Commission on Government
Forecasting and Accountability

FISCAL YEAR 2006
LIABILITIES OF THE STATE EMPLOYEES' GROUP INSURANCE PROGRAM

March 2005
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Springfield, Illinois 62706

Commission on Government Forecasting and Accountability

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FY 2006 Liabilities of the State Employees' Group Insurance Program

EXECUTIVE SUMMARY

The Commission on Government Forecasting and Accountability (CGFA) has several statutory requirements concerning the State Employees' Group Insurance Program.

- To estimate liabilities of the State Employees' Group Health Insurance Program.
- To meet with the Department of Central Management Services (CMS) and advise the department on all matters relating to policy and administration of the Group Insurance Act.
- To review and approve contracts recommended by the Director of CMS related to the Group Insurance Program.
- P.A 93-839 granted new statutory authority to the Commission. A detailed summary of these new responsibilities can be found in Appendix I.

The Governor has requested that a total of $1,780.3 million be appropriated for the State Employees' Group Health and Life Insurance program for FY 2006. The requested FY 2005 appropriation for the Group Health Insurance Program was $1,720.0 million. The following table represents historical appropriation and liability amounts, per CMS. The CGFA FY 2006 estimate of liability is $1,787.0 million, $34.5 million more than CMS.

According to CMS, the Group Insurance Program will fall $42.4 million short in the payment of FY 2005 claims, and expects a shortfall in FY 2006 of $48.5 million. Currently, the payment cycles for preferred providers is 35 days, while non-preferred providers have a payment cycle of 42 days. CMS projects that the ending payment cycle for preferred and non-preferred providers is 41 days for FY 2005. The projected payment cycle for FY 2006 is 43 days for preferred and non-preferred providers.

The FY 2006 monthly cost of an employee in the indemnity plan is expected to increase 4.7% over the FY 2005 cost. The monthly cost of an employee in the managed care plan is expected to increase 9.3% over the FY 2005 cost. In comparison, the FY 2005 monthly cost for an employee in the indemnity plan increased 12.6% over the FY 2004 cost. FY 2005 monthly costs for an employee in the managed care plan increased 10.2% over FY 2004.

APPROPRIATION AND LIABILITY HISTORY
FY 2001-2006
($ in Millions)

Fiscal Year	Appropriation	CMS Liability	CGFA Liability
FY 2001	$1,085.0	$1,081.7	
FY 2002	$1,262.7	*$1,176.3	
FY 2003	$1,390.9	*$1,305.0	
FY 2004	$1,609.8	*$1,486.7	
FY 2005	$1,720.0	*$1,656.7	
FY 2006	$1,780.3	*$1,752.5	*$1,787.0

*Estimated

FY 2006 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2006 cost projection utilizes the CMS revised estimate for FY 2005 medical claims as the basis for estimating claims for FY 2006. This revision is based on actual claims to date.

The CGFA cost estimate for FY 2006 uses the following assumptions based on historical claims data and anticipated cost increases:

TREND FACTORS	
Medical (indemnity plan/QCHP)	7.05%
Dental (QCHP and MC)	0%
HMO (medical and Rx)	10.44%
Prescription drugs (QCHP)	6.56%
Administrative service charges (QCHP)	27.75%
Life insurance	3.16%
Special programs (QCHP)	-4.27%

The medical trend inflation factor consists of several components. These include inflation, leveraging (the reduced impact of level deductibles and co-insurance limits), and cost shifting due to reductions in Medicare and Medicaid reimbursements. Other components of the medical trend inflation factor include anti-selection or the impact of employees shifting to HMOs and PPOs, which retains sicker, more costly employees in the indemnity plan; technological advances; social shifts including the aging population and greater acceptance of psychiatric and substance abuse care; and, increased utilization of equipment and services.

Based on these assumptions and inflation factors, the CGFA estimates a FY 2006 liability of approximately $1,787.0 million for the State Employee's Group Health Insurance Program. The table below shows a detailed comparison of the CGFA estimate for the various cost components and the CMS projection for FY 2006.

