FY 2027 Liabilities of the State Employees' Group Health Insurance Program

COMMISSION ON GOVERNMENT FORECASTING AND ACCOUNTABILITY

March
2026

Commission on Government Forecasting and Accountability

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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 contract information for the 2027 fiscal year indicating a continuation of certain contracts in place as well as an anticipated five-year renewal for the Open Access Plans and Quality Care Health Plan. The new fiscal year will also include negotiated rate increases for group insurance participants. According to CMS, projected FY 2027 liabilities are expected to rise **$379.9 million** over FY 2026, to **$4.6 billion.** This would be a 9.0% rise from the expected FY 2026 total liability of $4.2 billion. However, this would be a smaller increase year-to-year compared to FY 2025 (14.8% or $492.9 million over FY 2024) and FY 2026 (10.5% or $402.8 million over FY 2025). This translates to a **38.2%** increase in overall liabilities from FY 2024 to FY 2027. As documented in prior years, this rise is attributed to continued health cost inflation and various legislative mandates for health care procedures and coverage.

According to CMS, for the 2027 fiscal year, the GRF appropriation is projected to be $2.799 billion for SEGIP, with total expected revenues projected at approximately $4.552 billion. CMS estimates the FY 2027 liability to be $4.618 billion, a 9.0% increase from the FY 2026 anticipated final liability of $4.238 billion. Noting these predictions, the Commission also anticipates that liabilities and revenues will increase from FY 2026 and estimates a total SEGIP liability of $4.655 billion in FY 2027, $37.2 million more than CMS.

FY 2027 revenues are projected to increase compared to FY 2026 by approximately $366 million, primarily due to an increased GRF appropriation. For FY 2027, member contributions are projected to total $637 million, compared to $607 million in FY 2026, a $30 million increase. Reimbursements are projected to decrease to $536 million compared to $557 million in FY 2026. The Road Fund is projected to account for $156 million for FY 2027, a decrease of $17 million, compared to $173 million in FY 2026.

Table 1 GRF APPROPRIATION/REVENUE AND LIABILITY FY 2020-2027 ($ in Millions)			
Fiscal Year	Appropriation Received	Revenues	CMS Liability
FY 2020	$2,440.2	$3,699.1	$3,087.3
FY 2021	$2,022.8	$3,208.5	$3,163.8
FY 2022	$2,753.2	$3,967.4	$3,205.4
FY 2023	$1,846.4	$3,092.3	$3,212.0
FY 2024	$2,033.1	$3,346.1	$3,342.1
FY 2025	$2,335.4	$3,825.2	$3,835.0
FY 2026**	$2,480.5	$4,186.6	$4,237.8
FY 2027**	$2,799.1	$4,552.1	$4,617.7
FY 2020 included interfund borrowing to pay down held bills. FY 2022 includes a supplemental appropriation of $898 million. **Estimated for FY 2026 and projected for FY 2027.			

For SEGIP participants, the State 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 are largely expected to be unchanged in FY 2027.

In February 2025, Health Alliance announced that they would be ending their HMO participation in the SEGIP, causing 61,532 members and dependents to seek out alternate coverage options from the existing HMO, OAP, and PPO options. Most of these individuals chose to utilize existing OAP options, contributing to liability for that option to increase. Participant migration and its impact on SEGIP liabilities is discussed in later sections of this report.

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 fourth full year in FY 2027. 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. The current MA PPO plan option is expected to continue through December 2027 and has up to five one-year renewal options that can be exercised at that time.

CMS expects FY 2027 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.

FY 2027 PROPOSED PLAN CHANGES

While not a plan change made by the State, thousands of former Health Alliance members migrated to a variety of the other plans available to them during the last open enrollment period in May 2025. Accordingly, the existing HMO and OAP vendors experienced significant growth due to this migration, with most going to existing OAPs.

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 2027, 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 2027 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) utilizes the CMS forecast for FY 2027 medical costs as the basis for estimating costs for FY 2027 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)	8.2%
Dental (QCHP and MC)	4.6%
HMO (Medical and Rx)	6.8%
Prescription drugs (QCHP)	10.4%
Open Access Plan	9.7%
Life Insurance	12.1%

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 annual cost of providing healthcare for State employees, retirees and dependents continues to rise rapidly, particularly compared to a decade or more years ago.

Medical trend inflation for the State is driven by numerous components. These include general medical cost inflation and leveraging (lower impact of coinsurance limits, level deductibles, etc.). In Illinois, mandated coverage for certain conditions and medications further increases overall medical cost inflation. Additionally, advances in technological innovation, increased use of equipment/services, and demographic shifts towards an older

SEGIP population have contributed to higher health care costs for the State. Higher-cost/higher-risk employees often utilize the broad provider network within the QCHP program. This has the effect of raising the per-member cost of that program. In regard to cost reduction, the mandated transition of Medicare-eligible retirees from the QCHP/HMOs/OAPs into the State Medicare Advantage plan has reduced overall liability in the group insurance program and continues to help moderate total State costs.

CMS projects liability increases for all plans in the coming fiscal year. The QCHP (including ASC fees) plan is projected to rise to $557 million in FY 2027, a 6.8% increase from the FY 2026 estimate ($522 million). HMO liability is complicated by the departure of Health Alliance at the end of FY 2025. This departure lowered the overall HMO liability estimate for FY 2026 to $614 million, compared to a total liability of $1.2 billion in FY 2025. For FY 2027, HMO liability is projected to increase to $650 million, a 5.9% or $36 million increase from FY 2026.

The OAP line was also affected dramatically by the departure of Health Alliance, as many of their former customers chose to enroll in an OAP offered by the State of Illinois. This influx of participants caused overall liability to jump dramatically. From a liability total of $1.38 billion in FY 2024, OAP liability rose significantly to $1.7 billion in FY 2025, and is expected to rise to $2.7 billion in FY 2026. This represents a 93% increase in liability for that particular line item from FY 2024 to FY 2026. OAP liability is projected to increase to $2.9 billion ($242.8 million increase from FY 2026) in FY 2027. The CDHP is projected to rise from $54.7 million in FY 2026 to $61.8 million in FY 2027.

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 $122.6 million in FY 2027, compared to $84.3 million in FY 2026, as it returns to historical norms. State liabilities for Medicare Advantage in FY 2024 were $0, due to negotiations involved in the new contract and have steadily risen in following years.

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 2026 Segal Health Plan Cost Trend Survey.

- For 2026, health plan costs are projected to increase between 6.2 (Medicare Advantage plans) - 9.3 (PPO plans) %. Prescription plan prices are projected to increase by 11.0%

- For 2026, as in prior years, drug prices are expected to rise by over 11% (in the case of specialty drugs, by 11.9%) 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.

- Continued developments in anti-obesity medications have contributed to increased prescription costs. In plans that cover anti-obesity medications, obesity management was responsible for 6.7% out of the total 14.8% increase in the 2025 Segal report.

- Dental and vision plans are expected to continue to have increases of 3.0% to 5.0%, depending on plan type.

The 2026 Segal report identified several factors driving rising health care costs, including medical inflation, new treatments, the effects of aging and obesity, increased emphasis on detection and diagnostics, cost shifting, and regulatory changes. The report also highlighted a high prevalence of mental health claims among younger populations covered by health insurance plans. In 2024, between 25% of Baby Boomers (age 61+) and 36% of Generation Alpha (age 13 and younger) enrolled in health plans filed a mental health claim in 2024.

To help manage medical costs, Segal identified several strategies, including digital health coaching, well-being services, and targeted use of artificial intelligence to detect fraud and improve outreach. For pharmaceutical cost management, the report outlined approaches such as clinical controls and management strategies for GLP-1 medications used in obesity treatment. The State of Illinois currently uses several of these tools, including health coaching and network strategies, to help moderate costs.

