

choices

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

The Choices Newsletter

is designed to help

promote a sense

of our ownership

and responsibilities

within the program.

The New Dental Plan

The dental plan has always been the neglected step child of our benefits program. In the past the plan was bundled with our medical program and, since the revenues involved were quite small in comparison to our medical claims, the dental program was rarely looked at closely. This all changed last Fall when the dental plan began losing money. In fact, in the last two quarters of 2006 dental expenses exceeded revenues by 19%. As a result the IUBC, at their Fall meeting, decided to unbundle the dental plan from the medical plan and to send it out to bid separately. The hope was that we might get an even better plan which could include restorative coverage for children, a modest orthodontic benefit, coverage for our retired members, and all of this at a cost no greater than our current plan.

An RFP was prepared by Mercer, our plan consultants, and a review committee went over and ranked all bids and made their recommendations. Allegiance, our current dental plan administrator, came in second to Delta Dental. Delta's bid was accepted at the recently concluded InterUnits meeting and will be our new dental administrator starting July 1, 2007. The bidding process was successful in almost every respect. Children will be allowed on the Premium Plan and their restorations (fillings, crowns, etc.) can now be covered. An orthodontic benefit with a \$1500 lifetime cap will be added for both children and adult members and for the first time ever retirees will be allowed to enroll in the Premium Plan. The currently required two year commitment to either the Basic or the Premium Plan will end and active members will be able to elect either plan every year during the re-enrollment process. And the ultimate good news: premiums for this improved plan will be roughly comparable to rates currently being paid.

The Delta Dental Plan has a fairly standard design. It is a scheduled plan rather than a network plan. This means that procedures are paid at a fixed or scheduled rate regardless of whether or not you use a network provider or irrespective of what they charge. For example, you will be reimbursed \$72 for an adult prophylaxis (cleaning) and if your dentist charges \$80 for that procedure, you will be responsible for the balance. In most ways a scheduled plan simplifies things. You can ask your provider to give you an estimate of costs for each procedure, look at the MUS scheduled benefit, determine your out-of-pocket expenses, and budget accordingly. And if you are certain to get your required dental work done in a given plan year, you can even "flex" your out-of-pocket costs and pay for them with pre-tax dollars. The Delta Plan is designed to cover preventive procedures (annual oral exam, semiannual cleanings, x-rays, fluoride treatments and sealants) at 100% of charges. The Basic Plan covers only this preventive care. The Premium Plan, in addition to this preventative coverage, will pay for minor restorations (fillings) at approximately 80% of costs, and major restorations (root canals, crowns, dentures) at 50% of average charges. Both plans will cover surgery for impacted teeth. Purely cosmetic procedures (whitenings, caps, etc.) are not covered by either plan. There will be a plan year benefit maximum of \$750 per enrolled individual on the Basic Plan and \$1,500 per enrolled individual on the Premium Plan. The schedule of benefits can be found at www.deltadental.com.

Even though the Delta Plan is not technically a network plan, members who use one of the Delta Dental Premier or Delta Dental PPO providers will not be "balance billed" above the allowed fees for services due to the provider's contract with Delta Dental. Remember that our new plan only partially covers minor and major restorations under the Premium Plan, so members can expect to pay some out-of-pocket for those services. Since signing

the MUS contract Delta is now actively expanding its network in Montana. The current list of Delta Premier and PPO providers can be found at: www.deltadentalins.com/directory/index.html. The network list is limited for Montana at the present time, but should expand considerably by the time the new dental program begins on July 1. Updated provider lists will be made available at the time of enrollment.

The exact premiums have not been set yet, but they will be roughly comparable to the rates currently being charged. The retiree rates are not yet available either, but all of these premiums will be made known well before the re-enrollment deadline and will be published in the next *Choices Newsletter*. Employees will be required to enroll in the Basic Dental Plan at a minimum. Optionally, they can select the Premium Plan for themselves and elect to cover their spouse and/or children in either the Basic or the Premium Plan. For retirees and their families, electing the Premium Dental Plan for themselves and their dependents will be completely optional. However, retirees must sign up in the up-coming reenrollment period, and if they should ever in the future drop their dental coverage, they can never get back on the plan. The best advice is to look at you and your family's dental health, anticipate your needs in the coming plan year, and select the most appropriate coverage. Remember that restorations as the result of accidents will continue to be covered under the medical plans. Regular dental exams are essential for the early detection of oral diseases and cancers and for your overall health. Gum disease, for example, is often a major contributing factor in coronary disease. Some 35% of our members never file a claim in any given plan year. That means that they fail to get regular dental exams and their teeth cleaned even though our insurance covers their costs. So sign up for the new Delta Dental Plan and then use it. Get thee and thy family to the dentist at least twice a year. ■

The Redesign of the Medical and Pharmacy Plans.

