Illinois Comprehensive Health Insurance Plan

FOR YEAR ENDING DECEMBER 31, 2015

Bruce Rauner, Governor

Lisa Madigan, Attorney General

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The Mission And History Of CHIP

The Comprehensive Health Insurance Plan (CHIP) has a two-fold mission. One is to provide health coverage for Illinois residents who cannot obtain health insurance due to health reasons or have substantially similar coverage that cost more than the individual Traditional pool premium rate. The second is to provide coverage to Illinois residents that had recently lost group coverage and have exhausted COBRA or other continuation coverage.

The CHIP Act became law in 1987 with first coverage provided on May 1, 1989. Illinois was the fifteenth state to enact such a mechanism, known as a “high risk pool,” and the first to use state general revenue funds.

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

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

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

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

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

2015 Executive Summary

During 2015 CHIP Board and staff worked on the following: benefit structure changes, records retention, Federal High Risk Pool Grant ending, processing terminations due to other coverage through ACA, implementing ICD-10 through CHIP's Plan Administrator, and transitioning members to a new pharmacy benefits manager for prescription drugs limit that would become effective January 1, 2016.

Benefit Structure Changes

In January 2015, the staff implemented changes in the benefit structure for medical that consisted of an increase in the individual and family maximum out-of-pocket expense and the elimination of all HDHP deductibles and $500 and $1,000 standard deductibles. The prescription drug changes involved increases in prescription drug co-pays and maximum out-of-pocket limits. Members still active on January 1, 2015 were transitioned to the remaining $1,500, $2,500, or $5,000 standard deductible plans.

During the latter part of 2015 the Board and staff worked on eliminating the $1,500 deductible and transitioning these members to the $2,500 deductible. Plans available for active members are $2,500 and $5,000 effective January 1, 2016.

Federal High Risk Pool Grant

The Federal High Risk Pool Grant ended September 30, 2015. The Board Office notified 363 participants of the terminated premium rate credit of 5.75%.

Records Retention

CHIP staff scanned 488,790 pages (81 feet) of paper and have created an electronic data warehouse with a searchable index of key words, minimizing hardcopy files and improving document searchability.

Terminations

A total of 557 terminations were processed from January 1, 2015 through December 31, 2015, leaving 328 active members. The majority of the terminations were a result of members obtaining other coverage as a result of ACA.

International Classification of Diseases (ICD-10)

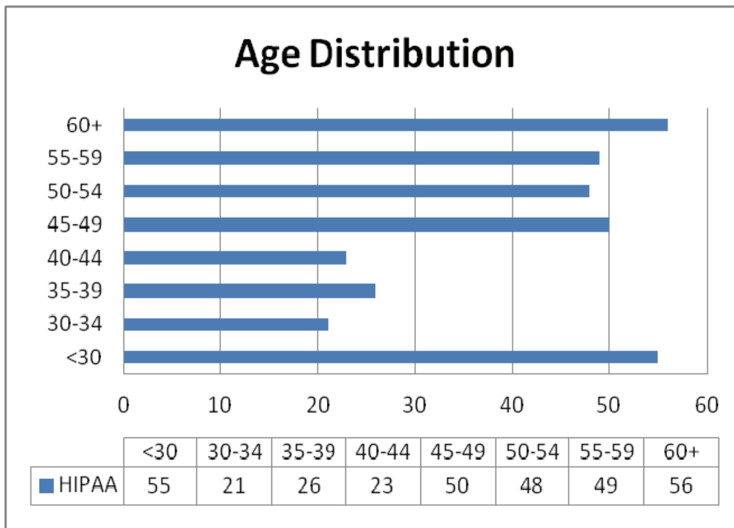
CHIP's Plan Administrator, Blue Cross and Blue Shield of IL (BCBSIL), in compliance with the U.S. Department of Health and Human Services, implemented version 10 of the International Classification of Diseases (ICD-10) effective October 1, 2015. All HIPAA-covered entities, including health plans, providers and billing services, are required to use the new codes. The ICD-10 codes will provide more detailed information, which can be useful for sharing a patient's medical history and supporting effective treatment. The implementation of ICD-10 eliminates any diagnosis codes for pre-existing conditions. Therefore, the Plan Administrator can no longer support any pre-existing condition investigations.

