

2019 Annual Report

Illinois Comprehensive Health Insurance Plan

For the year ending December 31, 2019



1989 - 2019



JB Pritzker, Governor

Kwame Raoul, Attorney General

Robert H. Muriel, Chairman of Board

Brodie Taylor, Interim Acting Executive Director

The Mission and History of CHIP

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

The CHIP program has a two-fold mission:

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

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

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

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

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

On March 23, 2010 the President signed into law the ACA that in part prohibits health insurers from denying coverage due to pre-existing conditions. In 2013, plans were developed and implemented in preparation for CHIP members who would be transitioning to other coverage through the new health insurance exchange or in the marketplace as a result of the ACA. In 2014 CHIP members continued to transition into the marketplace as a result of the ACA with year end enrollment of 885 members. The 2015 CHIP enrollment continued to decline with a year-end membership of 328. At the end of 2016, 2017, and 2018 the CHIP membership enrollment was 190, 146, and 114 respectively. By the end of 2019 the CHIP membership enrollment was 94.

TimeLine and End of Year Enrollment

May 1989 first coverage provided
3,834 enrolled at end of calendar year

July 1997
HIPAA plan
began

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
4,370	4,500	4,500	4,693	4,687	4,809	4,986	5,439	6,561	7,786

July 2003
HCTC plan
began

Jan 2008
HDHP plan
began

2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
10,120	12,170	14,101	16,055	16,409	16,707	16,731	16,427	15,682	16,085

Oct 2013
ACA Enrollment
began

Dec 2013
Medicare plan
& HCTC plan
discontinued

Mar 2010
ACA signed

2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
18,098	19,998	20,849	17,572	885	328	190	146	114	94

Apr 2014
Traditional plan
closed

Dec 2014
HDHP plan
closed

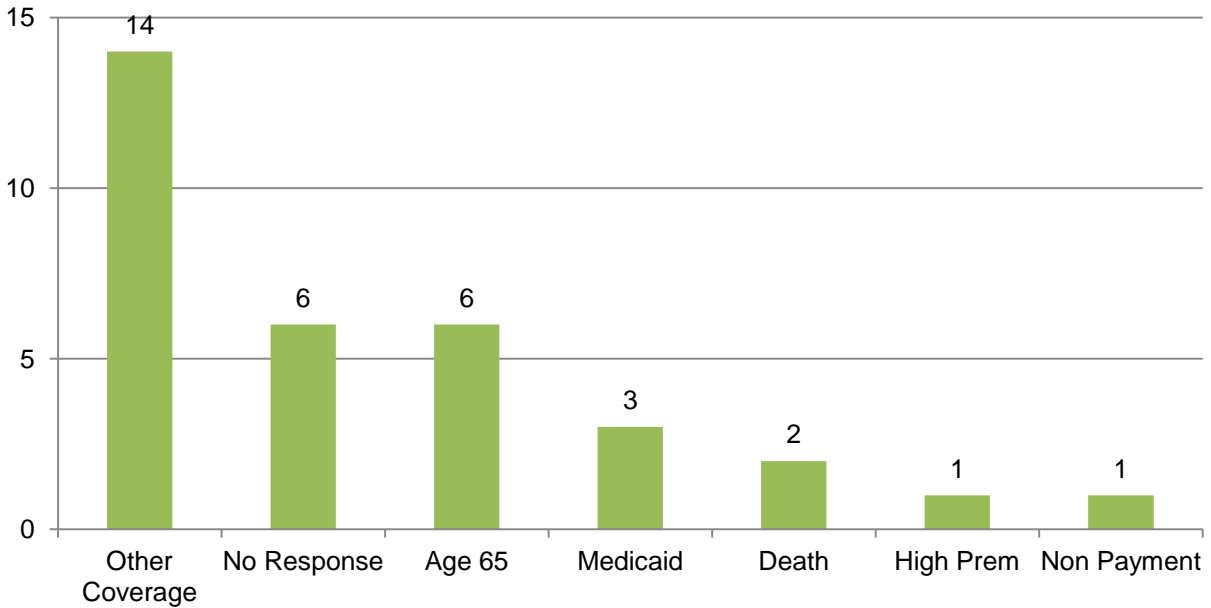
Member Profile for 2019

114 members January 1
 +13 enrollees added during calendar year
 - 33 members terminated during calendar year
 94 members December 31

Regarding the 13 that were added during 2019:

- 4 were later terminated during 2019 since they secured other coverage
- 9 continue to be active members

Reason the coverage terminated for the 33 members:

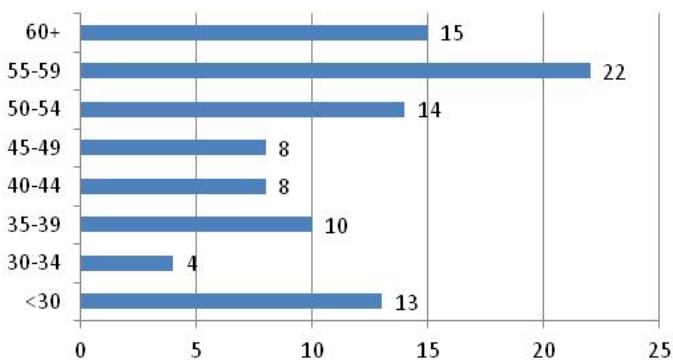


Further breakdown of the 94 December 31st members:

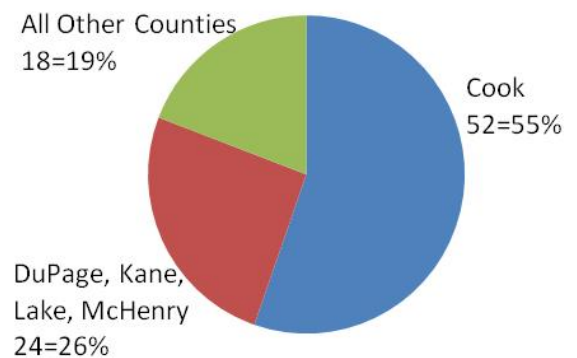
Deductible	Count	Percentage	Notes
\$2,500	83	88%	five did not meet their \$2,500 deductible during 2019
\$5,000	11	12%	three did not meet their \$5,000 deductible during 2019

There were two \$2,500 deductible members that had no claims during 2019.

