State Employees Group Insurance Program Projected FY 2011 Liabilities Report

Commission on Government Forecasting & Accountability
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FY 2011 Liabilities of the State Employee's Group Insurance Program

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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 the Department of Healthcare and Family Services (HFS) to advise the departments on all matters relating to policy and administration of the Group Insurance Act.
- To review and approve contracts recommended by the Director of HFS related to the Group Insurance Program.

The Governor has requested that a total of $2,224.0 million be appropriated for the State Employees' Group Health and Life Insurance program for FY 2011. The requested FY 2010 appropriation request for the Group Health Insurance Program was $2,163.3 million. The following table represents historical appropriation and liability amounts, per HFS. The CGFA FY 2011 estimate of liability is $2,337.5 million, $93.0 million more than HFS.

Currently, the payment cycle for preferred providers is 203 days, while non-preferred providers have a payment cycle of 231 days. The current amount of CIGNA claims being held is $335 million. DHFS has increased the amount of time it takes to make payments to managed care providers (HMO's) by 3.5 months. The value of what is currently being held for managed care providers is approximately $357 million. Dental claims, Rx claims, administrative service charges, and vision premiums are being paid in 112 days.

The FY 2011 estimated liability for the Quality Care Health Plan (QCHP) is expected to decrease -0.26% over the FY 2010 liability. The estimated liabilities for the State's managed care plans are expected to increase 3.9% over the FY 2010 cost. In comparison, the FY 2010 liability for the QCHP increased 2.6% over the FY 2009 cost. FY 2010 liability for the managed care plans increased 7.3% over FY 2009. The Department also projects prescription drug liability to increase 1.5% from $202.1 million to $205.1 million.

APPROPRIATION AND LIABILITY HISTORY
FY 2006-2011
($ in Millions)

Fiscal Year	Appropriation	HFS Liability	CGFA Liability
FY 2006	$1,779.8	$1,702.4	
FY 2007	$1,884.9	$1,790.6	
FY 2008	$1,983.0	$1,897.2	
FY 2009	$1,991.6	$2,043.8	
FY 2010	$2,163.3	$2,184.5	
FY 2011	$2,224.0	$2,244.4	$2,337.5

*Estimated

FY 2011 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) FY 2011 cost projection utilizes the HFS revised estimate for FY 2010 medical claims as the basis for estimating claims for FY 2011.

The CGFA cost estimate for FY 2011 uses the following assumptions based on historical claims data and anticipated cost increases:

TREND FACTORS	
Medical (QCHP plan)	4.72%
Dental (QCHP and MC)	12.36%
HMO (medical and Rx)	8.02%
Prescription drugs (QCHP)	7.51%
Administrative service charges (QCHP)	1.86%
Life insurance	5.01%
Special programs (QCHP)	-21.43%

The medical trend inflation factor consists of several components. These include inflation; leveraging (the reduced impact of level deductibles and coinsurance 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 QCHP; technological advances; social shifts including the aging population and greater acceptance of psychiatric and substance abuse care; and, increased utilization of equipment and services.

The Segal Company compiles a cost trend survey annually that gives data as to how large health plans are trending during the plan year. The following are some of the key findings of the Segal study.

- Projected prescription drug trends, which remain under 10 percent for the second consecutive year, continue to decline.
- In 2010, medical plan projections for most managed care plans are similar to those found in 2009, ranging from 10.2 percent to 10.8 percent. In contrast, high-deductible health plans are projected to increase by just over one percentage point to 11.9 percent.
- Forecasted Medicare medical plan trend rates for retirees age 65 and older are expected to increase, but are still projected to be lower than comparable medical plan trend rates for active participants and early retirees.
- The lowest trend rates are expected in the Midwest, and the highest trend rates are expected in the Northeast for preferred provider organizations and point-of-service plans combined.

- Inpatient hospital claim trend rates are expected to exceed both prescription drug and physician services claim trends in 2010.
- For 2010, dental QCHP plans and dental provider organization plans are expected to decrease over 2009 trend levels.

Table 1 below highlights national trending data and compares it to estimates by HFS and CGFA.

TABLE 1

NATIONAL HEALTH CARE TRENDING 2010

Component	National Trend	HFS Increase	COGFA Increase
PPO's	10.3%	-0.26%	4.72%
HMO's	10.0%	3.86%	8.02%
Rx	9.8%	1.48%	7.51%
Dental	5.6%	12.36%	12.36%
Vision	3.7%	0.0%	0.0%

Source: Segal 2010 Health Plan Cost Trend Survey

Although there is usually a strong correlation between trend rates and actual costs, trend and the net annual change in plan costs are not the same. Trend rates allow the Commission to benchmark health plan components to analyze and estimate claims data. Changes in the costs to plan sponsors can be very different from projected cost trends. Such factors as program design changes, employee contribution rate increases, and group demographics can significantly influence total costs.

