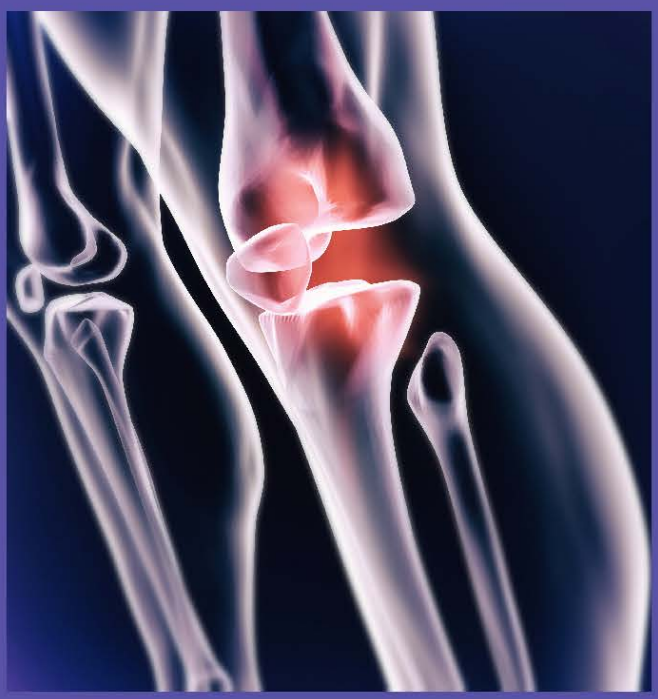
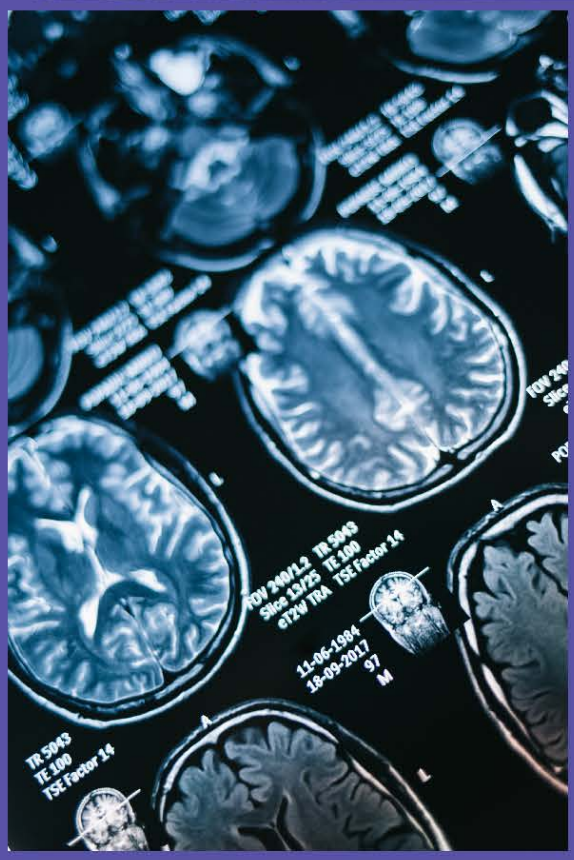
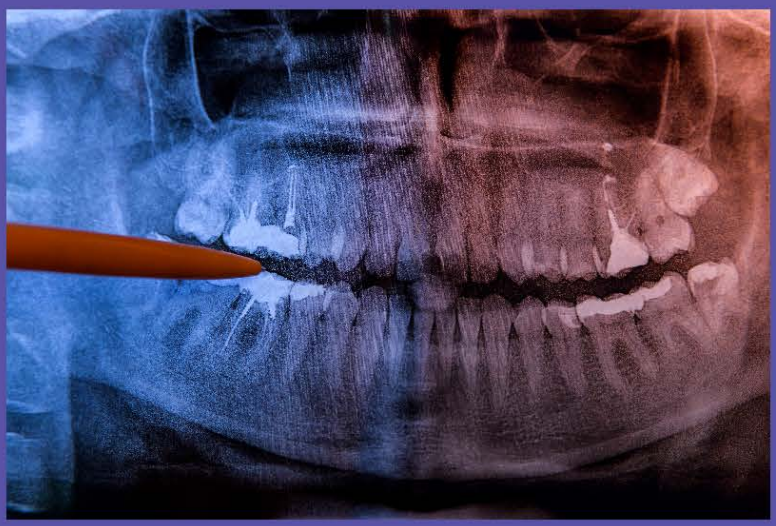
FY 2020 LIABILITIES OF THE STATE EMPLOYEES' GROUP HEALTH INSURANCE PROGRAM







COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

MARCH 2018

Commission on Government Forecasting and Accountability

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TABLE OF CONTENTS

FY 2020 State Employees' Group Insurance Report
March, 2019

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 liabilities of the State Employees' Group Health Insurance Program.
- To meet with the Department of Central Management Services (CMS) to advise the department on all matters relating to policy and administration of the Group Insurance Act.
- To review contracts recommended by the Director of CMS related to the Group Insurance Program.
- To give "advice and consent" when CMS determines it would be in the best interest of the State and employees to administer benefits with the State as a self-insurer.

CMS has provided information for the 2020 fiscal year indicating a continuation of the existing contracts in place as well as standard rate increases for group insurance participants. This is in contrast to the past few recent fiscal years, where an alternate plan was proposed to significantly increase employee contributions along with instituting a series of graduated tiers for health insurance coverage. Existing funding, contribution, and plan design components are largely unchanged.

According to CMS, for the 2020 fiscal year, the GRF appropriation is projected to be $2.028 billion for SEGIP, with total expected revenues projected at approximately $3.002 billion. CMS estimates the FY 2020 liability to be $3.105 billion, which is a 2.7% increase from the FY 2019 anticipated final liability of $3.023 billion. Noting these predictions, the Commission has presumed that liabilities and revenues will follow trends from FY 2019 and previous fiscal years and estimates a total SEGIP liability of $3.130 billion in FY 2020, $25.4 million more than CMS.

The FY 2019 and FY 2020 fiscal years have a number of noteworthy revenue and expenditure components. The revenue factors include bond revenues and increased contributions from the Road Fund. Liability changes include a significant reduction in projected Timely and Prompt Payment Interest and rising liability pressure from expenses incurred from a separate health insurance agreement negotiated by the previous administration with the Teamsters. These issues of revenue and liability will be discussed later in this report.

Finally, due in part to the stabilizing of revenues and expenditures into the SEGIP, projected hold times and delays in processing payments to healthcare vendors and insurance companies are expected to remain in line with FY 2019 timeframes. Most self-insured vendors are projected to have an approximate hold time of three months on their bills while the QCHP and OAP are projected to have hold times of 77 and 79 days respectively.

GRF APPROPRIATION/REVENUE AND LIABILITY HISTORY FY 2013-2020 ($ in Millions)			
Fiscal Year	**Appropriation**	**Revenues**	**CMS Liability**
FY 2013	$1,103.0	$2,088.8	$2,588.6
FY 2014	$1,697.0	$2,791.0	$2,616.3
FY 2015	$1,665.4	$2,674.3	$2,764.3
FY 2016*	$5.0	$876.9	$2,777.2
FY 2017*	$0.0	$1,082.1	$2,859.7
FY 2018	$1,340.0	$6,306.6	$3,119.4
FY 2019**	$2,562.2	$4,474.6	$3,023.4
FY 2020**	$2,028.0	$3,002.1	$3,104.6
*FY 2016 and FY 2017 had no official appropriation. A small amount was appropriated in FY 2015 but not received until FY 2016. **Estimated for FY 2019 and projected for FY 2020. FY 2018 and FY 2019 revenues include bond revenues intended to pay down held bills.			

FY 2020 PROPOSED PLAN CHANGES

For FY 2020, the State has opted to not propose the system of increased contributions and tiered plan options that was pursued for the past few fiscal years. Instead, contributions are expected to rise incrementally, as has been the historic trend. In addition, existing plan options, structures, copayments, and premiums are expected to remain substantially the same, with only technical amendments expected for the existing health insurance provider contracts expected for the 2020 fiscal year.

Therefore, this year's report bases estimates off of the standard estimate as provided by CMS. It is possible that plan changes in future years may be made as the State faces continuing cost pressures, but these changes are not anticipated in the materials provided to the Commission for the 2020 fiscal year.

FY 2020 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) utilizes the CMS forecast for FY 2020 medical costs as the basis for estimating costs for FY 2020 along with information provided by the Segal Company in their annual report on State employee insurance trends. The CGFA State of Illinois liability cost projection uses the assumptions on the next page based on historical claims data and anticipated cost changes.

Trend Factors	
Medical (QCHP plan)	6.3%
Dental (QCHP and MC)	1.0%
HMO (Medical and Rx)	2.5%
Prescription drugs (QCHP)	3.4%
Open Access Plan	7.9%
Life Insurance	1.1%

As in the past, it is important to note that the trend percentages listed above relate only to the portion of total medical costs incurred by the State of Illinois. The shifting of eligible retirees and their dependents into Medicare Advantage plans along with negotiated increases in employee contributions and co-payments have caused overall cost projections to the State to decline. However, the yearly cost of providing healthcare for State employees, retirees and dependents continues to rise, though at a slower rate than otherwise, due to the aforementioned cost-controlling measures.

