Illinois Comprehensive Health Insurance Plan 2017 Annual Report

Bruce Rauner, Governor

Lisa Madigan, Attorney General

Jennifer Hammer, 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 enrollees' 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 enrollees 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 enrollees 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 the CHIP membership enrollment was 190. By the end of 2017 the CHIP membership enrollment was 146.

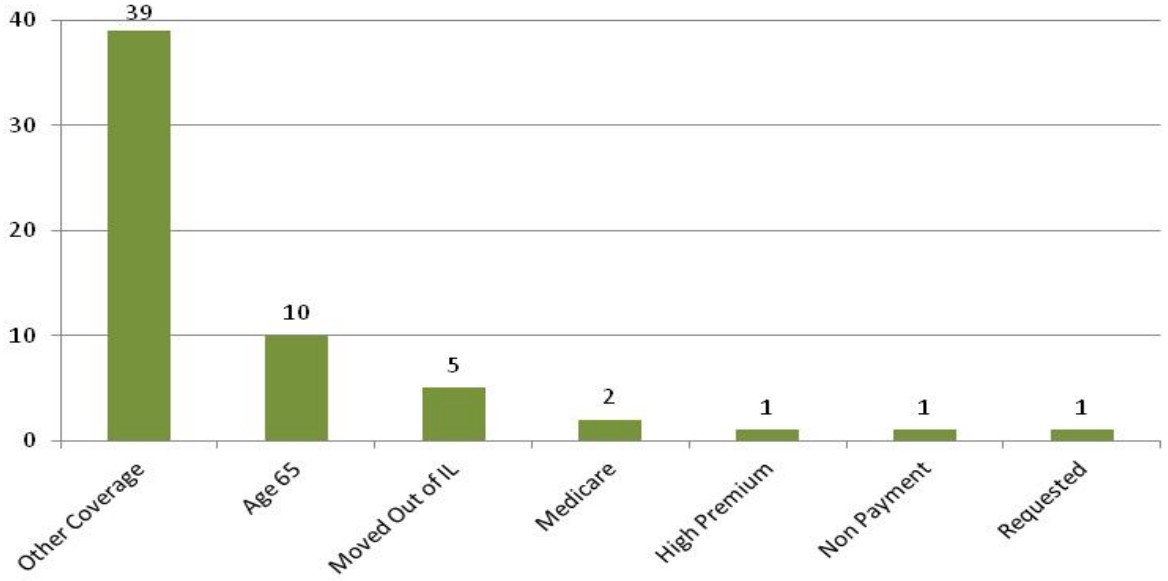
Enrollee Profile for 2017

190 enrollees January 1
+15 enrollees added during calendar year
- 59 enrollees termed during calendar year
146 enrollees December 31

Regarding the 15 that were added:

1. added 2 September 1 and termed December 31 due to Other Coverage
2. added 1 September 26 and termed November 1 due to Medicare Coverage
3. added 12 who continue to be Active enrollees

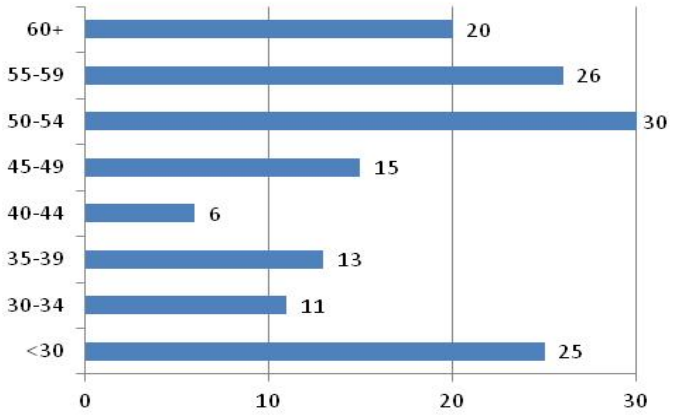
Reason the coverage terminated for the 59 enrollees:



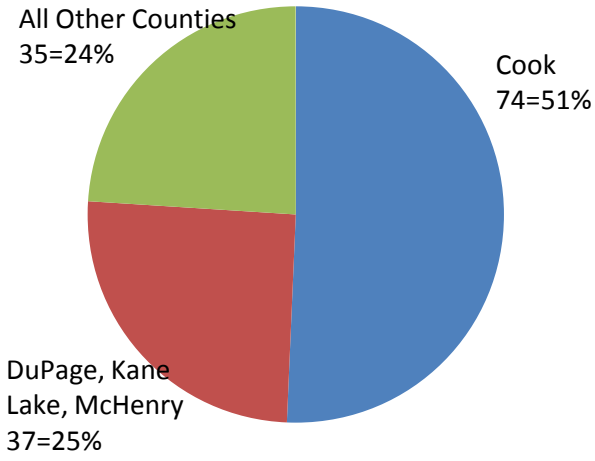
Further breakdown of the 146 December 31st enrollees:

