EMBARGOED UNTIL
12:01 a.m. Monday, April 16, 2007

For further information,
contact Laurence Msall at 312.201.9044

STATE MUST REIN IN EMPLOYEE HEALTH EXPENSES
Key Reforms Could Save the State as Much as $466 Million per Year

(CHICAGO) The combination of an excessively expensive indemnity plan, low required employee contribution levels, and the provision of free health insurance to many retirees has made the State of Illinois group insurance plan a significant drain on State finances, reports a new Civic Federation study released today on www.civicfed.org.

The State of Illinois provides health insurance for over 346,000 government employees, retirees, and their dependents. State spending on these employee health care plans has risen 131.4% between FY1998 and FY2007 to $1.8 billion or 3.4% of the total State operating budget. Employee health care liabilities have consistently risen at a faster rate than the Illinois budget, 9.4% per year versus 5.2%. "The State of Illinois is now spending a half a billion more on employee and retiree health care than on the total annual budget of the Department of Children and Family Services (DCFS). Without reform, the State's employee and retiree health insurance costs will soon overtake the entire budget for the Illinois Department of Transportation," said Laurence Msall, President of the Civic Federation. "State lawmakers must begin to ask the question of whether maintaining an extraordinarily generous employee health insurance program is really more of a priority for scarce tax dollars than safe homes for children and State spending for roads and transit."

There are three major aspects of the State's health insurance programs that far exceed what such programs cost both in the private sector and other state governments. Illinois' indemnity plan, which is also known as a fee-for-service or traditional plan is much more expensive in comparison to the managed care plans it offers, as well as indemnity plans in other states. The average cost per participant in the State's indemnity plan is estimated to be 51.3% higher than the cost for HMO coverage and 31.3% higher than the cost for the OAP (Open Access Plan, a PPO-like plan). Illinois' cost for a single enrollee in the indemnity plan is $7,294, which is 89% higher than the State of North Carolina's indemnity plan and 33% more costly than New York's indemnity plan. In fact, most private and public organizations in the U.S. have eliminated indemnity plans in favor of less costly managed care. Thirty-nine percent of Illinois' total enrollees, including 71% of its retirees, participate in the indemnity plan, while only 3% of enrollees across the country participated in indemnity plans in 2006.

The Federation study also found that State of Illinois retirees with more than twenty years of service do not contribute anything to their annual health care premiums. This means a total of 92.7% of State government retirees receive free health insurance at an annual cost of $356.1 million. Only fourteen other states offer free health insurance for Medicare-eligible retirees and less than nine percent of private sector retirees over age 65 receive free employer-sponsored health coverage. The fact that most Illinois retirees and their dependents are enrolled in the State's most expensive plan and yet do not have to contribute to its higher price is a large contributing factor to the mounting liabilities of the group insurance plan.

According to the Federation report, the percentage of premium costs that active State of Illinois employees pay for individual and family health insurance is significantly below the Kaiser Foundation survey averages for public and private plans and less than the average of state and local governments for family coverage in the HMOs and OAP. Relatively low employee contributions to premiums mean that Illinois taxpayers must shoulder a greater share of total health insurance costs than do other states and private organizations. This contributes to the State's escalating health insurance liabilities.

-more-

177 N. State Street, Suite 400 Chicago, Illinois 60601 ● Telephone (312) 201-9066 Fax (312) 201-9041 ● E-mail civicfed@civicfed.org

The Civic Federation's analysis proposes a number of changes which the State can make to its employee and retiree health plans to make them more cost efficient:

- Require the 92.7% of retirees who do not currently contribute anything toward the premium cost of their health insurance to make contributions of 15%, 25%, or 41% of premiums, which would save the State $53.4 million, $89 million, or as much as $146 million.
- Increasing employee contributions by a mere 1% would save the State $10.2 million; increasing contribution levels to match national averages (15% for individuals, 22% for families) would save as much as $67.3 million.
- Eliminate the indemnity plan and transfer enrollees into less expensive managed care (such as PPOs or HMOs), which could save the State between $176.6 and $253.4 million per year.

###

The Civic Federation is an independent, non-partisan government research organization founded in 1894. The Federation's membership includes business and professional leaders from a wide range of Chicago area corporations, professional service firms and institutions. For more information, please visit the Federation's web site at www.civicfed.org.

STATE OF ILLINOIS
EMPLOYEE HEALTH INSURANCE PLANS:

Analysis and Recommendations for Cost Containment

Prepared by
The Civic Federation
April 16, 2007

FOREWORD

The Civic Federation would like to express its sincere appreciation and gratitude to William Ketchum, Executive Advisor to the Federation, for managing the project and research team that produced this report. Mr. Ketchum's many years of experience in the employee benefits profession were an invaluable asset in preparing the report and developing its policy recommendations. In addition, the Civic Federation thanks Sarah Wetmore, Civic Federation Research and Communicator Advisor, for her efforts in researching, writing and editing this report.

This report would not have been possible without the assistance of Colm Brewer of the Illinois Department of Family Healthcare Services and Michael Moore of the Illinois Commission on Governmental Forecasting and Accountability. In addition, we are grateful to Lise Valentine and Roland Calia for providing us with editorial commentary.

About The Civic Federation

The Civic Federation is a nonpartisan government research organization founded in 1894. The Federation's membership includes business and professional leaders from a wide range of Chicago area companies and institutions.

The mission of the Civic Federation is to maximize the quality and cost effectiveness of government services in the Chicago region by:

- Promoting opportunities to reform local tax structures;
- Guarding against wasteful expenditure of public funds; and
- Serving as a technical resource to public officials and opinion leaders through non-partisan tax and fiscal research.

THE CIVIC FEDERATION
177 North State Street, Suite 400
Chicago, Illinois 60601
312.201-9066 (main)
312.201.9041 (fax)
civicfed@civicfed.org (E-mail)

Laurence Msall, President

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The purpose of this report is to review the features and costs of the current State of Illinois employee group health insurance program, explore the fiscal impact of this program on the State operating budget, and make policy recommendations for containing the program's rising costs.

Civic Federation Recommendations

To alleviate the fiscal pressures of mounting employee health insurance costs, the Civic Federation makes the following policy recommendations:

- Eliminate the costly indemnity plan and place enrollees in HMO or OAP plans that cost significantly less. This measure could save the State between **$176.6** and **$253.4 million per year**.
- Eliminate free health care for retirees, saving between **$53.4** and **$146.0 million per year** in premium costs.
- Increase employee premium contributions, which are low in comparison to employee contribution levels required by other state and local governments and private sector organizations. Bringing employee premium contributions in line with national averages could yield as much as **$67.3 million** in savings annually.

By implementing all of the Federation's recommendations, the State could reduce its total annual spending on employee health care by between **$297.3** and **$466 million**.

State of Illinois Employee Health Insurance Plans

The State of Illinois Group Insurance Program serves employees, retirees, and dependents of the State government, State universities, the General Assembly, and the judiciary. It offers three different health insurance plan types:

- A self insured indemnity plan, commonly called a fee-for-service or traditional plan (the Quality Care Health Plan),
- A modified preferred provider plan (the Open Access Plan or OAP), and
- Health maintenance organization (HMOs) plans.

There are over 346,000 enrollees in the State's three health insurance plans.

State of Illinois Group Health Insurance: Percent of Participants Who Are Retirees or Their Dependents: FY2006

	Employees + Dependents	Retirees + Dependents	Total	Retirees as % of Total
Indemnity Plan	61,452	73,470	**134,922**	54.5%
OAP Plan	25,943	3,445	**29,388**	11.7%
HMO Plans	155,381	26,394	**181,775**	14.5%
Total	242,776	103,309	**346,085**	29.9%

Source: Colm Brewer, Illinois Department of Healthcare and Family Services, September 8, 2006.

Rising State Employee Health Insurance Costs

Between FY1998 and FY2007, Illinois State health insurance liabilities are expected to rise from $802.8 million to $1.8 billion, a $1.0 billion or 131.4% increase.

These liabilities have risen at a much faster rate than State of Illinois total budgetary appropriations. The average rate of increase for budget appropriations between FY1998 and FY2007 was 5.2%. Health insurance liabilities rose much more steeply over the same period, by an average of 9.4% per year.

In FY2007, State employee health insurance liabilities represented approximately 3.4% of total State operating budget appropriations. The State's employee health care costs of $1.8 billion exceeded the entire $1.3 billion operating budget for the Illinois Department of Children and Family Services, and nearly equaled the $2.1 billion budget of the Illinois Department of Transportation.

Costly Provisions of the State Group Health Insurance Plan

Three features of the State of Illinois Group Health Insurance are significant factors in driving State health insurance costs: an expensive indemnity plan, below-average employee contribution levels, and the provision of free health insurance to many retired employees.

Illinois has an Expensive Indemnity Plan

The average cost per participant in the State's indemnity plan is expected to be 51.3% higher than the cost for HMO coverage and 31.1% higher than the cost for the OAP plans in FY2006. In FY2007, the cost differential is projected to widen, with indemnity plan average participant costs 57.4% higher than costs for HMO coverage and 35.3% higher then for OAP coverage.[1]

Estimated Average Annual Cost Per Participant

Plan	FY2006 Average Cost	FY2007 Average Cost	% CHG
Indemnity	$5,512	$6,128	11.2%
HMO	$3,634	$3,893	7.1%
OAP	$4,203	$4,527	7.7%

Source: Commission on Governmental Forecasting and Accountability
FY2007 Liabilities of the State Employees' Group Insurance Program, p. 9.

The cost of the indemnity plan is significant because 39.0% or 134,922 of the State of Illinois' 346,085 total group health insurance enrollees participated in the indemnity plan in 2006. Approximately 71.1% of all State retirees select the indemnity plan for their coverage. The rate of enrollment in Illinois' indemnity plan is extremely high compared to indemnity plan enrollment for other large firms and governments. A Kaiser Foundation Survey found that, for

[1] Commission on Government Forecasting and Accountability, *Fiscal Year 2007 Liabilities of the State Employees' Group Insurance Program*, 2006, p. 9.

firms and governments with over 5,000 employees, only 4% of covered workers are enrolled in indemnity plans.[2]

Illinois State Employees Pay Below-Average Percentages of Premium Costs

Illinois employees and retirees paid lower percentages of total premium costs than public and private employees in large (over 200 workers) firms across the nation according to the Kaiser Foundation's 2006 survey. The survey's data also shows that Illinois employees and retirees paid less than state and local government employees paid on average for family coverage in HMO and OAP plans. Relatively low employee contributions to premiums mean that the State of Illinois must shoulder a greater share of total health insurance costs than do other public and private organizations. This burden contributes to the State's escalating health insurance liabilities.

Annual Premium Contributions by Employees as a Percentage of Total Premiums

	Kaiser Survey All Large Plans Average	Kaiser Survey State/Local Govt Average	Illinois	Illinois Premium % compared to All Plans	Illinois Premium % compared to Govt. Average
Single					
HMO	15.6%	10.0%	5.4% to 11.6%	below	similar
OAP (HMO/PPO Hybrid)	15.6% to 16.4%	6.0% to 10.0%	6.2% to 9.0%	below	similar
Indemnity	14.1%	n/a	7.6% to 9.6%	below	n/a
Family					
HMO	22.9%	17.0%	12.3% to 16.3%	below	below
OAP (HMO/PPO Hybrid)	22.4% to 22.9%	17.0% to 18.0%	14.6% to 15.7%	below	below
Indemnity	21.2%	n/a	17.1% to 18.0%	below	n/a

Source: Kaiser Family Foundation and State of Illinois Benefit Choice Options FY2006. Kaiser Survey indemnity data from 2005.

Illinois Provides Free Health Care for Retirees with 20 Years of Service

State of Illinois retirees with more than twenty years of service do not have to contribute to their health care premiums. Illinois is one of only fifteen states that currently provide free health care insurance for some or all retirees over 65 with Medicare coverage. Of the 75,040 Illinois retirees reported in FY2006, 92.7% or 69,896 retirees receive free health insurance.[3] The cost of this subsidy to the State is estimated to have been as much as $356.1 million in FY2006.[4]

[2] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2006 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), V-3. See also Appendix A of this report.
[3] Information provided by the Illinois Department of Healthcare and Family Services.
[4] These estimates assume that 92.7% of the retirees enrolled in each of the different type of State health insurance program do not pay for the cost of their insurance. More precise calculations were not possible because the Illinois Department of Healthcare and Family Services did not provide a breakdown of the percentages per health insurance plan of enrollees who do not pay for health insurance.

Civic Federation Recommendations

To alleviate the fiscal pressures of mounting employee health insurance costs, the Civic Federation makes the following policy recommendations.

Eliminate the Indemnity Plan

The State of Illinois indemnity health insurance plan should be eliminated and enrollees placed in HMO or OAP plans that cost significantly less.

If all current indemnity plan enrollees were shifted into the HMO plans, the State could save as much as **$253.4 million** per year. These savings were calculated by multiplying the number of FY2006 participants in the indemnity plan (134,922) by the average savings per participant that would accrue to the State ($1,878) if the shift were made.[5]

If all current indemnity plan enrollees were shifted into the OAP plan, the State could save as much as **$176.6 million** per year. These savings were calculated by multiplying the number of FY2006 participants in the indemnity plan (134,922) by the average savings per participant that would accrue to the State ($1,309) if the shift were made.[6]

Increase Employee Premiums

The Civic Federation recommends that State of Illinois employees be required to increase the percentage of health insurance premiums that they pay to help defray the mounting cost of that program.

If employee premium contributions were increased by 1% from current premium contribution percentages (which vary according to plan and type), the State could save as much as **$10.2 million**.

If employee premium contribution levels were brought into line with the national average for all large plans (those that cover more than 200 workers), so that employees with individual coverage contributed 15% of their health insurance premium costs and employees with family coverage contributed 22%, the State could save as much as **$67.3 million**.

---

[5] There might be additional administrative costs for the conversion or possible reductions in administrative costs. It is not possible to calculate this factor, however, so we have assumed no change in administrative costs.

[6] There might be additional administrative costs for the conversion or possible reductions in administrative costs. It is not possible to calculate this factor, however, so we have assumed no change in administrative costs. It is also important to note that the projections presented above are estimates. It is unlikely that all current indemnity plan enrollees would choose the HMO plan or the OAP plan. It is more reasonable to assume that some percentage would choose each plan. Therefore, actual savings would probably total a dollar amount between $176.6 million and $253.4 million.

