

Illinois Comprehensive Health Insurance Plan 2018 Annual Report

For the year ending December 31, 2018



JB Pritzker, Governor

Kwame Raoul, Attorney General

Robert H. Muriel, Chairman of Board

Paulette Dove, Interim Acting Executive Director

The Mission and History of CHIP

The Comprehensive Health Insurance Plan Act (“CHIP”), 215 ILCS 105/1 *et seq.*, became law in 1987 with first coverage provided on May 1, 1989. Illinois was the fifteenth state to enact such a mechanism, known as a “high risk pool,” and the first to use state general revenue funds.

The CHIP program has a two-fold mission:

- To provide health coverage for Illinois residents who cannot obtain health insurance due to health reasons or have substantially similar coverage that costs more than the individual Traditional pool premium rate; and
- To provide coverage to Illinois residents who recently lost group coverage and have exhausted COBRA or other continuation coverage.

The original purpose of the CHIP program was to provide coverage to individuals who were “uninsurable”. This part of CHIP is known as the Traditional CHIP pool. There were two plans available under the Traditional pool. The Traditional Non Medicare Plan is for individuals who are either unable to obtain private coverage because of a medical condition or able to find coverage but at a rate exceeding the applicable CHIP rate. The Traditional Medicare Plan was for individuals under age 65 who were covered by Medicare Parts A and B because of end-stage renal disease or other disability. In 2013 the Board made the decision to discontinue the Traditional Medicare Plan effective December 31, 2013. In 2013, the Board made the policy decision not to enroll or renew individuals into the Traditional pool after April 30, 2014 due to the availability of guaranteed issue under the Patient Protection and Affordable Care Act (ACA).

Following the passage of the federal Health Insurance Portability and Accountability Act (HIPAA) in 1996, CHIP also became responsible for providing health coverage to individuals who have had, but subsequently lost, group insurance. On the state level, legislation was enacted creating the HIPAA-CHIP Pool, and coverage in it was first provided to eligible individuals on July 1, 1997. The pool is funded primarily by an assessment on health insurers and members’ premiums.

Additional responsibility came in 2003 with the designation of CHIP as a “qualified health plan” as established in the federal Trade Act of 2002. Qualified Illinois residents could use coverage in the HIPAA-CHIP pool to claim the Health Coverage Tax Credit (HCTC) if they were Trade Adjustment Act (TAA) certified or were receiving a pension from the Pension Benefit Guaranty Corporation (PBGC). Pursuant to federal law, the HCTC ended December 31, 2013.

In 2008 coverage changes were implemented in response to the Medicare Reform Act to provide High Deductible Health Plan (HDHP) options to CHIP members in either the Traditional or the HIPAA pool. HDHP plans can be used in conjunction with Health Savings Accounts to allow enrollees to take advantage of federal income tax provisions that allow payment for out-of-pocket medical expenses from pretax dollars. These plans were discontinued December 31, 2014.

On March 23, 2010 the President signed into law the ACA that in part prohibits health insurers from denying coverage due to pre-existing conditions. In 2013, plans were developed and implemented in preparation for CHIP members who would be transitioning to other coverage through the new health insurance exchange or in the marketplace as a result of the ACA. In 2014 CHIP members continued to transition into the marketplace as a result of the ACA with year end enrollment of 885 members. The 2015 CHIP enrollment continued to decline with a year-end membership of 328. At the end of 2016 and 2017 the CHIP membership enrollment was 190 and 146 respectively. By the end of 2018 the CHIP membership enrollment was 114.

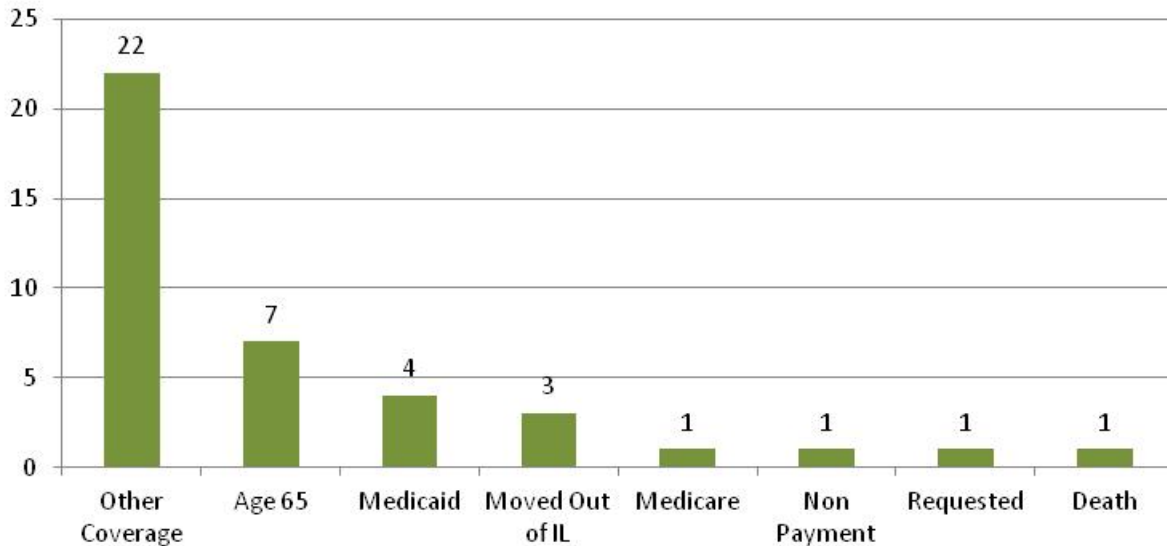
Member Profile for 2018

146 members January 1
 +8 enrollees added during calendar year
 - 40 members terminated during calendar year
 114 members December 31