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 2026

Component	National Trend	CMS Estimate	COGFA Estimate
HMOs	8.8%	5.9%	6.8%
Rx	11.0%	9.7%	10.4%
Dental	3.5%	4.6%	4.6%
Vision	1.0%	1.4%	1.4%

Source: Segal 2026 Health Plan Cost Trend Survey

National trend rates illustrate the overall direction of health care expenses though state-level data may differ significantly due to local conditions and market factors. These trend rates provide the Commission with a benchmark for analyzing health plan components and estimating future claims. Changes in the costs to plan sponsors may differ 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 have often been higher in the Northeast and West, aggregate trends in the Midwest have historically been lower.

The difference between national and state-level healthcare insurance trends can be seen when comparing the traditional health cost drivers listed in Table 3. While CMS and CGFA projections reflect national patterns, Illinois-specific trends incorporate health care availability and access in Illinois along with other factors, particularly for HMOs and Prescription Drugs. This presents an interesting contrast in cost containment.

As older individuals (who are more likely to utilize healthcare services) have been moved into a Medicare Advantage plan, inflationary pressure on traditional HMO rates has decreased. Combined with the movement of younger individuals into the CDHP, State employees, dependents, and retirees have more low-cost options (based on their preferences for coverage and care). Historically, this has resulted in lower overall cost increases to the State than might be expected from the trends in the Segal survey. However, ongoing medical inflation and coverage mandates make Illinois' liability distinct from national trends.

In general, CMS and CGFA trend estimates incorporate programmatic effects that influence projections beyond underlying market trends. Although national HMO liability trends are expected to increase significantly, Illinois' overall HMO liability is projected to grow at a more moderate rate (while OAP liability is anticipated to rise substantially). Migration to the Consumer Driven Health Plan along with other Illinois-specific factors independent of national trends would typically mitigate liability growth. However, for FY 2027, mandated treatment coverages and ongoing medical cost inflation in Illinois are projected to outweigh any savings generated from the CDHP. To its credit, CDHP participation has steadily increased over time and continues to grow in use among Illinois employees and their dependents.

In reference to Illinois dental and vision plan costs in Table 3, these costs are expected to remain relatively stable from year to year. However, dental liability is projected to increase $6.9 million between FY 2026 and FY 2027. Vision liability is projected to increase slightly in that same time period, from $7.2 million to $7.3 million. Because these categories represent a relatively small share of total liability, even modest dollar increases can translate into noticeable percentage changes. Despite these percentage increases, the overall fiscal impact remains limited. **Based on current assumptions, trends, and inflation factors, CGFA estimates that total FY 2027 liability for the State Employees' Group Insurance Program will be approximately $4.655 billion.** Table 4 provides a detailed comparison of the CGFA estimate and the CMS FY 2027 projection, with smaller program components combined for clarity and ease of analysis.

TABLE 4: FY 2027 GROUP HEALTH INSURANCE LIABILITY ($ in Millions)			
Liability Component	FY 2026 CMS Estimate	FY 2027 CMS Projection	FY 2027 CGFA Projection
QCHP Medical	$351.8	$374.3	$380.8
QCHP Prescriptions	$157.3	$172.5	$173.6
Dental	$148.6	$155.5	$155.5
HMO	$613.5	$649.6	$655.2
Medicare Advantage HMO/PPO	$84.3	$122.6	$124.7
Open Access Plan	$2,670.9	$2,913.7	$2,931.1
Consumer Driven Health Plan (CDHP)	$54.7	$61.8	$63.3
Vision	$7.2	$7.3	$7.3
Administrative Services	$16.3	$14.0	$15.0
Life	$100.3	$112.4	$112.4
Special Programs (Admin/Int./Other)	$32.8	$33.9	$35.9
TOTAL	**$4,237.7**	**$4,617.6**	**$4,654.8**
% increase over prior year	10.5%	9.0%	9.8%
*Rounding may cause slight differences.			

ESTIMATE COMPARISON

Overall, the Commission's FY 2027 estimate is $37.2 million higher than the FY 2027 estimate from CMS. CGFA's FY 2027 HMO and Open Access Plan liabilities estimates are $5.6 million and $17.4 million higher than CMS, respectively. CGFA's FY 2027 estimate for the Quality Care Health Plan Medical line is $6.5 million higher than the CMS estimate. The Commission's estimate for the CDHP is $1.5 million higher than CMS.

The FY 2027 group insurance liability estimates from CMS and CGFA are very similar, with a total difference of less than 0.9%. This consistency reflects broader trends in healthcare insurance and the relative stability in anticipated plan design changes anticipated for FY 2027. Larger differences in future liability projections may arise depending on various factors, including potential plan design changes as a result of labor negotiations or federal policy changes. The factors influencing liability for FY 2027 may have a greater or lesser impact, depending on participant utilization of required covered treatments and medications.

CMS estimates that approximately $4.552 billion in revenues will be collected to fund the FY 2027 Group Health Insurance Program. This estimate is $365 million or 8.7% higher than the FY 2026 estimated revenue of $4.187 billion. CMS estimates that the FY 2027 liability will be $4.618 billion, approximately $380 million, or 9.0% higher than the FY 2026 estimated liability of $4.238 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 2027 total $4.552 billion. This is a 8.7% increase from the 2026 fiscal year estimated revenue of $4.187 billion. These revenue projections represent the highest expected revenue for the SEGIP to date.

For FY 2027, the fiscal data provided by CMS shows the Group Health Insurance Program receiving $2.799 billion in GRF funds. This represents a $319 million (or 12.8%) increase from the FY 2026 expected GRF component of $2.481 billion (the official FY 2026 GRF enacted appropriation was $2.531 billion, but this includes an additional $50 million as a reserve). Despite a significant increase in other sources of funding, the GRF portion of SEGIP funding is unlikely to decline in the future, as liabilities have steadily increased.

Member contributions are projected to increase to $637 million in FY 2027 (compared to $607 million in FY 2026). In regard to member contributions, depending on employee plan choices and overall employment trends, 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. Furthermore, negotiated increases in employee/dependent contributions may cause this component of overall SEGIP funding to increase over time.

The Road Fund appropriation is projected to total $156 million in FY 2027, a moderate decline from the FY 2026 total of $173 million. The decline is reflected in the increased GRF appropriation due to a new contract with the Teamsters, as explained further in this report. The Other Funds reimbursements line is projected to decrease by $21 million, to a total of $536 million. University contributions are projected to be flat compared to the 2026 fiscal year, as the Administration has proposed keeping contributions at $45.0 million in FY 2027.

A newly emergent component of SEGIP funding is the Formulary Rebates line. Formulary Rebates refers to the amount of drug rebates the State receives from members

utilizing the State's Pharmacy Benefits Manager (PBM) and self-insured plans (such as the Open Access Plans). Under a new PBM contract, the State receives all rebate revenue from that source. According to CMS, the State receives some of the savings from fully-insured insurance plan formulary benefits in the form of reduced premiums, though these particular plans are not required to report the total value of the rebates they receive to the State. Following the migration of former Health Alliance members to OAPs, along with increased PBM revenues, formulary rebate revenue has grown significantly. From $118 million in FY 2022, the State is projecting a total of $361 million in formulary rebate revenue in FY 2027. This represents a 206% increase in revenue in the span of five years. The various funding components are shown in Chart 1.

