# FY 2026 Liabilities of the State Employees' Group Health Insurance Program

March
2025

***Commission on Government Forecasting and Accountability***


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**March 2025**


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# 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 (SEGIP).
- 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 2026 fiscal year indicating a continuation of the existing contracts in place as well as negotiated rate increases for group insurance participants. Currently, projected FY 2026 liabilities are expected to rise significantly over FY 2025, though at a lower overall percentage rate of increase (7.7% increase in FY 2026 projected liabilities compared to a 15.7% increase in estimated FY 2025 liabilities). This translates to a 30.7% increase in overall liabilities from FY 2023 to FY 2026. This rise is attributed to continued health cost inflation and various legislative mandates for health care procedures and coverage. The Department continues to offer a variety of Health Maintenance Organization (HMO), Open Access Plan (OAP), and Preferred Provider Organization (PPO) plans for members and dependents. In accordance with public employee union negotiations, current health insurance plan rates will differ depending on the specific plan chosen. Existing funding and plan design components were largely expected to be unchanged in FY 2026. However, the late-February 2025 announcement that Health Alliance is ending its health insurance services with the State at the end of FY 2025 (June 30, 2025) and in general (except for Medicare Advantage plans) at the end of calendar year 2025 will cause significant changes across the group insurance program. As a result of this recent and abrupt announcement, the population and liability figures provided in this report should be understood as a static photograph of the system and indicative of recent trends. The full population and liability impact of the exit of Health Alliance from the SEGIP is yet to be determined.

The Medicare Advantage PPO plan offered by Aetna, which replaced all other existing Medicare Advantage plans for retirees and their dependents at the end of the 2022 calendar year, will continue for the third full year in FY 2026. Due to federal requirements, Medicare Advantage plans begin and end in line with the calendar year rather than the Illinois fiscal year of July 1 to June 30. Accordingly, while the Aetna PPO MA plan began in January 2023, FY 2024 was the first full fiscal year with this plan in effect.

According to CMS, for the 2026 fiscal year, the GRF appropriation is projected to be $2.668 billion for SEGIP, with total expected revenues projected at approximately $4.155

billion. CMS estimates the FY 2026 liability to be $4.175 billion, a 7.7% increase from the FY 2025 anticipated final liability of $3.875 billion. Noting these predictions, the Commission anticipates that liabilities and revenues will increase from FY 2025 and estimates a total SEGIP liability of $4.229 billion in FY 2026, $54.7 million more than CMS.

As noted above, for FY 2026, liabilities are projected by CMS to increase (7.7%), though at a slower rate when compared to the 15.7% increase in FY 2025 liabilities over FY 2024 totals. This projected increase is the second largest in the last eight fiscal years after FY 2025. FY 2026 revenues are projected to increase compared to FY 2025 by approximately $267.1 million, primarily due to an increased GRF appropriation. For FY 2026, member contributions are projected to total $617 million, compared to $583 million in FY 2025, a $34 million increase. Reimbursements are projected to increase to $546 million compared to $496 million in FY 2025. The Road Fund is projected to account for $88 million for FY 2026, a $68 million decrease, compared to $156 million in FY 2025. Overall, liabilities are projected to continue to increase due to medical insurance inflationary pressures, especially in the Open Access Program line.

CMS expects FY 2026 to continue the goal of minimizing existing held claims and projected hold times on the part of CMS in processing payments to healthcare vendors and insurance companies, as has been the case since FY 2023. 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.

As previously noted in past reports, one of the significant long-term effects of COVID-19 on the SEGIP included the suspension of most non-essential care to prioritize COVID-19 care. This 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. However, the following fiscal year liabilities reflect a return to normal healthcare use and treatments (and associated increased liabilities).

**Table 1 GRF APPROPRIATION/REVENUE AND LIABILITY HISTORY FY 2019-2026 ($ in Millions)**

| Fiscal Year | Appropriation Received | Revenues | CMS Liability |
|---|---|---|---|
| FY 2019 | $2,176.2 | $3,201.8 | $3,103.8 |
| FY 2020 | $2,440.2 | $3,699.1 | $3,093.2 |
| FY 2021 | $2,022.8 | $3,208.5 | $3,173.9 |
| FY 2022 | $2,753.2 | $3,967.4 | $3,140.4 |
| FY 2023 | $1,846.4 | $3,092.3 | $3,193.6 |
| FY 2024 | $2,033.1 | $3,346.1 | $3,349.9 |
| FY 2025** | $2,374.7 | $3,887.8 | $3,874.9 |
| FY 2026** | $2,667.5 | $4,154.9 | $4,174.6 |

FY 2020 included interfund borrowing to pay down held bills. FY 2022 includes a supplemental appropriation of $898 million.
**Estimated for FY 2025 and projected for FY 2026.

## FY 2026 PROPOSED PLAN CHANGES

For FY 2026, the State is expected to introduce one significant policy change to the existing health insurance plan arrangement utilized by employees, retirees, and dependents. They plan to introduce a system of "plan splitting" that primarily affects retiree members. Under this change, when a retiree reaches Medicare eligibility, if they have dependent children, only the retiree will be moved to a Medicare Advantage plan, while the dependent children may remain on the existing HMO/OAP/etc. If the retiree has no dependent children, they and their spouse will be moved to a Medicare Advantage plan when the retiree reaches Medicare age eligibility. Additionally, while not a change made by the State, Health Alliance, a major HMO that currently serves approximately 60,000 SEGIP members and dependents, recently announced the ending of their health insurance services as of the end of the 2025 calendar year for all plans except for Medicare Advantage. A recent announcement from CMS regarding the status of the plans currently utilized by SEGIP members and dependents indicates that Health Alliance services for State members will end July 1, 2025. Accordingly, all 60,000 Health Alliance enrollees will be required to select a new health insurance plan or opt out of coverage entirely during the FY 2026 annual enrollment period (May 1, 2025 – June 2, 2025). It is likely that many current participants will switch to other existing HMO/PPO plans offered by the State. Any current Health Alliance enrollees who do not choose a plan during the annual enrollment period will be defaulted to the Quality Care Health Plan, which generally has the highest premium rates of all offered plans.

Otherwise, premiums are expected to increase in line with labor negotiations and the health plan premium graduation introduced in FY 2021. This increase is expected to be an additional $8/month for all employees and an additional $4/month for all dependent plans in FY 2026 and FY 2027, the last year of the current labor contract. The Consumer Driven Health Plan (CDHP) is expected to continue and increase in utilization in FY 2026, as the benefits for younger users continue to be attractive compared to more robust and costly 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 2026 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) utilizes the CMS forecast for FY 2026 medical costs as the basis for estimating costs for FY 2026 along with information provided by the Segal Company in their annual report on group insurance trends. The CGFA State of Illinois liability cost projection uses the following assumptions based on historical claims data and anticipated cost changes.

| Table 2 | Trend Factors |
|---|---|
| Medical (QCHP plan) | 0.9% |
| Dental (QCHP and MC) | 4.6% |
| HMO (Medical and Rx) | 4.8% |
| Prescription drugs (QCHP) | 3.4% |
| Open Access Plan | 13.1% |
| Life Insurance | 7.7% |

The percentages in this table refer only to the portion of total medical costs incurred by the State of Illinois. Other factors, such as policy choices, shifting eligible retirees and their dependents into Medicare Advantage plans, increases in employee contributions and co-payments, and the creation of the CDHP have been a moderating factor for State cost projections. However, the yearly cost of providing healthcare for State employees, retirees and dependents continues to rise very quickly, especially compared to 10 or more years ago.

Medical trend inflation factors for the State consist of numerous components. These components include general medical cost inflation and leveraging (lower impact of coinsurance limits, level deductibles, etc.). For Illinois specifically, recently mandated coverage for various conditions and medications adds to the overall rate of medical cost inflation. Traditionally, advances in technological innovation, increased use of equipment/services, and demographic shifts towards an older SEGIP population have contributed to greater health care costs for the State. Additionally, as a result of the shift of employees to HMOs, OAPs, and the CDHP from the Quality Care Health Program (QCHP), more costly/higher risk employees remain in the QCHP program. This has the effect of 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 help moderate overall State costs.

In reference to individual liability components, CMS projects liability increases for all plans. The QCHP (including ASC fees) plan is projected to rise to $545 million in FY 2026, a 0.5% increase from the FY 2025 estimate ($542.2 million). HMO liability is projected to increase to $1.29 billion in FY 2026, a 4.4% or $54.8 million increase from FY 2025 ($1.24 billion). The OAP line is expected to rise to $1.93 billion ($188.6 million increase from FY 2025) in FY 2026, continuing a series of large increases from $1.392 billion in FY 2024 to $1.740 billion in FY 2025. The CDHP is projected to rise from $43.8 million in FY 2025 to $52.5 million in FY 2026. Dental plan, vision, life insurance, and other liability is also projected to rise, though by significantly smaller amounts compared to the major medical plans noted above. Medicare Advantage premium liability is projected to total $54.1 million in FY 2026, compared to $25.2 million in FY 2025. State liabilities for Medicare Advantage in FY 2024 were $0, due to negotiations involved in the new contract.

