

The Choices We Made

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

choices

The Choices Newsletter

is designed to help

promote a sense

of our ownership

and responsibilities

within the program.

How well do we choose? We call our benefits program "Choices" and require that all of us select from a number of complex options during the re-enrollment period at the beginning of each plan year and our choices do not end there. Every time we utilize the medical, dental, or drug programs, we are confronted with a number of very complex decisions. Classified employees were and new employees still are required to choose among three very different retirement programs. Those in the defined contribution retirement programs (the State plan or TIAA-CREF) must decide further which funds they will invest in and how they will allocate their assets to ensure their financial security at the end of their careers. As we approach retirement, we face even more complex and, in many cases, irrevocable decisions in how we will set up our pensions and withdraw our funds. In light of the number and complexity of all of these decisions we make, the obvious question then becomes: how well do we do?

The *Choices* program is technically called a "cafeteria-style" benefits plan. A broad panorama of benefits are offered and participants can periodically "go through the line" and choose the trayful of benefits most appealing and hopefully "most nutritious" for them. Some parts of our program offer no choices at all. For example, participation in the Social Security and Medicare programs are obligatory and the contribution rates are set by Federal statutes. Other aspects of the program offer limited options. You must select a medical plan, for example, but can choose between the \$400 and the \$575 deductible plans or, in some cases, an HMO option. You must elect dental insurance but you may choose between the Basic and the Premium plans. Other programs in the *Choices* offerings are totally voluntary. Such things as the Vision Plan, long term care insurance, accidental death and dismemberment insurance, and extended life insurance coverage (\$10,000 is required) all fall into this completely optional category.

The theory behind a cafeteria plan is that individual circumstances differ greatly and that only the employees know what mix of benefits would best suit them and their family. By allowing choices, employees can then tailor the program to maximize the benefits for themselves and their dependents. For this theory to work, the presupposition is that the employees have informed themselves fully about the various options and are able to choose wisely and rationally. But of course, we are human beings who act emotionally as well as rationally and often make decisions based on very incomplete data and sometimes even misinformation. The central question returns: how well do we choose?

This article will attempt at least a partial answer. The data from the last plan year are now complete and we have voluminous reports from Blue Cross/Blue Shield - Montana and Eckerd Drug, our medical plan administrators as well as our plan advisor, Mellon Consultants. Our various retirement program administrators - TRS, MPERA, and TIAA-CREF have provided us with information on the overall choices you have made and the data is now complete on the big decision that our classified employees faced last plan year between the defined contribution and the defined benefits retirement plans. We will summarize these data and the statistics on how we actually utilized the medical, dental, and pharmacy plans. We will assess the overall fiscal health of the program at the end of FY 2003 and look, at least tentatively, at where we choose wisely and where we occasionally failed as a group. We begin with the "mother of all choices" last year - the irrevocable decision our classified employees made among retirement programs.

The Classified Employees Retirement Plans - The choice of retirement plans for our classified employees was certainly one of the most complex and difficult decisions ever asked of our members and made all the more terrifying by the fact that it was irrevocable. Unlike most choices we make, one could never go back and correct a mistake in a subsequent plan year. Four recent issues of the

Choices Newsletter were devoted to helping our classified employees sort through these complexities. The results are now in and the data reveal some surprises. As of July 17, 2003 (the deadline was June 30) when all of the elections forms were entered into the database, a total of 28,618 long-term State employees had filed their decisions. The vast majority chose to stay put in the defined

(Continued on Page 2)

The Choices We Made (Continued from Page 1)

benefit (DB) plan. The State defined contribution program (DC) was elected by 831 State employees and the ORP (TIAA-CREF) by 493 MUS employees. Remember that only MUS employees had the ORP as an option. The 4,746 new State employees hired in FY 2003 chose as follows: the DB plan - 4,591; the DC plan - 59; and the ORP - 96. MUS employees represent a subset of these data with c. 3,000 members. These MUS employees chose as follows: the DB plan - 2,404 or 80%; the DC plan - 7 or .2%; and the ORP - 589 or 20%.

The surprising thing about these statistics is how few opted for one of the two DC plans - only 1,479 or 4% of the 33,364 eligible State employees choose the DB or the ORP plans. For years our classified employees had been clamoring for a DC option in the retirement program and worked with their labor organizations to lobby the Montana Legislature for the enabling laws. Yet when the decision was before them, most passed on the DC options. There can be no doubt that the recent performance of the financial markets was a huge factor in their decisions; right after the laws were passed, stock funds suffered through one of the longest bear markets in modern history.