Contractual Overview

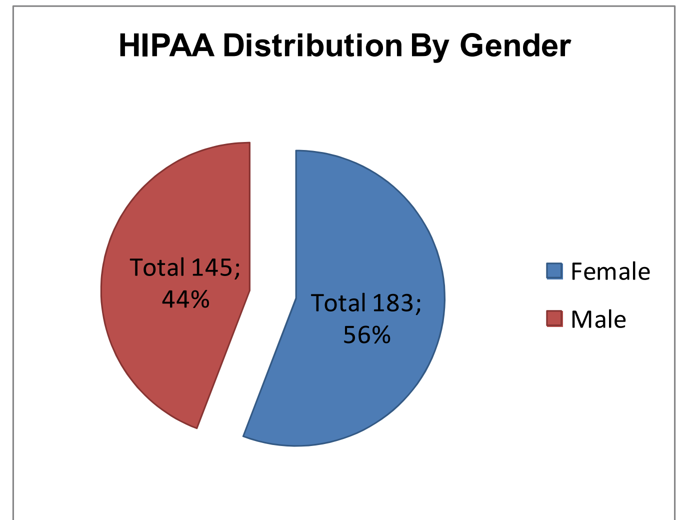
In 2015, CHIP staff coordinated the transition of the pharmacy benefits from Catamaran. Prime Therapeutics became the new Pharmacy Benefits Manager effective January 1, 2016.

Enrollee Profile/Rate Area Distribution

The following graphs show the largest number of participants in the age distribution are in the <30 and 60+ age brackets. Distribution by Gender during 2015 show females outnumbered males in the HIPAA Plan at 56%.



	<30	30-34	35-39	40-44	45-49	50-54	55-59	60+
HIPAA	55	21	26	23	50	48	49	56



As of 12/31/2015		
HIPAA Deductible	Total	Percentage
$ 1,500	222	67.7%
$ 2,500	59	18.0%
$ 5,000	47	14.3%
Total	328	100%

For rating purposes, the state is divided in 13 geographic rate areas that reflect the relative differences in the cost of medical care in those areas. The basis for area rating is the enrollee's county of residence.

Rate Area E	All of Cook County, including the City of Chicago
Rate Area F	Lake and McHenry counties
Rate Area G	DuPage and Kane counties
Rate Area H	Grundy, Kankakee, Kendall and Will counties
Rate Area J	Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson and Winnebago counties
Rate Area K	Bureau, Hancock, Henderson, Henry, Mercer, Rock Island, Warren and Whiteside counties
Rate Area L	Fulton, Knox, LaSalle, Marshall, McDonough, Peoria, Putnam, Stark, Tazewell and Woodford counties
Rate Area M	DeWitt, Livingston and McLean counties
Rate Area N	Champaign, Clark, Coles, Cumberland, Douglas, Edgar, Ford, Iroquois, Piatt and Vermilion counties
Rate Area O	Adams, Brown, Cass, Christian, Logan, Macon, Mason, Menard, Morgan, Moultrie, Pike, Sangamon, Schuyler, Scott and Shelby counties
Rate Area P	Bond, Calhoun, Clinton, Greene, Jersey, Macoupin, Montgomery, Randolph and Washington counties
Rate Area Q	Madison, Monroe and St. Clair counties
Rate Area R	Alexander, Clay, Crawford, Edwards, Effingham, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Perry, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White and Williamson counties.