Regarding the 8 that were added during 2018:

- 3 were later terminated during 2018 since they secured other coverage
- 3 were later terminated during 2018 since they became 65 years of age
- 2 continue to be active members

Reason the coverage terminated for the 40 members:

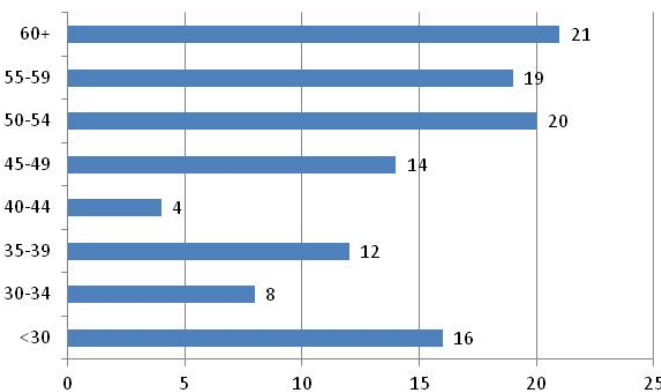


Further breakdown of the 114 December 31st members:

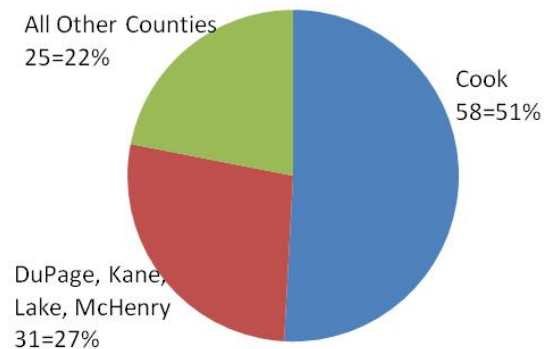
Deductible	Count	Percentage	Notes
\$2,500	102	89%	three did not meet their \$2,500 deductible during 2018
\$5,000	12	11%	all met their \$5,000 deductible during 2018

There were four \$2,500 deductible members that had no claims during 2018.

Age distribution as of 12/31/2018

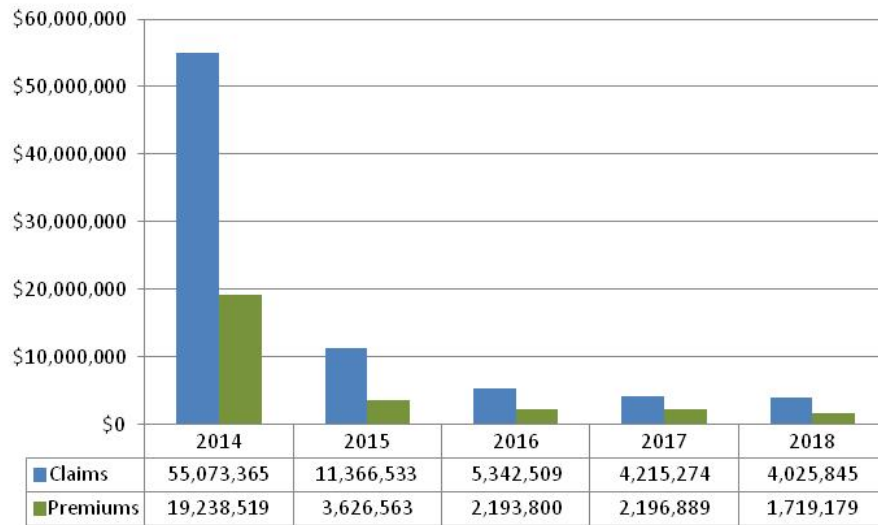


County distribution:

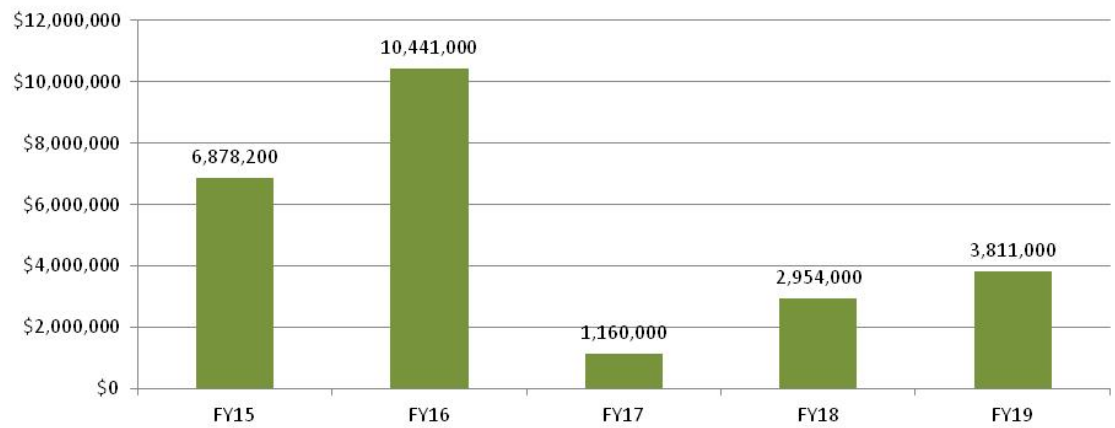


Financial Profile

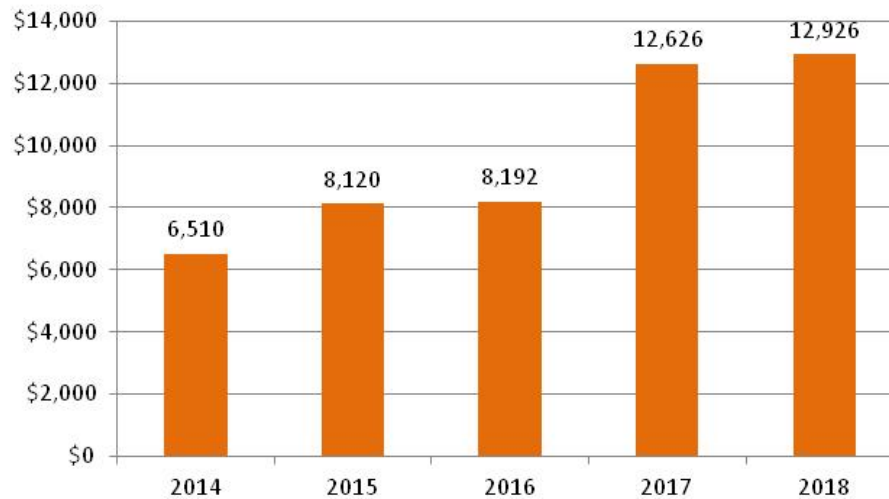
Total Claims Paid and Premiums Earned



Assessments to the Health Insurance Industry by Fiscal Year



Average Annual Premium



Claim Analysis for those Paid during calendar year 2018

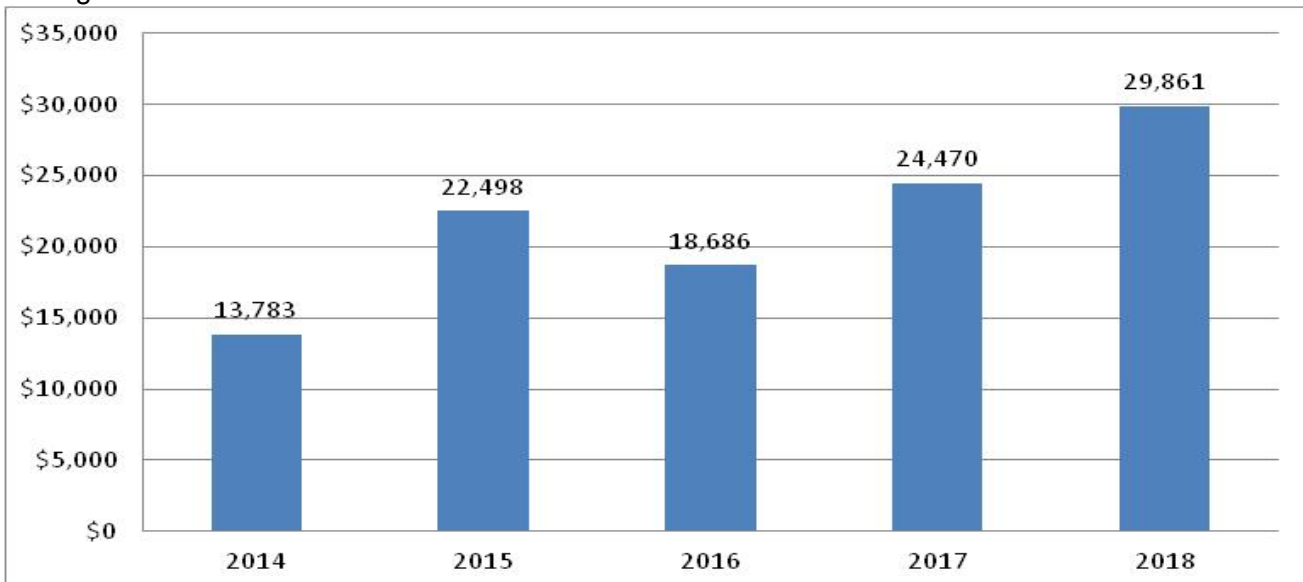
Description	2018			2017
	Traditional Total	HIPAA Total	Grand Total	Grand Total
Inpatient	\$ -	\$ 452,431	\$ 452,431	\$ 1,011,824
Outpatient	\$ -	\$ 1,324,030	\$ 1,324,030	\$ 1,207,651
ECF/SNF	\$ -	\$ 43,756	\$ 43,756	\$ 28,563
Coordinated Home Care	\$ -	\$ 20,931	\$ 20,931	\$ 18,390
Medicare Deductible	\$ -	\$ -	\$ -	\$ -
Physician Services	\$ (357)	\$ 933,528	\$ 933,171	\$ 1,055,006
Major Medical	\$ -	\$ 3,726	\$ 3,726	\$ 1,847
Subtotal	\$ (357)	\$ 2,778,402	\$ 2,778,045	\$ 3,323,281
Adjustments*	\$ (11,311)	\$ (27,100)	\$ (38,411)	\$ (410,217)
Total Blue Cross Medical	\$ (11,668)	\$ 2,751,302	\$ 2,739,634	\$ 2,913,064
Total Prescriptions		\$ 1,286,211	\$ 1,286,211	\$ 1,302,210
Total Paid Claims	\$ (11,668)	\$ 4,037,513	\$ 4,025,845	\$ 4,215,274
Prescription Rebates	\$ (12,818)	\$ (63,995)	\$ (76,813)	\$ (13,475)
Prescription Claim Refunds		\$ (46,409)	\$ (46,409)	\$ (18,401)
Medical Claim Refund		\$ (570)	\$ (570)	\$ 0
Change in Claim Reserves		\$ 45,000	\$ 45,000	\$ 41,000
Net Incurred Losses	\$ (24,486)	\$ 3,971,539	\$ 3,947,053	\$ 4,224,398