In preparing this report, the Commission utilizes information from the 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 2025 Segal Health Plan Cost Trend Survey.

- For 2025, health plan costs are projected to increase between 7.8-7.9%. Prescription plan prices are projected to increase by 11.4%
- Medicare Advantage PPO plans are forecasted to increase their rates by 4.9%.
- For 2025, drug prices are anticipated to rise significantly (in the case of specialty drugs, by 13.7%) due to utilization, marketing, replacement of existing drug therapies, etc.
- Cost trend increases are driven by various factors, notably medical price inflation, hospital prices, and outpatient costs.
- Recent developments in anti-obesity medications have contributed to increased prescription costs, on the order of nearly 5% for plans that have coverage for these medications compared to plans without this particular coverage.
- Dental and vision plans are expected to have increases of 3.0% to 5.0%, depending on plan type.

Table 3 below highlights national trend data and compares it to estimates by CMS and CGFA for State liability.

**TABLE 3**

**NATIONAL HEALTH CARE TRENDING 2025**

| Component | National Trend | CMS Estimate | COGFA Estimate |
|---|---|---|---|
| HMOs | 7.8% | 4.4% | 4.8% |
| Rx | 11.4% | 1.6% | 3.4% |
| Dental | 3.5% | 3.9% | 4.6% |
| Vision | 1.0% | 1.4% | 1.4% |

Source: Segal 2025 Health Plan Cost Trend Survey

National trend rates illustrate the overall direction of health care expenses while state-level data may differ significantly due to localized conditions and factors. 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 have historically tended 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 3. While CMS and CGFA projections reflect the direction of national trends, Illinois-specific trends incorporate health care availability and access in Illinois along with other factors in the case of HMOs and Prescription Drugs in particular. 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 a MA plan, the inflationary pressure on traditional HMO plan rates has been reduced. Combined with the movement of (primarily younger) individuals into the CDHP, State employees/dependents/retirees have more and less expensive options (based on their preferences for coverage and care) than in previous years. This has traditionally 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. However, due to the aforementioned medical inflation and coverage mandates, Illinois' liability is unique to this state.

In general, CMS and CGFA trend estimates include programmatic effects that likely affect estimates in addition to normal market trends. While HMO liability trends on the national level are expected to rise significantly, overall HMO liability for Illinois is projected to rise at a much lower rate (though OAP liability is projected to make up the difference). Migration to the Consumer Driven Health Plan (and other factors independent of national trends but specific to Illinois) would normally serve to reduce liabilities. However, the required treatment coverages and inflationary cost pressures for Illinois for FY 2026 are projected to far surpass any savings from the CDHP. To its credit, the CDHP has grown over time and is slowly becoming more utilized by Illinois employees and their dependents.

In reference to Illinois dental and vision plan costs in Table 3, these costs tend to remain relatively stable year to year, though dental liability is projected to increase $5.7 million between FY 2025 and FY 2026. Vision liability is projected to increase very slightly in that same time period, from $7.1 million to $7.2 million. 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. Correspondingly, they have a much smaller total fiscal impact, depending on the years examined. **Based on these assumptions, trends, and inflation factors, CGFA estimates a FY 2026 liability of approximately $4.229 billion for the State Employees' Group Health Insurance Program.** Table 4 shows a detailed comparison of the CGFA estimate for the various cost components and the CMS projection for FY 2026, with minor program component lines combined for easier viewing and analysis.

| TABLE 4: FY 2026 GROUP HEALTH INSURANCE LIABILITY ($ in Millions) | | | |
|---|---|---|---|
| Liability Component | FY 2025 CMS Estimate | FY 2026 CMS Projection | FY 2026 CGFA Projection |
| QCHP Medical | $367.7 | $368.6 | $371.1 |
| QCHP Prescriptions | $163.3 | $165.9 | $168.8 |
| Dental | $145.1 | $150.8 | $151.8 |
| HMO | $1,240.6 | $1,295.4 | $1,300.7 |
| Medicare Advantage HMO/PPO | $25.2 | $54.1 | $54.1 |
| Open Access Plan | $1,739.9 | $1,928.5 | $1,968.5 |
| Consumer Driven Health Plan (CDHP) | $43.8 | $52.5 | $55.5 |
| Vision | $7.1 | $7.2 | $7.2 |
| Administrative Services | $14.9 | $14.4 | $14.4 |
| Life | $96.9 | $104.4 | $104.4 |
| Special Programs (Admin/Int./Other) | $29.9 | $32.7 | $32.7 |
| ***TOTAL*** | **$3,874.4** | **$4,174.5** | **$4,229.2** |
| % increase over prior year | 15.7% | 7.7% | 9.2% |
| *Rounding may cause slight differences. | | | |

## ESTIMATE COMPARISON

Overall, the Commission's FY 2026 estimate is $54.7 million higher than the FY 2026 estimate from CMS. CGFA's FY 2026 HMO and Open Access Plan liabilities estimates are $5.3 million and $40.0 million higher than CMS, respectively. CGFA's FY 2026 estimate for the Quality Care Health Plan Medical line is $2.5 million higher than the CMS estimate. The Commission's estimate for the CDHP is $3.0 million higher than CMS.

The FY 2026 group insurance liability estimates between CMS and CGFA are very similar to each other, with less than 1.3% 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 2026. 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. The factors influencing liability for FY 2026 may have a greater or lesser impact, depending on participant utilization of newly required covered treatments and medications. The recent announcement of Health Alliance exiting the program may also impact the composition of these FY 2026 liabilities.

**CMS estimates that approximately $4.155 billion in revenues will be raised to fund the FY 2026 Group Health Insurance Program. This estimate is $267 million or 6.9% higher than the FY 2025 estimated revenue of $3.888 billion. CMS estimates that the FY 2026 liability will be $4.175 billion, approximately $300 million, or 7.8% higher than the FY 2025 estimated liability of $3.875 billion.**

## APPROPRIATION/FUNDING SOURCES

Funding for the State Employees' Group Insurance plans originates from two funds, the Health Insurance Reserve Fund (HIRF) and the Group Insurance Premium Fund (GIPF). Contributions and 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 2026 total $4.155 billion. This is a 6.9% increase from the 2025 fiscal year estimated revenue of $3.888 billion. These revenue projections represent the highest expected revenue for the SEGIP to date, surpassing FY 2022, which included a $898 million supplemental appropriation. This represents a steady upward trend that looks to continue into the foreseeable future.

For FY 2026, the fiscal data provided by CMS shows the Group Health Insurance Program receiving $2.668 billion in GRF funds. This represents a $301 million (or 12.7%) increase from the FY 2025 GRF component of $2.366 billion. The FY 2025 GRF component also includes an expected, though not yet passed, $39 million supplemental appropriation. Absent a large increase in other sources of funding, this GRF projection is unlikely to decline in the future, as liabilities have steadily increased.

Member contributions are projected to increase to $617 million in FY 2026 (compared to $583 million in FY 2025). In regard to member contributions, depending on employee plan choices and overall employment trends (a push in hiring or conversely, an early retirement initiative), 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.

The Road Fund appropriation is projected to total $88 million in FY 2026, a significant decline from the FY 2025 total of $156 million. This is largely due to a contract change between the Teamsters union and the state, wherein the new contract does not allow an opt-out from SEGIP to a Teamster-specific fund (previously funded through a Road Fund appropriation). Accordingly, this has resulted in a decreased Road Fund appropriation. The Other Funds reimbursements line is projected to increase by $50 million, while the Other/Formulary Rebates line is anticipated to decrease by $41 million. Finally, university contributions are projected to be flat compared to the 2025 fiscal year, as the Administration has proposed keeping contributions at $45.0 million in FY 2026.

