FY 2025 LIABILITIES OF THE STATE EMPLOYEES' GROUP HEALTH INSURANCE PROGRAM

COMMISSION ON GOVERNMENT FORECASTING & ACCOUNTABILITY

MARCH 2024

Commission on Government Forecasting and Accountability

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March, 2024

EXECUTIVE SUMMARY

Under the State Employees' Group Insurance Act of 1971 (5 ILCS 375), the Commission on Government Forecasting and Accountability (CGFA) has certain statutory requirements.

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

CMS has provided information for the 2025 fiscal year indicating a continuation of the existing contracts in place as well as negotiated rate increases for group insurance participants. However, FY 2025 expected liabilities are projected to be significantly higher than in FY 2024. CMS has stated that they expect this due to health cost inflation and various legislative mandates for health care procedures and coverage. The Department continues to offer a variety of Health Maintenance Organization (HMO), Open Access Plan (OAP), and Preferred Provider Organization (PPO) plans for members and dependents. In accordance with public employee union negotiations, current health insurance plan rates will differ depending on the specific plan chosen. Existing funding and plan design components are largely unchanged.

FY 2025 will see the second full year of the Medicare Advantage PPO plan offered by Aetna that replaced all other existing Medicare Advantage plans for retirees and their dependents at the end of the 2022 calendar year. Due to federal requirements, Medicare Advantage plans begin and end in line with the calendar year rather than the Illinois fiscal year of July 1 to June 30. Accordingly, while the Aetna PPO MA plan began in January 2023, FY 2024 was the first full fiscal year with this plan in effect.

According to CMS, for the 2025 fiscal year, the GRF appropriation is projected to be $2.327 billion for SEGIP, with total expected revenues projected at approximately $3.769 billion. CMS estimates the FY 2025 liability to be $3.775 billion, a 16.5% increase from the FY 2024 anticipated final liability of $3.242 billion. CMS has noted that this significant increase is reflective of medical cost inflation and more expansive medication coverages for the individuals in the SEGIP. Noting these predictions, the Commission has presumed that liabilities and revenues will increase from FY 2024 and estimates a total SEGIP liability of $3.799 billion in FY 2024, $24.4 million more than CMS.

As noted above, for FY 2025, liabilities are projected by CMS to increase significantly (16.5%), compared to a 4.0% increase in FY 2024 liabilities. This projected increase is the largest in the last eight fiscal years. FY 2025 revenues are projected to increase compared

to FY 2024 by approximately $463 million, primarily due to an increased GRF appropriation. For FY 2025, member contributions are projected to total $526 million, compared to $501 million in FY 2024, a $25 million increase. Reimbursements are projected to increase to $503 million compared to $414 million in FY 2024. The Road Fund is projected to account for $156 million for FY 2025, an $8 million increase, compared to $148 million in FY 2024. Two major liability changes anticipated in FY 2025 are (1) the general increase in health insurance liability lines due to healthcare cost inflation and recent legislation mandating various medication coverages, and (2) the continued elimination of almost all Medicare Advantage liability for FY 2025 as a result of contract negotiations that will eliminate premiums for the State and recipients (though copayments, etc. still will apply). The vision liability line is anticipated to decrease slightly ($1.6 million) compared to FY 2024.

CMS expects FY 2025 to continue the goal of minimizing existing held claims and projected hold times on the part of CMS in processing payments to healthcare vendors and insurance companies, as has been the case since FY 2023. Self-insured vendors are projected to have no additional hold time on their bills at CMS while the QCHP and OAPs are also projected to have no additional hold time.

As noted in the FY 2024 SEGIP Report, one of the significant long-term effects of COVID-19 on the SEGIP included the suspension of most non-essential care to prioritize COVID-19 care. This significantly offset costs for health plans. Many procedures and services which might otherwise have been performed and utilized were delayed or cancelled entirely, reducing overall costs for health insurers. For Illinois and the SEGIP, it may partially explain relatively level liabilities for the 2020-2023 fiscal years. However, FY 2024 expected total liabilities and FY 2025 projected liabilities reflect a return to normal healthcare use and treatments (and associated increased liabilities).

GRF APPROPRIATION/REVENUE AND LIABILITY HISTORY FY 2018-2025 ($ in Millions)

Fiscal Year	Appropriation Received	Revenues	CMS Liability
FY 2018	$1,340.0	$6,306.6	$3,159.1
FY 2019	$2,176.2	$3,201.8	$3,103.8
FY 2020	$2,440.2	$3,699.1	$3,093.2
FY 2021	$2,022.8	$3,208.5	$3,173.6
FY 2022	$2,753.2	$3,967.4	$3,089.1
FY 2023	$1,846.4	$3,092.3	$3,118.1
FY 2024**	$2,033.1	$3,306.6	$3,241.5
FY 2025**	$2,326.9	$3,769.1	$3,775.1

FY 2018 included bond revenue to pay down held bills and FY 2020 included interfund borrowing for the same purpose. FY 2022 includes a supplemental appropriation of $898 million.
**Estimated for FY 2024 and projected for FY 2025.

FY 2025 PROPOSED PLAN CHANGES

For FY 2025, the State is not expected to introduce new major policy changes to the existing health insurance plan arrangement utilized by employees, retirees, and dependents. However, various recently mandated requirements for state health insurance plans will allow coverage of a variety of specific medications not otherwise guaranteed to be covered, such as certain weight-loss medications. Otherwise, premiums are expected to increase in line with labor negotiations and the health plan premium graduation introduced in FY 2021. The Consumer Driven Health Plan (CDHP) is expected to continue and increase in utilization in FY 2025, as the benefits for younger users continue to be attractive compared to more robust and costly plans. Different types of plans (based on choices between individual and multiple dependent plans) will also continue to have a variety of rates, which will be detailed later in this report.

FY 2025 CGFA COST ESTIMATE

The Commission on Government Forecasting and Accountability (CGFA) utilizes the CMS forecast for FY 2025 medical costs as the basis for estimating costs for FY 2025 along with information provided by the Segal Company in their annual report on group insurance trends. The CGFA State of Illinois liability cost projection uses the following assumptions based on historical claims data and anticipated cost changes.

Trend Factors	
Medical (QCHP plan)	0.8%
Dental (QCHP)	6.3%
HMO (Medical and Rx)	18.0%
Prescription drugs (QCDP)	36.4%
Open Access Plan	21.5%
Life Insurance	7.2%

It is useful to remember that the trend percentages listed above relate only to the portion of total medical costs incurred by the State of Illinois. Various policy choices, such as the shifting of eligible retirees and their dependents into Medicare Advantage plans, negotiated increases in employee contributions and co-payments, and the creation of the CDHP have allowed overall cost projections to the State to remain level or experience a limited rise in recent years. However, the yearly cost of providing healthcare for State employees, retirees and dependents continues to rise very quickly, compared to 10 or more years ago.

The medical trend inflation factors for the State consist of numerous components. These components include general medical cost inflation and leveraging (lower impact of coinsurance limits, level deductibles, etc.). Specifically for Illinois, the previously mentioned recently mandated coverage for various conditions and medications will also play a role. Also, advances in technological innovation, more use of equipment/services, and the continued "greying" (aging and extended living) of the population have contributed to greater health care costs for the State. In addition to these factors, a

gradual shift by employees to HMOs, OAPs, and the CDHP, 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 the moderation of overall State costs.

In reference to individual liability components, CMS projects liability increases for all plans except the Vision plan. The QCHP (including ASC fees) plan is expected to rise to $534 million in FY 2025, an 11% increase from FY 2024 ($481 million). HMO liability is projected to increase to $1.2 billion in FY 2025, a 17.3% or $176.8 million increase from FY 2024 ($1.0 billion). The OAP line is expected to rise to $1.6 billion in FY 2025, a large increase of $277.4 million or 20.8% from FY 2024 ($1.3 billion) while the CDHP is projected to rise from $28.3 million in FY 2024 to $36.6 million in FY 2025, though this is partly due to projected migration from other plans increasing liabilities. Dental plan liability is also projected to rise 5.6% ($7.8 million) from $139.9 million in FY 2024 to $147.7 million in FY 2025. While Medicare Advantage premium liability is projected to total $0 in FY 2025 (due to the negotiated elimination of premiums paid by the State and recipients in the new plan), the liability increases across the other SEGIP plans eliminate any overall cost savings to the total SEGIP liability.

In preparing this report, the Commission utilizes information from the annual cost trend survey report provided by the Segal Company. This report examines how large health plans are trending during the plan year. The following are some relevant findings of the 2024 Segal Health Plan Cost Trend Survey.

- For 2024, health plan costs are projected to increase between 6.8-8%.
- Medicare Advantage PPO plans are forecasted to increase their rates by 4.9%.
- For 2024, drug prices are anticipated to rise significantly (in the case of specialty drugs, by 14.5%) due to utilization, marketing, replacement of existing drug therapies, etc.
- Cost trend increases are driven by various factors, including supply shortages, healthcare staffing challenges, and new treatments and technologies.
- Recent developments in anti-obesity medications have shown promise to many people, and have accordingly fueled an interest in and utilization of these medications.
- Dental and vision plans are expected to have increases of 2.8% to 4.0%, depending on plan type.

- Healthcare costs continue to represent an increasing portion of total US Gross Domestic Product. Additionally, this increase is growing faster than nominal wage growth.

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 2024

Component	National Trend	CMS Estimate	COGFA Estimate
HMOs	7.6%	17.3%	18.0%
Rx	9.9%	35.5%	36.4%
Dental	4.0%	5.6%	6.3%
Vision	1.0%	-19.1%	-19.1%

Source: Segal 2024 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 historically tend to be lower in the aggregate.

The difference between national trends and State-level healthcare insurance trends can be seen in the comparison of trends between traditional health cost drivers listed in Table 1. While CMS and CGFA projections reflect the direction of national trends, the scale (or intensity) of these trends is amplified in the case of HMOs and Prescription Drugs in particular. This continues to present an interesting contrast in terms of cost containment. As older individuals who are demographically more likely to utilize healthcare services have moved into a MA plan, the inflationary pressure on traditional HMO plan rates has been reduced. Combined with the movement of (primarily younger) individuals into the CDHP, Illinois State employees/dependents/retirees have more and less expensive options (based on their preferences for coverage and care) than in previous years. This has traditionally translated to much lower overall cost increases to the State than might otherwise be expected from the aforementioned medical plan trends in the Segal survey. However, due to the aforementioned medical inflation and coverage mandates, projected Illinois liability in various areas is higher than the trends established by the Segal survey.