Eliminate Free Health Care for Retirees[7]

Requiring retirees currently receiving free health insurance to contribute premiums equal to 15% of the total premium cost, which is the average percentage paid by active single employees in large public and private plans (those that cover over 200 workers) surveyed by the Kaiser Foundation in 2006, would generate as much as **$53.4 million in savings.**[8]

Requiring retirees currently receiving free health insurance to contribute premiums equal to 25% of the total premium cost would generate up to **$89.0 million in savings**.

Requiring retirees currently receiving free health insurance to contribute premiums equal to 41% of the total premium cost, which is the average for the largest private sector plans surveyed by the Kaiser Foundation in 2006, would generate up to **$146.0 million in savings**.[9]

NATIONAL TRENDS: HEALTH CARE COST INCREASES AND DRIVERS

Health care costs have risen faster than inflation for several years, prompting increased analysis of the factors fueling these steady cost increases. The following section describes the recent increases and the major drivers behind health care's escalating cost.

Medical Inflation

The U.S. Department of Health and Human Services projects that in 2006, total U.S. health care spending will exceed $2.1 trillion or 16.5% of the Gross Domestic Product (GDP), up from $1.3 trillion and 13.8% of GDP in 2000.[10] By 2015, health care spending is projected to reach $4.0 trillion, 20.0% of GDP.

U.S. Bureau of Labor Statistics show that the annual inflation for medical care products and services outpaced all consumer products and services by an average of 1.4 percentage points between 1996 and 2005 (see graph below). The gap between the two inflation rates peaked in 2002. The all products inflation rate was 1.6% that year, while medical care inflation was 4.7%. The Consumer Price Index (CPI) for medical care reflects out-of-pocket expenditures made by consumers, including health insurance premiums, net of any health insurance reimbursements to the consumer. It does *not* include health care expenditures made by employers.[11] The change in medical care prices also does not capture changes in medical care utilization.

---

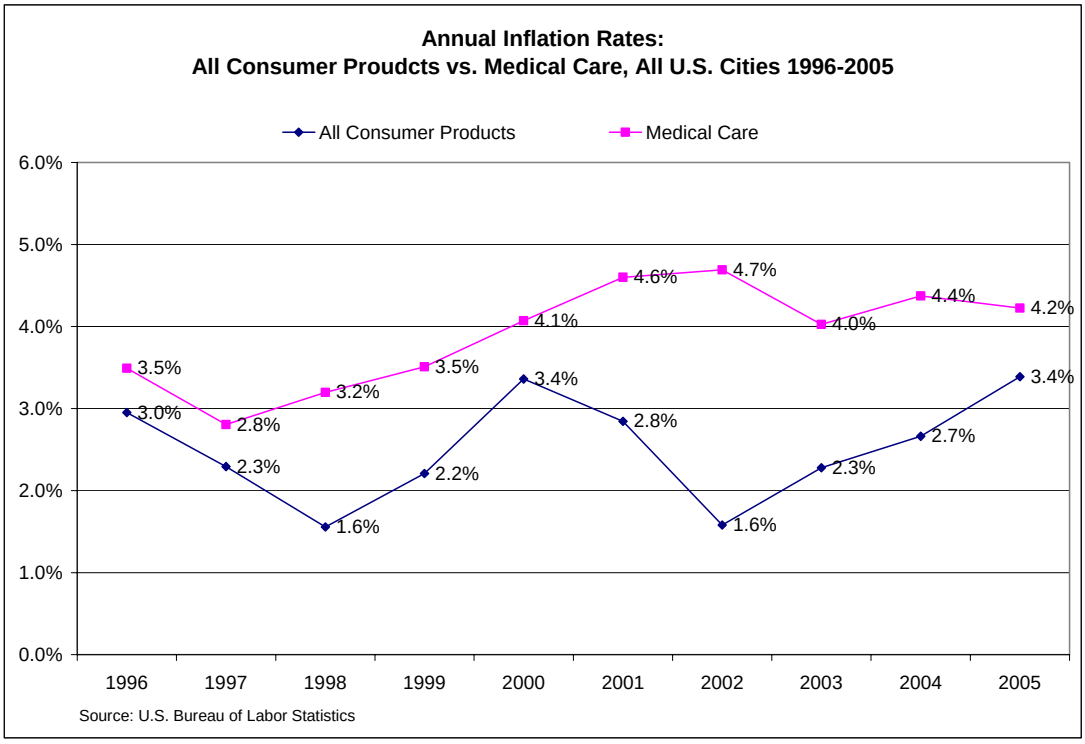
[7] These estimates assume that 92.7% of the retirees enrolled in each of the different type of State health insurance program do not pay for the cost of their insurance. More precise calculations were not possible because the Illinois Department of Healthcare and Family Services did not provide a breakdown of the percentages per health insurance plan of enrollees who do not pay for health insurance.

[8] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2006 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), XI-6-7.

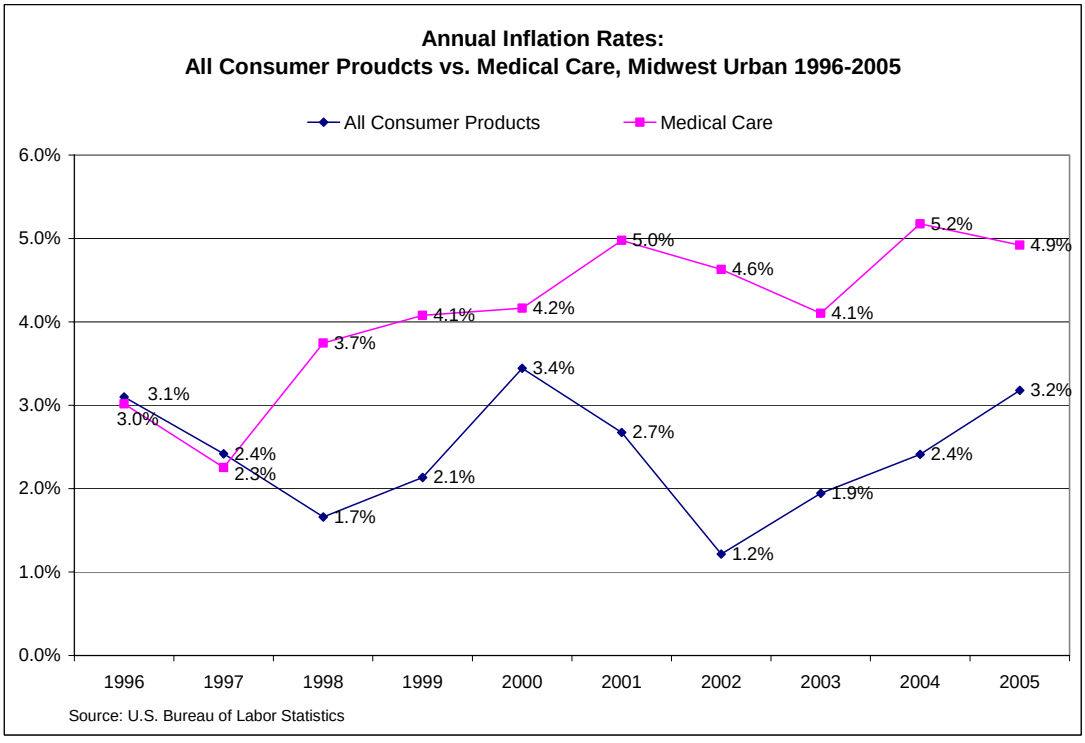
[9] *Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits*, p. 15.

[10] U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, *National Health Care Expenditures Projections: 2005-2015*, (Baltimore: Centers for Medicare & Medicaid Services, 2005), 4.

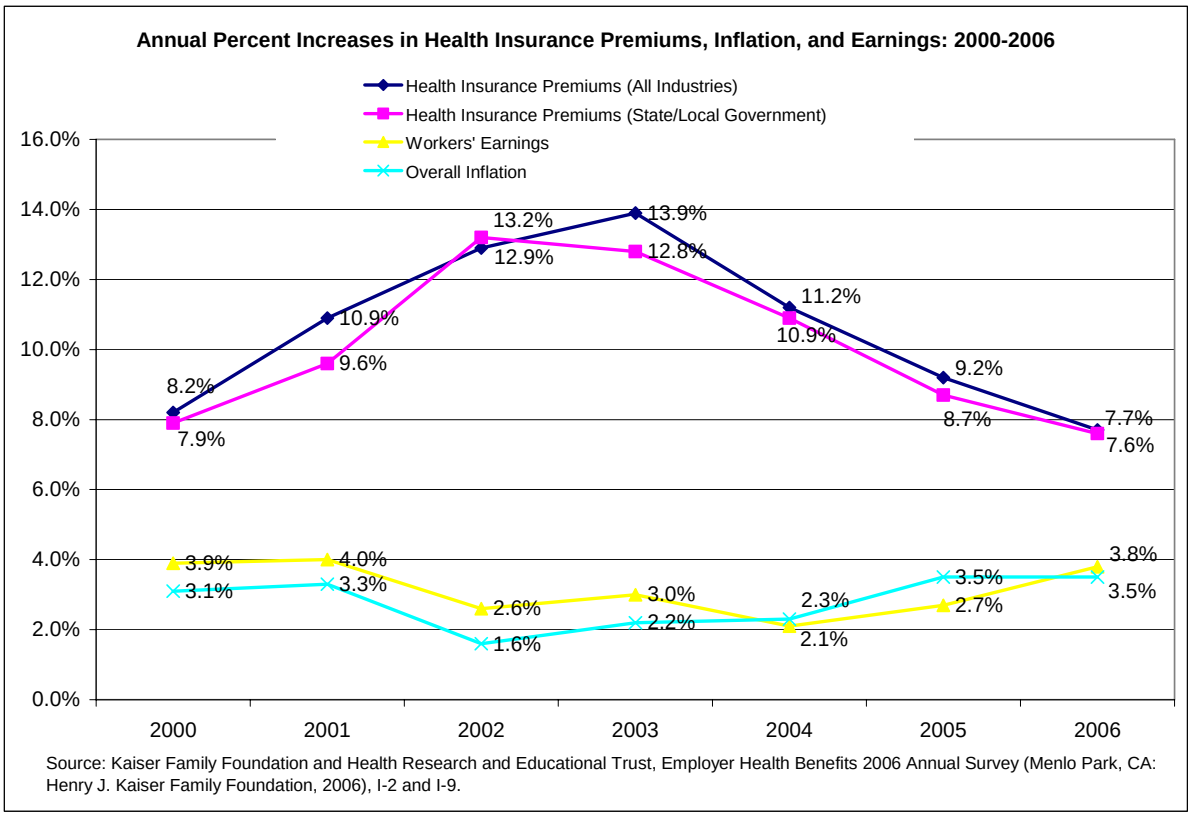
[11] See the U.S. Bureau of Labor Statistics "Measuring Price Change for Medical Care in the CPI" for more detail on methodology and what is included in the Medical Care CPI. www.bls.gov/cpi/cpifact4.htm



Between 1996 and 2005, the average annual gap between medical inflation and inflation for all products was slightly wider in the Midwest than for the nation. Medical inflation in the Midwest annually outpaced all product inflation by an average of 1.7 percentage points over that period.



The Kaiser Family Foundation's 2006 survey of employer-sponsored health benefits compared health insurance premium inflation (employer and employee share) to the inflation rate for all consumer products and to increases in workers' earnings between 2000 and 2006. As the figure below illustrates, health insurance premium increases far outpaced both inflation and increases in workers' earnings. In 2003 the rate of increase for health insurance costs peaked at 13.9% at a time when inflation was 2.2% and workers' earnings grew by 3.0%.[12]



Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2006 Annual Survey (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), I-2 and I-9.

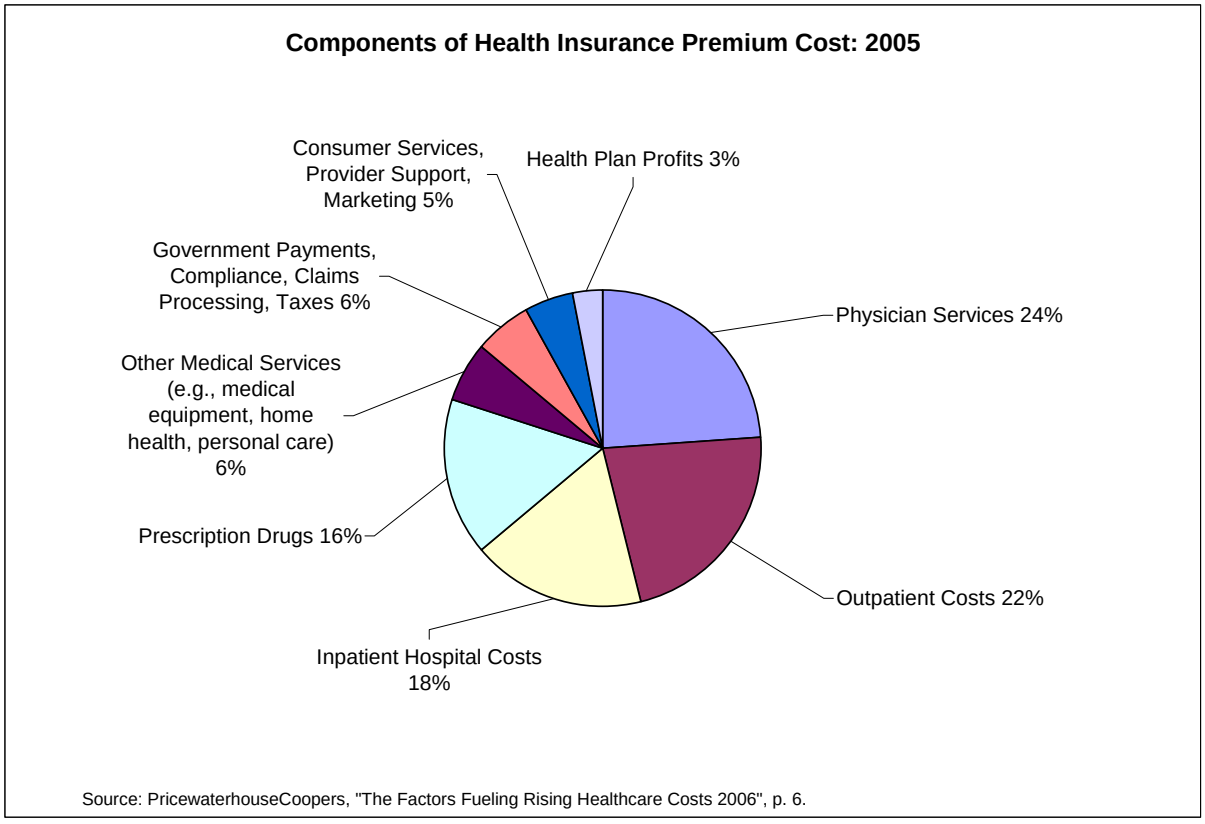
Components of Health Care Costs

The overall cost of health care can be broken down into its component parts. Changes in the cost of health insurance premiums tend to track the total costs of health care. Analysis of premiums is therefore commonly used as a proxy for analysis of total health care costs.[13] In its 2006 report on health care costs components, PricewaterhouseCoopers attributes 86% of health insurance premium costs to direct medical services such as physician care, outpatient and inpatient

[12] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2006 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), I-2. Note that the overall inflation rate is different from the annual inflation rate in the preceding table because the Kaiser study used the U.S. City Average Inflation from April to April rather than the standard annual rate.

