



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

The Transition to Allegiance!

The transition is approaching and the rumors are flying. Many of our members have expressed fears that they will be forced to endure changes in coverage, loss of existing relations with their physicians and other health care providers, and even denials of claims for current medical problems when Allegiance takes over. As this article hopes to show, these concerns are largely unwarranted. For most of our members the shift should be seamless and transparent. While a major change such as this will inevitably cause some start-up pain and problems in a few cases, our members should be reassured that the Commissioner's Office, the Director of Benefits, all of our local benefits offices, Allegiance, and even Blue Cross/Blue Shield are all working together to ensure that the change-over goes as smoothly as possible.

The basic reality is this: last Spring Allegiance Benefit Plan Management was chosen as our new indemnity health plan claims administrator and will replace Blue Cross/Blue Shield of Montana on July 1, 2005. This decision was the end result of a year long bidding procedure and much debate and consideration by the Administrative Services Subcommittee, the InterUnits Benefits Committee (IUBC), and the Commissioner's Office. The process was long, complex, and even contentious at times, but the final decision was based on the legal requirements mandated by the State of Montana bidding procedures and the overall best interests of our Benefits Program. The final decision to award the Administrative Services contract to Allegiance for the two years was made by the Commissioner of Higher Education.

A change of plan administration is not just a simple shift in the company that processes our claims and pays our bills. We are doing far more than just buying administrative services; we are shifting our medical provider networks as well. This is where potential problems are likely to occur and this is the area where the greatest efforts have been made to date. Our goal has been to do no harm to our members in this transition and to try to expand our networks to insure that most if not all of us can continue to use our existing providers. The fears that our Medical Plan will somehow be diminished by this transition are simply without merit. In fact, some of us will see a modest expansion in our coverage and a modest reduction in our out-of-pocket costs. The details follow.

A flurry of questions about this change-over have come in to the Commissioner's Office and to the benefits offices on the various campuses. This article hopes to address these most frequently asked questions and to inform our members about the processes and procedures that will be followed during the transition period.

Q1. We have been well served in recent years by Blue Cross/Blue Shield. Why have we been forced to shift to Allegiance?

This transition was never about any general dissatisfaction with BC/BS or the fine services it has provided us over the years. It is a result of the requirements of Montana statutes and its bidding requirements. In brief, all services paid for with State funds and over a certain amount **must** be sent out to bid periodically (generally every five years but current contracts can be extended under some conditions). A Request for Proposals (RFP) is drawn up defining the parameters of the services required and then published. Sealed bids are then submitted before the deadline to the chief officer of the agency and then typically, these bids are reviewed by a committee (in our case the Administrative Services Subcommittee of InterUnits). Bids that fail to meet the minimum standards and requirements of the RFP are

then dismissed and a group of finalists are selected. The public phase begins and those still in the bidding are asked to submit their "best and final" offers. All finalists are then interviewed and a recommendation is then sent forward (in our case, to the full InterUnits Committee and the Commissioner's Office) for final approval. We followed these bidding protocols carefully and Allegiance won the bid. A fuller description of this process was written up in the March 2004 issue of the *Choices Newsletter* (available online in PDF format at www.montana.edu/choices).

Q2. Why would we choose an unknown entity like Allegiance over a nationally known consortium of health care managers like Blue Cross/Blue Shield? While it is true the "Blues" have greater name recognition than almost any other group of health care managers nationwide, Allegiance has a strong presence in our region and years of experience managing health care plans. Allegiance has been providing administrative services to companies, associations, and government agencies in the Intermountain region since 1981. Its current clients include such well known organizations as Washington Corporation, Montana

The Choices Newsletter

is designed to help

promote a sense

of our ownership

and responsibilities

within the program.

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Unified School Trusts (Montana public school districts), Northwest Energy, and First Interstate Bank. In order to provide broad access to health care for its clients, Allegiance has contract agreements with a number of national provider networks.

Q3. How will our health care plan change when Allegiance takes over? This question is based on an erroneous assumption: that Allegiance is now somehow in charge of our indemnity plan design. Nothing is further from the truth. We are a self-insured plan and the plan design is in our hands. Allegiance will become our Third Party Administrator (TPA) in charge of managing the plan that we have designed. It is our InterUnits Committee and the Commissioner's Office that recommends modifications to our plan (co-pays, deductibles, coverage, premium rates, etc.) and not our TPA. Like most years there will be some modest changes in our plan for FY 06, but these changes will be the result of decisions to be made at the Spring InterUnits meeting.

