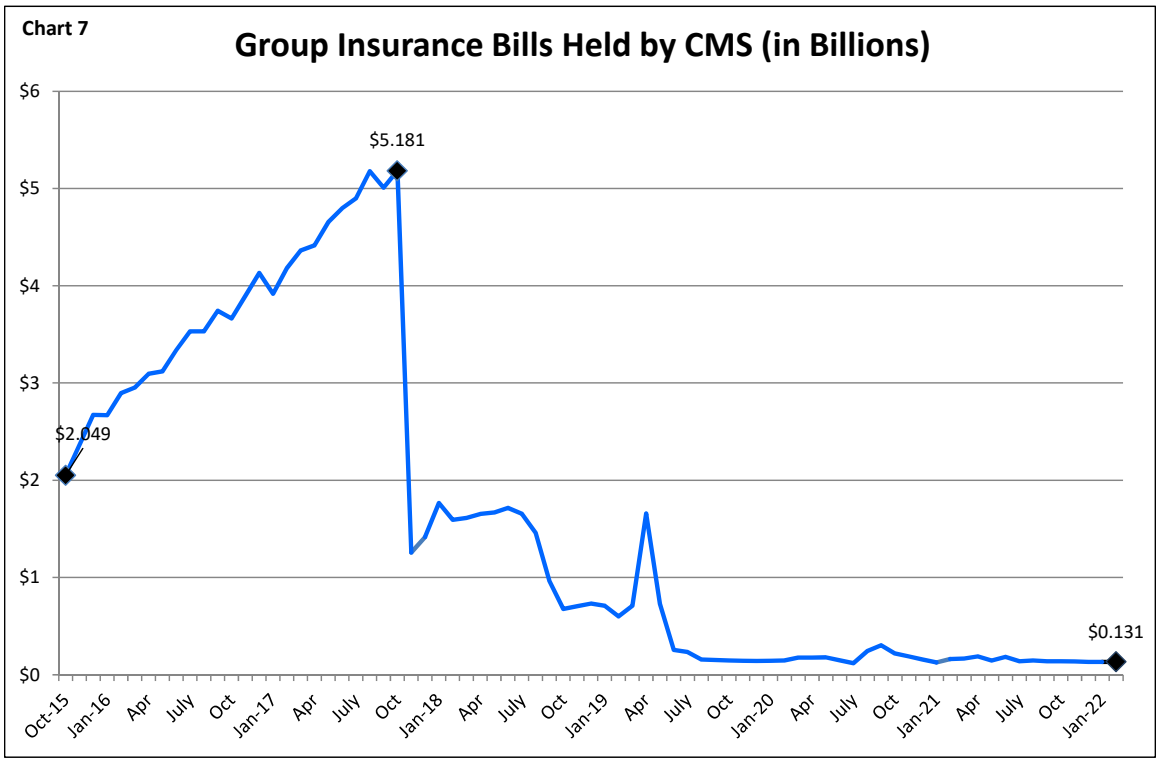
Since 2013, SEGIP interest payments have grown, sometimes at an alarming rate, as the State has been forced to push payments for services further and further into the future. This is done by "holding" claims until the actual money is available for payment. As a result, these "held claims" accrue interest 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 9.0% annually after an initial 30-day period.

Prompt Payment Interest (12.0%), 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 1.0% 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. Various attempts have been made to lower this interest rate to save money for the State, but concerns have been raised as to the long-term effects for contracts with businesses that would have chosen to not work with the state if the interest on anticipated late payments was not available.

Further exacerbating the issue was the inability of the State to pass a budget into law in recent years. Without spending authority, CMS was unable to pay down FY 2016 and FY 2017 year claims and held them as they accrued additional interest. CMS utilized employee premium contributions to help defray some of these costs (as this source of revenue was determined to be legally spendable outside traditional appropriations), but the vast majority of incurred claims remained unpaid and continued to accrue interest, including past-due interest (interest on interest) in some situations.

A State budget was eventually passed into law and provided funding for FY 2018, but no additional funding was provided to pay down the enormous amount of held bills. At the end of October 2017, the State had approximately $5.181 billion in health insurance claims waiting to be paid out. However, in November 2017, a bond sale was issued to pay down SEGIP and Medicaid bills. The bond proceeds were used to pay off approximately

$3.982 billion in held group insurance bills, bringing the total bills held by Illinois to $1.256 billion at the end of November 2017. This total has decreased significantly in the past few years. Chart 7 displays the historical backlog of Group Insurance bills.