Age distribution as of 12/31/2019

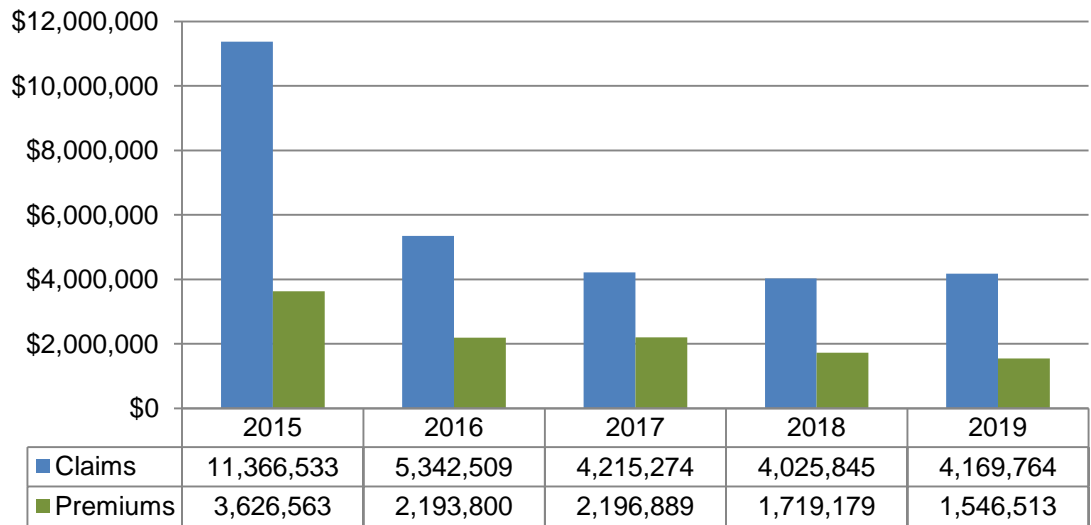


County distribution:

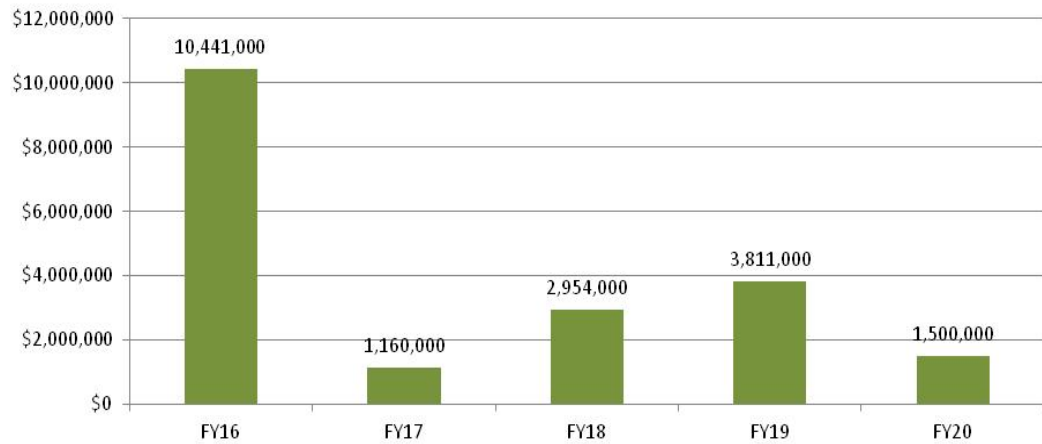


Financial Profile

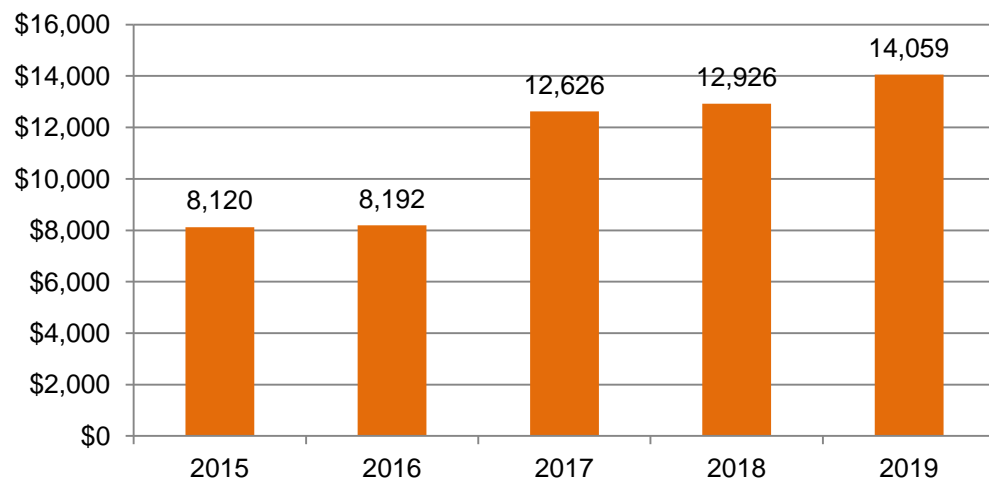
Total Claims Paid and Premiums Earned



Assessments to the Health Insurance Industry by Fiscal Year



Average Annual Premium



Claim Analysis for those Paid during calendar year 2019

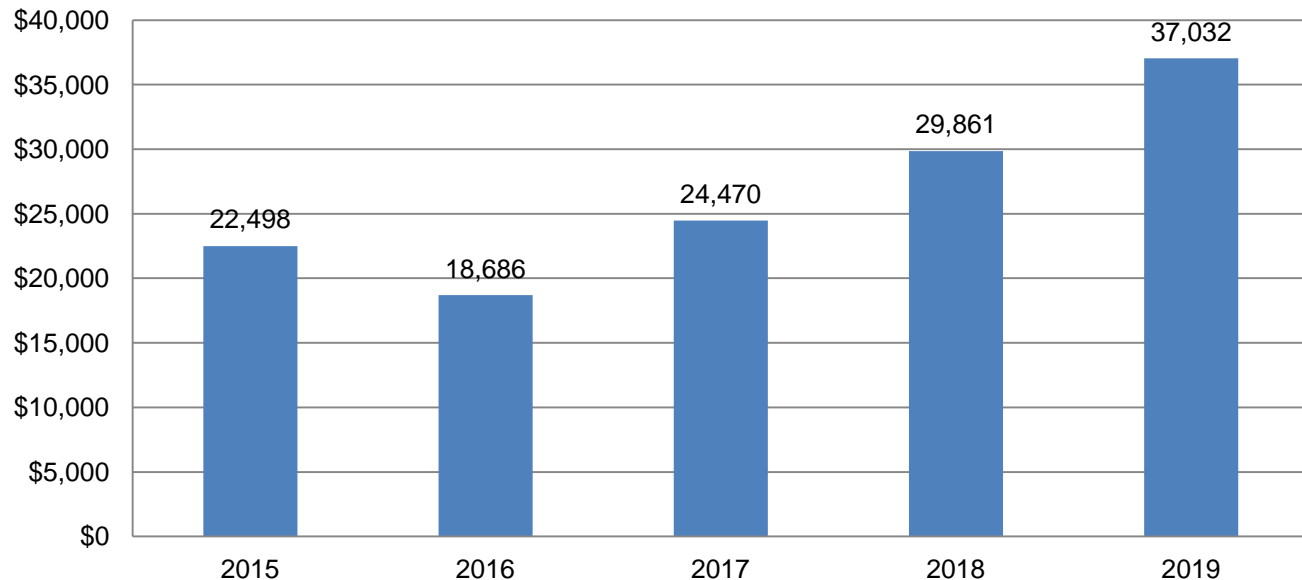
Description	2019			2018
	Traditional Total	HIPAA Total	Grand Total	Grand Total
Inpatient	\$ -	\$ 1,003,211	\$ 1,003,211	\$ 452,431
Outpatient	\$ (1,713)	\$ 1,098,492	\$ 1,096,779	\$ 1,324,030
ECF/SNF	\$ -	\$ 39,017	\$ 39,017	\$ 43,756
Coordinated Home Care	\$ -	\$ 20,130	\$ 20,130	\$ 20,931
Medicare Deductible	\$ -	\$ -	\$ -	\$ -
Physician Services	\$ (72)	\$ 806,492	\$ 806,421	\$ 933,171
Major Medical	\$ -	\$ 1,131	\$ 1,131	\$ 3,726
Subtotal	\$ (1,784)	\$ 2,968,474	\$ 2,966,690	\$ 2,778,045
Adjustments*	\$ (1,020)	\$ (40,673)	\$ (41,693)	\$ (38,411)
Total Blue Cross Medical	\$ (2,804)	\$ 2,927,801	\$ 2,924,997	\$ 2,739,634
Total Prescriptions		\$ 1,244,767	\$ 1,244,767	\$ 1,286,211
Total Paid Claims	\$ (2,804)	\$ 4,172,568	\$ 4,169,764	\$ 4,025,845
Prescription Rebates	\$ -	\$ (21,622)	\$ (21,622)	\$ (76,813)
Prescription Claim Refunds		\$ (2,408)	\$ (2,408)	\$ (46,409)
Medical Claim Refunds		\$ (9)	\$ (9)	\$ (570)
Change in Claim Reserves		\$ (75,000)	\$ (75,000)	\$ 45,000
Net Incurred Losses	\$ (2,804)	\$ 4,073,529	\$ 4,070,725	\$ 3,947,053

* includes Claim Recoveries, Subrogation Reimbursements, Discount Offsets

Average HIPAA Plan Claim Cost Per Member

Enrollment	110
Prescription Cost	\$ 11,098
Non-Prescription Cost	\$ 25,934
Total Plan Claim Cost	\$ 37,032