The medical trend inflation factors for the State consist of various components. These components include general medical cost inflation and leveraging (lower impact of coinsurance limits, level deductibles, etc.). Also, advances in technological innovation, more use of equipment/services, and the continued "greying" (aging and extended living) of the population have historically contributed to greater health care costs to the State. In addition to these, the impact of a gradual shift by employees to HMOs and OAPs from the Quality Care Health Program (QCHP) has resulted in more costly/higher risk employees remaining in the QCHP program, raising the per-member cost of that program. In terms of cost reduction, movement of Medicare-eligible retirees out of the QCHP/HMOs/OAPs has reduced overall liability within the group insurance program in the past and continues to be a factor in overall State costs being significantly lower than otherwise.

Regarding individual liability components, it is informative to consider CMS projections of noteworthy liability increases for the Open Access Plan and the QCHP. The OAP line is expected to rise to $887 million in FY 2020, a 6.9% increase from FY 2019 ($830 million) while the QCHP is projected to rise 5.6% to $428 million (from $405 million in FY 2019). Most of the other liabilities are projected to rise at significantly lower rates, on the order of 0.2% to 3.5%. Other items of interest are the Medicare Advantage liability, which CMS projects to decrease in FY 2020 by 2.1% to $193 million, and the Timely/Prompt Payment Interest Liability, which is projected to decrease to only $3.6 million total. This is a significant shift in liability as the Timely/Prompt Payment Interest line amounted to over $260 million/year in liability as recently as FY 2018.

In preparing this report, the Commission utilizes information from an annual cost trend survey report provided by the Segal Company. This report examines how large health plans are trending during the plan year. The following are some relevant findings of the 2019 Segal Health Plan Cost Trend Survey.

- For 2019, medical plan trends (insurance) are projected to be lower than in the 2018 calendar year. Accordingly, while rates are projected to increase, they are expected to increase at a lower rate than in 2018.

- Despite past trends and projections for higher prescription plan costs, the 2017 calendar year was one of the lowest in recent history. Furthermore, the rate of increase is projected to be lower in the 2019 calendar year, though price inflation continues to drive overall costs and is the primary driver of said costs.

- For 2019, most insurance plan trends are projected to be lower than in 2018 for active and retired members under age 65. Additionally, most of the trends are decreasing slightly over time in recent years, save for 2018.

- Medicare Advantage trend rates are expected to continue to increase for both MA Preferred Provider Organizations (PPOs such as UnitedHealthCare) and MA HMOs. Medicare Supplemental plans trends are projected to continue to decrease in 2019, following a similar path in 2018.

- General price inflation is the largest driver of increased insurance plan cost trends in 2019 for hospital and physician services, though this inflation can vary depending on a variety of factors, including negotiated reimbursement rates.

- In a reversal from 2018, dental plan trends are expected to decrease while vision plan trends are projected to increase.

Table 1 below highlights national trend data and compares it to estimates by CMS and CGFA for State liability.

TABLE 1

NATIONAL HEALTH CARE TRENDING 2019

Component	National Trend	CMS Estimate	COGFA Estimate
HMOs	6.6%	1.6%	2.5%
Rx	7.5%	2.7%	3.4%
Dental	3.9%	0.9%	1.0%
Vision	3.0%	0.2%	0.2%

Source: Segal 2019 Health Plan Cost Trend Survey

National trend rates demonstrate the general direction and scale of healthcare insurance rates, though individual state plan data points may differ significantly due to actions on the state level. Trend rates allow the Commission to benchmark health plan components to analyze and estimate claims data. Changes in the costs to plan sponsors can be very different from projected cost trends. To the extent that it can be measured, national trend data can be reflective of trends in various geographical regions of the US. While trends may be higher in the Northeast and West, for the Midwest, trends may, and frequently are, lower.

The difference between national trends and state-level healthcare insurance trends can be seen in Table 1. While CMS and CGFA projections reflect the direction of national trends, the scale (or intensity) of these trends is muted. This lower scaling can be attributed to many causes, though the bifurcation of Illinois HMO costs between traditional HMOs and Medicare Advantage (MA) HMOs presents an interesting contrast in terms of cost containment. As older individuals who are demographically more likely to utilize healthcare services have moved into MA HMO plans, the inflationary pressure on traditional HMO plan rates has been reduced. In reference to dental and vision plan costs, for Illinois, these costs tend to remain relatively stable year to year, with dental liability projected to increase less than $2 million between FY 2013 and FY 2020 and vision liability projected to decrease $3 million in that same time period. **Based on these assumptions, trends, and inflation factors, CGFA estimates a FY 2020 liability of approximately $3.130 billion for the State Employee's Group Health Insurance Program.** The following table shows a detailed comparison of the CGFA estimate for the various cost components and the CMS projection for FY 2020.

TABLE 2: FY 2020 GROUP HEALTH INSURANCE LIABILITY
($ in Millions)

Liability Component	FY 2019 CMS Estimate	FY 2020 CMS Projection	FY 2020 CGFA Projection
QCHP Medical	$405.5	$428.4	$430.9
QCHP Prescriptions	$118.7	$121.9	$122.7
Dental (QCHP/MC)	$118.3	$119.4	$119.5
HMO	$1,065.7	$1,082.8	$1,091.8
Medicare Advantage HMO/PPO	$197.9	$193.8	$193.8
Open Access Plan	$830.3	$887.5	$895.6
Mental Health	$5.6	$5.9	$5.9
Vision	$8.0	$8.0	$8.0
Administrative Services (QC)	$17.0	$16.9	$16.9
Life	$88.2	$89.1	$89.2
Special Programs (Admin/Int./Other)	$168.4	$151.0	$155.8
TOTAL	**$3,023.6**	**$3,104.7**	**$3,130.1**
% increase over prior year	-3.1%	2.7%	3.5%

*Rounding may cause slight differences. FY 2019 and FY 2020 Special Programs line includes Prompt Payment and Timely Payment Interest.

ESTIMATE COMPARISON

Overall, the Commission's FY 2020 estimate is $25.4 million higher than the FY 2020 estimate from CMS. CGFA's FY 2020 HMO and Open Access Plan liabilities estimates are $9.0 million and $8.1 million higher than CMS, respectively. CGFA's FY 2020 estimate for the Quality Care Health Plan Medical line is $2.5 million higher than the CMS estimates. The Commission's estimate for Special Programs (Interest, Admin, etc.) is $4.8 million higher than CMS.

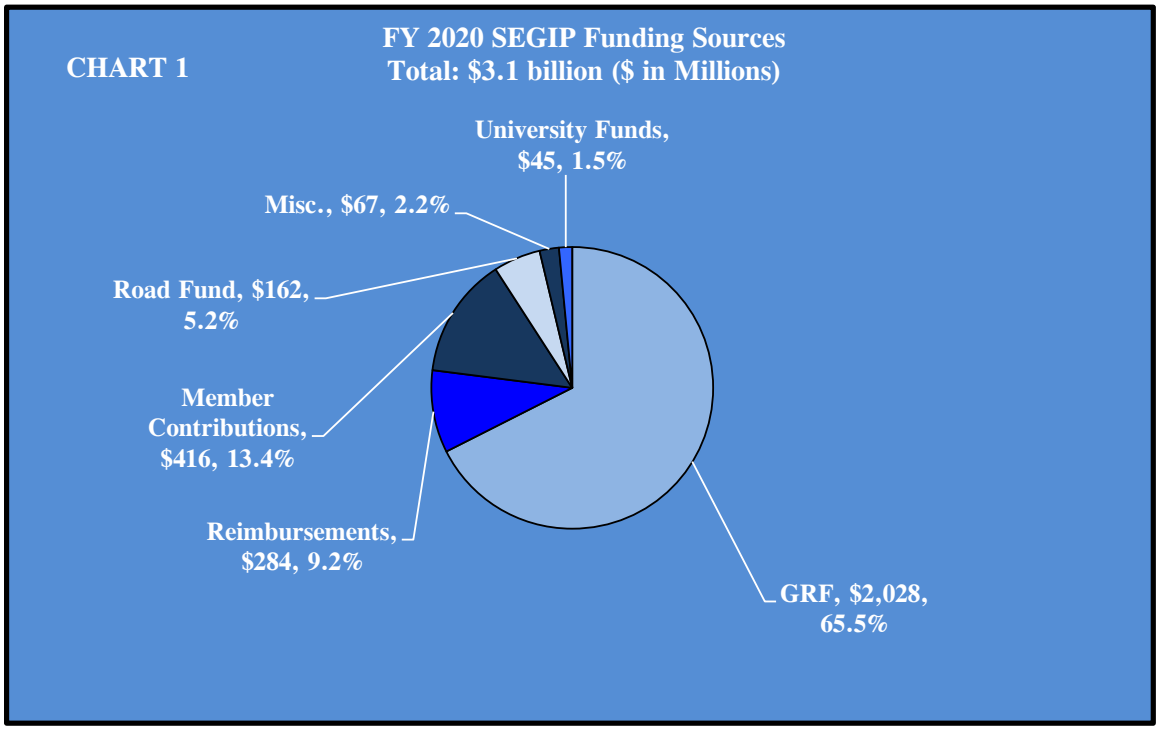
It is important to note that the FY 2020 group insurance liability estimates between CMS and CGFA are very close to each other, with less than a one percent total difference between them. This similarity in estimates is reflective of the general trends in healthcare insurance and the relative stability in overall plan design changes anticipated for FY 2020. Future (and larger) differences in liability projections may occur depending on various factors, including possible changes in plan design and applicability as a result of labor negotiations and/or changes on the federal level.