Based on these assumptions and inflation factors, the CGFA estimates a FY 2011 liability of approximately $2,337.5 million for the State Employee's Group Health Insurance Program. The table on the following page shows a detailed comparison of the CGFA estimate for the various cost components and the HFS projection for FY 2011.

TABLE 2: FY 2011 GROUP HEALTH INSURANCE LIABILITY			
	($ in Millions)		
Liability Component	FY 2010 HFS Estimate	FY 2011 HFS Estimate	FY 2011 CGFA Estimate
QCHP Medical	$541.5	$540.1	$567.1
QCHP Prescriptions	$202.1	$205.1	$217.3
Dental (QCHP/MC)	$110.8	$124.5	$124.5
HMO	$905.3	$940.2	$977.9
Open Access Plan	$240.9	$262.7	$272.7
POS	$0.0	$0.0	$0.0
Mental Health	$10.6	$10.4	$10.4
Vision	$8.3	$8.3	$8.3
Administrative Services (QCHP)	$32.2	$32.8	$32.8
Life	$83.9	$88.1	$88.1
Special Programs (Admin/Int/Other)	$48.9	$32.3	$38.4
TOTAL	**$2,184.5**	**$2,244.5**	**$2,337.5**
% increase over prior year		2.7%	7.0%
Rounding may cause slight differences			

ESTIMATE COMPARISON

Overall, the Commission's FY 2011 estimate is $93.0 million higher than the FY 2011 estimate from HFS. CGFA's FY 2011 HMO liability estimate is $37.7 million higher than HFS, CGFA's QCHP medical estimate is $27.0 million than HFS, and CGFA's dental estimate is the same as HFS. CGFA's FY 2011 estimate for prescriptions is $12.2 million higher than the HFS estimate.

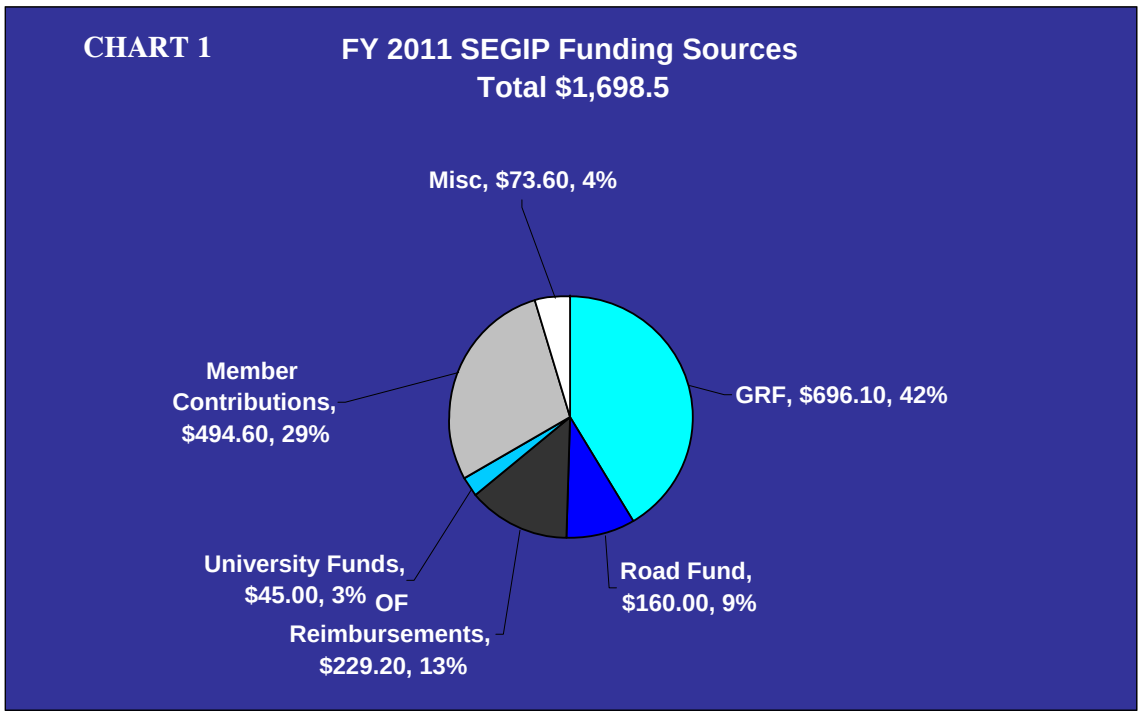
The CGFA estimates approximately $2,337.5 million would be required to fully fund the FY 2011 liabilities of the Group Health Insurance Program. This estimate is $153.0 million or 7.0% more than the FY 2010 estimated liability of $2,184.5 million.