TABLE 1: FY 2006 Group Health Insurance Liability
($ in millions)

Liability Component	FY 2005 CMS Estimate	FY 2006 CMS Estimate	FY 2006 CGFA Estimate	Difference
QCHP Medical	$519.3	$549.0	$555.9	$6.9
QCHP Prescriptions	$199.3	$195.9	$212.4	$16.5
Dental (QCHP/MC)	$93.6	$90.6	$93.6	$3.0
HMO	$608.3	$665.2	$671.8	$6.6
Open Access Plan	$95.9	$104.0	$104.0	$0
POS	$0	$0	$0	$0
Mental Health	$9.3	$9.5	$9.6	$.1
Vision	$11.5	$12.2	$12.6	$.4
Administrative Services (QCHP)	$24.1	$30.6	$30.8	$.2
Life	$67.3	$68.6	$69.4	$.8
Special Programs (Admin/Int/Other)	$28.1	$26.9	$26.9	$0
TOTAL	**$1,656.7**	**$1,752.5**	**$1,787.0**	**$34.5**
% Increase over FY 2005 CMS Estimate		5.8%	7.9%	

ESTIMATE COMPARISON

The Commission's FY 2006 estimate is $34.5 million higher than the FY 2006 estimate from CMS. CGFA's FY 2006 HMO liability estimate is $6.6 million higher than CMS, CGFA's indemnity medical estimate is $6.9 million higher than CMS, and CGFA's Dental estimate is the same as CMS. CGFA's FY 2006 estimate for prescriptions is $16.5 million higher than the CMS estimate.

The CGFA estimates approximately $1,787.0 million would be required to fully fund the FY 2006 liabilities of the Group Health Insurance Program. This estimate is $130.3 million or 7.9% more than the FY 2005 estimated liability of $1,656.7 million.

APPROPRIATION/FUNDING SOURCES

The FY 2006 budget request for the Group Health Insurance Program is $1,074.6 million in GRF funds. This represents a $140.4 million or a 15.0% increase from the FY 2005 GRF appropriation of $934.2 million. The FY 2006 Road Fund request of $128.4 million is $6.8 million or 5.6% higher than the FY 2005 appropriation level.

TABLE 2: Group Insurance Funding Sources
FY 2005 – FY 2006
($ in Millions)

	FY 2005	FY 2006	Increase	% Increase
GRF	934.2	1,074.6	140.4	15.0%
Road	121.6	128.4	6.8	5.6%
Other Sources	507.0	537.9	30.9	6.1%
TOTAL	**1,562.8**	**1,740.9**	**178.1**	**11.4%**

Additional Funding for the Group Insurance Program

Funding Source	*Type of Funding*	*FY 2005*	*FY 2006*
GRF Approp	*IBHE Approp*	*0*	*0*
Road Fund Approp	*CMS Supplemental Approp*	*0*	*0*
Other Sources	*University payments*	*45,000,000*	*45,000,000*
TOTAL		*45,000,000*	*45,000,000*

The Department of Central Management Services sets target end-of-year fund balances for both the Health Insurance Reserve Fund and the Group Insurance Premium Fund. The historical budget target balance for the Group Insurance Program is $10 million. For the GIPF, that target balance is $4 million, and the target HIRF balance is $6 million.

In the Governor's FY 2006 budget a major shift in the administration of the State Employees' Group Insurance Program is recommended. The Department of Healthcare and Family Services (formerly the Department of Public Aid) will assume responsibility for the procurement, payment, and administration of the program. The

Department of Central Management Services will also maintain an administrative role overseeing some aspects of the program including group life insurance, deferred compensation, and the flexible spending program. The Group Insurance program has a recommended $1,780.3 million appropriation in the FY 2006 budget book. The Department of Healthcare and Family Services is slated to receive $1,037.6 million in GRF and $128.4 million in Road Fund to administer the program. The Department of Central Management Services receives a GRF appropriation of $36.9 million in GRF to administer the program as well. At the time this report was written it is unclear how this recommended change will affect the liability, or the administration of the Group Insurance Program.