CHART 1 **FY 2027 SEGIP Funding Sources**
Total: $4.6 billion ($ in Millions)

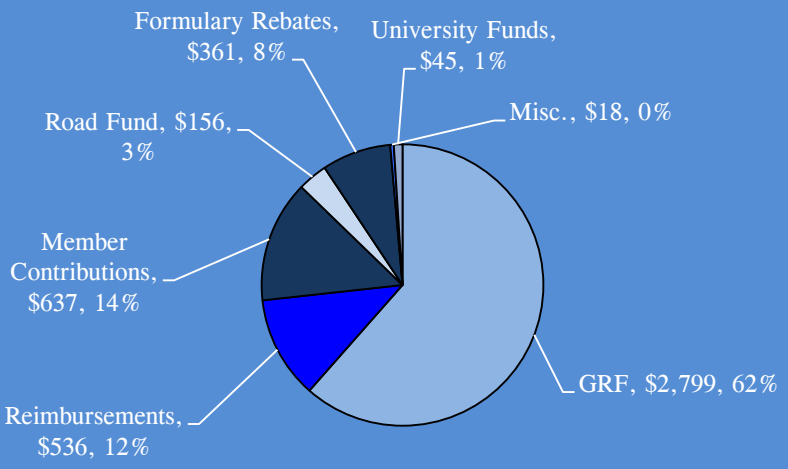


TABLE 5: GROUP INSURANCE FUNDING SOURCES
FY 2026 - FY 2027
($ in Millions)

	FY 2026	FY 2027	$ Change from FY26	% Change from FY26
GRF Appropriation	$2,480.5	$2,799.1	$318.6	12.8%
Road Fund	$172.8	$155.5	($17.3)	-10.0%
University Cont.	$45.0	$45.0	$0.0	0.0%
Member Cont.	$606.7	$637.0	$30.3	5.0%
Other Funds	$556.8	$535.8	($21.0)	-3.8%
Medicare Part D rebate	$3.9	$3.7	($0.2)	-5.1%
Formulary Rebates	$313.5	$361.2	$47.7	15.2%
Interest/Other.	$7.3	$14.7	$7.4	101.4%
TOTAL	**$4,186.5**	**$4,552.0**	**$365.5**	**8.7%**

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 offered through the Quality Care Health Plan (QCHP) and a range of managed care plans such as Health Maintenance Organizations (HMO), Open Access Plans (OAP), and the Consumer Driven Health Plan (CDHP). Vision coverage, covering services such as eye exams, glasses, and contact lenses, 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 allows patients to consult with physicians or nurses by telephone or online for routine medical needs, obtain information, receive prescriptions, and secure referrals without traveling to a healthcare facility.

Although telemedicine does not replace emergency care or physician-supervised actions that require a clinical setting to perform, it is an attractive option for users in rural areas, those with travel issues, or those with health-related limitations. On average across the health insurance sector, telemedicine copayments are about half the cost of an in-person physician visit, resulting in savings for consumers. In addition to cost savings, telemedicine helps reduce congestion at healthcare facilities and provides an effective triage tool for managing patient care.

Furthermore, telemedicine may help medical providers support other palliative care options. SEGIP participants are encouraged to use a variety of plan and member specific resources available online or by telephone to coordinate healthy lifestyle habits and other practices intended 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 2027, the Consumer Driven Health Plan (CDHP), similar to plans offered in other states such as Kansas and Texas. This plan offers a lower-premium option for employees who prefer to minimize health insurance deductions from their paychecks. Additionally, it is beneficial to the State by being relatively easier to administer with smaller overall liability compared to the other available plans. Specifically, the CDHP features a $1,600 deductible that employees must meet before primary health insurance benefits begin. For employees who anticipate few health insurance needs, the savings from choosing this plan may outweigh any routine health costs incurred throughout the year.

According to CMS’s actuarial analysis, younger members are expected to choose this plan, as they typically have fewer health-related expenses and overall healthcare needs compared to older employees. Older employees tend to utilize more comprehensive health insurance options as they are more likely to have health-related needs and have families who also would utilize benefits covered under higher premium plan alternatives. Accordingly, the CDHP is open specifically to only active employees and their

dependents. As of February 2026, CMS projects that approximately 6,312 active members and dependents will utilize this plan in FY 2027, compared with 5,983 in FY 2026.

When retirees reach the age of eligibility, they are enrolled in a Medicare Advantage plan. Since FY 2014, Medicare-eligible retirees and their Medicare-eligible dependents are moved into Medicare Advantage (MA) plans when they qualify. In FY 2027, individual retirees and dependents will be eligible for the Aetna MA PPO plan (the only current State-supported option).

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 2027, 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.

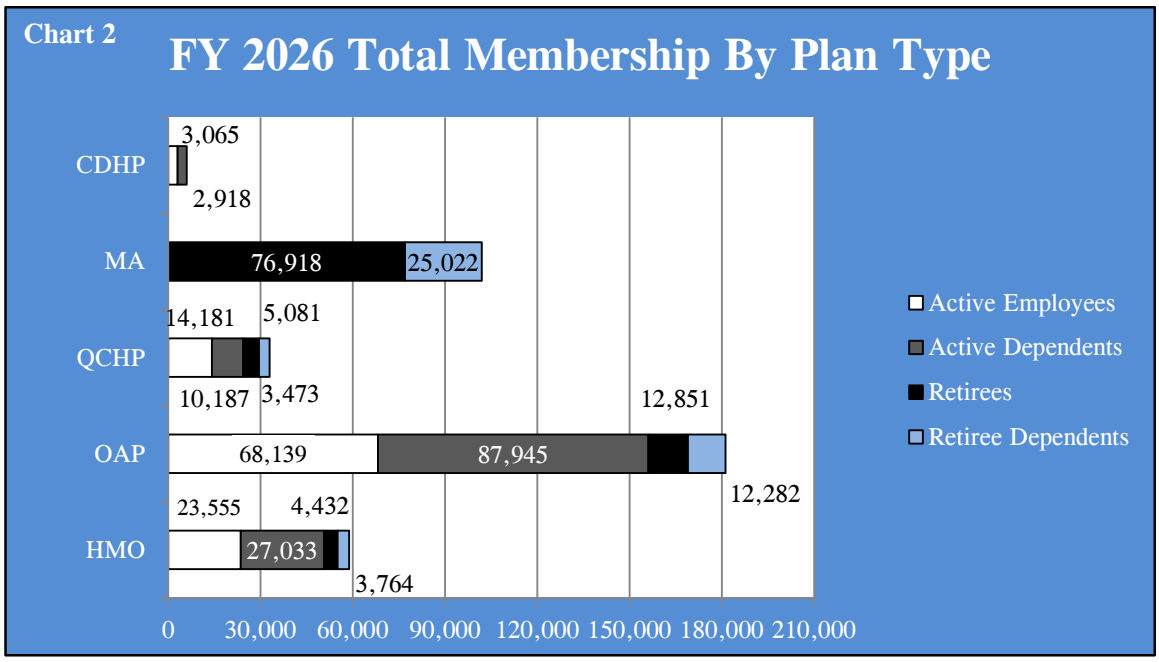
Basic life insurance is provided at no cost to employees, retirees and annuitants. According to the annual Benefits Choice booklet, full-time employees receive coverage equal to their annual salary. Retirees and annuitants receive coverage equal to the annual salary as of the last day of employment until 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