APPROPRIATION/FUNDING SOURCES

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

HIRF is the fund mainly used to administer the group insurance program. 5 ILCS 375/13.1 states "All contributions, appropriations, interest, and other dividend payments to fund the program of health benefits shall be deposited into the Health

Insurance Reserve Fund. Funding for HIRF comes from several different revenue sources, the General Revenue Fund (GRF), Road Fund, reimbursements, university funds, and misc funds. Estimated cash flow into HIRF for FY 2011 is $1.698.5 billion. A breakdown in the various funding sources is shown in the pie chart below.



The FY 2011 budget request for the Group Health Insurance Program is $696.1 million in GRF funds. This represents a -$328.8 million or a -32.1% decrease from the FY 2010 GRF appropriation of $1,024.8 million. The estimated FY 2011 Road Fund request of $160 million is $9.8 million or 6.5% higher than the FY 2010 appropriation level.

TABLE 3: GROUP INSURANCE FUNDING SOURCES FY 2010 – FY 2011 ($ in Millions)				
	FY 2010	FY 2011	$ Change	% Change
DHFS GRF Appropriation	$1,024.8	$696.1	$(328.8)	(32.1)%
Road	$150.2	$160.0	$9.8	6.5%
University Cont.	$45.0	$45.0	$0.0	0.0%
Member Cont.	$327.5	$494.6	$167.1	51.0%
Other Funds	$260.3	$229.2	$(31.1)	(11.9)%
Rebates/Interest/Med D	$69.0	$73.6	$4.6	6.6%
TOTAL Appropriations	**$1,876.8**	**$1,698.5**	**$(178.3)**	**(9.5)%**
Source: HFS				

HFS 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 FY 2011, the GIPF target balance is $4 million, and the target HIRF balance is $6 million.