[13] PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2006," January 2006, p. 3. http://www.pwc.com/extweb/pwcpublications.nsf/docid/E4C0FC004429297A852571090065A70B . See also Nicholas Greifer, "An Elected Official's Guide to Health Care Cost Containment," (Chicago: Government Finance Officers Association) 2005, p. 4.

procedures, prescription drugs, and medical devices. The authors note that the costs of malpractice insurance and defensive medicine are embedded in the cost of direct medical services. If these medical liability costs were excluded, direct medical services' share of the overall cost increase would drop by ten percentage points, from 86% to 76%.[14]



PricewaterhouseCoopers estimated that health insurance premiums rose 8.8% in 2005 (similar to the Kaiser Foundation estimate of 9.2%), and disaggregated this increase into three main drivers: general inflation (2.4%), medical inflation in excess of general inflation (2.6%), and increased utilization (3.8%). These three drivers are further divided into eight sub-components as follows:

[14] PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2006," January 2006, p. 7. http://www.pwc.com/extweb/pwcpublications.nsf/docid/E4C0FC004429297A852571090065A70B . "Defensive medicine" refers to activities meant to mitigate the threat of lawsuits, such as physicians ordering tests and procedures that they do not believe are medically necessary.

Cost Drivers of Total 8.8% Health Insurance Premium Increase: 2005	
DRIVER	**% SHARE**
General Inflation	**2.4%**
Medical Inflation in excess of General Inflation	**2.6%**
Cost Shifting from Public Providers and Uninsured	*0.5%*
Higher Priced Technologies	*1.0%*
Broader-Access Plans/Provider Consolidation	*1.1%*
Increased Utilization	**3.8%**
Aging	*0.5%*
Lifestyle (e.g., obesity, smoking)	*0.3%*
New Treatments	*1.0%*
More Intensive Diagnostic Testing/Defensive Medicine	*0.8%*
Increased Consumer Demand	*1.2%*

Source: PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2006", p. 10.

The costs of care for the uninsured and inadequate Medicaid reimbursements are shifted onto other payers and were estimated by PricewaterhouseCoopers to be responsible for a 0.5% share of the 8.8% increase in health insurance premiums in 2005. Higher priced technologies, including equipment as well as new prescription drugs, accounted for 1.0%. A trend toward plans that offer broader provider networks and less restricted access to specialists, as well as provider consolidation, has reduced competition and contributed a 1.1% share of premium cost increases.

Increased utilization was the most important factor in the 8.8% increase in premiums, particularly in the form of new treatments (1.0%) and increased consumer demand (1.2%). Many new treatments are for conditions that were not previously considered illnesses, or were not routinely treated using effective prescription drugs. Consumer demand for these treatments is boosted by efforts such as direct-to-consumer advertising.

Each of the three principal cost drivers affects particular medical service components of premium costs differently. For example, increased utilization is the biggest factor in increases for outpatient costs and prescription drugs, but not for inpatient hospital costs. The 13.7% growth in outpatient costs were, however, the single largest medical service contributor to the overall 8.8% increase in premiums. They accounted for a 3.0% share of the 8.8% increase. The table below examines the various direct medical service components of health insurance premium costs. It lists PricewaterhouseCoopers' estimates of annual spending growth rates for each component. It also gives PricewaterhouseCoopers' estimates of the share of the overall 8.8% increase in premium costs for which each medical service component was responsible.

Cost Drivers of Total 8.8% Health Insurance Premium Increase, by Direct Medical Service Component: 2005		
Component and Driver	**Spending Growth Rate**	**Share of 8.8% Increase in Premiums**
Physician Services		
General Inflation	*2.4%*	*0.6%*
Medical Inflation in excess of General Inflation	*2.3%*	*0.6%*
Increased Utilization	*3.1%*	*0.7%*
Total Physician Services	**7.8%**	**1.9%**
Outpatient Costs		
General Inflation	*2.4%*	*0.5%*
Medical Inflation in excess of General Inflation	*4.0%*	*0.9%*
Increased Utilization	*7.2%*	*1.6%*
Total Outpatient Costs	**13.6%**	**3.0%**
Inpatient Hospital Costs		
General Inflation	*2.4%*	*0.4%*
Medical Inflation in excess of General Inflation	*4.0%*	*0.7%*
Increased Utilization	*1.1%*	*0.2%*
Total Inpatient Hostpital Costs	**7.5%**	**1.3%**
Prescription Drugs		
General Inflation	*2.4%*	*0.4%*
Medical Inflation in excess of General Inflation	*1.1%*	*0.2%*
Increased Utilization	*5.1%*	*0.8%*
Total Prescription Drugs	**8.6%**	**1.4%**
Other Medical Service		
General Inflation	*2.3%*	*0.1%*
Medical Inflation in excess of General Inflation	*2.6%*	*0.2%*
Increased Utilization	*2.4%*	*0.1%*
Total Other Medical Service	**7.3%**	**0.4%**
Total Health Insurance Premium Increase		**8.8%**

Source: PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2006", p. 10.

In recent years, double-digit increases in the cost of prescription drugs had been the fastest growing component of health insurance premiums; but in 2005, prescription drug costs grew at just 8.6% and accounted for only a 1.4% share of the total 8.8% premium increase. The relative slowdown in prescription drug cost growth is attributed to various causes, including the increased use of tiered prescription drug plans and of generic drugs.[15]

EMPLOYER COST CONTAINMENT STRATEGIES

Employers have tried to contain rapidly rising health insurance costs by managing their plan offerings, vendors, and employees' health choices. Many of these strategies involve shifting costs onto employees in order to both reduce employer costs and influence employee health choices.

[15] Kaiser Family Foundation, *Prescription Drug Trends* (Menlo Park, CA: Henry J. Kaiser Family Foundation, June 2006), p. 4. See also Paul B. Ginsburg, Bradley C. Strunk, Michelle I. Banker, and John P. Cookson, "Tracking Health Care Costs: Continued Stability But At High Rates in 2005," *Health Affairs*—Web Exclusive, 3 October 2006, pp. W490-W491.

In 2004 the Government Finance Officers Association (GFOA) recommended five strategies for government employee health care cost containment.[16] These recommendations are based on the GFOA's analysis of the causes of health care cost increases as well as a review of cost containment measures used by the public sector and the private sector. The five strategies address plan design, vendor management, individual health management, aggregation, and cost sharing.

Plan Design

Plan design changes can be major, such as eliminating indemnity plans in favor of managed care options, or minor, such as adjusting provider networks. Adjusting employee cost differentials among plans can be an effective tool for steering higher cost employees toward certain lower cost plans.

Many employers are moving from indemnity plans, which are the most expensive plan type, to managed care plans such as HMO, PPO, and POS, which reduce costs through pre-contracting with health care providers and negotiating lower service fees. In its annual survey of health care insurers, administrators, and managed care organizations, The Segal Company has consistently found that projected cost increases for indemnity plans exceed those of all other plan types. In 2007, indemnity plan costs for all employers are projected to increase 13.7%, while costs for HMOs, PPOs, and other managed care plans are expected to increase between 11.1% and 12.0%.[17]

According to the 2006 Kaiser Foundation survey, 8% of state and local government employees are enrolled in indemnity plans, compared to 3% for all industries.

Employee Health Plan Enrollment by Type: 2006

INDUSTRY	Conventional (Indemnity)	HMO	PPO	POS	HDHP/SO
Retail	2%	19%	59%	18%	2%
Health Care	2%	23%	61%	10%	4%
Transportation/Communications/Utilities	2%	20%	69%*	7%*	1%*
Service	3%	20%	57%	17%*	3%
Finance	3%	19%	65%	10%	3%
Agriculture/Mining/Construction	4%	7%*	62%	18%	10%
Manufacturing	4%	16%*	64%	9%*	8%*
Wholesale	5%	17%	63%	9%	6%
State/Local Government	**8%**	**39%***	**41%***	**11%**	**1%***
ALL FIRMS	***3%***	***20%***	***60%***	***13%***	***4%***

* Estimate is statistically different from other industries at p<.05.

Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2006 Annual Survey (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), V-3.

[16] Government Finance Officers Association, "Recommended Practice: Health Care Cost Containment - 2004," www.gfoa.org/documents/HealthCareCostContainment.doc.

[17] The Segal Company, "2007 Segal Health Plan Cost Trend Survey," (2006), pp. 2-3. http://www.segalco.com/government/pub-govt.cfm?ID=674 . Results are for health plans excluding prescription drug plans.

Some employers are trying to contain costs using new plans types that feature health savings accounts, but evidence is mixed as to whether these plans will save money over the long-term.[18] Other efforts include adjusting eligibility criteria for part-time and temporary employees and requiring vesting periods for retiree health coverage.

Reducing the number of plans or carrier options can lower costs by introducing economies of scale and reducing adverse selection (healthier employees choosing low-cost plans and less healthy employees choosing comprehensive, high-cost plans). Conversely, limited vendor pools in some rural areas and a lack of competition arising from consolidation can boost costs.[19] Governments should seek a balance that ensures the greatest amount of effective competition among providers.

The introduction of tiered prescription drug formulas is an important plan design change that has helped slow the rate of increase in prescription drug costs (see p. 13). By setting different prices for generic and brand name drugs, and by lowering costs for those who use mail-order pharmacies, tiered plans encourage economical prescription drug choices among employees. The Kaiser Foundation survey found that 90% of all covered employees have tiered prescription drug formulas in 2006, compared to 67% in 2000.[20]

Vendor Management

Careful management of health insurance providers can hold down costs. Vendors should be managed and regularly audited in a professional manner to verify that they are meeting the terms of the contract. Employers should ensure that vendors require plan participants to regularly re-enroll and provide information about themselves and their dependents in order to verify eligibility.[21]

Frequent rebidding of contracts can help ensure that the employer is getting a competitively priced plan. A 2004 survey comparing the health purchasing practices of state governments and Fortune 500 companies found that states are less aggressive about dropping vendors during the bidding process and tend to contract with a larger number of carriers than do Fortune 500 companies.[22] The authors note that a competitive bidding process that eliminates some bidders is more effective at driving down premium prices. The survey also found that most states had multi-year contracts, while Fortune 500 companies re-bid their health insurance carriers annually. Government employers, though, often face bidding process restrictions, such as

[18] Nicholas Greifer, "An Elected Official's Guide to Health Care Cost Containment," (Chicago: Government Finance Officers Association, 2005), 22-24.
[19] The National Association of State Personnel Executives notes that state government health care plans are often more expensive than comparable large city government plans because they must serve dispersed workforces that are often located outside of competitive urban health care markets. National Association of State Personnel Executives Healthcare Taskforce, "White Paper: State Government Employee Healthcare Benefits," (September 2006), 7. http://www.naspe.net/index.cfm?PageID=6
[20] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2006 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), IX-5.
[21] Government Finance Officers Association, "Recommended Practice: Health Care Cost Containment - 2004," www.gfoa.org/documents/HealthCareCostContainment.doc.
[22] James Maxwell, Peter Temin, and Tanaz Petigara, "Private Health Purchasing Practices in the Public Sector: A Comparison of State Employers and the Fortune 500," *Health Affairs* (Vol. 23, No.2), 185.

contract length requirements and prohibitions against changing the number of plans available, that limit their maneuverability and keep them from achieving the most cost-effective health care plans available.

Individual Health Management

Individuals' behavior and lifestyle choices significantly affect health care costs. Therefore, efforts to increase employee cost awareness or to encourage lifestyle changes may help to reduce future health care costs.

Vendors can assist plan participants in making suitable health choices by providing detailed information about different treatments (their cost and effectiveness), doctors, hospitals, and plans.[23] Wellness programs that encourage healthy lifestyles and the prevention and early detection of disease improve employee well-being while simultaneously reducing health care costs. The 2006 Kaiser Foundation survey found that state and local governments generally provided wellness programs at a rate above the average for all firms, as illustrated below.

Among Firms Offering Health Benefits, Percentage of Firms Offering Wellness Programs to Employees: 2006

INDUSTRY	% of firms offering fitness programs or on-site health club facilities	% of firms offering smoking cessation programs	% of firms offering injury prevention programs	% of firms offering weight loss programs
Retail	3%*	2%*	30%	1%*
Health Care	6%	15%	21%	14%
Service	9%	8%	15%	6%
Manufacturing	10%	15%	17%	8%
Wholesale	11%	8%	18%	11%
State/Local Government	**13%**	**13%**	**30%***	**10%**
Transportation/Communications/Utilities	14%	9%	20%	9%
Agriculture/Mining/Construction	16%	2%*	39%*	2%*
Finance	19%	21%	5%*	4%
ALL FIRMS	***10%***	***9%***	***19%***	***6%***

* Estimate is statistically different from other industries at p<.05.

Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2006 Annual Survey (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), XII-6.

Maintaining the health of people with chronic conditions such as diabetes, asthma, hypertension, and high cholesterol is very important for cost containment because patients with such conditions account for the vast majority of health expenditures.[24] Disease management programs are meant to stabilize the health of people with chronic conditions by coordinating communication,

[23] Nicholas Greifer, "An Elected Official's Guide to Health Care Cost Containment," (Chicago: Government Finance Officers Association, 2005), 50.

[24] See Nicholas Greifer, "An Elected Official's Guide to Health Care Cost Containment," (Chicago: Government Finance Officers Association, 2005), 52-53 for a number of studies citing the costs of treating these conditions.

education, and treatment for these patients and facilitating their self-care through early diagnosis and healthy lifestyle choices. The 2006 Kaiser Foundation survey found that 23% of state and local governments offering health benefits have disease management plans, as compared to 26% of all firms, as illustrated below.

Among Firms Offering Health Benefits, Percentage of Firms Offering Disease Management Programs for the Plan with the Largest Enrollment: 2006	
INDUSTRY	**Plan Includes Disease Management**
Agriculture/Mining/Construction	19%
Wholesale	20%
Retail	21%
State/Local Government	**23%**
Transportation/Communications/Utilities	23%
Service	26%
Finance	33%
Manufacturing	34%
Health Care	41%
ALL FIRMS	***26%***

Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2006 Annual Survey (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), XII-3.