In general, CMS and CGFA trend estimates include programmatic effects that likely affect estimates beyond normal market trends. Hence, HMO liability is expected to increase for both CGFA and CMS projections for FY 2025 far above the projected increase on the

national level. While migration to the Consumer Driven Health Plan and other factors independent of national trends but specific to Illinois would normally serve to reduce liabilities, the required treatment coverages and inflationary cost pressures for Illinois for FY 2025 are projected to far surpass any savings from the CDHP. Over time, the CDHP is expected to become better known and utilized. This utilization is anticipated to help lower overall liabilities for existing non-CDHP plans.

In reference to Illinois dental and vision plan costs in Table 1, these costs tend to remain relatively stable year to year, though dental liability is projected to increase $7.6 million between FY 2024 and FY 2025. Vision liability is projected to decrease slightly in that same time period, from $8.4 million to $6.8 million. One practical note to keep in mind is that on a percentage basis, due to the relatively small amount of liability associated with these two categories, small increases in liability still have a significant percentage increase, depending on the years examined. **Based on these assumptions, trends, and inflation factors, CGFA estimates a FY 2025 liability of approximately $3.800 billion for the State Employee's Group Health Insurance Program.** Table 2 shows a detailed comparison of the CGFA estimate for the various cost components and the CMS projection for FY 2025, with minor program component lines combined for easier viewing and analysis.

TABLE 2: FY 2025 GROUP HEALTH INSURANCE LIABILITY
($ in Millions)

Liability Component	FY 2024 CMS Estimate	FY 2025 CMS Projection	FY 2025 CGFA Projection
QCHP Medical	$323.8	$324.1	$326.4
QCHP Prescriptions	$146.4	$198.4	$199.7
Dental	$136.5	$144.1	$145.1
HMO	$1,022.6	$1,199.4	$1,207.1
Medicare Advantage HMO/PPO	$0.0	$0.0	$0.0
Open Access Plan	$1,330.8	$1,608.2	$1,616.8
Consumer Driven Health Plan (CDHP)	$28.3	$36.6	$37.5
Teamsters Opt-Out Expense	$117.0	$123.8	$123.8
Vision	$8.4	$6.8	$6.8
Administrative Services	$14.7	$14.5	$14.6
Life	$89.2	$94.8	$95.6
Special Programs (Admin/Int./Other)	$23.9	$24.4	$26.1
TOTAL	**$3,241.6**	**$3,775.1**	**$3,799.5**
% increase over prior year	3.9%	16.5%	17.2%

*Rounding may cause slight differences. FY 2024 and FY 2025 Special Programs line includes Prompt Payment and Timely Payment Interest.

ESTIMATE COMPARISON

Overall, the Commission's FY 2025 estimate is $24.4 million higher than the FY 2025 estimate from CMS. CGFA's FY 2025 HMO and Open Access Plan liabilities estimates are $7.7 million and $8.6 million higher than CMS, respectively. CGFA's FY 2025 estimate for

the Quality Care Health Plan Medical line is $2.3 million higher than the CMS estimate. The Commission's estimate for the CDHP is $0.9 million higher than CMS.

The FY 2025 group insurance liability estimates between CMS and CGFA are very similar to each other, with less than 1% total difference between them. This consistency in estimates is reflective of the general trends in healthcare insurance and the relative stability in overall plan design changes anticipated for FY 2025. Future (and larger) differences in liability projections may occur depending on various factors, including possible changes in plan design and applicability as a result of labor negotiations and/or changes at the federal level. The factors influencing liability for FY 2025 may have a greater or lesser impact, depending on participant utilization of newly required covered treatments and medications.

CMS estimates that approximately $3.769 billion in revenues will be raised to fund the FY 2025 Group Health Insurance Program. This estimate is $463 million or 14% higher than the FY 2024 estimated revenue of $3.307 billion. CMS estimates that the FY 2025 liability will be $3.775 billion, approximately $533.5 million, or 16.5% higher than the FY 2024 estimated liability of $3.242 billion.

APPROPRIATION/FUNDING SOURCES

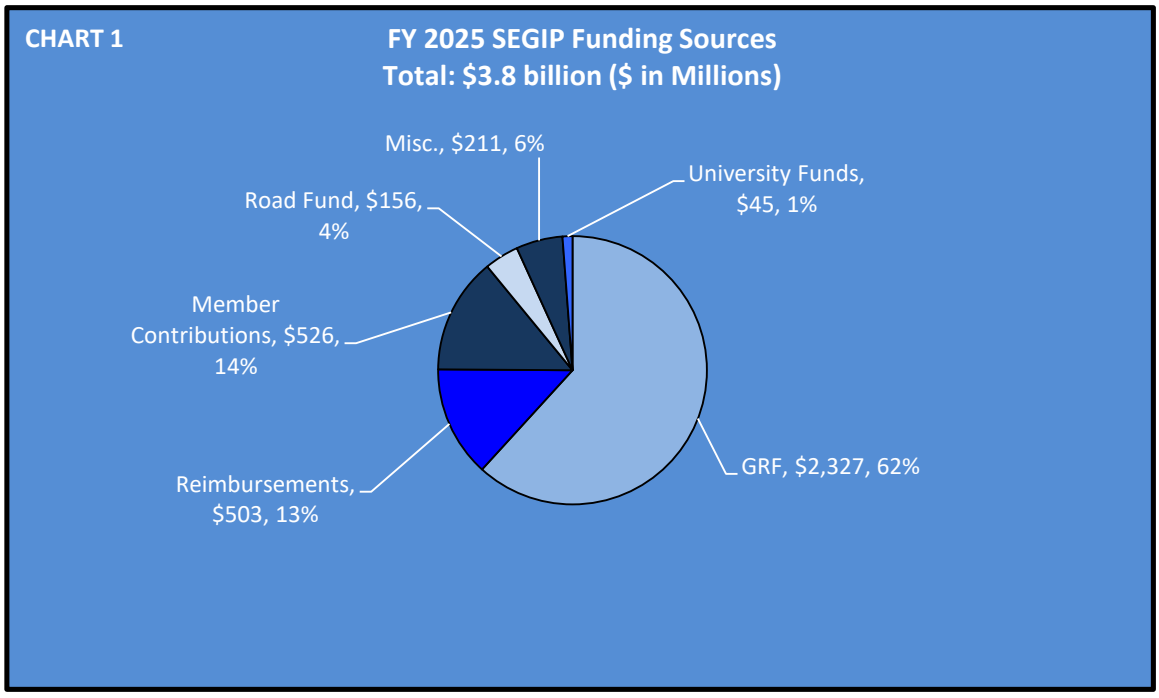
Funding for the State Employees' Group Insurance plans originates from two funds, the Health Insurance Reserve Fund (HIRF) and the Group Insurance Premium Fund (GIPF). Contributions and payments for health coverage benefits are deposited into HIRF, and contributions for life insurance are deposited into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

HIRF is the fund mainly used to administer the group insurance program. Pursuant to 5 ILCS 375/13.1, "All contributions, appropriations, interest, and other dividend payments to fund the program of health benefits shall be deposited into the Health Insurance Reserve Fund." Funding for HIRF comes from several different revenue sources, which include the General Revenue Fund (GRF), Road Fund, Member Contributions, Reimbursements, University Funds, and Miscellaneous Funds. The Department's estimated revenues for FY 2025 total $3.769 billion. This is a 14% increase from the 2024 fiscal year estimated revenue of $3.307 billion.

Member contributions are projected to increase to $526 million in FY 2025 (compared to $501 million in FY 2024). The Road Fund appropriation of $156 million expected in FY 2025 would be the highest appropriation since FY 2021, and an increase of $8 million from the $148 million expected in FY 2024. Other Funds reimbursements and Formulary Rebates are expected to increase by $89 million and $45 million respectively. Other components of total revenues are expected to remain substantially similar between FY 2024 and FY 2025.

These revenue projections represent the highest expected revenue for the SEGIP since FY 2022, which featured a supplemental $898 million appropriation. While some inflation

to revenues is anticipated over time as liabilities increase, the drastic increase to both liabilities and revenues is unlikely to repeat year-to-year unless similar inflation and coverage requirement expansions are repeated.



For FY 2025, the fiscal data provided by CMS shows the Group Health Insurance Program receiving $2.327 billion in GRF funds. This represents a $490 million (or 26.7%) increase from the FY 2024 GRF component of $1.837 billion. Absent a large increase in other sources of funding, this GRF projection should be anticipated to be the base for future years.

In regard to member contributions, depending on employee plan choices and overall employment trends (a push in hiring or conversely, an early retirement initiative), member contributions may increase or decrease as employees migrate to preferred plans based on the new premium rate structure. For example, if fewer employees choose to move to CDHP (a High Deductible Health Plan), employee contributions may be higher as they will pay higher premiums depending on their preferred plan choice. Finally, university contributions are projected to be flat compared to the 2024 fiscal year, as the Administration has proposed keeping contributions at $45.0 million in FY 2025.

TABLE 3: GROUP INSURANCE FUNDING SOURCES FY 2024 - FY 2025 ($ in Millions)				
	FY 2024	FY 2025	$ Change from FY24	% Change from FY24
GRF Appropriation	$1,836.8	$2,326.9	$490.1	26.7%
Proposed GRF Supplemental	$182.8	$0.0	($182.8)	0.0%
Prior Year GRF	$13.5	$0.0	($13.5)	0.0%
Road Fund	$148.3	$156.5	$8.2	5.5%
University Cont.	$45.0	$45.0	$0.0	0.0%
Prior Year Univ. Cont.	$0.1	$0.0	($0.1)	0.0%
Member Cont.	$500.6	$526.4	$25.8	5.2%
Other Funds	$413.7	$503.1	$89.4	21.6%
Medicare Part D rebate	$0.0	$3.9	$3.9	0.0%
Rebates/Interest/Other.	$165.9	$207.4	$41.5	25.0%
TOTAL	**$3,306.7**	**$3,769.2**	**$462.5**	**14.0%**
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 2025 budget projected target balance for the Group Insurance Program is $28.4 million. For FY 2025, the GIPF target balance is $5 million, and the target HIRF balance is $23.4 million.