Average Annual HIPAA Plan Claim Cost Per Member



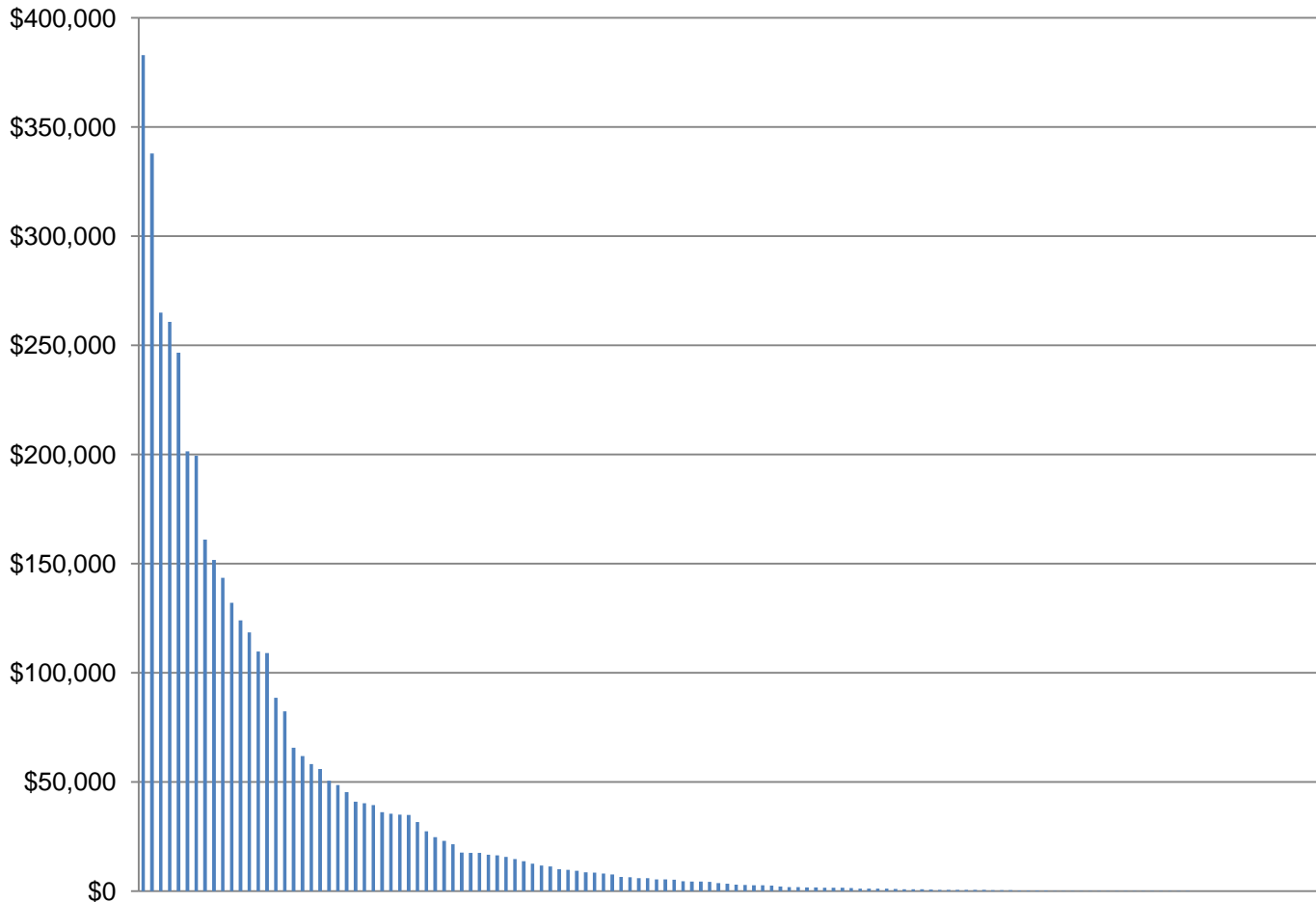
Claim Analysis for those Paid during calendar year 2019

Claims Paid by Month:

	Medical	Drug	Total
January	\$452,507	\$93,211	\$545,719
February	\$172,343	\$110,429	\$282,772
March	\$253,416	\$107,752	\$361,168
April	\$261,990	\$107,696	\$369,687
May	\$223,246	\$140,508	\$363,754
June	\$150,661	\$112,720	\$263,381
July	\$320,598	\$65,539	\$386,137
August	\$154,648	\$102,884	\$257,532
September	\$274,599	\$89,126	\$363,725
October	\$161,391	\$74,210	\$235,602
November	\$228,258	\$164,258	\$392,516
December	\$271,339	\$76,434	\$347,773
Total	\$2,924,997	\$1,244,767	\$4,169,764

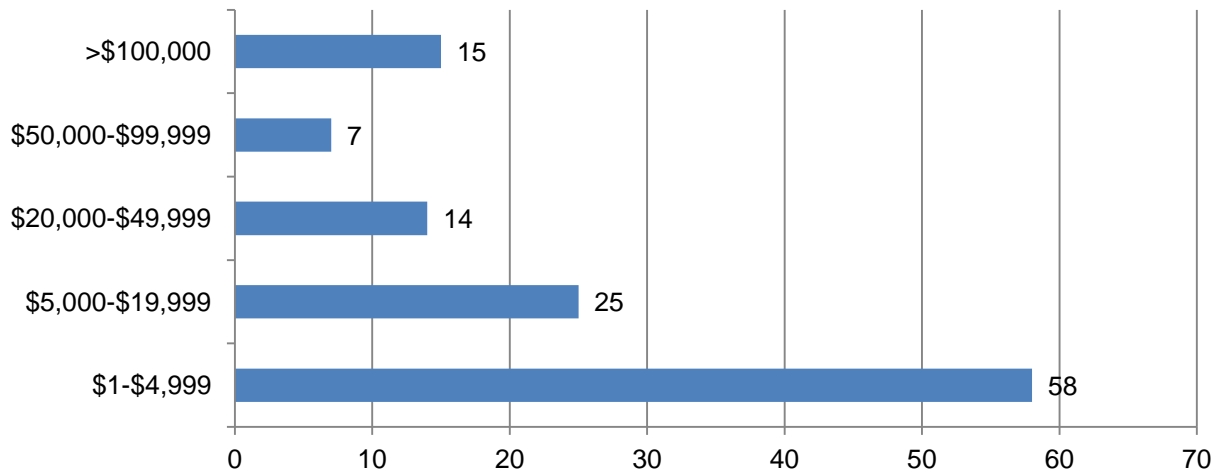
During 2019 claims were paid for 149 current and prior years Members.