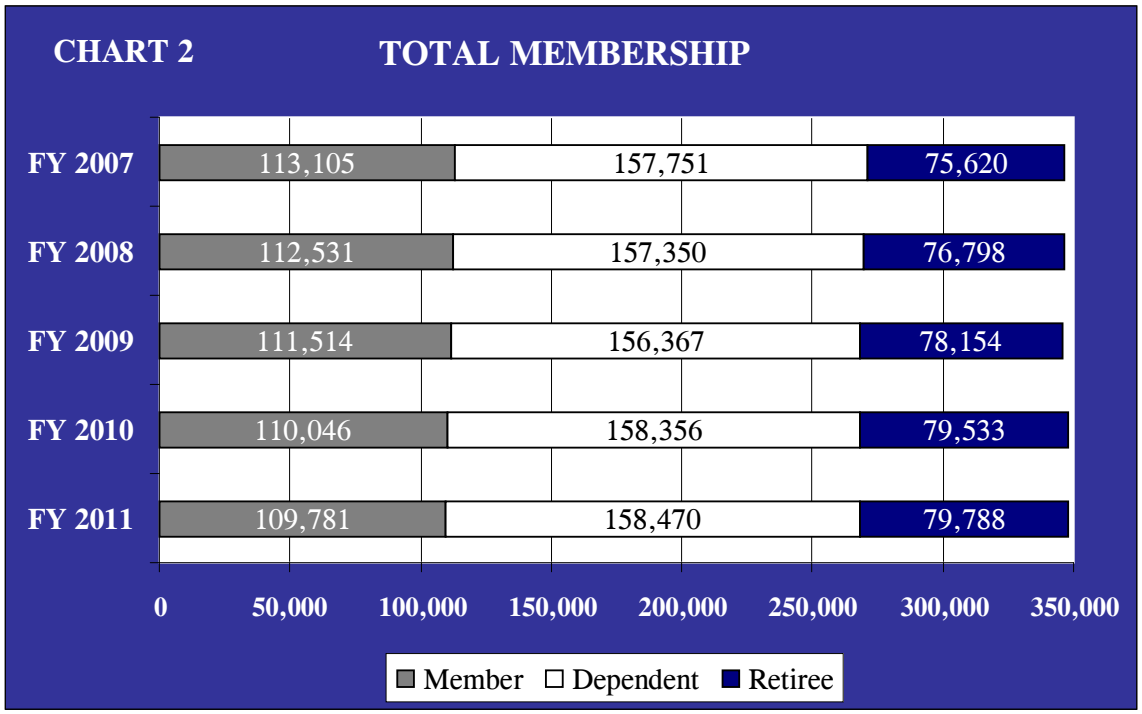
BENEFITS

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

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

MEMBERSHIP

The State Employees' Group Health Insurance Program currently has an estimated 347,935 participants, of which 227,090 are in managed care, and 120,845 are in the Quality Care Health Plan. The QCHP is estimated to have 25,299 employees; 39,672 dependents; and 54,566 retirees in FY 2011. Managed care plans are estimated to have 84,552 employees; 118,798 dependents; and 25,222 retirees in FY 2011. Membership in the Group Health Insurance Plan is projected to increase slightly in FY 2011, as evidenced in Chart 2 below.



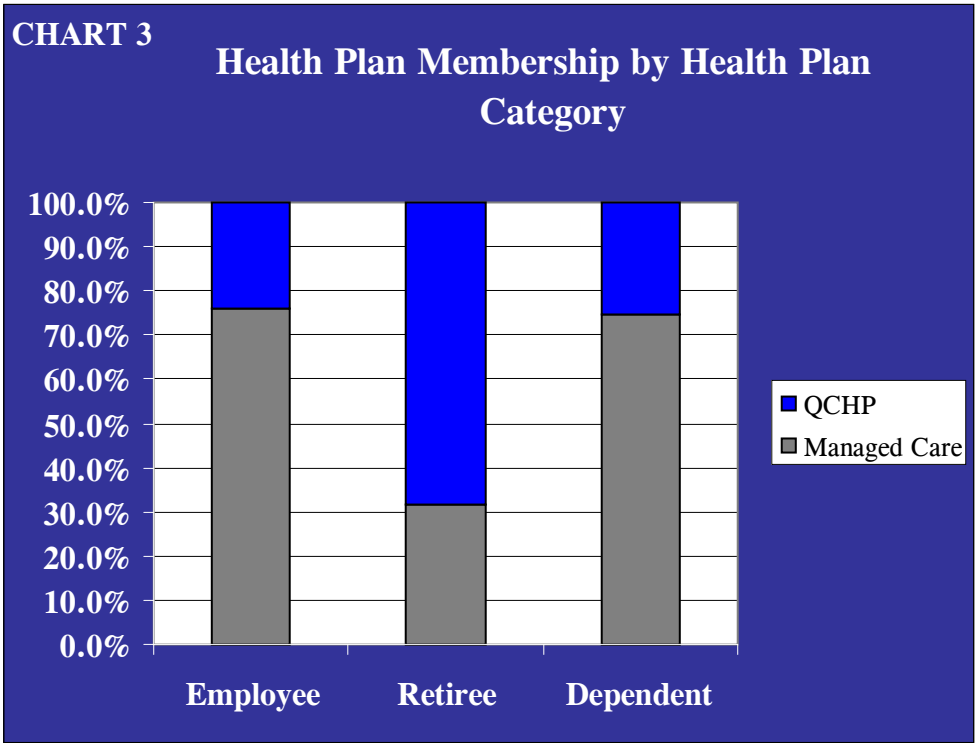
- **Membership is estimated for FY 2010 and FY 2011.**

ENROLLMENT TRENDS

Membership in the group insurance program is expected to increase very slightly in FY 2011, adding only 104 members. Membership in the Quality Care Plan has been decreasing since FY 2005, HFS estimates that QCHP membership will decline -1.1% from 120,845 in FY 2010 to an estimated 119,467 in FY 2011. Membership in the States' managed care offerings has been increasing since FY 2004. Membership enrollment in managed care will increase 0.5% in FY 2011, going from 185,817 to 186,669. The State also offers an Open Access Plan. Membership in the OAP is expected to increase in FY 2011 by 1.5%.

Chart 3, on the following page, shows the breakdown of employee, dependant and retiree enrollment in the overall group insurance program. The QCHP continues to be the most popular plan for retirees. Retirees favor the QCHP because of provider access

and other issues. In FY 2010, 68.4% of retirees were enrolled in the QCHP. Chart 3 shows that while retirees overwhelmingly choose the QCHP, dependents and employees prefer managed care.



LIABILITY

The Department's estimate of liability for FY 2011 represents a 2.7% growth rate over FY 2010. This increase in estimated liability is lower than the increase from FY 2009 to FY 2010, when liability increased 6.9%. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2002 through FY 2011.