Rate Area Distribution

DISTRIBUTION BY COUNTY

As of 12/31/2015

County	Total	Percentage
Cook	148	45.1%
DuPage	51	15.5%
Lake	20	6.1%
Kane	11	3.4%
Peoria	9	2.7%
DeKalb	7	2.1%
Will	6	1.8%
Kendall	5	1.5%
McHenry	5	1.5%
Madison	4	1.2%
Winnebago	4	1.2%
LaSalle	3	0.9%
Monroe	3	0.9%
Sangamon	3	0.9%
Williamson	3	0.9%
Boone	2	0.6%
Edgar	2	0.6%
Effingham	2	0.6%
Fayette	2	0.6%
Iroquois	2	0.6%
Jefferson	2	0.6%
Putnam	2	0.6%
Shelby	2	0.6%
Tazewell	2	0.6%
All Other Counties	28	8.5%
Total	**328**	**100%**

Yearly Enrollment Activity

Enrollment Year	New Enrollees			Members in Active Status on 12/31/15				Percentage in Active Status		
	HIPAA	Traditional	Total Enrollees	HIPAA	Traditional	Total Active	Years Active	HIPAA	Traditional	Total Percentage
1989		4,542	4,542		0	0			0.0%	0.0%
1990		1,345	1,345		0	0			0.0%	0.0%
1991		1,016	1,016		0	0			0.0%	0.0%
1992		971	971		0	0			0.0%	0.0%
1993		1,250	1,250		0	0			0.0%	0.0%
1994		1,073	1,073		0	0			0.0%	0.0%
1995		1,110	1,110		0	0			0.0%	0.0%
1996		1,225	1,225		0	0			0.0%	0.0%
1997	445	1,253	1,698	2	0	2	18	0.4%	0.0%	0.1%
1998	1,405	1,046	2,451	4	0	4	17	0.3%	0.0%	0.2%
1999	1,671	1,210	2,881	4	0	4	16	0.2%	0.0%	0.1%
2000	2,983	1,328	4,311	8	0	8	15	0.3%	0.0%	0.2%
2001	3,018	1,486	4,504	10	0	10	14	0.3%	0.0%	0.2%
2002	3,705	1,445	5,150	22	0	22	13	0.6%	0.0%	0.4%
2003	4,070	1,138	5,208	12	0	12	12	0.3%	0.0%	0.2%
2004	3,292	1,202	4,494	10	0	10	11	0.3%	0.0%	0.2%
2005	3,072	1,181	4,253	15	0	15	10	0.5%	0.0%	0.4%
2006	2,871	1,172	4,043	17	0	17	9	0.6%	0.0%	0.4%
2007	2,914	1,091	4,005	17	0	17	8	0.6%	0.0%	0.4%
2008	3,016	948	3,964	23	0	23	7	0.8%	0.0%	0.6%
2009	3,733	918	4,651	32	0	32	6	0.9%	0.0%	0.7%
2010	5,193	988	6,181	28	0	28	5	0.5%	0.0%	0.5%
2011	5,555	1,057	6,612	53	0	53	4	1.0%	0.0%	0.8%
2012	4,976	1,066	6,042	38	0	38	3	0.8%	0.0%	0.6%
2013	3,569	682	4,251	28	0	28	2	0.8%	0.0%	0.7%
2014	16	0	16	4	0	4	1	25.0%	0.0%	25.0%
2015	5	0	*5	1	0	1	0	20.0%	0.0%	20.0%
Grand Totals	**55,509**	**31,743**	**87,252**	**328**	**0**	**328**		**0.6%**	**0.0%**	**0.4%**

*Four of the five new enrollees termed in 2015. Three had a short enrollment period until ACA coverage became effective the 1st of the following month; one enrollee was added for four months before becoming eligible in employer's group health plan; and one 87-year-old enrollee lost group health under daughter's plan and did not qualify for ACA. However, that enrollee's coverage will terminate in 2016 upon becoming eligible for Medicare A & B.