As of the end of February 2022, approximately $131 million in Group Insurance bills are being held by CMS awaiting transmission to the Comptroller's office for payment. Of that total, there are $94 million in HMO claims (including Medicare Advantage) awaiting payment with no current interest payments yet to be paid off on those claims. Open Access Plans claims account for $0 currently in claims (but approximately $969,000 in interest owed). Aetna PPO (QCHP) claims account for $524,000 in interest owed.

Life Insurance ($6.8 million) and Administrative Service Charges ($3.3 million) make up the majority of the remaining claims held by Illinois. No interest is currently due on these debts as of the end of February, 2022. Current projections by CMS estimate a total of $3.1 million in interest liability (not including amounts sent to the Comptroller awaiting payment to vendors) at this point. Table 5 details the major portions of the current claims hold situation with existing interest rates of 9 and 12 percent, as of February 2022.

Table 5 Claims Hold Data for SEGIP (as of February 28, 2022)			
Vendor	Claims Hold	Length of Claims Hold (in days)	Interest Owed (Including Past Due Interest)
Aetna - PPO	$0	92	$523,602
Dental Claims Hold – PPO	$5,997,754	92	$91,466
Dental - Non-PPO	$17,468,056	92	$436,846
Magellan (Mental Health) Claims	$135,059	34	$32,704
Aetna HMO	$6,240,754	65	$0
Health Alliance HMO	$47,795,763	95	$0
HMO Illinois	$19,619,747	95	$0
Blue Advantage	$8,019,386	65	$0
HealthLink OAP	$0	93	$476,409
BCBS OAP	$0	87	$47,826
Aetna OAP	$0	99	$445,275
CVS/Caremark	$0	89	$1,029,071
Aetna MA	$808,340	34	$0
Health Alliance MA	$398,640	34	$0
Humana Benefit Plan MA	$25,756	34	$0
Humana Health Plan MA	$592,255	34	$0
United Healthcare MA	$10,399,452	65	$0
Eyemed (Vision)	$699,531	34	$0
Metropolitan Life	$6,808,930	3	$0
Other (Fees/ASC/etc.)	$3,346,475	3-218	$1,755
Total	**$128,355,898**	**3-156**	**$3,084,954**
Source: CMS. MA stands for Medicare Advantage.			

In regard to payment cycles, the 2023 fiscal year is projected to eliminate all existing payment cycle delays between CMS and the various health vendors. Under this system, vouchers for services submitted by vendors to the state for payment would be processed by CMS in a month or less. If this plan is successful, it would be a vast improvement over prior years, when payment vouchers would await servicing for months, if not years. The success of this plan will be evaluated in future years in this report.