Aggregation (Purchasing Alliances)

In order to obtain better pricing and market leverage, employers should consider uniting their purchasing power through alliances or consortia. This includes formation of health care insurance pools, joint agreements for procurement of prescription drugs, partnership with private sector organizations, and local participation in state master agreements.[25]

Aggregation of purchasing power can be an effective counter to consolidation trends in the health care industry (see page 12). Pooling can be especially beneficial for smaller governments because it can give them access to a self-funded plan and to the expertise of other pool members.[26] Aggregation can also lead to lower premium prices, lower administrative costs, greater negotiating leverage, better customer service, and budgetary stability resulting from a larger (and thus more predictable) pool.

However, some governments are reluctant to aggregate for several reasons. It requires relinquishing some autonomy in terms of plan design and offerings, which may bring governments into conflict with collective bargaining agreements. Also, cost savings may be insignificant if the pool is small. Finally, a pool member with a relatively low risk profile (e.g., with younger workers) may not benefit from joining with employee groups with higher claims

[25] Government Finance Officers Association, "Recommended Practice: Health Care Cost Containment - 2004," www.gfoa.org/documents/HealthCareCostContainment.doc.

[26] Nicholas Greifer, "An Elected Official's Guide to Health Care Cost Containment" (Chicago: Government Finance Officers Association, 2005), 31-32.

experiences. This last problem can be addressed by arranging for separate, risk-adjusted premium assignments for each participating government.[27]

A 2003 survey by the International City/County Management Association (ICMA) found that smaller local governments were more likely to be a part of consortia than larger ones. Still, only one third of those smaller governments reported being part of a purchasing consortium.[28]

Cost Sharing

Requiring employees to share in the cost of health care not only reduces employer costs, it also raises employee awareness about health care costs and influences their health care consumption. Virtually all covered services are subject to payment limitations and most require the employee to share in the costs of coverage. The most significant opportunities for cost sharing include premiums, office visits, hospital stays, deductibles, prescription drugs, and retiree coverage limitations. Another tactic is to provide financial incentives for employees to leave the employer's plan in favor of a spouse's health insurance.

The 2006 Kaiser Foundation survey found that state and local governments contribute a greater percentage of premium costs than do private sector employers. The following table compares by industry the percent of premiums that employers paid for HMO and PPO plans (roughly 80% of all employees included in the survey were covered by their employers' HMO or PPO plans[29]). State and local government employers paid the highest percentage of all industries: 90% for single coverage in HMO plans and 94% for single coverage PPO plans, compared to all firm averages of 85% for both plans.

[27] Nicholas Greifer, "An Elected Official's Guide to Health Care Cost Containment," (Chicago: Government Finance Officers Association, 2005), 33-34.
[28] Evelina Moulder, *Financing Health Care Plans for Local Government Employees* (Washington, D.C.: International City/County Management Association, 2003), 3.
[29] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2006 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), V-3.

Average Percent of Premium Paid by Employer for Covered Workers: 2006		
Plan Type	**Single Coverage**	**Family Coverage**
HMO (Health Maintenance Organization)		
Agriculture/Mining/Construction	insufficient data	insufficient data
Wholesale	80*%	72%
Manufacturing	81*%	76%
Retail	82%	64%
Finance	83%	69%
Health Care	84%	73%
Service	86%	69%
Transportation/Communications/Utilities	86%	73%
State/Local Government	**90*%**	**83*%**
ALL FIRMS	***85%***	***72%***
PPO (Preferred Provider Organization)		
Retail	80*%	68*%
Manufacturing	82*%	79%
Agriculture/Mining/Construction	83%	71%
Wholesale	83%	76%
Service	83%	69*%
Finance	86%	76%
Transportation/Communications/Utilities	86%	79*%
Health Care	88*%	78%
State/Local Government	**94*%**	**82*%**
ALL FIRMS	***85%***	***74%***

* Estimate is statistically different from other industries at p<.05.

Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2006 Annual Survey (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), VI-18.

In most states, the amount that employees pay toward their health insurance varies by the plan type and coverage options selected. In five states, including Illinois, the employee premium contribution also varies by salary. Thirteen states require no employee premium contribution, and three states give employees the option of choosing a plan with no employee premium contribution.[30] In three other states, the employee has the option of selecting a plan that will be fully paid by the employer. Taking from each state the health care plan with the largest number of enrollees, Workplace Economics, Inc. found that in 2006 the average total health insurance premium for an active state employee with single coverage was $5,340 annually and $12,204 for an active state employee with family coverage.[31] The 2006 Kaiser Foundation survey found that state and local governments had among the highest total annual premium costs for HMO and PPO plans when compared to other industries.[32] Differences among industries can reflect many factors, including the age and health of employees.

[30] Workplace Economics, Inc., *2006 State Employee Benefits Survey*, (Washington, D.C.: Workplace Economics, 2006), 71. It is important to note that Workplace Economics data reflects only the plan enrolling the largest number of employees in each state.
[31] Workplace Economics, Inc., *2006 State Employee Benefits Survey*, (Washington, D.C.: Workplace Economics, 2006), 71.
[32] Claxton et al., *Employer Health Benefits 2006 Annual Survey*, I-1.

Average Total Annual Premium for Covered Workers: 2006		
Plan Type	**Single Coverage**	**Family Coverage**
HMO (Health Maintenance Organization)		
Agriculture/Mining/Construction	insufficient data	insufficient data
Wholesale	$3,638	$10,150
Finance	$3,767	$10,633
Retail	$3,924	$12,663
Service	$3,990	$11,231
Manufacturing	$4,027	$11,066
Health Care	$4,140	$11,247
Transportation/Communications/Utilities	$4,287	$11,402
State/Local Government	**$4,329***	**$11,491**
ALL FIRMS	***$4,049***	***$11,278***
PPO (Preferred Provider Organization)		
Retail	$3,904*	$10,785*
Agriculture/Mining/Construction	$4,065*	$11,354
Manufacturing	$4,072*	$11,390
Wholesale	$4,334	$12,144
Service	$4,375	$11,443
Finance	$4,430	$12,385
Transportation/Communications/Utilities	$4,508	$12,116
State/Local Government	**$4,879***	**$11,933**
Health Care	$5,032*	$13,188*
ALL FIRMS	***$4,385***	***$11,765***

* Estimate is statistically different from other industries at p<.05.

Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2006 Annual Survey (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), I-13.

Cost-sharing through increases in co-payments for office visits and other services is another common measure used to limit employer costs and influence participant behavior. A 2005 survey of public employers conducted by the Center for Studying Health System Change found that nearly half of the state and local governments surveyed had increased prescription drug, doctor visit, or emergency visit co-payments in the previous two years.[33]

Retiree Coverage

The 2006 Kaiser Foundation survey found that state and local governments are much more likely than private sector employers to provide retiree health benefits, with 82% of large governments offering them, compared to only 35% of all large firms. Many private sector employers reduced their retiree health benefits following the implementation of Financial Accounting Standards Board Statement 106 (FASB 106) in 1993, which required firms to begin reporting accrued liabilities for retiree health benefits in their financial statements rather than accounting for them on a pay-as-you-go basis.[34] The imminent implementation of a similar accounting standard for

[33] Hurley et al., "MarketWatch: Public Employees' Health Benefits Survive Major Threats, So Far," *Health Affairs* 25, no. 3 (2006): W198.

[34] Hewitt Associates, "The Retiree Health Care Challenge," (TIAA-CREF Institute Symposium, *Seeking Remedies to the Retiree Health Care Challenge*: November 2006), 3.

governments (Governmental Accounting Standards Board Statements 43 and 45) could eventually have similar effects on public sector provision of retiree health benefits.[35]

Percent of Employers Offering Retiree Health Benefits, Among Firms Offering Active Employee Health Benefits: 2006		
INDUSTRY	**All Small Firms (3-199 Employees)**	**All Large Firms (200+ employees)**
Retail	0*%	11*%
Health Care	5%	15*%
Wholesale	3*%	17*%
Agriculture/Mining/Construction	13%	28%
Manufacturing	6%	31%
Service	8%	37%
Finance	17%	47%
Transportation/Communications/Utilities	11%	52*%
State/Local Government	**29*%**	**82*%**
ALL FIRMS	***9%***	***35%***

* Estimate is statistically different from other industries at p<.05.

Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2006 Annual Survey (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), III-4.

All 50 states offer health insurance for pre-Medicare retirees (under age 65), and forty-eight states offer health insurance for Medicare-eligible retirees. Eighty-six percent of state employers opted to maintain a prescription drug plan for Medicare eligible retirees equal to or better than the standardized Medicare Part D benefit. Ten percent opted to offer only a supplemental plan while four percent stopped offering drug coverage to Medicare eligible retirees entirely.[36]

Retiree health care costs can be shared in many of the same ways as active employee costs. Premium cost sharing is very common. In their 2006 survey of large private-sector firms (over 1,000 employees) that provide retiree health care, the Kaiser Foundation and Hewitt Associates found that 92% of firms required pre-Medicare retirees in the largest plan to contribute to their premiums, and 17% required retirees to pay the entire premium cost.[37] The 2006 survey of state employee benefits conducted by Workplace Economics, Inc. found that 39 states required pre-Medicare retirees in the largest plan to contribute to their premiums, and 12 required retirees to pay the entire premium cost.[38]

[35] For more on GASB 43 and 45, see The Civic Federation's "Other Post Employment Benefits: GASB Statements No. 43 and 45 Reporting Guidelines for Government Financial Statements," http://www.civicfed.org/articles/civicfed_202.pdf. Implementation is phased in based on government size. Most large governments will be required to begin reporting in their FY2007 financial statements.

[36] Workplace Economics, Inc., *2006 State Employee Benefits Survey*, (Washington, D.C.: Workplace Economics, 2006), 72.

[37] Kaiser Family Foundation and Hewitt Associates, "Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits," (December 2006), p. 16. http://www.kff.org/medicare/upload/7587.pdf

[38] Workplace Economics, Inc., *2006 State Employee Benefits Survey*, (Washington, D.C.: Workplace Economics, 2006), 74-75.

In addition to sharing premium costs, many employers have capped the amount they are obligated to pay toward future retiree health costs. This means that beneficiaries are responsible for funding much or all future cost increases in premiums above a certain amount unless the employer adjusts the cap.[39] Another measure that some governments use to mitigate the impact greater cost-sharing has on retirees is to establish tax-advantaged savings vehicles with which employees can build assets to use for paying their health care bills in retirement.[40]

STATE OF ILLINOIS HEALTH INSURANCE PLAN FEATURES AND COSTS

The State of Illinois Group Insurance Program serves employees, retirees, and dependents of the State government, State universities, the General Assembly, and the judiciary. It offers three different health insurance plan types. The following sections describe the major features of the plans, the number of participants in each, and the employer and participant costs.

Plan Types

Employees and retirees can choose from three major plan types: an indemnity plan (Quality Care Health Plan), a modified preferred provider plan (Open Access Plan), and a health maintenance organization (various HMOs).

The indemnity plan, Open Access Plan, and two of the HMOs (Health Alliance Illinois and OSF Winnebago) are self-insured, meaning that the State bears the financial risk for the cost of health insurance claims. The other five HMO plans are fully insured, meaning that the State has contracted with an HMO provider who then bears the risk and responsibility for participants' medical claims.[41]

Quality Care Health Plan (Indemnity Plan)

The Quality Care Health Plan (QCHP) is a self-insured indemnity plan, also commonly called a "traditional plan" or a "fee-for-service plan." It is administered for the State by CIGNA. Indemnity plans were the standard health insurance program before the rise of managed care plans (e.g., HMOs and PPOs) in the 1980s. A major service feature distinguishing indemnity plans from managed care plans is the degree of freedom that enrollees have in choosing medical service providers. Participants are permitted to choose any physician or hospital, although QCHP provides discounted rates for use of physicians that are members of a network, a feature modeled on PPO plans. Indemnity plans also typically have higher participant out-of-pocket costs than managed care plans.

---

[39] Employee Benefit Research Institute, "The Impact of the Erosion of Retiree Health benefits on Workers and Retirees," *EBRI Issue Brief #279* (March 2005): 6.

[40] Nicholas Greifer, "An Elected Official's Guide to Health Care Cost Containment," (Chicago: Government Finance Officers Association, 2005), 56.

[41] Prescription drug benefits for the indemnity, OAP, and self-insured HMO plans are administered by Merck Medco in a contract which began in July 2005. The five fully-insured HMOs provide prescription drug coverage as part of their plans. Retail prescription drug co-pay levels are the same for all plans: $9 generic, $18 preferred brand, $36 non-preferred brand.

Open Access Plan (modified Preferred Provider Organization)

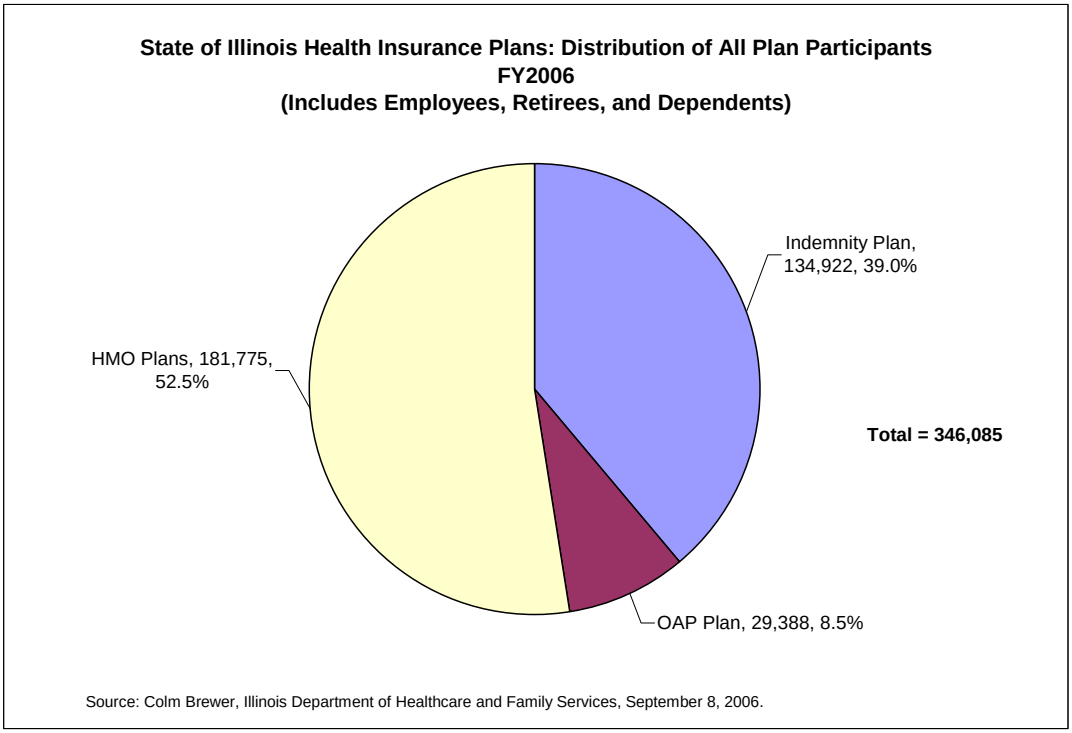
The Open Access Plan (OAP) is a modified Preferred Provider Organization (PPO), which is a plan that uses significant monetary incentives to encourage the use of network providers. The State's OAP is administered by Healthlink. The OAP has three tiers, which represent different levels of freedom of choice and participant cost-sharing. Tier I functions like an HMO. It has specified medical service providers and low participant costs. Tier II affords participants more choice. It offers self-referral options and has higher participant costs. Tier III is similar to the indemnity plan in that it allows open access to out-of-network providers at a significantly higher cost to participants. The distinguishing feature of the OAP is that is allows participants to use Tier I, II, and III services as desired.