Change is the enduring reality of all medical plans and in the upcoming re-enrollment, our members will see even more change than usual. While our reserves remain healthy at the present time, projections based on current trends have put some fear for our future fiscal health in the minds and hearts of all of our InterUnits representatives. Even with the increases in the State contributions proposed in the Governor's budget for the next biennium, Mercer anticipates that we will start bleeding money by the end of FY 2008 (just a year from now). Going out a year further into FY 2009, the projections are even grimmer: we will incur \$1.08 in costs for every dollar in income.

There is little we can do on the revenue side to maintain our fiscal balance, since our income is largely dependent on the decisions of the Montana Legislature. Since we are self-insured, we are required to keep our books in balance and we can only do this by plan redesign and by plugging the leaks when we find them. It is these fiscal realities and the continuing complexities and challenges of our health care system that lead to these constant plan redesigns.

The following are the major changes in our medical and pharmacy plans. Some are in effect at the present, but most will be implemented on July 1:

1. The Indemnity or Traditional Plans - The traditional plans have been almost completely redesigned and the new buzz word is not deductible and coinsurance but "steerage." Last year we discovered that our hospital claims costs rose dramatically in both Billings and Missoula, the result of losing the deep discounts that these area hospitals had provided us in the past. Billings and Missoula are the only two communities in the State with competing hospitals and providers are unwilling to offer us those deep discounts unless we "steer" the majority of our members to one hospital rather than the other. Hence, it made good economic sense for us to restructure our plans to include a "steerage" component.

Starting July 1 there will be two options in our indemnity offerings: Plan A and Plan B. Plan A incorporates steerage and a restricted hospital network (steerage) with severe penalties for going out-of-network. Plan B has a wide open network (no steerage) but the premiums will be considerably higher. In Missoula the preferred hospital will be St. Patrick's and in Billings, St. Vincent's. If one signs up for Plan A and chooses to go

to Community Hospital in Missoula or the Billings Clinic, your coinsurance payments will be higher, you will be subject to "balance billing" by the hospital, and those payments will not be applied to your out-of-pocket maximums. These penalties will not be assessed in an emergency situation and you can and should go to the nearest hospital. Maternity services at Community Hospital in Missoula and psychiatric services at the Billings Clinic will be treated as if in-network and no penalties will be levied in these cases.

Plan A will have steerage in Billings and Missoula only, a \$400 deductible, 25% coinsurance, and an out-of-pocket maximum of \$1250 per individual and \$2500 per family. Plan B will have no steerage, a \$600 deductible, 25% coinsurance, and out-of-pocket maximums of \$2500 per individual and \$5000 per family. The rates for these plans have not been set yet but we anticipate that despite its higher maximums and deductibles, Non-steerage Plan B will cost 10% to 15% more than steerage Plan A. Retirees will have open enrollment this year only and will be allowed to choose between Plan A and Plan B. An additional option of Plan B with a \$1500 deductible will be offered to retirees only.

For most of our members who do not live in Missoula or Billings, steerage is less of an issue, and they will likely be better served by the less expensive Plan A. They must be mindful of their steerage restrictions, however, should they end up in Billings or Missoula for services. Active members including those living in Billings and Missoula and even many of our retirees might have an even better option still - one of our managed care plans.

2. The Managed Care Plans - Both New West and Blue Cross/Blue Shield managed care plans have both hospitals in Missoula and Billings within their networks and therefore steerage will not be an issue with either plan. There will be no major changes to the structure of our managed care plans in the upcoming plan year and the range of network providers continues to expand. The managed care options from Allegiance, Peak, New West, and BC/BS are excellent programs with good preventive and first dollar coverages and the lowest premiums of any of our plan offerings.

Not all plans are available in all communities, however, and while steerage is not an issue, the list of network of providers is crit-

ical. Anyone considering a managed care option should carefully research the network of the plan they are considering to be certain that they can live with the participating providers. With these plans going out-of-network can have serious economic consequences. Nor are these plans just for the young and the healthy. Retirees living in-state should seriously consider one of these managed care plans if available in their area. Coverage of chronic illnesses is at least as good as that of the indemnity plans and member satisfaction seems quite comparable as well. Because of the network issues, these plans are probably not the best choice for retirees living out-of-state.

3. The Pharmacy Plan - Pharmacare will continue to manage our pharmacy program and there will be no basic plan changes. Copayments, deductibles, and individual and family maximums will remain as they are now in both our network pharmacy and mail-order programs. Look at your plan documents for details. Until recently we have had what is known as a three tiered plan: generic, formulary, and non-formulary drugs each with different copayment amounts. We have just added a fourth tier: the Pharmacare ProtoCall Specialty Drug Plan. This ProtoCall Plan is currently in effect.