BENEFITS

The State Employees' Group Insurance Program has traditionally provided medical, dental, vision, and life insurance coverage to State employees, retirees and their dependents. Medical coverage is provided separately to members in their choice of the QCHP plan and various types of managed care plans such as Health Maintenance Organizations (HMO), Open Access Plan (OAP), and the Consumer Driven Health Plan (CDHP). Vision coverage, which includes savings on exams, glasses, and contacts, is provided at no additional premium costs.

As in prior years, providers are encouraging the use of telemedicine and other preventative/diagnostic options. Telemedicine is the practice wherein patients will have the option to consult physicians/nurses via telephone regarding standard medical needs and obtain information, prescriptions, and referrals rather than the patient being required to physically travel and consult a healthcare provider. While this option does not preclude emergency care or physician-supervised actions that require a clinical setting to perform, telemedicine is an attractive option for users in rural areas, or with significant travel issues, or other health/etc. related issues. Additionally, the copayment for telemedicine services is (on average, across the health insurance sector) one-half the current charge for a physical physician's consultation copayment, providing fiscal savings for consumers. While it is likely to be used in future years as a source of easing congestion

at medical provider locations and providing a triage opportunity in administering care, telemedicine may be useful in assisting other palliative options for medical providers. Furthermore, SEGIP participants are encouraged to use a variety of plan/member specific resources available online or via telephone to coordinate healthy lifestyle habits and other practices that are hoped to reduce the usage of more expensive healthcare resources and procedures.

As in prior years, the State will offer a High Deductible Health Plan in FY 2025, the Consumer Driven Health Plan (CDHP), similar to other states such as Kansas and Texas. This plan offers a low-premium option for employees who prefer to minimize their health insurance deductions from their paychecks. Additionally, this plan is beneficial to the State as it is expected to be less difficult to administer with smaller overall liability compared to the other available plans. Specifically, the CDHP features a $1,600 deductible for employees to reach before primary health insurance benefits would be administered. For employees anticipating few health insurance needs, the savings from choosing this plan would potentially outweigh any routine health costs incurred over the course of the year.

According to CMS and their actuarial analysis, it is expected that primarily younger members will choose this plan as their option, as those individuals tend to have fewer health-related expenses and overall needs compared to older employees. Older employees tend to utilize more health insurance options as they are more likely to have health-related needs (and require services covered by higher premium plan options) and have families who also would utilize benefits covered under higher premium plan alternatives. As such, this plan is open specifically to only active employees and their dependents. As of the drafting of this report, CMS projects approximately 5,099 active members and dependents will utilize this plan in FY 2025, compared to the utilization from FY 2024 (4,153).

When retirees reach the age of eligibility, they are enrolled in a Medicare Advantage plan. Starting in FY 2014, Medicare-eligible retirees and their Medicare-eligible dependents were moved into Medicare Advantage (MA) plans. As of FY 2025, individual retirees and dependents are eligible for the Aetna MA PPO plan. This is a change from prior years, where a variety of MA HMO plans were available, but the current option is the only State-supported option as of January 2023.

Retirees and dependents can still access benefits from the same dental, vision and life insurance plans that current State employees and dependents utilize. For FY 2025, 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. Appendix I provides further details regarding the types of health and dental plans offered by the State.

Basic life insurance is provided at no cost to employees, retirees and annuitants. 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

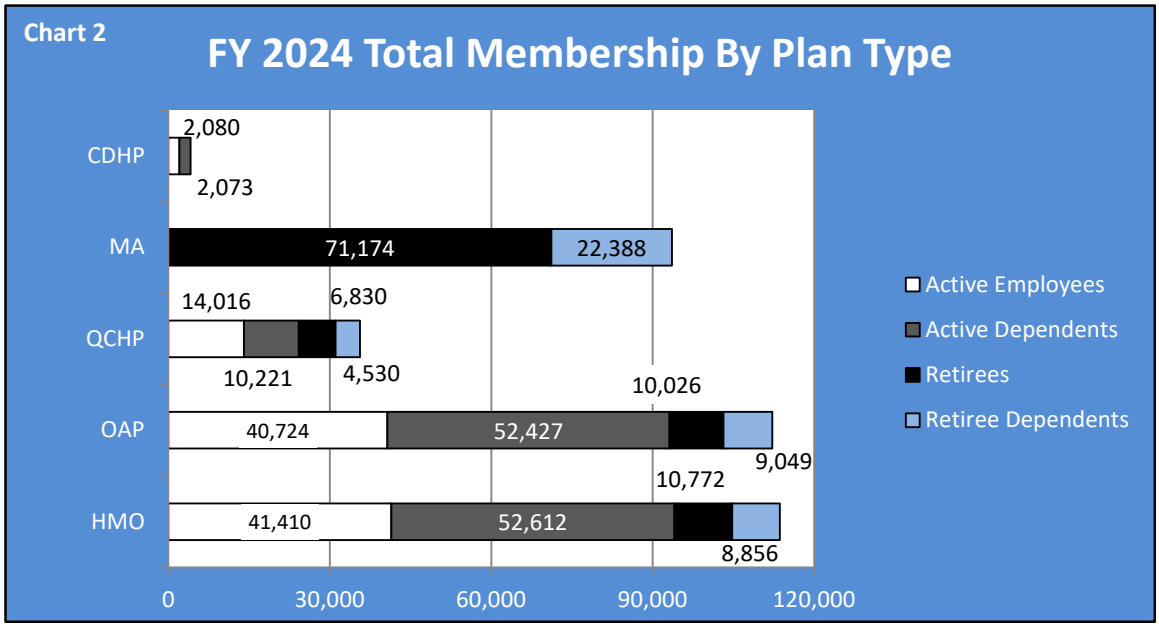
of 60, at which time the benefit amount becomes $5,000. Employees are allowed to purchase optional term life insurance up to eight times their annual salary, as well as spouse and child term life insurance at group rates.

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

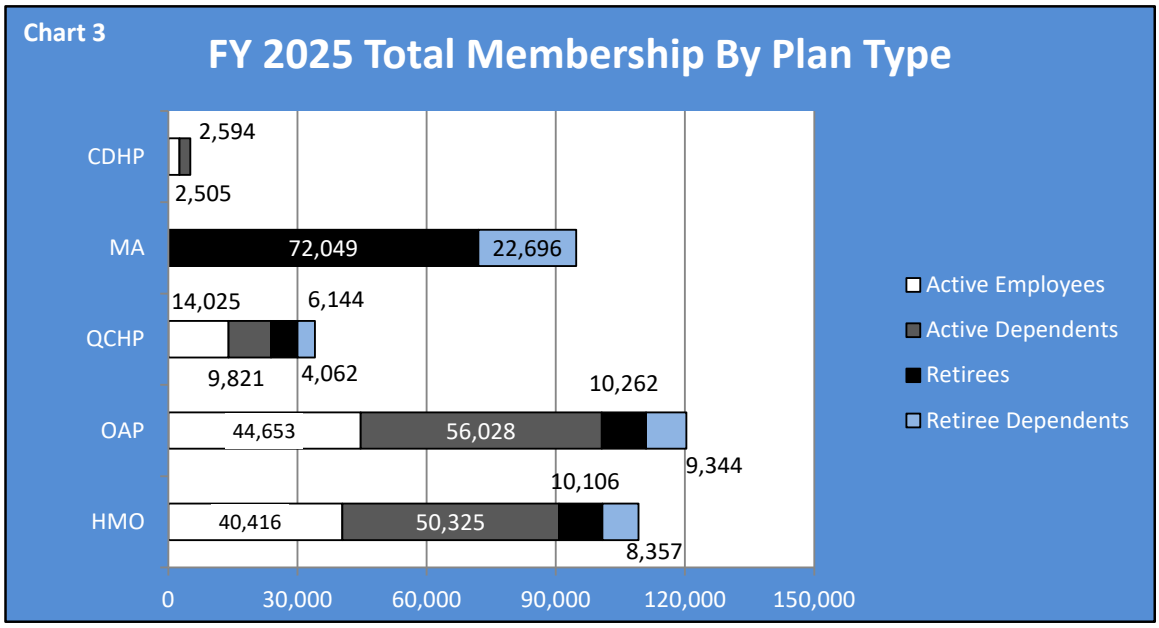
According to CMS, the State Employees' Group Health Insurance Program has an estimated 359,188 participants for FY 2024, of which 113,650 are in a non-Medicare Advantage HMO, 4,153 are in the CDHP, 93,562 are in the Medicare Advantage PPO, 112,226 are in an Open Access Plan, and 35,597 are in the Quality Care Health Plan. The QCHP is estimated to have 14,016 employees, 10,221 active employee dependents, 4,530 retiree dependents, and 6,830 retirees in FY 2024.

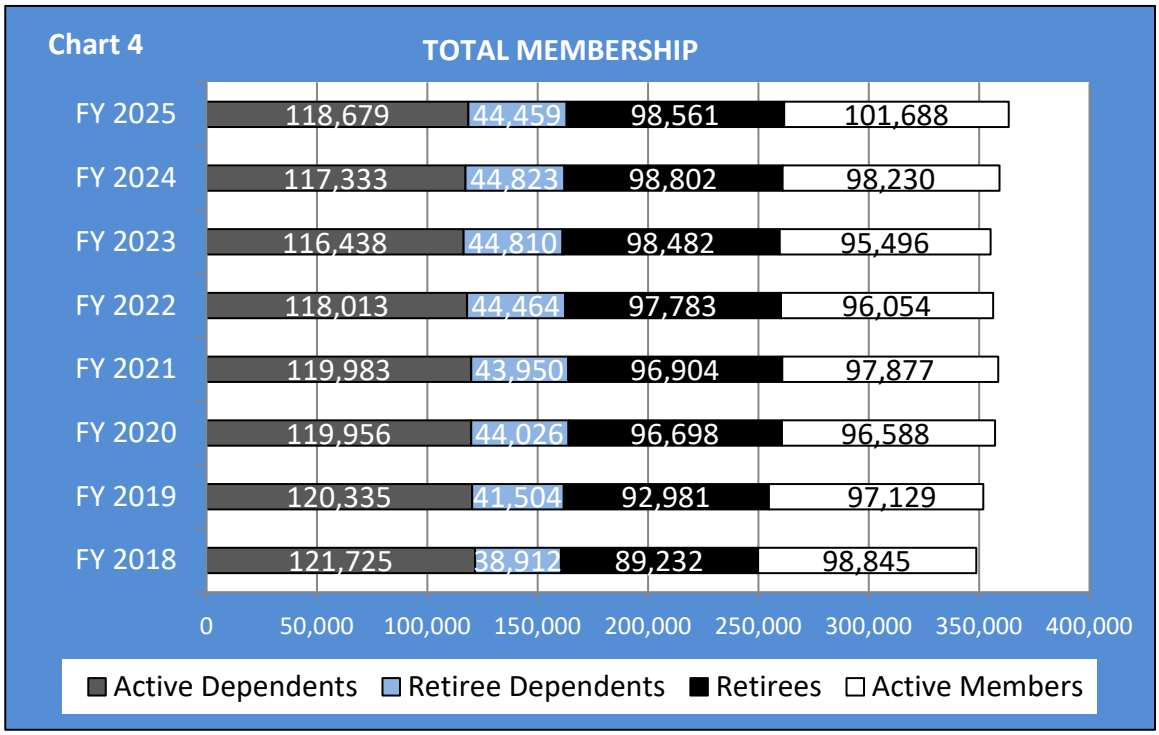
Traditional HMO plans are estimated to have 41,410 employees, 52,612 active employee dependents, 8,856 retiree dependents, and 10,772 retirees in FY 2024. The CDHP is estimated to have 2,080 active employees and 2,073 active employee dependents. The Medicare Advantage plan in FY 2024 includes 22,388 dependents and 71,174 retirees. OAPs are anticipated to have 40,724 employees, 52,427 active employee dependents, 9,049 retiree dependents, and 10,026 retirees in FY 2024. This information is displayed in Chart 2.