Health Maintenance Organizations

Health Maintenance Organizations (HMO) are typically the most restrictive, but the lowest cost health insurance programs. The State Group Insurance Program contracts with seven HMOs: Health Alliance HMO, Health Alliance Illinois, HMO Illinois, OSF Health Plans, OSF Winnebago, PersonalCare, and Unicare HMO. Depending on the county in which they live, participants can generally choose among one to four HMOs. HMO plan coverage is restricted to network providers only and referrals for specialized services or hospitalization must be directed by the patient's primary care physician. Participant plan costs are low, with no deductibles and limited co-payments.

Enrollment

State of Illinois Group Insurance Plans had a total of 346,085 participants in FY2006. Slightly more than half were enrolled in HMO plans, 39.0% in indemnity plans, and 8.5% in the OAP.



As the following two tables illustrate, the distribution of active employees and retirees among the plans is notably different. The indemnity plan is clearly the preferred choice among retirees, with 71.1% of retirees and their dependents choosing QCHP. Only 25.3% of active employees and their dependents are enrolled in this plan.

State of Illinois Employees and Dependents Covered by State Health Plans: FY2006				
	Employees	Dependents	**Total**	**% of Total**
Indemnity Plan	33,206	28,246	**61,452**	25.3%
OAP Plan	11,133	14,810	**25,943**	10.7%
HMO Plans	68,660	86,721	**155,381**	64.0%
Total	**112,999**	**129,777**	**242,776**	100.0%

Source: Colm Brewer, Illinois Department of Healthcare and Family Services, September 8, 2006.

State of Illinois Retirees and Dependents Covered by State Health Plans: FY2006				
	Retirees	Dependents	**Total**	**% of Total**
Indemnity Plan	55,039	18,431	**73,470**	71.1%
OAP Plan	2,106	1,339	**3,445**	3.3%
HMO Plans	17,895	8,499	**26,394**	25.5%
Total	**75,040**	**28,269**	**103,309**	100.0%

Source: Colm Brewer, Illinois Department of Healthcare and Family Services, September 8, 2006.

In fact, retirees and their dependents represent only 29.9% of total health plan participants, but 54.5% of indemnity plan participants, as indicated in the table below.

State of Illinois Group Health Insurance: Percent of Participants Who Are Retirees or Their Dependents: FY2006				
	Employees + Dependents	**Retirees + Dependents**	**Total**	**Retirees as % of Total**
Indemnity Plan	61,452	73,470	**134,922**	54.5%
OAP Plan	25,943	3,445	**29,388**	11.7%
HMO Plans	155,381	26,394	**181,775**	14.5%
Total	242,776	103,309	**346,085**	29.9%

Source: Colm Brewer, Illinois Department of Healthcare and Family Services, September 8, 2006.

Plan Costs

In general, the more a health plan is managed, the less expensive it is. HMOs are usually the least expensive health care option in terms of both total costs and employees costs. PPOs are more expensive and indemnity plans are the most expensive.[42]

The following table shows total premium and premium-equivalent costs for the nine State health insurance plans. The indemnity plan, which costs $7,294 for an individual and $16,746 for a family plan, has the highest premium equivalent costs. This is almost 80% higher than the lowest individual HMO premium and 68% higher than the lowest family HMO premium. It is

[42] Nicholas Greifer, "An Elected Official's Guide to Health Care Cost Containment," (Chicago: Government Finance Officers Association, 2005), 20-21.

noteworthy that the State's four self-insured plans, including the two HMOs, have the most expensive premiums.

Illinois State Health Insurance Total Premium By Plan Type: FY2006*		
	Individual	**Family****
Indemnity Plan (QCHP)***	$7,294	$16,746
Modified PPO (Healthlink OAP)***	$5,258	$12,863
HMOs		
Unicare HMO	$4,249	$10,402
HMO Illinois	$4,072	$9,968
PersonalCare	$4,681	$11,455
OSF Health Plan	$4,993	$12,216
Health Alliance HMO	$4,882	$11,948
Health Alliance Illinois***	$6,048	$14,791
OSF Winnebago***	$5,415	$13,247

*Total premiums are based on COBRA rates minus a 2% administrative charge.

**"Family" here means employee plus 2 or more dependents. The dependents premium contribution is a flat amount added to the individual premium.

***Self-insured

Source: State of Illinois Department of Central Management Services Bureau of Benefits, "Benefit Choice Options: Effective July 1, 2005 - June 30, 2006." http://www.state.il.us/cms/download/pdfs_benefits/fy06statebcbook4.pdf; COBRA rates

Employee premium contributions vary based on salary and plan type, with one contribution level for the indemnity plan and another level for all of the managed care plans (OAP and HMOs). Contributions for dependents are set at a flat rate that differs by plan. The following two tables show employee premium contribution amounts for each plan by salary. Indemnity plan contributions are 50-70% higher than managed care plan contributions depending on salary. As discussed on page 32 of this report, retirees with more than twenty years of service make no premium contribution.[43]

Illinois State Employee Annual Premium Contribution By Plan Type, Indemnity and OAP: FY2006				
	Indemnity Plan (QCHP)		Modified PPO (OAP)	
Salary Range	**Individual**	**Family***	**Individual**	**Family***
$27,800 or less	$552	$2,856	$324	$1,872
$27,801-$42,000	$612	$2,916	$384	$1,932
$42,001-$55,900	$642	$2,946	$414	$1,962
$55,901-$70,000	$672	$2,976	$444	$1,992
$70,001 and over	$702	$3,006	$474	$2,022

*"Family" here means employee plus 2 or more dependents. The dependents premium contribution is a flat amount added to the individual premium.

Source: State of Illinois Department of Central Management Services Bureau of Benefits, "Benefit Choice Options: Effective July 1, 2005 - June 30, 2006." http://www.state.il.us/cms/download/pdfs_benefits/fy06statebcbook4.pdf

[43] This applies to people retiring after 1/1/1998.

Illinois State Employee Annual Premium Contribution By Plan Type, HMOs: FY2006								
	All HMOs	Unicare HMO	HMO Illinois	PersonalCare	OSF Health Plan	Health Alliance HMO	Health Alliance Illinois	OSF Winnebago
Salary Range	**Individual**	**Family***						
$27,800 or less	$324	$1,440	$1,476	$1,644	$1,644	$1,680	$1,824	$1,908
$27,801-$42,000	$384	$1,500	$1,536	$1,704	$1,704	$1,740	$1,884	$1,968
$42,001-$55,900	$414	$1,530	$1,566	$1,734	$1,734	$1,770	$1,914	$1,998
$55,901-$70,000	$444	$1,560	$1,596	$1,764	$1,764	$1,800	$1,944	$2,028
$70,001 and over	$474	$1,590	$1,626	$1,794	$1,794	$1,830	$1,974	$2,058

*"Family" here means employee plus 2 or more dependents. The dependents premium contribution is a flat amount added to the individual premium. All HMOs have the same individual premium rate.

Source: State of Illinois Department of Central Management Services Bureau of Benefits, "Benefit Choice Options: Effective July 1, 2005 - June 30, 2006." http://www.state.il.us/cms/download/pdfs_benefits/fy06statebcbook4.pdf

Because the employee share of premium varies by salary, so does the employee contribution as a percentage of the total premium. As noted on page 32 of this report, employee premium contributions range from 5.4% to 11.6% of total premiums for individual HMO plans, 6.2% to 9.0% of total premium equivalents for the OAP, and 8.9% to 10.9% of total premium equivalents for the indemnity plan. Ranges for family premiums are 12.3% to 16.3% for HMOs, 14.6% to 15.7% for the OAP, and 17.1% to 18.0% for the indemnity plan.

Appendix A provides more detail on participant costs for deductibles, coinsurance, and specific medical services.

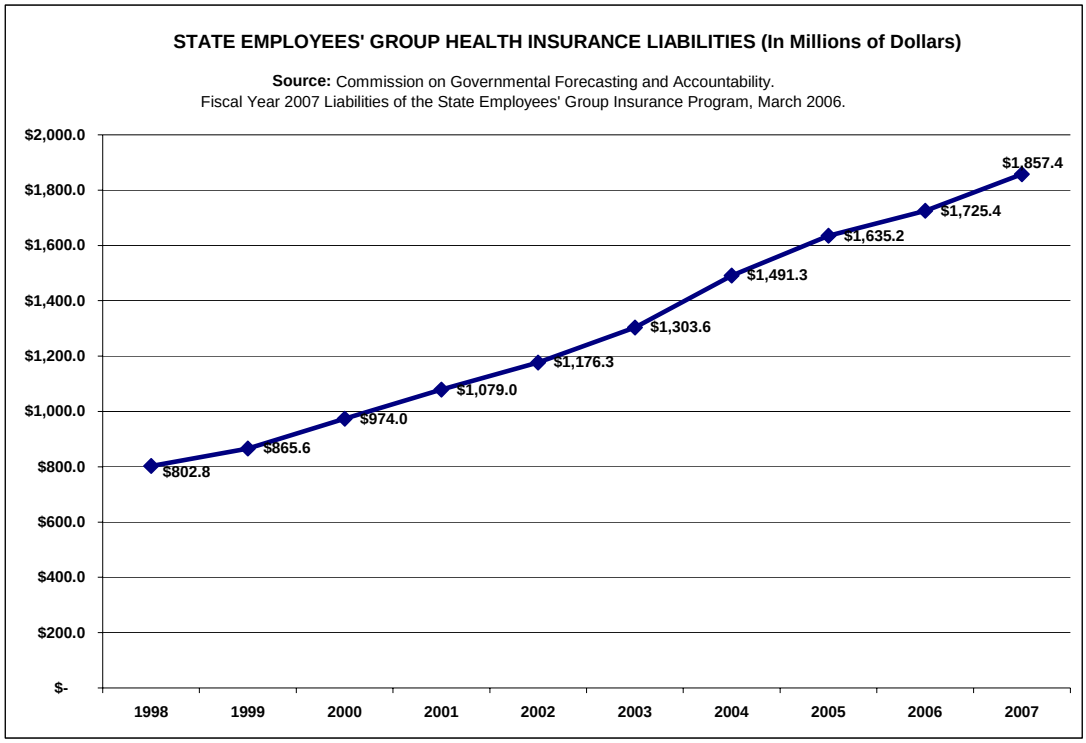
RISING STATE EMPLOYEE HEALTH INSURANCE COSTS IN ILLINOIS

State of Illinois employee healthcare liabilities are rising at a rate that far outstrips increases in state budgetary appropriations. The problem is compounded by several features or provisions of the State's health insurance plan that are more costly than those in place in many other state plans. Because of the State's ongoing fiscal difficulties, these rising costs are not sustainable in the long term.

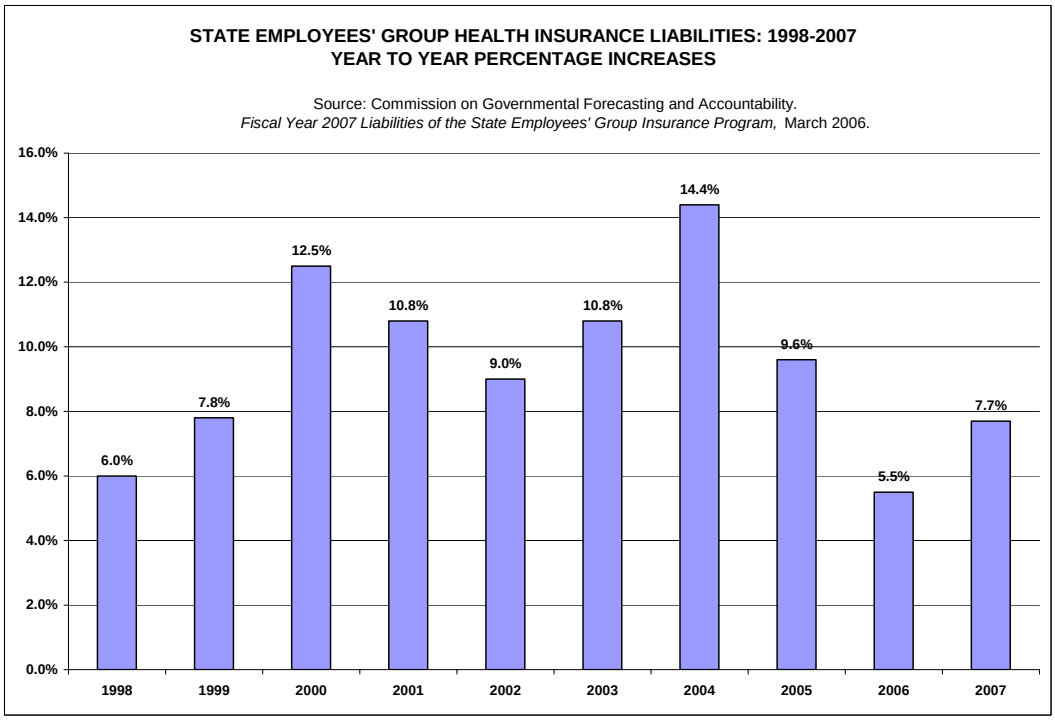
State Employee Group Health Insurance Liabilities: The Budgetary Context