Table 4 demonstrates how several components make up for the majority of the State's total liability. Historically, the Quality Care Health Plan, Prescription Drugs, and HMO's have made up the largest segment of total liability. The dental plan and the Open Access Plan also are larger components of the total insurance obligation.

TABLE 4 STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY
FY 2002-FY 2011
$ in (millions)

Liability Component	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
QCHP Medical/Rx	$561.9	$584.0	$663.5	$697.8	$690.8	$695.5	$694.5	$732.6	$743.6	$745.2
HMO Medical	$402.1	$469.3	$539.9	$597.5	$655.0	$711.8	$780.8	$843.4	$905.3	$940.2
Dental	$58.7	$63.7	$69.9	$88.9	$84.9	$95.6	$102.3	$108.6	$110.8	$124.5
POS	$7.6	$8.6	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Open Access Plan	$36.8	$54.9	$62.9	$81.6	$102.8	$154.0	$178.3	$212.8	$240.9	$262.7
QC Mental Health	$9.3	$9.2	$9.5	$9.2	$8.9	$8.8	$8.6	$8.3	$10.6	$10.4
Vision	$10.9	$11.2	$11.5	$11.7	$8.2	$8.2	$8.2	$8.2	$8.3	$8.3
Life Insurance	$61.7	$63.6	$66.8	$69.3	$76.1	$75.8	$78.4	$80.9	$84.2	$88.1
QC ASC	$19.6	$24.4	$23.2	$24.0	$29.4	$27.9	$29.6	$30.8	$32.2	$32.8
Admin/Int/Other	$11.8	$14.3	$31.8	$38.5	$33.8	$33.6	$16.3	$18.2	$48.9	$32.3
Total	**$1,180.4**	**$1,303.2**	**$1,479.0**	**$1,618.5**	**$1,689.9**	**$1,811.2**	**$1,897.0**	**$2,043.5**	**$2,184.8**	**$2,244.5**
% change over py		10.40%	13.49%	9.43%	4.41%	7.18%	4.74%	7.74%	6.90%	2.74%

Rounding causes slight differences in 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 4 shows the steady increase each year in cost per participant. This increase can be attributed to medical inflation as evidenced in Table 4. In FY 2003, the annual cost per participant in the group health insurance program was $3,735. **According to HFS, the estimated cost per participant for FY 2011 is $6,449, a 72.7% increase from the FY 2003 cost per participant**. The cost per participant increased 6.3% from FY 2009 to FY 2010. The FY 2011 cost per participant is estimated to increase 2.7% over FY 2010.