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

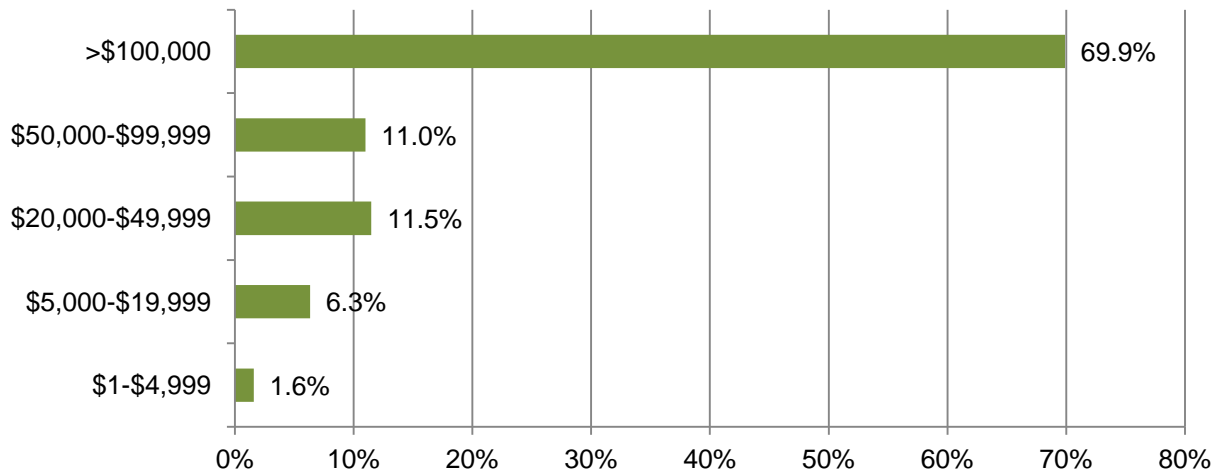


Claim Analysis for those Paid during calendar year 2019

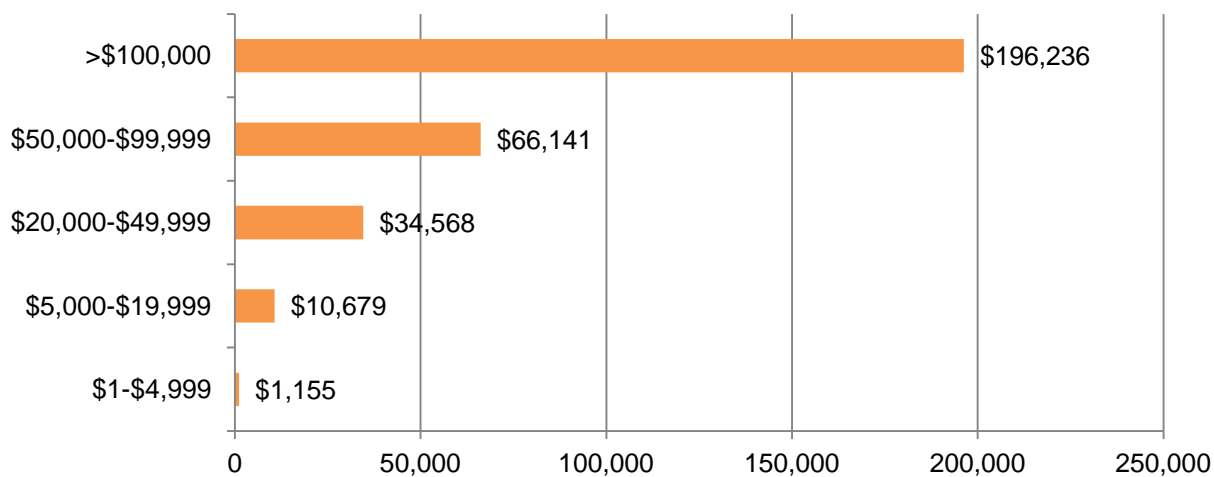
Number of Members in each Range



