IMPORTANT INFORMATION FOR AFSCME MEMBERS IN STATE GOVERNMENT AND STATE UNIVERSITIES REGARDING CHANGES TO THE GROUP HEALTH PLAN

Protecting Members' Access and Provider Choice

Earlier this year the State announced that it was changing plan administrators in order to achieve savings in the group health plan. From the outset the Union has acted to ensure that AFSCME members, to the maximum extent possible, are able to access the medical provider of their choice at no substantial additional cost.

At this point, more than 90% of the current medical providers will be accessible to AFSCME members through one or more of the new health plans selected by the State, and many, if not most, will be available at no or little additional cost .

There are strong indications, though no absolute guarantee, that even more medical providers will join the list in the coming days and weeks.

In the past, the state has added some vendors and dropped others, requiring members to choose a new plan. However, this year the change in vendors has been much more dramatic with some longtime vendors gone from the State's plan, confronting thousands of members with making a decision about which plan is best for them.

Consequently the Union has been very careful in monitoring the State's decisions to ensure that members' interests are protected.

After months of pressing for all documentation relevant to the change in group health plan administrators, AFSCME Council 31 has now been provided with much of this information and the union is in the process of analyzing all of the relevant materials.

In addition, the union's benefits experts have met with both the former and the new health care vendors, as well as with DCMS and DHFS, in order to ensure that union members will not lose convenient access to medical care or have relationships with trusted medical providers disrupted.

Both the new vendors and the State have continued to insist that the overwhelming majority of providers who had participated in the discontinued networks have already or will soon come into the new networks—so that neither choice of provider nor geographic proximity will be significantly impacted.

However, in the event that the change should result in undue disruption or difficulty for employees, AFSCME has filed a grievance at the third step based on contract language that references state law barring such disruption in medical treatment.

At AFSCME's urging, DCMS agreed to extend the Benefits Choice Period beyond its scheduled closure on May 31. However, there is now considerable concern as to whether all necessary information will be available by the new date of June 17. So the Union pressed DCMS to again extend the deadline. The State is refusing to do so, but has pledged to schedule a second Benefits Choice Period in the Fall, giving employees the option to change their choice of plan.

Understanding Your Options

For FY 2012, the State elected to offer the following health plan options. If you are already in one of these plans and are satisfied with it, you need to do nothing to remain in it:

*Quality Care Health Plan PPO (currently offered)
*HMO Illinois (currently offered)
*Blue Advantage HMO (new HMO offering, same service areas as HMO Illinois)
*HealthLink Open Access Plan (OAP, currently offered)
*PersonalCare Open Access Plan (new OAP offering)

However, ***if you have been enrolled in one of the following health plans, you MUST elect a new health plan by June 17th or you will be automatically enrolled in the Quality Care Health Plan effective July 1, 2011:***

Plans no longer offered effective July 1, 2012:
Health Alliance HMO
Health Alliance Illinois HMO
Personal Care HMO
Humana Health Plan (HMO)
Humana-Winnebago (HMO).

The two Open Access Plans (OAPs) are being offered statewide and are effectively an HMO when using Tier 1 hospitals, doctors, and other medical providers, but with freedom to see Tier 2 and non-network (Tier 3) providers. This is something that employees do not have the option of doing with an HMO.

What is an "Open Access Plan"?

There is considerable confusion as to how an Open Access Plan operates. Many employees have participated in an HMO for many years and have never given the OAP a careful look. However, some 6,000 state and university employees and retirees in southern Illinois have participated in the HealthLink OAP for many years, and find it a very satisfactory benefit plan.

OAPs are essentially plans that combine the best aspects of HMOs and PPOs. An OAP is a form of "managed care plan" and, as such, the employee premium to participate in an OAP (your paycheck deduction) is on the same basis as an HMO plan:

- The monthly premium paid by the employee for 'employee only' coverage is identical between OAP and HMO.