* includes Claim Recoveries, Subrogation Reimbursements, Discount Offsets

Average HIPAA Plan Claim Cost Per Member

Enrollment	133
Prescription Cost	\$8,841
Non-Prescription Cost	\$21,020
Plan Claim Cost	\$29,861

Average Annual HIPAA Plan Claim Cost Per Member



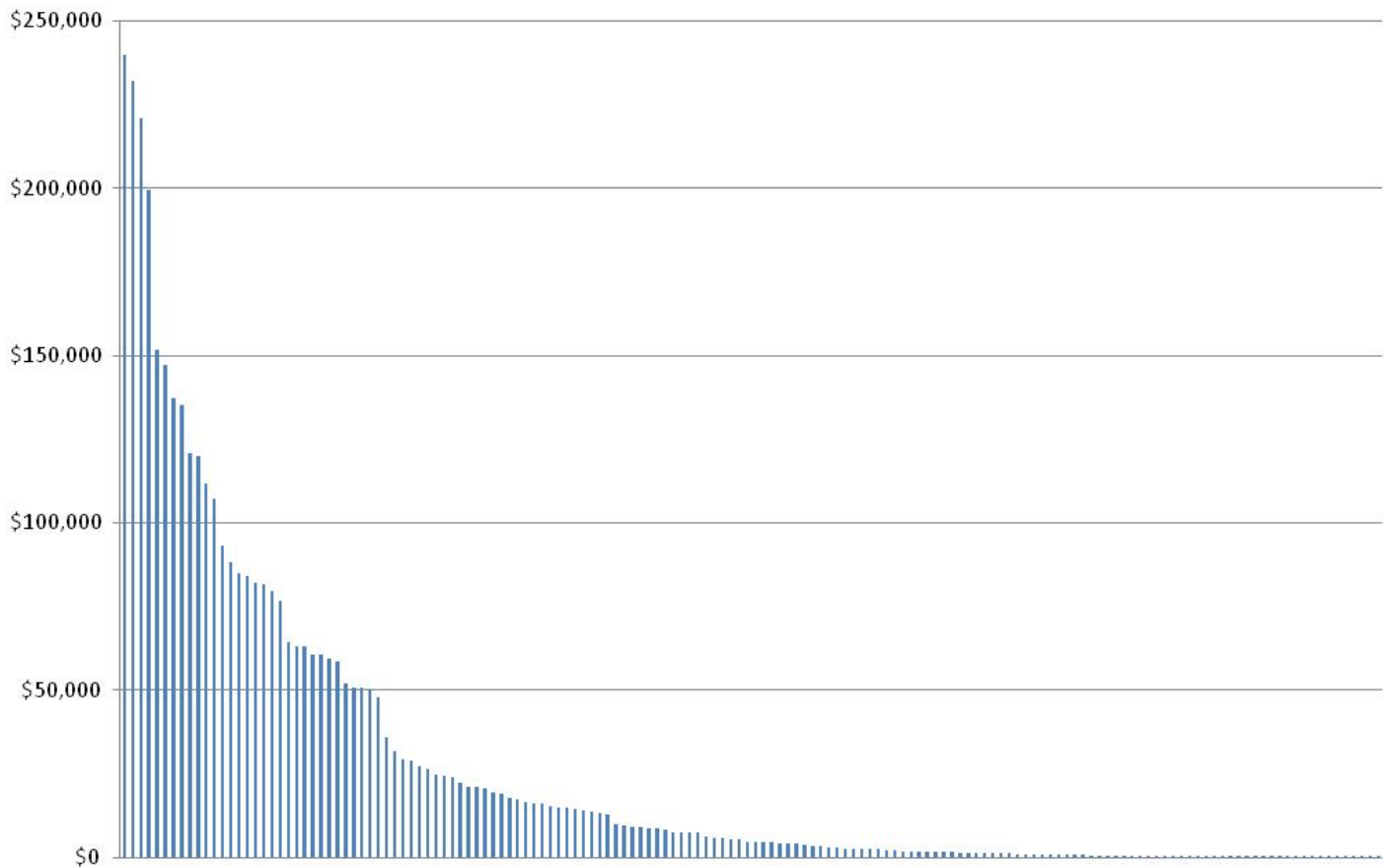
Claim Analysis for those Paid during calendar year 2018

Claims Paid by Month:

	Medical	Drug	Total
January	\$221,728	\$117,233	\$338,961
February	\$151,159	\$106,408	\$257,568
March	\$365,316	\$130,844	\$496,160
April	\$246,564	\$148,742	\$395,306
May	\$253,150	\$62,284	\$315,435
June	\$208,018	\$92,762	\$300,780
July	\$188,291	\$79,345	\$267,635
August	\$223,164	\$99,481	\$322,645
September	\$190,908	\$101,080	\$291,988
October	\$226,994	\$84,517	\$311,511
November	\$270,576	\$125,621	\$396,197
December	\$193,764	\$137,894	\$331,658
Total	\$2,739,634	\$1,286,211	\$4,025,845