CGFA estimates that approximately $3.130 billion would be required to fully fund the FY 2020 liabilities of the Group Health Insurance Program. This estimate is $106.5 million or 3.5% higher than the FY 2019 estimated liability of $3.023 billion. CMS estimates that the FY 2020 liability will be $3.105 billion, approximately $81 million higher than FY 2019.

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 2020 total $3.002 billion. This is a large decrease from the 2019 fiscal year estimated revenue of $4.511 billion due mostly to an allocation of $900 billion in bond proceeds and a decrease of $534.2 million in GRF composed of prior year funding from FY 2018 that was received in FY 2019. A similar situation is not expected in FY 2020. The decrease in funding is partially offset by a projected increase of $43.6 million in Road Fund appropriation from FY 2019. A breakdown in the various funding sources is shown in the following chart.



For FY 2020, the fiscal data provided by CMS shows the Group Health Insurance Program receiving $2.028 billion in GRF funds. As previously noted, this represents a $534.2 million or a 20.8% decrease from the FY 2019 GRF component of $2.562 billion. However, the FY 2020 GRF appropriation request is significantly higher than any previous year GRF request, even without any anticipated prior fiscal year funding being received in FY 2020. In FY 2018 and FY 2019, bond revenues counted as part of GRF for the purposes of funding, making their totals artificially higher than the actual GRF budget request in those years. For FY 2020, as mentioned above, the Road Fund request of $161.5 million is $43.6 million higher than the projected FY 2019 appropriation level of $117.9 million. Member contributions are anticipated to remain relatively flat in FY 2020, at $416.3 million, compared to $418.8 million in FY 2019. Other Funds reimbursements are anticipated to be significantly lower in FY 2020, at $284.3 million compared to $335.9 million in FY 2019. University employee contributions are projected to be flat compared to the 2019 fiscal year, as the administration has proposed keeping contributions at $45.0 million in FY 2020.

TABLE 3: GROUP INSURANCE FUNDING SOURCES FY 2019 - FY 2020				
($ in Millions)				
	FY 2019	FY 2020	$ Change from FY19	% Change from FY19
GRF Appropriation	$2,026.0	$2,028.0	$2.0	0.1%
Prior Year GRF	$536.2	$0.0	($536.2)	-100.0%
Road Fund	$118.0	$161.5	$43.6	36.9%
Bond Proceeds	$900.0	$0.0	($900.0)	-100.0%
University Cont.	$45.0	$45.0	$0.0	0.0%
Prior Year Univ. Cont.	$15.1	$0.0	($15.1)	-100.0%
Member Cont.	$418.8	$416.3	($2.6)	-0.6%
Other Funds	$335.9	$284.3	($51.6)	-15.4%
Medicare Part D rebate	$5.4	$2.9	($2.5)	-46.6%
Rebates/Interest/Other.	$74.2	$64.1	($10.1)	-13.6%
TOTAL	**$4,474.6**	**$3,002.1**	**-$1,472.5**	**-32.9%**
Source: CMS				

CMS sets target end-of-year fund balances for both the Health Insurance Reserve Fund and the Group Insurance Premium Fund. The FY 2020 budget target balance for the Group Insurance Program is $30.0 million. For FY 2020, as in previous years, the GIPF target balance is $8.0 million, and the target HIRF balance is $22.0 million.

A possible influence on SEGIP revenues (or possibly liabilities) is the stated intent of CMS to save between $90 and $100 million from the Group Insurance Program in FY 2020. As of this report, the final form of those anticipated savings has not been determined, though efforts to utilize the Dependent Verification Audit (mentioned in prior reports) and other initiatives have been discussed.

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 the 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 I describes the types of health and dental plans offered by the State.

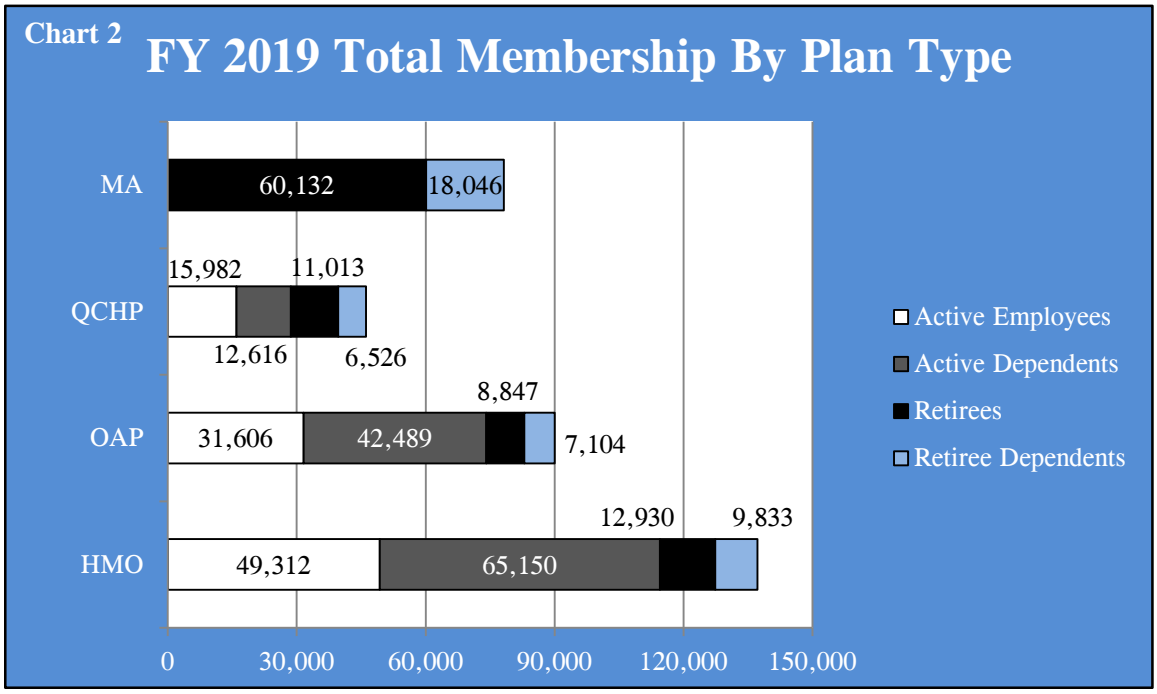
Basic life insurance is provided at no cost to employees, retirees and annuitants. Full-time employees receive coverage equal to their annual salary. Retirees and annuitants receive coverage equal to the annual salary as of the last day of employment until the age of 60, at which time the benefit amount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

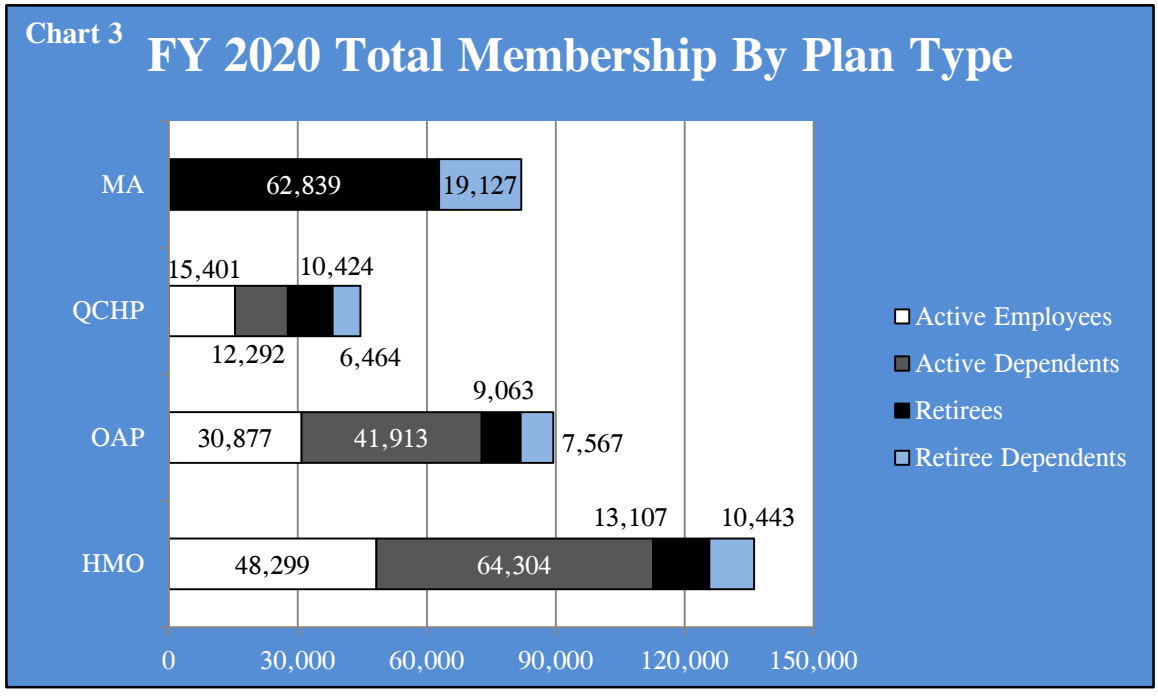
Starting in FY 2014, Medicare-eligible retirees and their Medicare-eligible dependents were moved into Medicare Advantage (MA) plans. Individual retirees and dependents have the choice of five different plans that range from MA HMO plans to a MA PPO plan. These plans became effective February 1, 2014 (Health Alliance MA HMO - 2015). The 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 2020, 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.