Deductible	$2,500	134	92%
	$5,000	12	8%

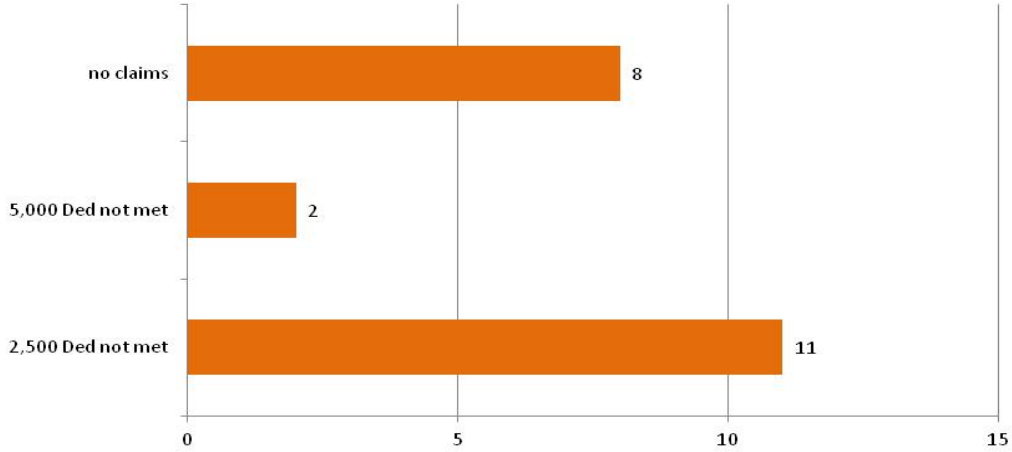
Age distribution:



County distribution:



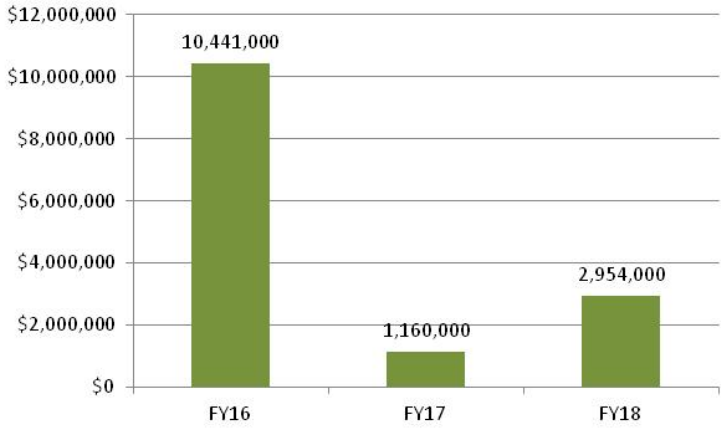
There were 146 active Enrollees as of December 31, 2017. Of those, the following chart identifies the number who did not meet their respective deductible or submitted no claims during the calendar year.



Financial Profile for calendar year 2017

Total Claims Paid and Premiums Earned

Assessments to the Health Insurance Industry



Average Annual Premium

Claim Analysis for those Paid during calendar year 2017

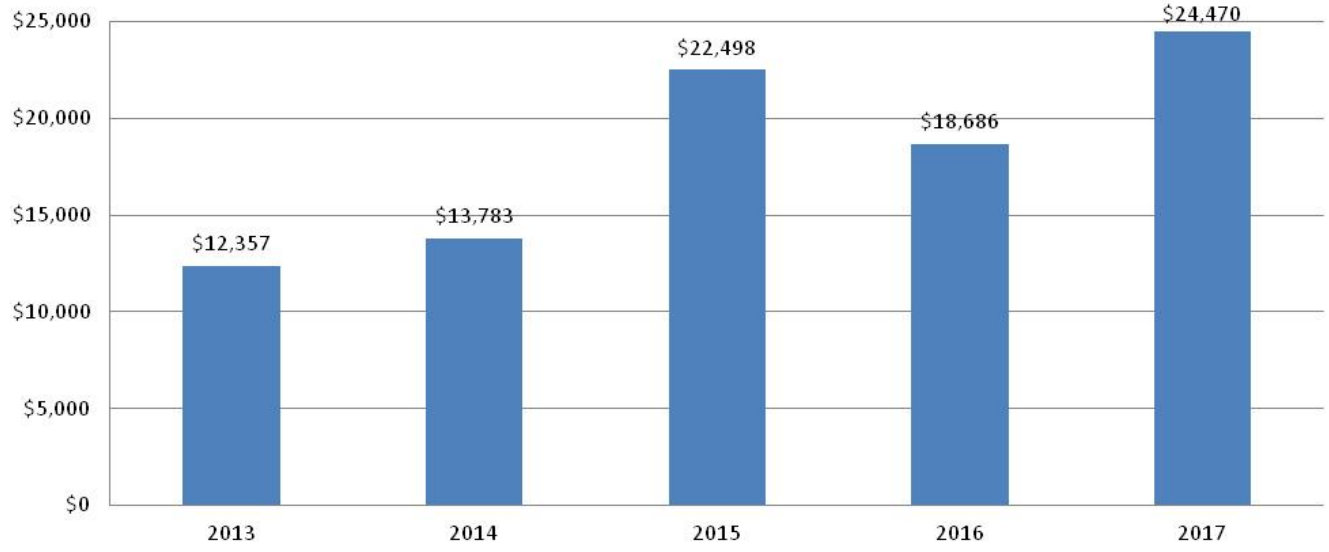
	2017			2016
Description	Traditional	HIPAA	Total	Total
Inpatient	$0	$1,011,824	$1,011,824	$785,019
Outpatient	($346)	$1,207,997	$1,207,651	$1,487,026
ECF/SNF	$0	$28,563	$28,563	$16,672
Coordinated Home Care	$0	$18,390	$18,390	$26,355
Medicare Deductible	$0		$0	$0
Physician Services	$66	$1,054,940	$1,055,006	$1,461,291
Major Medical	$0	$1,847	$1,847	$4,383
Subtotal	($280)	$3,323,561	$3,323,281	$3,780,747
Adjustments*	($33,173)	($377,044)	($410,217)	($174,816)
Total Blue Cross Medical	($33,453)	$2,946,517	$2,913,064	$3,605,931
Total Prescriptions		$1,302,210	$1,302,210	$1,736,578
Total Paid Claims	($33,453)	$4,248,727	$4,215,274	$5,342,509
Prescription Rebates		($13,475)	($13,475)	($116,124)
Claim Refunds		($18,401)	($18,401)	($53,965)
Change in Claim Reserves		$41,000	$41,000	($187,259)
Net Incurred Losses	($33,453)	$4,257,851	$4,224,398	$4,985,161

