

choices

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

Choosing Your Medical Plan

Everyone seems to like choices, yet sometimes the options are so daunting and so complex that members are likely to throw up their arms in despair and long for the “good old days” when one plan fit all. Nothing is more important to the welfare of you and your dependents as the medical plan you select and you must make this election every year during the re-enrollment period. A brief and informal survey of payroll/benefits personnel on the various campuses indicates that no other choice causes more confusion, more stress, and more questions during the annual Spring re-enrollment than does the selection of a medical plan. The truth of the matter is that this decision is critical and that one plan simply does not fit all.

How then is one to choose between the traditional indemnity plans and the more recent managed care options. If one decides to go the traditional route, there are two options to choose from: the Premium Plan and the Basic Plan, both administered by Allegiance. There are four managed care plans in the MUS program: Peak, New West, Blue Choice, and one administered by Allegiance, but not all are available in every geographic area in the State. Some areas have only one available plan. It must be noted by way of clarification that Blue Choice is **NOT** the same as our old indemnity plan administered by Blue Cross/Blue Shield of Montana, but a separate managed care plan of a totally different design. It is offered by BC/BS-MT and employs a similar but by no means identical network of providers and it does offer connections to the other “Blues” nationwide and internationally. However, Blue Choice does follow essentially the same plan design as the other two historical managed care plans in the MUS program: Peak and New West, and the new CHO plan administered by Allegiance.

Our active employees have had this complexity of choices for several years now. Up until now fewer options have been granted our retired members, but this is about to change. During the next re-enrollment period, **retired member will now be allowed for the first time to choose one of the managed care options** if offered in their current geographical area. In the past, the \$575 deductible plan was the only option available to under age 65 retirees and the \$400 deductible plan the only choice for our over 65 Medicare participants. Two years ago a high deductible \$1500 plan was added to offer all retirees a more affordable alternative. Remember that retirees no longer receive a State contribution and must pay their premiums wholly out-of-pocket. A high deductible plan was felt to be better than forcing some retirees off the plan because of increased costs. With the addition of the managed care plans, retirees now face a complexity of choices similar to those of our active employees, and it is further compounded by the fact that retirees choices cannot be changed as freely every year as can our active members. The choice of the high deductible plan is irrevocable for under 65 retirees until they reach Medicare eligibility at which point they can change plans. If a retiree chooses the high deductible plan after age 65, the decision is irrevocable forever. The coordination of benefits with Medicare adds additional complications for our older retirees. The point of this article then is to help both our active and retired members wade through these complexities so that they are informed enough to make the best possible choices during the upcoming re-enrollment.

1. The Basics of Indemnity Plans - Indemnity plans are designed to provide excellent catastrophic coverage for serious illnesses that might jeopardize a family's finances, but they offer little by way of “first dollar” coverage for routine medical care. They are structured on the principles of deductibles, co-insurance, co-payments and stop-losses. A **deductible** is the amount that must be paid first in any given plan year before insurance coverage begins. The family deductible amount is typically twice that of the individual amount. **Co-insurance** is the percentage amount that must be paid by the

member up to a certain maximum - the stop-loss. A **stop-loss** is the maximum amount paid out-of-pocket in co-insurance. After the stop-loss is reached, the indemnity plan pays 100% of allowed charges for the remainder of the plan year. Again, the stop-loss amount for a family is typically twice that of the individual amount. A **co-payment** is a set dollar amount that must be paid for any given benefit after which the plan pays the remainder. Co-pays are independent of deductibles and stop-losses and must be paid in every case.

The Choices Newsletter

is designed to help

promote a sense

of our ownership

and responsibilities

within the program.