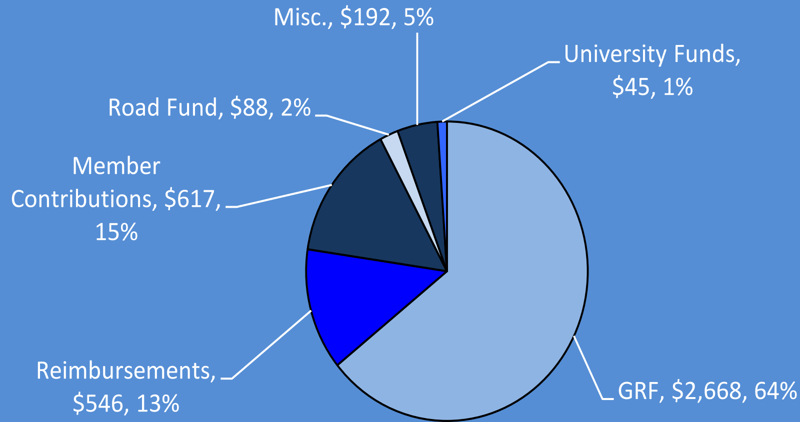



**TABLE 5: GROUP INSURANCE FUNDING SOURCES**
**FY 2025 - FY 2026**
**($ in Millions)**

| | FY 2025 | FY 2026 | $ Change from FY25 | % Change from FY25 |
|---|---|---|---|---|
| GRF Appropriation | $2,366.2 | $2,667.5 | $301.3 | 12.7% |
| Prior Year GRF | $8.5 | $0.0 | ($8.5) | 0.0% |
| Road Fund | $156.5 | $88.2 | ($68.3) | -43.7% |
| University Cont. | $45.0 | $45.0 | $0.0 | 0.0% |
| Prior Year Univ. Cont. | $0.0 | $0.0 | $0.0 | 0.0% |
| Member Cont. | $583.1 | $616.6 | $33.5 | 5.7% |
| Other Funds | $496.0 | $546.1 | $50.2 | 10.1% |
| Medicare Part D rebate | $4.1 | $3.9 | ($0.2) | -4.4% |
| Rebates/Interest/Other. | $228.5 | $187.6 | ($40.8) | -17.9% |
| **TOTAL** | **$3,887.9** | **$4,154.9** | **$267.2** | **6.9%** |

Source: CMS

## 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), Open Access Plan (OAP), 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 now standard practice is the use of telemedicine and other preventative/diagnostic options, as encouraged by providers. Telemedicine is the practice wherein patients will have the option to consult physicians/nurses 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 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 (on average, across the health insurance sector) one-half the current charge for a physical physician's consultation copayment, providing fiscal savings for consumers. This practice has an additional ancillary effect of easing congestion at medical provider locations and providing a triage opportunity in administering care. Furthermore, telemedicine may be useful in assisting other palliative options for medical providers. SEGIP participants are encouraged to use a variety of plan/member specific resources available online or via telephone to coordinate healthy lifestyle habits and other practices that are hoped to reduce the usage of more expensive healthcare resources and procedures. For example, HMO telemedicine services are $10/consultation, compared to $30/physical doctor's office visit for SEGIP members.

As in prior years, the State will continue to offer a High Deductible Health Plan in FY 2026, the Consumer Driven Health Plan (CDHP), similar to other states such as Kansas and Texas. This plan offers a lower-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 $1,600 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 5,736 active members and dependents will utilize this plan in FY 2026, compared to the utilization from FY 2025 (5,156).

When retirees reach the age of eligibility, they are enrolled in a Medicare Advantage plan. Starting in FY 2014, Medicare-eligible retirees and their Medicare-eligible dependents were moved into Medicare Advantage (MA) plans. In FY 2026, individual retirees and dependents will be eligible for the Aetna MA PPO plan (the only State-supported option as of 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 2026, 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, apart from the issue with Health Alliance mentioned previously. Appendix I provides further details regarding the types of health and dental plans offered by the State.

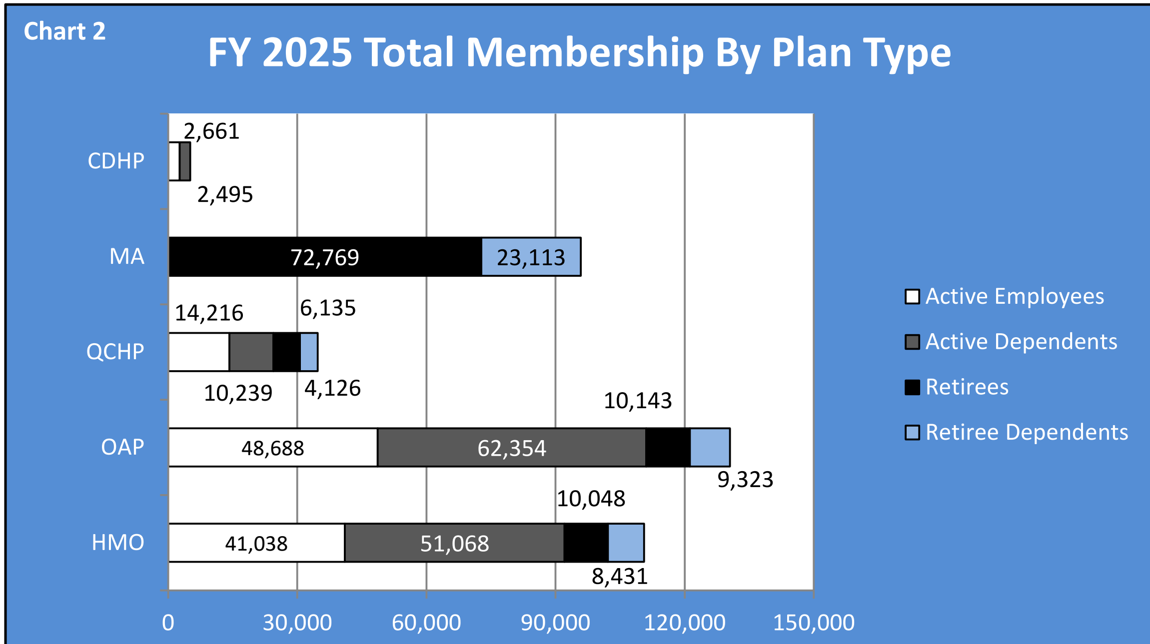
Basic life insurance is provided at no cost to employees, retirees and annuitants. According to the annual Benefits Choice booklet, full-time employees receive coverage equal to their annual salary. Retirees and annuitants receive coverage equal to the annual salary as of the last day of employment until the age of 60, at which time the benefit amount becomes $5,000. Employees and retirees under age 60 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. Retirees over age 60 may purchase up to four times their base $5,000 benefit.

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 within certain limitations without being required to provide evidence of insurability. Group rates are based on age with an administrative fee added.

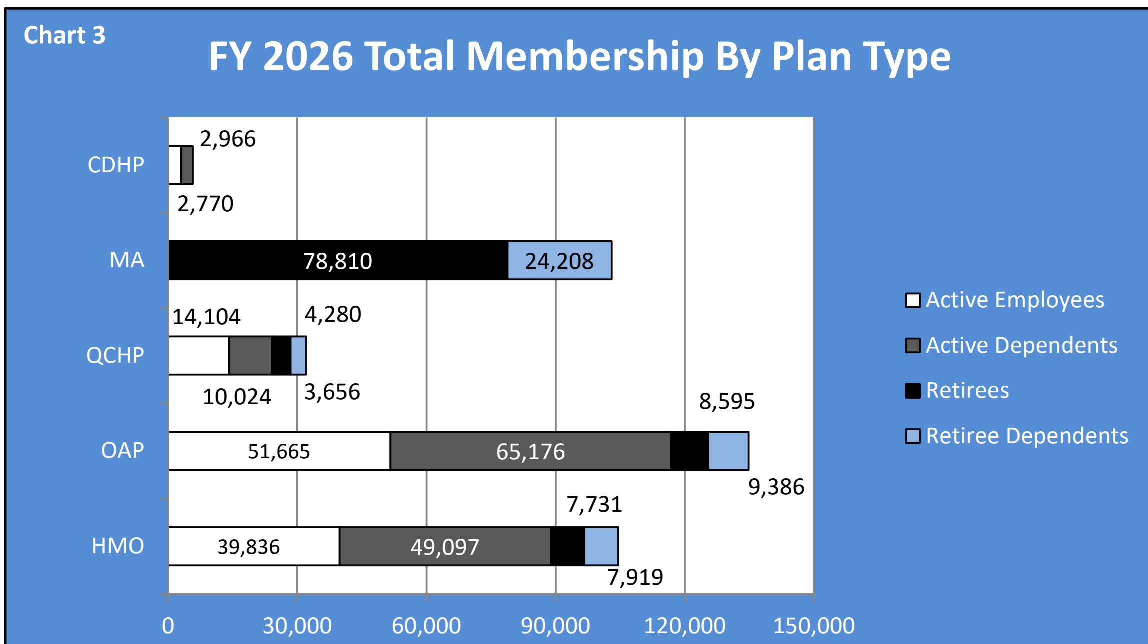
## MEMBERSHIP/ENROLLMENT TRENDS

According to CMS, the State Employees' Group Health Insurance Program has an estimated 376,847 participants for FY 2025, of which 110,585 are in a non-Medicare Advantage HMO, 5,156 are in the CDHP, 95,882 are in the Medicare Advantage PPO, 130,508 are in an Open Access Plan, and 34,716 are in the Quality Care Health Plan. The QCHP is estimated to have 14,216 employees, 10,239 active employee dependents, 4,126 retiree dependents, and 6,135 retirees in FY 2025.