BENEFITS

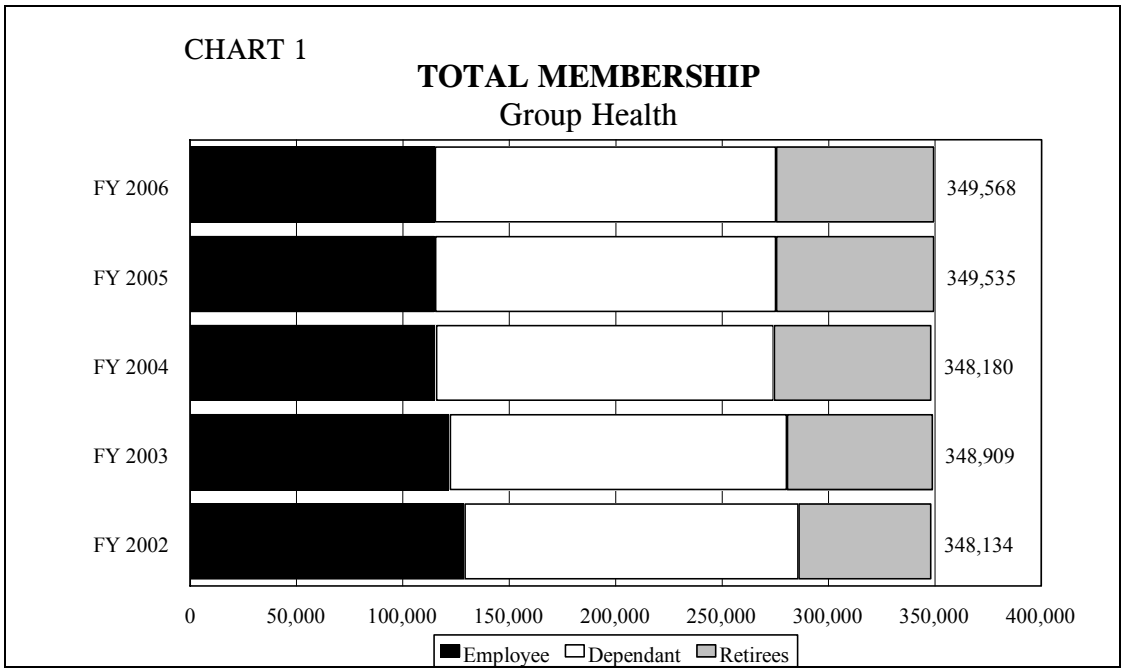
The State Employees' Group Insurance Program provides medical, dental, vision, and life insurance coverage to State employees, retirees and their dependents. Medical coverage is provided separately to members in their choice of: indemnity plan, and various types of managed care plans such as Health Maintenance Organizations (HMO). Vision coverage, which includes savings on exams, glasses, and contacts is provided at no additional premium costs. Appendix II describes the types of health and dental plans offered by the State. CMS no longer offers a managed care option for dental benefits.

Basic life insurance is provided at no cost to employees, retirees and annuitants. Full-time employees receive coverage equal to their annual salary. Retirees and annuitants receive coverage equal to the annual salary as of the last day of employment until the age of 60, at which time the benefit amount becomes $5,000. Employees are allowed to purchase optional term life insurance up to eight times their annual salary, as well as spouse and child term life insurance at group rates. Beginning January 1, 1995, CMS added a portability feature to the optional life program, thereby allowing employees leaving State service to continue optional term life insurance coverage indefinitely at group rates without being required to provide evidence of insurability. Group rates are based on age with an administration fee added.

MEMBERSHIP

The State Employees' Group Health Insurance Program currently has 349,535 participants. 206,756 in managed care, and 142,779 in the Quality Care Health Plan. Membership in the Group Health Insurance Plan is projected to increase slightly FY 2006 as evidenced in Chart 1.

CHART 1



- Membership for FY 2005 and FY 2006 is estimated.

COST SAVINGS

The Department of Central Management Services (CMS) has been attempting to reduce the cost of the medical indemnity program for the past several years. The Department has implemented various cost containment measures and has encouraged members to participate in managed care plans. Some of the cost containment measures include the establishment of preferred provider networks, medical case management, pre-admission review, hospital bill audit, retail pharmacy network and a behavioral health program. Managed care remains the preferred method for cost containment nationwide.

As a result of the negotiations with AFSCME there have been several plan design changes that will result in savings for the program. Table 3 highlights the different changes that CMS states will provide cost savings.

TABLE 3: Plan Design Changes/Resulting in Cost Savings FY 2005-2006		
Benefit Design Item	Change in FY 2005	Change in FY 2006
QCHP Out of Network Out of Pocket	+$500/2x	+$300/2x
QCHP ER Deductible		+$100
QCHP Pre-Certification Penalty	+$400	
QCHP Employee Deductible		+$50
QCHP Dependant Deductible		+$50
QCHP Family Deductible	2.5 Times Employee/Ded.	
QCHP In Network Out of Pocket		+$100/2.5x
QCHP Lab/X-ray	Covered at 90%	
QCHP Rx Copay	+$1/2/4	+$1/2/4
QCHP Member Contribution		+$10
QCHP Dependant Contribution		+$12
Managed Care Outpatient Copay	+$100	
Managed Care Hospital Copay		+$50
Managed Care ER Copay		+$50
Managed Care Home Health Visit Copay		+$15
Managed Care Rx Copay	+$2/9/3	+$2/4/8
Quality Care Dental Contribution	+$2.50	
Elimination of Managed Dental Quality Care Dental Deductible		+$50
2x: Denotes that a dependent deductible is two times employee deductible.		

The Department of Central Management Services provided the Commission an original estimate for liabilities on January 25, 2005. On February 15th, 2005, the Department informed the Commission that liability figures had been updated to account for new cost savings items. The following table shows the CMS original liability estimate, reductions based on savings, and the new CMS liability estimate.