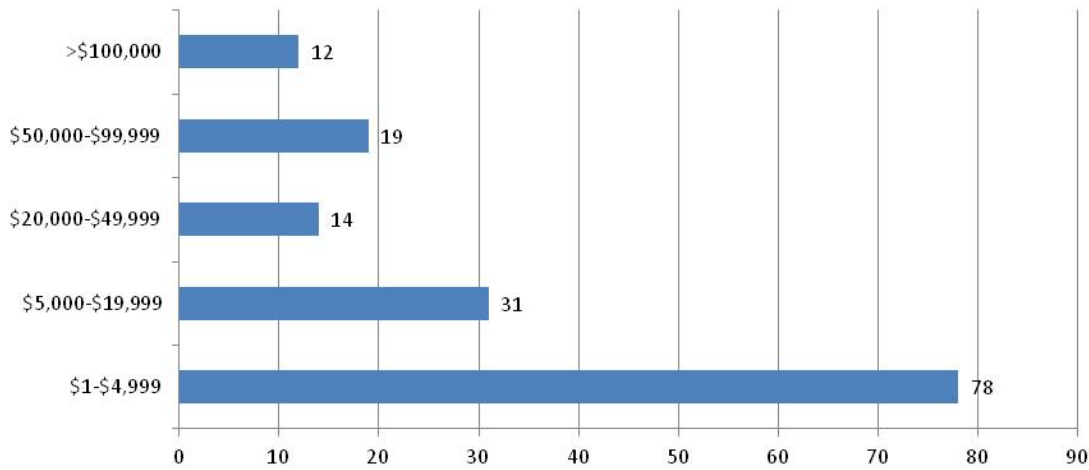
During 2018 claims were paid for 197 Participants.

Below is a bar chart that provides total amount paid by Member from highest to lowest.