(Continued on Page 2)

Choosing Your Medical Plan *(Continued from Page 1)*

The maximum financial liability that any individual or family might face in a given plan year can be estimated by adding together the deductible amounts for both the medical and the drug coverages, the stop-loss amounts, and any co-pays typically paid (for drugs, for example). This assumes that the member stays with network providers and uses preferred facilities. The use of a non-participating provider subjects the individual potentially to "balance billing" of uncovered amounts and the use of a non-preferred facility results in a higher co-insurance percentage and a resulting higher stop-loss amount. Remember also that certain treatments are limited by dollar amounts or number of visits (chiropractic services, substance abuse treatment, counseling services, etc.) and that other things are not covered at all (Botax treatments, plastic surgery, certain screenings, etc.).

If this all sounds complex, it certainly is. Yet every individual and every family should try to make a good faith effort to estimate their potential financial liability under any of these indemnity plans and be certain that a major medical catastrophe would not "break the bank." The same advice applies to our managed care plans, though the calculations are somewhat different.

2. The Premium Plan - The premium plan has a \$400 deductible per individual and \$800 per family. The coinsurance percentages are 25% for providers, 20% for preferred facilities and 25% for other facilities and these coinsurance amounts are applied to the first \$5,000 in coverage (after the deductibles are met) per individual and \$10,000 per family. This results in stop-loss amounts averaging \$1,250 per individual and \$2,500 per family (depending on whether preferred facilities were used or not).

3. The Basic Plan - The basic plan has a \$575 deductible per individual and \$1,150 per family. The coinsurance percentages are same as the premium plan (25% for providers, 20% for preferred facilities and 25% for other facilities) but apply to the first \$10,000 in coverage (after the deductibles are met) per individual and \$20,000 per family. This results in total stop-loss amounts averaging \$2,500 per individual and \$5,000 per family (again depending on facilities used).

4. Coverage Limitations and Co-payments under the Premium and Basic Plans - Coverage restrictions and co-pays are the same under both indemnity plans. There is a \$25 co-pay for an emergency room visit (waived if admitted). There are no deductibles on annu-

al mammograms and gynecological and prostate exams, and up to allowable amounts. Immunizations are fully covered up to \$250 annually for those under age 20 and up to \$75 a year thereafter. In addition \$50 per year is available for flu and pneumonia shots. Well child care is covered up to \$500 during the first two years of life.

The **Drug Plan** includes a \$100 deductible and co-pays of \$10 or 20% (whichever is higher) for generic drugs, \$20 or 30% for preferred drugs (formulary), and \$30 or 40% for non-preferred drugs (non-formulary). The mail order drug plan has no deductible and \$20, \$40, and \$60 co-pays for a 90 day supply of generics, preferred, or non-preferred drugs respectively.

The list above gives some of the basic restrictions in coverage and special co-payments, but it is by no means exhaustive. For a complete list go to www.montana.edu/choices or your enrollment workbook.

5. The Basics of Managed Care Plans - All of the managed care plans are quite different in design from the indemnity plans but essentially similar to each other. In the past managed care plans were known as HMOs. Our plans with Peak, New West, Blue Choice and Allegiance all follow a common design. The plans offer better coverage for preventative and routine care. The in-network deductibles are lower, but the networks themselves are far more limited and restrictive.

The networks themselves are often quite limited and there is some risk that the member will be required to travel some distance to see a network specialist. The consequences of going out of network are more severe than those of indemnity plans. In addition to the network deductibles and co-insurance, the member must meet a separate set of deductibles and co-insurance amounts when using non-participating providers. Despite these limitations, these managed care plans offer good value to those happy with their attending physician and willing to stay in network for the majority of their health care needs.

6. The Managed Care Plans - All of our managed care plans have two sets of deductible, coinsurance, and stop-loss amounts: one set for in-network care and another set for out-of-network providers. Both sets must be met separately. In-network the deductibles are \$300 per individual and \$600 per family. Co-insurance is 25% up to a maximum (stop-loss) of \$2,000 per individual and \$4,000 per family. The out-of-network deductibles

are \$500 and \$1,000 and the co-insurance is 35% up to a maximum of \$2,000 per individual and \$4,000 per family. Routine annual physicals, well child visits, and physician services require a \$15 co-pay. There is no co-pay for mammograms and a \$50 co-pay for prenatal care. Cardiac, speech, and physical therapy require a co-pay of \$15 per visit and are restricted to 30 visits per year. The emergency room co-pay is \$75 dollars, but is waived if the patient is admitted. Ambulance services require a \$100 co-pay. Co-pays for drugs are exactly the same as those described above for the indemnity plans.

