

The Newsletter of the Montana University System's Flexible Benefits Program

Plan Changes for Next Year

The road was long, arduous, and even quite contentious at times, but the InterUnits Committee has made its final decisions and the *Choices* program is set for next year. These decisions were made earlier than in prior years and give our members plenty of advanced notice and time to consider their options well in advance of the re-enrollment period which begins on May 15. The fact that there are fewer plan changes this year than in the typical year glosses over the reality of how much advanced work, blood, sweat, and even tears, at times, went into these final decisions.

In most respects it should have been a easy year for the InterUnits committee. The last legislature froze our salaries, but was quite generous in its increased allotments to the Benefits Program. In FY 2005 the State contributions will go from \$410 to \$460 per employee per month and this should be sufficient to cover our anticipated increases in expenses. Furthermore, despite double digit medical and drug inflation, our claims costs remain well within our projections and we anticipate entering the next fiscal year in good fiscal health and with monies in our reserve accounts more than adequate to meet our needs. In previous years the Committee was typically faced with the distasteful task of either reducing benefits, increasing premiums, or a combination of both. That was never the in the cards this year. The increased State contribution should be sufficient to meet inflation and there will be no reduction in benefits and no increases in out-of-pocket costs for our active members. Since our retirees do not receive any State contributions, their costs will rise accordingly, but even here our strong fiscal situation allowed us to reduce the premium increase on an average slightly below the \$50 rise to match the State increase.

All of this sounds like unremitting good news as well it should. What then was the problem? The difficulties came in the requirements we had in rebidding our life insurance and long-term disability programs and especially in sending our administrative contract out to bid. Rumors have been flying about the contentious struggle between Blue Cross/Blue Shield and Allegiance to gain the contract as our claims administrator and allegations are being made about how "secretive and unfair" the entire process was. What follows is, as best as we can reconstruct it, a general description of the Request for Proposal (RFP) procedures and the actions taken by the Administrative Contract Subcommittee, the full InterUnits Committee, and the Commissioner's Office with regard to this critically important RFP. The net result of this long and difficult process is that, at least for next year, we ended close to where we began and there will be few changes in FY 2005. This article will outline the specifics of these few plan changes for next year and the re-enrollment schedule and procedures. The storm of the decision making is over and there is plenty of time now to make our choices during the calm.

The RFP/Bidding Process – State statute requires that all services in excess of \$5,000 per year be sent out for bid, or in the case of ongoing services, periodically for rebid. The general guidelines require that all contracts be rebid every five years or so, but if there is insufficient time to go through the RFP process, State agencies are allowed to renew contracts on a temporary basis for a year or two while the RFPs (Requests for Proposals) are prepared and the bidding process completed. In practice, the RFP process often takes in excess of a year to complete and, because of the temporary renewal provisions permitted by statute, many State contracts might go seven or eight years without rebidding. Nor is the State agency always required to accept the lowest bid. Very often a higher bidder might be better positioned to offer a level of service far superior to the low bidder, in

which case the agency can accept the higher bid. When that happens, the agency involved must publicly provide clear justification for going with the higher cost vendor.

The bidding (rebidding) process begins with the selection of a committee, or in our case, a subcommittee of the full InterUnits Committee. This committee meets to specify the general parameters of the services required and then works with the Commissioner's Office and legal staff to draw up the formal document or Request for Proposal (RFP). The RFP is then publicized and circulated among the appropriate vendors associations. The RFP process then enters the **confidential phase**. The vendors must then respond with a detailed sealed bid by the formal deadline. The bid committee then meets to evaluate the submitted bids and to

*The Choices Newsletter
is designed to help
promote a sense
of our ownership
and responsibilities
within the program.*

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exclude those submissions that do not meet the minimum requirements of the RFP. Interviews are then held in private with the remaining vendors. These finalist(s) are then ranked and the committee ends the private phase and makes public its preliminary recommendation.

The **public phase** then begins. The bids of the finalist (including all pricing information but excluding any proprietary business information) are then available for all to review including the contenders for the final contract. The vendors still in the running are then asked to submit their "best and final offer" and to clarify any issues formally addressed to them by the committee or the Commissioner's Office. Once these clarifications are made and the "best and final offers" submitted, the committee reconvenes to make its final recommendation to the larger committee (in our case, InterUnits) for its action and then that recommendation is sent on to the Commissioner for final approval. Remember that all of the InterUnits' recommendations are advisory and can be overturned by the Commissioner and that the Commissioner also has the right to cancel the RFP process at any time and order a temporary renewal with an existing vendor.