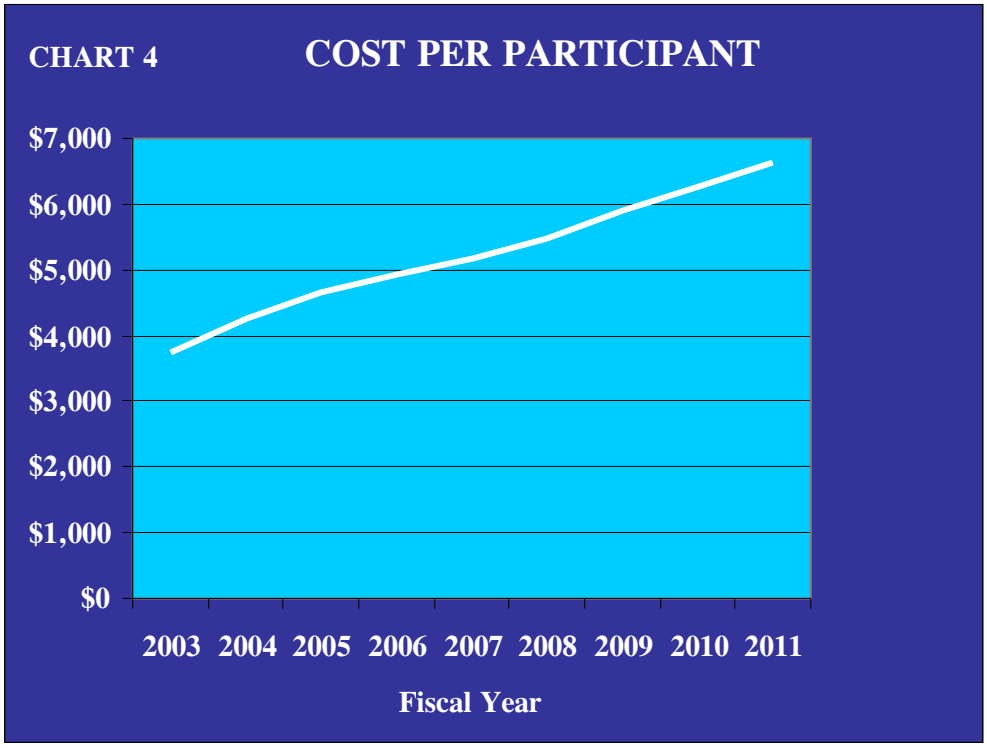


TABLE 5: AVERAGE ANNUAL COST PER PARTICIPANT				
	FY 2011 Average Cost Per Participant	FY 2010 Average Cost Per Participant	FY 2011 Total Participants	FY 2010 Total Participants
QCHP	$6,576	$6,486	119,467	120,845
HMO	$5,037	$4,872	186,669	185,817
OAP	$6,270	$5,837	41,903	41,273
			348,039	347,935
• OAP 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 5, the average cost for FY 2011 is lowest for members in a HMO plan and highest for those in the PPO. **The FY 2011 ACPP in the QCHP is approximately 30.6% higher than managed care. The average cost per enrollee in the QCHP is estimated to be $6,576 in FY 2011.**

MEMBER CONTRIBUTIONS

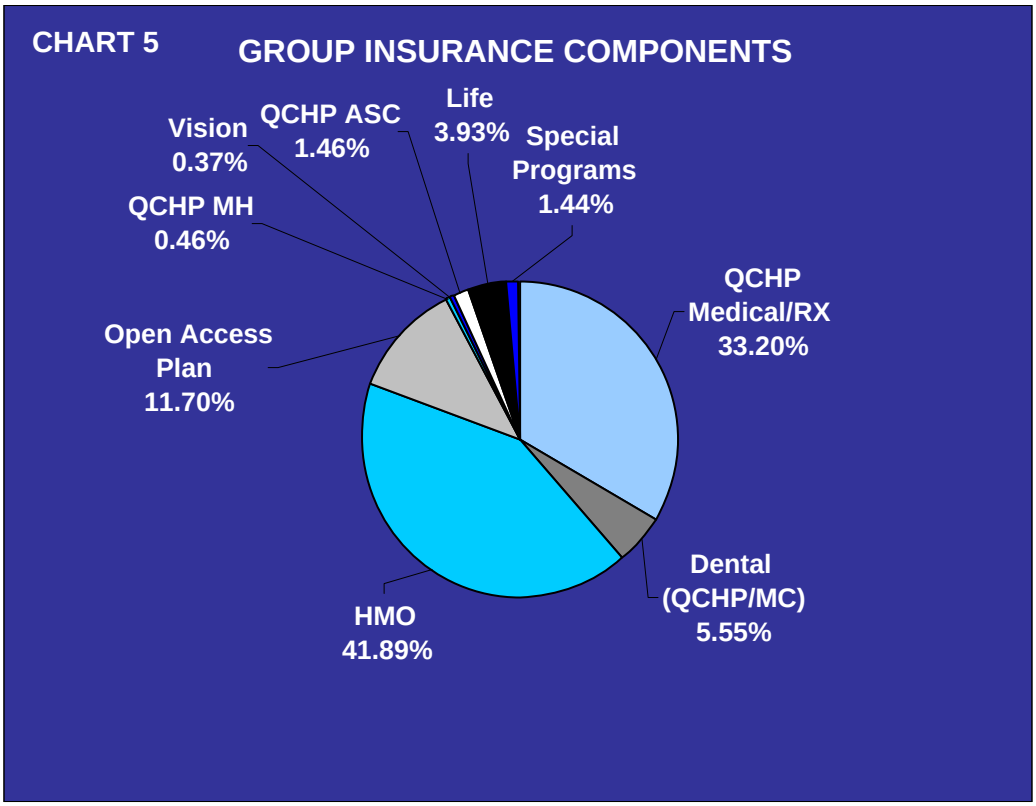
An important factor in the examination of cost per participant is the amount paid by the State versus the member. The ACPP per enrollee in the QCHP is $6,486 in FY 2010. Total member contributions for QCHP enrollees totaled $96.8 million. This means that of the total cost per participant ($6,486), $801 of that cost is covered by member contributions. Table 6 below examines the relationship between overall cost, and the offset by member contributions.

TABLE 6	MEMBER CONTRIBUTIONS AND ACPP			
	FY 2010 Average cost per participant	FY 2010 Member Contributions	Member contribution per year	State cost minus member contributions
QCHP	$6,486	$96,769,944	$801	$5,685
HMO + OAP	$5,047	$148,284,345	$653	$4,394
Dental	$331	$29,347,855	$86	$245
Source: HFS				

The table above shows that QCHP members contribute approximately 12.3% of the overall annual cost of providing their insurance. HMO members contribute 12.9% of the overall liability cost. Members that participate in the State's dental offering pay 25.9% percent of the overall liability cost.