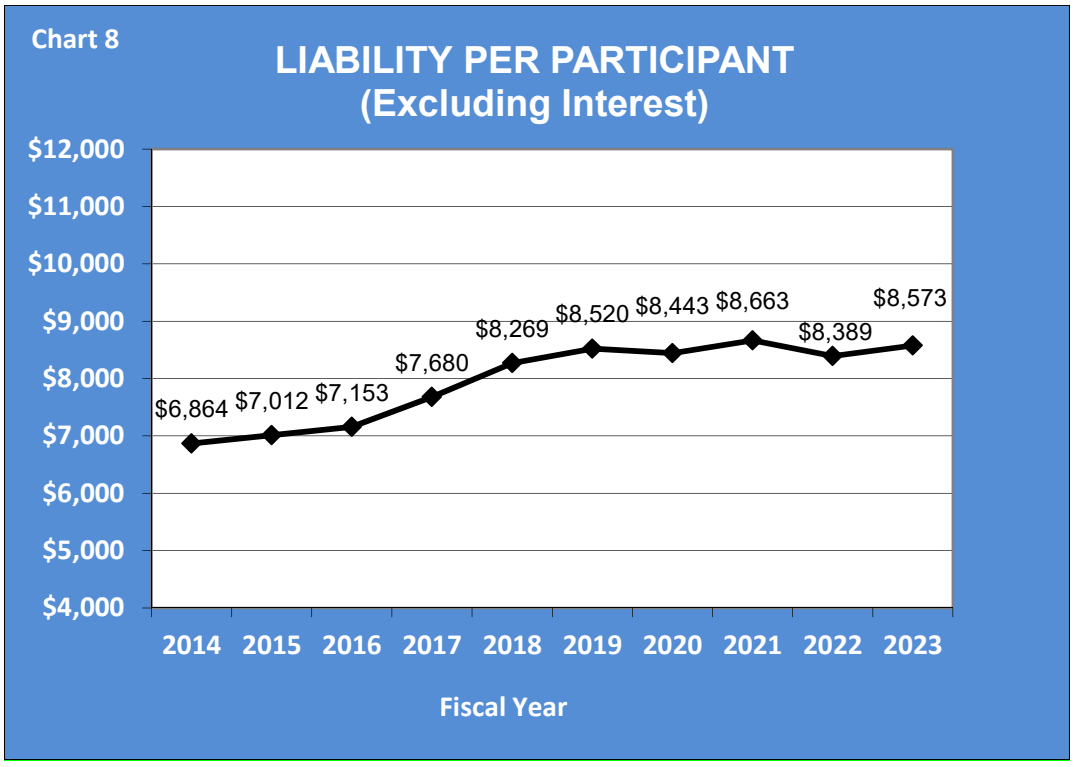
One important note on this subject is that this accounts only for the time for CMS to process claims and does not include time for the Comptroller to process and send out payment to the vendors in question. The Comptroller's timeliness depends on current cash flow needs and funds availability, which fluctuates daily. According to the Comptroller's office, as of the end of January 2022, they had approximately $530 million in Health Insurance Reserve Fund vouchers awaiting payment as the cash flow becomes available. Regardless of the means utilized, stable fiscal commitment is required to ensure prompt payment of claims to vendors and avoid excessive interest payments that dramatically inhibited state health insurance spending priorities only a few years ago.

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 8 shows the steady increase each year in cost per participant, though FY 17 through FY 19 deviate from past fiscal years, in part due to the accumulation of held bills that temporarily inflated overall liability. As plan participants live increasingly longer lives, utilization of medical insurance plans (and thereby liabilities to the state) have tended to increase accordingly.

For FY 2014 – FY 2023 in Chart 8, this information is displayed without including interest payments in order to illustrate general medical plan trends more accurately. While interest was a major component of overall liability less than 5 years ago, this component has shrunk in recent years and is expected to be eliminated in FY 2023. For comparison with the current year, the annual liability per participant in the group health insurance program was $6,864 in FY 2014.

According to CMS, the liability per participant for FY 2022 will decrease slightly to $8,389, a decrease of $274 compared to FY 2021. For FY 2023, the estimated liability per participant is $8,573, an increase of $184. This represents a 24.9% increase over FY 2014, though only a 3.7% increase over FY 2018.



As such, the FY 2023 liability per participant is projected to increase 2.2% from FY 2022. It is necessary 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. While it is informative of general liability trends, it is not necessarily indicative of all medical inflation factors.

In the wake of the COVID-19 pandemic, the impact from the state introducing the Consumer Driven Health Plan (CDHP) in the 2021 fiscal year has been fiscally promising, as in conjunction with Medicare Advantage plans, overall liabilities per participant have moderated . While savings are expected for the state in the long run, as younger employees and dependents utilize this plan, the overall SEGIP liability is anticipated to remain on an upward trajectory due to traditional extraneous factors such as demographics and medical service utilization. It is likely that absent a major change in these areas, overall liability and liability per participant will rise from year to year, though the CDHP represents a successful attempt to address medical service utilization and demographics in a manner so as to save money for both individual participants and the State of Illinois.

For FY 2023, how the State addresses COVID-related effects on the health industry will continue to affect health options for participants. As discussed above, limiting service utilization in favor of leaving availability for COVID-related medical issues resulted in a degree of savings for health insurance providers. Depending on actions taken to deal with COVID and subsequent mutations and variant strains known to exist or expected to exist in the future, group health liabilities for Illinois will necessarily be affected.