Percent of Total 2019 Claims in each Range



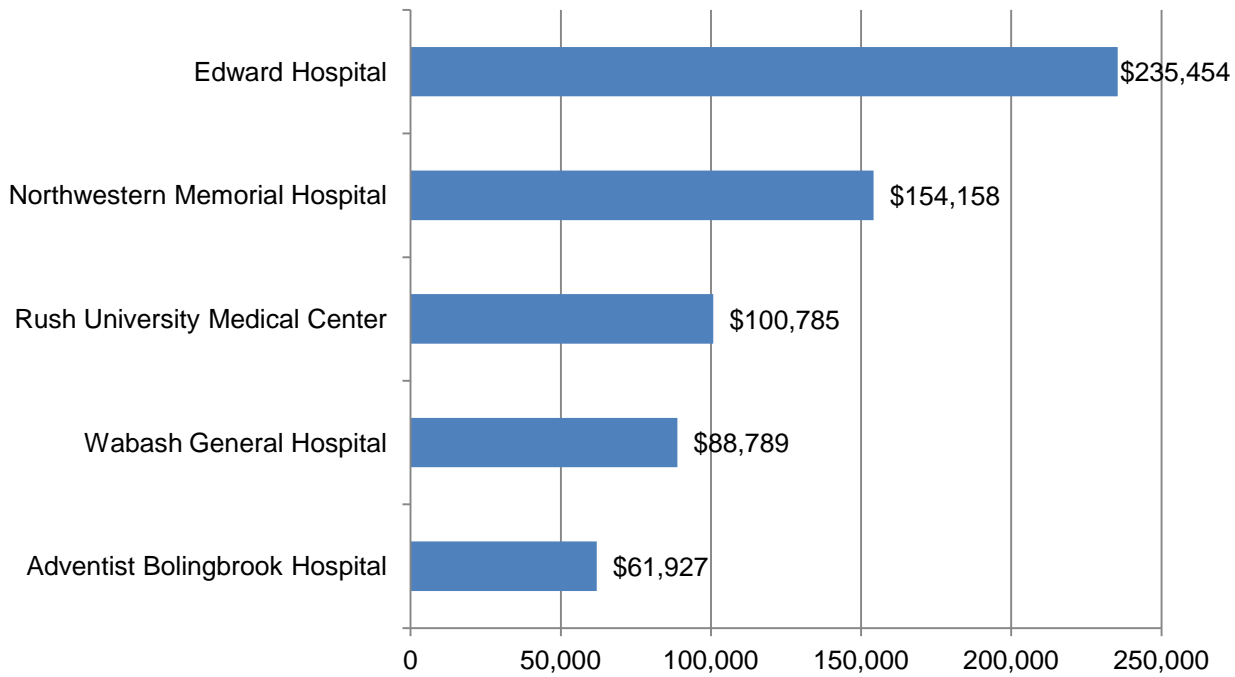
Average Total Per Member in each Range



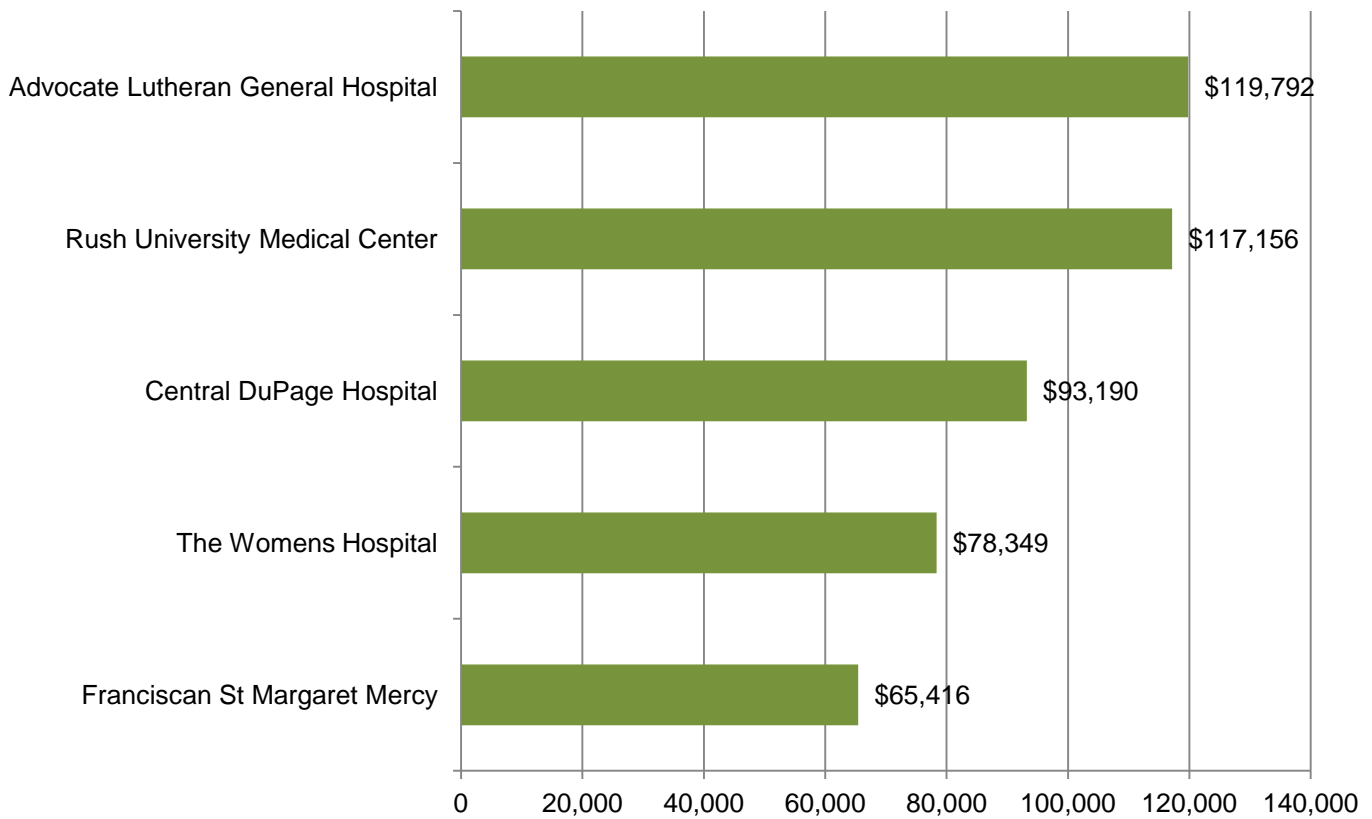
During 2019 there were 30 Members that had only adjustment claims with a total dollar amount of -12,977.