Keep in mind that the description above is a broad outline of only some of the managed care provisions and that the Blue Choice, New West, Peak and CHO plans differ in some small details. For complete information you should review the respective plan documents at www.montana.edu/choices.

7. Deciding on a Plan - Armed with this background information we can now return to the central question that we started with: how are we to decide upon our medical plan? It should be obvious by now that one size does not fit all and that some plans are clearly better suited to some individuals and families in certain circumstances and stages in life and other plans to other circumstances. The following factors should be considered when electing a plan.

a. Medical Status and History - Review your medical records in recent years to determine your utilization patterns and out-of-pocket costs. Make a list of all of your family's providers and note which ones are primary care and which ones are specialists. Assess the health status of all of your family members and try to anticipate all of your medical needs in the coming plan year. A catastrophic event cannot, of course, be planned for, but past history is usually a good indicator of future medical needs.

b. Network - The provider network is everything. If you have a good existing long-term relationship with your doctor, you are probably reluctant to change providers. The indemnity plans have the most extensive networks. Over 90% of all medical providers in the State have signed agreements with Allegiance and most of the State's hospitals are in the network as well. The managed care plans have far more restrictive networks and the consequences of going out-of-network are far more severe. By law managed care plans can only be offered in geographical areas where there is a suffi-

(Continued on Page 3)

ciently large network of providers. Most of the larger areas of Montana including Billings, Bozeman, Butte, Dillon, Helena, Havre, Kalispel, and Missoula have such networks and active members and retirees living in these places are free to choose an available managed care plan. However, active members living in some of the more remote areas of the State and retirees living permanently out of State must remain with one of the indemnity plans for the lack of a suitable managed care network.

The next step in your decision making is to do a search of the network you are considering to see if your existing providers participate. You can review the networks of Allegiance, Blue Choice, New West, and Peak by following the links off of the *Choices website*. Many providers participate in more than one of these networks. If all of your current providers are in the network you are considering, you are lucky and free to choose based on other factors. If you are leaning towards a managed care plan and must change your primary care physician, you might consider "interviewing" the new doctor before you decide. Remember that your overall satisfaction with a plan will largely be determined by your relationships with the network providers.

c. Costs - The premiums for our managed care plans are approximately 8% lower than our \$400 indemnity plan and roughly on a par with the \$575 plan (the premium schedules for FY 07 are just being set and will be printed in the next *Choices Newsletter*). The managed care in-network deductible is lower and the coverage for routine care far better than those of the indemnity plans. The trade-off is a smaller network of providers and more limited access to specialists. When assessing costs, your out-of-pocket expenses must be factored in. If you are forced or choose to go out of network, the cost savings of these managed care plans can quickly evaporate.

d. Retirees - Retirees have special considerations. Most have long term relationships with their providers and are understandably hesitant to change providers in order to join a managed care plan. Older individuals are more likely to require the services of specialists, something less restrictive in an indemnity plan. Nonetheless, those retirees in reasonably good health and with a provider network that they can live with will likely find the managed plans offer good service and good value. They now have the managed care option before them for the first time. They might well consider trying

one of these managed care plans for a year. The decision is not irrevocable and if after a year they are dissatisfied, they can return to their indemnity plan during the next re-enrollment.

e. Restrictions on Choices - Active members can choose any plan without restriction and change to any other plan during the following re-enrollment period. The only exception to this are the Dental Plans (Basic or Premium) which require a two year commitment. Retirees have slightly more restrictions. Under 65 retirees can now choose among the \$575 plan, the high deductible \$1500 plan or a managed care plan if available in their area. If the early retiree chooses the \$1500 plan, they must live with it until age 65 or opt for a managed care plan. If they choose to return to an indemnity plan, they will revert to the \$1500 plan. At age 65 a retiree can choose among the \$400 plan, the \$1500 plan, or a managed care plan. Once the \$1500 plan is chosen, it becomes the only indemnity option available for the rest of the member's life. However, the retiree can switch every year, if they wish, between their indemnity plan and a managed care plan.