Table 6: ANNUAL LIABILITY PER PARTICIPANT

	FY 2022	FY 2023	FY 2022	FY 2023
	Total Participants	Total Participants	Liability Per Participant	Liability Per Participant
QCHP	39,851	36,015	$12,264	$12,975
CDHP	2,340	2,735	$6,928	$7,360
MA HMO / PPO	91,755	99,814	$1,718	$1,673
HMO	125,668	117,723	$7,842	$8,236
OAP	98,414	101,239	$10,130	$10,518
Totals	**358,028**	**357,526**		

OAP is the Open Access Plan. CDHP is the Consumer Driven Health Plan. ALPP does not include dental, vision, admin/interest/other, or life insurance. FY 2023 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 2023, as in FY 2022, 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 over the years, especially in FY 2014 – FY 2015 as people have steadily migrated to HMOs and OAPs. 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 more expensive to cover (requiring more treatment, medicines, etc.). 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 higher projected liability for QCHP participants (compared to others) in FY 2023. OAPs remain higher than HMOs, but lower than the QCHP.

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 $12,264 in FY 2022. Member contributions for QCHP enrollees are expected to total $74 million in FY 2022. 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 (starting in FY 2014) 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). While lower, the other medical plans (Traditional HMOs, Medicare Advantage HMOs, and Open Access Plans) also have significant average liabilities per participant which are only partially offset by member contributions. Table 7 examines the relationship between overall cost and the offset by member contributions for FY 2022 and FY 2023.

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

	FY 2022 ALPP	FY 2022 Member Contributions	FY 2022 State Liability	FY 2023 ALPP	FY 2023 Member Contributions	FY 2023 State Liability
QCHP	$12,264	$1,854	$10,410	$12,975	$2,066	$10,909
CDHP	$6,928	$1,511	$5,417	$7,360	$1,644	$5,717
MA HMO/PPO	$1,718	$365	$1,353	$1,673	$368	$1,305
HMO	$7,842	$1,358	$6,483	$8,236	$1,482	$6,754
OAP	$10,130	$1,466	$8,664	$10,518	$1,596	$8,922
Dental	$373	$114	$260	$383	$123	$259

Source: CMS.

Table 7 shows that QCHP members are expected to contribute 15.9% of the overall annual cost of providing their insurance in FY 2023. HMO/OAP/MA HMO (and PPO) members are expected to contribute 18.0%, 15.2%, and 22.0% of their overall liability cost in the

same time period. Members of the Consumer Driven Health Plan are estimated to contribute 22.3% of the overall liability, a higher proportion than the other options. Members that participate in the State's dental offering are expected to pay 32.1% percent of the overall liability cost in FY 2023, an increase from 30.6% in FY 2022. 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.

Liability may also change slightly year-to-year based on expenses incurred in a particular fiscal year from paying down held bills in a particular category (HMOs/etc.). For example, the Dental line in Table 7 may be slightly higher due in part to extra dental liabilities being incurred/paid off in a particular fiscal year. A stable budget that promptly pays down these liabilities would help alleviate this issue, though some liabilities will always be incurred in future fiscal years due to the natural billing cycle between providers, CMS, and the Comptroller's office.

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* resulted in reduced contributions for many retirees. Table 8 displays a comparison of the costs for these groups taken from data obtained from CMS as of February 2022.

TABLE 8: RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 2023
(Numbers in Millions)

Category	Cost	Category	Cost
Retiree Cost	$610.1	Active Employee Cost	$1,273.0
Retiree Contribution	-$40.1	Active Employee Contribution	-$279.8
Other Revenues	-$15.9	Other Revenues	-$42.5
Net State Cost	**$554.1**	**Net State Cost**	**$950.7**
Retiree Dependent Cost	$274.3	Active Employee Dependent Cost	$907.5
Retiree Dependent Contribution	-$76.9	Active Employee Dependent Contribution	-$154.1
Other Revenues	-$12.5	Other Revenues	-$47.8
Net State Cost	**$185.0**	**Net State Cost**	**$705.6**
Total Retiree Cost	$884.4	Total Active Cost	$2,180.6
Total Retiree Contribution	-$117.0	Total Active Contribution	-$433.9
Other Revenues	-$28.4	Other Revenues	-$90.3
Total State Cost	**$739.1**	**Total State Cost**	**$1,656.3**

Source: CMS

Based on data provided by CMS, retiree dependents (but not 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. For FY 2023, retirees and retiree dependents are projected to pay 6.6% and 28.0% of their healthcare costs, a decrease from 7.3% and an increase from 26.1% in FY 2022. This contrasts with active employees and their dependents, who are projected to pay 22.0% and 17.0% of their healthcare costs, a slight rise for active employees and active employee dependents compared to 22.0% and 16.4% respectively in FY 2022. In total, the aggregate contributions of active employees and dependents (19.9% for both groups combined in FY 2023 compared to 19.7% in FY 2022) remain significantly higher as a percentage than the aggregate contributions of retirees and retiree dependents (13.2% for both groups combined in FY 2023 compared to 13.1% in FY 2022). This difference is accounted for by retirees utilizing Medicare Advantage HMO and PPO plans (resulting in savings for the State of Illinois) along with increased contributions by active employees and their dependents expected in FY 2023.