Retirees and their survivors (with less than 20 years of creditable service) are required to pay a portion of their health care costs (P.A. 90-0065). The remainder is paid by the State. The following chart includes the various components of the FY 2011 HFS liability estimate of $2,244.5 million. The largest component of the State Group

Insurance Program is the State's managed care plans (HMO and OAP) which represent (53.6%) of FY 2011 liability, while dental care, life insurance, vision care, and other charges comprise (10.8%) of total liability. The QCHP component (35.6%) includes medical/prescriptions, mental health coverage, and administrative service charges.



CHANGES IN PLAN MEMBERSHIP FROM FY 2009 TO FY 2010

As of 08/07/2009, the State Employees' Group Health Insurance Program saw .95 % of its members (employees and retirees) changing their health carriers for the FY 2010 enrollment period. The QCHP experienced a -1.69% decrease in membership, with 1,633 members migrating from the QCHP to a managed care plan. Despite the overall decrease in QCHP enrollment, 536 managed care participants moved to the QCHP. In addition, 1,792 members went from one managed care plan to another.

The largest age group switching to a managed care plan from the QCHP in FY 2010 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 QCHP, 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 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).

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 Humana Winnebago. Greater detail about FY 2009 and FY 2010 plan enrollment is listed in Table 7 below.

TABLE 7 MANAGED CARE PLANS
FY 2009-2010 Actual Membership

HMO/OAP	FY09 # of Participants	FY10 # of Participants	% Change
Health Alliance HMO	77,998	78,651	0.84%
Health Alliance Illinois	7,931	7,991	0.76%
HMO Illinois	49,796	51,003	2.42%
Humana of Illinois	10,232	10,254	0.22%
Personal Care	25,286	25,934	2.56%
Unicare HMO	11,128	11,143	0,13%
Humana Winnebago	1,640	1,616	-1.46%
Health Link OAP	38,734	40,759	5.23%
TOTALS	**222,745**	**227,351**	**0.43%**

Source: HFS

MONTHLY PREMIUMS

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. The QCHP continues to be more expensive than HMO's.

According to the Department, the estimated monthly cost for a current employee in the QCHP for FY 2010 is $721.28 and will increase to $728.76 (1.0%) in FY 2011.

The monthly premium for a current employee in a managed care plan varies based on each plan's rates, but the FY 2011 estimated average cost for a member in a managed care plan will be $555.69 per month.

According to the Governor's FY 2011 budget book, the maximum subsidy the State would pay for retiree health premiums in FY 2011 would be $300 a month. Currently, the full monthly rate for a non-Medicare retiree in the QCHP is $804.43, and $590.54 monthly for a non-Medicare retiree in an HMO. This recommended change would result in QCHP non-Medicare retirees, currently being subsidized the entire cost of coverage, to pay $504.43 per month for their health care premium, or $6,053 per year. Likewise, an HMO non-Medicare retiree would pay $290.54 per month, or $3,486 per year. Currently, a non-Medicare retiree in the QCHP pays $14.00 a month on average. This change would represent a $490.43 increase in monthly premium, or a 3,403% increase. HMO non-medicare retirees would see premiums increase on average $277.87, or 2,193%. Numbers in the above paragraph are different than those shown in Table 8. HFS used a different methodology to calculate the rates for the retiree numbers given above.

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.

FY 2011 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 (SEGIA) may not extend beyond 5 fiscal years. Upon recommendation of CGFA, the Director of CMS or HFS 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 2011 weighted average monthly rates for managed care plans and the QCHP plans, as well as the State and member contributions. The State's contribution varies, depending on a member's salary.

TABLE 8: MONTHLY PREMIUMS
Managed Care vs. Indemnity Plan
Weighted Average
FY 2011 Rates (Projected)

	QCHP			Managed Care		
Membership	TOTAL	Member	State	TOTAL	Member	State
Employee	$ 728.76	$ 89.32	$ 639.44	$ 555.69	$ 59.59	$ 496.10
Medicare Retiree	$ 347.69	$ 56.37	$ 291.32	$ 303.88	$ 20.90	$ 282.98
Non-Medicare Retiree	$ 962.67	$ 518.43	$ 444.24	$ 819.57	$ 303.21	$ 516.36
1 Dependent	$ 729.68	$ 308.00	$ 421.68	$ 465.92	$ 110.82	$ 355.10
2+ Dependents	$ 968.07	$ 305.03	$ 663.04	$ 802.15	$ 150.26	$ 651.89
Medicare Dependent	$ 360.24	$ 60.51	$ 299.73	$ 309.39	$ 61.29	$ 248.10