Termination Activity

The Plan processed 557 terminations in 2015 which included 348 participants who were retroactively terminated back to 2014 and not reported in the 2014 Annual Report. The top three reasons were attributed to Other Coverage, Insured's Request and Non-Payment.

MAJOR REASONS FOR TERMINATIONS		
Reason	**Count**	**Percentage**
Other Coverage	312	57%
Insured's Request	64	11%
Non-Payment	61	11%
Non-Resident	39	7%
Over 65	25	4%
NSF	22	4%
Premium too High	12	2%
Death	9	2%
Medical Assistance	8	1%
Medicare Disability	5	1%
Total Terminations	**557**	**100%**

	Other Coverage	Insured's Request	Non-Payment	Non-Resident	Age 65	NSF	Premium too High	Death	Medical Assistance	Medicare Disability	Total
January	48	27	7	1	3	15	7	0	1	4	113
February	61	11	7	1	3	1	2	2	1	0	89
March	11	9	2	0	2	2	1	0	2	0	29
April	11	5	2	5	2	0	0	0	0	0	25
May	2	1	0	8	2	0	0	2	0	1	16
June	3	0	0	7	2	1	0	1	1	0	15
July	0	0	2	7	4	0	0	1	0	0	14
August	3	2	2	7	2	0	0	1	0	0	17
September	1	0	0	1	2	0	0	1	1	0	6
October	2	0	2	1	2	1	0	0	0	0	8
November	2	0	33	0	0	0	0	1	0	0	36
December	168	9	4	1	1	2	2	0	2	0	189
Total	**312**	**64**	**61**	**39**	**25**	**22**	**12**	**9**	**8**	**5**	**557**

Financial Highlights

The following is a summary of the Plan's income and expenses for calendar years 2015 and 2014. Premiums, net of refunds, decreased $15.6 million, or 81.1%, from the prior year as a result of an 84.9% decrease in average enrollment, offset slightly by an increase in the premium rates charged. Incurred losses decreased $29.1 million, or 74.8%. This decrease is due to the large decrease in average enrollment offset by an increase in the average health care cost per member in 2015. Earned assessments decreased $23.4 million, or 69.7%, as a result of the substantially lower assessments approved to cover the projected deficit for calendar year 2015 due to the lower average enrollment. The change in net position was $10.9 million lower in 2015 primarily due to the $29.1 million decrease in incurred losses offset by the $15.6 million decrease in premium income and the $23.4 million decrease in earned assessments.