For FY 2025, the QCHP is estimated to have 14,025 employees, 9,821 active employee dependents, 4,062 retiree dependents, and 6,144 retirees. The Medicare Advantage PPO plan is expected to have 22,696 dependents and 72,049 retirees. Non-Medicare

Advantage HMO Plans are expected to have 40,416 employees, 50,325 active dependent lives, 8,357 retiree dependents, and 10,106 retirees. OAPs are expected to have 44,653 employees, 56,028 active dependents, 9,344 retiree dependents, and 10,262 retirees in FY 2025. The Consumer Driven Health Plan is projected to have 2,594 employees and 2,505 active employee dependents, which are primarily assumed to come from existing HMO plans. Total FY 2025 membership is expected to increase by 340 participants from 359,188 to 363,387. This information is displayed in Charts 3 and 4.





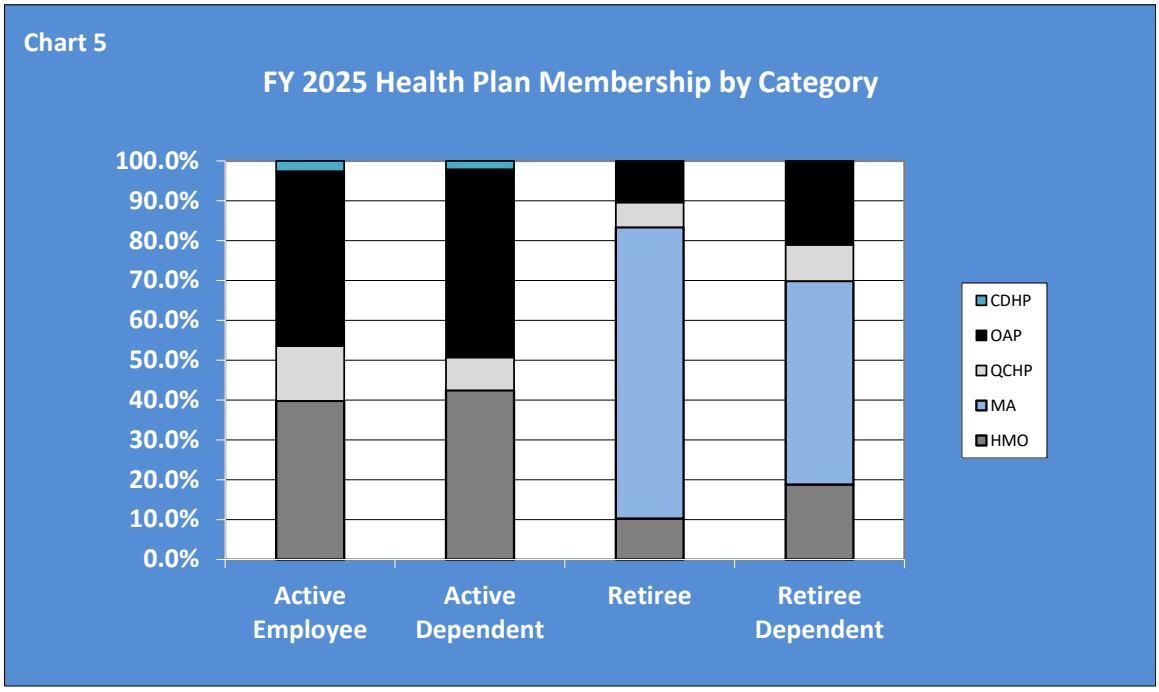
- **Membership is projected for FY 2025.**

ENROLLMENT TRENDS

Membership in the Quality Care Plan has been decreasing since FY 2005, while membership in the States' managed care offerings has been increasing since FY 2004. Since FY 2012, many participants have transitioned away from traditional managed care (HMOs) to alternatives such as the Open Access Plan (OAP) and the CDHP (since FY 2021). This trend is reflected in FY 2024-FY 2025 membership projections by CMS.

For FY 2025, membership in HMOs is broken down by standard HMO membership and CDHP membership. OAP membership is expected to continue the trend from FY 2024 to be the highest participant category (for active employees and their dependents) among those measured (QCHP, HMOs, etc.). The Medicare Advantage PPO plan is expected to rise from 93,562 in FY 2024 to 94,745 for FY 2025. Membership is expected to continue 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 Medicare Advantage by retirees, the QCHP has become less utilized among employees as a whole, especially retirees. In FY 2025, 73% of retirees and 51% of their dependents are expected to enroll in the Medicare Advantage PPO. This represents an inflection point wherein a majority of all retirees/dependents are now on a significantly lower-cost plan (in terms of liability) for the State. Chart 5 demonstrates that employees and dependents are moving towards managed care and Open Access Plans, though some are moving to the new CDHP.



LIABILITY

The Department's estimate of liability for FY 2025 represents a 16.5% increase from FY 2024, primarily due to significantly increased medical trend inflation and new required coverage for certain treatments/medications (as stated by CMS). Table 4 illustrates the cost components for the Group Health Insurance Program from FY 2016 through FY 2025 and demonstrates how several areas have increased/decreased over time to make up the majority of the State's total liability. Historically, the Quality Care Health Plan, Prescription Drugs, and HMO's have made up the largest segments of total liability. However, in recent years, the majority of liability has been contained within the HMO, OAP, and QCHP lines. The Open Access Plan is anticipated to compose the largest component of overall liability for FY 2025, with $1.61 billion out of a total group insurance liability (estimated) of $3.78 billion.

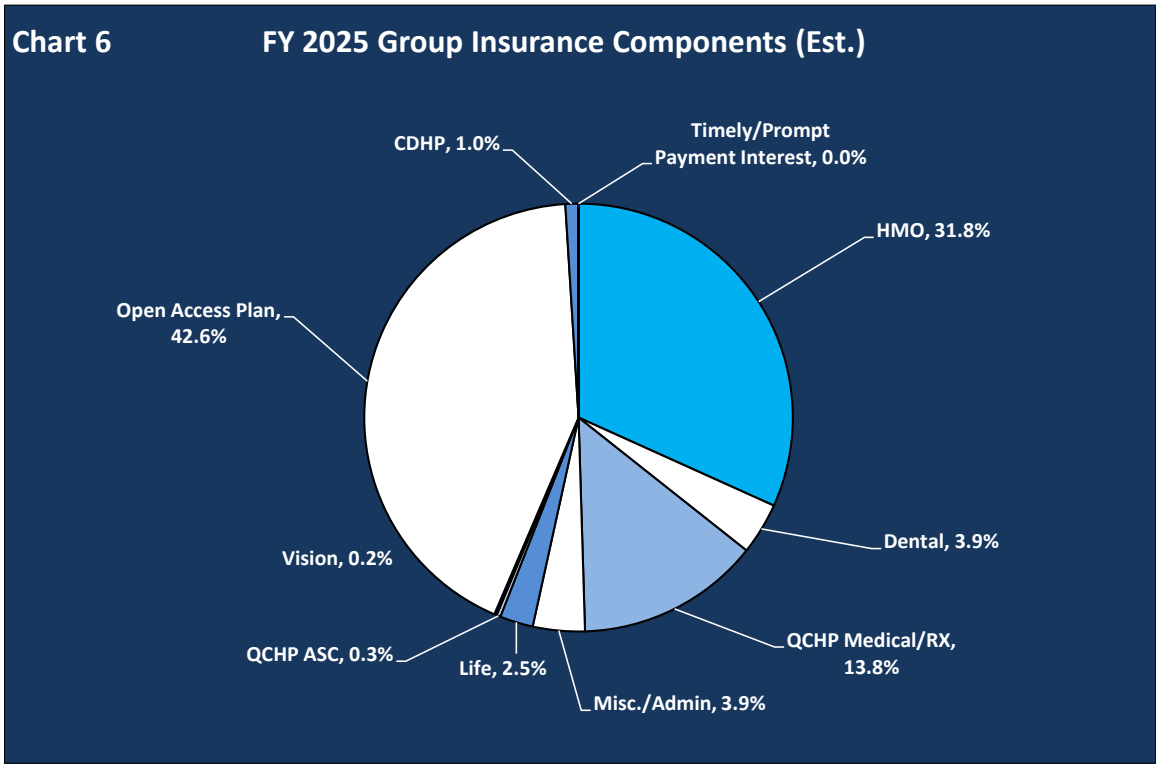
The Interest Payments category has been virtually eliminated in recent fiscal years due to large payments made in FY 2018/FY 2019, and was almost entirely negated in FY 2023 due primarily to an expected supplemental appropriation in FY 2022. This was the first time in many years that Interest Payments was not a significant component of group insurance liability. The issue of State interest payments and paying down those liabilities is addressed in the following section of this report. The Administration/Other category continues to rise, primarily due to steadily 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. Under this agreement, the Teamsters are allowed to opt-out of the SEGIP and enroll in a health plan administered by the Teamsters Health and Welfare Funds. According to the collective bargaining agreement signed with the State, the State pays a specific dollar amount for each person who opted-out and enrolled in the alternative plan. The liability for this "opt-out" has risen from $6 million in FY 2015 to $124 million in FY 2025. While a subsequent bargaining agreement has ensured that no new members will be permitted to opt-out, it is expected that rates will continue to increase through inflation and existing members becoming more expensive to insure over time absent corrective/negotiated action by the State. This information may change, given that it is current as of February 2024 and the liability projections available from CMS at that time.