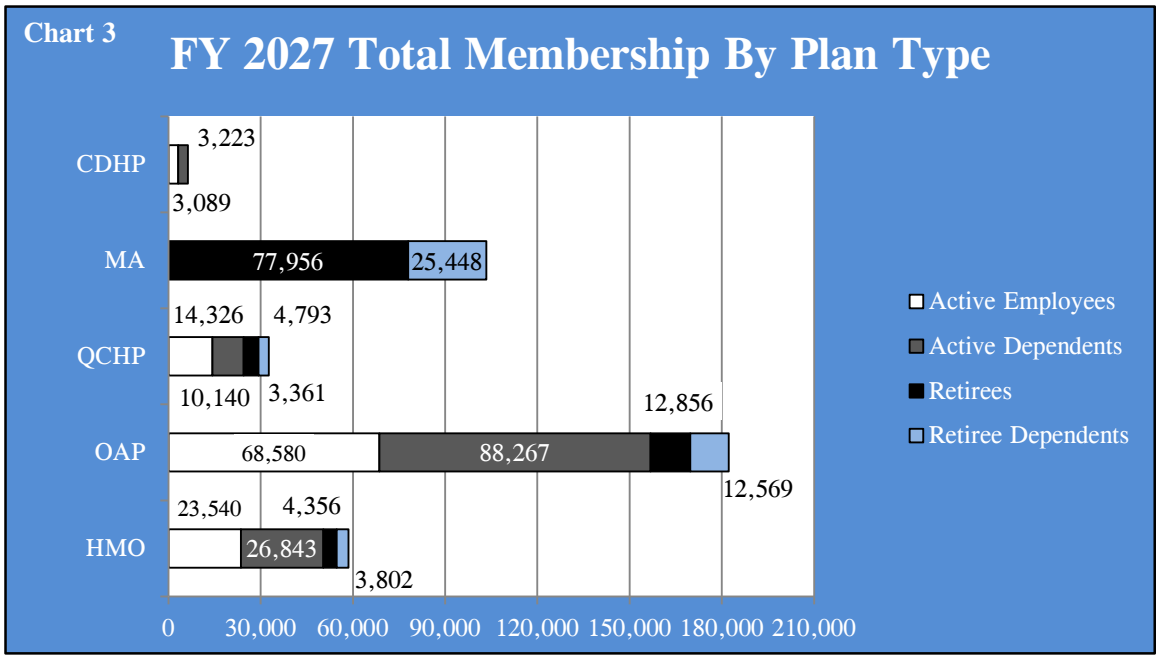
According to CMS, the State Employees' Group Health Insurance Program has an estimated 380,846 participants for FY 2026, of which 58,784 are in a non-Medicare Advantage HMO, 5,983 are in the CDHP, 101,940 are in the Medicare Advantage PPO, 181,217 are in an Open Access Plan, and 32,922 are in the Quality Care Health Plan. The QCHP is estimated to have 14,181 employees, 10,187 active employee dependents, 3,473 retiree dependents, and 5,081 retirees in FY 2026. These numbers reflect a large shift of former Health Alliance participants migrating to other plans, predominantly OAP options.

Traditional HMO plans are estimated to have 23,555 employees, 27,033 active employee dependents, 3,764 retiree dependents, and 4,432 retirees in FY 2026. The CDHP is estimated to have 3,065 active employees and 2,918 active employee dependents. The Medicare Advantage plan in FY 2026 includes 25,022 dependents and 76,918 retirees. OAPs are anticipated to have 68,139 employees, 87,945 active employee dependents, 12,282 retiree dependents, and 12,851 retirees in FY 2026. This information is displayed in Chart 2.



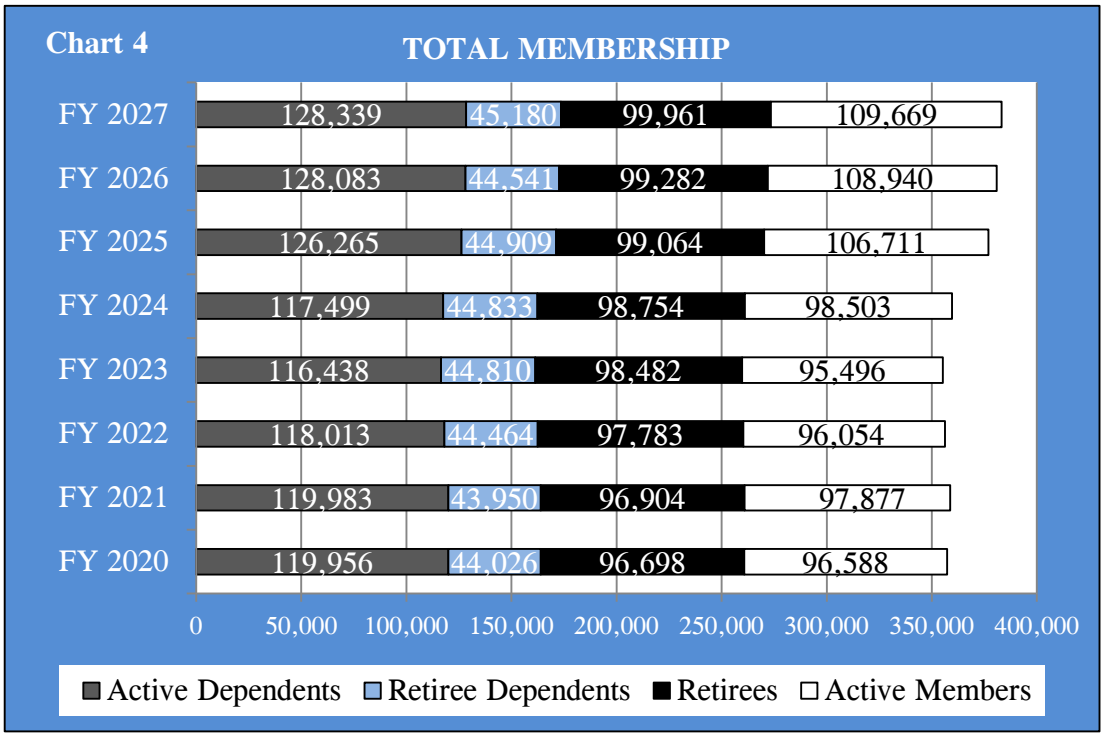
For FY 2027, the people who migrated out of the former Health Alliance plan option are expected to stay with their new plans. While every plan option saw an increase from this migration, the OAP options saw the largest growth as a result of this process. At the time of the drafting of this report, the QCHP is projected to have 14,326 employees, 10,140 active employee dependents, 3,361 retiree dependents, and 4,793 retirees. The Medicare Advantage PPO plan is expected to have 25,448 dependents and 77,956 retirees. Non-Medicare Advantage HMO Plans are expected to have 23,540 employees, 26,843 active dependent lives, 3,802 retiree dependents, and 4,356 retirees. OAPs are expected to have 68,580 employees, 88,267 active dependents, 12,569 retiree dependents, and

12,856 retirees in FY 2027. The Consumer Driven Health Plan is projected to have 3,223 employees and 3,089 active employee dependents. Total FY 2027 membership is expected to increase by 2,303 participants from 380,846 to 383,149. This information is displayed in Charts 2 and 3.