Traditional HMO plans are estimated to have 41,038 employees, 51,068 active employee dependents, 8,431 retiree dependents, and 10,048 retirees in FY 2025. The CDHP is estimated to have 2,661 active employees and 2,495 active employee dependents. The Medicare Advantage plan in FY 2025 includes 23,113 dependents and 72,769 retirees. OAPs are anticipated to have 48,688 employees, 62,354 active employee dependents, 9,323 retiree dependents, and 10,143 retirees in FY 2025. This information is displayed in Chart 2.

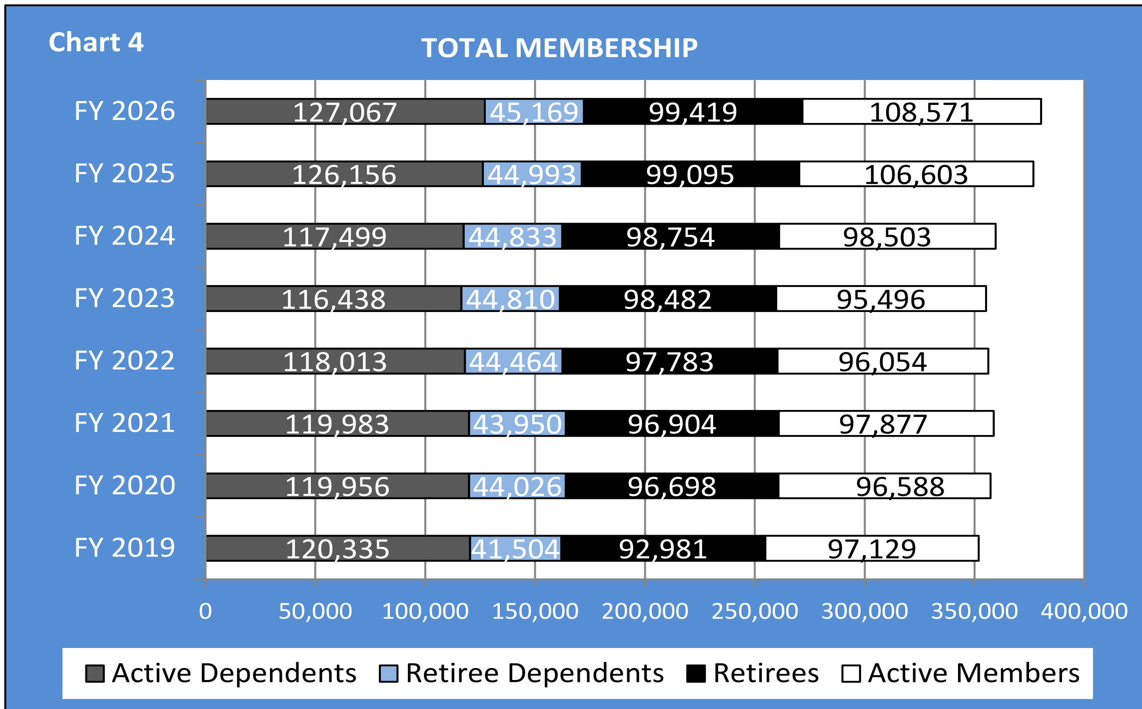


For FY 2026, the announced changes from Health Alliance will likely have a significant impact on the following figures, but at the time of the drafting of this report, the QCHP is estimated to have 14,104 employees, 10,024 active employee dependents, 3,656 retiree dependents, and 4,280 retirees. The Medicare Advantage PPO plan is expected to have 24,208 dependents and 78,810 retirees. Non-Medicare Advantage HMO Plans are expected to have 39,836 employees, 49,097 active dependent lives, 7,919 retiree dependents, and 7,731 retirees. OAPs are expected to have 51,665 employees, 65,176 active dependents, 9,386 retiree dependents, and 8,595 retirees in FY 2026. The Consumer Driven Health Plan is projected to have 2,966 employees and 2,770 active employee dependents. Total FY 2026 membership is expected to increase by 3,376 participants from 376,847 to 380,223. This information is displayed in Charts 3 and 4.



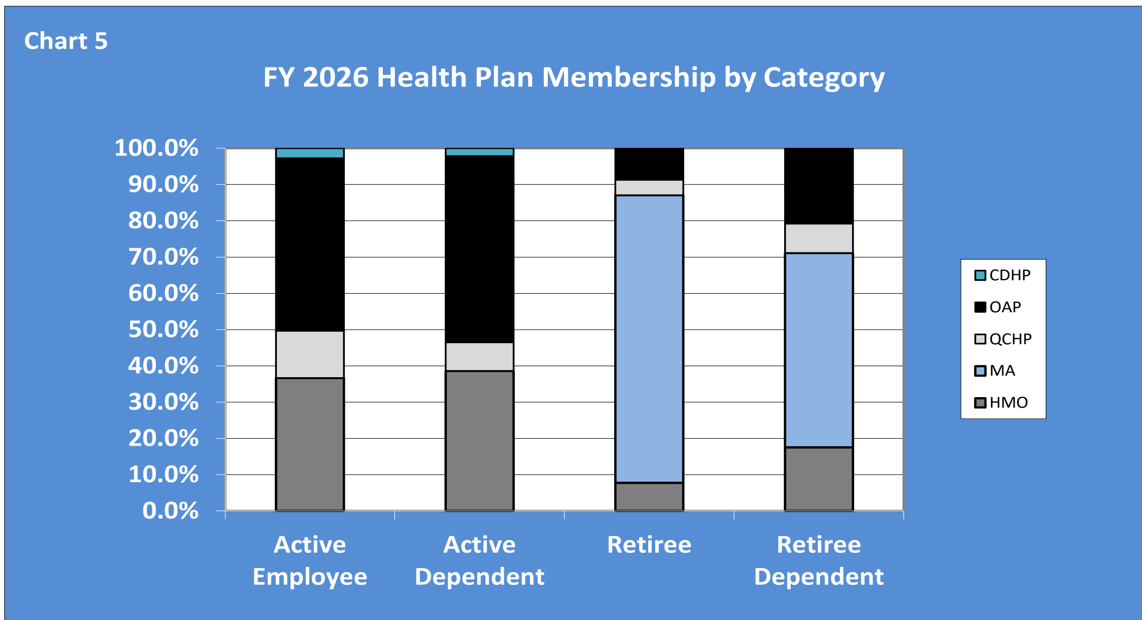

Membership in the Quality Care Plan has been decreasing since FY 2005, while membership in the States' managed care offerings has been increasing since FY 2004. Since FY 2012, many participants have transitioned away from traditional managed care (HMOs) to alternatives such as the Open Access Plan (OAP) and the CDHP (since FY 2021). This trend has continued in FY 2025-FY 2026 membership projections by CMS.

For FY 2026, membership in HMOs is broken down by standard HMO membership and CDHP membership. OAP membership is expected to continue the trend from FY 2025 to be the highest participant category (for active employees and their dependents) among those measured (QCHP, HMOs, etc.). The Medicare Advantage PPO plan is expected to rise from 95,882 in FY 2025 to 103,018 for FY 2026. Membership is expected to continue to grow in future years as retirees continue to qualify for Medicare Advantage.




- **Membership is projected for FY 2026.**

Chart 5 shows the breakdown of employee, dependent, and retiree enrollment in the overall group insurance program. Due to the state required migration to Medicare Advantage by eligible retirees, the QCHP has become less utilized among employees as a whole. In FY 2026, 79% of retirees and 54% of their dependents are expected to enroll in the Medicare Advantage PPO. This represents an inflection point wherein a majority of all retirees/dependents are now on a significantly lower-cost plan (in terms of liability) for the State. Chart 5 demonstrates that employees and dependents are moving towards managed care and Open Access Plans, though some are moving to the CDHP.



## LIABILITY

The Department's estimate of liability for FY 2026 represents a 7.7% increase from FY 2025, primarily due to significantly increased medical trend inflation and new required coverage for certain treatments/medications (as stated by CMS). Table 6 illustrates the cost components for the Group Health Insurance Program from FY 2017 through FY 2026 and demonstrates how several areas have increased/decreased over time to 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 2026, with $1.929 billion out of a total group insurance liability (estimated) of $4.175 billion.