Other components of liability such as Vision, Dental, and Life Insurance are projected to increase somewhat from FY 2024 to FY 2025, except for the Vision component, which is projected to decrease slightly. These components are only a minor portion of total liability as a whole, and are expected to remain in that position in years to come, as much more expensive QCHP/HMO/OAP plans are utilized by most State employees, retirees, and dependents. Depending on the participation rate by active members and their dependents, the CDHP may become a significant component of overall liability over time, as it is projected to amount to $37 million in FY 2025, after totaling $28 million in FY 2024.

Table 4 STATE EMPLOYEES' GROUP HEALTH INSURANCE LIABILITY (CMS ESTIMATE) FY 2016-FY 2025										
$ in (millions)										
Liability Component	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025 (Est.)**
QCHP Medical/Rx	$488	$488	$512	$517	$497	$511	$550	$486	$470	$523
CDHP	$0	$0	$0	$0	$0	$9	$27	$23	$28	$37
HMO Medical	$934	$976	$1,037	$1,067	$1,088	$1,083	$984	$994	$1,023	$1,199
Medicare Advantage	$168	$183	$200	$197	$188	$175	$154	$75	$0	$0
Dental	$118	$113	$118	$124	$108	$133	$130	$133	$140	$148
Open Access Plan	$669	$703	$779	$842	$860	$990	$988	$1,169	$1,331	$1,608
QC Mental Health	$5	$6	$5	$6	$6	$6	$0	$0	$0	$0
Vision	$8	$8	$8	$8	$8	$9	$8	$8	$8	$7
Life Insurance	$91	$90	$90	$88	$92	$94	$82	$85	$89	$95
QC ASC	$15	$14	$15	$14	$15	$14	$13	$12	$11	$11
Interest Payments	$262	$196	$275	$104	$73	$24	$25	$0	$0	$0
Admin/Other	$53	$103	$120	$137	$159	$126	$129	$133	$140	$148
Total	**$2,810**	**$2,878**	**$3,159**	**$3,104**	**$3,093**	**$3,173**	**$3,091**	**$3,119**	**$3,240**	**$3,776**
% change over PY	**1.7%**	**2.4%**	**9.8%**	**-1.8%**	**-0.3%**	**2.6%**	**-2.6%**	**0.9%**	**3.9%**	**16.5%**
Source: CMS. Rounding causes slight differences in totals.										

Chart 6 includes the various components of the FY 2025 CMS liability estimate of approximately $3.776 billion. The largest component of the State Group Insurance Program continues to be the State's Managed Care (HMO and OAP) plans, which together have grown to represent 74.4% of FY 2025 liability. In comparison, the CDHP is projected to amount to 1.0% of FY 2025 liability.

Dental care, life insurance, and vision care equal 6.6% of total liability, down from 7.3% in FY 2024. The QCHP component (14.1%) is lower than FY 2024 (15.9%) and includes medical/prescriptions, mental health coverage, and administrative service charges. As mentioned previously, for FY 2025, interest payments are projected to not contribute significantly to Group Insurance liability, reflecting the proposed minimization of payment interest as a liability issue for the SEGIP.



As the movement of retirees to Medicare Advantage continues, it is highly 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 the Medicare Advantage PPO plan for the State of Illinois indicates that this area of liability is not likely to shrink in consistent size or proportion of total population enrollment in the near future.

In regard to Open Access Plans, they remain a popular option for State employees and non-Medicare eligible individuals who seek a middle ground between the affordability of HMOs and the options available to QCHP participants. However, their cost to the State has grown as more people migrate to OAPs. A new OAP option from Blue Cross Blue Shield started in FY 2022.

One important note regarding liability is the successful attempt by the State to address interest payment liabilities and the issue of "lost money," i.e. money that could be spent on other liabilities within the SEGIP. An increased GRF commitment to cover increased year-to-year liabilities paid down significant health insurance bill interest in FY 2020 and the supplemental appropriation for FY 2022 paid down the remainder of existing held bills. As the State has been able to keep bills paid on a timely basis in FY 2024, the saved money that would otherwise be paid out in interest payments can be used for a variety of purposes, including keeping overall SEGIP liabilities lower than otherwise.

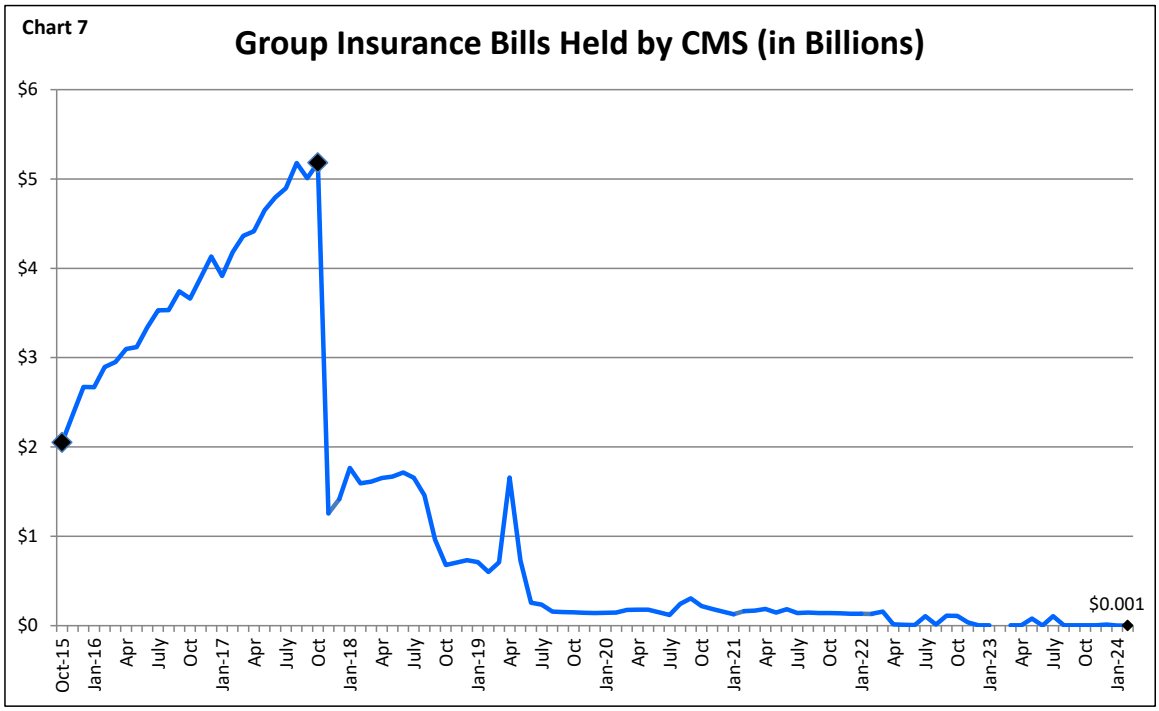
HISTORICAL GROUP INSURANCE INTEREST AND BONDING

Since 2013, SEGIP interest payments had grown, sometimes at an alarming rate, as the State was forced to push payments for services further and further into the future. This was done by "holding" claims until the actual money was available for payment. As a result, these "held claims" accrued interest at rates of 9% or 12% annually depending on the criteria of the claim. Timely Pay Interest (0.75% per month), as cited in the Illinois Insurance Code, covers QCHP, OAP, Dental, and Mental Health claims payments. This interest is calculated at 9.0% annually after an initial 30-day period.

Prompt Payment Interest (12.0%), as cited in the Prompt Payment Act, covers HMOs, Vision, Life Insurance, and administrative fees for the QCHP/OAP/Dental/Mental Health programs. This interest is calculated at 1.0% per month after an initial 90-day period. For example, claims in the QCHP, are typically paid out under the 9% calculation, while claims from HMOs are paid out at 12%. Various attempts have been made to lower this interest rate to save money for the State, but concerns have been raised as to the long-term effects for contracts with businesses that would have chosen to not work with the State if the interest on anticipated late payments was not available.

Further exacerbating the issue was the inability of the State to pass a budget into law in the late 2010s. Without spending authority, CMS was unable to pay down FY 2016 and FY 2017 claims and found it necessary to hold them as they accrued additional interest. CMS utilized employee premium contributions to help defray some of these costs (as this source of revenue was determined to be legally spendable outside traditional appropriations), but the vast majority of incurred claims remained unpaid and continued to accrue interest, including past-due interest (interest on interest) in some situations.

A State budget was eventually passed into law and provided funding for FY 2018, but no additional funding was provided to pay down the enormous amount of held bills. At the end of October 2017, the State had approximately $5.181 billion in health insurance claims waiting to be paid out. However, in November 2017, a bond sale was issued to pay down SEGIP and Medicaid bills. The bond proceeds were used to pay off approximately $3.982 billion in held group insurance bills, bringing the total bills held by Illinois to $1.256 billion at the end of November 2017. This total has been virtually eliminated in the past few years. Chart 7 displays the historical backlog of Group Insurance bills held at CMS.



As of the end of February 2024, approximately $1.3 million in Group Insurance bills (Dental claims) are being held by CMS awaiting transmission to the Comptroller's office for payment. Table 5 details the major portions of the current claims hold situation with existing interest rates of 9% and 12%, as of February 2024.