*examples include Rebates, Subrogation Reimbursements, Discount Offsets

Average Plan Claim Cost Per Member

Enrollment	174
Prescription Cost	$7,407
Non-Prescription Cost	$17,064
Plan Claim Cost	$24,470

Average Annual Plan Claim Cost Per Member

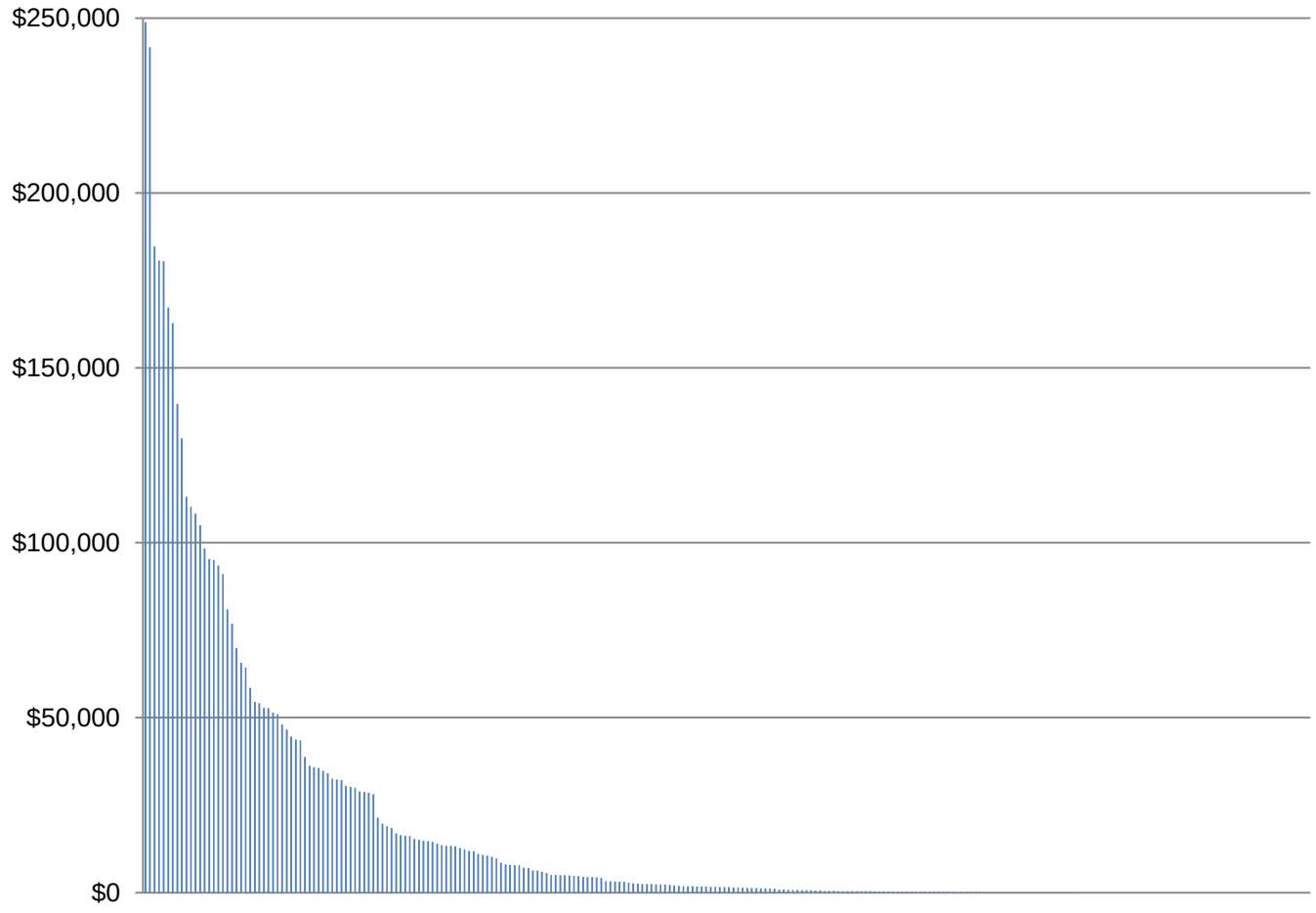


Claim Analysis for those Paid during calendar year 2017

Claims Paid by Month (excluding adjustments):