Historically, the Interest Payments category was a major component and strain on overall SEGIP liabilities for many years until FY 2023. It has now been virtually eliminated in recent fiscal years due to large payments made in FY 2018, FY 2019, and a supplemental appropriation in FY 2022. The issue of State interest payments and paying down those liabilities is addressed in the following section of this report.

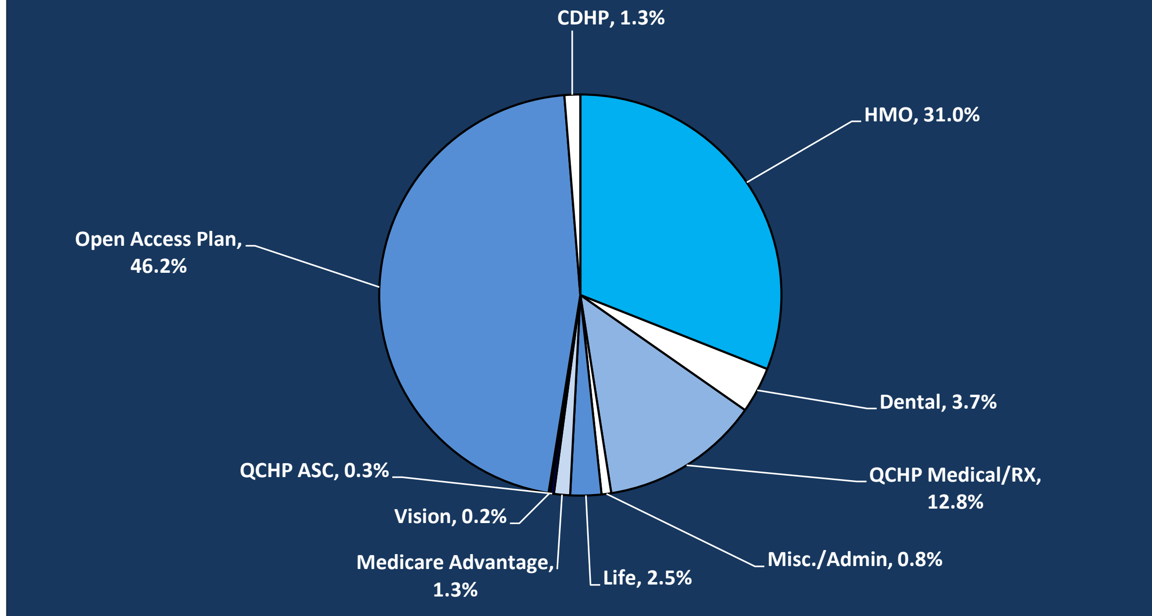
The Administration/Other category has been reduced significantly due to a major reduction in liabilities tied to a new contract with the Teamsters, who previously had a health insurance arrangement outside the rest of the SEGIP membership. Under this agreement, the Teamsters were allowed to opt-out of the SEGIP and enroll in a health plan administered by the Teamsters Health and Welfare Funds. According to the old collective bargaining agreement signed with the State, the State paid a specific dollar amount for each person who opted-out and enrolled in the alternative plan. Under the new collective bargaining agreement, the Teamsters are folded back into SEGIP, reducing Road Fund liability significantly compared to the prior arrangement. General Revenue Funding is expected to increase to make up the difference. This also means that liabilities for individual program lines are larger than otherwise due to the influx of "new" members.

Other components of liability such as Vision, Dental, and Life Insurance are projected to increase from FY 2025 to FY 2026. These components are only a minor portion of total liability (even with life insurance liability expected to total $104 million in FY 2026) as a whole, and are expected to remain in that position in years to come, as much more expensive QCHP/HMO/OAP plans are utilized by State employees, retirees, and dependents. The CDHP may become a significant component of overall liability over time, as it has continued to rise, albeit slowly. This is not surprising, as its particular qualities of limited benefits in exchange for a lower premium (and exclusion from retirees) serve as a moderating factor in its uptake among SEGIP members. It is projected to amount to $53 million in FY 2026, after totaling $44 million in FY 2025.

| Table 6 STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY (CMS ESTIMATE) FY 2017-FY 2026 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| $ in (millions) | | | | | | | | | | |
| **Liability Component** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** | **2025** | **2026 (Est.)** |
| QCHP Medical/Rx | $488 | $512 | $517 | $497 | $511 | $549 | $497 | $504 | $531 | $535 |
| CDHP | $0 | $0 | $0 | $0 | $9 | $27 | $22 | $31 | $44 | $53 |
| HMO Medical | $976 | $1,037 | $1,067 | $1,088 | $1,083 | $984 | $994 | $1,029 | $1,241 | $1,295 |
| Medicare Advantage | $183 | $200 | $197 | $188 | $175 | $154 | $75 | $0 | $25 | $54 |
| Dental | $113 | $118 | $124 | $108 | $133 | $131 | $134 | $137 | $149 | $155 |
| Open Access Plan | $703 | $779 | $842 | $860 | $990 | $1,040 | $1,233 | $1,392 | $1,740 | $1,929 |
| QC Mental Health | $6 | $5 | $6 | $6 | $6 | $0 | $0 | $0 | $0 | $0 |
| Vision | $8 | $8 | $8 | $8 | $9 | $8 | $8 | $9 | $7 | $7 |
| Life Insurance | $90 | $90 | $88 | $92 | $94 | $82 | $85 | $90 | $97 | $104 |
| QC ASC | $14 | $15 | $14 | $15 | $14 | $12 | $12 | $11 | $11 | $11 |
| Interest Payments | $196 | $275 | $104 | $73 | $24 | $25 | $0 | $0 | $0 | $0 |
| Admin/Other | $103 | $120 | $137 | $159 | $126 | $129 | $134 | $147 | $30 | $32 |
| **Total** | **$2,878** | **$3,159** | **$3,104** | **$3,093** | **$3,173** | **$3,141** | **$3,194** | **$3,350** | **$3,875** | **$4,175** |
| **% change over PY** | **2.4%** | **9.8%** | **-1.8%** | **-0.3%** | **2.6%** | **-1.0%** | **1.7%** | **4.9%** | **15.7%** | **7.8%** |
| Source: CMS. Rounding causes slight differences in totals. | | | | | | | | | | |

Chart 6 includes the various components of the FY 2026 CMS liability estimate of approximately $4.175 billion. The largest component of the State Group Insurance Program continues to be the State's Managed Care (HMO and OAP) plans, which together have grown to represent 78.5% of FY 2026 liability. In comparison, the CDHP is projected to amount to 1.3% of FY 2026 liability.

Dental care, life insurance, and vision care equal 6.4% of total liability, slightly down from 6.6% in FY 2025. The QCHP component (13.1%) is lower than FY 2025 (14.1%) and includes medical/prescriptions, mental health coverage, and administrative service charges. As mentioned previously, for FY 2026, interest payments are projected to not contribute significantly to Group Insurance liability, reflecting the proposed minimization of payment interest as a liability issue for the SEGIP.




It is highly unlikely that the QCHP will rise to the proportion of the total group insurance liability it had attained before FY 2014. This trend is in large part because of the movement of older participants who are more likely to utilize services in the QCHP to the Medicare Advantage plan. The availability, affordability, and migration requirement of the Medicare Advantage PPO plan for the State of Illinois strongly suggests that this area of liability is not likely to shrink in size or proportion of total population enrollment in the near future.

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. It is likely that the current OAPs offered by the State will see considerable additional interest from members forced to switch from their current Health Alliance plan in the FY 2026 Benefits Choice period in May 2025.

One important note regarding liability is the successful 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 supplemental appropriation for FY 2022 paid down the remainder of existing held bills. The State has been able to keep bills paid on a timely basis since FY 2024. This trend is expected to continue in FY 2026.

## HISTORICAL GROUP INSURANCE INTEREST AND BONDING

Since 2013, SEGIP interest payments had grown, sometimes at an alarming rate, as the State was forced to push payments for services further and further into the future. This was done by "holding" claims until the actual money was available for payment. As a result, these "held claims" accrued interest at rates of 9% or 12% 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% calculation, while claims from HMOs are paid out at 12%. 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 the late 2010s. Without spending authority, CMS was unable to pay down FY 2016 and FY 2017 claims and found it necessary to hold 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 been virtually eliminated in the past few years.