These are the standard procedures of the RFP process and were followed carefully in the two bids let by the InterUnits Committee this year. The Life Insurance and Long Term Disability Insurance Subcommittee has easier time of it than the Administrative Services Subcommittee. Life and LTD insurance are simple products in most respects and as long as the bidders met our specifications and had a good credit rating, the Subcommittee was free to take the lowest bidder. UNUM has been our Life and LTD vendor for the past X years, but they were outbid this time by Standard Insurance. If an issue relating to LTD coverage for faculty on sabbatical or research leave is resolved satisfactorily, Standard will be awarded the contract and members will see a modest reduction in premium costs next year.

The Administrative Services RFP was far more complicated and contentious. Blue Cross/Blue Shield of Montana has been our medical plan administrator since 199x. Since that time the contract was rebid once in 1999 and BC/BS was the only vendor to submit a proposal. They were renewed at that point for an additional 5 years. These five years have now elapsed and a Administrative Services Subcommittee was formed at the March 2003 consisting of three IUBC members and three MUS administrators. The formation of this committee and its charge were announced

last year in the May 2003 *Choices Newsletter*. The Administrative Services Subcommittee has worked diligently this last year to complete this RFP process.

What complicates this particular bid is the nature of these services. The Subcommittee was doing far more than simply choosing a vendor to administer our claims. By choosing one company over another you are also buying into their network of medical providers in addition to their capacity to administer our plan. These various Preferred Provider Organizations (PPOs) offer networks far different from one another and this creates potential problems for our members. By changing administrators we may be forcing our members to change physicians against their wills. If their doctor is not in the new vendor's network, the members must face the unpleasant choice of staying put and facing a 10% payment penalty and possible "balance billing" over and above the covered costs or going with a new and unknown medical provider within the new network. Furthermore, if a required medical service is not provided within the network, the patient faces the same 10% penalty and balance billing jeopardy. All of this could potentially cause untold financial harm to our members.

The Administrative Services Subcommittee was well aware of these potential problems when they met to draw up specifications for the RFP. They put in a strict specification that each bidder must demonstrate a "satisfactory network of preferred providers" in each of the geographical areas serving a significant number of our members. Four vendors responded to the bid and after these proposals were reviewed, two were judged to have met the basic specifications of the RFP: Blue Cross/Blue Shield of Montana and Allegiance Benefit Plan Management of Missoula. Both vendors were then interviewed during this confidential phase and both were declared finalists and asked to submit their "best and final" offers. In the initial bid Allegiance was far less expensive, but BC/BS has a far more extensive network of providers statewide and nationwide. When BC/BS saw the Allegiance bid during the public phase, they sharpened their pencils and matched the prices in their "best and final" offer. When the final dust had settled, Allegiance had very modestly outscored BC/BS. The Subcommittee decided to recommend offering the contract to Allegiance but only if they could demonstrate that they had an adequate network in the Bozeman area, a region where they had far fewer providers than BC/BS.

That set the stage for the very heated debate at the February InterUnits meeting. Allegiance had a more extensive network of providers in the Missoula area including some anesthesiologists and radiologists. In a dispute over reimbursement rates these same anesthesiologists and radiologists had dropped out of the BC/BS network and this has caused great financial hardship for our members in the western part of the State. On the other hand, Bozeman Deaconess, the only hospital in that region, is not an Allegiance member, and far fewer physicians in the Bozeman area participate with Allegiance. The best interest of UM and the best interests of MSU were clearly at odds and the ensuing debate seemed, at times, like a Cat-Grizzly game.

All of the InterUnits votes were extremely close. It was first moved to renew with BC/BS for one year and then rebid the contract. That would give Allegiance a year to develop their network. That motion failed by a single vote. A second motion was made to accept the Allegiance bid and issue them a four year contract. That motion passed 13 to 8. That was not the end of the story by any means. The MSU campus and its administrators appealed to Commissioner Stearns to overturn the InterUnits recommendation based on the potential harm it would cause to its Bozeman area employees. In the end Commissioner Stearns ruled that BC/BS be given a one year extension in FY 2005 and that the contract be awarded to Allegiance afterwards for the following two or three years if they can demonstrate that they have in place an "adequate network of preferred providers" to service the Bozeman area and our retirees. As this is being written, the campus are in the process of defining the specifics of this "adequate network."