- For dependent coverage, the OAPs are similar to HMOs. PersonalCare OAP dependent coverage will cost the same as PersonalCare HMO does now. HealthLink OAP dependent coverage will cost the same as it does today.

Employees who want to minimize their out-of-pocket costs can utilize Tier 1 providers when they seek care through the OAP--and their co-pays for services and prescriptions are IDENTICAL to HMO benefits.

But, in addition, employees have the OPTION to seek services with other providers at Tier 2 or Tier 3 benefit levels. Costs for using a Tier 2 provider are essentially like an "in network" PPO benefit, while Tier 3 is like a "non-network" PPO benefit.

Tier 2 benefits are, in fact, not onerous and much better than Quality Care Health Plan benefits. The annual deductible is $200 per enrollee. Coverage is 90% (your coinsurance is 10%). The annual out-of-pocket limit is $600/person or $1200/family. All preventive services are covered 100% with no copayment. Prescription drug benefits are the same in all tiers.

In many instances, after the deductible is met, a doctor visit will cost less under Tier 2 in an OAP than the visit would have cost in an HMO. A $100 charge would result in a $10 copayment, which is less than the current $15 office visit copay in an HMO.

Will current Health Alliance HMO and other HMO providers sign contracts to become Tier 1 or Tier 2 providers in one or both of the OAPs?

There is no way to know for sure at this time, which is why AFSCME has filed a grievance to protect the union's position should the providers fail to migrate to the new networks.

However, the early signs are encouraging. HealthAlliance testified in Springfield that it took them "years" to get Springfield Clinic under a managed care contract. However, it took HealthLink only a matter of days to sign the Springfield Clinic as a Tier 1 provider in their OAP for the new plan year. This is the largest multi-specialty medical practice in Sangamon County, and has a wide reach in the market. Negotiations are now underway between either HealthLink or PersonalCare, and the remaining providers that have been historically available in Health Alliance and Humana HMOs.

Should employees wait until June 17th to make their plan election?

For most individuals, the answer is no. The Union has been informed that currently nearly 90% of the current Health Alliance doctors are signed up in Tier 1 of one or both OAPs. There is no need for employees currently enrolled in a terminated HMO to wait until June 17th to make a health plan election if they can find their current doctors on Tier 1 of an OAP Plan. For example, employees who are in HealthAlliance now and use Springfield Clinic doctors can enroll in HealthLink OAP and be assured that their doctors are on Tier 1 of that Plan.

It will, however, be to the advantage of some employees to wait until they can see which OAP, if any, their provider joins on Tier 1. It is likely that many other providers are going to come to agreements to become Tier 1 PersonalCare or HealthLink providers in the days ahead, hopefully prior to June 17th. For example, Carle Clinic doctors in Champaign/Urbana are currently Tier 2 providers in the OAP, but may well become Tier 1 providers in one or both of the OAPs prior to June 17th.

However, not every physician or physician group will sign contracts with one or both OAPs by June 17th to be in Tier 1. Employees who use current HealthAlliance or Humana doctors who are slow to sign Tier 1 agreements should attempt to verify that they are on Tier 2 with PersonalCare or HealthLink OAP, and join the plan where the current providers participate in the highest tier.

In recognition of the short time period available, **the State has committed to a second Benefit Choice period for the fall of this year, for making changes in health plan enrollment only**. This is very important because doctors might become Tier 1 providers after June 17th, and there is no way of knowing in advance if they will do this for PersonalCare OAP, HealthLink OAP, or both.

WHERE TO GET MORE INFORMATION

Copies of all relevant documents, including the Benefit Choice Booklet, the State of Illinois Benefits Handbook, the Quality Care Health Plan hospital network, the new Quality Care Dental Plan reimbursement allowances, etc. are available CMS benefits website: www.benefitschoice.il.gov New updated Benefits Handbooks are supposed to be available on July 1, 2011.