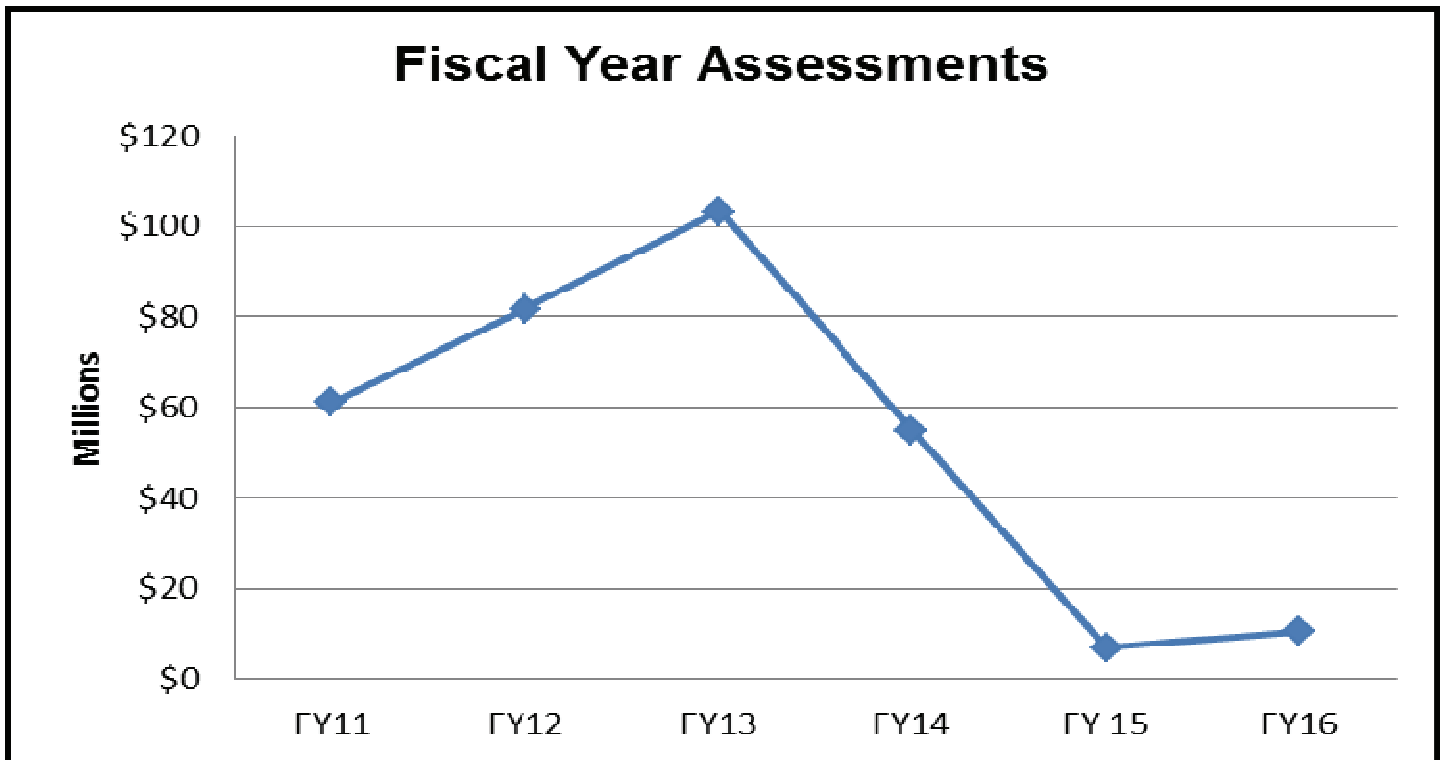
Illinois Comprehensive Health Insurance Plan
Financial Summary Data (unaudited)
Total Plan
Year Ended December 31

	2015	2014
Plan Income		
Premiums, Net of Refunds	$ 3,626,563	$ 19,238,519
Investment Income	$ 89,506	$ 160,155
Total Plan Income	**$ 3,716,069**	**$ 19,398,674**
Plan Expenses		
Incurred Losses	$ 9,807,312	$ 38,911,884
Administrator Fees	$ 129,474	$ (146,927)
CHIP Board Office Expenses	$ 2,449,543	$ 2,582,969
Total Plan Expenses	**$ 12,386,329**	**$ 41,347,926**
Plan Surplus (Deficit)	**$ (8,670,260)**	**$ (21,949,252)**
Nonoperating Revenues		
Earned Appropriations	$ -	$ -
Earned Assessments	$ 10,191,000	$ 33,630,759
Federal Grants	$ 134,984	$ 846,932
Other Revenue	$ -	$ -
Total Nonoperating Revenues	**$ 10,325,984**	**$ 34,477,691**
Change in Net Position	**$ 1,655,724**	**$ 12,528,439**

Fiscal Year Assessments and Premiums

The assessment amounts sharply declined over the past three years as shown in the graph below. The decline in assessments is attributed to the number of members who terminated because of other coverage due to the ACA.