TABLE 4: Cost Savings Detailed -- Comparison of FY 2005 to FY 2006				
	Estimated FY 2005	FY 2006 Original (Jan. 05)	Savings Initiatives	Revised Estimated FY 2006 (Feb. 05)
Quality Care Health	$519.3	$579.0	$(30.0)	$549.0
Quality Care Prescriptions	$199.3	$223.3	$(27.3)	$195.9
Quality Care Dental	$93.6	$90.6		$90.6
HMO	$608.3	$669.9	$(4.7)	$665.2
Open Access Plan	$95.9	$106.6	$(2.5)	$104.0
Quality Care Mental Health	$9.3	$9.5		$9.5
Vision Service Plan	$11.5	$12.2		$12.2
Quality Care ASC	$24.1	$26.6	$3.9	$30.6
Administration	$25.1	$30.6	$(6.7)	$23.9
Employee Assistance Program	$0.7	$0.7		$0.7
Timely Payment Interest	$2.3	$2.3		$2.3
Life Insurance	$67.3	$68.6		$68.6
TOTAL	**$1,656.7**	**$1,819.9**	**$(67.4)**	**$1,752.6**
Individual Savings Components				
FY06 Administration Reduction		$(6.7)	$(6.7)	
HMO-Medicare Part D		$(7.3)		
QCRx-Medicare Part D		$(8.4)		
			$(15.7)	
Medco ASC		$3.9		
Medco Contract		$(18.9)		
Medco Net Savings			$(15.0)	
QCHP PPO Negotiations		$(30.0)	$(30.0)	
TOTAL SAVINGS INITIATIVES			**$(67.4)**	

ENROLLMENT TRENDS

Between FY 2001 and FY 2003, membership in the Quality Care Plan generally decreased. However, there was a slight increase in enrollment in the Quality Care Plan between FY 2003 and FY 2004. New data from CMS projects a further decrease of -4.2% for FY 2005 and an additional decrease in FY 2006, -0.3%. In FY 2005, the percentage of enrollees in managed care (59.2%) was slightly higher than the FY 2004 level of (57.2%). The percentage of FY 2005 enrollees in the indemnity plan, (40.8%), was slightly lower than FY 2004 enrollment of (42.8%). From FY 2004 to FY 2005 there was a slight decrease in enrollment in the indemnity plan, in comparison; there was a slight increase in enrollment in managed care plans. As a means of cost control it has been the objective of CMS to encourage group insurance members to enroll in managed care plans.

LIABILITY

While the mid-1990's saw health care cost increases slow, recent years have experienced steady increases, ranging from 8.7% to 13.9% over prior years. The Department's estimate of liability for FY 2006 represents a 5.8% growth rate over FY 2005. This increase in estimated liability is lower than the increase from FY 2004 to FY 2005, when liability increased 11.8%. Table 5 illustrates the cost components for the Group Health Insurance Program from FY 1997 through FY 2006.

TABLE 5: STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY
FY 1997 to FY 2006
($ in Millions)

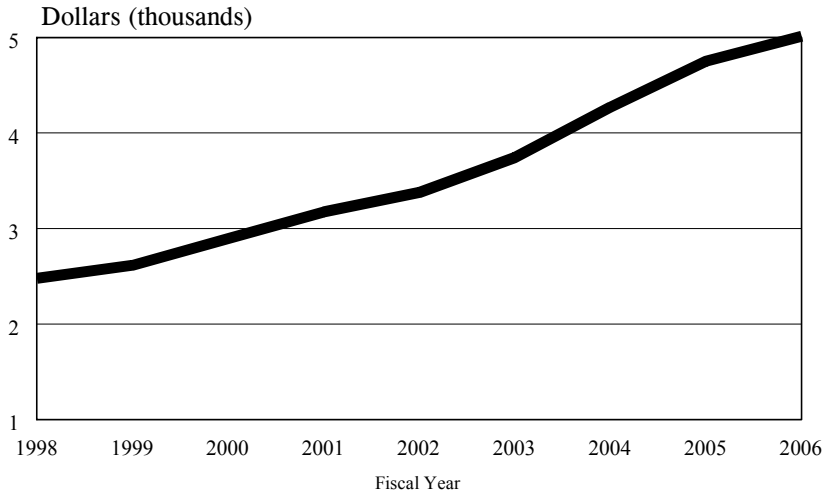
Liability Component	1997	1998	1999	2000	2001	2002*	2003*	2004*	2005*	2006*
QCHP Medical/Rx	356.8	381.7	425.1	497.0	536.0	558.5	585.5	663.6	718.6	744.9
HMO Medical	238.0	250.2	269.9	307.0	364.1	402.1	469.3	545.4	608.3	665.2
Dental	39.5	39.0	39.6	40.5	49.2	58.7	63.6	68.6	93.6	90.6
POS	19.1	20.8	23.0	16.1	7.8	7.6	8.6	-	-	-
Open Access Plan						36.8	54.9	68.0	95.9	104.0
QC Mental Health	11.3	11.0	10.8	11.1	11.0	9.3	9.2	9.5	9.3	9.5
Vision	6.9	7.7	8.5	7.5	10.4	10.9	11.2	11.5	11.5	12.2
Life Insurance	58.8	57.7	59.8	64.8	69.6	61.3	63.6	65.0	67.3	68.6
QC ASC	19.3	23.9	18.2	18.6	18.8	19.1	24.4	23.2	24.1	30.6
Admin/Int/Other	7.5	10.9	10.6	12.8	14.7	12.2	14.8	31.9	28.1	26.9
TOTAL	**757.2**	**802.8**	**865.5**	**975.4**	**1,081.7**	**1,176.3**	**1,305.0**	**1,486.7**	**1,656.7**	**1,752.5**
% Inc over py	6.7%	6.0%	7.8%	12.7%	10.9%	8.7%	10.5%	13.9%	11.4%	5.8%