Table 5 Claims Hold Data for SEGIP (as of February 29, 2024)			
Vendor	Claims Hold	Length of Claims Hold (in days)	Interest Owed (Including Past Due Interest)
Aetna - PPO	$0	0	$0
Dental Claims Hold – PPO	$286,914	25	$0
Dental - Non-PPO	$1,041,829	25	$0
Magellan (Mental Health) Claims	$0	0	$0
Aetna HMO	$0	0	$0
Health Alliance HMO	$0	0	$0
HMO Illinois	$0	0	$0
Blue Advantage	$0	0	$0
HealthLink OAP	$0	0	$0
BCBS OAP	$0	0	$0
Aetna OAP	$0	0	$0
CVS/Caremark	$0	0	$0
Aetna MA	$0	0	$0
Health Alliance MA	$0	0	$0
Humana Benefit Plan MA	$0	0	$0
Humana Health Plan MA	$0	0	$0
United Healthcare MA	$0	0	$0
Eyemed (Vision)	$0	0	$0
Metropolitan Life	$0	0	$0
Other (Fees/ASC/etc.)	$0	7	$0
Total	**$1,328,743**	**7-37**	**$0**
Source: CMS. MA stands for Medicare Advantage.			

In regard to payment cycles, the 2025 fiscal year is projected to minimize existing payment cycle delays between CMS and the various health vendors to less than $1 million. Under this system, vouchers for services submitted by vendors to the State for payment would be processed by CMS in a month or less. This has been sustained from FY 2023, and serves as an improvement over prior years, when payment vouchers would await servicing for months, if not years.

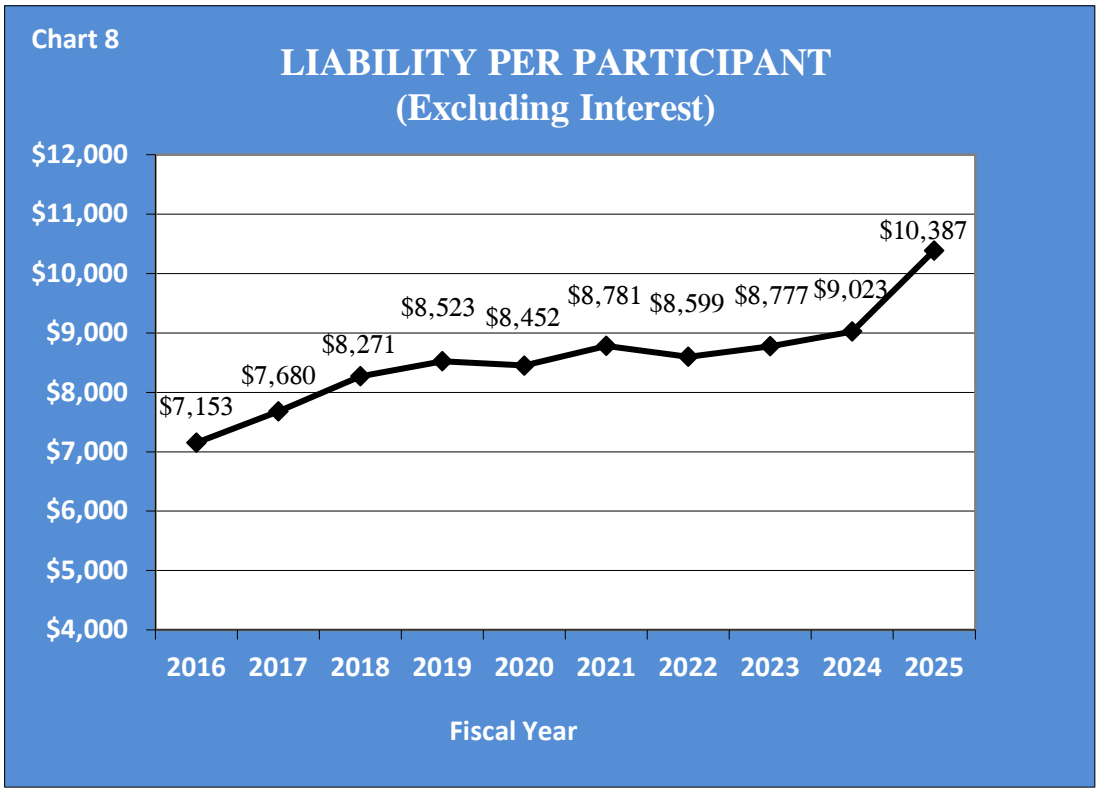
One important note on this subject is that this accounts only for the time for CMS to process claims and does not include time for the Comptroller to process and send out payment to the vendors in question. The Comptroller's timeliness depends on current cash flow needs and funds availability, which fluctuates daily. According to the Comptroller's office, as of the end of January 2024, they had approximately $107 million in Health Insurance Reserve Fund vouchers awaiting payment (an issue of timing forestalls complete payment of all vouchers, rather than availability of funds). Regardless of the means utilized, stable fiscal commitment is required to ensure prompt payment of claims to vendors and avoid excessive interest payments that dramatically inhibited State health insurance spending priorities only a few years ago.

ANNUAL LIABILITY PER PARTICIPANT

The liability per participant in the State Employees' Group Insurance Program is the total of the State's liability across all participants. Chart 8 shows the overall upward trend each year in cost per participant. As plan participants live increasingly longer lives, utilization of medical insurance plans (and thereby liabilities to the State) have tended to increase accordingly.

For FY 2016 – FY 2025 in Chart 8, this information is displayed without including interest payments in order to illustrate general medical plan trends more accurately. While interest was a major component of overall liability less than 7 years ago, this component has shrunk in recent years and has been minimal since FY 2023. For comparison with the current year, the annual liability per participant in the group health insurance program was $7,153 in FY 2016.

According to CMS, the liability per participant for FY 2024 will increase to $9,023, an increase of $246 compared to FY 2023. For FY 2025, the estimated liability per participant is projected to be $10,387, a large increase of $1,364. This represents a 45.2% increase over FY 2016. From FY 2016 to FY 2025, liability has increased $359/year.



As such, the FY 2025 liability per participant is projected to increase 15% from FY 2024. It is necessary to note that this is only an aggregate liability representation, which is not itemized based on the types of plans used by participants or any other variables. While it is informative of general liability trends, it is not indicative of all possible medical inflation factors.

In the wake of the COVID-19 pandemic, the impact from the State introducing the Consumer Driven Health Plan (CDHP) in the 2021 fiscal year has been fiscally promising. In conjunction with the Medicare Advantage plan, overall liabilities per participant moderated compared to increases in prior years. While savings are expected for the State in the long run, as younger employees and dependents utilize this plan, the overall SEGIP liability is anticipated to remain on an upward trajectory due to traditional extraneous factors such as demographics and medical service utilization. For example, in the case of FY 2025, while the CDHP reduces liabilities compared to any other health plan, the savings are projected to be overshadowed by other factors. It is likely that absent a major change in these areas, overall liability and liability per participant will rise from year to year (as is observably the case for FY 2024 in retrospect and projected for FY 2025), though the CDHP represents a successful attempt to address medical service utilization and demographics in a manner so as to save money for both individual active participants and the State of Illinois.

Table 6: ANNUAL LIABILITY PER PARTICIPANT

	FY 2024 Total Participants	FY 2025 Total Participants	FY 2024 Liability Per Participant	FY 2025 Liability Per Participant
QCHP	35,597	34,052	$13,301	$15,619
CDHP	4,153	5,099	$7,089	$7,721
MA HMO / PPO	93,562	94,745	$0	$0
HMO	113,650	109,204	$9,050	$11,157
OAP	112,226	120,287	$11,972	$13,666
Totals	**359,188**	**363,387**		

OAP is the Open Access Plan. CDHP is the Consumer Driven Health Plan. ALPP does not include dental, vision, admin/interest/other, or life insurance. FY 2025 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. MA liability is virtually eliminated due to

When comparing annual liability per participant (ALPP) in Table 6, the annual liability for FY 2025, as in prior years, is lowest for members in the CDHP and highest for members in the QCHP. The total number of participants in the QCHP has declined over the years, especially in FY 2014 – FY 2015 as people have steadily migrated to HMOs and OAPs. Accordingly, this shift has resulted in an increase in average cost for remaining QCHP participants, as those who remain, including non-Medicare eligible retirees and dependents are predominantly more expensive to cover (requiring more treatment,

medicines, etc.). The QCHP is also the preferred plan for retirees and dependents (until they move to the Medicare Advantage PPO plan) who live or travel primarily out of Illinois, as traditional HMOs/OAPs have limited coverage and higher co-payments outside the State. This results in the higher projected liability for QCHP participants (compared to others) in FY 2025. 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 $13,620 in FY 2024. Member contributions for QCHP enrollees are expected to total $66 million in FY 2024. In addition, many retirees (starting in FY 2014) have been moved out of QCHP into the Medicare Advantage 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 and Open Access Plans) also have significant average liabilities per participant which are only partially offset by member contributions. The Medicare Advantage plan is an outlier, as discussed previously. Table 7 examines the relationship between overall cost and the offset by member contributions for FY 2024 and FY 2025.

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

	FY 2024 State ALPP	FY 2024 Member Contributions	FY 2024 Member Contribution %	FY 2024 State Liability	FY 2025 State ALPP	FY 2025 Member Contributions	FY 2025 Member Contribution %	FY 2025 State Liability
QCHP	$13,620	$1,865	13.7%	$11,755	$15,943	$1,952	12.2%	$13,991
CDHP	$7,089	$1,404	19.8%	$5,684	$7,721	$1,449	18.8%	$6,272
MA HMO/PPO	$0	$10	N/A	($10)	$0	$10	N/A	($10)
HMO	$9,050	$1,425	15.7%	$7,626	$11,157	$1,500	13.4%	$9,657
OAP	$11,972	$1,513	12.6%	$10,459	$13,666	$1,580	11.6%	$12,086
Dental	$386	$116	30.1%	$269	$401	$126	31.4%	$275

Source: CMS.

Table 7 shows that QCHP members are expected to contribute 12.2% of the overall annual cost of providing their insurance in FY 2025. HMO and OAP members are expected to contribute 13.4% and 11.6% of their overall liability cost in the same time period. Members of the Consumer Driven Health Plan are estimated to contribute 18.8% of the overall liability, a higher proportion than the other standard options. Members that participate in the State's dental offering are expected to pay 31.4% of the overall liability cost in FY 2025. 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.

Liability may also change slightly year-to-year based on expenses incurred in a particular fiscal year from paying down held bills in a particular category (HMOs/etc.). For example, the Dental line in Table 7 may be slightly higher due in part to extra dental liabilities being incurred/paid off in a particular fiscal year. A stable budget that continues to promptly pays down these liabilities helps alleviate this issue, though some liabilities will always be

incurred in future fiscal years due to the natural billing cycle between providers, CMS, and the Comptroller's office.