Did our employees miss a one time opportunity and make serious mistakes? Perhaps and perhaps not. One cannot be certain and the data are quite incomplete. On the one hand, early last year presented a golden opportunity to enter into the financial markets at greatly discounted prices and "buy low." On the other hand, DC programs are inherently more risky and our members were reminded that a bear market at the time of retirement could greatly reduce one's pension. Perhaps, a better strategy was to stay put, using Social Security and the DB as the foundation of one's retirement and invest one's supplemental savings in the stock market. This strategy assumes, of course, that the individual will follow through and put money aside in the 457 or one of the 403(b) programs. There is no way of knowing at this point if this has or will actually happen. One thing is certain, however: after enduring the recent fluctuations in the financial markets, our members saw their existing DB plan as more and more attractive and responded accordingly.

We do not have a very good statistical profile of those who stayed in the DB plan or those who chose the DC plan, but there is some good data on those who elected to shift to TIAA-CREF. There are many factors such as years to retirement, marital status, spouse's retirement plan, general health, family histo-

ry, number of dependents, family finances, etc. that were critical factors in a wise decision and for which we have no way of knowing. Age and years of service were certainly two of the most important considerations and the only ones for which we have clear data. The chart below gives the age and years of service data for those choosing the ORP. This evidence shows that the younger employees and those with few service years made up the bulk of those electing the ORP. Were they wise to do this? Most probably and resoundingly, yes. The vast majority had 0-4 years of service and therefore were not vested in the DB plan. Choosing the ORP was the only way that these employees could be certain that they would get the employer's contributions to go with them should they leave University employ and we know that younger employees are far more likely to leave. Portability of the pension plan is critical for these individuals. DC plans work best for the young who have many years to grow their investments. DB plans favor the older employees with many years of service.

We can only intimate from the limited data that we have that the vast majority of older and longer term employees elected to stay in the DB plan. Was this wise? Most certainly. These employees are already vested and since they are far more likely than their younger colleagues to remain with the University until retirement, portability is far less of an issue. If older employees were to have shifted, they would have missed out on the "bump" in benefits that all DB give at the end of one's career. Aside from some younger employees who might have benefited from the ORP, the drift of the evidence suggests that the vast majority of our classified colleagues chose very wisely indeed.

ORP Electors Profile		
Years of Service	Number	Average Age
0 - 4	453	35
5 - 9	110	40
10 - 14	20	47
15 - 19	6	42
Total	589	36

Note that all members age 50 or older who elected the ORP had 9 years of service or less and that those with 15 to 19 years of service electing the ORP tended to be relatively young 39 - 44 year olds.

The Medical Plan - The utilization reports are now complete and the evidence suggests that our employees are very much in line with national trends and averages. Medical claims increased in FY 2003 at a 9.5% rate while nationwide the average was 13.2%. Blue Cross/Blue Shield MT noted that Montana tends to lag the country by a year and that we might well see double digit increases during the current plan year. The most worrisome trend is in our drug costs. Pharmaceutical claims increased 19.6% and this was almost exactly in line with the 20% national average. We spent 16 cents of every claim dollar on drugs. The figure is 20 cents on the dollar nationally.

Medical insurance experts like to talk about the "20/80 Rule" - 20% of the members will incur 80% of the medical claims costs. This kind of claims concentration is typical and were are no different than most medical plans: 21% of our members spent 88% of our claims dollars in the last plan year.

At the end of June 2003 there were a total of 7,886 employees and retirees enrolled in all of our medical plan options: 6,769 in the BC/BS Indemnity plan and 1,117 in one of the HMO options. The BC/BS Indemnity plan included 5,355 active employees and 1,414 retirees. There were 713 enrolled in the New West HMO, 113 in the PEAK/Big Sky HMO, and 291 in the BC/BS HMO. On average there is one dependent for every enrolled employee. Therefore, we estimate that there are a total of approximately 16,000 lives covered under all of our medical plans.

BC/BS has built up their network of contract hospitals and member providers over the last year. Some 93% of all physicians in the State now participate and 32 of 56 hospitals are under contract. There are still some major holes in the network, however. Radiation oncologist in Billings and Missoula refuse to participate and many of the State's neurologist are nonparticipants.

A review of the utilization data reveal some interesting statistics. There were 73 hospital admissions for every 1000 members (some may have been their dependents). The average length of stay was 4.89 days and the average cost per admission was \$7,103. That works out to an average cost per day of \$1,453. Hospital outpatient services (emergency rooms not followed by admissions, urgent care centers, same-day surgery centers, etc.) cost the plan \$295 on average per visit.

(Continued on Page 3)

Bozeman Deaconess was our largest provider in terms of total claims paid, followed by St. Patrick's, Missoula; St. Vincent's, Billings; and Community Hospital, Missoula. This does not imply that Bozeman Deaconess was overcharging. Our greatest concentration of employees are in the Bozeman and Missoula areas, but in Missoula the claims are split between two hospitals. In fact, there is good evidence to suggest that the Bozeman Deaconess charges are more modest, in many cases, than those of many other hospitals in the State.