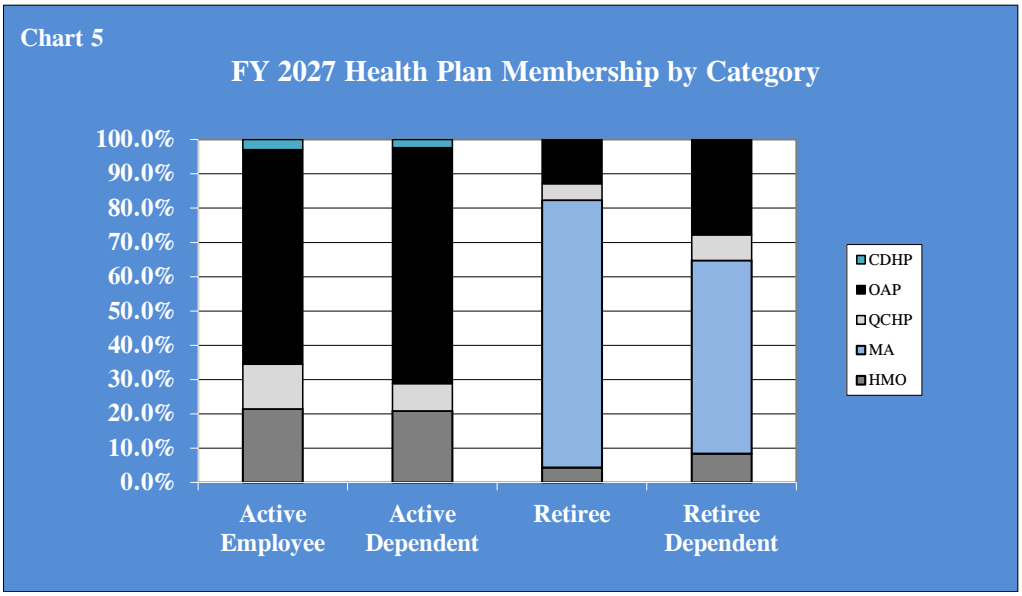
Membership in the Quality Care Plan has been decreasing since FY 2005, while membership in the States' managed care offerings has been increasing since FY 2004. Since FY 2012, many participants have transitioned away from traditional managed care (HMOs) to alternatives such as the Open Access Plan (OAP) and the CDHP (since FY 2021). This trend has accelerated in FY 2026-FY 2027 membership projections by CMS due in large part to the movement of members from the Health Alliance HMO plan into the various OAP options.

For FY 2027, membership in HMOs is broken down by standard HMO membership and CDHP membership. OAP membership is expected to continue 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 101,940 in FY 2026 to 103,404 for FY 2027. Membership is expected to continue to grow in future years as retirees continue to qualify for Medicare Advantage.



- **Membership is projected for FY 2027.**

Chart 5 shows the breakdown of employee, dependent, and retiree enrollment in the 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 2027, 78% of retirees and 56% 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 toward Open Access Plans, though some are moving to the CDHP. Due to the departure of Health Alliance from the SEGIP, the OAP portion of Chart 5 has increased significantly, as 65% of current employees and 69% of dependents are members of an OAP.



LIABILITY

The Department's estimate of liability for FY 2027 represents a 9.0% increase from FY 2026, primarily due to significantly increased medical trend inflation and required coverage for certain treatments/medications (as stated by CMS). Table 6 illustrates the cost components for the Group Health Insurance Program from FY 2018 through FY 2027 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 2027, with $2.914 billion (63%) out of a total group insurance liability (estimated) of $4.618 billion. It should be noted that the Open Access Plan portion also contains many more members currently than in prior years due to the migration of many former Health Alliance HMO members to various OAPs.

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.

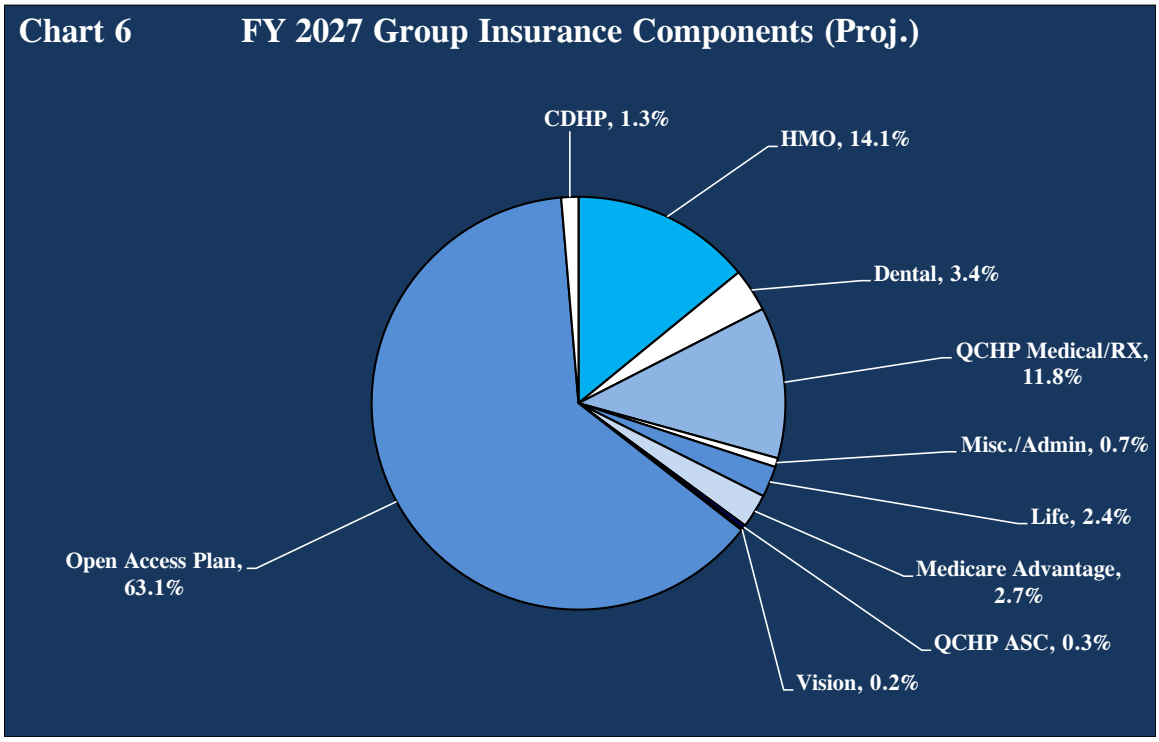
The Administration/Other category has been reduced significantly due to a major reduction in liabilities tied to the FY 2025 bargaining unit contract with the Teamsters, who previously had a health insurance arrangement outside the rest of the SEGIP membership. Under this agreement, the Teamsters were allowed to opt-out of the SEGIP and enroll in a health plan administered by the Teamsters Health and Welfare Funds. According to the previous collective bargaining agreement, the State paid a specific dollar amount for each person who opted-out and enrolled in the alternative plan. Under the FY 2025 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 contract extends from FY 2025 to the end of FY 2029. 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 also projected to increase from FY 2026 to FY 2027. These components are only a small portion of total liability (even with life insurance liability expected to total $112 million in FY 2027) as a whole, and are expected to remain in that position in years to come, as more expensive QCHP/HMO/OAP plans are utilized by State employees, retirees, and dependents. The CDHP is becoming a larger 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 $62 million in FY 2027, after totaling $55 million in FY 2026.

Table 6 STATE EMPLOYEES' GROUP HEALTH INSURANCE (CMS ESTIMATE) FY 2018-FY 2027										
$ in (millions)										
Liability Component	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027 (Est.)**
QCHP Medical/Rx	$512	$517	$497	$511	$549	$497	$502	$509	$509	$547
CDHP	$0	$0	$0	$9	$27	$22	$31	$42	$55	$62
HMO Medical	$1,037	$1,067	$1,088	$1,083	$984	$994	$1,029	$1,239	$614	$650
Medicare Advantage	$200	$197	$188	$175	$154	$75	$0	$25	$84	$123
Dental	$118	$124	$104	$130	$127	$131	$137	$145	$149	$156
Open Access Plan	$779	$842	$860	$981	$1,107	$1,253	$1,384	$1,726	$2,671	$2,914
QC Mental Health	$5	$6	$6	$6	$0	$0	$0	$0	$0	$0
Vision	$8	$8	$8	$9	$8	$8	$8	$7	$7	$7
Life Insurance	$90	$88	$92	$94	$82	$85	$90	$96	$100	$112
QC ASC	$15	$14	$18	$18	$16	$11	$15	$14	$16	$14
Interest Payments	$275	$104	$73	$24	$25	$0	$0	$0	$0	$0
Admin/Other	$120	$137	$154	$126	$126	$135	$145	$32	$32	$34
Total	**$3,159**	**$3,104**	**$3,087**	**$3,164**	**$3,205**	**$3,212**	**$3,342**	**$3,835**	**$4,237**	**$4,618**
% change over PY	**9.8%**	**-1.8%**	**-0.5%**	**2.5%**	**1.3%**	**0.2%**	**4.0%**	**14.7%**	**10.5%**	**9.0%**
Source: CMS. Rounding causes slight differences in totals.										