EMPLOYEE/RETIREE COST COMPARISON

A subject of interest in recent years is the breakdown of costs for active employees and their dependents and retirees and their dependents. Table 8 displays a comparison of the costs for these groups taken from data obtained from CMS as of February 2024.

TABLE 8: RETIREE/DEPENDENT COSTS AND CONTRIBUTIONS FOR FY 2025
(Numbers in Millions)

Category	Cost	Category	Cost
Retiree Cost	$636.2	Active Employee Cost	$1,658.6
Retiree Contribution	-$38.1	Active Employee Contribution	-$296.9
Retiree Contribution %	6.7%	Active Employee Contribution %	23.1%
Other Revenues	-$27.4	Other Revenues	-$77.3
Net State Cost	**$570.7**	**Net State Cost**	**$1,284.4**
Retiree Dependent Cost	$302.3	Active Employee Dependent Cost	$1,178.0
Retiree Dependent Contribution	-$44.5	Active Employee Dependent Contribution	-$146.9
Retiree Dependent Contribution %	18.8%	Active Employee Dependent Contribution %	15.5%
Other Revenues	-$21.2	Other Revenues	-$85.4
Net State Cost	**$236.6**	**Net State Cost**	**$945.7**
Total Retiree Cost	$938.5	Total Active Cost	$2,836.6
Total Retiree Contribution	-$82.6	Total Active Contribution	-$443.8
Total Retiree Cont. %	10.2%	Total Active Cont. %	19.9%
Other Revenues	-$48.6	Other Revenues	-$162.7
Total State Cost	**$807.3**	**Total State Cost**	**$2,230.1**
Source: CMS			

Based on data provided by CMS, retiree dependents (but not active employee dependents) continue to pay a substantially larger portion of their total costs to the State in the form of contributions for their healthcare coverage. For FY 2025, retirees and retiree dependents are projected to pay 6.7% and 18.8%. This contrasts with active employees and their dependents, who are projected to pay 23.1% and 15.5% of their healthcare costs. In total, the aggregate contributions of active employees and dependents (19.9% for both groups combined in FY 2025 compared to 18.4% in FY 2024) remain significantly higher as a percentage than the aggregate contributions of retirees

and retiree dependents (10.2% for both groups combined in FY 2025 compared to 10.6% in FY 2024). This difference is accounted for by retirees utilizing the Medicare Advantage PPO plan (with no premiums, which results in savings for the State of Illinois) along with increased contributions by active employees and their dependents expected in FY 2025 (as was also the case in FY 2024).

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 2023, FY 2024, and FY 2025 plan enrollment is listed in Table 9.

TABLE 9: MANAGED CARE PLANS
FY 2023-2025 All Lives (Active Members/Dependents and non-MA Retirees/Dependents)

HMO/OAP	FY23 # of Participants	FY24 # of Participants	% Change 2023-2024	FY25 # of Participants	% Change 2024-2025
Health Alliance HMO	64,363	62,648	-2.66%	61,062	-2.53%
HMO Illinois	30,531	27,263	-10.70%	24,123	-11.52%
Blue Advantage	14,583	14,279	-2.08%	14,082	-1.38%
Aetna/Coventry Health Care HMO	9,043	9,460	4.61%	9,937	5.04%
Aetna/Coventry Health Care OAP	37,411	39,377	5.26%	41,554	5.53%
Health Link OAP	54,838	53,742	-2.00%	52,764	-1.82%
BCBS OAP	12,421	19,107	53.83%	25,969	35.91%
Consumer Driven Health Plan HDHP	3,245	4,153	27.98%	5,099	22.78%
TOTALS	**226,435**	**230,029**	**1.59%**	**234,590**	**1.98%**

Source CMS. FY 25 numbers are projected as of February 2024.

The Consumer Driven Health Plan draws some people out of existing plans, along with migration expected towards HMOs and lower-priced options in general. Under the contracts signed between the State and employee unions, rate increases are expected to continue for existing plans with higher rates expected for more expensive plans rather than the traditional equivalency between HMO and OAP options. This is discussed in further detail in the Monthly Premiums section of this report.

MEDICARE ADVANTAGE

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 program. FY 2023 population totals are reflective of all participants shifting to Aetna PPO in January 2023 (at the midpoint of FY 2023) at the start of the 2023 calendar year, due to federal requirements.

TABLE 10: MEDICARE ADVANTAGE PLANS
FY 2023-2025

HMO/PPO	FY23 # of Participants	FY24 # of Participants	FY25 # of Participants
Aetna HMO	3,002	0	0
Humana Benefit Plan HMO	91	0	0
Humana Health Plan HMO	2,211	0	0
Health Alliance HMO	1,267	0	0
United HealthCare PPO	38,975	0	0
Aetna PPO	46,000	93,562	94,745
TOTALS	**91,546**	**93,562**	**94,745**

Source: CMS. FY 25 numbers are projected as of February 2024.

It is important to note that except for a limited number of retirees and dependents coming from a HMO or OAP program, most of the 94,745 people projected to be covered in FY 2025 by the MA PPO plan came from the QCHP. In regard to MA, as a result of the State's MA provider contract award, the arrangement for FY 2024 and beyond is a single MA PPO plan provided by Aetna, rather than the assortment of plans in prior years. 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. Continuing in the 2025 fiscal year, as a result of negotiations with public employee unions, premiums for HMO/OAP/QCHP options are expected to moderately increase or remain steady, depending on plan coverage options and the specific plan provider chosen. Under this arrangement, HMO premiums are generally substantially lower than OAP premiums, though individual demographic cohorts within specific plans may be more comparable.

TABLE 11: PROJECTED MONTHLY COSTS
FY 2018 - FY 2025
Employee Only

	QCHP				CDHP			
	TOTAL	% Inc.	Member	State	TOTAL	%Inc.	Member	State
FY 18	$913	1.7%	$168	$745	N/A	N/A	N/A	N/A
FY 19	$984	7.8%	$168	$816	N/A	N/A	N/A	N/A
FY 20	$1,005	2.1%	$168	$837	N/A	N/A	N/A	N/A
FY 21	$1,077	7.2%	$195	$882	N/A	N/A	N/A	N/A
FY 22	$1,237	14.8%	$211	$1,026	N/A	N/A	N/A	N/A
FY 23	$1,152	-6.8%	$230	$922	$805	N/A	$179	$626
FY 24	$1,178	2.2%	$232	$946	$840	4.4%	$180	$660
FY 25	$1,386	17.7%	$243	$1,144	$933	11.0%	$191	$742

	HMO				OAP			
	TOTAL	% Inc.	Member	State	TOTAL	% Inc.	Member	State
FY 18	$800	6.7%	$126	$674	$947	11.4%	$125	$822
FY 19	$822	2.8%	$126	$696	$987	4.2%	$125	$862
FY 20	$836	1.7%	$127	$709	$973	-1.4%	$128	$845
FY 21	$850	1.7%	$155	$695	$1,093	12.4%	$167	$925
FY 22	$823	-3.1%	$170	$654	$1,118	2.3%	$183	$935
FY 23	$875	6.3%	$187	$688	$1,205	7.8%	$202	$1,003
FY 24	$943	7.8%	$192	$751	$1,252	3.9%	$204	$1,049
FY 25	$1,151	22.0%	$203	$949	$1,428	14.0%	$214	$1,214

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 2018 to the projected values for members in FY 2025. Whether members are in the QCHP, a traditional HMO, or an Open Access Plan, the monthly cost of such plans has steadily increased. Concurrently, the employee premiums for these plans have also increased, though at a much lower rate year-to-year until recently. For the purposes of comparison, the total costs and projected member contributions of the proposed Consumer Driven Health Plan (CDHP) are still lower than other alternatives.

Table 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 2025 fiscal year. As in previous years, members/dependents are

expected to pay a relatively small portion of total monthly rates compared to the total cost of health insurance coverage, though the increased contributions agreed to as a result of labor negotiations may reduce that gap over time.

TABLE 12: MONTHLY PREMIUMS
QCHP / CDHP / HMO / OAP
Weighted Average
FY 2025 Rates (Projected for Median Salary)

	QCHP			CDHP		
	TOTAL	Member	State	TOTAL	Member	State
Employee	$1,386	$243	$1,144	$933	$191	$742
Medicare Retiree	$935	$43	$893	$0	$0	$0
Non-Medicare Retiree	$2,116	$10	$2,107	$0	$0	$0
1 Dependent	$1,670	$302	$1,369	$784	$178	$605
2+ Dependents	$2,234	$345	$1,888	$1,343	$226	$1,117
Medicare Dependent	$2,034	$198	$1,836	$606	$152	$454

	HMO			OAP		
	TOTAL	Member	State	TOTAL	Member	State
Employee	$1,151	$203	$949	$1,428	$214	$1,214
Medicare Retiree	$767	$53	$713	$968	$53	$915
Non-Medicare Retiree	$1,786	$11	$1,775	$2,197	$11	$2,187
1 Dependent	$986	$193	$793	$1,215	$205	$1,010
2+ Dependents	$1,705	$240	$1,464	$2,090	$254	$1,836
Medicare Dependent	$804	$170	$634	$973	$179	$795

As with Employee-only premium projections and associated costs, premiums for all applicable active SEGIP member and dependent cohorts are projected to continue to rise (following a trend beginning in FY 2021). It is important to note that despite this increase and the traditional cost differential between plans, certain HMO/OAP/CDHP options may have a lower projected median premium than their traditionally less-expensive contemporaries.