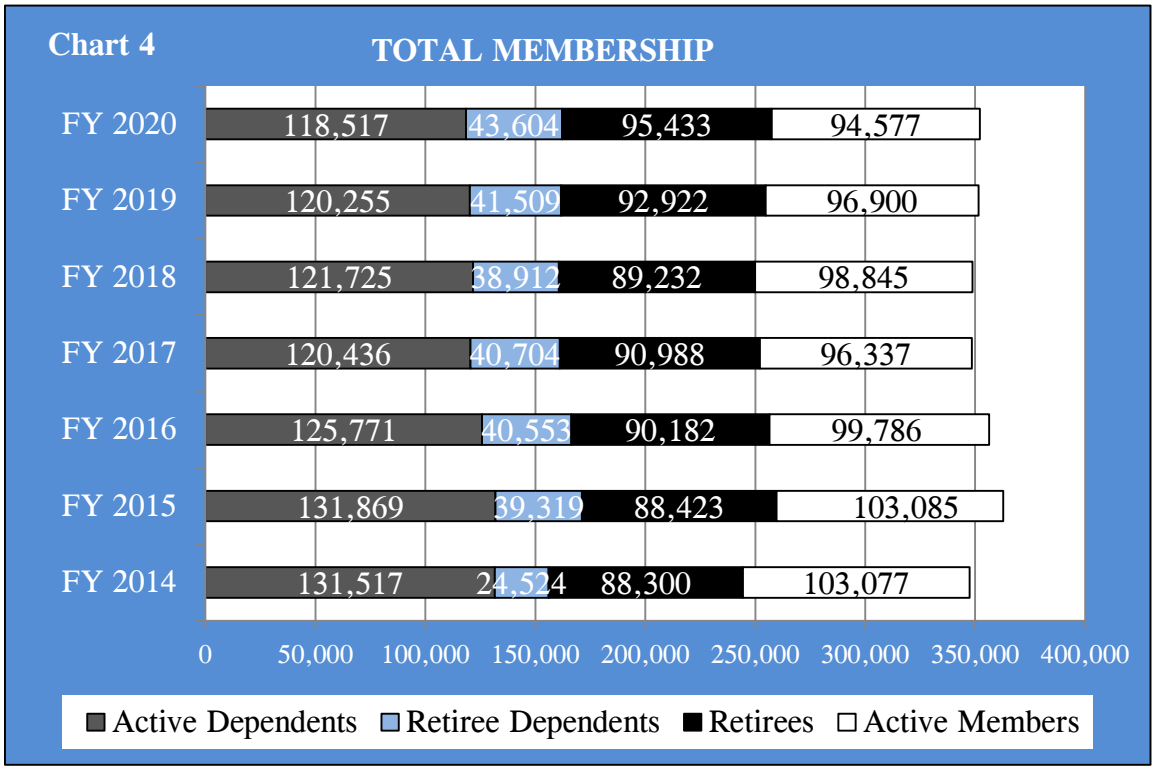
MEMBERSHIP

According to CMS, the State Employees' Group Health Insurance Program has an estimated 351,586 participants for FY 2019, of which 137,225 are in a non-Medicare Advantage HMO, 78,178 are in a Medicare Advantage HMO/PPO, 90,046 are in an Open Access Plan, and 46,137 are in the Quality Care Health Plan. The QCHP is estimated to have 15,982 employees, 12,616 active employee dependents, 6,526 retiree dependents, and 11,013 retirees in FY 2019. HMO plans are estimated to have 49,312 employees, 65,150 active employee dependents, 9,833 retiree dependents, and 12,930 retirees in FY 2019. Medicare Advantage plans in FY 2019 include 18,046 dependents and 60,132 retirees. OAPs are anticipated to have 31,606 employees, 42,489 active employee dependents, 7,104 retiree dependents, and 8,847 retirees in FY 2019. This information is displayed in the chart on the next page.



For FY 2020, the QCHP is estimated to have 15,401 employees, 12,292 active employee dependents, 6,464 retiree dependents, and 10,424 retirees. Medicare advantage HMO/PPO plans are expected to have 19,127 dependents and 62,839 retirees. Non-Medicare Advantage HMO Plans are expected to have 48,299 employees, 64,304 active dependent lives, 10,446 retiree dependents, and 13,107 retirees. OAPs are expected to have 30,877 employees, 41,913 active dependents, 7,567 retiree dependents, and 9,063 retirees in FY 2020. Total FY 2020 membership is expected to increase 0.2% from 351,586 to 352,131. This information is displayed in the following chart.





- **Membership (including CIP, TRIP, etc.) is estimated for FY 2020.**

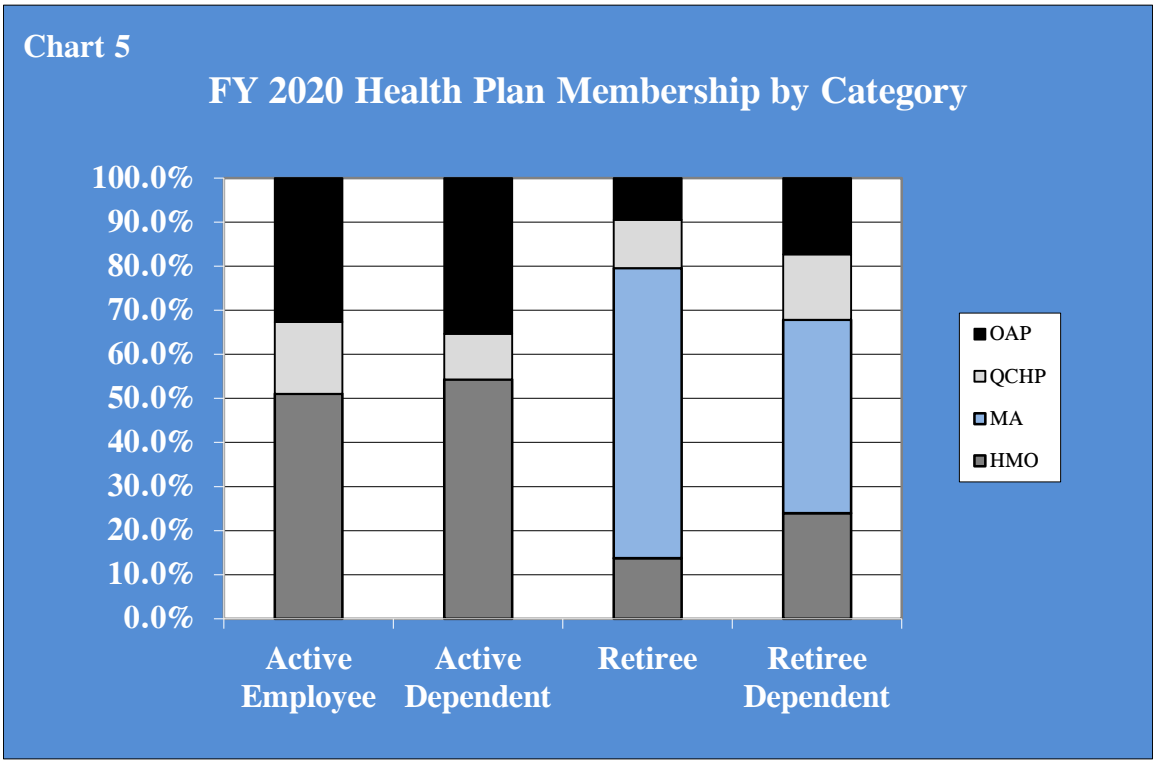
ENROLLMENT TRENDS

Membership in the Quality Care Plan has been decreasing since FY 2005 while membership in the States' managed care offerings had 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). This trend has stabilized and is reflected in FY 2019-FY 2020 membership projections by CMS. In recent years, the movement of retirees/dependents to Medicare Advantage plans has resulted in lower enrollment for both HMOs and OAPs.

For FY 2020, membership in HMOs is broken down by standard HMO membership and Medicare Advantage HMO/PPO membership. Though it has fluctuated over time, standard HMO membership is expected to continue to remain the highest population category among those measured (QCHP, OAP, etc.). Medicare Advantage HMO/PPO plans are expected to rise from 78,178 in FY 2019 to 81,966 for FY 2020. Membership is expected to grow in future years as retirees continue to qualify for Medicare Advantage.

Chart 5 shows the breakdown of employee, dependent and retiree enrollment in the overall group insurance program. Due to the shift towards MA HMO/PPO plans by retirees, the QCHP has become less utilized among employees as a whole, especially retirees. In FY 2020, 65.8% of retirees are expected to enroll in a Medicare

Advantage HMO/PPO. Chart 5 shows that employees, retirees, and dependents from both groups are moving towards managed care and Open Access Plans.