Q4. How will our Managed Care plans from New West, BC/BS of Montana, and Peak be affected by the transition to Allegiance? These plans are structured by the individual providers following guidelines of the Mt. Assoc. of Health Care Purchasers. There should be few if any changes for next year, and the good news is that the premiums are scheduled to go down modestly in FY 2006.

Q5. How will our pharmacy plan change? Eckerd (new name PharmaCare) is the administrator of our drug plan which is separate from our medical plans. We anticipate no changes in our pharmacy plan for FY 2006.

Q6. Will we be forced to change doctors? Probably not. The networks of Allegiance and BC/BS overlap to a large extent. Both have about 90% of all physicians in the State, but it is, of course, a different 90%. Therefore, you may find initially that your doctor is not in the Allegiance network, but that is unlikely to continue in the long term.

Let's take Bozeman as an example. Bozeman has been the one area of the State that historically has had the most problems with doctors reluctant to sign participating provider agreements. You may recall that when BC/BS was first chosen as the new administrator of the MUS plan, only about 50% of Bozeman's physicians were BC/BS providers. That went up to 90% almost immediately. The reasons were simple. MSU employees represent about one third of the total medical market in the Bozeman area and physicians did not want to jeopardize MSU's business by refusing to

participate. The exact same reality holds true for the transition to Allegiance.

If your current providers cooperate with BC/BS, there are really no reasons why they would not sign on with Allegiance, if they have not done so already. Their reimbursement rates (the money they make for a given procedure) will be essentially the same as BC/BS's; they can bill Allegiance directly; and claims will be paid in a timely manner. For the vast majority of providers the transition should be quite transparent as well.

Q7. I travel extensively and Allegiance does not seem to have anything comparable to the Blue Card program. What do I do out of State? While it is true that Allegiance has a regional rather than a national presence, they have contracted with a number of countrywide networks to insure that our members will have good access to care everywhere in the US. In non-emergency situations, you will be able to login to the Allegiance website and search for member providers wherever your travels may take you. In emergency situations you should just get the care you need. If the providers are in one of Allegiance's networks, the situation will be exactly the same as home; you pay the deductibles and co-pays and Allegiance pays the rest. In an emergency situation, always get the care you need and sort out the financial situation afterwards. You may be required to pay up front, but save your receipts and submit your claims to Allegiance. If the providers turn out to be in the networks, you will be reimbursed exactly the same as with your local providers. If they are out-of-network, Allegiance will intervene on your behalf and attempt to get the providers to accept their allotments as payment in full so that you will not be billed for the balances.

Q8. What do I do when traveling internationally? Again, you should always get the care you need. No network can possibly cover all members everywhere in the world. This is true of BC/BS as well as Allegiance. Save your receipts and submit your claims, and you will be properly reimbursed. It may be prudent for those who travel abroad frequently, especially those going to third world countries, to purchase international medical insurance and evacuation policies. Those engaged in professional activities can usually pay for this insurance out of their research grants. This advice is exactly the same as that which currently applies under BC/BS.

Q9. What about retirees living out of State? How will they arrange coverage? Allegiance currently has the addresses of all cov-

ered retirees in-state and out-of-state. They also have the recent claims records of all retirees. Allegiance will be contacting all of the out-of-state providers currently being used by retirees and asking them to sign preferred provider agreements. Since the allowed rates are essentially the same as those under BC/BS, there is little reason for providers not to sign.

Q10. How do I find out which doctors are in the Allegiance networks? The reenrollment period begins in mid April. Before that time, all members will be given access to the Allegiance Provider Lookup through a link on the *Choices* website. Members can use the Allegiance Provider Lookup to see if their provider is currently in the network. Nomination forms will also be available on the Allegiance link. If a member sees that one of the providers they currently use is not on the list, they can "nominate" them. Allegiance will then contact the provider directly and ask that they sign an agreement. Out-of-state retirees will be asked to nominate their providers in a similar manner.

Q11. How often will I have to pay for the cost of my medical care up front? That is difficult to say. If you go to a local participating provider, you should never have to pay anything but the applicable co-pays and deductibles. The provider will bill Allegiance directly and a "no balance billing" provision protects you from excessive charges. In the case of out-of-state or out-of-country providers, you may be required to guarantee payment up front, submit claims, and be reimbursed later. Of course, you should never forego needed care even if you are forced to pay immediately. Members who use participating providers should see few changes in costs or billing practices.