Illinois State employee health insurance liabilities have mounted rapidly over the past ten years. Between FY1998 and FY2007, liabilities are expected to rise from $802.8 million to $1.8 billion, a $1.0 billion or 131.4% increase. The State historically has appropriated an amount that is slightly larger than the estimated liability for each fiscal year. However, the Commission on Government Forecasting and Accountability forecasts that the liabilities for State employee health insurance will exceed the appropriations in FY2007 by $10 million; this represents appropriations of $1.88 billion and liabilities of $1.89 billion. The State estimates that appropriations will exceed liabilities by $27.9 million.[44]

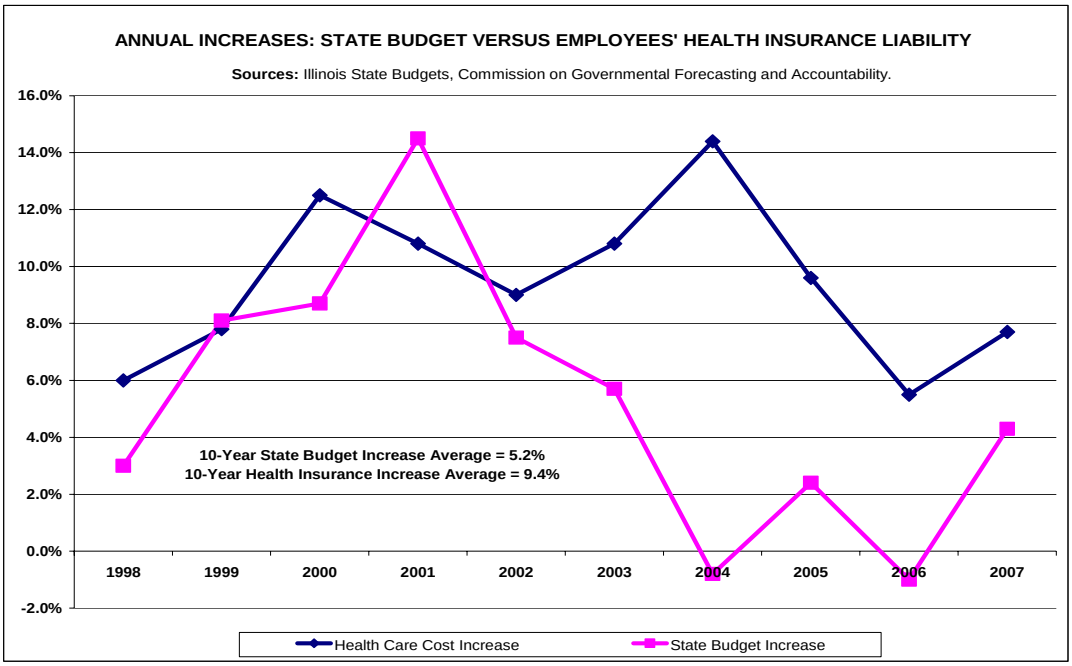
[44] Commission on Governmental Forecasting and Accountability. *Fiscal Year 2007 Liabilities of the State Employees' Group Insurance Program*, p. 1.



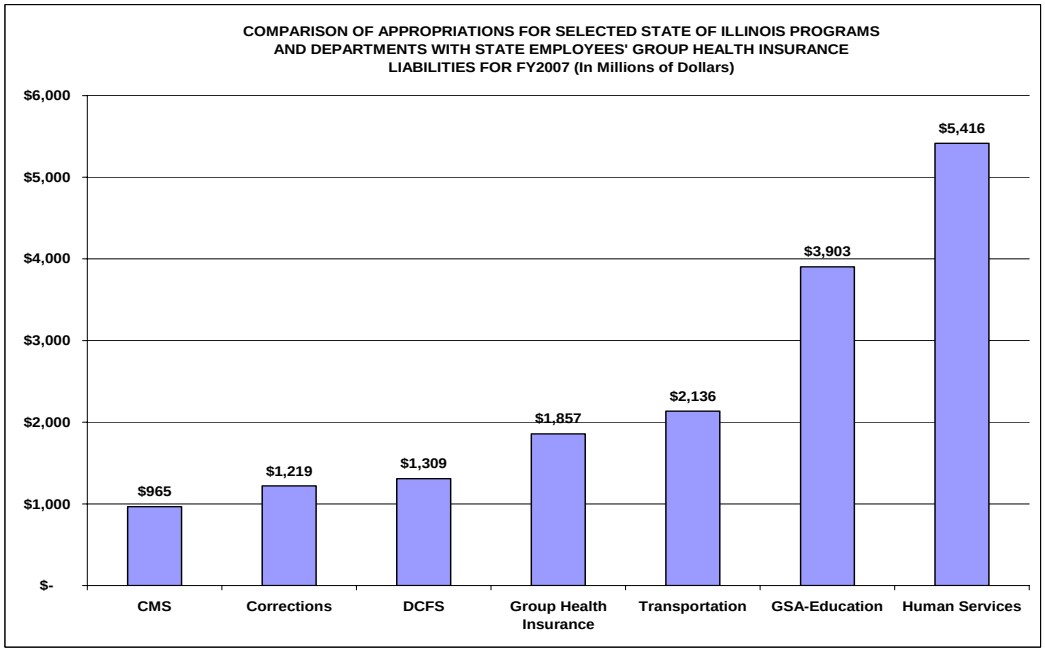
The next exhibit presents information regarding year-to-year percentage increases in liabilities of the State Employees' Group Insurance program. Over the ten-year period reviewed, liability increases averaged 9.4%. The increases ranged from a high of 14.4% in FY2004 to a low of 5.5% in FY2006.



State Employees' Group Health Insurance liabilities have risen much faster than the State's total budgetary appropriations. Between FY1998 and FY2007, the rate of increase for health insurance exceeded that of total appropriations in eight of ten years. On average, budget appropriations increased by 5.2% annually, while the average health insurance liabilities increase was 9.4% over this period.



In FY2007, the $1.8 billion in employee health insurance liabilities represented 3.4% of total State budget appropriations. They exceeded the Department of Children and Family Services' $1.3 billion budget and nearly equaled the Department of Transportation's $2.1 billion budget.



Costly Provisions of the State Group Health Insurance Plan

Three features of the State of Illinois Group Health Insurance plan significantly drive State health insurance costs: an expensive indemnity plan, below-average employee contributions to premiums, and the provision of free health insurance to many retired employees. Unlike market driven or economic factors over which the State has limited control, all of these features can be managed through negotiation with State employees. They therefore represent opportunities for the State to significantly control costs.

An Expensive Indemnity Plan

In addition to its large number of enrollees, the State's indemnity plan is noteworthy for its high costs relative both to other State plans and to indemnity plans offered by other states. Illinois' indemnity plan is exorbitantly expensive, and its high cost is a major factor in driving overall State health insurance cost increases.

As noted on page 23 of this report, it is estimated that 39.0% or 134,922 of the State's 346,085 group health insurance plans participants were enrolled in an indemnity plan. Approximately 71.1% of all State retirees select the indemnity plan for their coverage. The high rate of enrollment in the State indemnity plan contrasts significantly with the Kaiser Foundation Survey finding that, in firms and governments with over 5,000 employees, only 4% of covered workers are enrolled in indemnity plans.[45]

The average cost per participant in the State's indemnity plan is expected to be 51.3% higher than the cost for HMO coverage and 31.1% higher than the cost for the Open Access Plan (OAP) plans in FY2006. In FY2007 the cost differential is projected to widen, with indemnity plan average participant costs 57.4% higher than costs for HMO coverage and 35.3% higher then for OAP coverage.[46]

Estimated Average Annual Cost Per Participant			
Plan	FY2006 Average Cost	FY2007 Average Cost	% CHG
Indemnity	$5,512	$6,128	11.2%
HMO	$3,634	$3,893	7.1%
OAP	$4,203	$4,527	7.7%

Source: Commission on Governmental Forecasting and Accountability
FY2007 Liabilities of the State Employees' Group Insurance Program, p. 9.

The relative size of the State's indemnity plan liabilities is shown in the next exhibit. When the medical, prescription drug, and administrative liabilities are totaled, the indemnity plan will represent over 42% of all health insurance liabilities for Illinois in FY2006 and FY2007.

[45] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2006 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), V-3. See also Appendix A of this report.
[46] Commission on Government Forecasting and Accountability, *Fiscal Year 2007 Liabilities of the State Employees' Group Insurance Program*, 2006, p. 9.

The Indemnity Plan and Total Group Health Insurance Liabilities			
Liability Components	FY2006 HFS Est.**	FY2007 HFS Est.**	FY2007 CGFA Est.
Indemnity Medical	$ 516.2	$ 546.4	$ 558.6
Indemnity Prescription Drug	$ 197.7	$ 217.0	$ 218.2
Indemnity Plan Administrative Services	$ 22.0	$ 20.8	$ 22.0
Subtotal Indemnity Plan*	**$ 735.9**	**$ 784.2**	**$ 798.8**
Total Group Health Insurance Liabilities	$ 1,725.3	$ 1,857.4	$ 1,895.3
Indemnity Plan as a % of Total Liabilities	**42.7%**	**42.2%**	**42.1%**

* This figure does not include indemnity costs for dental insurance because these costs are reported in combination with managed care plan dental costs.

**The Illinois Department of Human of Healthcare and Family Services also provides estimates of these figures, which can be compared with the CGFA estimate.

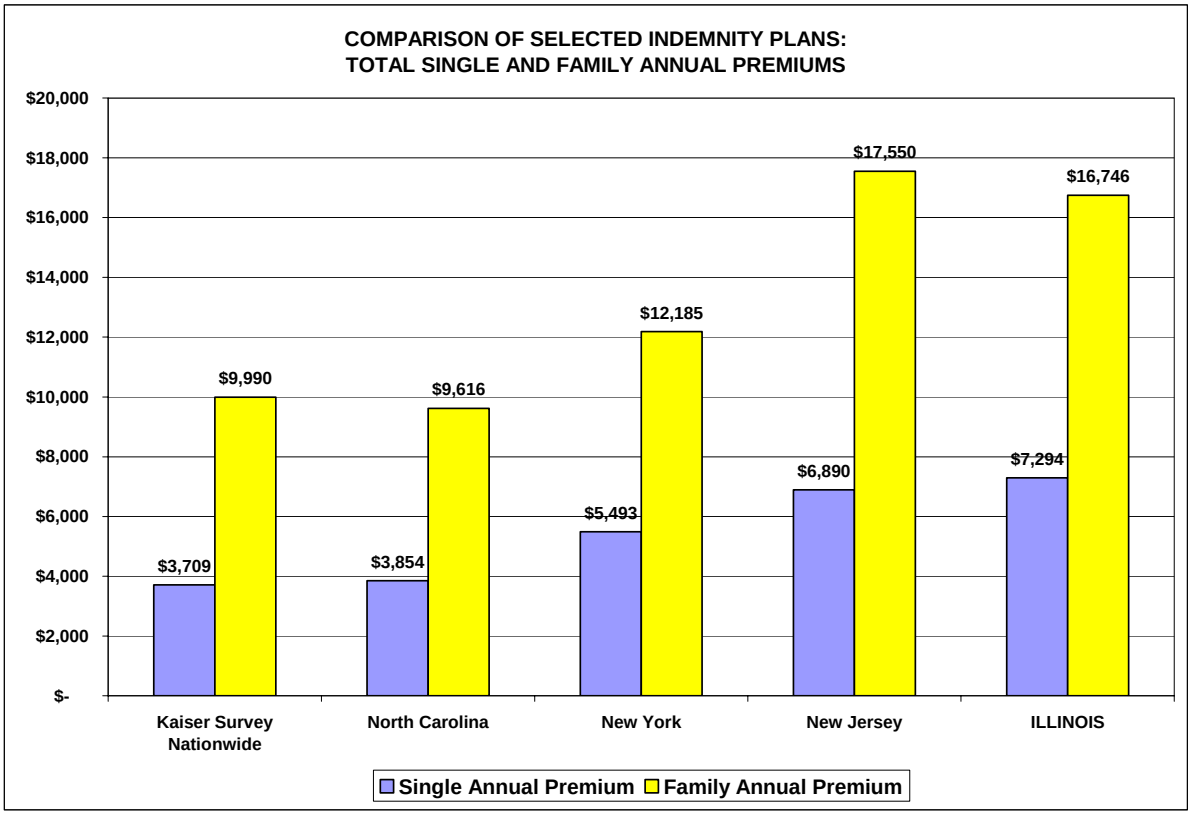
Source: Commission on Government Forecasting and Accountability.

The next exhibit compares the total annual single premium equivalent cost of the Illinois indemnity plan with other large indemnity plans. It shows that the single total annual premium equivalent in Illinois of $7,294 is:

- 97% higher than the Kaiser Foundation national survey average of large (over 200 workers) private and public sector indemnity plans, which is $3,709;
- 89% more expensive than North Carolina's plan's premium, which is $3,854;
- Nearly 33% more costly the New York indemnity plan, which has a $5,493 premium; and
- About 6% more expensive than the New Jersey plan, which costs $6,890 annually.[47]

Total family premium equivalents for the State's indemnity plans are also more expensive than those for plans offered by New York, North Carolina, and all public and private sector firms with more than 200 workers. In the Kaiser Foundation's comparison sample, only New Jersey paid more for family premiums than Illinois. Prompted by rising costs, Michigan used the collective bargaining process to exchange its indemnity plan for a modified PPO plan that took effect in 2003.[48]

[47] See Appendix A of this report.
[48] Conversation with Lauri Schmidt, Michigan Department of Civil Service, January 4, 2007.



Conclusion: The data show that the Illinois' indemnity plan is much more expensive than its HMO and OAP plans. This problem is compounded by the fact that a large percentage of participants choose the indemnity plan. These factors contribute substantially to increases in Illinois' employee health insurance costs.

Premium Sharing

Health insurance premiums are paid by both employers and employees. In Illinois employees pay varying percentages of total premium and premium equivalent costs depending on the insurance plan they select (see Appendix A):

- For HMO plans, employees pay 5.4% to 11.6% of the total annual premium costs for individual plans (which cost between $4,072 and $6,048 in 2006) and 12.3% to 16.3% of the total annual premiums for family coverage (which cost between $9,968 to $14,791 in 2006).
- For the OAP plan, a hybrid HMO/PPO plan, individual premium contributions ranged from 6.2% to 9.0% of a total annual premium equivalent of $5,258. Family premium contributions ranged from 14.6% to 15.7% of a total annual premium equivalent of $12,863.
- For the indemnity plan, individual premium contributions ranged from 8.9% to 10.9% of total annual premium equivalent of $7,294. Family premium contributions ranged from 17.1% to 18.0% of a total annual premium equivalent of $16,746.