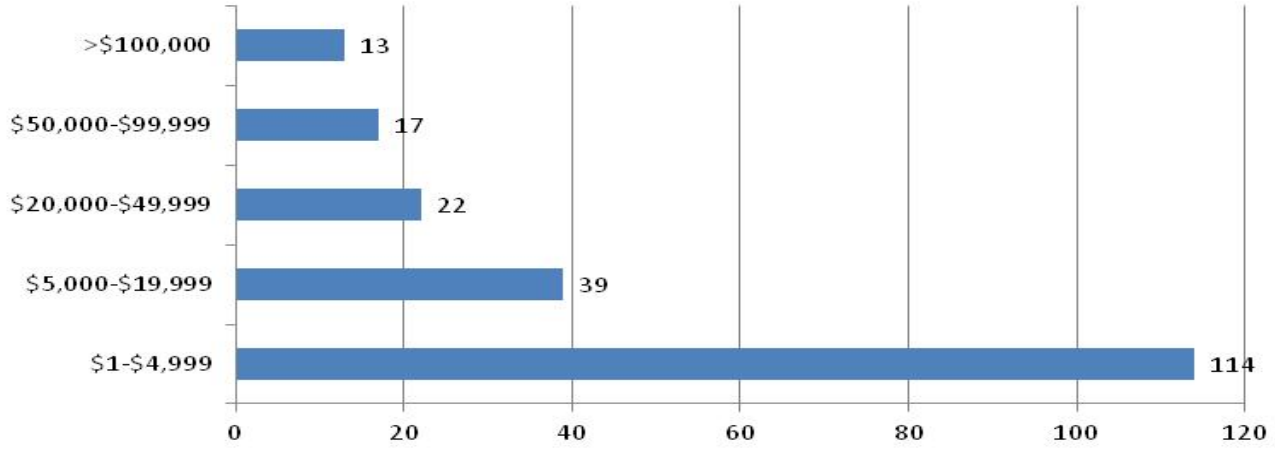
	Medical	Drug	Total
January	$248,389	$89,528	$337,917
February	$324,295	$127,678	$451,973
March	$297,050	$115,911	$412,961
April	$176,307	$120,574	$296,881
May	$294,140	$88,777	$382,917
June	$295,741	$127,480	$423,221
July	$232,755	$68,773	$301,528
August	$264,146	$98,326	$362,472
September	$268,193	$106,951	$375,143
October	$351,662	$87,693	$439,354
November	$311,997	$116,020	$428,017
December	$258,607	$154,724	$413,331
Total	$3,323,281	$1,302,434	$4,625,715

During 2017 claims were paid for 285 Enrollees.
This includes claims for 147 Enrollees that terminated coverage prior to 12/31/2017.
Below is a bar chart that provides total amount paid by Enrollee from highest to lowest.