LIABILITY

The Department's estimate of liability for FY 2020 represents a 2.7% increase from FY 2019, mostly due to increases in QCHP, HMO, and OAP liability. Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2011 through FY 2020 and demonstrates how several components 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 sections. The Open Access Plan is anticipated to continue to have more liability for the State of Illinois than the QCHP and prescription components as a whole in FY 2020 ($887 million compared to $550 million). In addition, the Interest Payments category has continued to decline in FY 2019 due to large payments made in FY 2018, and is projected to amount to only $4 million in FY 2020. However, the Administration/Other category has risen significantly over the past few fiscal years, primarily due to the rapidly increasing health insurance expenses for the Teamsters, who negotiated a health insurance arrangement outside of the rest of the participants in the group insurance program. The liability for this "opt-out" has risen from $6 million in FY 2015 to $118 million (out of a total Admin/Other liability of $147 million) projected in FY 2020.

Other components of liability such as Mental Health, Vision, Dental, and Life Insurance are projected to mostly hold steady or change slightly from FY 2019 to FY 2020. These components are only a small fraction of total liability as a whole, and are expected to remain in that position in years to come, as QCHP/HMO/OAP plans are utilized more by most State employees, retirees, and dependents. In recent years, interest on payments has become a major issue for the State of Illinois, though the bond sale revenues in FY 2018 and FY 2019 were utilized to pay down most of that component of liability. The issue of state interest payments and paying down those liabilities is addressed in the following section of this report.

Table 4 STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY (CMS ESTIMATE) (FY 2011-FY 2020)

$ in (millions)

Liability Component	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020 (Proposed)
QCHP Medical/Rx	$730	$750	$731	$598	$493	$488	$481	$508	$524	$550
HMO Medical	$1,008	$853	$894	$910	$917	$934	$975	$1,037	$1,066	$1,083
Medicare Advantage	$0	$0	$0	$62	$154	$168	$183	$200	$198	$194
Dental	$129	$115	$118	$118	$118	$114	$114	$113	$118	$119
Open Access Plan	$287	$528	$582	$616	$657	$669	$703	$756	$830	$887
QC Mental Health	$8	$7	$7	$6	$5	$5	$6	$5	$6	$6
Vision	$10	$11	$12	$11	$11	$8	$8	$8	$8	$8
Life Insurance	$85	$83	$84	$88	$95	$91	$90	$90	$88	$89
QC ASC	$29	$30	$32	$26	$19	$17	$17	$17	$17	$17
Interest Payments	$47	$50	$112	$130	$221	$229	$177	$260	$33	$4
Admin/Other	$13	$12	$15	$51	$73	$53	$106	$124	$136	$147
Total	**$2,346**	**$2,440**	**$2,587**	**$2,616**	**$2,764**	**$2,776**	**$2,860**	**$3,118**	**$3,024**	**$3,104**
% change over PY	**7.2%**	**4.0%**	**6.0%**	**1.1%**	**5.7%**	**0.4%**	**3.0%**	**9.0%**	**-3.0%**	**2.6%**

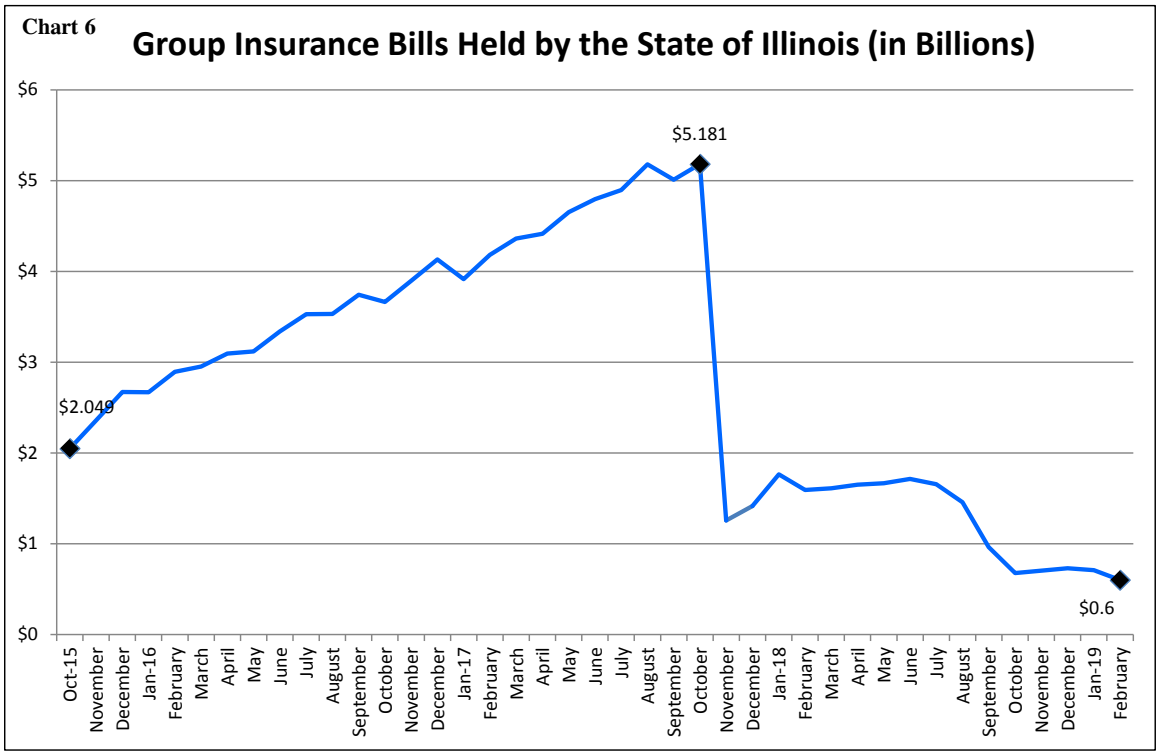
Source: CMS. Rounding causes slight differences in totals.

GROUP INSURANCE INTEREST AND BONDING

Since at least 2013, SEGIP interest payments have grown at an alarming rate as the State has been forced to push payments for services further and further into the future. This is done by "holding" claims until the actual money is available for payment. As a result, these "held claims" accrue interest at rates of 9 or 12 percent annually depending on the criteria of the claim. Timely Pay Interest (0.75% per month), as cited in the Illinois Insurance Code, covers QCHP, OAP, Dental, and Mental Health claims payments. This interest is calculated at 9.0% annually after an initial 30-day period. Prompt Payment Interest (12.0%), as cited in the Prompt Payment Act, covers HMOs, Vision, Life Insurance, and administrative fees for the QCHP/OAP/Dental/Mental Health programs. This interest is calculated at 1.0% per month after an initial 90-day period.

For example, claims in the QCHP, are typically paid out under the 9 percent calculation, while claims from HMOs are paid out at 12 percent. Further exacerbating

the issue was the inability of the State in recent years to pass a budget into law. Without spending authority, CMS was unable to pay down FY 2016 and FY 2017 year claims and held them as they accrued additional interest. CMS utilized employee premium contributions to help defray some of these costs (as this source of revenue was determined to be legally spendable outside traditional appropriations), but the vast majority of incurred claims remained unpaid and continued to accrue interest, including past-due interest (interest on interest) in some situations. A State budget was eventually passed into law and provided funding for FY 2018, but no additional funding was provided to pay down the enormous amount of held bills. At the end of October 2017, the State had approximately $5.181 billion in health insurance claims waiting to be paid out. However, in November 2017, a bond sale was issued to pay down SEGIP and Medicaid bills. The bond proceeds were used to pay off approximately $3.982 billion in held group insurance bills, bringing the total bills held by Illinois to $1.256 billion at the end of November 2017. This total has fluctuated since that time, but has trended downward in recent months. A chart displaying the historical backlog of Group Insurance bills is provided below.



As of the end of February 2019, approximately $601 million in Group Insurance bills are being held by the State of Illinois. Of that total, there are no HMO claims (including Medicare Advantage) awaiting payment, though approximately $15.6 million in interest payments has yet to be paid off. Open Access Plans claims account for $333.1 million and Aetna PPO (QCHP) claims account for $178.4 million, making up the majority of existing claims being held by the State. Dental ($60.4 million), Mental Health ($5.0 million), and Prescription claims ($23.3 million) make up the majority of

the remaining claims held by Illinois. This does not include the interest due on these debts. Though much lower than at this point in FY 2018, as of February 28, 2019, the State is obligated to pay $31.5 million in interest payments on bills that have been held beyond the 30 or 90-day grace period. Current projections by CMS estimate only $3.6 million in interest liability in FY 2020, after a projected total of $335.0 million as recently as FY 2018. The table below details the major portions of the current claims hold situation with existing interest rates of 9 and 12 percent, as of February 2019.

Table 5 Claims Hold Data for SEGIP
(as of February 28, 2019)

Vendor	Claims Hold	Length of Claims Hold (in days)	Interest Owed (Including Past Due Interest)
Aetna - PPO	$178,418,976	186	$2,690,973
Dental Claims Hold – PPO	$41,399,112	188	$1,604,216
Dental - Non-PPO	$19,000,593	305	$1,301,541
Magellan (Mental Health) Claims	$5,001,955	242	$172,936
Aetna HMO	$0	0	$809,776
Health Alliance HMO	$0	0	$7,852,931
HMO Illinois	$0	156	$3,534,068
Blue Advantage	$0	156	$755,824
HealthLink OAP	$257,946,475	186	$4,185,876
Aetna OAP	$75,187,971	185	$1,065,313
CVS/Caremark	$23,348,586	12	$3,810,579
Aetna/Coventry MA	$0	0	$97,433
Health Alliance MA	$0	0	$28,892
Humana Benefit Plan MA	$0	0	$2,327
Humana Health Plan MA	$0	0	$53,257
United Healthcare MA	$0	0	$2,478,660
Fidelity (Vision)	$0	0	$71,929
Minnesota Life	$0	0	$0
Other (Fees/ASC/etc.)	$481,260	195	$956,725
Total	**$600,784,928**	**0-305**	**$31,473,254**

Source: CMS. MA stands for Medicare Advantage. Aetna represents Coventry, unless indicated otherwise.