Fiscal Year	Assessment Amount
FY11	$ 61,154,000
FY12	$ 81,713,009
FY13	$ 103,311,000
FY14	$ 54,987,000
FY15	$ 6,878,200
FY16	$ 10,441,000



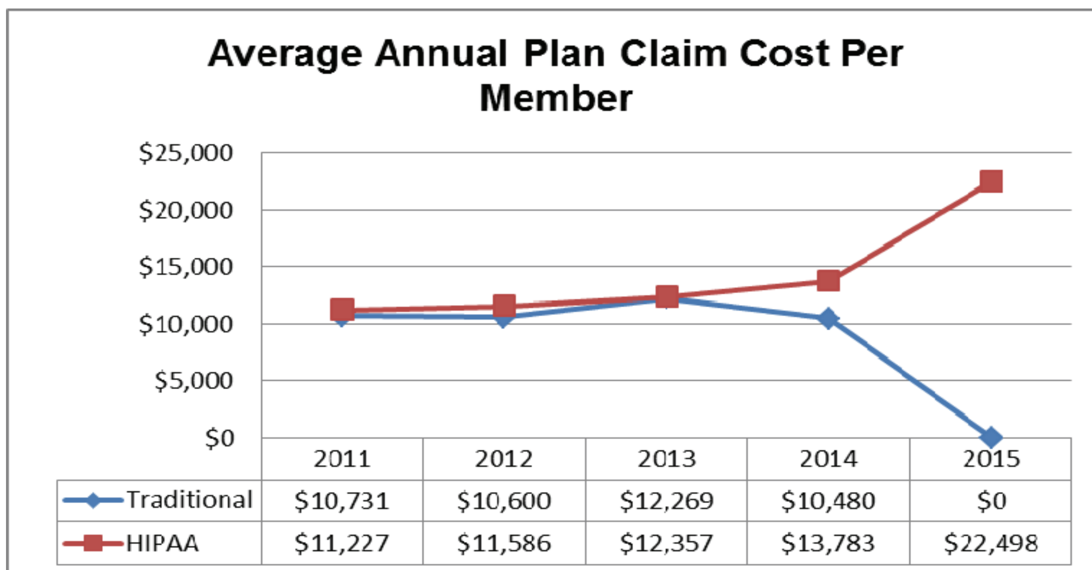
Claims

Description	2015 Traditional	2015 HIPAA	2015 Total	2014 Total
Inpatient	$ -	$ 3,209,146	$ 3,209,146	$ 13,696,352
Outpatient	$ -	$ 2,933,413	$ 2,933,413	$ 14,868,385
ECF/SNF	$ -	$ 79,058	$ 79,058	$ 511,016
Coordinated Home Care	$ -	$ 53,899	$ 53,899	$ 298,750
Medicare Deductible	$ -	$ -	$ -	$ 2,157
Physician Services	$ -	$ 2,374,055	$ 2,374,055	$ 12,875,437
Major Medical	$ -	$ 111,227	$ 111,227	$ 186,304
Subtotal	$ -	$ 8,760,798	$ 8,760,798	$ 42,438,401
Adjustments*	$ (108,248)	$ (329,726)	$ (437,974)	$ (546,261)
Total Blue Cross Medical	$ (108,248)	$ 8,431,072	$ 8,322,824	$ 41,892,140
Total Prescriptions	$ (5,140)	$ 3,048,849	$ 3,043,709	$ 13,181,225
Total Paid Claims	**$ (113,388)**	**$ 11,479,921**	**$ 11,366,533**	**$ 55,073,365**
Prescription Rebates	$ 4,785	$ (80,363)	$ (75,578)	$ (307,513)
Claim Refunds	$ (80,071)	$ (185,831)	$ (265,902)	$ 1,019,968
Change in Claim Reserves	$ (60,741)	$ (1,157,000)	$ (1,217,741)	$ (14,834,000)
Net Incurred Losses	**$ (249,415)**	**$ 10,056,727**	**$ 9,807,312**	**$ 38,911,884**

**Examples include Rebates, Subrogation Reimbursements, Discount Offsets*

Plan Claim Cost Per Member

	HIPAA
Average Enrollment	447
Average Prescription Cost	$ 6,641
Average Non-Prescription Cost	$ 15,857
Average Plan Claim Cost	$ 22,498