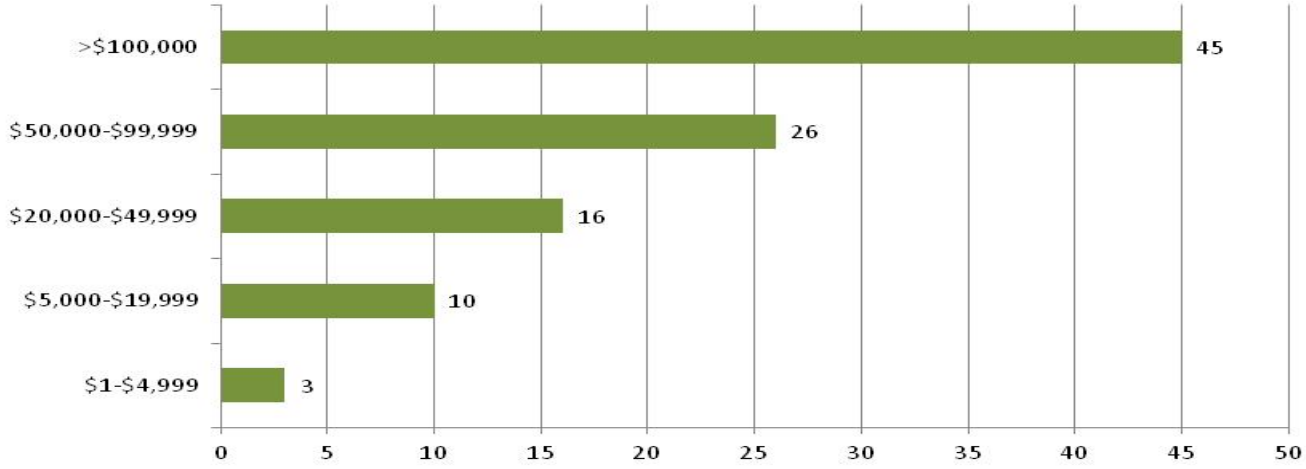


Claim Analysis for those Paid during calendar year 2017

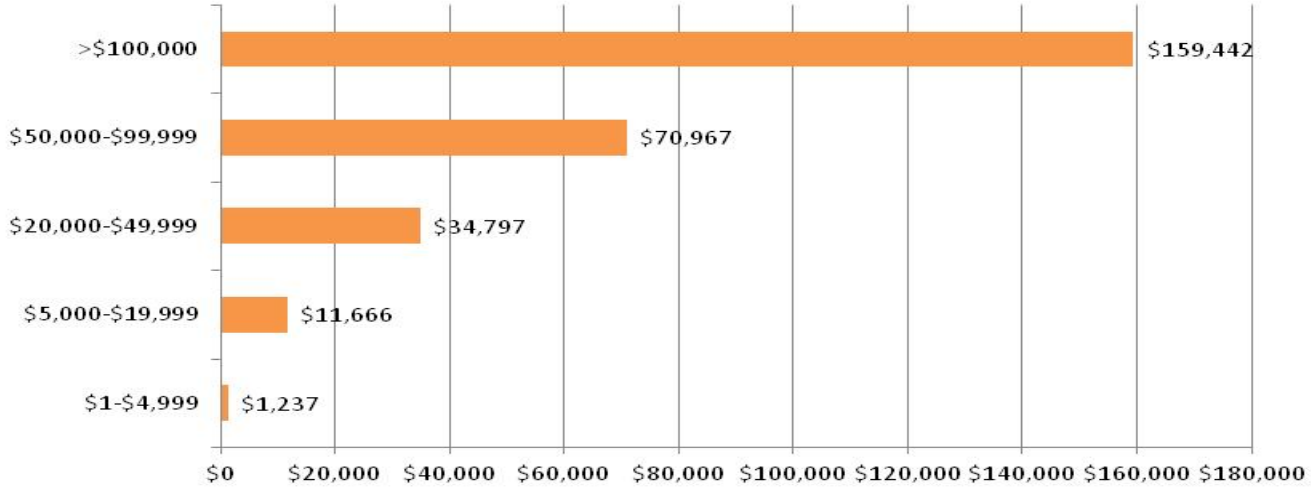
Number of Enrollees in each Range



Percent of Total 2017 Claims in each Range



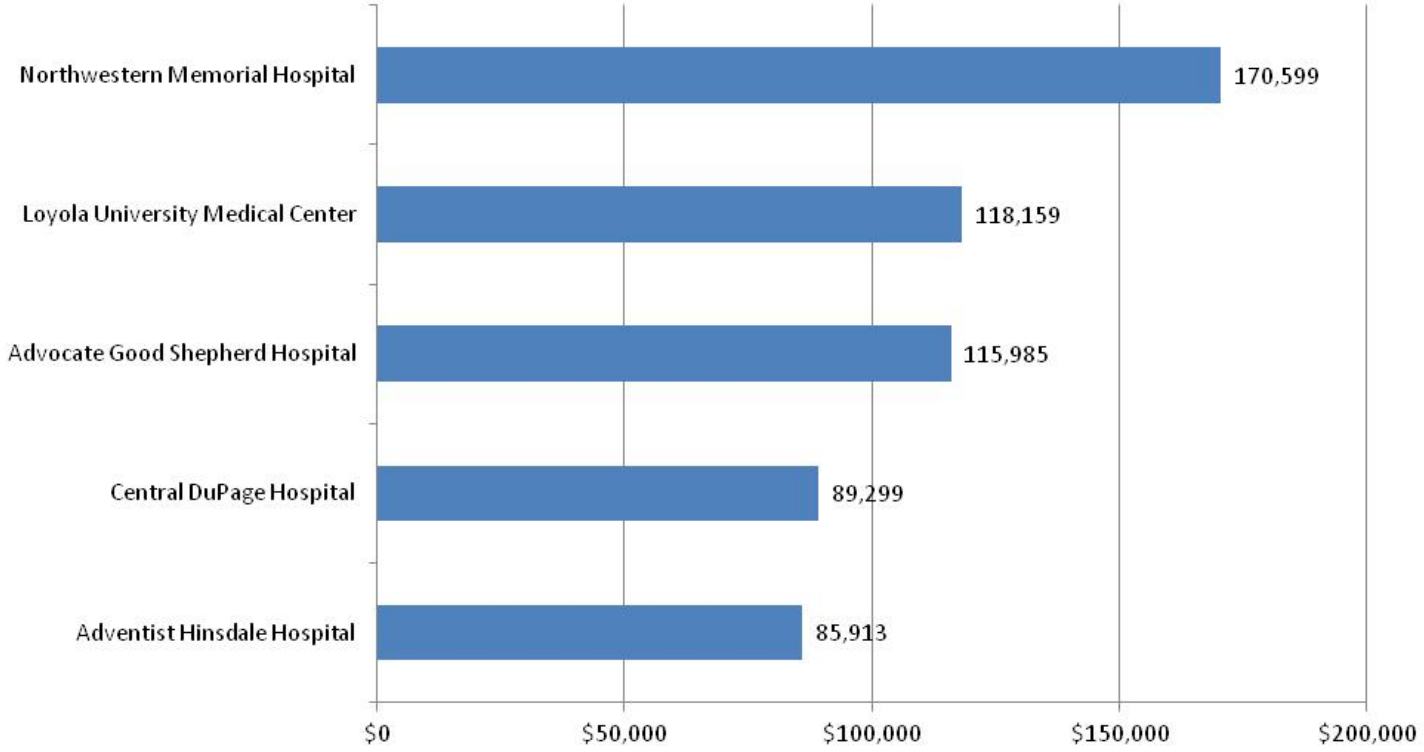
Average Total Per Enrollee in each Range