The percentage of premiums Illinois employees and retirees paid for individual and family health insurance coverage was uniformly below the Kaiser Foundation survey averages reported for all

private and public plans. Illinois participants in the HMO and OAP plans made percentage contributions for single coverage similar to those made by their peers in other state and local governments, but paid less than their peers for family coverage.[49]

Annual Premium Contributions by Employees as a Percentage of Total Premiums					
	Kaiser Survey All Large Plans Average	**Kaiser Survey State/Local Govt Average**	**Illinois**	**Illinois Premium % compared to All Plans**	**Illinois Premium % compared to Govt. Average**
Single					
HMO	15.6%	10.0%	5.4% to 11.6%	below	similar
OAP (HMO/PPO Hybrid)	15.6% to 16.4%	6.0% to 10.0%	6.2% to 9.0%	below	similar
Indemnity	14.1%	n/a	7.6% to 9.6%	below	n/a
Family					
HMO	22.9%	17.0%	12.3% to 16.3%	below	below
OAP (HMO/PPO Hybrid)	22.4% to 22.9%	17.0% to 18.0%	14.6% to 15.7%	below	below
Indemnity	21.2%	n/a	17.1% to 18.0%	below	n/a

Source: Kaiser Family Foundation and State of Illinois Benefit Choice Options FY2006. Kaiser Survey indemnity data from 2005.

Conclusion: Illinois employees and retirees paid lower percentages of total premium costs than public and private employees across the nation according to the Kaiser Foundation's 2006 survey. They also paid less than the average of other state and local governments surveyed by the Kaiser Foundation for family coverage in HMO and OAP plans. Relatively low employee contributions mean that the State of Illinois must shoulder a greater share of total health insurance costs than do other public and private organizations. This contributes to the State's escalating health insurance liabilities.

Free Health Care Coverage for Retirees with 20 Years of Service

State of Illinois retirees with more than twenty years of service do not have to contribute to their health care premiums. Employees retiring after January 1, 1998 with fewer than twenty years of service are required to contribute a portion of their premiums. For these employees, the State pays 5% of premium costs per year of service and the retiree pays the remaining costs (e.g., 5% x 15 years = 75% State contribution).[50]

Of the 75,040 Illinois retirees reported in FY2006, 92.7% or 69,906 retirees receive free health insurance, according to the Illinois Department of Healthcare and Family Services.[51] The cost of this generous subsidy is estimated to have been as high as $356.1 million in FY2006. The next exhibit estimates the cost of providing free retiree health insurance based on the assumption that 92.7% of the enrollees in each type of health insurance plan do not pay for their insurance.[52]

[49] See also Appendix A of this report.
[50] Commission on Government Forecasting and Accountability, *Fiscal Year 2007 Liabilities of the State Employees' Group Insurance Program*, 2006, p. 7 and Workplace Economics. *2006 Employee Benefits*, pp. 79.
[51] Information provided by the Illinois Department of Healthcare and Family Services.
[52] The Illinois Department of Healthcare and Family Services did not provide a breakdown of the percentages per health insurance of enrollees who do not pay for health insurance. To calculate estimates we applied the aggregate 92.7% figure of the total number of retirees receiving free health insurance to each category. Therefore, a more precise estimate of cost savings would be different.

Estimated Cost of Free Illinois Retiree Health Insurance			
Indemnity	**Number**	**Cost/Retiree Receiving Free Health Care**	**Cost**
Medicare Eligible	36,649	$ 4,303	$ 157,700,647
Non-Medicare Eligible	14,372	$ 8,256	$ 118,655,232
Subtotal Indemnity	51,021	12,559	$ 276,355,879
Managed Care			
Medicare Eligible	7,894	$ 3,082	$ 24,329,308
Non-Medicare Eligible	10,980	$ 5,052	$ 55,470,960
Subtotal Managed Care	18,874	8,134	$ 79,800,268
Total	**69,895**		**356,156,147**

Source: Illinois Department of Health and Family Services.

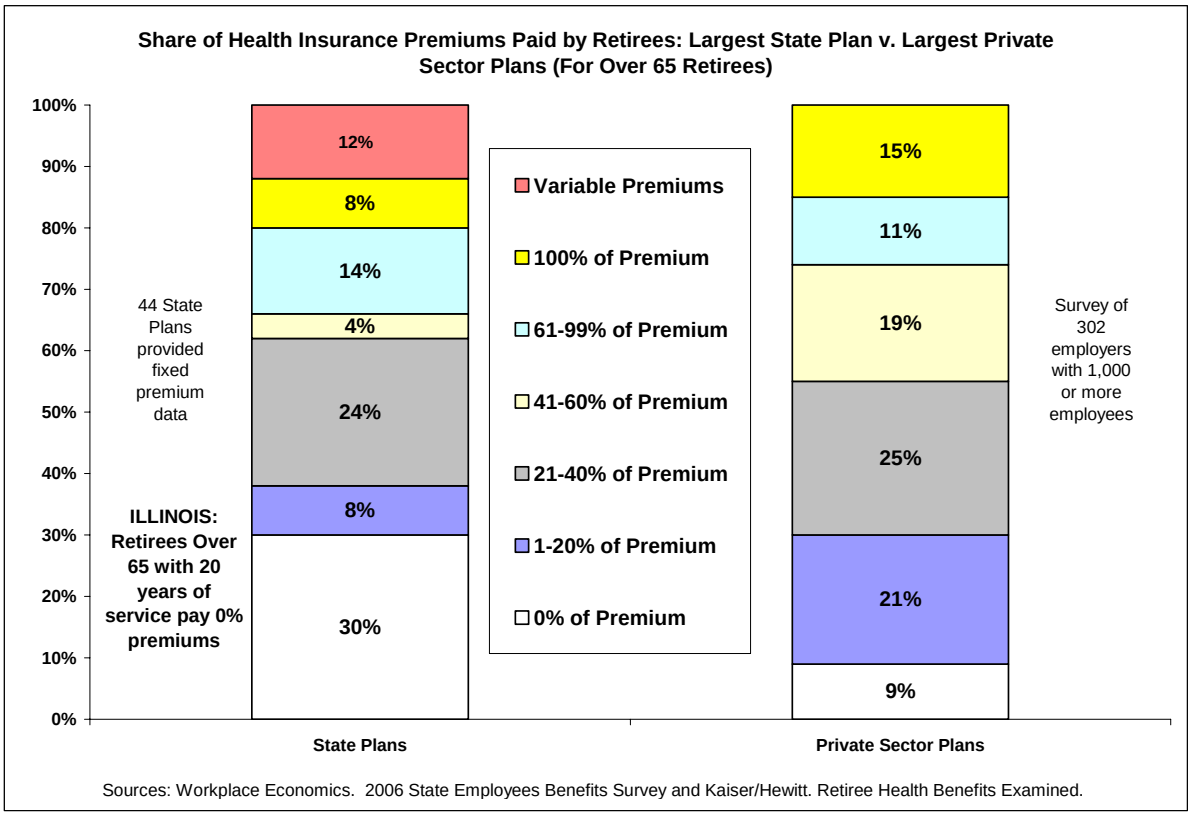
Illinois is one of only 15 states that do not charge at least some of their retired employees over 65 with Medicare coverage for health insurance.

States Providing Free Health Insurance to Some or All Retired Employees over 65 with Medicare Coverage
Alabama
Alaska
California
Connecticut
Delaware
ILLINOIS
Kentucky
Maine
Michigan
New Hampshire
North Carolina
Ohio
Pennsylvania
Rhode Island
Texas

Based on statistics for State's largest health insurance plan.
Source: Workplace Economics. *2006 State Employee Benefits.* Table 10. Health Insurance, pp. 74-75.

The private sector is far less generous in providing free retiree health insurance than Illinois and most other state governments. New private sector retirees – both over and under age 65 - contribute on average 41% of the total premium.[53] As the following exhibit shows, only 9% of the 302 large private sector employers (those with 1,000 or more employees) surveyed in 2006 by Kaiser/Hewitt did not require premium contributions from retirees 65 and older. By contrast, 30% of states – including Illinois – provide free health insurance to some or all retirees.

[53] Kaiser Family Foundation and Hewitt. *Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits,* p. 15.



Conclusion: Illinois is one of only fifteen states that currently provide free health care insurance for some or all retires over 65 with Medicare coverage. This generous subsidy costs the State of Illinois millions of dollars per year and contributes to the mounting liabilities of the State of Illinois Group Health Insurance Plan.

CIVIC FEDERATION RECOMMENDATIONS

Based on our review of the State of Illinois Group Health Insurance Plan features, the Civic Federation offers the following recommendations to help Illinois control its escalating health insurance costs.

Eliminate the Indemnity Plan

The indemnity plan is too costly and offers benefits that are far too generous. According to the Kaiser Foundation, indemnity plans are increasingly rare. In its 2006 survey of employer health benefits, the Foundation stated that it had eliminated nearly all survey questions pertaining to indemnity plans because of the dramatic declines in indemnity plan enrollment.[54] Only 3% of enrollees were reported to be in indemnity plans in 2006, down from 73% in 1988.[55]

[54] Kaiser Family Foundation. *Employer Health Benefits 2006 Annual Survey*, p. 1.
[55] Kaiser Family Foundation. *Employer Health Benefits 2006 Annual Survey*, Exhibit 5.1. Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2006, p. 2.

The Civic Federation recommends that the State of Illinois' indemnity health insurance plan be eliminated and that enrollees be placed in existing HMO or OAP plans that cost significantly less. The annual savings from such a move could be substantial.

In FY2006 the HMO plan cost an average of $3,634 per enrollee, $1,878 less than the indemnity plan's cost of $5,512. The OAP plan cost an average of $4,203 per enrollee, $1,309 less than the indemnity plan's cost of $5,512.[56]

If all current indemnity plan enrollees were shifted into the HMO plan, the State could save as much as $253.4 million per year. These savings were calculated by multiplying the number of FY2006 participants in the indemnity plan (134,922) by the average savings per participant that would accrue to the State ($1,878) if the shift were made. There might be either additional administrative costs related to the conversion or reductions in administrative costs. It is not possible to calculate this factor, however, so we have assumed no change in administrative costs.

If all current indemnity plan enrollees were shifted into the OAP plan, the State could save as much as $176.6 million per year. These savings were calculated by multiplying the number of FY2006 participants in the indemnity plan (134,922) by the average savings per participant that would accrue to the State ($1,309) if the shift were made. There might be either additional administrative costs related to the conversion or reductions in administrative costs. It is not possible to calculate this factor, however, so we have assumed no change in administrative costs.

It is important to note that the projections presented above are estimates. It is unlikely that all current indemnity plan enrollees would choose the HMO plan or the OAP plan. It is more reasonable to assume that some percentage would choose each plan. Therefore, actual savings would probably fall between the hypothetical HMO and OAP numbers.

Increase Employee Premiums

The percentage of premiums that Illinois employees and retirees pay for individual and family health insurance coverage is uniformly below the Kaiser Foundation national survey averages reported for all large private and public plans (those covering over 200 workers).

The Civic Federation recommends that State of Illinois employees be required to increase the percentage of health insurance premiums that they pay to help defray mounting health insurance costs. If employees were required to increase by one percentage point the percentages of premiums that they pay (percentages vary according to plan and type), the State could save as much as $10.2 million.

[56] Commission on Government Forecasting and Accountability, *Fiscal Year 2007 Liabilities of the State Employees' Group Insurance Program*, 2006, p. 9.

Potential Savings from Increasing Employee Health Insurance Premium Contributions by 1%				
	Employer current cost	Employee current cost	Employee new projected cost	Estimated Employer savings
Indemnity: Employee Only	$105,535,799	$10,230,834	$11,388,500	$1,157,666
Indemnity: Employee + 1*	$86,106,984	$18,188,652	$19,231,608	$1,042,956
Indemnity: Employee +2*	$95,894,829	$20,658,150	$21,823,680	$1,165,530
Subtotal Indemnity Plans	**$287,537,612**	**$49,077,636**	**$52,443,788**	**$3,366,152**
Managed Care: Employee Only	$136,371,027	$12,250,608	$13,736,824	$1,486,216
Managed Care: Employee + 1*	$153,799,607	$25,711,110	$27,506,217	$1,795,107
Managed Care: Employee +2*	$306,274,624	$52,422,090	$56,009,057	$3,586,967
Subtotal Managed Care Plans	**$596,445,257**	**$90,383,808**	**$97,252,099**	**$6,868,291**
Grand Total	**$883,982,869**	**$139,461,444**	**$149,695,887**	**$10,234,443**

* Based on Non Medicare-eligible figures.
Sources: Department of Healthcare and Family Services; Central Management Services. *Benefit Choice Options: Your Benefits Working for You* , July 1, 2005; Commission on Government Forecasting and Accountability. Fiscal Year 2006 Liabilities of the State Employees' Group Insurance Program, p. 14.

The Kaiser Family Foundation's 2006 survey of national private and public health insurance plans reports that employees in large firms (those with more than 200 workers) paid approximately 15% of total premiums for single coverage and 22.9% for family coverage. If Illinois employees were required to increase their premium contributions so that the percentages they paid were in line with national averages, the State could save as much as $67.3 million.

Potential Savings from Increasing Individual Employee Health Insurance Premiums to 15% and Family Premiums to 22%				
	Employer current cost	Employee current cost	Employee new projected cost	Estimated Employer savings
Indemnity: Employee Only	$105,535,799	$10,230,834	$17,368,483	$7,137,649
Indemnity: Employee + 1*	$86,106,984	$18,188,652	$22,946,185	$4,757,533
Indemnity: Employee +2*	$95,894,829	$20,658,150	$25,611,132	$4,952,982
Subtotal Indemnity Plans	**$287,537,612**	**$49,077,636**	**$65,925,800**	**$16,848,164**
Managed Care: Employee Only	$136,371,027	$12,250,608	$22,356,879	$10,106,271
Managed Care: Employee + 1*	$153,799,607	$25,711,110	$39,533,435	$13,822,325
Managed Care: Employee +2*	$306,274,624	$52,422,090	$78,965,647	$26,543,557
Subtotal Managed Care Plans	**$596,445,257**	**$90,383,808**	**$140,855,961**	**$50,472,153**
Grand Total	**$883,982,869**	**$139,461,444**	**$206,781,761**	**$67,320,317**

* Based on Non Medicare-eligible figures.
Sources: Department of Healthcare and Family Services; Central Management Services. *Benefit Choice Options: Your Benefits Working for You* , July 1, 2005; Commission on Government Forecasting and Accountability. Fiscal Year 2006 Liabilities of the State Employees' Group Insurance Program, p. 14.