TABLE 9: PROJECTED COSTS
FY 2005 – FY 2011
Employee Only

	QCHP				Managed Care			
	TOTAL	% Increase	Member	State	TOTAL	% Increase	Member	State
FY 2005	$ 538.72		$ 48.59	$ 490.13	$ 362.40		$ 36.85	$ 325.55
FY 2006	$ 578.72	7.43%	$ 60.10	$ 518.62	$ 394.98	8.99%	$ 37.29	$ 357.69
FY 2007	$ 599.79	3.64%	$ 68.93	$ 530.86	$ 421.16	6.63%	$ 41.60	$ 379.56
FY 2008	$ 617.02	2.87%	$ 75.41	$ 541.61	$ 457.80	8.70%	$ 45.71	$ 412.09
FY 2009	$ 669.96	8.58%	$ 79.16	$ 590.80	$ 497.62	8.70%	$ 49.45	$ 448.17
FY 2010	$ 721.28	7.66%	$ 89.41	$ 631.87	$ 540.21	8.56%	$ 59.62	$ 480.59
FY 2011	$ 728.76	1.04%	$ 89.32	$ 639.44	$ 555.69	2.87%	$ 59.59	$ 496.10

TABLE 10: EMPLOYEE MONTHLY PREMIUM COMPARISON				
State	State Share	Employee Share	Total	Employee %
IL	**$412.13**	**$45.71**	**$457.84**	**11.09%**
CA	$382.00	$90.00	$472.00	23.56%
IN	$349.68	$66.06	$415.74	18.89%
IA	$398.49	$0.00	$398.49	0.00%
MO	$445.00	$31.00	$476.00	6.97%
NY	$343.41	$38.12	$381.53	11.10%
OH	$277.46	$49.38	$326.84	17.80%
TX	$360.54	$0.00	$360.54	0.00%
WI	$477.50	$31.00	$508.50	6.49%
Source: NCSL (Employee Only CY 2009)				

Illinois compares fairly well with other states when it comes to health insurance costs. In this multi-state comparison done by NCSL, Illinois has the 3rd highest cost for individual employee health coverage, behind Wisconsin and Missouri. Four state's, (CA, IN, OH, NY) require State employees to pay a higher portion of the overall premium. Texas and Iowa do not require employees to pay any portion for individual coverage.

APPENDIX I

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 and DHS 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 dependants.
- 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 Economic and Fiscal Commission are listed below:

- By April 1st of each year, the Director (CMS/DHS) 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/DHS) must provide updated, and any new information to the Commission until the employee benefits program for the fiscal year has been determined.
- Requires CMS/DHS 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/DHS 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
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. 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

Contracts to be bid or renewed for FY 11 at DHFS	
Service	**Vendor**
Managed Care Health Plans **(HMO Contracts must be bid in FY 2011 for the FY 2012 plan year)**	Health Alliance HMO Health Alliance Illinois OSF Winnebago OSF Health Plans Personal Care Healthlink OAP HMO Illinois
Prescription Benefit Manager (PBM) for self-funded plans **(Initial term ends June 30, 2010. Department can exercise up to 5-one year renewals.)**	Medco
Vision **(Initial term ends June 30, 2010. Department can exercise up to 5-one year renewals.)**	EyeMed
Behavioral Health/EAP	Magellan
Dental **(Entering last year of renewal options. Must be bid in FY 2011 for the FY 2012 plan year."**	CompDent
Hospital Bill Audit	SHPS
Subrogation	ACS
Peer Review	CIMRO
Flu Shots	Varies each plan year
Consulting Contracts	Willis of Illinois Blalock Consulting Mercer Consulting Fairbanks

Contract to be bid or renewed for FY 11 at DCMS	
Service	**Vendor**
Life Insurance	Minnesota Life
Long Term Care	Metropolitan Life
Flexible Spending	FBMC
Commuter Savings Program	FBMC

BACKGROUND

The Commission on Government Forecasting and Accountability, 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; and

5) 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.

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 two primary reports. The "Revenue Estimate and Economic Outlook" describes and projects economic conditions and their impact on State revenues. "The Illinois Bond Watcher" examines the State's debt position as well as other issues directly related to conditions in the financial markets. The Commission also periodically publishes special topic reports that have or could have an impact on the economic well being of Illinois.

These reports are available from:

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

Reports can also be accessed from our Webpage:

http://www.legis.state.il.us/commission/ecfisc/ecfisc_home.html