8. The Bottom Line - Managed care plans are very well suited to reasonably healthy individuals and families with routine medical expenses. Their "first dollar" coverage for routine and preventative services is better by design. Members and families with ongoing and serious medical issues, especially those under the long-term care of a specialist, might be better off staying with an indemnity plan, but even here, there may be situations where a managed care plan might serve them equally as well. Retirees might be more mobile or living out of State and a nationwide network of providers will be key to their decision. No one knows if and when the "big one" will hit, but rest assured that the catastrophic coverage in all of these plans is excellent. You cannot go far wrong with any of these options, and, if dissatisfied, you will be allowed to change plans every year during re-enrollment. ■

Tax Tip

It is not too late to contribute to a Roth or regular IRA for 2005. You have until April 17 to make your contribution of up to \$4,000 (or \$4,500 if over age 50) and the regular IRA may be eligible for tax deferral. See your tax workbooks or accountant for IRA restrictions. Note that you may make this contribution even if you have already filed your tax returns. ■

The InterUnits Benefits Committee met in Helena on February 2 and March 9, 2006. Glen Leavitt, the Director of Benefits, shocked everybody at the Winter meeting by announcing his retirement at the end of March 2006. He and Buck Consultants issued financial reports at both meetings. Our favorable claims records continued to hold through the first three quarters of FY 06 and our surpluses remain in a very healthy state. As a result, premiums will remain essentially the same for active employees next year, raise only modestly for under 65 retirees, and actually decrease 18% for older retirees as a result of the Medicare subsidy (see page 4 for details).

Several plan changes were proposed at the Winter meeting, reviewed at on-campus employee meetings that followed, and passed at the Spring meeting. These plan changes include: a lifetime cap of \$2 million per individual and \$4 million per family on all medical plans, skilled nursing care limited to 70 days per year and hospice care to 180 days, outpatient therapies limited to \$2,000 per year but up to \$10,000 with prior authorization, chemical dependency coverage increased to \$7,000 per year and \$14,000 lifetime and transplant maximums were set. The above 65 retiree plans and premiums were altered to qualify the plans for the Medicare subsidy. Finally, retirees will be allowed to elect the managed care plans where available. ■

The Director's Chair by Glen Leavitt

This will be my last appearance in this column as I will be joining the retiree ranks on April Fools Day. As there always is with transitions, I have mixed emotions. I served as a member of the InterUnit Benefits Committee from one of the campuses for 16 years, and have been even more involved with the benefits program as Director of Benefits for almost eight years. The health plans have changed a lot in that time.

Working with the IUBC and the HR/Benefits people on the campuses is one of the things I will miss. The committee has had to make some tough decisions over the years. Balancing the needs of our higher-ed community with the fiduciary duty to keep the plan solvent can be difficult. Your committee has always had free-wheeling open discussions. Comments from the audience, whether from those who will be affected by plan or premium changes, or those HR folks who will have to actually implement them, are always considered. The committee has never been a rubber stamp for the administration or any other group. We are lucky to have colleagues who are willing to take the time and make the effort to serve on the IUBC. ■

Questions & Answers

Q I am about to retire at the end of June and have been told that retirees are no longer eligible for dental coverage. I have periodontal disease and must see my dentist regularly. I do not understand why I cannot continue my dental plan if I am willing to pay the full cost of the coverage out-of-pocket? J.V., UM-Missoula

A. There is good news for you, at least in part. A new reading of the very complex Federal COBRA legislation by our COBRA administrator has determined that everyone leaving service for any reason (and that would include all those about to retire) is eligible to extend their dental coverage for a period of 18 months under these Federal mandates. COBRA was originally designed to handle the transition periods between jobs when a worker may lack medical coverage. As it turns out, the transition into retirement is covered as well.