*Estimated
- FY 2002-2006 figures are estimates: Source-CMS
- Rounding causes slight differences in cumulative totals.

ANNUAL COST PER PARTICIPANT

The cost per participant in the State Employees' Group Insurance Program is the total of the State's cost and the employee's contribution each month. Chart 3 shows the steady increase each year in cost per participant. This increase can be attributed to medical inflation as evidenced in the previous table. In FY 1997, the annual cost per participant in the group health insurance program was $2,372. **The estimated cost per participant for FY 2006 is $5,014, a 111% increase from the FY 1997 cost per participant**. The cost per participant increased 11.0% from FY 2004 to FY 2005. The FY 2006 cost per participant is estimated to increase more than 5.8% over FY 2005.

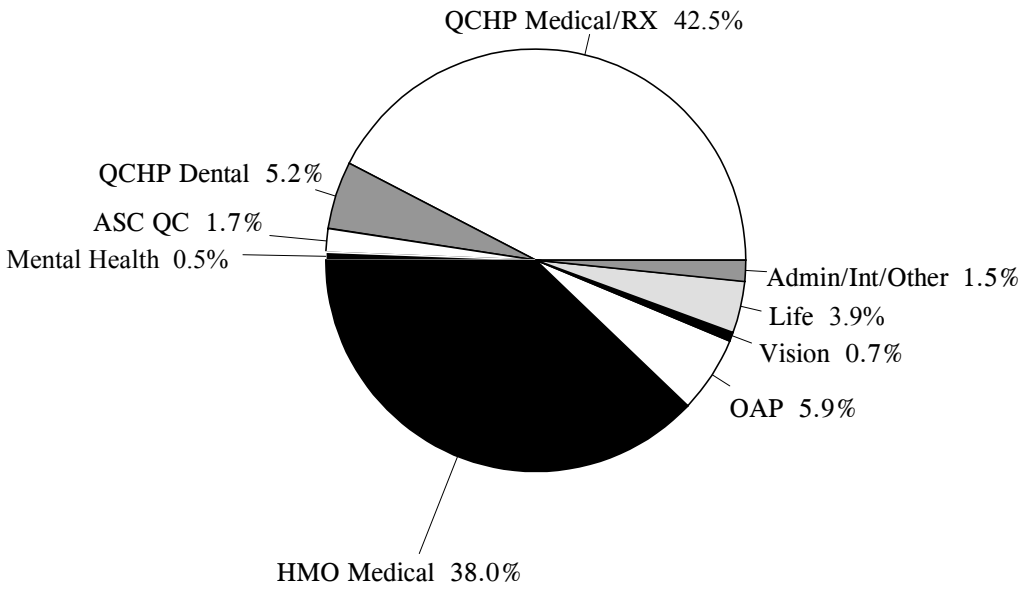
CHART 2



Retirees and their survivors (with less than 20 years of creditable service) are required to pay a portion of their health care costs (P.A. 90-0065). The remainder is paid by the State. The following chart includes the various components of the FY 2006 CMS liability estimate of $1,752.5 million. The largest component of the State Group Insurance Program is the indemnity plan, (Quality Care Health Plan) administered by CIGNA. The indemnity component (44.7%) includes medical/prescriptions, behavioral health coverage, and administrative service charges. Managed care plans (HMO and OAP) represent 43.9% of FY 2006 liability, while dental care, life insurance, vision care, and other charges comprise 11.4% of total liability.