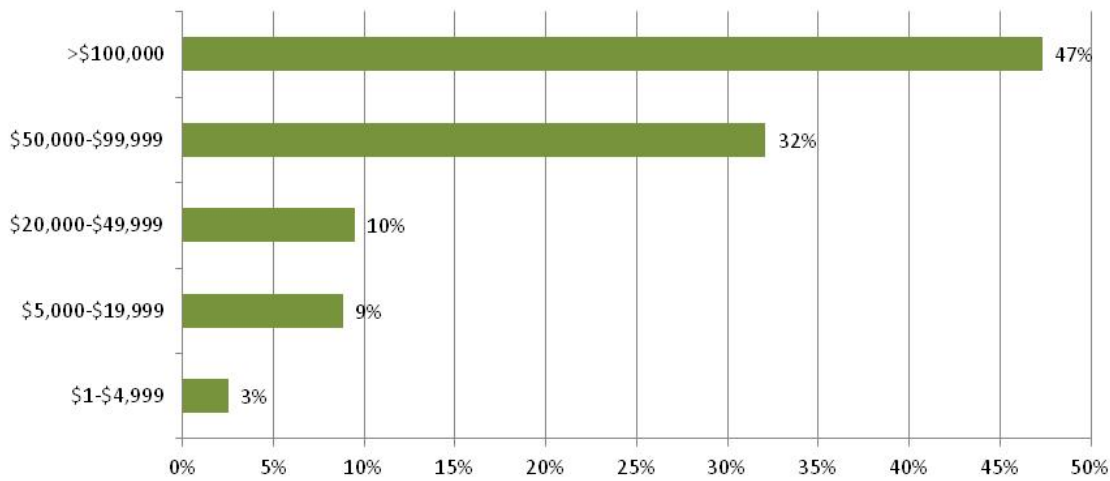


Claim Analysis for those Paid during calendar year 2018

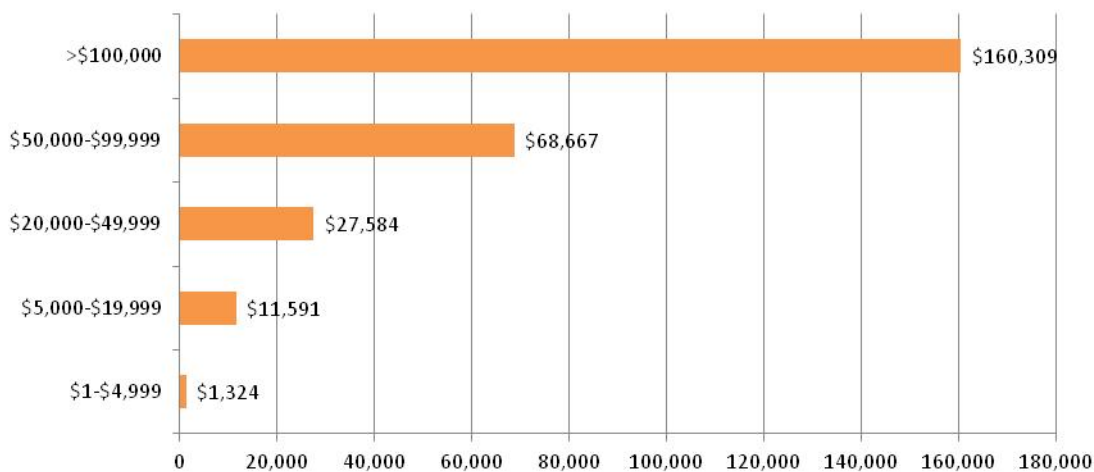
Number of Members in each Range



Percent of Total 2018 Claims in each Range