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 2021, FY 2022, and FY 2023 plan enrollment is listed in Table 9.

TABLE 9: MANAGED CARE PLANS FY 2021-2023 All Lives (Active Members/Dependents and non-MA Retirees/Dependents)					
HMO/OAP	FY21 # of Participants	FY22 # of Participants	% Change 2021-2022	FY23 # of Participants	% Change 2022-2023
Health Alliance HMO	69,999	66,878	-4.46%	63,779	-4.63%
HMO Illinois	38,690	34,492	-10.85%	30,346	-12.02%
Blue Advantage	15,541	15,302	-1.54%	15,062	-1.57%
Aetna/Coventry Health Care HMO	9,457	8,996	-4.87%	8,536	-5.11%
Aetna/Coventry Health Care OAP	32,510	36,249	11.50%	39,786	9.76%
Health Link OAP	62,972	57,190	-9.18%	51,485	-9.98%
BCBS OAP	0	4,975	N/A	9,968	100.36%
Consumer Driven Health Plan HDHP	1,618	2,340	44.62%	2,735	16.88%
TOTALS	**230,787**	**226,422**	**-1.89%**	**221,697**	**-2.09%**
Source CMS. FY 23 numbers are projected as of February 2022.					

The Consumer Driven Health Plan draws some people out of existing plans, along with migration expected towards HMOs and lower-priced options in general. Under the new contracts signed between the state and employee unions, rate increases are expected to continue for existing plans with higher rates expected for more expensive plans rather than the traditional equivalency between HMO and OAP options. This is discussed in further detail in the Monthly Premiums section of this report.

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 shows the population figures involved with this new program.

TABLE 10: MEDICARE ADVANTAGE PLANS FY 2021-2023			
HMO/PPO	FY21 # of Participants	FY22 # of Participants	FY23 # of Participants
Aetna HMO	5,260	6,038	6,867
Humana Benefit Plan HMO	158	193	232
Humana Health Plan HMO	3,828	4,477	5,173
Health Alliance HMO	1,970	2,626	3,364
United HealthCare PPO	72,912	78,421	84,178
TOTALS	**84,128**	**91,755**	**99,814**
Source: CMS. FY 23 numbers are projected as of February 2022.			

It is important to note that except for a limited number of retirees and dependents coming from a HMO or OAP program, most of the 99,814 people projected to be covered in FY 2023 by a MA HMO or PPO plan will come from the QCHP. In regard 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. These plans are currently going through the bidding process at CMS.

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.

In recent years, efforts have been made to increase member/employee contributions to pay for a larger portion of the costs of providing health coverage. Continuing in the 2023 fiscal year, as a result of negotiations with public employee unions, premiums for HMO/OAP/QCHP options will continue to increase, with most plans experiencing an increase of between $10 to $40/month depending on plan coverage options and the specific plan provider chosen. Under this arrangement, HMO premiums are generally substantially lower than OAP premiums, though individual demographic cohorts within specific plans may be more comparable.

TABLE 11: PROJECTED MONTHLY COSTS
FY 2016 - FY 2023
Employee Only

	QCHP				CDHP			
	TOTAL	% Inc.	Member	State	TOTAL	%Inc.	Member	State
FY 16	$894		$170	$724	N/A	N/A	N/A	N/A
FY 17	$897	0.4%	$169	$728	N/A	N/A	N/A	N/A
FY 18	$943	5.1%	$168	$775	N/A	N/A	N/A	N/A
FY 19	$1,023	8.5%	$168	$855	N/A	N/A	N/A	N/A
FY 20	$1,020	-0.3%	$168	$852	N/A	N/A	N/A	N/A
FY 21	$1,052	3.2%	$195	$857	N/A	N/A	N/A	N/A
FY 22	$1,101	4.6%	$211	$890	$739	N/A	$164	$574
FY 23	$1,156	5.0%	$227	$929	$775	4.9	$175	$600