Specialty drugs are those very expensive medications for the treatment of such things as HIV/AIDS, hemophilia, arthritis, hepatitis C, MS, transplant management, etc. If you are on one of these ProtoCall Drugs, you will be receiving a letter from Pharmacare asking you to join this program. Under the ProtoCall plan a 30 day supply of your specialty drug will be shipped to you or your physician and **there will be no cost or copayment to you whatever.** A case manager will be assigned to you and needed ancillary supplies such as syringes and needles will be supplied free of charge as well. If you go to retail for these same drugs, you will be assessed the greater of \$40 or 50% of retail charges for a 30 supply. The markup on specialty drugs is tremendous, but through the ProtoCall Plan we are able to obtain these same medications at deep discounts. It is a win-win for all. The plan will save significant acquisition costs and you will get your needed medications essentially for free. You can find a current list of these specialty drugs and more details about the ProtoCall Plan at www.pharmacare.com. ■

Health Care Fraud *by Joye Kohl, Retiree, Arizona*

How much do you know about Medicare and insurance fraud? And if you think it couldn't happen to you, you are probably wrong! The National Center for Policy Analysis website says: "Scam artists are using their computers to find holes in the Medicare and Medicaid payout system to commit massive fraud, according to reports. First they register as providers of equipment or services. Then they file a variety of exploratory claims through the payment system to see what happens. Once they hit upon types of claims that are automatically approved by Medicare and Medicaid computers - with no human scrutiny involved - they launch a barrage of claims, then sit back and wait for the checks to roll in. Crime technologists say that the health care industry suffers a rapidly spreading plague of fly-by-night medical businesses that set up in storefronts, register as providers, bill fast and furiously for a short while - then disappear without a trace."

My husband, an MUS retiree, was a recent victim of this very situation. The first indication of any problem was on Feb. 1st with the receipt of an Explanation of Benefits from Allegiance listing incorrect claims. After making immediate calls on Feb. 2nd, it was abundantly clear that the Medicare number had been misappropriated resulting in a single case of Medicare and insurance fraud totaling more than \$5700 in payments already paid out (\$4616.03 by Medicare and \$1154.01 by Allegiance, the secondary insurer). The claim had been submitted to Allegiance by Medicare. Most of the day was spent trying to get action on the problem, before finally reaching the Arizona Dept. of Insurance who supplied the name of a real person and the direct phone number for Medicare. On Monday, February 4th we received in the mail the Medicare Summary Notice dated January 26, 2007 for claims which had been processed by Medicare between October and January. Time is of the essence in these scams and it would be naive to think that we were the only individuals victimized by this fraud.

The perpetrators in this case, rented an office for their "storefront scam operation". They even set up a telephone and it was listed in the city phone book. Sometime during the Fall they obtained access to patient information and records - perhaps by infiltrating a legitimate medical office through an employee or maybe hacking into the electronic processing records of legitimate medical providers. In this case, the "scam storefront office" was apparently opened up in January and cleared out by February

although leaving some medical equipment visible through the window. After finding a telephone listing I called only to discover that the phone had been disconnected. By the time the police checked the "storefront" operation sometime the week of Feb. 5th, the perpetrators were already gone. Who knows whether anyone will ever be caught and how many dollars were fraudulently acquired by this one set of criminals. A next door tenant said the "foursome" were there only about a month and investigators now believe that they stole several million dollars during this time.

The FBI says: "All health care programs are subject to fraud, although Medicare and Medicaid programs are the most visible. Estimates of fraudulent billings to health care programs, both public and private, are estimated to be between 3 percent and 10 percent of total health care expenditures.... Health Care Fraud is expected to continue to rise as people live longer. Fraudulent billings and medically unnecessary services billed to health care insurers are prevalent throughout the country.... With health care expenditures rising at three times the rate of inflation, it is especially important to coordinate all investigative efforts to combat fraud within the health care system." www.fbi.gov.

Something must be done to correct what is happening with Medicare and insurance fraud. We all need to remember that it is the individual consumer who must identify the problem and notify the authorities. It is critical that each consumer takes the time to check the Explanation of Benefits as soon as it arrives and to contact authorities promptly. It is apparent that the people who commit Medicare and insurance fraud know precisely how much time they have to wait for the payments for fraudulent claims to roll in to their pockets. Then they clear out and simply head somewhere else to repeat their operation. And it is no wonder that those who make fraudulent claims get away with it. Even if one is a vigilant consumer, traversing the system requires time, skill and an abundance of tenacity. The system also needs to be more responsive, user friendly, interconnected and effective.