CHART 3

GROUP INSURANCE COMPONENTS
FY 2006 Estimated Liability



CHANGES IN PLAN MEMBERSHIP FROM FY 2004 TO FY 2005

As of 7/23/04, the State Employees' Group Health Insurance Program saw 2.6% of its members (employees and retirees) changing their health carriers for the FY 2005 enrollment period. The indemnity plan experienced a 0.5% increase in membership, with 886 members migrating from managed care to the Quality Care Health Plan. Despite this overall increase in indemnity plan enrollment, 2,809 members moved from the indemnity plan to a managed care plan in FY 2005. In addition, 1,133 members went from one managed care plan to another.

Total enrollment (employees, retirees, and dependents) in the Quality Care Health Plan decreased 4.2% from 148,990 to 142,779. HMO plan membership increased from 178,723 to 180,982. Open Access Plan (managed care) membership increased 25.9% from 20,467 to 25,774.

The enrollment in the indemnity, HMO, OAP, and POS plans for FY 2004 and FY 2005 are shown in Table 6 below. **FY 2006 enrollment has been estimated by CMS, but is not included in Table 6 because the enrollment period has not occurred yet.**

TABLE 6: Average Annual Cost per Participant Average Enrollment				
	FY 2005	**FY 2004**	**FY 2005**	**FY 2004**
	Average Cost Per Participant*	Average Cost Per Participant*	Total Participants	Total Participants
Indemnity (QCHP)	$5,249	$4,660	142,779	148,990
HMO	$3,361	$3,052	180,982	178,723
OAP	$3,721	$3,322	25,774	20,467
		TOTAL:	**349,535**	**348,180**
OAP is the Health Link Open Access Plan. ACPP does not include dental, vision, admin/int/other, or life insurance.				

When comparing average cost per participant (ACPP) in Table 6, the average cost for FY 2005 is lowest for members in a HMO plan and highest for those in the indemnity plan. **The FY 2005 ACPP in the indemnity plan is approximately 41.1% higher than in the OAP plans, and 56.2% higher than the ACPP in the HMO plans. The average cost per enrollee in the indemnity plan is estimated to be $5,496 in FY 2006.**

The largest age group switching to a managed care plan from an indemnity plan in FY 2005 was the 0-39 age group. Predominately, the members joining a managed care plan tend to be under the age of 55. Persons in this age group typically include parents and their dependents. While dependent care coverage is less expensive in a managed care plan than in the indemnity plan, members over the age of 55 have shown a reluctance to switch to a managed care plan. These members have higher medical utilization and may fear being denied access to specialists. Members over the age of 55 may also be unwilling to change primary physicians. For members on Medicare, the coordination of benefits with a managed care plan may be confusing and/or disadvantageous.

MANAGED CARE PLANS

HMO-style plans differ from typical indemnity plans in several ways. Members are required 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 indemnity plans typically do not. However, the State's indemnity 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 indemnity plan are in accordance with the current collective bargaining agreement with the American Federation of State, County and Municipal Employees (AFSCME).

The Open Access Plan (Health Link), 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.

The plan with the largest enrollment is Health Alliance HMO, and the plan with the smallest is OSF Winnebago. Greater detail about FY 2004 and FY 2005 plan enrollment, as well as the areas served by each plan, is listed in Table 7 below.

It is believed that one of the best ways to control medical costs is to institute managed care plans, which closely control the use of medical services to keep costs down. The State has realized some cost savings from implementing managed care plans. The long-term effect on costs as a result of implementing managed care, however, remains to be seen.

TABLE 7: MANAGED CARE PLANS
FY 2004 – FY 2005 Actual Membership

HMO/POS	FY04 # of Participants thru Dec. FY04	FY05 # of Participants thru Dec. FY05	% CHG	Areas Served
Health Alliance HMO	74,125	75,409	1.7%	Downstate IL
Health Alliance IL	7,442	7,645	2.7%	DeKalb County & Western IL
HMO IL	47,251	48,279	2.2%	Chicago & Springfield areas
OSF Health Plans	10,035	10,065	0.3%	Northern & Central IL
Personal Care	24,352	24,182	-0.7%	Eastern & Central IL
Unicare HMO	13,569	13,480	-0.7%	Chicago area
OSF Winnebago	2,034	2,025	-.04%	Winnebago County
Health Link OAP	20,594	26,108	26.8%	Central & Southern IL
TOTAL Members + Dependents	**199,402**	**207,193**	**3.9%**	

As of July 1, 2004, 8 plans were available to employees and their dependents.