Medical claims including drug costs totalled \$20.5 million in FY 2003 and dental claims totalled \$2.8 million. The top five medical claims categories for both inpatient and outpatient services were:

1. **Health Status** - infectious diseases, minor problems, flu, etc. - \$3.9 million;
2. **Musculoskeletal** - arthritis, fractures, sprains, etc. - \$3.8 million;
3. **Circulatory** - stroke, heart disease, etc. - \$2.3 million;
4. **Digestive** - \$1.9 million;
5. **Nervous Disorders** - \$1.4 million.

About 63% of our members received claims payments of \$500 or less. At the other end of the scale, there were 9 cases (.1%) where claims exceeded \$100,000. Perhaps the most interesting statistic is that 16.5% of our members filed no claims at all during the last plan year. What makes this surprising is that both the basic and the premium dental plans cover semiannual routine cleanings almost fully. Either a good share of our members and their families have extraordinarily good teeth or the level of dental phobia amongst our members is much higher than we first thought.

The Prescription Drug Plan - Since our drug costs have been inflating over 20% a year recently and thereby threatening the overall fiscal health of our plan, drug utilization deserves special focus. In most ways our experiences are reflective of national trends and the experiences of other health plans. Many factors drive this drug cost inflation. There are many more treatable chronic illnesses due, in part, to the aging of the population, improved early detection procedures, and new drug therapies. Some drug therapies serve as alternatives to hospitalization and are probably cost effective. New brand name drugs enter the market and are used instead of generics or over-the-counter alternatives. Patients with drug coverage pay only their copays and deductibles and are

unaware of or indifferent to the true cost of their medications. Drug companies spend twice as much now on marketing than they do on research and development and these costs must be recovered. Finally, direct advertising to the consumer has greatly increased the utilization of very expensive branded drugs. Eckerd estimates that 52% of our drug inflation is driven by increased utilization, while 48% is the result of the increased costs of the drugs.

It is naive to think that the MUS plan is free from these national trends and influences. A case in point: 7 of the 10 most costly drugs prescribed in our program last year were heavily advertised brand name medicines. Likewise, few of us know the true cost of our medications, as we see only the copay and deductible amounts. Fewer still ever do a cost-benefit analysis of those drug therapies treating minor or self-limiting conditions (toe fungus, colds, etc.). In using medications, there are better choices that many of us certainly can make. We should always ask our pharmacist to tell us the true costs of the drugs we are using. We should avoid asking our doctors to prescribe only heavily advertised medications, trust their best medical judgements, and always ask if there are generic equivalents that might work as well as the brand name drugs. Only by being informed and responsible medical consumers can we get this drug genie (should we say "monster") back in the bottle.

Overall Assessment - Our general overall fiscal health remains sound. We entered FY 2003 with \$5.0 million in our reserve accounts. The BC/BS indemnity plan had a total funding of \$33 million and expenses of \$32.6 million for a positive balance of \$400,000 for the year. The HMOs did even better. They were funded at \$5 million and spent \$2.7 million. Both surpluses resulted in a \$2.7 million net for the year. As a result we entered the current plan year with a healthy \$7.7 million in our reserve accounts.

In recent years our InterUnits Benefits Committee has not been faced with easy decisions and has struggled to keep the plan sound by adjusting benefits, copays, deductibles, and premiums. Increasing the out-of-pocket costs to our members in these difficult economic times has not been easy. Nonetheless, the InterUnit Committee should be commended for making these difficult but ultimately wise decisions that have kept our plan healthy. Overall, it is clear in reviewing all of the data that the Committee and the majority of us seem to make wise choices most of the time. ■

The InterUnits Committee has met twice so far this plan year. The Fall workshop was held at Big Sky in September and members heard extensive annual reports from Blue Cross/Blue Shield, Eckerd Drugs, New West, and our advisor, Mellon Consultants. The previous article summarizes much of the data from these reports. On the second day of the workshop, Kirk Keller, MSU Wellness Director, and Jill Young, UM Wellness Director, presented the current research on wellness programs nationally and offered several options for enhancing our own program in order to both improve member health and ultimately contain claims costs. After much discussion, these suggestions were referred back to the Wellness Subcommittee. This Subcommittee was charged with coming back to the full committee with specific recommendations for enhancing our Wellness Program in light of current research and "best practices."