Q12. If I use a non-participating provider, will I be subject to the 10% penalty as I am now under BC/BS? No. Allegiance and MUS have agreed that, for the first year of the program and as the networks are being built up, there will be no reduction in allowable amounts or penalties for using a non-network provider. You should understand, however, that you may be subject to balance billing from the non-participating provider for the difference between the allowable amount and the amount billed.

Change is never easy and the transition to Allegiance is no exception. Yet members should be reassured that both the University System and Allegiance are going to extraordinary lengths to be certain that no harm is done to us in the interim period. ■

The Affordability Program

A year and a half ago Regent John Mercer asked the InterUnits Committee to address the issue of the affordability of dependent coverage for our lowest paid employees. The worry was that many of our fellow employees at the bottom end of the wage scale were not covering their children simply because of costs. An Affordability Subcommittee was established to look into this issue.

The goal was a simple one, but the task proved to be more complex than first thought. The Subcommittee set strict guidelines; they mandated that any program be fair, open to all employees below a certain wage level, strictly confidential, and that the program avoid any form of "means testing." They did not want to mandate that employees submit tax returns or other documents as proof of eligibility, as the Subcommittee felt this to be a violation of member privacy.

The program described below meets these strict requirements. It has been given preliminary approval by the InterUnits Committee at its Winter meeting and is being sent out to our campuses for review by our members before final acceptance.

■ The program will be considered a general expense to the plan, much like our Wellness Program. There will be no robbing of Peter to pay Paul; that is, there will be no taking away benefits from the upper end and transferring these funds to those less well off.

■ All employees with an annualized income of \$30,000 or less are eligible. This means that a part-time employee of .5 FTE, for example, and a MUS income of \$15,000 or less would be eligible. Remember that an employee must be, in general, at .5 FTE or higher to participate in our Benefits Plan.

■ The cost of the program will be reviewed every year and approved by the InterUnits Committee annually.

■ The affordability benefit will come in the form of a premium waiver for the coverage of children under the Medical Plan. Spousal coverage only will not receive the waiver, only "employee + child(ren)" and "employee + family." The benefit for next year is expected to be worth \$103 to \$110 per month depending upon the plan selected.

■ The program will be approved as a pilot program and evaluated on the basis of the overall costs of the waivers and the overall impact on our claims costs. Our best esti-

mate is that the first year of the program will require somewhere between \$400,000 and \$500,000 in plan funds. It should be noted that our reserves are currently healthy enough to meet this expense.

■ All employees will be offered the opportunity to sign up for the out-of-pocket dependent child(ren) fee waiver program at the next re-enrollment period beginning in the middle of April 2005. The payroll benefits office will certify eligibility by checking the employee's annualized MUS salary only.

■ The employee must actively sign on to the plan annually; it is not automatic. Those employees whose overall family income is high despite a low MUS salary and feel they do not need this waiver need not sign up. In fact, they are encouraged not to take the waiver so that the funds can go to those in greater need.

■ The names of those who sign up for the waiver program will be held in strict confidence by their respective benefits offices.

■ The Affordability Plan is scheduled to begin on July 1, 2005 and run through FY 2006. It is still subject to final approval by the InterUnits Benefits Committee and the Commissioner.

If you have any comments or suggestions concerning this proposal, you should get them to your InterUnits Benefits representative as soon as possible. The *May Choices Newsletter* will describe the final details of the plan and sign up procedures. ■

Corrections - The lead article in the last issue of the *Choices Newsletter* (December 2004) dealt with "Phased Retirement." The methods by which termination pay can be handled under PERS are more flexible than described in that article. While it is true that PERS members cannot directly use their total termination pay in the calculation of their final average salary as stated in the article, this termination pay can be used partially to enhance their retirement benefit. The procedure is somewhat complex, but basically involves using this pay to fill in those months where pay was less than their final months income. What happens is that the highest months then become the average months. Contact MPERA for details and a personal estimate. You can also save taxes by deferring as much of this termination pay as possible into your 457 or 403b plan. ■

The Winter InterUnits Meeting

The InterUnits Benefits Committee met in Helena on February 1, 2005. Glen Leavitt, the Director of Benefits, issued a very positive financial report. If the last 6 months' trends hold, Glen anticipates a surplus of \$1.0 to \$2.6 million in the indemnity plan alone. When the HMO surpluses are added in, the overall gain in reserves will be somewhere between \$4.6 to \$6.2 million at the end of the current fiscal year. Mellon Corporation, our consultants, concurred with Glen's assessment. Their worse case scenario has our reserves increasing \$3.5 million by June 30; the best case scenario projects an increase of \$6.1 million.