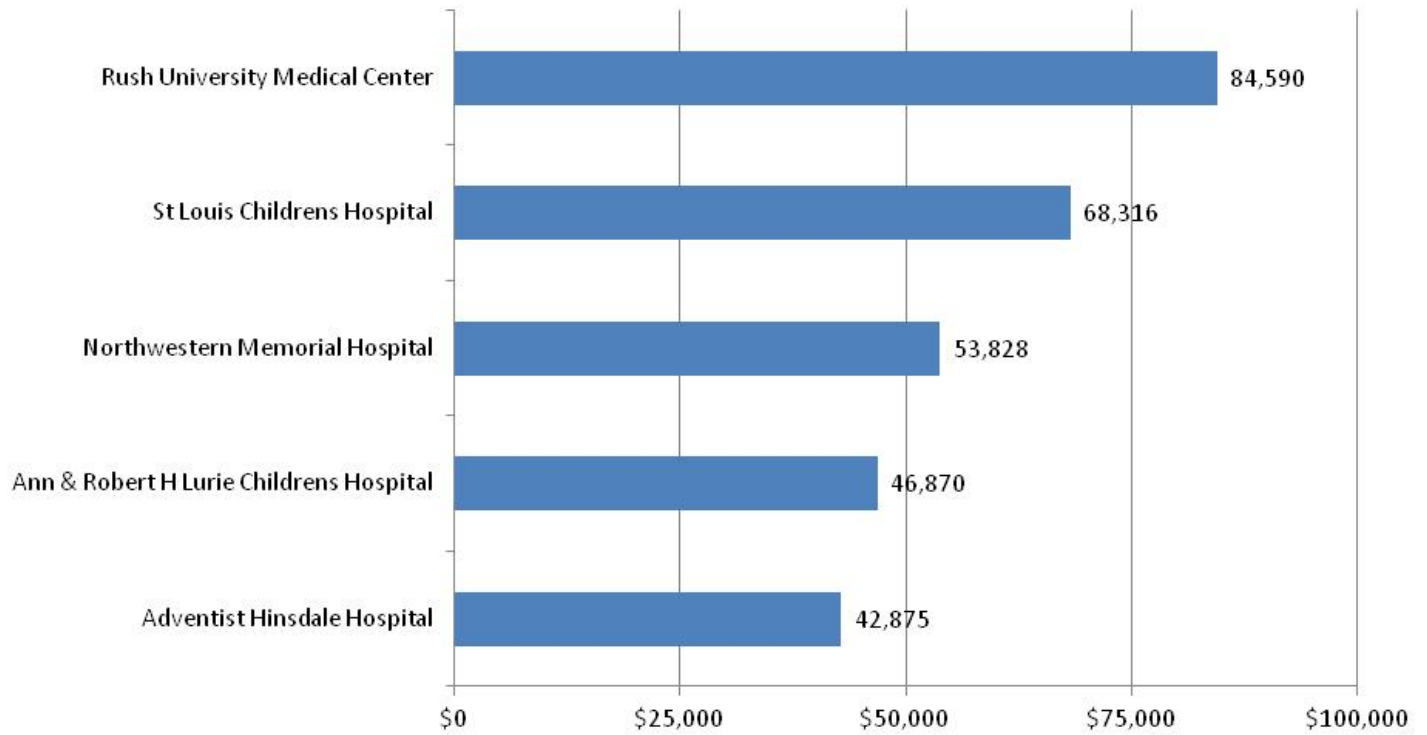
Average Total Per Member in each Range



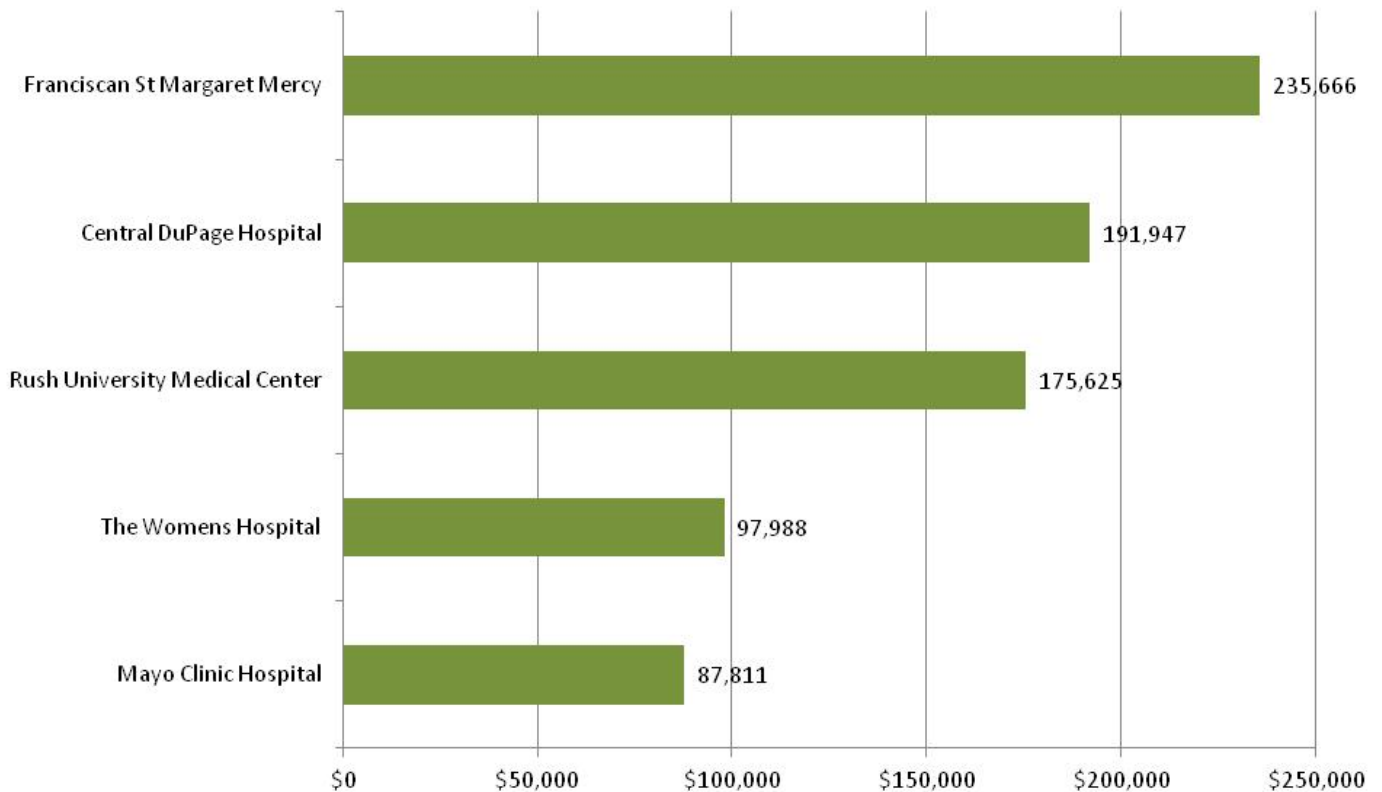
During 2018 there were 43 Members that had only adjustment claims with a total dollar amount of -13,488.