Chart 6 includes the various components of the FY 2027 CMS liability estimate of approximately $4.618 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 77.2% of FY 2027 liability. In comparison, the CDHP is projected to maintain its share of 1.3% of FY 2027 liability, as was the case in 2026.

Dental care, life insurance, and vision care equal 6.0% of total liability, slightly down from 6.4% in FY 2026. The QCHP component (12.1%) is lower than FY 2026 (13.1%) and includes medical/prescriptions, mental health coverage, and administrative service charges. As mentioned previously, for FY 2027, interest payments are not projected to contribute significantly to Group Insurance liability, continuing the pattern of prompt bill payment.



Based on current trends, it is unlikely that the QCHP will return to the larger share of the total group insurance liability it had attained in prior years. This is largely due to 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 suggests that this portion of liability is not likely to shrink in size or proportion of total population enrollment in the near future. The QCHP remains an option for individuals seeking the most expansive choices for providers and network access.

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. The current OAPs offered by the State experienced considerable additional interest from members forced to switch from their current Health Alliance plan in the FY 2026 Benefits Choice period in May 2025.

The State continues to pay its health insurance bills in a timely manner, after prior years of issues with held bills and lengthy payment cycles. An increased GRF commitment to cover year-to-year liabilities paid down significant health insurance bill interest in FY 2020 and a supplemental appropriation in FY 2022 paid down the backlog of unpaid bills. The State has been able to keep bills paid on a timely basis since FY 2023. This trend is expected to continue in FY 2027.

HISTORICAL GROUP INSURANCE INTEREST PAYMENTS AND BONDING

SEGIP interest payments have been an issue in the past due to the State waiting to pay claims to vendors. 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.

As of the end of February 2026, approximately $77.2 million in Group Insurance bills 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 2026. These bills displayed below are awaiting payment, but are otherwise "up to date", as this is a snapshot in time of the current bill status of the SEGIP. Of note, the claims hold length is very low for most of these claims, except for certain administrative service charges, which have a current hold of approximately 6 months.

Table 7 Claims Hold Data for SEGIP (as of February 28, 2026)			
Vendor	Claims Hold	Length of Claims Hold (in days)	Interest Owed (Including Past Due Interest)
Aetna - PPO	$0	0	$0
Dental Claims Hold – PPO	$770,083	13	$0
Dental - Non-PPO	$2,528,874	13	$0
Magellan (Mental Health) Claims	$0	0	$0
Aetna HMO	$24,954,242	3	$0
HMO Illinois	$12,949,180	3	$0
Blue Advantage	$12,995,972	3	$0
HealthLink OAP	$0	0	$0
BCBS OAP	$8,574,360	8	$28,598
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)	$601,399	3	$0
Metropolitan Life	$8,305,955	3	$0
Other (Fees/ASC/etc.)	$5,538,644	187	$2,633
Total	**$77,218,709**	**3-187**	**$31,231**
Source: CMS. MA stands for Medicare Advantage.			

In regard to payment cycles, the 2027 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 administrative charges as noted in the "Other" section in Table 7.

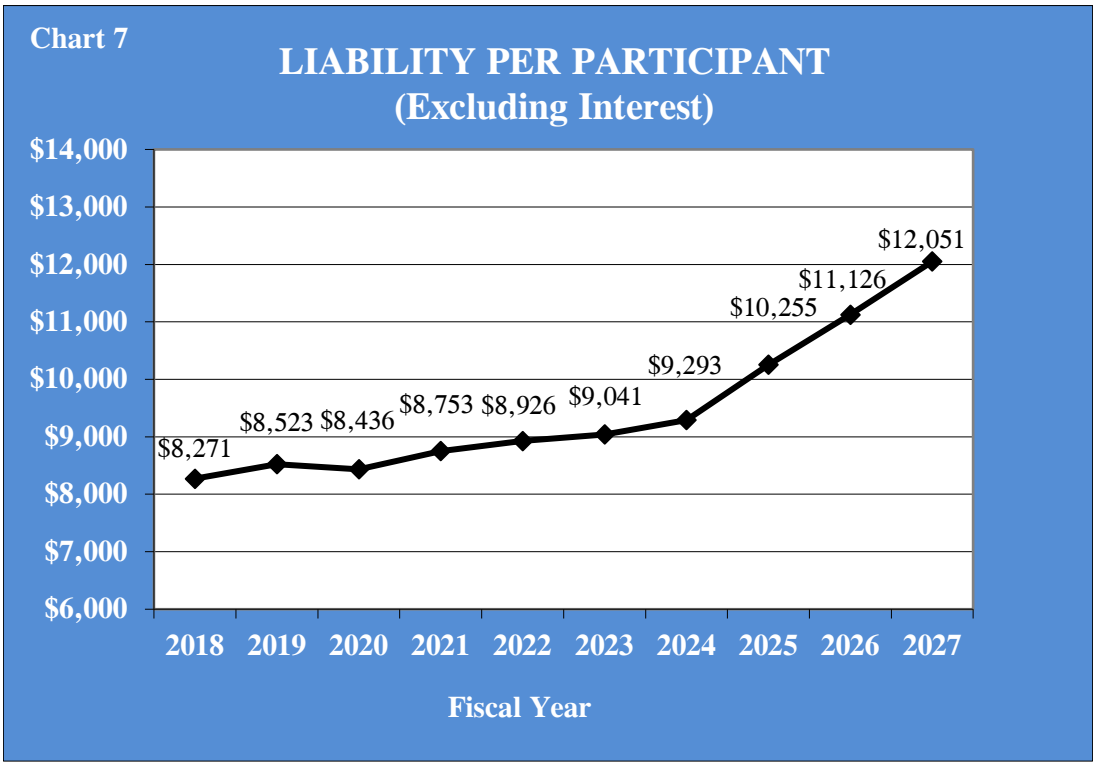
One important note on this subject is that this accounts only for the time for CMS to process claims and does not include time for the Comptroller to process and send out payment to the vendors in question. The Comptroller's timeliness depends on current cash flow needs and funds availability, which fluctuates daily. A stable budget that continues to promptly pays down 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.

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 7 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 2018 – FY 2027 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 $8,271 in FY 2018.

According to CMS, the liability per participant for FY 2026 will increase to $11,126, an increase of $871 (8.5%) compared to FY 2025. For FY 2027, the estimated liability per participant is projected to be $12,051, an increase of $925 (8.3%). This represents a 45.7% increase over FY 2018. From FY 2018 to FY 2027, liability has increased $420/year (11.1%) on average.



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, as anticipated in the FY 2026 SEGIP report, the migration

of former Health Alliance HMO members to more-expensive OAP plan options caused overall liabilities to increase accordingly.