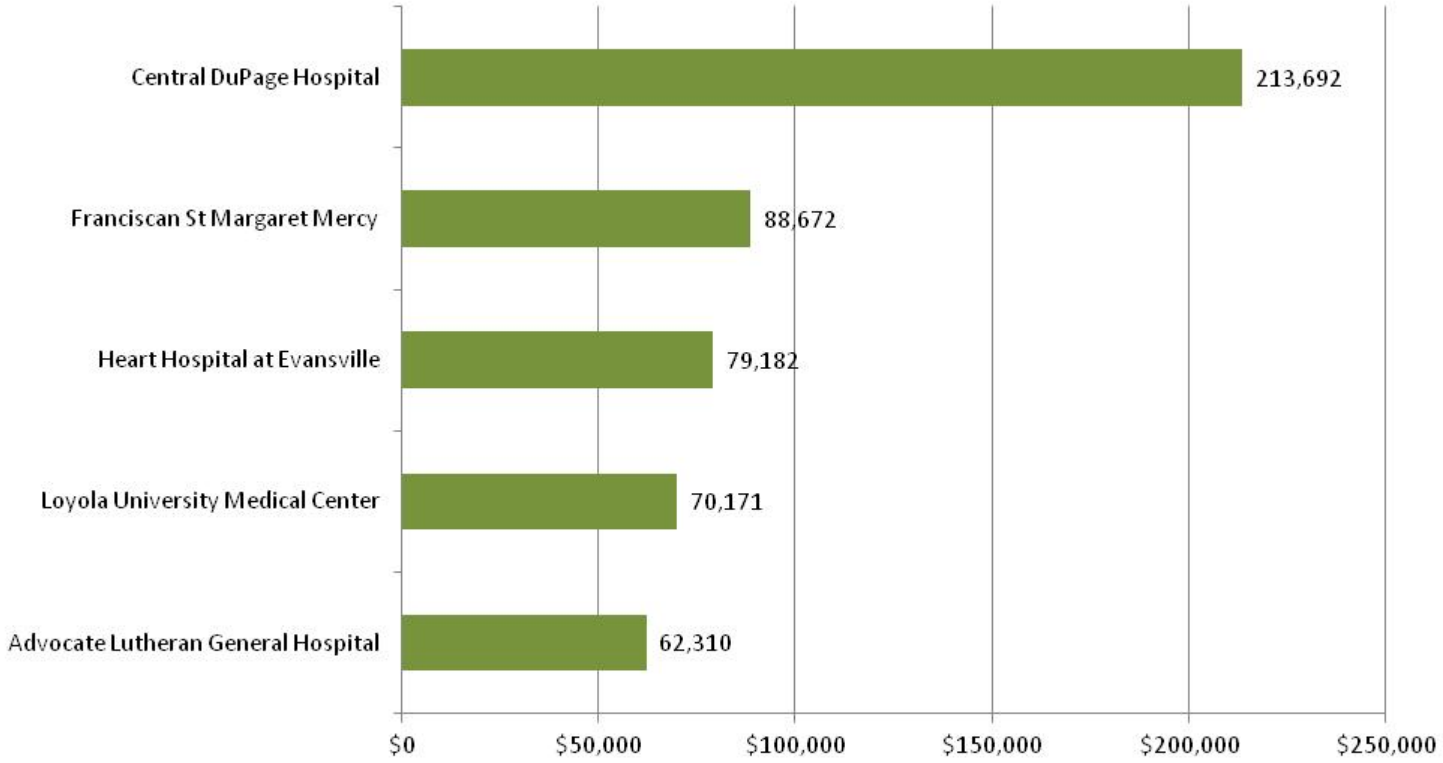
During 2017 there were 80 Enrollees that had only adjustment claims with a total dollar amount of -15,057.42.