To be eligible, you must apply for coverage during the COBRA qualifying period at the time when you first retire and you must pay the full cost of the dental plan plus a 2% surcharge. This would mean that the individual would pay \$37 per month for the Premium Plan and \$17 for the Basic Plan. The employee + spouse would pay \$66 for the Premium Plan and \$29 for the Basic Plan. Long-term retirees are no longer eligible for COBRA. Those about to retire who wish dental coverage should contact Allegiance COBRA Services at 406-721-2222 to sign up and to make arrangements for payment.

This year the InterUnits Benefits Committee also looked into the possibility of offering a dental plan for all retirees and determined that it was

impractical. The only way that a dental plan would be affordable would be to make coverage mandatory for all retirees. This would seriously impact our lower income retirees already struggling to pay for their medical plan. An optional dental plan would cost individual retirees \$81 a month and an additional \$81 for a spouse. IUBC deemed that amount excessive and tabled the proposal. ■

Q Last year I read in the Choices Newsletter that Medicare would be offering a subsidy to all insurance plans that continue drug coverage for over 65 retirees and that subsidy would go to premium reduction. Yet my premiums went up again this year. What gives? M.S., UM-Retiree

A. Like so many things the Federal government does, the Medicare Reform Act that instituted Part D drug coverage was quite complex and the requirements to meet eligibility for the subsidy extremely convoluted. We were required to make certain changes in our program and demonstrate that our pharmaceutical coverage was "creditable," that is to say, at least as good as the Medicare Part D Plan. Good news. We have finally met all of the Federal eligibility standards for next year and will be receiving a subsidy of approximately \$174,000 per month. This infusion of money from the Medicare program must go, by law, directly to subsidize premium costs. **This will result in a premium reduction next year for over 65 retirees of approximately \$42 per member per month** and corresponding reductions in other categories. A complete schedule of premiums for FY 2007 will be printed in the next Choices Newsletter. ■

CHOICES NEWSLETTER

JERRY COFFEY, EDITOR
ENGLISH DEPARTMENT, MSU
BOZEMAN, MT 59717-2300
PHONE: (406) 994-5327
E-Mail: choices@english.montana.edu
WEBSITE: www.montana.edu/choices

DIRECTOR OF BENEFITS

PAUL BOGUMILL
MONTANA UNIVERSITY SYSTEM
46 NORTH LAST CHANCE GULCH
HELENA, MT 59620-3201
(406) 444-6570

BENEFITS PROVIDERS

ALLEGIANCE (877) 778-8600
BC/BS-MT (800) 820-1674
NEW WEST (800) 290-3657
PEAK (406) 723-3783
FACULTY STAFF ASSISTANCE PROGRAM
APS (800) 833-3031
MANAGED CARE (800) 782-3083
PHARMACY PROGRAMS
PHARMACARE (888) 645-9303
RIDGWAY (800) 630-3214
STANDARD INSURANCE
LIFE & LTD (800) 759-8702
VSP (800) 877-7195

RETIREMENT SYSTEMS

PUBLIC EMPLOYEES RETIREMENT ADMIN.
(406) 444-3154
TEACHERS RETIREMENT SYSTEM
(406) 444-3134
TIAA-CREF (ORP)
(800) 842-2009

ANNUITIES/DEFERRED COMP

MT DEFERRED COMP (800) 981-2786
AETNA (800) 542-0425
METLIFE (406) 452-7250
SCUDDER (800) 323-6105
T. ROWE PRICE (800) 638-5660
TIAA-CREF (800) 842-2009
VALIC (800) 448-2542

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.

MISSOULA, MT 59800
PERMIT NO. 536
PAID
U.S. POSTAGE
ORGANIZATION
NON-PROFIT

choices
Benefits Program
Montana University System
46 North Last Chance Gulch
Helena, MT 59620-3201