Because of the favorable economic situation, premium increases should be kept to a minimum. The State contribution will increase \$46 per month next year and this should be sufficient to cover increased costs. Therefore, we anticipate no increase in the premium rates for active employees in the indemnity plan. Those currently in one of the HMO plans will actually see a modest **decrease** in rates based on their good performances in the last year and a half. Retiree rates will rise a modest 4% next year. This is far less than increases in recent years. A chart outlining retiree rates for FY 2006 will be published in the next *Choices Newsletter*. The InterUnits Committee will also consider covering screening colonoscopies next year. The tentative plan is to pay for a colonoscopy in whole or in part starting at age 50 and then every 5 to 10 years thereafter. Details will follow in the next *Choices Newsletter*.

The Montana University System has used an Affidavit of Common Law Marriage to provide eligibility for opposite sex domestic partners. In December the Montana Supreme Court ruled that the affidavit did not establish a common law marriage, therefore, under the equal protection clause, if we are to continue such coverage we would have to offer similar coverage to same sex domestic partners. The IUBC reaffirmed its recommendation to provide such coverage. The Commissioner of Higher Education will make a recommendation to the Board of Regents at its March meeting. IUBC meets next on March 10. ■

Linda Ryckman Passes

Linda Ryckman, the Benefits Specialist in the Commissioner's Office, died unexpectedly after Christmas. All of those who worked closely with Linda and those members who asked her assistance in dealing with a difficult benefits issue witnessed her great skill, patience, and compassion over the years. Her knowledge, kindness, and helpfulness will be greatly missed. Deepest condolences go out to Linda's husband, family, and friends. ■

Legislative Update

The 2005 Montana Legislature began on January 3, 2005 and is scheduled to complete its work and adjourn by April 25, 2005. As we write, the Legislature is on transmittal break, but will resume its deliberations by the time you read this. There are a number bills before the Legislature that directly affect our benefits programs. Many MUS officials (including our own director, Glen Leavitt) have been monitoring these bills, attending hearings, and providing expert testimony. Listed are the most important of these bills, a summary of their provisions, and their current statuses:

HB 2 - General Appropriations - This general funding bill includes allocations for all of the campuses and the Commissioner's Office. Included is funding for scholarships, equipment, and program development for the University System. In Appropriations Committee.

HB 134 - Tax Credit for College Expenses - for MUS students. A credit of 10% of Hope Scholarship but not to exceed \$500. In Appropriations.

HB 181 - Increase Funding and Adjust Benefits in TRS - Would increase employer contribution rates including the ORP supplement to meet TRS's unfunded liabilities. In Appropriations.

HB 338 - Professional Retirement Option for TRS Members - Provides an enhanced benefit for those continuing to teach after reaching full retirement eligibility. In Committee.

HB 329 - Eliminate Allowing TRS and PERS Retirees to be Reemployed without Benefit Loss - would effectively end post-retirement employment. Died in Committee.

HB 430 - State Assumption of Supplemental Contributions to TRS for MUS ORP - The State would pay for the unfunded liability that resulted from the switch to the ORP instead of the employee. Strongly supported by MUS. Tabled.

HB 447 - Employee Pay Plan - A 3.5% increase in salary or \$1005 (whichever is greater) is proposed for FY 2006 and 4.0% or \$1188 for FY 2007. Also included in this bill is an increased State contribution to the Benefits Plan of \$46 next year (FY 2006) and \$51 the following year (FY 2007). Signed by Governor.

SB 72 - Continuing of Employer Provided Health Insurance as a Retirement Incentive - All employees eligible for a retirement benefit in any PERS plan would receive one year of employer contributions to their State health insurance plan for every 5 years of State service. Employees must have reached "normal retirement age" and retire between July 1, 2005 and October 1, 2005. The maximum benefit is 4 years of premiums and ends when the retiree becomes eligible for Medicare at age 65. Unfunded and must be paid for through vacancy savings. Passed a second reading.

There are a number of minor housekeeping bills in addition to those listed above. Those of you who wish to review the texts of these bills or track their status can find complete information on the Montana Legislature Website at <http://leg.state.mt.us>. As a citizen you have every right to make your wishes known to your representatives. Committee memberships and contact information is also available on this same site. ■

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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