

choices

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

New Self-Audit Awards

■ We have met the insurance company and it is us. One of the greatest misconceptions that many of our members hold is that our insurance company is really Allegiance, New West, Blue Cross-Blue Shield, or Peak and that somehow these faceless corporate entities just dip into their endless store of funds to pay our claims and that we have nothing to worry about. Nothing could be farther from the truth. We are the insurance company. **All of our indemnity plans and all of our managed care plans are self-insured.** We design our own plans; decide on coverage, coinsurance rates, deductibles, and premiums; and we contract with Allegiance, New West, Blue Cross-Blue Shield, and Peak to administer our plans and pay claims out of our finite pool of funds. When the money runs low, we have only two recourses: raise premiums or reduce coverage.

Understanding this, we then realize that whatever money we are able to save by being wise medical consumers will, in the long run, help offset future premium increases. Saving money for the system is not easy, however. Most patients and providers are reluctant to talk about costs. Hospitals and physicians sometimes provide only summary statements that make it impossible to audit the account for accuracy and duplicate billings. When we question a charge or a cost, we are often told not to worry: "the insurance company will pay for it." Those on Medicare or those with a secondary insurance company through a spouse learn quickly that it is almost impossible to find out the amounts billed or who pays what as benefits are "coordinated." We pay our co-pays to Pharmacare or Ridgeway and never know the true costs of our medications billed to the plan. It almost seems, at times, like a grand conspiracy to keep us in the dark about the true costs of our medical care. How then are we to be wise medical consumers, when it is almost impossible to find out what our real costs are?

The point of this article is to provide strategies for saving ourselves and the plan money by being proactive when entering the "system." Few of us would purchase an appliance or a car without exploring the costs of ownership. Yet for some of us, our health care costs may be our "biggest ticket" in any given year. Yet few of us check prices or coverage beforehand, audit our bills afterwards, or even know what the true costs are. Granted that the medical "marketplace" is unlike any other. Usually we cannot decide to delay our "purchases" and most certainly all of us want the best care possible regardless of price. Yet the most expensive treatment is not always the best treatment and there are a number of ways we can get the best care possible and save ourselves and the plan money in the process.

As an incentive for encouraging us to monitor our billings for duplicate or unprovided services, the MUS Benefits Plan will institute the Self-Audit Awards plan on October 1. It is often only the patient who knows what services were actually provided. If the hospital bills for three MRIs, for example, and the member only received two, the current system has no way of picking up that error. The Self-Audit Awards will split the savings with the member up to \$1,000 for any billing errors first detected by the member. The details of this incentive program follow our list of cost-saving/care-enhancing strategies.

1. Cost-saving/Care-enhancing Strategies: Preserving your health and saving the plan money are not necessarily opposed. Sometimes the best treatment plan is not only good for your health but for your pocketbook as well. You may be familiar with and practice some of these strategies already and some may be new to you. All are designed to provide you the best possible care while saving the plan money in the process:

1. An Ounce of Prevention - The greatest savings come obviously from not getting sick to begin with. You have heard it all before: eat well, watch your weight, get exercise regularly, make sure your im-

munizations are up to date, etc. We all know what needs to be done. The point is that now we actually need to do it.

2. Participate in your Wellness Program - The annual WellChecks and health screens can detect problems early when they are easily treatable. You know that it is just possible that one of these screens could actually save your life and save the plan a ton of money in the process. Yet the data show that we seem to be making little progress on the Wellness front. The statistics on hypertension, diabetes, obesity, and cholesterol never seem to

The Choices Newsletter

is designed to help

promote a sense

of our ownership

and responsibilities

within the program.

New Self-Audit Awards *(Continued from Page 1)*

improve from one year to the next. It is never enough to detect a problem. We must take the next step and actually do something about it. So get with a Wellness dietician and fitness advisor, make a plan, start it, and stick to it. Most Wellness services are free or available at a very modest cost.

3. Get a Gatekeeper - Develop a long term relationship with a primary care network provider. This may be a family practitioner, gynecologist, pediatrician, nurse practitioner, physicians assistant, or internist, depending upon the age and gender of the individual, but all members and all dependents need a gatekeeper. This individual should have your complete medical history including immunizations, medications, and allergies and should serve as a repository for all of your medical records from other providers. The gatekeeper can then insure that your screenings and immunizations are up to date and advise you as to how to enter the system should any serious problems come up.