Much of the migration that took place during the FY 2005 enrollment period was due to HealthLink expanding their service into 36 new counties. Health Alliance also expanded into three additional counties. As identified in Table 6 above, HealthLink saw a substantial increase in enrollment (26.8%). HealthLink works in a similar fashion as the QCHP and has cheaper out-of–pocket expenses, and most of the new members that joined HealthLink OAP migrated from the QCHP.

MONTHLY PREMIUMS

Typically, members in managed care plans cost the State less since the risk of providing health care is assumed by the HMO. The indemnity plan continues to be the significantly more expensive plan.

According to the Department, the estimated monthly cost for a current employee in the Quality Care indemnity plan for FY 2005 is $529 and will increase to $564 (6.6%) in FY 2006.

The monthly premium for a current employee in a managed care plan varies based on each plan's rates, but the FY 2005 estimated average cost for a member in a managed care plan will be $359 per month. Until CMS completes negotiating rates with Managed Care providers, the Department is unable to calculate the average amount paid by each member for FY 2006.

In FY 1998, a new approach for negotiating premium rates with managed care vendors was utilized. Previously, premium rates were negotiated based on four rate tiers; member only, one dependent, two or more dependents, and Medicare dependent. In FY 1998 and FY 1999, multipliers based on historical claims and enrollment experience were used for each of the dependent rate tiers. Thus, only the employee rate is negotiated with each managed care provider, and then the appropriate multiplier is applied to that rate. Thus far, multipliers remain unchanged since FY 2001. CMS must wait for contract negotiations to take place before releasing the FY 2006 multiplier, below is the multipliers used for FY 2005.

FY 2006 Managed Care Multipliers

Current Employee	1.00
Medicare Retiree	.65
Non-Medicare Retiree	1.48
1 Dependent	.84
2+ Dependents	1.44
Medicare Dependent	.65

Under current law, the term of any contract (group life insurance, health benefits, other employee benefits, and administrative services) authorized under the State Employees' Group Insurance Act of 1971 (SEGIA) may not extend beyond 5 fiscal years. Upon recommendation of CGFA, the Director of CMS may exercise renewal options of the same contract for up to a period of 5 years. The State enters into contracts with the HMOs and pays them a dollar amount per individual enrolled in that particular HMO. The HMO then assumes the financial risk of providing services to its participants.

Table 8 shows the FY 2006 weighted average monthly rates for managed care plans and the indemnity plans, as well as the State and member contributions. The State's

contribution varies, depending on a member's salary. Some information is not yet available due to current negotiations with vendors.

TABLE 8: Monthly Premiums
Managed Care vs. Indemnity Plan
Weighted Average
FY 2006 Rates (Projected)

	QCHP			Managed Care		
Membership	TOTAL	Member	State	TOTAL	Member	State
Employee	**$564.67**	$53.91	$475.57	N/A	$34.10	N/A
Medicare Retiree	**$320.91**	$8.55	$314.91	N/A	$13.66	N/A
Non-Medicare Retiree	**$806.45**	$9.96	$747.35	N/A	$6.96	N/A
1 Dependent	**$612.39**	$162.00	$412.44	N/A	$72.21	N/A
2+ Dependents	**$757.26**	$192.00	$514.37	N/A	$110.31	N/A
Medicare Dependent	**$344.95**	$108.00	$240.71	N/A	$68.12	N/A

N/A: Managed Care contracts are currently being negotiated by CMS and total premiums have yet to be determined.

TABLE 9: Projected Costs
FY 2003 – FY 2006
Employee Only

	QCHP				Managed Care			
	TOTAL	% Increase	Member	**State**	TOTAL	% Increase	Member	State
FY 2003	$413.84		$40.54	$387.12	$280.31		$31.41	$248.90
FY 2004	$472.49	14.17%	$43.61	446.86	$322.53	15.06%	$33.48	$288.70
FY 2005	$529.48	12.06%	$43.91	$498.74	$358.53	11.16%	$33.76	$333.48
FY 2006	$564.67	6.64%	$53.91	$475.57	N/A	N/A	$34.18	N/A

N/A: Managed Care contracts are currently being negotiated by CMS and total premiums have yet to be determined.

CGFA estimate of group insurance liability for FY 2006 reflects a continued trend in prescription drug costs. Noteworthy trends used to estimate the growth in liability from FY 2005 to FY 2006 include the following:

- Prescription drug (QCHP) 6.56%
- HMO Medical/Rx 10.44%
- QC Medical 7.05%

APPENDIX I

STATE EMPLOYEES' GROUP INSURANCE OVERSIGHT CHANGES

One of the several statutory changes for the CGFA contained in 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 the Department of Central Management Services 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 conditions, 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 (CGFA) 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 the Department of Central Management Services 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.