	HMO				OAP			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY 16	$699		$126	$573	$773		$125	$648
FY 17	$749	7.2%	$126	$623	$850	10.0%	$125	$725
FY 18	$800	6.7%	$126	$674	$947	11.4%	$125	$822
FY 19	$822	2.8%	$126	$696	$987	4.2%	$125	$862
FY 20	$836	1.7%	$127	$709	$971	-1.6%	$128	$843
FY 21	$850	1.7%	$155	$695	$1,065	9.6%	$167	$897
FY 22	$823	-3.2%	$169	$654	$1,070	0.5%	$183	$887
FY 23	$864	5.0%	$182	$682	$1,114	4.1%	$198	$916

Table 11 displays the gradual increases in total monthly costs to the State for providing the three main types of health insurance plans for members/dependents from FY 2016 to the projected values for members in FY 2023. Whether members are in the QCHP, a traditional HMO, or an Open Access Plan, the monthly cost of such plans has steadily increased. Concurrently, the employee premiums for these plans have also increased, though at a much lower rate year-to-year until recently. For FY 2023, employee contributions are projected to cause the total cost of health insurance provision for HMO plans to the state to decrease somewhat. However, the total costs and projected member contributions of the proposed Consumer Driven Health Plan (a HDHP) are still lower than other alternatives.

Table 12 displays the projected monthly rates for the provision of health plans across the QCHP/HMO/OAP spectrum along with the projected State and member contributions expected for the 2023 fiscal year. As in previous years, members/dependents are expected to pay a relatively small portion of total monthly rates compared to the total cost of health insurance coverage, though the increased contributions agreed to as a result of labor negotiations may reduce that gap over time.

TABLE 12: MONTHLY PREMIUMS
QCHP / CDHP / HMO / OAP
Weighted Average
FY 2023 Rates (Projected for Median Salary)

	QCHP			CDHP		
	TOTAL	Member	State	TOTAL	Member	State
Employee	$1,156	$227	$929	$775	$175	$600
Medicare Retiree	$608	$18	$590	$0	$0	$0
Non-Medicare Retiree	$1,667	$20	$1,647	$0	$0	$0
1 Dependent	$1,363	$296	$1,067	$718	$172	$545
2+ Dependents	$1,767	$339	$1,427	$1,109	$220	$889
Medicare Dependent	$789	$192	$597	$559	$146	$413

	HMO			OAP		
	TOTAL	Member	State	TOTAL	Member	State
Employee	$864	$182	$682	$1,114	$198	$916
Medicare Retiree	$560	$21	$539	$727	$21	$705
Non-Medicare Retiree	$1,313	$14	$1,299	$1,663	$14	$1,649
1 Dependent	$735	$186	$549	$937	$200	$737
2+ Dependents	$1,266	$233	$1,034	$1,616	$250	$1,366
Medicare Dependent	$573	$160	$413	$732	$173	$559

As with Employee-only premium projections and associated costs, premiums for all applicable active SEGIP member and dependent cohorts are expected to continue the rise started in FY 2021. It is important to note that despite this increase and the traditional

cost differential between plans, certain HMO/OAP/CDHP options may have a lower projected median premium than their traditionally less-expensive contemporaries.