The impact from the State introducing the Consumer Driven Health Plan (CDHP) in the 2021 fiscal year has been fiscally promising, though limited. In conjunction with the Medicare Advantage plan, these served as a moderating influence for overall liabilities per participant. While savings from the CDHP 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 FY 2027, while the CDHP is projected to have lower liability per participant 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 2026 Total Participants	FY 2027 Total Participants	FY 2026 Liability Per Participant	FY 2027 Liability Per Participant
QCHP	32,922	32,620	$15,842	$17,069
CDHP	5,983	6,312	$9,146	$9,797
MA HMO / PPO	101,940	103,404	$827	$1,186
HMO	58,784	58,541	$10,437	$11,096
OAP	181,217	182,272	$14,739	$15,986
Totals	**380,846**	**383,149**		

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 2027 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 non-Medicare members in FY 2027, 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 2027. 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 $15,842 in FY 2026. Member contributions for QCHP enrollees are expected to total $70 million in FY 2026 (and $72 million in FY 2027). 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 2026 and FY 2027.

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

	FY 2026 State ALPP	FY 2026 Member Contributions	FY 2026 Member Contribution %	FY 2026 State Liability	FY 2027 State ALPP	FY 2027 Member Contributions	FY 2027 Member Contribution %	FY 2027 State Liability
QCHP	$15,842	$2,125	13.4%	$13,717	$17,069	$2,215	13.0%	$14,854
CDHP	$9,146	$1,773	19.4%	$7,374	$9,797	$1,845	18.8%	$7,952
MA HMO/PPO	$827	$43	5.2%	$784	$1,186	$57	4.8%	$1,129
HMO	$10,437	$1,598	15.3%	$8,840	$11,096	$1,669	15.0%	$9,428
OAP	$14,739	$1,716	11.6%	$13,022	$15,986	$1,784	11.2%	$14,202
Dental	$396	$141	35.6%	$255	$413	$153	37.0%	$260

Source: CMS.

Table 9 shows that QCHP members are expected to contribute 13.0% of the overall annual cost of providing their insurance in FY 2027. HMO and OAP members are expected to contribute 15.0% and 11.2% of their overall liability cost in the same time period. Members of the Consumer Driven Health Plan are estimated to contribute 18.8% of the overall liability, a higher proportion than the other standard health plan options. For comparison, members that participate in the State's dental offering are expected to pay 37.0% of the overall liability cost in FY 2027. Retirees and their survivors (with less than 20 years of creditable service) are required to pay a portion (5% for each year of service) of their health care premiums (P.A. 90-0065). The remainder is paid by the State.

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 2026.

TABLE 10: MEMBER/RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 2027 (Numbers in Millions)					
Non-Medicare Advantage	**Cost**	**Medicare Advantage**	**Cost**	**Active Employee**	**Cost**
Non-MAPD Retiree Cost	$656.5	MAPD Retiree Cost	$98.5	Active Employee Cost	$2,108.3
Non-MAPD Retiree Contribution	-$145.3	MAPD Retiree Contribution	-$3.7	Active Employee Contribution	-$369.9
Non-MAPD Retiree Contribution %	22.1%	MAPD Retiree Contribution %	3.8%	Active Employee Contribution %	17.5%
Other Revenues	-$32.6	Other Revenues	-$2.3	Other Revenues	-$145.4
Net State Cost	**$478.6**	**Net State Cost**	**$92.5**	**Net State Cost**	**$1,593.0**
Non-MAPD Retiree Dependent Cost	$304.6	MAPD Retiree Dependent Cost	$32.2	Active Employee Dependent Cost	$1,417.6
Non-MAPD Retiree Dependent Contribution	-$42.0	MAPD Retiree Dependent Contribution	-$0.8	Active Employee Dependent Contribution	-$177.6
Non-MAPD Retiree Dependent Contribution %	13.8%	MAPD Retiree Dependent Contribution %	2.5%	Active Employee Dependent Contribution %	12.5%
Other Revenues	-$28.6	Other Revenues	-$0.8	Other Revenues	-$170.0
Net State Cost	**$234.0**	**Net State Cost**	**$30.6**	**Net State Cost**	**$1,070.0**
Total Non-MAPD Retiree Cost	$961.1	Total MAPD Retiree Cost	$130.7	Total Active Cost	$3,525.9
Total Non-MAPD Retiree Contribution	-$187.2	Total MAPD Retiree Contribution	-$4.5	Total Active Contribution	-$547.5
Total Non-MAPD Retiree Cont. %	19.5%	Total MAPD Retiree Cont. %	3.4%	Total Active Cont. %	15.5%
Other Revenues	-$61.2	Other Revenues	-$3.1	Other Revenues	-$315.3
Total State Cost	**$712.7**	**Total State Cost**	**$123.1**	**Total State Cost**	**$2,663.1**
Source: CMS					

Based on data provided by CMS, non-Medicare Advantage retiree dependents pay a substantially larger portion of their total costs to the State in the form of contributions for their healthcare coverage compared to Medicare Advantage retirees (due to the structure of the program and its premiums). For FY 2027, non-Medicare Advantage retirees and retiree dependents are projected to pay 22.1% and 13.8%. Medicare Advantage retirees and their dependents are projected to pay 3.8% and 2.5%. This contrasts with active employees and their dependents, who are projected to pay 17.5% and 12.5% of their healthcare costs. In total, the aggregate contributions of active employees and dependents (15.5% for both groups combined in FY 2027 compared to 16.4% in FY 2026) is expected to be lower than non-Medicare Advantage retirees, but significantly higher than Medicare Advantage retirees.

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 2025, FY 2026, and FY 2027 plan enrollment is listed in Table 11. The numbers listed for FY 2026 and FY 2027 reflect the departure of Health Alliance HMO from the SEGIP and demonstrate the migration of the majority of their former members to the various OAPs. The Aetna HMO and Blue Advantage HMO plans also saw a significant increase due to this migration.

TABLE 11: MANAGED CARE PLANS
FY 2025-2027 All Lives (Active Members/Dependents and non-MA Retirees/Dependents)

HMO/OAP	FY25 # of Participants	FY26 # of Participants (est.)	% Change 2025-2026	FY27 # of Participants (proj.)	% Change 2026-2027
Health Alliance HMO	61,532	0	-100.00%	0	0.00%
HMO Illinois	24,726	17,915	-27.55%	17,342	-3.20%
Blue Advantage	14,822	19,262	29.96%	19,606	1.79%
Aetna/Coventry Health Care HMO	9,393	21,607	130.03%	21,593	-0.06%
Aetna/Coventry Health Care OAP	42,204	69,969	65.79%	70,107	0.20%
Health Link OAP	55,942	63,207	12.99%	62,812	-0.62%
BCBS OAP	32,551	48,041	47.59%	49,353	2.73%
Consumer Driven Health Plan HDHP	5,184	5,983	15.41%	6,312	5.50%
TOTALS	**246,354**	**245,984**	**-0.15%**	**247,125**	**0.46%**

Source CMS. FY 27 numbers are projected as of February 2026.