As of the end of February 2025, approximately $7.4 million in Group Insurance bills ($2.1 million in Dental claims and $5.3 million in administrative costs) are being held by CMS awaiting transmission to the Comptroller's office for payment. Table 7 details the major portions of the current claims hold situation with existing interest rates of 9% and 12%, as of February 2025.

| Table 7 | Claims Hold Data for SEGIP (as of February 29, 2025) | | |
|---|---|---|---|
| Vendor | Claims Hold | Length of Claims Hold (in days) | Interest Owed (Including Past Due Interest) |
| Aetna - PPO | $0 | 0 | $0 |
| Dental Claims Hold – PPO | $422,045 | 5 | $0 |
| Dental - Non-PPO | $1,650,080 | 5 | $0 |
| Magellan (Mental Health) Claims | $0 | 0 | $0 |
| Aetna HMO | $0 | 0 | $0 |
| Health Alliance HMO | $0 | 0 | $0 |
| HMO Illinois | $0 | 0 | $0 |
| Blue Advantage | $0 | 0 | $0 |
| HealthLink OAP | $0 | 0 | $0 |
| BCBS OAP | $0 | 0 | $0 |
| Aetna OAP | $0 | 0 | $0 |
| CVS/Caremark | $0 | 0 | $0 |
| Aetna MA | $0 | 0 | $0 |
| Health Alliance MA | $0 | 0 | $0 |
| Humana Benefit Plan MA | $0 | 0 | $0 |
| Humana Health Plan MA | $0 | 0 | $0 |
| United Healthcare MA | $0 | 0 | $0 |
| Eyemed (Vision) | $0 | 0 | $0 |
| Metropolitan Life | $0 | 0 | $0 |
| Other (Fees/ASC/etc.) | $5,287,392 | 255 | $11,421 |
| **Total** | **$7,359,517** | **5-255** | **$11,421** |
| Source: CMS. MA stands for Medicare Advantage. | | | |

In regard to payment cycles, the 2026 fiscal year is projected to continue minimizing existing payment cycle delays between CMS and the various health vendors. Under this system, most vouchers for services submitted by vendors to the State for payment would be processed by CMS in a month or less, except for a few consultant contracts as noted in the "Other" section in Table 7. This has been sustained from FY 2023, and serves as an improvement over prior years, when payment vouchers would await servicing for months, if not years.

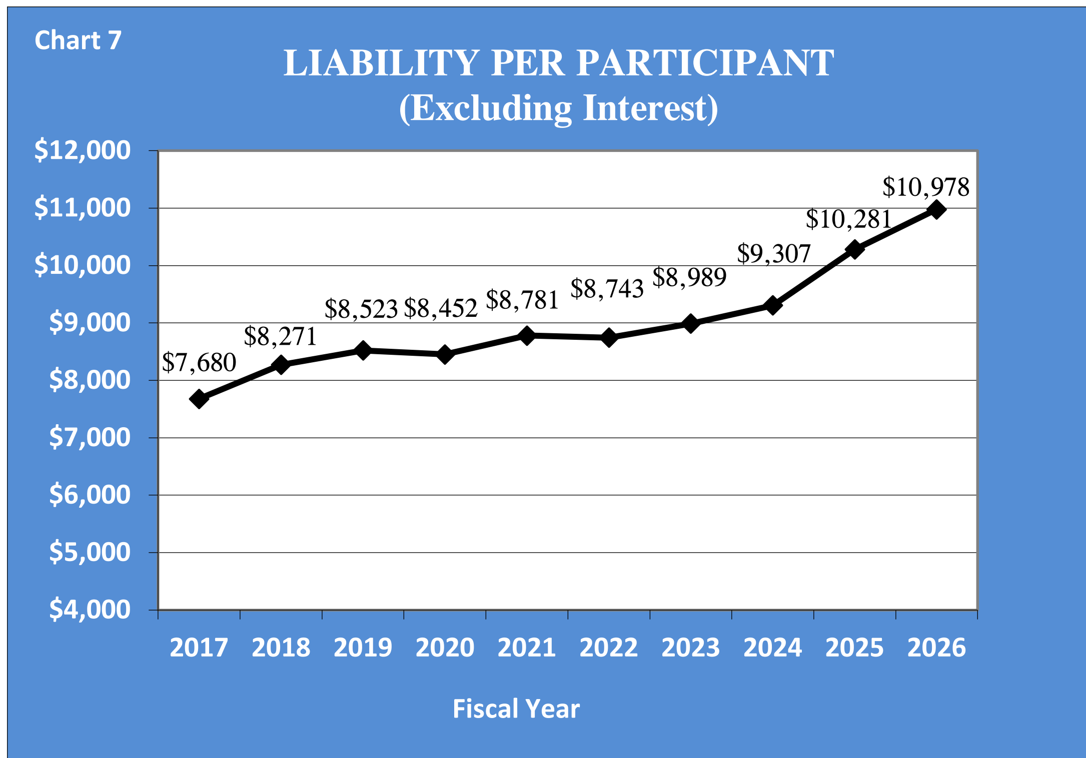
One important note on this subject is that this accounts only for the time for CMS to process claims and does not include time for the Comptroller to process and send out payment to the vendors in question. The Comptroller's timeliness depends on current cash flow needs and funds availability, which fluctuates daily. According to the Comptroller's office, as of the end of January 2025, they had approximately $54 million in Health Insurance Reserve Fund vouchers awaiting payment (an issue of timing forestalls complete payment of all vouchers, rather than availability of funds). 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 annual liability per participant in the State Employees' Group Insurance Program is the yearly total of the State's liability across all participants. Chart 8 shows the overall upward trend each year in cost per participant. 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 2017 – FY 2026 in Chart 7, 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 in the past, this component has shrunk in recent years and has been minimal since FY 2023. For comparison with the current year, the annual liability per participant in the group health insurance program was $7,680 in FY 2017.

**According to CMS, the liability per participant for FY 2025 will increase to $10,281, an increase of $974 (10.5%) compared to FY 2024. For FY 2026, the estimated liability per participant is projected to be $10,978, an increase of $697 (6.7%). This represents a 42.9% increase over FY 2017. From FY 2017 to FY 2026, liability has increased $330/year on average.**




As noted, the FY 2026 liability per participant is projected to increase 6.7% from FY 2025. 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 indicative of all possible medical inflation factors. Furthermore, in the expected migration of Health Alliance members to other plans, it is likely that as members move to other non-HMO plans, the overall costs will increase accordingly, though without exact migration numbers, the specific increase is unknown.

The impact from the State introducing the Consumer Driven Health Plan (CDHP) in the 2021 fiscal year has been fiscally promising. In conjunction with the Medicare Advantage plan, overall liabilities per participant moderated somewhat compared to increases in prior years. While savings are expected for the State in the long run, as younger employees and their 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. For example, in the case of FY 2026, while the CDHP reduces liabilities compared to any other health plan, the savings are projected to be overshadowed by other factors. 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 active participants and the State of Illinois.

**Table 8: ANNUAL LIABILITY PER PARTICIPANT**

| | FY 2025 | FY 2026 | FY 2025 | FY 2026 |
|---|---|---|---|---|
| | **Total Participants** | **Total Participants** | **Liability Per Participant** | **Liability Per Participant** |
| **QCHP** | 34,716 | 32,064 | $15,620 | $16,997 |
| **CDHP** | 5,156 | 5,736 | $8,499 | $9,161 |
| **MA HMO / PPO** | 95,882 | 103,018 | $262 | $525 |
| **HMO** | 110,585 | 104,583 | $11,219 | $12,386 |
| **OAP** | 130,508 | 134,822 | $13,332 | $14,304 |
| **Totals** | **376,847** | **380,223** | | |

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 2026 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 8, the annual liability for FY 2026, as in prior years, is lowest for members in the CDHP and highest for members in the QCHP. The total number of participants in the QCHP has declined over the years as people have steadily migrated to HMOs and OAPs. Accordingly, this shift has resulted in an increase in average cost for remaining QCHP participants, as those who remain, especially 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 (until they move to the Medicare Advantage

PPO plan) who live or travel primarily out of Illinois, as traditional HMOs/OAPs have limited coverage and higher co-payments outside the State. This results in the higher projected liability for QCHP participants (compared to others) in FY 2026. 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 $15,620 in FY 2025. Member contributions for QCHP enrollees are expected to total $70 million in FY 2025. While lower, the other medical plans (Traditional HMOs and Open Access Plans) also have significant average liabilities per participant which are only partially offset by member contributions. The Medicare Advantage plan is an outlier, as discussed previously. Table 9 examines the relationship between overall cost and the offset by member contributions for FY 2025 and FY 2026.