In regard to payment cycles, the situation for the 2020 fiscal year has vastly improved compared to FY 2019, after improving significantly from FY 2018, due to the continued stability in payments provided by the influx of funding from the aforementioned bond legislation. The projected FY 2020 claims hold cycles are:

- AETNA claims: 77 days
- Managed Care claims: Approximately 3 months
- OAP/Prescription claims: 79 days
- Dental claims: 77 days for network claims, 116 days for non-network claims

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.

ANNUAL LIABILITY PER PARTICIPANT

The liability per participant in the State Employees' Group Insurance Program is the total of the State's liability across all participants. Chart 7 shows the steady increase each year in cost per participant, though FY 17 through FY 19 deviate significantly from past fiscal years, in part due to the accumulation of held bills that temporarily inflated overall liability. As plan participants live increasingly longer lives, utilization of medical insurance plans (and thereby liabilities to the state) have tended to increase accordingly. For FY 2011 – FY 2020, for Chart 7, this information is displayed without including interest payments in order to illustrate general medical plan trends more accurately. In earlier years, interest payments composed a much smaller portion of total liability than in recent years. Therefore, in FY 2011, the annual liability per participant in the group health insurance program was $6,526.

According to CMS, the liability per participant for FY 2019 will increase to $8,506, an increase over FY 2018. This is in part due to the large amount of bills paid off in November 2017, which were included in the overall liabilities for that year and some liabilities which were paid off in the following fiscal year also. For FY 2020, the estimated liability per participant is $8,806, which represents a 34.9% increase over a ten-year period, sharply increasing since FY 2016.

The FY 2020 liability per participant is projected to increase 3.5% from FY 2019. It is necessary to note that this is only an aggregate liability representation, which is not itemized based on the types of plans used by participants or any other variables. While it is informative of general liability trends, it is not necessarily indicative of all medical inflation factors.

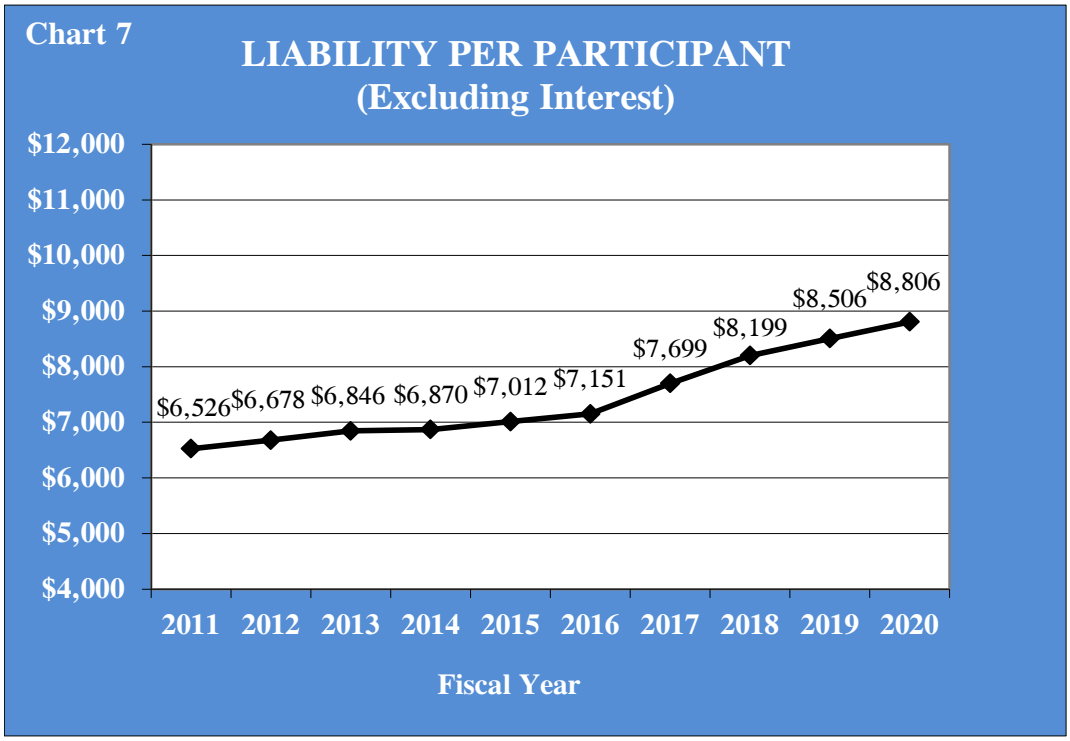


Table 6: ANNUAL LIABILITY PER PARTICIPANT				
	FY 2019	FY 2020	FY 2019	FY 2020
	Total Participants	Total Participants	Liability Per Participant	Liability Per Participant
QCHP	46,137	44,581	$11,783	$12,784
MA HMO / PPO	78,178	81,974	$2,531	$2,365
HMO	137,225	136,156	$7,766	$7,952
OAP	90,046	89,420	$9,220	$9,925
Totals	**351,586**	**352,131**		

OAP is the Open Access Plan. ALPP does not include dental, vision, admin/interest/other, or life insurance. FY 2019 QCHP liability assumes more individual retirees and dependents not yet Medicare Advantage qualified, but still utilizing services, making it proportionately more expensive for remaining participants. Numbers are not adjusted for risk.

When comparing annual liability per participant (ALPP) in Table 6, the annual liability for FY 2019 is lowest for members in the Medicare Advantage HMO and highest for members in the QCHP. The total number of participants in the QCHP has declined in recent years as people have steadily migrated to HMOs and OAPs. This trend was accelerated in FY 2014 and FY 2015, as most retirees (over 90 percent) were moved from QCHP to a Medicare Advantage HMO/PPO plan. This shift has resulted in an increase in average cost for remaining QCHP participants, as those who remain, including non-Medicare eligible retirees and dependents are predominantly the more expensive to cover (requiring more treatment, medicines, etc.). The QCHP is also the preferred plan for retirees and dependents who live or travel primarily out of Illinois, as traditional HMOs/OAPs have limited coverage outside the state. This results in the higher projected liability for QCHP participants (compared to others) in FY 2020. 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 $11,783 in FY 2019. Member contributions for QCHP enrollees are expected to total $70 million. This means that of the total cost per participant, $1,523 or 12.9% of that cost is covered by member contributions. Prior to the *Kanerva* decision by the Illinois Supreme Court, retirees were contributing part of their pension income towards their group insurance coverage. However, since that court decision, contributions from retirees have dropped sharply from the set of retirees with 20 years or more of service, who are exempt from health insurance contribution deductions from their pension income. In addition, many retirees have been moved out of QCHP towards a Medicare Advantage HMO/PPO plan. This leaves fewer people in the QCHP, causing the cost per participant for that program to rise (due to the generally increased expenses incurred by QCHP participants). While lower, the other medical plans (Traditional HMOs, Medicare Advantage HMOs, and Open Access Plans) also have significant

average liabilities per participant which are only partially offset by member contributions. Table 7 examines the relationship between overall cost and the offset by member contributions for FY 2019 and FY 2020.

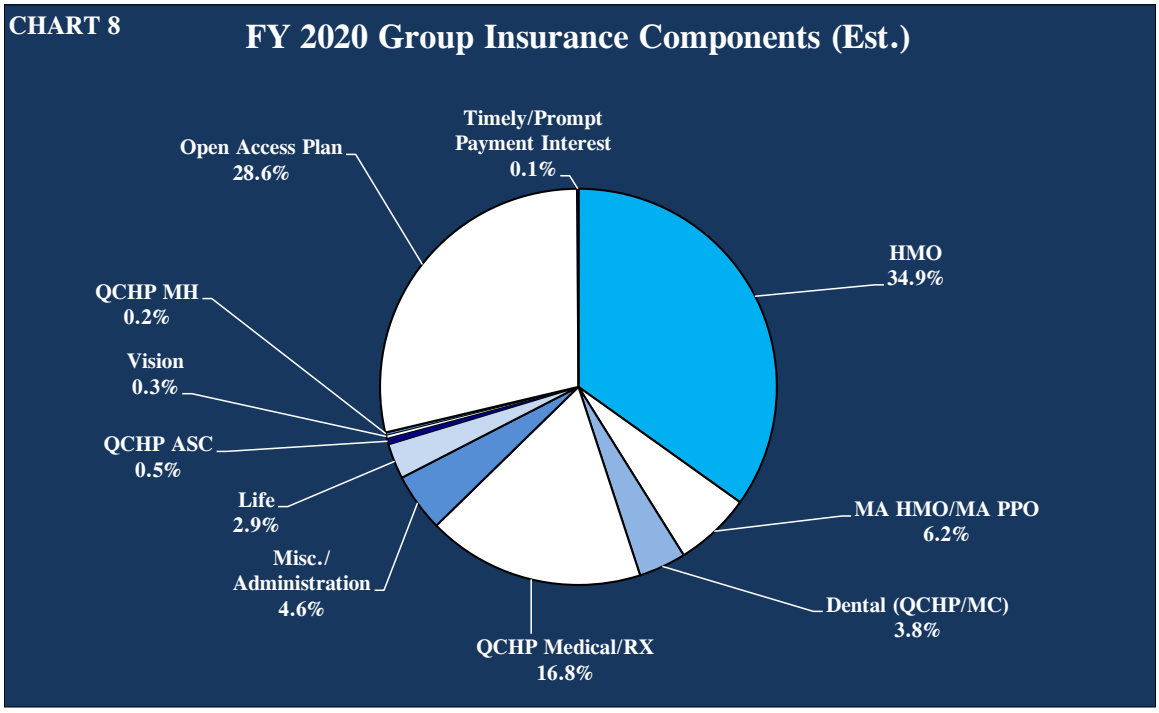
TABLE 7: MEMBER CONTRIBUTIONS AND AVERAGE LIABILITY PER PARTICIPANT PER YEAR (ALPP)