So in most ways, despite all of the work and debate, we all ended close to where we began. There will be no major changes in the plan itself, nor in the plan administrator or network in the coming year. UNUM will be replaced Standard Insurance and our supplemental LTD and life insurance rates will go down modestly. The increased State contribution of \$50 per month will offset our increased costs and active members will see no increase in their out-of-pocket premium expenses in the coming year. The retirees receive no help from the State and their costs will go up accordingly. Yet because of the overall sound financial health of the plan and the adequate state of our reserve funds, the InterUnits Committee acted at the March meeting to reduce the proposed in-

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creases somewhat below the \$50 average increases. The chart below reflects rates slightly below those proposed premiums circulated on campus after the February meeting. The retirees have taken terrible hits in recent years, but be assured that the InterUnits Committee remains committed to helping them however possible. In the final analysis, the InterUnits Committee has shed much blood, sweat, and tears over these difficult decisions this year. Contentment was only the result of each member representing as forcefully as possible the best interests of their respective members and campuses. There was nothing unfair or secretive about the process and we have all survived to struggle another day. ■

RETIREE PREMIUMS FOR FY 2005	
Retiree Under Age 65 \$575 Plan	
Retiree Only	\$386
Retiree + One	\$520
Retiree + Two	\$571
Retiree + Spouse (mp)	\$427
Ret + Sp (mp) + Child(ren)	\$580
Survivor	\$386
Survivor + Child(ren)	\$508
Retiree Under Age 65 \$1500 Plan	
Retiree Only	\$336
Retiree + One	\$452
Retiree + Two	\$537
Retiree + Spouse (mp)	\$372
Ret + Sp (mp) + Child(ren)	\$505
Survivor	\$336
Survivor + Child(ren)	\$443
Retiree Over Age 65 \$400 Plan	
Retiree(mp)	\$273
Retiree(mp) + One	\$427
Retiree(mp) + Two	\$564
Retiree(mp) + Sp(mp)	\$346
Ret(mp)+Sp(mp) + Child(ren)	\$414
Survivor(mp)	\$273
Survivor(mp) + Child(ren)	\$404
Retiree Over Age 65 \$1500 Plan	
Retiree(mp)	\$235
Retiree(mp) + One	\$372
Retiree(mp) + Two	\$528
Retiree(mp) + Sp(mp)	\$298
Ret(mp)+Sp(mp) + Child(ren)	\$358
Survivor(mp)	\$235
Survivor(mp) + Child(ren)	\$349

*mp = Medicare Participant

There were many other issues and actions taken by the InterUnits Committee at their February and March meetings in addition to the plan change decisions described in the previous article:

Wellness Program Level II - During the Fall InterUnits retreat Kirk Keller, Wellness Director of MSU, and Jill Young, Wellness Director of UM, gave an information program to the Committee on the current state of wellness research and the different levels of services available in various wellness programs nationwide. A grid was presented which detailed modest Level I services which provided basic screenings and information to employees all the way up to Level V programs involving direct interventions and active health care management for high risk individuals. The Directors explained that the current MUS programs were basically at Level I with a few elements of Level II and they recommended that we move to a full Level II program. In addition to the screenings, Level II would provide programs targeted to non-participants and much more print and electronic information on individual health care management. The InterUnits Committee suggested at that time that the wellness directors come up with a specific recommendation to the InterUnits Committee complete with program details and a budget.

This Level II proposal was presented at the Winter meeting and given preliminary approval. At the Spring meeting, the proposal was modified, the budget reduced somewhat, and the modified proposal approved. This new Level II program, in addition to all of the services currently being offered, will offer targeted promotions to all members and their families and much more extensive information to individuals on how best to manage their own health care. New tracking and accounting software will enable better identification of member participation levels and more uniform reporting to the Commissioner's Office. There will be additional information programs on the campuses, an enhanced website, and a Wellness insert added to the *Choices Newsletter* several times a year. This expanded Wellness Program was budgeted for an additional \$xx,xxx and will begin with the new fiscal year.