Claim Analysis for those Paid during calendar year 2018

Top 5 Inpatient Providers – total paid for all Inpatient = \$452,431

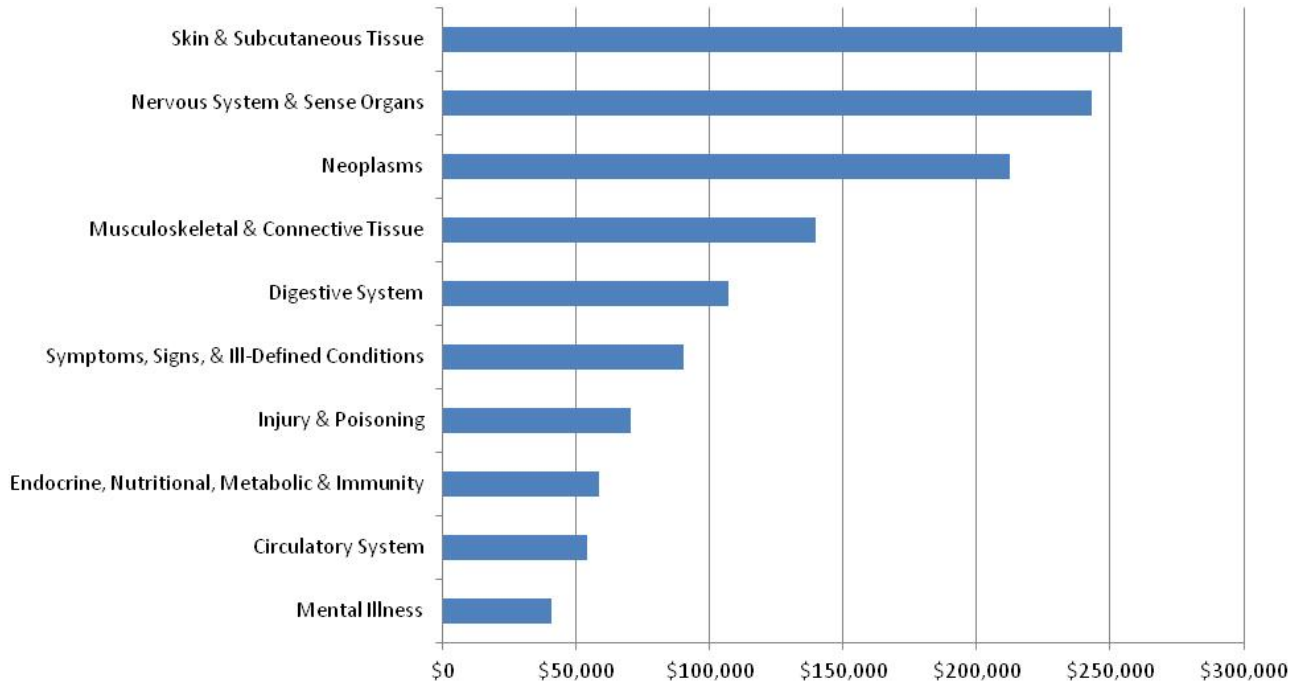


Top 5 Outpatient Providers – total paid for all Outpatient = \$1,324,030

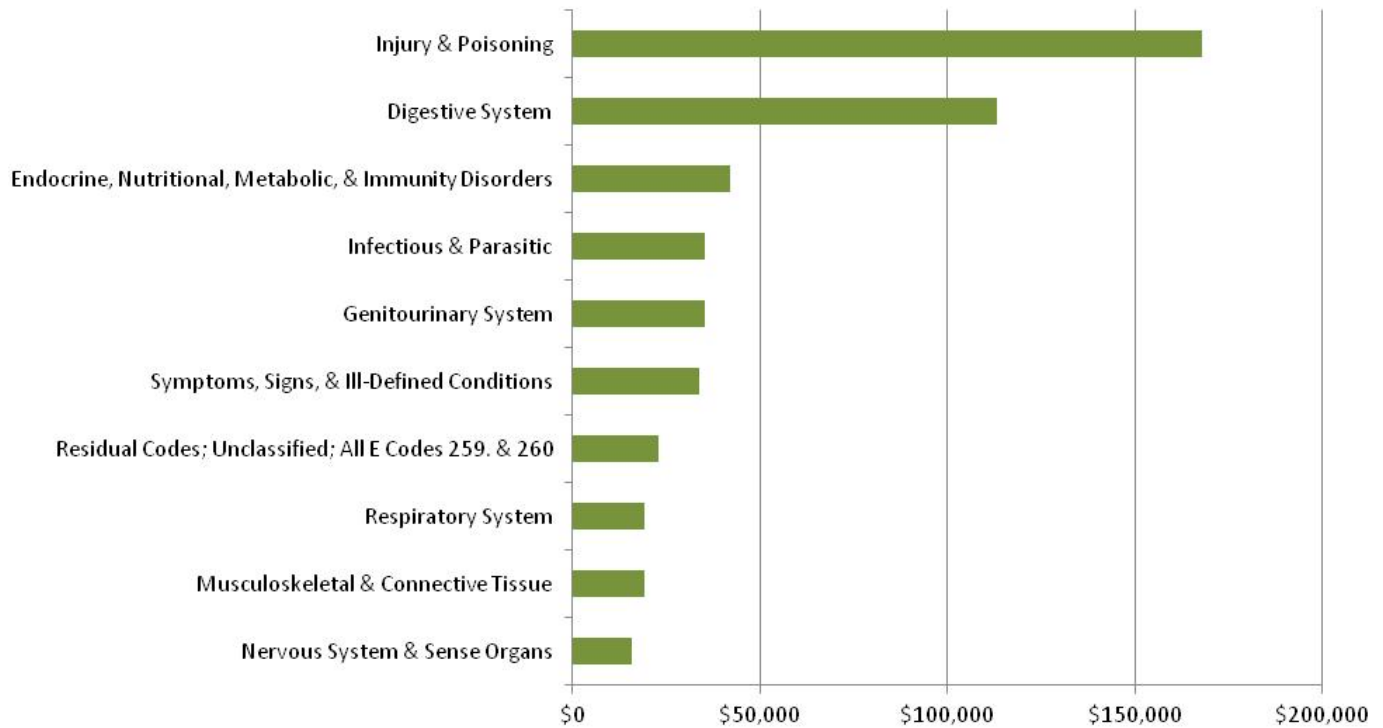


Claim Analysis for those Paid during calendar year 2018

Top 10 Medical Outpatient Claims by Diagnosis

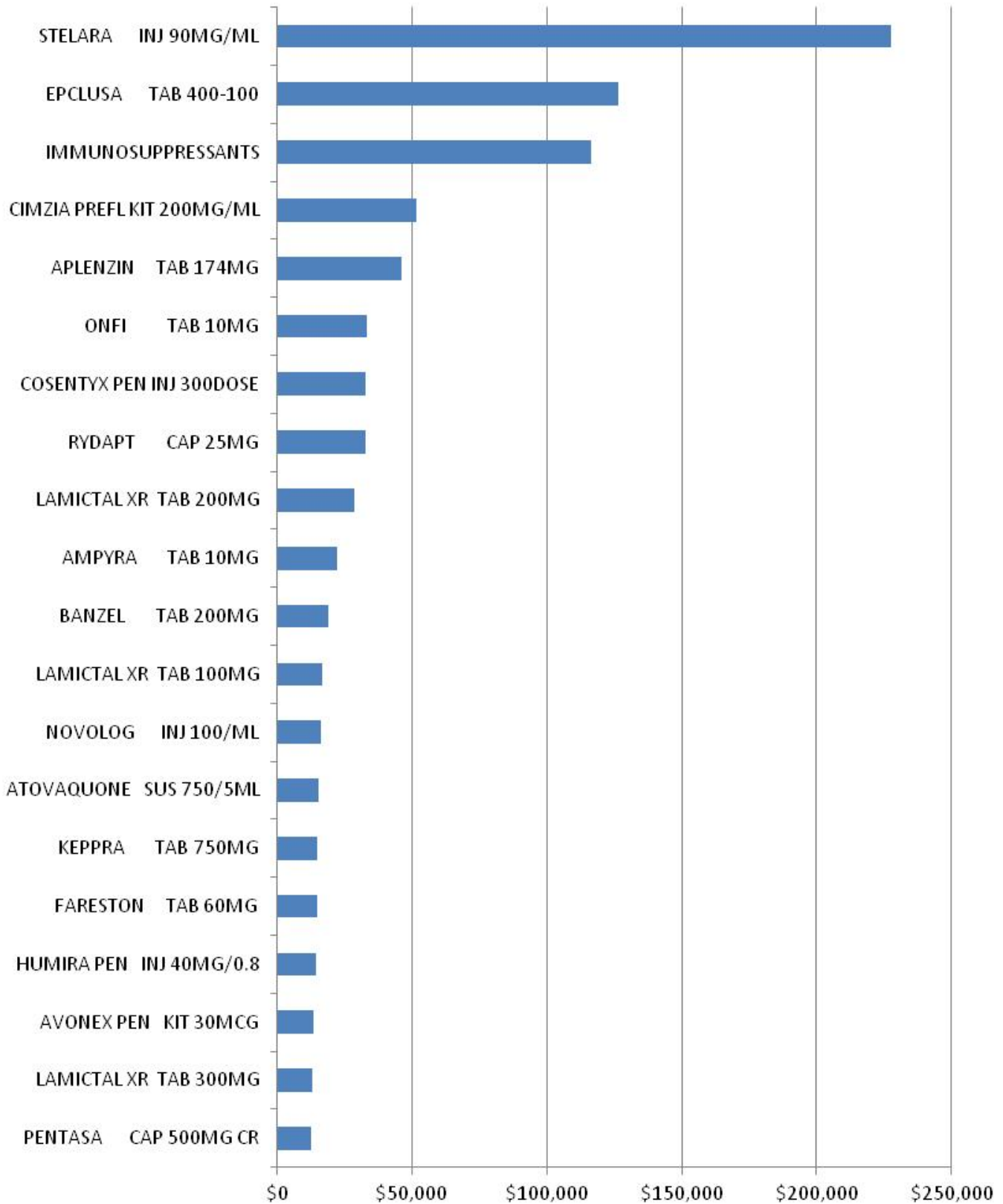


Top 10 Medical Inpatient Claims by Diagnosis



Claim Analysis for those Paid during calendar year 2018

Top 20 Prescription Drugs



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