APPENDIX II

TYPES OF MEDICAL & DENTAL GROUP INSURANCE PLANS

Type of Plan	Coverage	Characteristics	Geographic Location
Indemnity 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.
Indemnity Dental	Preventive, diagnostic, restorative, orthodontic, endodontic, and periodontic services as well as extractions and prosthetics.	Choice of dental care providers, reimbursement on a scheduled basis. No deductibles. Premiums for members and dependents.	No limitations.
HMO Medical	Comprehensive medical benefits including preventive care.	Prepaid benefits, primary care physician who coordinates all care chosen from HMO network. Co-payments vary by HMO plan. Employee premiums, based on salary, vary for dependents by plan.	Statewide coverage
OAP	Comprehensive medical benefits including preventive care.	Three tiers of benefit levels. Patients may see specialists without referral from the primary care physician. Co-payment levels vary.	Southern Illinois, St. Louis Metro-East area.

APPENDIX III

Group Insurance Contracts to be Awarded or Renewed for FY 2006		
Contract	Type of Contract	Renewal/Competitively Selected
Medco*	Rx benefit administrator (QCHP members)	Awarded Competitively selected
CIGNA	Claims administrator for health care benefits (QCHP members)	Multi-Year
CompDent (2)	Dental (QCHP and managed care members)	Multi-year
Fringe Benefit Management Company	Flexible Spending Administrator	Multi-year
Intracorp	Utilization review administrator (QCHP members)	Multi-Year
Magellan Behavioral Health	Mental health/substance abuse services (QCHP members)	Multi-year
Medical Cost Management	Peer review	Multi-year
Minnesota Life Insurance Company	Term life insurance	Multi-year
Primax	Subrogation	Multi-Year
Sykes Health Plan Services	Hospital bill auditing	Multi-Year
Vision Service Plan	Vision care (all members)	Competitively selected
Wage Works	Qualified Transportation Benefit Administrator	Multi-Year

*CGFA has not received a copy of this contract. Therefore, the 30-day review process (P.A 93-0839) has not started.

Managed Care Contracts thru FY 2006		
Health Alliance HMO		In initial term/Amended
Health Alliance Illinois		In initial term/Amended
Health Link OAP		In initial term/Amended
HMO Illinois		In initial term/Amended
OSF Health Plan		In initial term/Amended
OSF Winnebago		In initial term/Amended
Personal Care		In initial term/Amended
Unicare HMO		In initial term/Amended

BACKGROUND

The Commission on Government Forecasting and Accountability (CGFA), a bipartisan, joint legislative commission, provides the General Assembly with information relevant to the Illinois economy, taxes and other sources of revenue and debt obligations of the State. The Commission's specific responsibilities include:

1) Preparation of annual revenue estimates with periodic updates;
2) Analysis of the fiscal impact of revenue bills;
3) Preparation of "State Debt Impact Notes" on legislation which would appropriate bond funds or increase bond authorization;
4) Periodic assessment of capital facility plans;
5) Annual estimates of public pension funding requirements and preparation of pension impact notes;
6) Annual estimates of the liabilities of the State's group health insurance program and approval of contract renewals promulgated by the Department of Central Management Services;
7) Administration of the State Facility Closure Act.

The Commission also has a mandate to report to the General Assembly ". . . on economic trends in relation to long-range planning and budgeting; and to study and make such recommendations as it deems appropriate on local and regional economic and fiscal policies and on federal fiscal policy as it may affect Illinois. . . ." This results in several reports on various economic issues throughout the year.

The Commission publishes several reports each year. In addition to a Monthly Briefing, the Commission publishes the "Revenue Estimate and Economic Outlook" which describes and projects economic conditions and their impact on State revenues. The "Illinois Bond Watcher" report examines the State's debt position as well as other issues directly related to conditions in the financial markets. The "Financial Conditions of the Illinois Public Retirement Systems" provides an overview of the funding condition of the State's retirement systems. Also published are an Annual Fiscal Year Budget Summary; Report on the Liabilities of the State Employees' Group Insurance Program; and Report of the Cost and Savings of the State Employees' Early Retirement Incentive Program. The Commission also publishes each year special topic reports that have or could have an impact on the economic well being of Illinois. All reports are available on the Commission's website.

These reports are available from:

Commission on Government Forecasting and Accountability
703 Stratton Office Building
Springfield, Illinois 62706
(217) 782-5320
(217) 782-3513 (FAX)

http://www.ilga.gov/commission/cgfa/cgfa_home.html