

**Fact sheet on the RFP process for managed care vendors
April 6, 2011**

The Illinois Department of Healthcare and Family Services has posted a notice of intent to award contracts to four managed care organizations to provide managed care (HMO and Open Access Plan (OAP)) benefits to state employees, dependents and retirees starting July 1. The plans will also provide care to members of the Local Government Health Plan, the Teachers' Retirement Insurance Program and College Insurance Program. The awards were arrived at through a competitive RFP process governed by the state Procurement Code. The state intends to award the contract for administering HMO services to BlueCross BlueShield HMO Illinois and BlueCross BlueShield BlueAdvantage and to HealthLink OAP and PersonalCare OAP for administering the OAP products.

An analysis of the competing proposals found that these contract awards will result in a savings of approximately \$102 million per year, and a savings of over \$1 billion over the potential 10-year life of the contracts.

The new contracts will take effect July 1. Group insurance plan members will have the option to select an insurance plan in May, during the annual Benefit Choice period. Information regarding the plans for the upcoming fiscal year is sent every April to members in advance of the May 1st – May 31st annual Benefit Choice period. Letters will be sent to all members near the end of April regarding these changes. The annual Benefits Choice Options book, which outlines all changes for the health care plan for fiscal year 2012, will be available on the Benefits website (www.benefitschoice.il.gov) beginning May 1, 2011.

The RFP process started last fall as the ten-year terms (five initial years plus five one-year extensions) for existing contracts were set to expire on June 30, 2011. The new contracts have a term of five initial years, plus the option for five one-year extensions.

Questions and Answers

Q: Will members be able to continue to receive care from their existing primary care physician?

A: Members will continue to have access to their trusted family health care providers, although for some it will be through different health plans. While some current family health care providers may only be available initially through the Tier 2 level benefit within the OAP plans, we expect that over time, these providers will adjust to market needs. The providers impacted by these changes can choose to immediately contract with the new vendors in order to expand their coverage options.

Q: What does a member need to do if he or she is enrolled in one of the health plans that will no longer be available after June 30, 2011?

A: Members enrolled in any managed care plan that is no longer available under the Program must elect a new carrier during the Benefit Choice Period. Members who fail to make an election will be automatically defaulted to the Quality Care Health Plan effective July 1, 2011. Contact information for the vendors (including phone numbers and email addresses), enrollment forms, county coverage information and costs will be provided in the Benefit Choice Options book available on the Benefits website (www.benefitschoice.il.gov) beginning May 1st.

Q: Why are the savings not being shared with group members?

A: Contribution levels for the State plan are set by the Collective Bargaining Agreement and are not subject to increase, or decrease, unless agreed to by all parties. For the state employee plan, the State pays approximately 90% of the costs associated with health care.

Q: How were the proposals scored and ranked?

A: Proposals were received and evaluated according to the procurement laws and rules. Under the RFP for the HMOs, technical scores accounted for 30 percent of the total, and pricing accounted for 70 percent. For the OAP RFP technical scores accounted for 72 percent of the total while pricing accounted for 28 percent. The difference in scoring for the 2 different plans is based on the fact that the HMO is an insured plan, whereas the OAPs are self-insured.

Q: How can the state change benefit plans for bargaining unit members without going through the collective bargaining process?

A: The Collective Bargaining Agreement says, “the State shall continue to offer enrollment in Managed Care Health Plans (MCHP) — OAPs and HMOs are both MCHPs.” The State continues to meet this obligation under this contract award.

Q: What is the difference between and HMO and OAP?

A: HMO plans provide benefits on an in-network basis. Out-of-network services are generally not covered. OAP plans offer a three-tiered benefit structure, thereby offering more flexibility of coverage options. Tier 1 is an HMO; Tier 2 is a PPO, which requires a deductible; Tier 3 is Out-of-Network.