TABLE 13: MONTHLY PREMIUMS ACROSS ALL PLANS HMOs / OAPs / CDHP FY 2024 Rates (for Median Salary)								
	Health Alliance	Aetna HMO	HMO Illinois	Blue Advantage	HealthLink OAP	BCBS OAP	Aetna OAP	CDHP
Employee	$196.11	$186.94	$184.47	$157.22	$205.51	$191.52	$194.80	$176.66
Medicare Retiree	$35.38	$35.38	$35.38	$35.38	$35.38	$35.38	$35.38	$0.00
Non-Medicare Retiree	$30.64	$30.64	$30.64	$30.64	$30.64	$30.64	$30.64	$0.00
1 Dependent	$198.35	$199.65	$165.98	$160.93	$208.40	$190.44	$190.44	$172.13
2 + Dependents	$248.60	$246.10	$209.41	$200.02	$261.19	$236.87	$236.87	$219.60
Medicare Dependent	$171.00	$172.00	$141.00	$137.00	$181.00	$163.00	$163.00	$146.00
FY 2025 Proposed Rates (for Median Salary)								
	Health Alliance	Aetna HMO	HMO Illinois	Blue Advantage	HealthLink OAP	BCBS OAP	Aetna OAP	CDHP
Employee	$213.04	$201.45	$200.44	$173.68	$221.08	$206.88	$210.94	$190.58
Medicare Retiree	$53.42	$53.42	$53.42	$53.42	$53.42	$53.42	$53.42	$0.00
Non-Medicare Retiree	$10.86	$10.86	$10.86	$10.86	$10.86	$10.86	$10.86	$0.00
1 Dependent	$204.45	$205.79	$172.13	$167.04	$214.53	$196.58	$196.58	$178.25
2 + Dependents	$254.79	$252.25	$215.66	$206.20	$267.29	$243.02	$243.02	$225.79
Medicare Dependent	$177.00	$178.00	$147.00	$143.00	$186.00	$169.00	$169.00	$152.00

Table 13 displays the average projected rates for employees, retirees, and dependents across all the HMO, OAP, and CDHP options. HMO plans are not necessarily less costly than OAPs. There are numerous factors involved in the rates submitted by health insurance providers, indicating that some plans may be better for participants based on their current status of active or retired, with or without dependents, etc. The Consumer Driven Health Plan (CDHP) option will have lower rates than most other options due to its unique characteristics, but it is limited to active employees and their dependents only.

Plan rates will be set by the particular plan type and optional demographic option, rather than a generally similar rate across all HMOs and OAPs. Accordingly, there is an approximate $48-$61/month spread between the most expensive and least expensive plans in Table 13 for FY 2025 (as was the case in FY 2024), with different plans having lower rates than others depending on the particular demographic components of the plan being considered. For example, while the CDHP is projected to have lower rates than most other plans in the table, the average rate for Employee-only and 1 Dependent plans make other HMOs and OAPs potentially more desirable (before taking their increased options into account). It is expected that competition between the various health insurance vendors will lead to more competitive rates in future fiscal years.

Table 14 shows a comparison between FY 2023, FY 2024, and projected FY 2025 MA rates for retirees and dependents. As discussed, while already low rates in FY 2023 meant relative equality across plan options, the adoption of a single PPO plan with no premiums (for at least the first 5 years of the plan according to the contract) is a significant financial benefit to both the State and individual participants.

TABLE 14: MONTHLY PREMIUMS FOR STATE MEDICARE ADVANTAGE PLANS FY 2023-2025 Rates (As of February 2024)			
Aetna PPO	FY 2023	FY 2024	FY 2025
Medicare Retiree	$0.40	$0.38	$0.36
Two or More Dependents	$5.05	$5.05	$5.05
Medicare Dependent	$2.46	$2.46	$2.46
Aetna HMO	FY 2023	FY 2024	FY 2025
Medicare Retiree	$7.59	$0.00	$0.00
Two or More Dependents	$126.00	$0.00	$0.00
Medicare Dependent	$89.91	$0.00	$0.00
Humana Benefit Plan HMO	FY 2023	FY 2024	FY 2025
Medicare Retiree	$7.59	$0.00	$0.00
Two or More Dependents	$126.00	$0.00	$0.00
Medicare Dependent	$89.91	$0.00	$0.00
Humana Health Plan HMO	FY 2023	FY 2024	FY 2025
Medicare Retiree	$7.59	$0.00	$0.00
Two or More Dependents	$126.00	$0.00	$0.00
Medicare Dependent	$89.91	$0.00	$0.00
United HealthCare	FY 2023	FY 2024	FY 2025
Medicare Retiree	$7.09	$0.00	$0.00
Two or More Dependents	$155.00	$0.00	$0.00
Medicare Dependent	$110.00	$0.00	$0.00
Health Alliance HMO	FY 2023	FY 2024	FY 2025
Medicare Retiree	$7.59	$0.00	$0.00
Two or More Dependents	$126.00	$0.00	$0.00
Medicare Dependent	$89.91	$0.00	$0.00

APPENDIX I

TYPES OF MEDICAL & DENTAL GROUP INSURANCE PLANS			
Type of Plan	Coverage	Characteristics	Geographic Location
QCHP Medical	Care related to the treatment of an illness or injury. Preventive care includes well-baby care, routine and school physicals, annual pap smears and mammograms.	Choice of physician and other medical care providers. Annual deductibles and employee contributions based on member salary. Dependent premiums do not vary.	No limitation; preferred hospital providers statewide.
QCHP Dental	Preventive, diagnostic, restorative, orthodontic, endodontic, and periodontic services as well as extractions and prosthetics.	Choice of dental care providers, reimbursement on a scheduled basis. No deductibles for preventative services. Premiums for members and dependents.	No limitations.
HMO Medical	Comprehensive medical benefits including preventive care.	Prepaid benefits, primary care physician who coordinates all care chosen from HMO network. Co-payments vary by HMO plan. Employee premiums, based on salary and plan choice, vary for dependents by plan.	Statewide coverage
OAP	Comprehensive medical benefits including preventive care.	Three tiers of benefit levels. Patients may see specialists without referral from the primary care physician. Co-payment / coinsurance levels vary. Premiums vary based on salary and plan choice.	Statewide coverage
MA 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
CDHP	High-deductible health plan. Significantly lower premiums compared to traditional HMO/PPO/etc. plans.	$1500 deductible required before health services are covered. Network providers and coverage options. Similar provisions to HMO plans.	Statewide coverage

APPENDIX II

Under current law, the term of any contract (group life insurance, health benefits, other employee benefits, and administrative services) authorized under the State Employees' Group Insurance Act (SEGIA) may not extend beyond 5 fiscal years. Upon recommendation of CGFA, the Director of CMS may exercise renewal options of the same contract for up to 5 one-year renewals. The State enters into contracts with the HMOs and pays them a dollar amount per individual enrolled in that particular HMO. The HMO then assumes the financial risk of providing services to its participants. For FY 2025, there are no contracts that statutorily require CGFA's recommended approval.

Status of Contracts for FY 25 at DCMS		
Service	**Vendor**	**Contract Term Details**
Managed Care Health Plans	Health Alliance HMO / Aetna HMO / Aetna OAP / Healthlink OAP / BC HMO Illinois / BC Blue Advantage	**Ongoing** - HMO Terms go to June 30, 2026 with five 1-year renewals. OAPs are pending Request for Proposal. (RFP)
Medicare Advantage Health Plans	Aetna PPO	**Ongoing -** Term goes to December 31, 2027 with five 1-year renewals.
Self-Insured Medical Plan Administration	Aetna	**Ongoing -** Term goes to June 30, 2026.
Vision	EyeMed	**Ending** - Term goes to June 30, 2024. RFP in progress.
Behavioral Health/EAP	ComPsych	**Ongoing** - Term goes to June 30, 2026.
Life Insurance	Metropolitan Life Insurance Company	**Ongoing** - Term goes to June 30, 2026.
Flexible Spending	Optum	**New -** Term goes from July 1, 2023 to June 30, 2028.
Administration of Dental Claims	Delta Dental	**Ongoing** - Term goes to June 30, 2026.
Prescription Drugs	CVS/Caremark	**Ending** - Term goes to June 30, 2024. RFP in progress.
Commuter Savings Program	Edenred	**Ending** - Term goes to June 30, 2024. RFP in progress.

APPENDIX III

STATE EMPLOYEES' GROUP INSURANCE OVERSIGHT

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

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

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

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

COMMISSION OVERVIEW

The Commission on Government Forecasting & Accountability is a bipartisan legislative support service agency responsible for advising the Illinois General Assembly on economic and fiscal policy issues and for providing objective policy research for legislators and legislative staff. The Commission's board is comprised of twelve legislators—split evenly between the House and Senate and between Democrats and Republicans.

The Commission has three internal units—Revenue, Pensions, and Research, each of which has a staff of analysts and researchers who analyze policy proposals, legislation, State revenues & expenditures, and benefit programs, and who provide research services to members and staff of the General Assembly. The Commission's staff fulfills the statutory obligations set forth in the Commission on Government Forecasting and Accountability Act (25 ILCS 155/), the State Debt Impact Note Act (25 ILCS 65/), the Illinois Pension Code (40 ILCS 5/), the Pension Impact Note Act (25 ILCS 55/), the State Facilities Closure Act (30 ILCS 608/), the State Employees Group Insurance Act of 1971 (5 ILCS 375/), the Public Safety Employee Benefits Act (820 ILCS 320/), the Legislative Commission Reorganization Act of 1984 (25 ILCS 130/), and the Reports to the Commission on Government Forecasting and Accountability Act (25 ILCS 110/).

- The **Revenue Unit** issues an annual revenue estimate, reports monthly on the State's financial and economic condition, and prepares bill analyses and debt impact notes on proposed legislation having a financial impact on the State. The Unit publishes a number of statutorily mandated reports, as well as on-demand reports, including the *Monthly Briefing* newsletter and annually, the *Budget Summary*, *Capital Plan Analysis*, *Illinois Economic Forecast Report*, *Wagering in Illinois Update*, and *Liabilities of the State Employees' Group Insurance Program*, among others. The Unit's staff also fulfills the agency's obligations set forth in the State Facilities Closure Act.
- The **Pension Unit** prepares pension impact notes on proposed pension legislation and publishes several statutorily mandated reports including the *Financial Condition of the Illinois State Retirement Systems*, the *Financial Condition of Illinois Public Pension Systems* and the *Fiscal Analysis of the Downstate Police & Fire Pension Funds in Illinois*. The Unit's staff also fulfills the statutory responsibilities set forth in the Public Safety Employee Benefits Act.
- The **Research Unit** primarily performs research and provides information as may be requested by members of the General Assembly or legislative staffs. Additionally, the Unit maintains a research library and, per statute, collects information concerning State government and the general welfare of the State, examines the effects of constitutional provisions and previously enacted statutes, and considers public policy issues and questions of State-wide interest. Additionally, the Unit publishes *First Reading*, a quarterly newsletter which includes abstracts of annual reports or special studies from other State agencies, the *Illinois Tax Handbook for Legislators*, *Federal Funds to State Agencies*, various reports detailing appointments to State Boards and Commissions, the *1970 Illinois Constitution Annotated for Legislators*, the *Roster of Illinois Legislators*, and numerous special topic publications.

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