TABLE 13: MONTHLY PREMIUMS ACROSS ALL PLANS HMOs / OAPs / CDHP FY 2022 Rates (for Median Salary)								
	Health Alliance	Aetna HMO	HMO Illinois	Blue Advantage	HealthLink OAP	BCBS OAP	Aetna OAP	CDHP
Employee	$178.94	$167.55	$165.41	$140.40	$187.62	$174.98	$174.98	$167.23
Medicare Retiree	$30.56	$30.56	$30.56	$30.56	$30.56	$30.56	$30.56	N/A
Non-Medicare Retiree	$18.73	$18.73	$18.73	$18.73	$18.73	$18.73	$18.73	N/A
1 Dependent	$180.04	$181.22	$147.54	$142.60	$191.03	$173.03	$173.03	$154.82
2 + Dependents	$230.04	$227.64	$190.66	$181.46	$243.91	$219.44	$219.44	$202.08
Medicare Dependent	$153.00	$154.00	$123.00	$119.00	$163.00	$146.00	$146.00	$129.00
FY 2023 Proposed Rates (for Median Salary)								
	Health Alliance	Aetna HMO	HMO Illinois	Blue Advantage	HealthLink OAP	BCBS OAP	Aetna OAP	CDHP
Employee	$194.03	$182.32	$179.08	$152.32	$203.69	$191.77	$191.77	$175.00
Medicare Retiree	$21.26	$21.26	$21.26	$21.26	$21.26	$21.26	$21.26	$0.00
Non-Medicare Retiree	$13.80	$13.85	$13.80	$13.80	$13.80	$13.80	$13.80	$0.00
1 Dependent	$198.35	$199.65	$165.98	$160.93	$209.42	$190.44	$190.44	$172.00
2 + Dependents	$248.60	$246.10	$209.41	$200.02	$262.20	$236.87	$236.87	$220.00
Medicare Dependent	$171.00	$172.00	$141.00	$137.00	$181.00	$163.00	$163.00	$146.00

Table 13 displays the average projected rates for employees, retirees, and dependents across all the HMO, OAP, and CDHP options. 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. The new Consumer Driven Health Plan (CDHP) option will have lower rates than most other options due to its unique characteristics, but it is limited to active employees and their dependents only.

Continuing the trend started last year in FY 2021, plan rates will be set by the particular plan type and optional demographic option, rather than a generally similar rate across all HMOs and OAPs. Accordingly, there is an approximate $40-$63/month spread between the most expensive and least expensive plans in Table 13, with different plans having lower rates than others depending on the particular demographic components of the plan being considered. For example, while the CDHP is projected to have lower rates than most other plans in the table, the average rate for Employee-only and 1 Dependent plans make other HMOs and OAPs potentially more desirable. It is expected that competition between the various health insurance vendors will lead to more competitive rates in future fiscal years.

Table 14 shows a comparison between FY 2021, FY 2022, and projected FY 2023 MA rates for retirees and dependents. Unlike non-Medicare Advantage plans, rates in the Medicare Advantage SEGIP plans are expected to remain steady.

TABLE 14: MONTHLY PREMIUMS FOR STATE MEDICARE ADVANTAGE PLANS
FY 2021-2023 Rates (As of February 2022)

Aetna HMO	FY 2021	FY 2022	FY 2023
Medicare Retiree	$8.80	$6.85	$6.91
Two or More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91
Humana Benefit Plan HMO	FY 2021	FY 2022	FY 2023
Medicare Retiree	$8.80	$6.85	$6.91
Two or More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91
Humana Health Plan HMO	FY 2021	FY 2022	FY 2023
Medicare Retiree	$8.80	$6.85	$6.91
Two or More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91
United HealthCare	FY 2021	FY 2022	FY 2023
Medicare Retiree	$10.20	$6.51	$6.31
Two or More Dependents	$155.00	$155.00	$155.00
Medicare Dependent	$110.00	$110.00	$110.00
Health Alliance HMO	FY 2021	FY 2022	FY 2023
Medicare Retiree	$8.80	$6.85	$6.91
Two or More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91