Eliminate Free Health Care for Retirees

Requiring the 92.7% of State of Illinois retirees who currently do not contribute anything to the cost of their health insurance to begin contributing could save millions of dollars annually. The following cost savings estimates assume that 92.7% of the retirees enrolled in each of the State's health insurance programs do not pay for their insurance:[57]

- Requiring retirees to contribute 15% of the total premium cost, which is the average for the large public and private plans (those that cover over 200 workers) surveyed by the Kaiser Foundation in 2006, would generate as much as $53.4 million in savings.[58]
- Requiring retirees to contribute 25% of the total premium cost would generate up to $89.0 million in savings.
- Requiring retirees to contribute 41% of the total premium cost, which is the average for the largest private sector plans surveyed by the Kaiser Foundation in 2006, would generate up to $146.0 million in savings.[59]

Potential Savings from Requiring Retirees to Contribute to Health Insurance Costs

Indemnity	Number Receiving Free Health Care	Cost/Retiree Receiving Free Health Care	Savings from a 15% Premium Contribution	Savings from a 25% Premium Contribution	Savings from a 41% Premium Contribution
Medicare Eligible	36,649	$ 4,303	$ 23,655,097	$ 39,425,162	$ 64,657,265
Non-Medicare Eligible	14,372	$ 8,256	$ 17,798,285	$ 29,663,808	$ 48,648,645
Subtotal Indemnity	**51,021**	**$ 12,559**	**$ 41,453,382**	**$ 69,088,970**	**$ 113,305,910**
Managed Care					
Medicare Eligible	7,894	$ 3,082	$ 3,649,396	$ 6,082,327	$ 9,975,016
Non-Medicare Eligible	10,980	$ 5,052	$ 8,320,644	$ 13,867,740	$ 22,743,094
Subtotal Managed Care	**18,874**	**$ 8,134**	**$ 11,970,040**	**$ 19,950,067**	**$ 32,718,110**
Total	**69,895**	**$ 20,693**	**$ 53,423,422**	**$ 89,039,037**	**$ 146,024,020**

Computed from data provided by Illinois Department of Health and Family Services.

[57] The Illinois Department of Healthcare and Family Services did not provide a breakdown of the percentages per health insurance plan of enrollees who do not pay for health insurance. To calculate estimates we applied the aggregate 92.7% figure of the total number of retirees receiving free health insurance to each category. Therefore, a more precise estimate of cost savings would be different.

[58] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2006 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), XI-6-7.

[59] *Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits*, p. 15.

APPENDIX A: STATE EMPLOYEE HEALTH PLAN COSTS, PROVISIONS AND COMPARISONS

State of Illinois Employee Indemnity Plan Major Provisions, with Comparison to National Average for All Firms and Three States

	FY2006 State of Illinois Quality Care Health Plan (Indemnity Plan)		2005[1] Kaiser Survey Nationwide Indemnity Plans (All Industries)		FY2006 State of New York Empire Plan (Indemnity/PPO Hybrid)		FY2006 State of North Carolina Comprehensive Major Medical (Indemnity)		FY2006 State of New Jersey Traditional Plan (Indemnity)	
Annual Total Premium										
Single	$7,294[2]		$3709[3]		$5,493		$3,854		$6,890	
Family	$16,746[2]		$9990[3]		$12,185		$9,616		$17,550	
Annual Employee Premium Contribution	**$**	**% of total**	**$**	**% of total**	**$**	**% of total**	**$**	**% of total**	**$**	**% of total**
Single	$552 to $702[4]	7.6% to 9.6%	$535[3]	14.1%	$549	10.0%	$0	0.0%	$1,722	25.0%
Family	$2,856 to $3,006[4]	17.1% to 18.0%	$2115[3]	21.2%	$2,222	18.2%	$5,762	60.0%	$4,387	25.0%
Deductible					**In Network**	**Out of Network**			**State Employee**	**Local or Retiree**
Single	$250 - $400[4]		$434[5]		$0	$332	$350		$250	$100
Family	$625 - $1000[4]		$1022[5]		$0	$996	$1,050		$500	$200
Out-of-Pocket Maximum (Plan Year)	**In Network**	**Out of Network**								
Single	$900	$3,800	49% of all covered workers' maximum is $1,999 or less[3]		not applicable	$1,500	$2,000		$400 + $250 deductible	$400 + $100 deductible
Family	$2,250	$7,600	47% of all covered workers' maximum is $3,999 or less[3]		not applicable	$4,500	$6,000		$400 x number of dependents + deductibles	
Lifetime Maximum Benefit	Unlimited		not available		not available		$5 million		$1 million	
Inpatient Coinsurance	10%	20% or 35%	16%[3,6]		$0	10%	$150		$0 for 365 days, 20% thereafter	
Outpatient Surgery Coinsurance	10% for PPO provider		not available		$35	greater of 10% or $75	$75		$0 for basic surgeries, 20% for others	
Emergency Room Copayment	$300		not available		$50	$50	$200		$0 for accident, 20% for others	
Physician Copayment	10%	20% of Usual & Customary	94% of covered workers with coinsurance pay 20-25%[7]		$15	20% of Usual & Customary	$15		20%	
Plan Enrollment	39% of enrollees		4% of all covered workers[5,8]		87.2% of enrollees		not available		not available	

[1]2006 Kaiser Survey did not include indemnity plans in most measures due to insufficient data, so 2005 is used

[2]Based on COBRA rate for FY2006, minus 2% administrative cost

[3]Average for large firms (over 200 employees)--largest firm size available

[4]Ranges are based on salary level.

[5]Average for jumbo firms (over 5,000 employees)--largest firm size available

[6]15% of covered workers have coinsurance

[7]For all firms, all sizes; does not include those covered workers that do not have coinsurance

[8]2006 Kaiser Survey figure

Note: Coinsurance is % of charges paid by employee after deductible or copayment.

Sources: State of Illinois *Benefit Choice Options* FY2006 (effective July 1, 2005-June 30, 2006); Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2005 and 2006 Annual Surveys; Illinois enrollment figures provided by Colm Brewer, Illinois Department of Healthcare and Family Services, September 8, 2006; New Jersey Department of Pensions and Benefits (http://www.state.nj.us/treasury/pensions/shbp.htm); North Carolina State Health Care Plan (http://statehealthplan.state.nc.us); New York State Health Insurance Plans Online (http://www.cs.state.ny.us/ebd/eppef/hb.cfm)

State of Illinois HMO Plans Major Provisions, and Comparison to National Average for All Firms																		
Annual Total Premium	**Health Alliance HMO**		**Health Alliance Illinois**		**HMO Illinois**		**OSF Health Plan**		**OSF Winnebago**		**Personal Care**		**Unicare HMO**		**2006 Kaiser Survey Nationwide HMO Plans (All Industries Average)**		**2006 Kaiser Survey Nationwide HMO Plans (State/Local Govt. Average)**	
Single[1]	$4,882		$6,048		$4,072		$4,993		$5,415		$4,681		$4,249		$4,114[2]		$4,329	
Family[1]	$11,948		$14,791		$9,968		$12,216		$13,247		$11,455		$10,402		$11,339[2]		$11,491	
Annual Employee Premium Contribution	**$**	**% of total**	**$**	**% of total**	**$**	**% of total**	**$**	**% of total**	**$**	**% of total**	**$**	**% of total**	**$**	**% of total**	**$**	**% of total**	**$**	**% of total**
Single[3]	$324 to $474	6.6% to 9.7%	$324 to $474	5.4% to 7.8%	$324 to $474	8.0% to 11.6%	$324 to $474	6.5% to 9.5%	$324 to $474	6.0% to 8.8%	$324 to $474	6.9% to 10.1%	$324 to $474	7.6% to 11.2%	$642[2]	15.6%	not available	10.0%
Family[3]	$1,680 to $1,830	14.1% to 15.3%	$1,824 to $1,974	12.3% to 13.3%	$1,476 to $1,626	14.8% to 16.3%	$1,644 to $1,794	13.5% to 14.7%	$1,908to $2,058	14.4% to 15.5%	$1,644 to $1,794	14.4% to 15.7%	$1,440 to $1,590	13.8% to 15.3%	$2,598[2]	22.9%	not available	17.0%
Deductible																		
Single	$0														$268[2,4]		not available	
Family															$666 aggregate[2,5]		not available	
Out-of-Pocket Maximum																		
Single	$1,500														69% of all covered workers' maximum is $1,999 or less		not available	
Family	$3,000														68% of all covered workers' maximum is $3,999 or less		not available	
Lifetime Maximum	not available																	
Inpatient Copayment	$200														$233 / 15%		not available	
Outpatient Surgery Copayment	$100														$118 / 15%		not available	
Emergency Room Copayment	$150														not available		not available	
Physician Copayment	$10														61% of all covered workers pay $15 or less		not available	
Plan Enrollment	52.5% of enrollees														23% of all covered workers[6]		39% of all covered workers	

[1]Illinois figures are based on COBRA rate for FY2006, minus 2% administrative cost

[2]Average for large firms (over 200 employees)--largest firm size available

[3]Illinois figures are ranges are based on salary level

[4]Figure is for the 10% of HMO covered workers in large firms had a deductible for single coverage

[5]Figure is for the 11% of HMO covered workers in large firms had a deductible for family coverage (per-person not available)

[6]Average for jumbo firms (over 5,000 employees)--largest firm size available

Sources: State of Illinois *Benefit Choice Options* FY2006 (effective July 1, 2005-June 30, 2006); Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2006 Annual Survey; Illinois enrollment figures provided by Colm Brewer, Illinois Department of Healthcare and Family Services, September 8, 2006.

State of Illinois Open Access Plan (HMO/PPO hybrid) Major Provisions, and Comparison to National Average for All Firms												
	FY2006 Illinois State Employees Health Link Open Access Plan (OAP)			2006 Kaiser Survey Nationwide								
	Tier I	Tier II	Tier III	HMO Plans (All Industries Average)		HMO Plans (State/Local Govt. Average)		PPO Plans (All Industries Average)		PPO Plans (State/Local Govt. Average)	
Annual Total Premium	**(In Network)**	**(In Network)**	**(Out of Network)**								
Single	$5,258[1]			$4,114[2]		$4,329		$4,326[2]		$4,879	
Family	$12,863[1]			$11,339[2]		$11,491		$11,752[2]		$11,933	
Annual Employee Premium Contribution	**$**	**% of total**		**$**	**% of total**	**$**	**% of total**	**$**	**% of total**	**$**	**% of total**
Single	$324 to $474[3]	6.2% to 9.0%		$642[2]	15.6%	available	10.0%	$709[2]	16.4%	available	6.0%
Family	$1,872 to $2,022[3]	14.6% to 15.7%		$2,598[2]	22.9%	available	17.0%	$2,628[2]	22.4%	available	18.0%
Deductible											
Single	$0	$200	$300	$268[2,4]		not available		$375[2,5]		not available	
Family		$200 per person	$300 per person	$666 aggregate[2,6]		not available		$610 per person[2,7]		not available	
Out-of-Pocket Maximum (Plan Year)											
Single	not applicable	$600	$1,500	69% of all covered workers' maximum is $1,999 or less		not available		52% of all covered workers' maximum is $1,999 or less		not available	
Family	not applicable	$1,200	$3,500	68% of all covered workers' maximum is $3,999 or less		not available		53% of all covered workers' maximum is $3,999 or less		not available	
Maximum	Unlimited	Unlimited	$1 million	not available		not available		not available		not available	
Inpatient Copayment + Coinsurance	$200	$250 + 10% of network charges	$350 + 20% of Usual & Customary charge	$233 / 15%		not available		$238 / 17%		not available	
Outpatient Surgery Copayment + Coinsurance	$100	10% of network charges after $100 copayment	20% of Usual & Customary charge after $100 copayment	$118 / 15%		not available		$144 / 17%		not available	
Emergency Room Copayment	$150	$150+10% network charges	$150+20% network charges	not available		not available		not available		not available	
Physician Copayment	$10	10% of network charges for covered services	20% of Usual & Customary charge for covered services	61% of all covered workers pay $15 or less		not available		38% of all covered workers pay $15 or less		not available	
Plan Enrollment	8.5% of enrollees			23% of all covered workers[8]		39% of all covered workers		60% of all covered workers[8]		41% of all covered workers	

[1]Based on COBRA rate for FY2006, minus 2% administrative cost

[2]Average for large firms (over 200 employees)--largest firm size available

[3]Ranges are based on salary level.

[4]Figure is for the 10% of HMO covered workers in large firms had a deductible for single coverage

[5]Figure is for the 69% of PPO covered workers in large firms had a deductible for single coverage (in-network)

[6]Figure is for the 11% of HMO covered workers in large firms had a deductible for family coverage (per-person not available)

[7]Figure is for the 70% of PPO covered workers in large firms had a deductible for family coverage (in-network)

[8]Average for jumbo firms (over 5,000 employees)--largest firm size available

Note: Coinsurance is % of charges paid by employee after deductible or copayment.

Sources: State of Illinois *Benefit Choice Options* FY2006 (effective July 1, 2005-June 30, 2006); Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2006 Annual Survey; Illinois enrollment figures provided by Colm Brewer, Illinois Department of Healthcare and Family Services, September 8, 2006.

APPENDIX B: GLOSSARY

HDHP/SO: High Deductible Health Plans with a Savings Option. The 2006 Kaiser Foundation survey separated out these plans for the first time in 2006 (previously they were included as PPO, HMO, POS, or indemnity plans). HDHP/SO plans include those with a deductible of $1,000 or over for single and $2,000 or over for family coverage with a health reimbursement arrangement (HRA). They also include plans that meet federal legal requirements for allowing enrollees to establish health savings accounts (HSAs).[60]

HMO: Health Maintenance Organization. An HMO is the most restrictive kind of managed care plan in terms of medical service choice. A participant may typically choose a primary care physician from a network, but all other medical services and referrals must be directed through the patient's primary care physician. HMOs are typically the least expensive plan type.

Indemnity Plan: Also commonly called a "traditional," "conventional," or "fee-for-service" plan, indemnity plans were the standard health insurance program before the rise of managed care plans (e.g., HMOs and PPOs) in the 1980s. A major service feature distinguishing indemnity plans from managed care plans is the degree of freedom in medical service provider choice. Participants are permitted to choose any physician or hospital, although there may be discounts offered for use of networks. Indemnity plans tend to be the most expensive plan type.

PPO: Preferred Provider Organization. A PPO is a managed care plan that is less restrictive than an HMO in terms of medical service choice. Typically, PPO participants are allowed to select physicians and services from within a network without having to go through a primary care physician for referrals. PPOs are generally in the mid-range of expense among plan types.

POS: Point-of-Service. A POS plan is a PPO/HMO hybrid that generally functions like an HMO for in-network services, but permits out-of network services with reimbursement levels similar to indemnity plans.

[60] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2006 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2006), V-1.