The Fall InterUnits Benefits Committee meeting was held on October 28. The claims data for the first quarter were reported and factored in to our projections for the year. For the BC/BS Indemnity Plan we had a good first quarter with an expense ratio of 91% (expenses/income). The HMO options showed even better results with a 66% expense ratio. Three months of data are insufficient to make accurate projections for the full year and we know that the last quarter of every plan year tends to be an expensive one as members who have met their deductibles bundle in procedures before the end. Nonetheless, prospects are good for the remainder of the year and, if current trends hold, we anticipate a surplus of \$1.5 million on June 30, 2004.

David Senn of TRS and Keith McCallum of MPERA reported large increases in unfunded liabilities in our DB plans as a result of recent market losses. Both anticipate going to the next Legislature and asking for relief by way of modest increases in contribution rates.

John Wing of Valic explained the implementation procedures for the Montana VEBA Health Reimbursement Accounts. Unlike our Medical Reimbursement (Flex Spending) Accounts, the VEBA monies can carry over from one tax year to the next without penalty. The provisions of the VEBA are quite complex. To add to the complexity, the new Medicare Reform Act allows for Health Savings Accounts with a similar carry-over provision (see p. 4). A future issue of the Choices Newsletter will focus on these three different medical savings plans. Progress on the Medical Plan Administrator and 403(b) RFP bids was reported and an Innovative Solutions Subcommittee was formed to look into long term answers for our runaway medical and drug inflation problems. The InterUnits Committee meets next in Butte on February 5. ■

The Recent Medicare Reform Act

The Medicare Reform Act was passed by Congress in late November and adds a prescription drug benefit to the medical plan. This pharmacy benefit will be phased in over the next few years. The law also establishes medical savings accounts that allow for using pre-tax dollars to pay for out-of-pocket medical expenses - such things as co-pays, deductibles, over-the-counter medications, etc. Like so many things Congress does, the provisions of this law are extremely complex and we have yet to fully understand all of its ramifications. Therefore, the following summary and assessment of the Medicare Reform Act and its impact on our own plan must be seen as very preliminary.

The Drug Plan - will be implemented in various stages over the next few years:

Stage I - The Card: Starting in Spring 2004, Medicare eligible seniors can purchase a temporary card for about \$30 which will entitle them to a 10% to 25% discount on most prescriptions. Seniors with incomes of \$12,000 or less will get \$600 a year credited to their cards.

Stage II - The Doughnut Hole: In May 2006 the card plan will be discontinued and an indemnity plan will replace it. Seniors who elect the plan pay a \$420 annual premium plus a \$250 annual deductible. After that, enrollees will get a 75% discount on prescription drug up to \$2,250 in a given year. The plan effectively ends between \$2,251 to \$5,100 and creates the so-called "doughnut hole." After \$5,100, the plan covers 95% of all drug costs.

Stage III - The Sliding Scale: Starting in 2007, Part B of Medicare which covers physicians and outpatient services will cost more affluent beneficiaries considerably more. Currently, all pay \$799 annually for Part B coverage. Those with annual incomes of \$80,000 or more for singles or \$160,000 for couples will see significant premium increases based on a sliding scale.

Stage IV - The Experiment: In 2010 Medicare will begin an experiment whereby they compete head-to-head with private insurers in six metropolitan areas. This competition is unlikely to impact Montana residents.

Our own drug plan offers far better coverage and retirees can be reassured that we have no plans to drop them when Medicare kicks in. Those retirees with incomes under \$12,000 should obviously take advantage of the card plan. The rest should stay put for now.

Medical Savings Accounts - One important provision of the Act applies not just to retirees but to all of us; those with high deductible medical insurance plans can establish Health Savings Accounts. Singles with a \$1,000 deductible plan can put away \$2,250 per year in pre-tax dollars to pay for unreimbursed medical expenses and families with a \$2000 deductible can set aside \$4,000 annually. There are no "use it or lose it" provisions and these funds can carry over from one year to the next. The InterUnits Committee will likely consider adding a high deductible option before the next re-enrollment period so that our active employees will be eligible for these HSAs. Stay tuned. ■

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

GLEN LEAVITT
MONTANA UNIVERSITY SYSTEM
2500 BROADWAY
HELENA, MT 59620-3101
(406) 444-6570

BENEFITS PROVIDERS

PEAK (406) 723-3783
NEW WEST (800) 290-3657
FACULTY STAFF ASSISTANCE PROGRAM
APS (800) 833-3031
BLUE CROSS/BLUE SHIELD - MONTANA
(800) 820-1674
MANAGED CARE (800) 782-3083
PHARMACY PROGRAMS
ECKKRD (888) 645-9303
RIDGWAY (800) 630-3214
UNUM LTD (800) 424-2008
LIFE (800) 445-0402
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.

HELENA, MT 59604
PERMIT NO. 105
PAID
U.S. POSTAGE
ORGANIZATION
NON-PROFIT

choices
Benefits Program
Montana University System
2500 Broadway
Helena, MT 59620-3101