**TABLE 9: MEMBER CONTRIBUTIONS AND AVERAGE LIABILITY PER PARTICIPANT PER YEAR (ALPP)**

| | FY 2025 State ALPP | FY 2025 Member Contributions | FY 2025 Member Contribution % | FY 2025 State Liability | FY 2026 State ALPP | FY 2026 Member Contributions | FY 2026 Member Contribution % | FY 2026 State Liability |
|---|---|---|---|---|---|---|---|---|
| QCHP | $15,620 | $2,010 | 12.9% | $13,610 | $16,997 | $2,174 | 12.8% | $14,823 |
| CDHP | $8,499 | $1,682 | 19.8% | $6,817 | $9,161 | $1,782 | 19.5% | $7,380 |
| MA HMO/PPO | $262 | $20 | 7.6% | $242 | $525 | $30 | 5.7% | $494 |
| HMO | $11,219 | $1,572 | 14.0% | $9,646 | $12,386 | $1,678 | 13.5% | $10,708 |
| OAP | $13,332 | $1,667 | 12.5% | $11,666 | $14,304 | $1,768 | 12.4% | $12,537 |
| Dental | $390 | $132 | 33.8% | $258 | $401 | $142 | 35.4% | $259 |

Source: CMS.

Table 9 shows that QCHP members are expected to contribute 12.8% of the overall annual cost of providing their insurance in FY 2026. HMO and OAP members are expected to contribute 13.5% and 12.4% of their overall liability cost in the same time period. Members of the Consumer Driven Health Plan are estimated to contribute 19.5% of the overall liability, a higher proportion than the other standard health plan options. Members that participate in the State's dental offering are expected to pay 35.4% of the overall liability cost in FY 2026. Retirees and their survivors (with less than 20 years of creditable service) are required to pay a portion of their health care premiums (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 9 may be slightly higher due in part to extra dental liabilities being incurred/paid off in a particular fiscal year. A stable budget that continues to promptly pays down these liabilities helps 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, broken out by participation in Medicare Advantage. Table 10 displays a comparison of the costs for these groups taken from data obtained from CMS as of February 2025.

| TABLE 10: MEMBER/RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 2026 (Numbers in Millions) | | | | | |
|---|---|---|---|---|---|
| **Category** | **Cost** | **Category** | **Cost** | **Category** | **Cost** |
| Non-MAPD Retiree Cost | $600.0 | MAPD Retiree Cost | $47.3 | Active Employee Cost | $1,914.1 |
| Non-MAPD Retiree Contribution | -$92.1 | MAPD Retiree Contribution | -$1.4 | Active Employee Contribution | -$355.5 |
| Non-MAPD Retiree Contribution % | 15.4% | MAPD Retiree Contribution % | 3.0% | Active Employee Contribution % | 18.6% |
| Other Revenues | -$16.1 | Other Revenues | $0.2 | Other Revenues | -$74.0 |
| **Net State Cost** | **$491.7** | **Net State Cost** | **$45.7** | **Net State Cost** | **$1,484.6** |
| | | | | | |
| Non-MAPD Retiree Dependent Cost | $303.7 | MAPD Retiree Dependent Cost | $14.5 | Active Employee Dependent Cost | $1,295.0 |
| Non-MAPD Retiree Dependent Contribution | -$44.3 | MAPD Retiree Dependent Contribution | -$0.7 | Active Employee Dependent Contribution | -$171.2 |
| Non-MAPD Retiree Dependent Contribution % | 14.6% | MAPD Retiree Dependent Contribution % | 4.8% | Active Employee Dependent Contribution % | 13.2% |
| Other Revenues | -$17.4 | Other Revenues | -$0.1 | Other Revenues | -$83.8 |
| **Net State Cost** | **$242.0** | **Net State Cost** | **$13.7** | **Net State Cost** | **$1,040.0** |
| | | | | | |
| Total Non-MAPD Retiree Cost | $903.7 | Total MAPD Retiree Cost | $61.8 | Total Active Cost | $3,209.0 |
| Total Non-MAPD Retiree Contribution | -$136.4 | Total MAPD Retiree Contribution | -$2.1 | Total Active Contribution | -$526.7 |
| Total Non-MAPD Retiree Cont. % | 15.1% | Total MAPD Retiree Cont. % | 3.4% | Total Active Cont. % | 16.4% |
| Other Revenues | -$33.6 | Other Revenues | -$0.3 | Other Revenues | -$157.7 |
| **Total State Cost** | **$733.7** | **Total State Cost** | **$59.5** | **Total State Cost** | **$2,524.6** |
| 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 2026, retirees and retiree dependents are projected to pay 6.9% and 14.1%. This contrasts with active employees and their dependents, who are projected to pay 18.6% and 13.2% of their healthcare costs. In total, the aggregate contributions of active employees and dependents (16.4% for both groups combined in FY 2026 compared to 19.9% in FY 2025) remain significantly higher as a percentage than the aggregate contributions of retirees and retiree dependents (9.3% for both groups combined in FY 2026 compared to 10.2% in FY 2025). This difference is accounted for by retirees utilizing the Medicare Advantage PPO plan along with increased contributions by active employees and their dependents expected in FY 2026 (as was also the case in FY 2025).

# 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 2024, FY 2025, and FY 2026 plan enrollment is listed in Table 11. The numbers listed for FY 2026 will likely be different as Health Alliance will not be a vendor, but this news was announced after the information was given to CGFA for the creation of this report. Accordingly, these numbers should be taken as trend values, rather than exact figures.

**TABLE 11: MANAGED CARE PLANS**
**FY 2024-2026 All Lives (Active Members/Dependents and non-MA Retirees/Dependents)**

| HMO/OAP | FY24 # of Participants | FY25 # of Participants | % Change 2024-2025 | FY26 # of Participants | % Change 2025-2026 |
|---|---|---|---|---|---|
| Health Alliance HMO | 62,629 | 61,675 | -1.52% | 59,016 | -4.31% |
| HMO Illinois | 27,283 | 24,773 | -9.20% | 21,872 | -11.71% |
| Blue Advantage | 14,300 | 14,773 | 3.31% | 14,182 | -4.00% |
| Aetna/Coventry Health Care HMO | 9,490 | 9,364 | -1.33% | 9,513 | 1.59% |
| Aetna/Coventry Health Care OAP | 39,473 | 42,185 | 6.87% | 43,420 | 2.93% |
| Health Link OAP | 53,762 | 55,917 | 4.01% | 54,168 | -3.13% |
| BCBS OAP | 19,238 | 32,406 | 68.45% | 37,234 | 14.90% |
| Consumer Driven Health Plan HDHP | 4,171 | 5,156 | 23.62% | 5,736 | 11.25% |
| **TOTALS** | **230,346** | **246,249** | **6.90%** | **245,141** | **-0.45%** |

Source CMS. FY 26 numbers are projected as of February 2025.

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 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

Since their inception in the 2014 fiscal year, Medicare Advantage (MA) plans have served Illinois Medicare-eligible retirees and their dependents. 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. In regard to MA, as a result of the State's MA provider contract award, the arrangement for FY 2024 and beyond is a single MA PPO plan provided by Aetna, rather than the assortment of plans in prior years. All participants shifted to Aetna PPO in January 2023 (at the midpoint of FY 2023) at the start of the 2023 calendar year, due to federal requirements, which is reflected in FY 2024 onward. For FY 2024, the Aetna PPO had 93,628 participants. In FY 2025 and FY 2026, the plan is expected to have 95,882 and 103,018 participants respectively.

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 103,018 people projected to be covered in FY 2026 by the MA PPO plan would have otherwise been covered in the QCHP. The monthly rate for the State's Medicare Advantage plan is discussed in the Monthly Premiums section of this report.

## 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 2026 fiscal year, as a result of negotiations with public employee unions, premiums for HMO/OAP/QCHP options are expected to moderately increase or remain steady, depending on plan coverage options and the specific plan provider chosen. Under this arrangement, HMO premiums are generally lower than OAP premiums, though individual demographic cohorts within specific plans may be more comparable.

| TABLE 12: PROJECTED MONTHLY COSTS FY 2019 - FY 2026 Employee Only | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | QCHP | | | | CDHP | | | |
| | TOTAL | % Inc. | Member | State | TOTAL | %Inc. | Member | State |
| FY 19 | $985 | 7.8% | $155 | $830 | N/A | N/A | N/A | N/A |
| FY 20 | $1,005 | 2.1% | $155 | $850 | N/A | N/A | N/A | N/A |
| FY 21 | $1,077 | 7.1% | $180 | $897 | $646 | N/A | $145 | $500 |
| FY 22 | $1,235 | 14.7% | $194 | $1,041 | $1,157 | 79.2% | $145 | $1,012 |
| FY 23 | $1,179 | -4.5% | $212 | $968 | $760 | -34.3% | $170 | $590 |
| FY 24 | $1,245 | 5.6% | $214 | $1,032 | $836 | 9.9% | $171 | $664 |
| FY 25 | $1,352 | 8.6% | $229 | $1,124 | $923 | 10.4% | $188 | $735 |
| FY 26 | $1,467 | 8.5% | $242 | $1,226 | $995 | 7.8% | $202 | $793 |
| | | | | | | | | |
| | HMO | | | | OAP | | | |
| | TOTAL | % Inc. | Member | State | TOTAL | % Inc. | Member | State |
| FY 19 | $822 | 2.8% | $117 | $705 | $987 | 4.2% | $116 | $871 |
| FY 20 | $836 | 1.7% | $118 | $718 | $973 | -1.4% | $119 | $854 |
| FY 21 | $850 | 1.7% | $143 | $707 | $1,093 | 12.4% | $155 | $938 |
| FY 22 | $824 | -3.1% | $157 | $667 | $1,177 | 7.7% | $170 | $1,007 |
| FY 23 | $875 | 6.3% | $173 | $702 | $1,282 | 8.9% | $187 | $1,095 |
| FY 24 | $945 | 7.9% | $178 | $767 | $1,352 | 5.4% | $191 | $1,161 |
| FY 25 | $1,157 | 22.5% | $194 | $962 | $1,404 | 3.9% | $205 | $1,199 |
| FY 26 | $1,277 | 10.4% | $210 | $1,067 | $1,507 | 7.3% | $220 | $1,287 |

Table 12 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 2019 to the projected values for members in FY 2026. 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 the purposes of comparison, the total costs and projected member contributions of the proposed Consumer Driven Health Plan (CDHP) are still lower than other alternatives.