	FY 2019 ALPP	FY 2019 Member Contributions	FY 2019 State Liability	FY 2020 ALPP	FY 2020 Member Contributions	FY 2020 State Liability
QCHP	$11,783	$1,523	$10,260	$12,784	$1,539	$11,245
MA HMO/PPO	$2,531	$390	$2,141	$2,365	$389	$1,976
HMO	$7,766	$998	$6,768	$7,952	$997	$6,955
OAP	$9,220	$1,047	$8,173	$9,925	$1,044	$8,881
Dental	$348	$94	$254	$348	$94	$254

Source: CMS.

The table above shows that QCHP members are expected to contribute 12.0% of the overall annual cost of providing their insurance in FY 2020. HMO/OAP/MA HMO (and PPO) members are expected to contribute 12.5%, 10.5%, and 16.5% of their overall liability cost in the same time period. Members that participate in the State's dental offering are expected to pay 27.7% 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.

Chart 8 on the following page includes the various components of the FY 2020 CMS liability estimate of approximately $3.105 billion. The largest component of the State Group Insurance Program continues to be the State's managed care plans (HMO, OAP, MA HMO/MA PPO), and has grown to represent 69.7% of FY 2019 liability. Dental care, life insurance, and vision care equal 7.0% of total liability, down from 9.0% in FY 2019, and reflective of the increasing proportion of total liability taken by managed care. The QCHP component (18.4%) is slightly higher than FY 2019 (17.5%) and includes medical/prescriptions, mental health coverage, and administrative service charges. For FY 20, interest payments are a small fraction of the FY 19 value (3.8%) as a total projected percentage of the components of Group Insurance liability at 0.1%, reflecting the near elimination of payment interest as a major liability issue for the SEGIP.



As the movement of retirees to MA HMO/PPO plans continues, it is extremely unlikely that the QCHP will rise to the proportion of the total group insurance liability it had attained before FY 2014. At the same time, the availability, affordability, and migration requirement of MA HMO/PPO plans for the State of Illinois indicates that this area of liability is not likely to shrink in consistent size or proportion in the near future, though it has decreased 1 to 2 percent in FY 19 and FY 20. 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 is likely to grow if more people migrate to OAPs.

One important note regarding liability is the anticipated successful attempt by the State to address interest payment liabilities and the issue of "lost money," i.e. money that could be spent on other liabilities within the SEGIP. An increased GRF commitment to cover increased year-to-year liabilities is projected to almost eliminate the impact of interest payments for FY 2020. The long-term impact on overall State finances of using a bond to pay the held bill interest from prior years is yet to be determined, but for the purposes of the SEGIP, steady fiscal commitment from the State that accounts for liabilities will presumably allow the State to avoid a similar situation with interest payments from occurring in the future.

EMPLOYEE/RETIREE COST COMPARISON

A subject of interest in recent years is the breakdown of costs for active employees and their dependents and retirees and their dependents. The Illinois Supreme Court decision in *Kanerva* resulted in reduced contributions for many retirees. Table 8 displays a comparison of the costs for these groups taken from data obtained from CMS as of February 2019.

TABLE 8: RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 20
(Numbers in Millions)

Category	Cost	Category	Cost
Retiree Cost	$742.0	Active Employee Cost	$1,203.2
Retiree Contribution	-$44.5	Active Employee Contribution	-$203.0
Other Revenues	-$13.0	Other Revenues	-$24.4
Net State Cost	**$684.5**	**Net State Cost**	**$975.9**
Retiree Dependent Cost	$302.0	Active Employee Dependent Cost	$857.3
Retiree Dependent Contribution	-$61.1	Active Employee Dependent Contribution	-$107.7
Other Revenues	-$7.6	Other Revenues	-$27.0
Net State Cost	**$233.3**	**Net State Cost**	**$722.7**
Total Retiree Cost	$1,044.0	Total Active Cost	$2,060.6
Total Retiree Contribution	-$105.6	Total Active Contribution	-$310.6
Other Revenues	-$20.7	Other Revenues	-$51.4
Total State Cost	**$917.7**	**Total State Cost**	**$1,698.6**
Source: CMS			

Based on data provided by CMS, retiree dependents (but not active employee dependents) continue to pay a substantially larger portion of their total costs to the State in the form of contributions for their healthcare coverage. However, due to the Illinois Supreme Court decision in the *Kanerva* case, which rejected State of Illinois attempts to increase contributions from retirees and dependents, those contributions decreased. For FY 2020, retirees and retiree dependents are projected to pay 6.0% and 20.2% of their healthcare costs respectively, a slight decline from FY 2019. This aligns with active employees and their dependents, who are projected to pay 16.9% and 12.6% respectively, also a slight decline from FY 2019. In total, the contributions of active employees and dependents (15.1%) remain significantly higher as a percentage than retirees and retiree dependents (10.2%), though both dropped slightly from the last fiscal year. This cost difference results in part from retirees utilizing Medicare Advantage HMO and PPO plans and resulting savings for the State of Illinois.

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 2018, FY 2019, and FY 2020 plan enrollment is listed in Table 9.

TABLE 9: MANAGED CARE PLANS
FY 2018-2020 All Lives (Active Members/Dependents and non-MA Retirees/Dependents)

HMO/OAP	FY18 # of Participants	FY19 # of Participants	% Change 2018-2019	FY20 # of Participants	% Change 2019-2020
Health Alliance HMO	75,121	73,491	-2.17%	72,770	-0.98%
HMO Illinois	45,026	43,161	-4.14%	42,456	-1.63%
Blue Advantage	10,855	12,273	13.06%	12,520	2.01%
Aetna/Coventry Health Care HMO	7,009	8,300	18.42%	8,410	1.33%
Coventry Health Care OAP	21,005	24,622	17.22%	24,802	0.73%
Health Link OAP	66,525	65,424	-1.66%	64,618	-1.23%
TOTALS	**225,541**	**227,271**	**0.77%**	**225,576**	**-0.75%**

Source CMS. FY 20 numbers are projected as of February 2019.

MEDICARE ADVANTAGE

A continuing development from the 2014 fiscal year onward is the movement of eligible retirees and dependents into a system of Medicare Advantage (MA) plans. These plans were set forth in an effort to save the State money as well as to provide quality service and care for retirees and their dependents. Table 10 shows the population figures involved with this new program.

TABLE 10: MEDICARE ADVANTAGE PLANS FY 2018-2020

HMO/PPO	FY18 # of Participants	FY19 # of Participants	FY20 # of Participants
Aetna HMO	4,437	4,737	5,015
Humana Benefit Plan HMO	137	139	146
Humana Health Plan HMO	2,998	3,250	3,521
Health Alliance HMO	1,178	1,395	1,577
United HealthCare PPO	66,509	68,657	71,715
TOTALS	**75,259**	**78,178**	**81,974**

Source: CMS. FY 20 numbers are projected as of February 2019.

It is important to note that except for a limited number of retirees and dependents coming from a HMO or OAP program, almost all of the 78,178 people covered in FY 2019 by a MA HMO or PPO plan came from the QCHP. In regard to MA, there are two different HMO benefit plans being offered by Humana as Humana Benefit Plan is intended for Livingston and Knox counties while Humana Health Plan is a traditional open area Medicare Advantage plan. The Health Alliance HMO plan was first offered during the 2015 fiscal year. The monthly rates for the State's Medicare Advantage plans are discussed in the Monthly Premiums section of this report.

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. For the 2020 fiscal year, however, the State has proposed monthly premiums in line with historical trends. These premiums, though increasing slightly year-to-year, do not demonstrate the significantly increased contributions that were proposed previously.