Claim Analysis for those Paid during calendar year 2019

Top 5 Inpatient Providers – total paid for all Inpatient = \$1,003,211

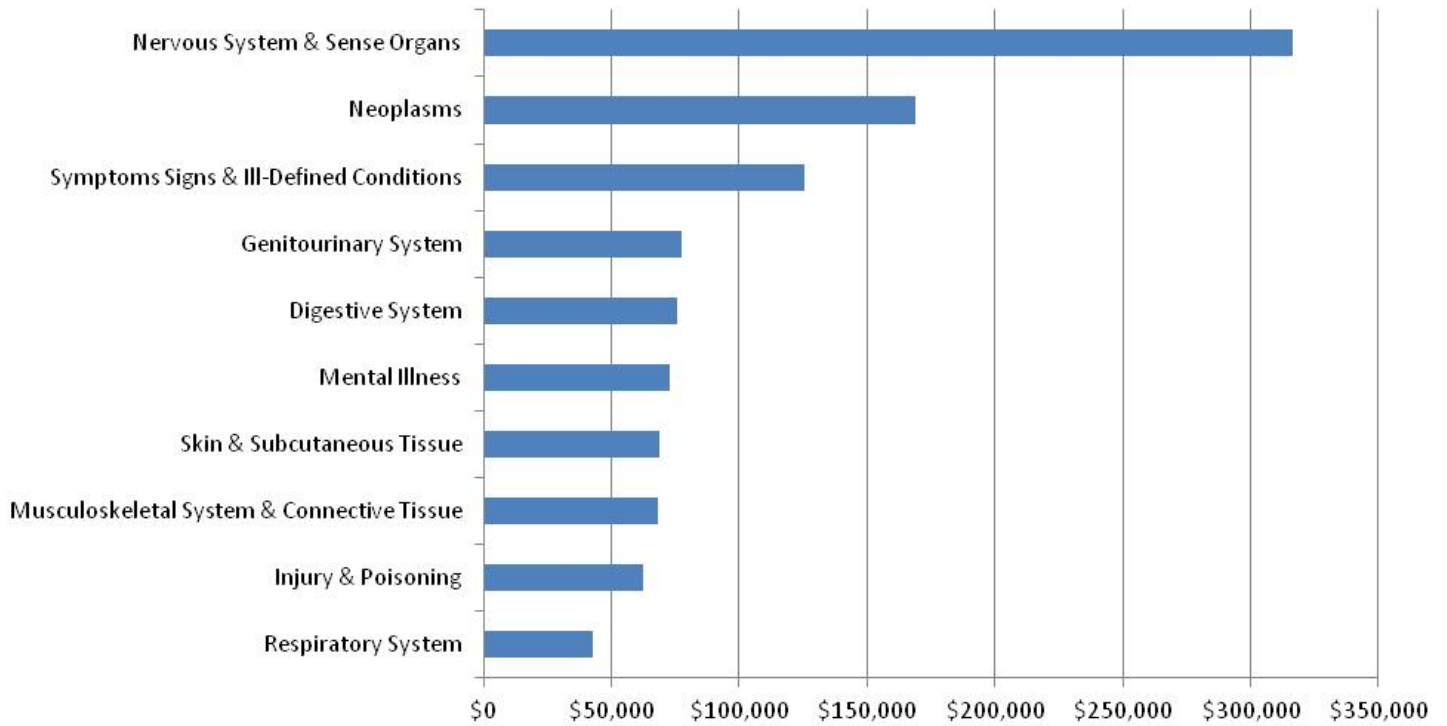


Top 5 Outpatient Providers – total paid for all Outpatient = \$1,096,779

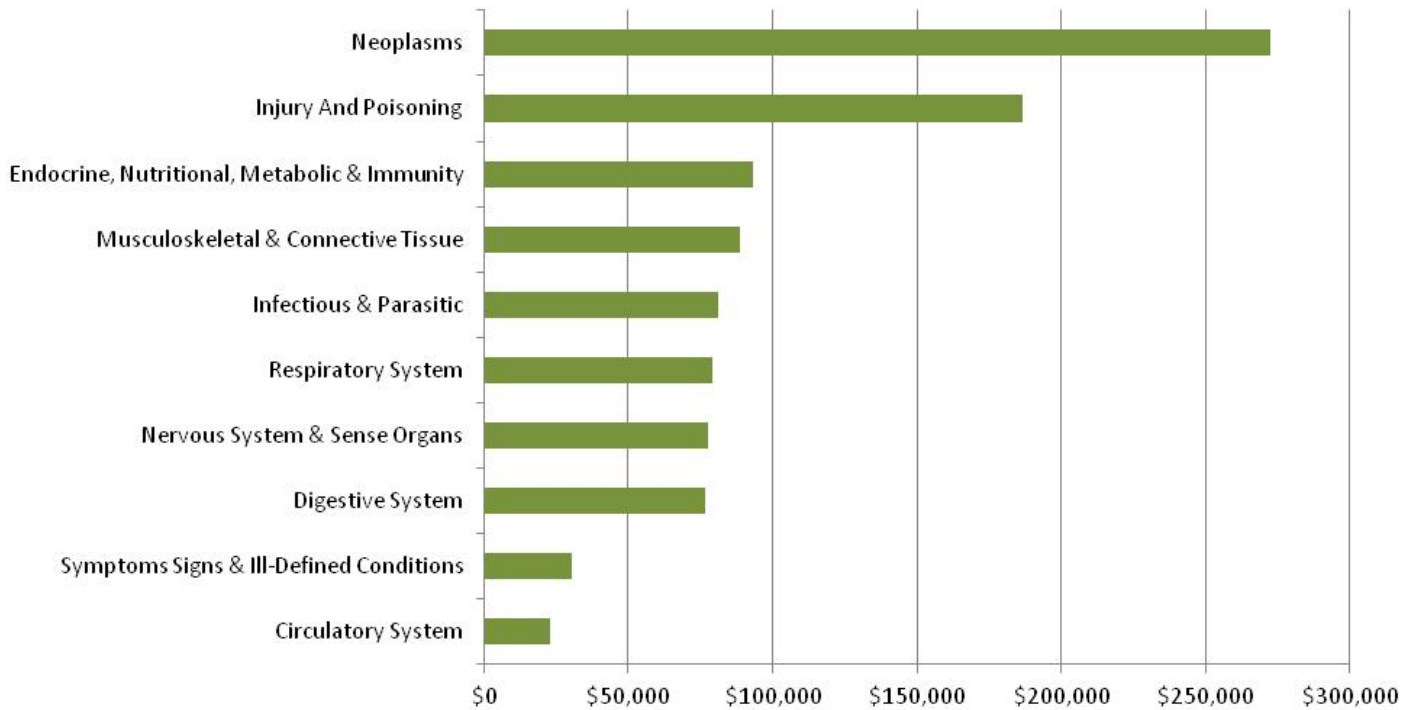