Medical Claims

TOP 10 INPATIENT MEDICAL PAID EXPENSES IN 2015

RANK	NAME	TOTAL PLAN PAID
1	NEOPLASMS	$ 535,341
2	INJURY AND POISONING	$ 409,219
3	COMPLICATIONS OF PREGNANCY;CHILDBIRTH; AND THE PUERPERIUM	$ 387,363
4	CIRCULATORY	$ 361,987
5	NERVOUS SYSTEM	$ 294,293
6	DIGESTIVE SYSTEM	$ 264,026
7	MUSCULOSKELETAL AND CONNECTIVE TISSUE	$ 230,086
8	SYMPTOMS, SIGNS & ILL-DEFINED CONDITIONS HEALTH STATUS	$ 144,082
9	RESPIRATORY	$ 138,020
10	GENITOURINARY	$ 18,120

TOP 10 OUTPATIENT MEDICAL PAID EXPENSES IN 2015

RANK	NAME	TOTAL PLAN PAID
1	NEOPLASMS	$ 917,308
2	GENITOURINARY	$ 486,461
3	NERVOUS SYSTEM	$ 303,474
4	SYMPTOMS, SIGNS & ILL-DEFINED CONDITION HEALTH STATUS	$ 232,674
5	DIGESTIVE	$ 195,214
6	MUSCULOSKELETAL AND CONNECTIVE TISSUE	$ 164,510
7	CIRCULATORY	$ 161,124
8	RESPIRATORY	$ 102,551
9	INJURY AND POISONING	$ 84,945
10	COMPLICATIONS OF PREGNANCY;CHILDBIRTH; AND THE PUERPERIUM	$ 3,192

Prescription Drug Claims

TOP DRUGS BY TOTAL PLAN PAID IN 2015

RANK	DRUG LABEL	TOTAL PLAN PAID
1	HARVONI	$ 355,988
2	H P ACTHAR	$ 317,038
3	HUMIRA	$ 203,722
4	EXJADE	$ 108,480
5	COPAZONE	$ 61,179
6	ORENCIA	$ 59,648
7	ATRIPLA	$ 54,746
8	GENOTROPIN	$ 52,910
9	ENBREL	$ 50,680
10	TRUVADA	$ 48,761
11	LANTUS	$ 37,851
12	ABILIFY	$ 35,627
13	ENOXAPARIN	$ 35,553
14	REYATAZ	$ 33,914
15	NOVOLOG	$ 33,811
16	XYREM	$ 32,790
17	CIMZIA	$ 30,968
18	IBRANCE	$ 29,896
19	HUMALOG	$ 29,700
20	DULOXETINE	$ 27,866

TOP DRUGS BY AVERAGE PLAN COST IN 2015

RANK	DRUG LABEL	AVERAGE PLAN COST
1	H P ACTHAR INJ	$ 12,682
2	XYREM	$ 10,930
3	HARVONI	$ 8,279
4	TYSABRI	$ 4,840
5	VALCYTE	$ 3,531
6	EXJADE	$ 3,191
7	REYATAZ	$ 2,342
8	GILENYA	$ 2,328
9	GENOTROPIN	$ 2,216
10	SUBSYS	$ 2,165
11	ATRIPLA	$ 1,825
12	LINEZOLID	$ 1,730
13	CIMZIA	$ 1,684
14	ENBREL	$ 1,582
15	LIDOCAINE	$ 1,465
16	HUMIRA	$ 1,450
17	IBRANCE	$ 1,424
18	DUEXIS	$ 1,271
19	ATOVAQUONE	$ 1,269
20	WELLBUTRIN	$ 1,248

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Frank J. Mautino, Spring Valley, IL – State Representative 76th District (through November 30, 2015)

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David Hill, Evanston, IL

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Catamaran Rx, PBM Administrator

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