TABLE 11: PROJECTED MONTHLY COSTS FY 2012 - FY 2019 Employee Only												
	QCHP				HMO				OAP			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY13	$794		$90	$704	$607		$60	$547	$705		$60	$645
FY14	$812	2.3%	$166	$646	$643	5.8%	$122	$521	$719	2.0%	$121	$599
FY15	$859	5.8%	$168	$691	$672	4.5%	$125	$547	$761	5.8%	$124	$637
FY16	$895	4.1%	$170	$725	$699	4.1%	$126	$573	$773	1.6%	$125	$649
FY17	$895	0.0%	$169	$726	$750	7.3%	$126	$624	$851	10.0%	$125	$726
FY18	$989	10.5%	$168	$821	$801	6.7%	$126	$675	$919	8.0%	$125	$794
FY19	$1,058	7.0%	$168	$890	$823	2.8%	$126	$697	$975	6.1%	$125	$850
FY20	$1,132	7.0%	$169	$963	$838	1.7%	$127	$711	$1,043	7.0%	$126	$917

Table 11 displays the gradual increases in total monthly costs to the State for providing the three main types of health insurance plans for members/dependents from FY 2013 to the projected values in FY 2020. Whether members are in the QCHP, a traditional HMO, or an Open Access Plan, the monthly cost of such plans has steadily increased. Concurrently, the employee premiums for these plans have also increased, though at a much lower rate year-to-year.

Table 12 displays the projected monthly rates for the provision of health plans across the QCHP/HMO/OAP spectrum along with the projected State and member contributions expected for the 2020 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.

TABLE 12: MONTHLY PREMIUMS Managed Care vs. Indemnity Plan Weighted Average FY 2020 Rates (Projected for Median Salary)									
	QCHP			HMO			OAP		
Platnium Membership	TOTAL	Member	State	TOTAL	Member	State	TOTAL	Member	State
Employee	$1,132	$169	$963	$838	$127	$711	$1,043	$126	$917
Medicare Retiree	$532	$20	$512	$545	$39	$507	$691	$39	$652
Non-Medicare Retiree	$1,707	$26	$1,681	$1,268	$22	$1,246	$1,565	$22	$1,543
1 Dependent	$1,344	$253	$1,091	$708	$109	$599	$879	$125	$755
2+ Dependents	$1,754	$296	$1,458	$1,227	$155	$1,071	$1,513	$176	$1,337
Medicare Dependent	$725	$148	$577	$561	$85	$475	$695	$99	$596

TABLE 13: MONTHLY PREMIUMS ACROSS ALL PLANS HMOs and OAPs FY 2020 Proposed Rates						
Median Salary	Health Alliance	Aetna HMO	HMO Illinois	Blue Advantage	HealthLink OAP	Coventry OAP
Employee	$126.47	$126.56	$128.56	$124.97	$125.50	$126.56
Medicare Retiree	$38.68	$38.68	$38.68	$38.68	$38.68	$38.68
Non-Medicare Retiree	$22.44	$22.44	$22.44	$22.44	$22.44	$22.44
1 Dependent	$114.94	$113.65	$102.46	$97.78	$128.72	$113.65
2 + Dependents	$164.02	$159.97	$144.81	$136.09	$181.92	$159.97
Medicare Dependent	$89.00	$88.00	$79.00	$75.00	$102.00	$88.00

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. Table 13 displays the average projected rates for employees, retirees, and dependents across all the HMO and OAP options. As one can see in the table, the rates are relatively alike regardless of plan for individual employees, though for dependents, there is a larger gap in rates. Table 14 shows a comparison between FY 2018, FY 2019, and projected FY 2020 MA rates for retirees and dependents. Overall, very limited changes are expected for the rates in the Medicare Advantage SEGIP plans.

TABLE 14: MONTHLY PREMIUMS FOR STATE MEDICARE ADVANTAGE PLANS FY 2018-2020 Rates (As of February 2019)			
Aetna HMO	FY 2018	FY 2019	FY 2020
Medicare Retiree	$10.50	$9.81	$9.29
Two of More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91
Humana Benefit Plan HMO	FY 2018	FY 2019	FY 2020
Medicare Retiree	$10.50	$9.81	$9.29
Two of More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91
Humana Health Plan HMO	FY 2018	FY 2019	FY 2020
Medicare Retiree	$10.50	$9.81	$9.29
Two of More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91
United HealthCare	FY 2018	FY 2019	FY 2020
Medicare Retiree	$10.78	$10.12	$9.66
Two of More Dependents	$155.00	$155.00	$155.00
Medicare Dependent	$110.00	$110.00	$110.00
Health Alliance HMO	FY 2018	FY 2019	FY 2020
Medicare Retiree	$10.50	$9.81	$9.29
Two of More Dependents	$126.00	$126.00	$126.00
Medicare Dependent	$89.91	$89.91	$89.91

APPENDIX I

TYPES OF MEDICAL & DENTAL GROUP INSURANCE PLANS			
Type of Plan	Coverage	Characteristics	Geographic Location
QCHP Medical	Care related to the treatment of an illness or injury. Preventive care includes well-baby care, routine and school physicals, annual pap smears and mammograms.	Choice of physician and other medical care providers. Annual deductibles and employee contributions based on member salary. Dependent premiums do not vary.	No limitation; preferred hospital providers statewide.
QCHP Dental	Preventive, diagnostic, restorative, orthodontic, endodontic, and periodontic services as well as extractions and prosthetics.	Choice of dental care providers, reimbursement on a scheduled basis. No deductibles for preventative services. Premiums for members and dependents.	No limitations.
HMO Medical	Comprehensive medical benefits including preventive care.	Prepaid benefits, primary care physician who coordinates all care chosen from HMO network. Co-payments vary by HMO plan. Employee premiums, based on salary, 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.	Statewide coverage
MA HMO	Comprehensive medical benefits including preventive care.	Prepaid benefits, primary care physician who coordinates all care chosen from HMO network.	Statewide coverage
MA PPO	Comprehensive medical benefits including preventive care.	Choice of physician and other medical care providers.	Statewide coverage

APPENDIX II

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

Status of Contracts for FY 20 at DCMS		
Service	**Vendor**	**Contract Term Details**
Managed Care Health Plans	Health Alliance HMO / Aetna HMO / Aetna OAP / Healthlink OAP / BC HMO Illinois / BC Blue Advantage	**Renew** - Term goes to June 30, 2019 with up to two 1-year renewals.
Medicare Advantage Health Plans	Aetna/Coventry HMO / Health Alliance HMO / Humana Benefits Plan HMO / Humana Health Plan HMO / UnitedHealthCare PPO	**Ongoing** - Term goes to December 30, 2019 with up to three 1-year renewals.
Self-Insured Medical Plan Administration	Aetna	**Ongoing -** Term goes to June 30, 2021 with up to five 1-year renewals
Vision	EyeMed	**Ongoing** - Term goes to June 30, 2020 with up to five 1-year renewals.
Behavioral Health/EAP	Magellan	**Ongoing** - Term goes to June 30, 2021.
Life Insurance	Minnesota Life	**Renew** - Term goes to June 30, 2021.
Flexible Spending	ConnectYourCare	**Renew -** Term goes to June 30, 2019 with up to five 1-year renewals
Administration of Dental Claims	Delta Dental	**Ongoing** - Term goes to June 30, 2021.
Prescription Drugs	CVS/Caremark	**Ongoing -**Term goes to June 30, 2024.
Commuter Savings Program	Edenred	**Ongoing** - Term goes to June 30, 2020 with up to five 1-year renewals.

APPENDIX III

STATE EMPLOYEES' GROUP INSURANCE OVERSIGHT

P.A 93-0839 strengthened the Commission's oversight role of the State Employees' Group Health Insurance Program. P.A 93-0839, clarified State policy for the administration of the Group Insurance Program, and requires CMS to administer the program within set policy parameters. Those key parameters are:

- Maintain stability and continuity of coverage, care, and services for members and their dependents.
- Members should have continued access, on substantially similar terms and condition, to trusted family health care providers with whom they have developed a long-term relationship.
- The Director (CMS) may consider affordability, cost of coverage and care, and competition among health insurers and providers in the contract review process.

The specific changes in oversight authority for the Commission on Government Forecasting and Accountability are listed below:

- By April 1st of each year, the Director (CMS) must report and provide information to the Commission concerning the status of the employee benefits program to be offered the next fiscal year.
- By the first of each month thereafter, the Director (CMS) must provide updated, and any new information to the Commission until the employee benefits program for the fiscal year has been determined.
- Requires CMS to promptly, but no later than 5 business days after receipt of a request, respond to a written request by the Commission for information.
- Within 30 days after notice of the awarding of a contract has appeared in the Illinois Procurement Bulletin, the Commission may request information about a contract. The Commission must receive information promptly and in no later than 5 business days.
- No contract may be entered into until the 30-day period has expired.
- Changes or modifications to proposed contracts must be reported to the Commission in accordance with the aforementioned points.
- CMS must provide to the Commission a final contract or agreement by the beginning of the annual benefit choice period.
- States that the benefits choice period must begin on May 1st unless interrupted by the collective bargaining process. In the case that the collective bargaining process is still pending on April 15, the benefit choice period will begin 15 days after the ratification of the agreement.
- Specifies the methods used to provide the Commission with requested information and discusses confidentiality.
- States that all contracts are subject to appropriation and must comply with the Illinois procurement code.

BACKGROUND

The Commission on Government Forecasting and Accountability (CGFA) is a not-for-profit, bipartisan, joint legislative research commission that provides the Illinois 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 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 research reports each year, a sample of which are listed below. 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 “Capital Plan Analysis” examines the State's capital appropriations plan and debt position. “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 may publish special topic reports that have or could have an impact on the economic well-being of Illinois. For a listing of all reports published, visit the Commission’s website.

These reports are available from:

Commission on Government Forecasting and Accountability
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(217) 782-5320
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