Claim Analysis for those Paid during calendar year 2017

Top 5 Inpatient Providers – total paid for all Inpatient = $1,011,824

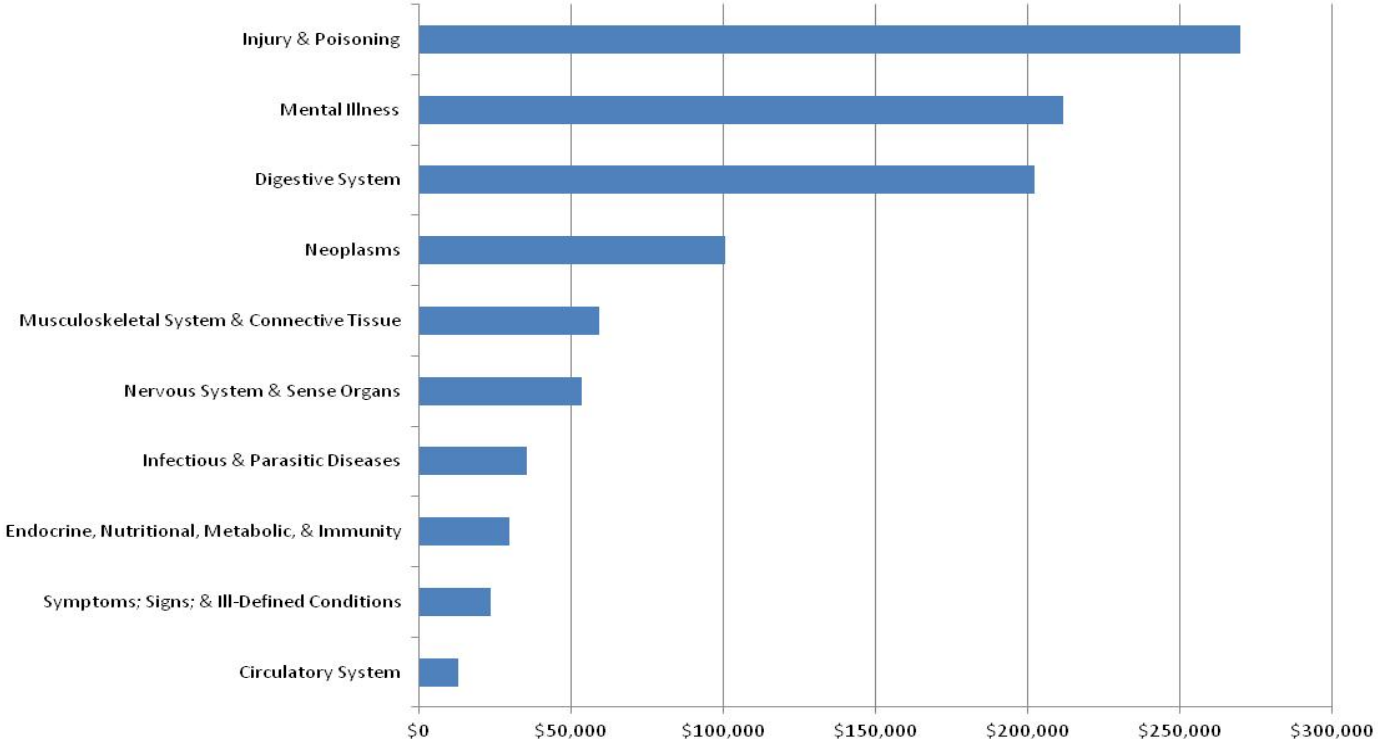


Top 5 Outpatient Providers – total paid for all Outpatient = $1,207,651

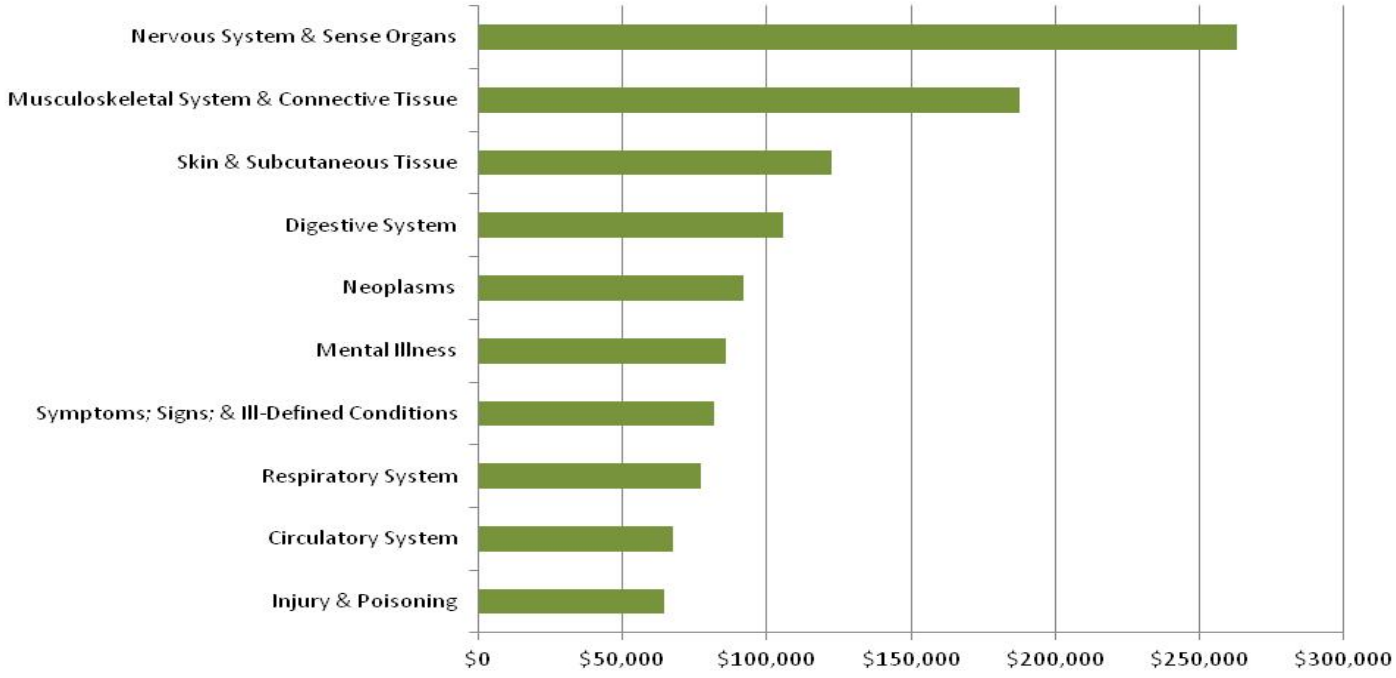


Claim Analysis for those Paid during calendar year 2017

Top 10 Medical Inpatient Claims by Diagnosis

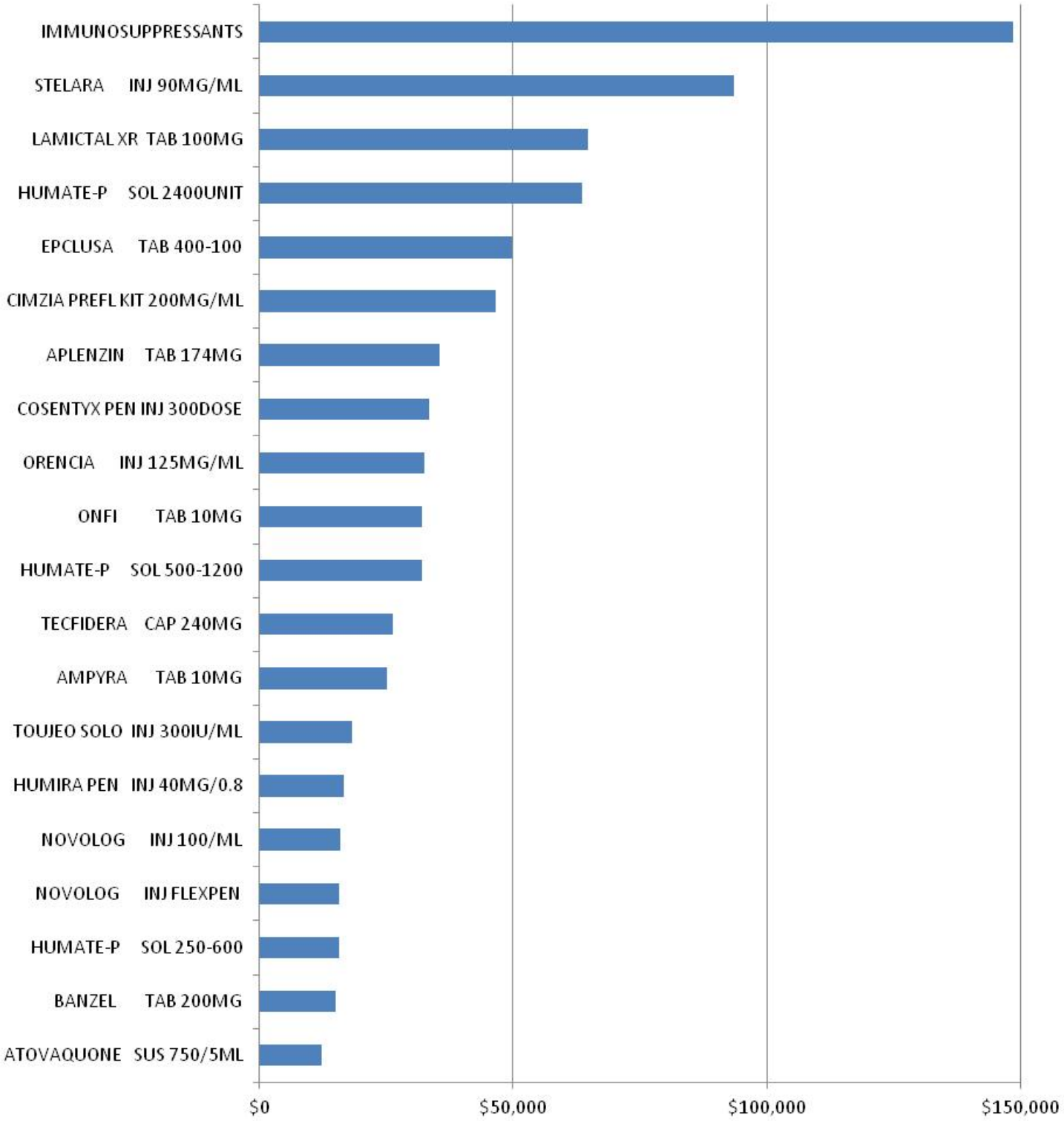


Top 10 Medical Outpatient Claims by Diagnosis



Claim Analysis for those Paid during calendar year 2017

Top 20 Prescription Drugs



2017 Board of Directors

STATUTORY MEMBERS
Lisa Madigan, Attorney General
Jennifer Hammer, Director, IL Department of Insurance, Board Chair
Scott Harry, Director, Governor's Office of Management & Budget

LEGISLATIVE MEMBERS
Bill Brady, Bloomington, IL – State Senator 44th District
Don Harmon, Oak Park, IL – State Senator 39th District

APPOINTED MEMBERS
Nasiruddin Rana, MD, MPH, FACOG, FACS
Eva Serrano, Ed.D.
Howard J. Bolnick, F.S.A.
Carrie McAteer

PLAN ADMINISTRATORS
Blue Cross and Blue Shield of Illinois, Plan Administrator
Prime Therapeutics, PBM Administrator

ACTUARIAL ADVISORY COMMITTEE
Nicole Styka, Chairman
Dan Good