Editors's note: Thanks Joye for your diligence and your willingness to share your experience and research. Remember that our Self-Audit Award Program will grant you 50% of all cost saving to our plans up to \$1000 for detecting and reporting fraudulent claims to your health care insurer. See the September 2006 Choices Newsletter for details (available on-line at www.montana.edu/choices). ■

The Allegiance Contract Renewed

If you recall two years ago when Allegiance was selected as our plan administrators, they were given only a two year contract. That agreement is set to expire on June 30th. It was therefore necessary that we go out to bid somewhat earlier than usual. Mercer prepared a Request for Proposals (RFP) and bids were let late last year and submitted in January. A subcommittee of InterUnits members reviewed all bids and made their recommendations to the full InterUnits Committee.

Two close finalists emerged from this process: Blue Cross-Blue Shield of Montana and Allegiance. Their bids were roughly comparable with regard to service standards and administrative fees. However, Allegiance was able to negotiate contracts with some of our key providers that offered us deeper discounts. These cost savings are considerable. Therefore, the Allegiance bid was accepted and a 3 year contract was issued. If Allegiance meets performance standards, this contract can be renewed twice for a period of two years each. ■

The Winter InterUnits Meeting

The Winter InterUnits meeting was held in Helena on February 23. Mercer, our consultants, gave a generally positive financial report. In the past year revenues exceeded expenses by 12.6%. About 82% of these excesses came from our managed care plans which consistently seem to be more cost effective than our indemnity plans. It was not all good news, however. In the last two quarters of 2006 our dental plans began losing money. Mercer's projections are worrisome as well. Even with the anticipated increases in the State contribution in the next biennium, we could start bleeding money by the end of the next fiscal year. In the second year of the biennium (FY 09), projections indicate that we will be spending \$1.08 for every dollar of income. Paul Bogumill gave a report on the current bills pending in the Legislature that might effect benefits. It is too early to tell what might happen. There will be a summary of legislative action in the *May Choices Newsletter*.

Actions taken by the InterUnits Committee include: the renewal of the Allegiance contract, the restructuring of our indemnity plans to include steerage Plan A and non-steerage Plan B, the addition of the Proto-Call Specialty Drug Plan to our Pharmicare program, and the acceptance of the Delta Dental bid with the provision that limited orthodontic coverage be added. Details of these changes are elsewhere in this newsletter. The InterUnits Committee will meet next in Helena on March 13. ■

Our Flex Plan Debit Card and the IRS

Q I just received a letter from Employee Benefits Resources requesting full documentation for all charges I made since July 1, 2006 on my flex account Benny debit card. Needless to say, I cannot find all records from charges made over nine months ago. EBR says that I must pay back any amount for which I do not have receipts. This is my money and I do not want to lose it. What am I to do?
T.J. UM - Missoula

A. You are not the only one to find yourself in this situation. When the debit card program began, participants were asked to save all receipts in case they were needed, but of course it is easy to forget something like this or to misplace your records. Up until January these documents were simply "on call" if needed. In January the IRS issued a ruling that requires the Flex Plan Administrator to review every record and receipt. This IRS "crack-down" puts Employee Benefits Resources in a difficult situation. If they fail to comply, the IRS might well revoke the flex plan's tax status. Yet EBR is well aware of the fact that many of these records might well be "unproducible" at this point. There is still time to solve this problem. Look at your records and see if your providers can supply duplicate receipts. Consider other medical expense for which you have not filed claims and file. Load up on medical supplies and over-the-counter drugs before June 30th. If your flex balance is high, think about getting needed dental care or eyewear. There is still plenty of time to use it before you lose it. The following article by Ellen Feaver, our Flex Plan Administrator, should help put things in perspective:

"In January 2007, the IRS issued a notice clarifying the rules for Flex Plan Debit Card use. The January notice underscores the importance of Employee Benefit Resources, LLP, (our TPA) examining documentation for all transactions except those meeting Inventory Information Approval Systems (IIAS) standards. The merchants currently meeting the IIAS standards include Pharmicare, Walgreen's, Wal-Mart, Sam's Club and Drugstore.com.

In order for Employee Benefit Resources, LLP to ensure that our plan meets the IRS requirements, EBR may have recently sent you a letter requesting your documentation for debit card transactions since July 1, 2006, the beginning of our plan year. You can see a record of your transactions on www.mybennycom. EBR will be sending debit card holders instructions regarding use of this website. If you cannot find all of the documentation requested, you may substitute documentation for other allowable expenses that you have not previously claimed. If you do not have other expenses, the plan must recover the amount paid for which you cannot supply appropriate documentation.

Needless to say, it is difficult for everyone when the rules change in the middle of the year. While debit card holders were notified when they received their cards that they needed to keep their documentation, it is difficult for some to find the documents for the last eight months. The upside is that you still have more than 3 months to use your flex money." ■

Ellen Feaver, CPA, Employee Benefits Resources

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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