Table 13 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 2026 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 13: MONTHLY PREMIUMS<br>QCHP / CDHP / HMO / OAP<br>Weighted Average<br>FY 2026 Rates (Projected for Median Salary) | | | | | | |
|---|---|---|---|---|---|---|
| | QCHP | | | CDHP | | |
| | TOTAL | Member | State | TOTAL | Member | State |
| Employee | $1,467 | $242 | $1,226 | $995 | $202 | $793 |
| Medicare Retiree | $885 | $53 | $833 | $0 | $0 | $0 |
| Non-Medicare Retiree | $2,357 | $7 | $2,350 | $0 | $0 | $0 |
| 1 Dependent | $1,762 | $303 | $1,460 | $836 | $181 | $655 |
| 2+ Dependents | $2,375 | $341 | $2,033 | $1,433 | $226 | $1,207 |
| Medicare Dependent | $1,931 | $197 | $1,735 | $647 | $156 | $491 |
| | | | | | | |
| | HMO | | | OAP | | |
| | TOTAL | Member | State | TOTAL | Member | State |
| Employee | $1,277 | $210 | $1,067 | $1,507 | $220 | $1,287 |
| Medicare Retiree | $855 | $57 | $798 | $972 | $57 | $915 |
| Non-Medicare Retiree | $1,989 | $37 | $1,952 | $2,341 | $37 | $2,304 |
| 1 Dependent | $1,092 | $193 | $898 | $1,285 | $204 | $1,081 |
| 2+ Dependents | $1,905 | $238 | $1,667 | $2,208 | $253 | $1,955 |
| Medicare Dependent | $911 | $175 | $736 | $1,045 | $183 | $861 |

As with Employee-only premium projections and associated costs, premiums for all applicable active SEGIP member and dependent cohorts are projected to continue to rise. 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 14: MONTHLY PREMIUMS ACROSS ALL PLANS<br>HMOs / OAPs / CDHP<br>FY 2025 Rates (for Median Salary) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Health Alliance | Aetna HMO | HMO Illinois | Blue Advantage | HealthLink OAP | BCBS OAP | Aetna OAP | CDHP |
| Employee | $213.04 | $201.45 | $200.44 | $173.68 | $221.08 | $206.88 | $210.94 | $190.58 |
| Medicare Retiree | $53.42 | $53.42 | $53.42 | $53.42 | $53.42 | $53.42 | $53.42 | $0.00 |
| Non-Medicare Retiree | $10.86 | $10.86 | $10.86 | $10.86 | $10.86 | $10.86 | $10.86 | $0.00 |
| 1 Dependent | $204.45 | $205.79 | $172.13 | $167.04 | $214.53 | $196.58 | $196.58 | $178.25 |
| 2 + Dependents | $254.79 | $252.25 | $215.66 | $206.20 | $267.29 | $243.02 | $243.02 | $225.79 |
| Medicare Dependent | $177.00 | $178.00 | $147.00 | $143.00 | $186.00 | $169.00 | $169.00 | $152.00 |
| FY 2026 Proposed Rates (for Median Salary) | | | | | | | | |
| | Health Alliance | Aetna HMO | HMO Illinois | Blue Advantage | HealthLink OAP | BCBS OAP | Aetna OAP | CDHP |
| Employee | $218.95 | $206.20 | $208.41 | $185.18 | $229.54 | $212.02 | $217.14 | $202.39 |
| Medicare Retiree | $57.29 | $57.29 | $57.29 | $57.29 | $57.29 | $57.29 | $57.29 | $0.00 |
| Non-Medicare Retiree | $36.97 | $36.97 | $36.97 | $36.97 | $36.97 | $36.97 | $36.97 | $0.00 |
| 1 Dependent | $205.34 | $205.00 | $172.78 | $168.99 | $214.41 | $197.60 | $196.74 | $180.51 |
| 2 + Dependents | $251.51 | $250.50 | $213.17 | $207.75 | $267.42 | $243.25 | $242.68 | $226.40 |
| Medicare Dependent | $181.62 | $182.00 | $151.00 | $153.45 | $190.00 | $173.00 | $174.31 | $156.00 |

Table 14 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 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.

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 $47-$61/month spread between the most expensive and least expensive plans in Table 14 for FY 2026, 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 (before taking their increased options into account). It is expected that competition between the various health insurance vendors will lead to more competitive rates in future fiscal years.

Table 15 shows a comparison between FY 2024, FY 2025, and projected FY 2026 MA rates for retirees and dependents. As discussed previously, the adoption of a single PPO plan has the potential to provide a significant financial benefit to the State. It should be noted that employees with 20 or more years of eligible State service do not have to pay a monthly premium for their coverage until they become Medicare Advantage eligible. At that point, they are required to pay the federal Medicare Part B premium (based on annual income as shown on your yearly tax return two years prior to the current year), though not the Medicare Advantage premium. In 2025, the cost is $185/month if a retiree's yearly income in 2023 was $106,000 or less. It is $259/month if their yearly income was above $106,000 up to $133,000. The cost is $370/month if their yearly income was above $133,000 up to $167,000. The total federal Medicare Part B premium can range from $185/month to as much as $629/month in FY 2025 depending on the retiree's taxable income.

**TABLE 15: MONTHLY PREMIUMS FOR STATE MEDICARE ADVANTAGE PLANS**
**FY 2024-2026 Rates (As of February 2025)**

| **Aetna PPO** | FY 2024 | FY 2025 | FY 2026 |
|---|---|---|---|
| Medicare Retiree | $0.38 | $1.46 | $2.55 |
| Two or More Dependents | $5.05 | $5.05 | $5.05 |
| Medicare Dependent | $2.46 | $2.46 | $2.46 |

# 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 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. For FY 2026, there are no contracts that statutorily require CGFA's recommended approval. Numerous contracts will be up for one-year renewals for FY 2027.

| Status of Contracts for FY 26 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**/Ending - HMO Terms go to June 30, 2026 with five 1-year renewals. Health Alliance is choosing to end their contract with the State on June 30, 2025. |
| Medicare Advantage Health Plans | Aetna PPO | **Ongoing -** Term goes to December 31, 2027 with five 1-year renewals. |
| Self-Insured Medical Plan Administration | Aetna | **Ongoing** - Term goes to June 30, 2026. No renewal options. |
| Vision | EyeMed | **Ongoing** - Term goes to June 30, 2029. Five 1-year renewals. |
| Behavioral Health/EAP | ComPsych | **Ongoing** - Term goes to June 30, 2026. Five 1-year renewals. |
| Life Insurance | Metropolitan Life Insurance Company | Ongoing - Term goes to June 30, 2026. Five 1-year renewals. |
| Flexible Spending | Optum | **Ongoing** - Term goes to June 30, 2028. Five 1-year renewals. |
| Administration of Dental Claims | Delta Dental | **Ongoing** - Term goes to June 30, 2026. Five 1-year renewals. |
| Prescription Drugs | CVS/Caremark | **Ongoing** - Term goes to June 30, 2027. Seven 1-year renewals. |
| Commuter Savings Program | Endred | **Ongoing** - Term goes to June 30, 2029. Five 1-year renewals. |

# 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.

The Commission has three internal units—Revenue, Pensions, and Research, each of which has a staff of analysts 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 a monthly Abstracts Report of annual reports or special studies from other state agencies, the *Illinois Tax Handbook for Legislators*, *Federal Funds to State Agencies*, *Preface to Lawmaking,* 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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