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. In FY 2026 and FY 2027, the plan is expected to have 101,940 and 103,404 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 103,404 people projected to be covered in FY 2027 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 2027 fiscal year, as a result of negotiations with public employee unions, premiums for HMO/OAP/QCHP options are expected to moderately increase, 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 2020 - FY 2027 Employee Only								
	QCHP				CDHP			
	TOTAL	% Inc.	Member	State	TOTAL	%Inc.	Member	State
FY 20	$1,004	2.1%	$155	$849	N/A	N/A	N/A	N/A
FY 21	$1,076	7.2%	$180	$897	$802	N/A	$157	$645
FY 22	$1,236	14.9%	$194	$1,042	$1,163	45.0%	$157	$1,006
FY 23	$1,176	-4.9%	$212	$964	$764	-34.3%	$157	$607
FY 24	$1,235	5.0%	$214	$1,021	$840	10.0%	$171	$669
FY 25	$1,293	4.7%	$229	$1,064	$888	5.8%	$188	$700
FY 26	$1,378	6.6%	$240	$1,137	$994	11.9%	$201	$793
FY 27	$1,489	8.1%	$246	$1,244	$1,066	7.2%	$208	$859
	HMO				OAP			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY 20	$835	1.7%	$118	$717	$971	-1.4%	$119	$852
FY 21	$850	1.8%	$143	$706	$1,084	11.6%	$155	$928
FY 22	$823	-3.1%	$157	$666	$1,185	9.4%	$170	$1,016
FY 23	$876	6.4%	$173	$702	$1,255	5.9%	$186	$1,069
FY 24	$944	7.8%	$178	$767	$1,288	2.6%	$189	$1,100
FY 25	$1,157	22.5%	$195	$962	$1,391	8.0%	$205	$1,186
FY 26	$1,068	-7.7%	$199	$869	$1,554	11.7%	$218	$1,336
FY 27	$1,132	6.0%	$206	$926	$1,686	8.5%	$224	$1,462

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 2020 to the projected values for members in FY 2027. Whether members are in the QCHP, a traditional HMO, the CDHP, or an Open Access Plan, the monthly cost of such plans has generally 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 cost of the 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 2027 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 QCHP / CDHP / HMO / OAP Weighted Average FY 2027 Rates (Projected for Median Salary)						
	QCHP			CDHP		
	TOTAL	Member	State	TOTAL	Member	State
Employee	$1,489	$246	$1,244	$1,066	$208	$859
Medicare Retiree	$923	$26	$897	$0	$0	$0
Non-Medicare Retiree	$2,369	$18	$2,351	$0	$0	$0
1 Dependent	$1,735	$307	$1,428	$896	$185	$711
2+ Dependents	$2,403	$345	$2,058	$1,535	$230	$1,305
Medicare Dependent	$1,914	$201	$1,714	$693	$160	$533
	HMO			OAP		
	TOTAL	Member	State	TOTAL	Member	State
Employee	$1,132	$206	$926	$1,686	$224	$1,462
Medicare Retiree	$748	$25	$722	$1,114	$25	$1,088
Non-Medicare Retiree	$1,788	$16	$1,772	$2,577	$16	$2,561
1 Dependent	$976	$187	$788	$1,430	$207	$1,223
2+ Dependents	$1,701	$230	$1,471	$2,456	$255	$2,200
Medicare Dependent	$826	$172	$654	$1,120	$184	$936

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 HMOs / OAPs / CDHP FY 2026 Rates (for Median Salary)							
	Aetna HMO	HMO Illinois	Blue Advantage	HealthLink OAP	Aetna OAP	BCBS OAP	CDHP
Employee	$201.45	$200.44	$173.68	$221.08	$210.94	$206.88	$190.58
Medicare Retiree	$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	$0.00
1 Dependent	$205.79	$172.13	$167.04	$214.53	$196.58	$196.58	$178.25
2 + Dependents	$252.25	$215.66	$206.20	$267.29	$243.02	$243.02	$225.79
Medicare Dependent	$178.00	$147.00	$143.00	$186.00	$169.00	$169.00	$152.00
FY 2027 Proposed Rates (for Median Salary)							
	Aetna HMO	HMO Illinois	Blue Advantage	HealthLink OAP	Aetna OAP	BCBS OAP	CDHP
Employee	$215.32	$209.80	$195.18	$233.32	$220.02	$219.65	$208.00
Medicare Retiree	$25.28	$25.28	$25.28	$25.28	$25.28	$25.28	$0.00
Non-Medicare Retiree	$15.75	$15.75	$15.75	$15.75	$15.75	$15.75	$0.00
1 Dependent	$209.00	$176.80	$173.01	$218.41	$200.75	$201.63	$185.00
2 + Dependents	$254.51	$217.21	$211.84	$271.43	$246.70	$247.29	$230.00
Medicare Dependent	$186.00	$155.00	$157.62	$194.00	$178.34	$177.00	$160.00

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 $31-$60/month spread between the most expensive and least expensive plans in Table 14 for FY 2027, with different plans having lower rates than others depending on the particular demographic components of the plan being considered. For example, while the CDHP usually has lower rates than most other plans in the table, the average rate for Employee-only, 1 Dependent, and 2 Dependent plans make other HMOs potentially more competitive (before taking their increased options into account).

Table 15 shows a comparison between FY 2025, FY 2026, and projected FY 2027 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 2026, the cost is $203/month if a retiree's yearly income in 2024 was $109,000 or less. It is $284/month if their yearly income was above $109,000 up to $137,000. The cost is $406/month if their yearly income was above $137,000 up to $171,000. The total federal Medicare Part B premium can range from $203/month to as much as $689/month in FY 2026 depending on the retiree's taxable income.

TABLE 15: MONTHLY PREMIUMS FOR STATE MEDICARE ADVANTAGE PLANS
FY 2025-2027 Rates (As of February 2026)

Aetna PPO	FY 2025	FY 2026	FY 2027
Medicare Retiree	$1.48	$3.92	$5.39
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 2027, there are numerous contracts up for one-year and multi-year renewals. All contracts up for renewal are italicized in the chart below.

Status of Contracts for FY 27 at DCMS		
Service	**Vendor**	**Contract Term Details**
Managed Care Health Plans	*Aetna HMO / Aetna OAP / Healthlink OAP / BC HMO Illinois / BC Blue Advantage*	***Original/Current Term:*** *July 1, 2021 to June 30, 2026.* ***Proposed Term:*** *(HMOs) July 1, 2026 to June 30, 2027 / (OAPs) July 1, 2026 to June 30, 2031.* ***Renewal Years Remaining:*** *HMOs - 4 years / OAPs - 0 years (if approved)*
Medicare Advantage Health Plans	Aetna PPO	**Original/Current Term:** January 1, 2023 to December 31, 2027. **Renewal Years Remaining:** 5 years.
Self-Insured Medical Plan Administration	*Aetna*	***Original/Current Term:*** *July 1, 2021 to June 30, 2026.* ***Proposed Term:*** *July 1, 2026 to June 30, 2029. Renewal Years Remaining: 7 years (if approved).*
Vision	EyeMed	**Original/Current Term:** July 1, 2024 to June 30, 2029. **Renewal Years Remaining:** 5 Years.
Behavioral Health/EAP	*ComPsych*	***Original/Current Term:*** *July 1, 2021 to June 30, 2026.* ***Proposed Term:*** *July 1, 2026 to June 30, 2027.* ***Renewal Years Remaining:*** *4 years (if approved).*
Life Insurance	*Metropolitan Life Insurance Company*	***Original/Current Term:*** *July 1, 2021 to June 30, 2026.* ***Proposed Term:*** *July 1, 2026 to June 30, 2029.* ***Renewal Years Remaining:*** *2 years (if approved).*
Flexible Spending	Optum	**Original/Current Term:** July 1, 2023 to June 30, 2028. **Renewal Years Remaining:** 5 years.
Administration of Dental Claims	*Delta Dental*	***Original/Current Term:*** *July 1, 2021 to June 30, 2026.* ***Proposed Term:*** *July 1, 2026 to June 30, 2031.* ***Renewal Years Remaining:*** *0 years (if approved).*
Prescription Drugs	CVS/Caremark	**Original/Current Term:** July 1, 2024 to June 30, 2027. **Renewal Years Remaining:** 7 years.
Commuter Savings Program	Endred	**Original/Current Term:** July 1, 2024 to June 30, 2029. **Renewal Years Remaining:** 5 years.

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 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. The Unit publishes a monthly Grant Alerts report and an Abstracts Report of annual reports or special studies from other state agencies. Other reports include 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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