4. Get an Advocate - If you must be hospitalized or begin long-term treatment for a serious medical problem, do not go it alone. You may well be sedated or unconscious at times and unable to monitor your own treatment. Your advocate (typically a spouse, parent, or close friend) can watch to be sure that you are being given the care you need and that you are not forgotten in the hubbub of the modern hospital. This same advocate will also be aware of the treatments you have received and be in a position to review your billings for accuracy and duplication.

5. Get a Case Manager - When a serious medical issue arises, you need help navigating the complexities of the health care system. A case manager works to insure that you get the best possible treatment in the timely fashion. For example, your case manager can help arrange services at a "Center of Excellence" for such things as specialized cancer treatments, stem cells, transplants, etc. Data show that using a center that specializes in the particular procedure usually results in a better outcome. Cathy Reagor, RN, is our contract case manager and works at the Montana State Benefits Bureau. Any MUS member in any of our plans who is dealing with serious medical issues is free to call Cathy directly at 1-800-287-8266, ext. 3853 for a free and confidential consultation.

6. Use Urgent Care Where Appropriate - Many of the problems that show up at the emergency room could more easily be dealt with at an urgent care center. All emergency rooms triage and if your problem is consid-

ered minor, you might have to wait a long time for your care. If your visit is not followed by a hospital admission, you will be assessed a \$50 co-pay as well. So for non-life-threatening emergencies such as cuts, ear aches, abrasions, or even simple fractures, go to your urgent care center. You will get excellent treatment quickly and save both yourself and the plan money.

7. Use the Speciality Drug Program - The markup on genetically engineered biotech speciality drugs and cancer infusions is enormous. If you are required to take one of these drugs, call Cathy Reagor, our case manager. She is usually able to obtain these medications at "less than wholesale" and will waive all co-pays and deductibles. She can even arrange the administration of these drugs at a local infusion center. Again, you save and the plan saves.

8. Use a Mailorder Pharmacy for Maintenance Drugs - If you are required to take a drug on a regular basis (90 days or more), use the Pharmacare or Ridgeway mailorder pharmacy. Your out-of-pocket costs will be considerably less than had you used a network pharmacy and the plan will save money in the process.

9. Stay in Network - Your costs are always less if you use a network provider. Use the search tools linked to the *Choices Website* to determine whether your physician or specialist is in network. If forced out-of-network, you should always ask if the provider would be willing to accept the MUS allotments as payment in full and not "balance bill" you.

10. Talk to Your Providers About Costs - Have that conversation. There may be less expensive alternate treatments that are equally effective. Do not accept the statement: "Don't worry. The insurance company will pay for it." It is our money and when we save, you save in the long run.

11. Get Full Statements and Audit All Charges - Hospitals are allowed to give you only summary statements. These statements make it impossible for you to audit bills for duplicate or unprovided charges. However, you are entitled by law to a full and complete itemization of all services rendered, but you must request it. Always ask for a complete and fully itemized statement and audit it very carefully. Should you detect errors that save the plan money, you could be the richer for it. The new Self -Audit Award program begins on October 1 and the plan will share savings with you for any billing errors you detect. Details follow.

II. The Self-Audit Awards: Check bills from your medical providers to make sure you have not been double-billed for services or billed for services you haven't received, and receive an award of 50 percent of identified overcharges up to \$1,000.

Plan members who identify overcharge errors in medical bills which:

- a. Have not already been detected by the Plan's claims administration company or reported by the provider;
- b. Involve charges which are allowable and covered by the MUS Employee Benefit Plan; and
- c. Amount to \$50 or more in over charges

may be eligible to receive a self-audit award of one half of the savings obtained from billing adjustments, up to a maximum of \$1,000.

To receive this self-audit award, the member must:

- a. Notify the claims administration company of the error before it is detected by the claims administration company or by the health care provider;
- b. Contact the provider to verify the error and determine or work out a correct billing; and
- c. Have copies of the corrected billing sent to the claims administration company for verification, claims adjustment, and calculation of the self-audit award.

The new Self-Audit Award Program begins on October 1, 2006 and applies to provider charges incurred after that date.