The "Mercer" Subcommittee - Last spring Commissioner Mercer had requested that the InterUnits Committee "explore methods for reducing the cost of health care for lower paid employees by increasing the cost of health care for higher paid employees." This subcommittee met in February and established the criteria for criteria. They decided that any proposal must be revenue neutral, easy to administer, legal, easy to explain, and must

maintain the dignity of all participants. The subcommittee agreed to come up with 2-4 options and supporting research for the InterUnits Committee to consider at its next meeting.

AFLAC had asked the InterUnits Committee to consider offering a Supplemental Benefits program and Prepaid Legal submitted a proposal for offering optional legal insurance. The InterUnits Committee decided not to consider either request at this time. The Committee meets next at Big Sky in the fall for its annual retreat. ■

The Director's Chair by Glen Leavitt

In addition to the annual plan and premium design changes we go through every year, we have been working on the implementation of the new Health Insurance Portability and Accountability Act of 1996 (HIPAA), federal rules for the safeguarding of personally identifiable health information that may come into our possession. This information is called Protected Health Information (PHI). As a plan sponsor, the Montana University System must notify all plan members of our policy on the access, use, safeguarding, and disclosure of this PHI. You should have received notification from your benefits/HR office or in the mail on how to access this information. The notice and policy are available through our website at www.montana.edu/choices/.

This has been a relatively good year for our self-insured health plan. Our spending increase trends are in the double digits, but we expected that, set premiums last year accordingly, and expect to come through year-end with a positive cash flow. Next year, we again expect the total trend to exceed 15 percent, and that is why we are asking for some out-of-pocket increase for dependent coverage. These increases are not unique to our plan. In fact, they are very much in line with what employers and benefits consultants are reporting all across the nation. It explains why smaller employers are dropping health coverage for their employees and the number of uninsured is rising in the state and the nation.

Another ad hoc committee, with members extending beyond the Inter-Unit Benefits Committee, will continue to explore ways to reduce costs to retirees and lower paid employees. As you can see from the above and elsewhere in this newsletter, health plan design is a dynamic process. Gone are the days when plans remained unchanged for years with small increases in premiums from

Questions & Answers

Q I recently learned that Eckerd Drug wrote a letter to my physician about my prescription medications. Isn't this a violation of my privacy and an interference in the doctor/patient relationship? I thought there were Federal regulations that insured the privacy of my medical records. K. S., Billings

A. Eckerd Health Services (EHS) is our pharmacy benefit manager. As a pharmacy benefit manager they provide us with many services over and above providing us with the option of mail-order prescriptions and Network providers to fill our prescriptions at our local pharmacies.

Drug Utilization Review (DURNOW) is a very important service provided to MUS members for many reasons. Within hours of dispensing a prescription a retrospective review occurs. EHS provides this service so costly and dangerous medication errors are caught in near real time, corrected and hopefully prevented from occurring in the future. This review looks at drug to drug interaction; high utilization; therapeutic duplication; retail to mail opportunities; brand to generic opportunities; and acute frequency.

When problems are found, appropriate communications are sent to the prescribing physician or dispensing pharmacist and if necessary, to the patient. The communication sent to the doctor is HIPAA compliant and simply states, "During a recent assessment of patient profiles, we noted that possible therapeutic duplication, described below, may exist for on of your patients." EHS also encloses a postage paid response form re-

garding this issue. If the doctor is aware of the medication concerns and is comfortable with this situation, all they have to do is fill out the form and send it back to EHS.

Members ask why is someone other than their physician involved in his or her decision-making process. Often times physicians do not know what other medications their patient may be taking. Unknowingly, a patient may be on allergy medication, pain medication, cholesterol lowering medication and antidepressants. Any or all of these could have dire interactions when taken together. Maybe a member is seeing two different doctors for two different reason and both doctors prescribe the very same medication. The patient thinks they should take both medications as prescribed because they are for different problems. Wrong; this could cause serious harm to the patient.

This service could potentially save someone's life, prevent a drug interaction which could cause serious side effects and prevent nonperformance of the medication. None of these interventions performed by Eckerd Health Services violate the federal Health Insurance Privacy Assurance Act or HIPPA. You can be confident that all of this information will remain within your individual provider network and that all of the communication will remain completely confidential.

Linda Rykmann, Benefits Specialist, Commissioner's Office ■

CHOICES NEWSLETTER

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Since each individual and family situation is unique, you should always consult your family physician before taking action on any medical advice given here and you should consult your personal financial advisor before acting on any financial advice in the Newsletter. Consult plan documents for complete information.

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