Claim Analysis for those Paid during calendar year 2019

Top 10 Medical Outpatient Claims by Diagnosis

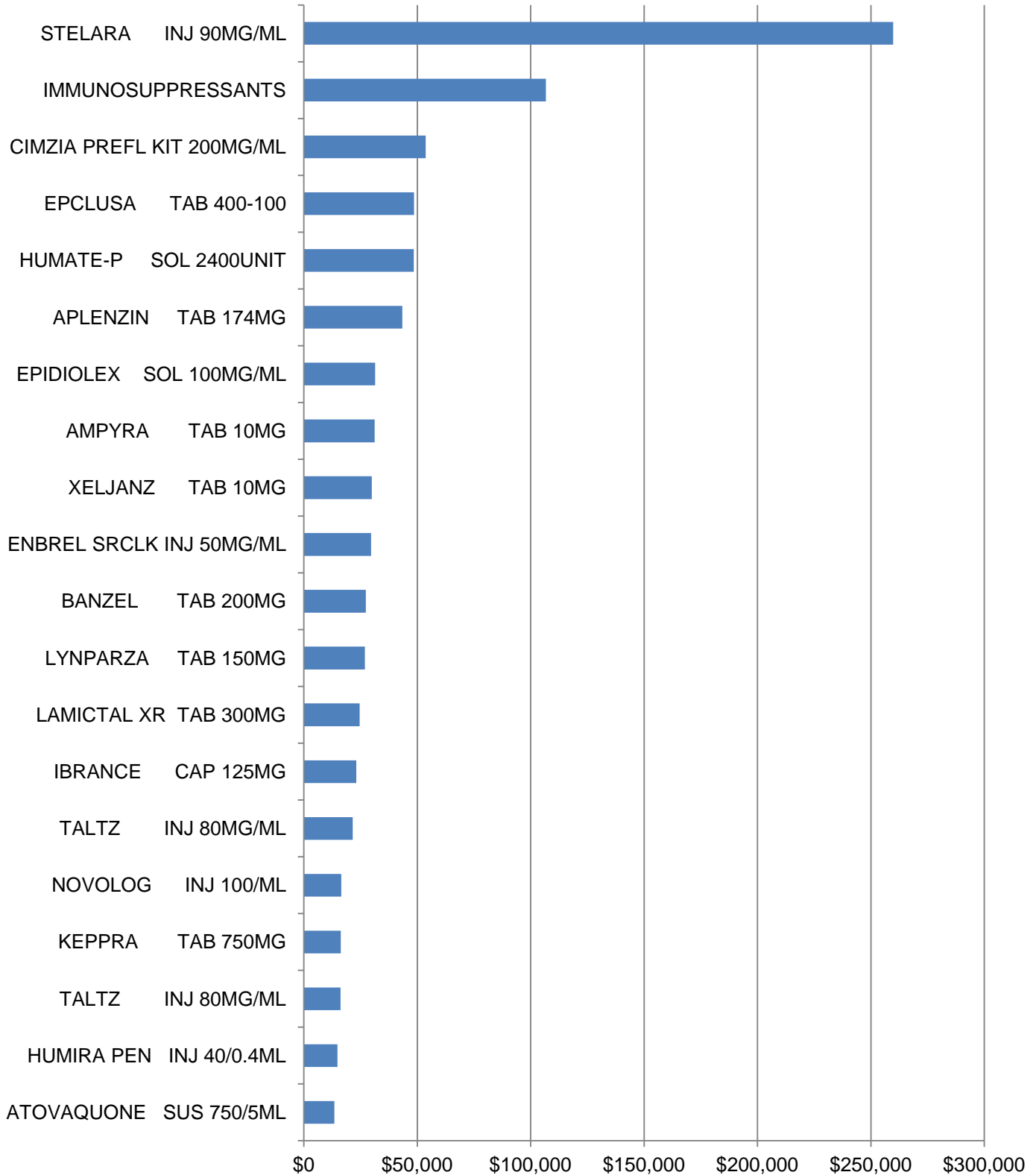


Top 10 Medical Inpatient Claims by Diagnosis



Claim Analysis for those Paid during calendar year 2019

Top 20 Prescription Drugs



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