III. Conclusions: Nothing in this article should imply that providers are necessarily greedy or dishonest. Physicians are properly focused on the best possible treatment for their patients and often do not know the actual costs of various procedures or drugs they prescribe. Most are amenable to saving the patient money whenever possible. Nor are all or even most overcharges fraudulent. We are dealing with extremely complex systems that often result in mistakes. You should never ever accuse a provider of dishonesty. Just report the mistake to your plan administrator. They see large amounts of data and are in the best position to separate deliberate fraud from honest error. After all, we must remember that providers and patients alike are all engaged in the same struggle to keep the best care affordable for us all. ■

Reenrollment Data

This last Spring during our annual reenrollment, our members had more options than ever in choosing their medical and supplemental plans. Allegiance was added to the list of our managed care plans and for the first time ever our retirees were allowed to choose one of the managed care options. The data are just now in on the choices we made and reveal interesting information about who we are as a group and some interesting trends.

Members include the employees, spouses, and eligible dependents (mostly children.). Our numbers went down slightly last year from 16,949 to 16,003 members despite an increase in the number of MUS employees. There was a drop in the percentage of younger members and a corresponding increase in older members. Many explanations are possible. Some children and dependents may have shifted over to coverage under a spouse's plan, but this probably does not account for the entire decrease.

The data strongly suggest that many of our employees are dropping coverage on their dependents and allowing them to go "naked" or enrolling them every other year and concentrating health care in the covered year. This is never a good idea. For one thing, such "cherry picking" adversely affects the plan's finances and increases the average age of our members. Should a catastrophic event occur to that uncovered individual, it would likely destroy the family financially. Furthermore, all of us end up paying in the long run. We estimate that a third or more of our total claims dollars are the result of "cost shifting"; that is, those of us with good insurance pay more to cover those who are uninsured and cannot pay.

We urge all members to cover all of their dependents all of the time. Premiums for spousal and dependent coverage are below our real claims costs and are, in effect, being subsidized. Last year we introduced the Affordability Program that allows our lower paid employees to cover their children for free. See your HR office for eligibility requirements and details. In short, MUS is committed to keeping coverage available for all of our member's dependents. Do your part and make sure that they are enrolled.

The drop in dependent coverage this year resulted in an increase in the mean age of our members from 40.85 in FY06 to 42.01 in FY07. We are, as a group, older than the national average and that places us at a higher risk for claims (a 1.2 ratio compared to an average risk ratio of 1.0).

The 16,003 total members are made up of 13,620 active members and their dependents, 570 under 65 early retirees and 1,813 Medicare participating retirees. A total of 10,199 members enrolled in our indemnity plans and 5,804 members in one of our managed care plans - 1,517 in BC/BS, 3,898 in New West, 357 in Peak, and 32 in Allegiance. Only 55 retirees choose one of our managed care options.

The mean age of members in our indemnity plans is 46.23. Our managed care enrollees are much younger with a mean age ranging between 32 to 35 for the various plans. This is understandable since the vast majority of our retirees are in the indemnity plans and the lower rates and better first dollar coverage in the managed care plans make them very attractive to younger families. Director of Benefits, Paul Bogumill would like to see growth in our managed care options: "These are good plans and appropriate for all of our members of any age. Many of our members fail to understand that all appeals are done in-house by me and my staff for all of our plans. Cases sometimes fall between the cracks or require an experimental treatment as yet unapproved. When that appeal hits my desk, I will give it the same consideration regardless of which plan the member is enrolled in. The rights of appeal and the exceptions granted are exactly the same under all of our plans." Perhaps this reassurance will encourage more of our members to try one of our managed options during the next reenrollment period. Remember that this election is only a single year commitment. ■

Benefits Expert Hired

Susan Schmitt recently joined the MUS Benefits staff at OCHE as a Benefits Analyst. She is a 1975 graduate of Montana State University with a degree in Health Education. Sue brings thirty years of experience in medical insurance, accounting, human resources, teaching, and customer service to the OCHE Benefits Office. Her position will roll all of her skills into one job, where she will be working with the Medicare Drug Subsidy Program, retiree problems, quality assurance, contract issues, and backup for specific accounting tasks. Sue is especially knowledgeable about retiree issues and Medicare. Retirees and those approaching retirement with concerns and questions should feel free to contact her. You can reach Sue at 406-444-0614 from 12 to 5 Monday-Friday or e-mail her at sschmitt@oche.montana.edu. ■

The Director's Chair

by Paul Bogumill

Employer Sponsored Health Plans like ours will continue to shoulder the burdens of our health care system, especially here in Montana. Nationally, the number of Americans without health insurance grew by nearly 1.3 million, the sixth straight year it has increased. Nearly 46.6 million people are now uninsured, the U.S. Census Bureau reported earlier this month. If that doesn't push health care into the center ring of the 2008 election circus, it is hard to know what will.