APPENDIX I

TYPES OF MEDICAL & DENTAL GROUP INSURANCE PLANS			
Type of Plan	Coverage	Characteristics	Geographic Location
QCHP Medical	Care related to the treatment of an illness or injury. Preventive care includes well-baby care, routine and school physicals, annual pap smears and mammograms.	Choice of physician and other medical care providers. Annual deductibles and employee contributions based on member salary. Dependent premiums do not vary.	No limitation; preferred hospital providers statewide.
QCHP Dental	Preventive, diagnostic, restorative, orthodontic, endodontic, and periodontic services as well as extractions and prosthetics.	Choice of dental care providers, reimbursement on a scheduled basis. No deductibles 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 and plan choice, 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. Premiums vary based on salary and plan choice.	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
CDHP	High-deductible health plan. Significantly lower premiums compared to traditional HMO/PPO/etc. plans.	$1500 deductible required before health services are covered. Network providers and coverage options. Similar provisions to HMO plans.	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 5 one-year renewals. 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 23 at DCMS		
Service	**Vendor**	**Contract Term Details**
Managed Care Health Plans	Health Alliance HMO / Aetna HMO / Aetna OAP / Healthlink OAP / BC HMO Illinois / BC Blue Advantage	**Ongoing** - HMO Terms go to June 30, 2026 with five 1-year renewals. OAPs are pending Request for Proposal. (RFP)
Medicare Advantage Health Plans	Aetna/Coventry HMO / Health Alliance HMO / Humana Benefits Plan HMO / Humana Health Plan HMO / UnitedHealthCare PPO	**Ending** - Terms go to December 30, 2022. RFP is pending.
Self-Insured Medical Plan Administration	Aetna	**Ongoing -** Term goes to June 30, 2026.
Vision	EyeMed	**Ongoing** - Term goes to June 30, 2023.
Behavioral Health/EAP	ComPsych	**Ongoing (New)** - Term goes to June 30, 2026.
Life Insurance	Metropolitan Life Insurance Company	**Ongoing (New)** - Term goes to June 30, 2026.
Flexible Spending	ConnectYourCare	**Ongoing -** Term goes to June 30, 2023
Administration of Dental Claims	Delta Dental	**Ongoing** - Term goes to June 30, 2026.
Prescription Drugs	CVS/Caremark	**Ongoing -**Term goes to June 30, 2024.
Commuter Savings Program	Edenred	**Ongoing** - Term goes to June 30, 2024.

APPENDIX III

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.

COMMISSION OVERVIEW

The Commission on Government Forecasting & Accountability is a bipartisan legislative support service agency responsible for advising the Illinois General Assembly on economic and fiscal policy issues and for providing objective policy research for legislators and legislative staff. The Commission's board is comprised of twelve legislators—split evenly between the House and Senate and between Democrats and Republicans. Effective December 10, 2018, pursuant to P.A. 100-1148 the former Legislative Research Unit was merged into the Commission.

The Commission has three internal units—Revenue, Pensions, and Research, each of which has a staff of analysts and researchers who analyze policy proposals, legislation, state revenues & expenditures, and benefit programs, and who provide research services to members and staff of the General Assembly. The Commission's staff fulfills the statutory obligations set forth in the Commission on Government Forecasting and Accountability Act (25 ILCS 155/), the State Debt Impact Note Act (25 ILCS 65/), the Illinois Pension Code (40 ILCS 5/), the Pension Impact Note Act (25 ILCS 55/), the State Facilities Closure Act (30 ILCS 608/), the State Employees Group Insurance Act of 1971 (5 ILCS 375/), the Public Safety Employee Benefits Act (820 ILCS 320/), the Legislative Commission Reorganization Act of 1984 (25 ILCS 130/), and the Reports to the Commission on Government Forecasting and Accountability Act (25 ILCS 110/).

- The **Revenue Unit** issues an annual revenue estimate, reports monthly on the state's financial and economic condition, and prepares bill analyses and debt impact notes on proposed legislation having a financial impact on the State. The Unit publishes a number of statutorily mandated reports, as well as on-demand reports, including the *Monthly Briefing* newsletter and annually, the *Budget Summary*, *Capital Plan Analysis*, *Illinois Economic Forecast Report*, *Wagering in Illinois Update*, and *Liabilities of the State Employees' Group Insurance Program*, among others. The Unit's staff also fulfills the agency's obligations set forth in the State Facilities Closure Act.
- The **Pension Unit** prepares pension impact notes on proposed pension legislation and publishes several statutorily mandated reports including the *Financial Condition of the Illinois State Retirement Systems*, the *Financial Condition of Illinois Public Pension Systems* and the *Fiscal Analysis of the Downstate Police & Fire Pension Funds in Illinois*. The Unit's staff also fulfills the statutory responsibilities set forth in the Public Safety Employee Benefits Act.
- The **Research Unit** primarily performs research and provides information as may be requested by members of the General Assembly or legislative staffs. Additionally, the Unit maintains a research library and, per statute, collects information concerning state government and the general welfare of the state, examines the effects of constitutional provisions and previously enacted statutes, and considers public policy issues and questions of state-wide interest. Additionally, the Unit publishes *First Reading*, a quarterly newsletter which includes abstracts of annual reports or special studies from other state agencies, the *Illinois Tax Handbook for Legislators*, *Federal Funds to State Agencies*, various reports detailing appointments to State Boards and Commissions, the *1970 Illinois Constitution Annotated for Legislators*, the *Roster of Illinois Legislators*, and numerous special topic publications.

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