These changes have major impact on our own MUS health plan that we all depend upon. That's because the cost of caring for people without insurance is covered either by tax dollars (through Medicaid, which makes payments to hospitals based on their number of uninsured patients), or by "cost-shifting." That's a long-standing practice by hospitals of charging people with insurance more than what it costs to care for them; the extra money covers care to those who cannot pay. Some experts estimate that the cost shift adds \$900 a year to the premiums of plans like ours. To make matters worse, Congress has recently voted to cut billions of dollars from Medicaid, which will further increase the "cost-shift" to us.

To stem the tide of this shift, we will be incorporating a number of plan enhancements over the next few months and into our '08 benefits offerings. We will initiate new disease management program for diabetes and depression. New medical, dental, and vision plans are in the offing. We will be sending out to bid our supplemental (403b) retirement plans and we hope also to offer a Roth 403b program just as soon as the Federal legislation and regulations are in place. In short, it should prove to be an exciting year with many plan changes on the way.

Communications of these changes will be key to their success. The MUS plan is blessed to have strong top-down communications programs through this newsletter and our IUBC and campus benefits representatives. We are well positioned to stay ahead of this inflationary trend. But to do so, we all must stay involved and make every effort to become wise and well-informed medical consumers. ■

Questions & Answers

Q Both my wife and I are MUS employees. We are both approaching 65 and will soon be eligible for Medicare. I will continue to work, but my wife plans to retire at the end of the school year. We are confused about what to do about Medicare Parts A, B, and D and when to sign up for Social Security. Help! J..M., UM - Missoula

A. You should both begin the process of signing up for Medicare Part A three months before you turn 65 regardless of your employment status. Notify your HR office when Medicare begins so that your premiums can be adjusted (lowered). When your wife retires, she should immediately sign up for Part B as well. At that point, your health insurance situations are different. As an active employee, MUS pays first and Medicare pays second. For your retired spouse, Medicare is primary and MUS secondary. Neither of you should sign up for Part D (the Medicare Drug Plan). The MUS drug plan is far superior and there will be no penalty for enrolling in Part D later on should you decide to leave the MUS plan. **You could lose your MUS eligibility by signing on to Part D.**

You fail to mention whether or not you are a veteran and eligible for Tricare for Life. This adds another complication. Tricare is the medical and drug plan for active and retired military. All active military members and many retired former military are eligible to receive benefits. The eligibility requirements are complex, so call the Defense Enrollment Eligibility Registration System (DEERS) at 1-800-538-9552 to be certain you qualify for the free Tricare for Life program. If you do, enroll in Medicare Parts A and B when you turn 65 and the Tricare for Life plan. Since Tricare has an excellent drug plan, you will not require that coverage from the MUS plan.

The Federal government subsidizes the Tricare program and you will be getting equivalent or better drug coverage with very modest copays. MUS is currently negotiating a "Medigap equivalent" policy that will wrap around the Tricare plan. Since Medicare and Tricare will pick up most of the liability, our Tricare "gap" policy will have very low rates. You can find more information on Tricare program at www.tricare.osd.mil and stay tuned for details on our new "Tricare gap" policy.

The advice as to when you and your spouse should begin taking your Social Security benefits is complex. You are eligible for benefits starting at age 62, but for active employees it is probably not wise to begin this early. Your benefits will be reduced permanently and because your income will likely exceed \$12,480, your benefits will be reduced further until you reach the age of full Social Security eligibility (66 for those born between 1943 and 1964 and gradually moving up to age 67 for those born thereafter). See your annual S.S. statement for your specific eligibility dates and estimate of benefits at various ages.

Once either or both of you reach your full eligibility ages, there is probably little reason to delay. Your spouse will be eligible for a benefit based on her own income or on the spousal benefit, whichever is greater, and you will be eligible to receive full benefits regardless of how long you continue to work or how much income you earn. Those at higher income levels will be required to pay income tax on part of the benefit however. Consult a financial or tax advisor on the timing of benefits and on the resulting tax consequences. More information on these issues can be found at www.medicare.gov and at www.ssa.gov. ■

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.

CHOICES NEWSLETTER

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