Classified Retirement Choices - Part IV (Continued)

to the MPERA website at *www.mperachoice.com* and run the modeling software.

It is those in the middle with around 10 years of service credit and with 15 to 20 years to go until retirement who face the hardest choice. In this situation any of the options might work out well depending on a number of factors. The following guidelines might help those of you who find yourselves wavering in the uncertainty of that middle ground.

Guideline 6 - If you enjoy personal finance and are willing to learn about investments and manage your retirement portfolio, then one of the DC plans may be for you, all other things being equal. Understand that you must be willing to learn about you investment options, monitor expenses, establish an appropriate asset allocation, and rebalance your portfolio on a regular basis for this strategy to be successful.

Guideline 7 - If, on the other hand, you hate personal finance and have no tolerance for risk in the investment markets, you may be better off staying with the DB plan. Investing your entire retirement portfolio in money market funds is not a strategy that will succeed and life is too short if you lie awake at night worried because the DOW took a 200 point plunge that day.

Guideline 8 - Consider the overall situation of your family's finances and other retirement assets in making your final decision. If your spouse has a defined benefit plan at work, you may be in a situation where you can take more risks with your retirement funds for the potentially higher rewards. Consider then one of the DC plans. Conversely, If your spouse has a 401(K), 403(b) or 457 plan largely invested in the stock market, you may wish to balance your family's risks through the safety of your current DB plan.

Guideline 10 - Regardless of the option you choose, take steps to maximize your benefit. Use Part III of this series to help you choose between the two DC plans should you decide to go this route. Watch expenses, choose an appropriate asset allocation and rebalance your portfolio on a regular basis. If you remain in the DB plan, maximize your benefit by purchasing all of the service credit to which you are entitled and by using every means possible (raises, overtime, additional comp, etc.) to increase your income average in your highest 3 years.

Make the best decision possible by using all of the resources listed in Part I of this series with the understanding that all three options have the potential for financial success in retirement. Most importantly, do not agonize afterwards if the stock market happens to make a dramatic shift up or down. The "what if" game is bad for your psychological health. No one can possibly know what the future will bring including all of the talking heads on CNN and there are no "perfect" choices, only several workable options. Remember that success in retirement has often more to do with family, friends, health and outside interest than it has to do with finances. ■

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Volume 6 Issue 3 March 2003

choices

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

What's Up With The Pharmacy Plan?

The changes in our pharmacy plan seem to be occurring at a maddeningly regular rate recently, a rate so high in fact that it is difficult to keep up. At the same time the out-of-pocket costs of our drugs have increased significantly in recent years. Since the "good old Albertsons" days we have shifted our drug plan administrator once and we have been forced to introduce such structural changes such as "formularies" and differential pricing for generic and brand name drugs. And if all of this isn't confusing enough, we are forced once again to restructure the pharmacy plan and increase costs for the upcoming plan year. It is only natural to wonder *what's up with the pharmacy plan?*

What is driving all of these changes is simply put - money. The claims costs for our drug program are inflating out of sight and putting the overall fiscal health of our entire benefits program in serious jeopardy. Let's look at recent history. In the last three years the average cost of drug claims per active employee per month have increased from $45 to $75. The increases for our retires are even more dramatic - for those under age 65 drug claims have gone from $95 to $145 per month and for those 65 and older, from $105 to $190 per month. The fact that our older members are using more drugs is not surprising. As we age, the likelihood that we will be using one or more maintenance drugs increases significantly. These differences in drug utilization are only to be expected. What's surprising are the price differentials. Just a few years ago drugs represented less than 25% of the total claims cost for our retires. This last year over 50% of our total claims dollars for retirees went for pharmaceuticals. In recent years our overall drug cost have been increasing at a 20% plus rate. It does not take a genius to conclude that this rate of inflation is unsustainable and threatens the overall health of our plan.

The continual tweaking of pharmacy plan is an attempt to address these serious issues of increasing drug claims. There are many reasons why drug costs are going up. Direct advertising of prescription drugs to consumers has no doubt increased the utilization of very expensive brand name medicines. Countries such as Canada put strict limitations on drug prices. Drug companies then recover their costs and maintain their profit margins by charging more for these same drugs in unregulated economies such as our own. Marketing costs have risen dramatically in recent years. American drug companies now spend more on marketing than they do on research and development. These costs must be recovered. In fairness to the drug industry it must be noted that there are now many illness that were once untreatable or treatable only by very expensive hospital procedures that now can be successfully addressed by a course of drug therapy. The pharmaceutical industry claims that these new "wonder" drugs have reduced hospital stays significantly. Perhaps that is true. The causal links are hard to show and our plan has not seen any real savings. Even though our overall days in the hospital have gone down in recent years, our hospital claims have remained relatively flat. Hospitals seem to be compensating for fewer admissions and shorter stays by charging more per day. The overall result seems to be a wash.

The Choices Newsletter is designed to help promote a sense of our ownership and responsibilities within the program.

There can be no doubt that the many recent changes in the drug plan have lead to considerable confusion amongst our members and increased out-of-pocket costs to those requiring medications. In fact, there are more calls to our Benefits Office in Helena over problems with our drug plan than over any other part of our benefits program. This article will attempt to address some of these common misconceptions and suggest strategies for using the plan in the most cost effective way. We will also preview the changes in the drug plan that are coming our way next year.

The Basics - A ***brand name*** is a medication still under patent and manufactured solely by the pharmaceutical company that did the original research and development; a ***generic*** is a drug no longer under patent and often produced by a number of different drug companies. Generics are always considerably less expensive than brand names. A ***generic equivalent***, while not identical to the corresponding brand name drug, is used to treat a similar diagnosis. A ***onetime*** prescription is a drug taken on a short term basis for 30 days or less. A ***maintenance drug*** is a medication taken on an ongoing basis, typically 90 days or more. The ***Eckerd Network Pharmacy Plan*** is de-

(Continued on Page 2)

What's Up With The Pharmacy Plan? (Continued from Page 1)

signed to fill short-term prescriptions at your local pharmacy. The ***mail-order plan*** through Ridgeway (1-800-630-3214) or Express Pharmacy (1-888-645-9303) offers a 90 day supplies of maintenance drugs at a lower cost than the local pharmacy network.

The Formulary - Perhaps the greatest source of misunderstanding amongst our members revolves around the formulary. Many assume that there are a group of mindless Eckerd insurance company executives sitting around and deciding for you and your doctor what drugs you are allowed. This is not exactly true. A ***formulary*** is a list of drugs judged to be appropriate and effective in treating a given illness in a cost effective manner. The decision to place or remove a drug from the formulary is made by physicians and professional pharmacists under contract by Eckerd. These professionals have the final say and not Eckerd. Sometimes there will only be a single and expensive brand name drug effective in treating a certain diagnosis. That drug will be placed on the formulary. At other times, there may be three or four related drugs effective for a given illness. With an eye on costs, one or two of those drugs will typically be selected for the formulary. The others will be categorized as ***non-formulary drugs***. Formularies enable very cost effective bulk buying.

It is important to realize that the formulary is in a constant state of flux. As new drugs are approved by the FDA and come on the market, they are evaluated and often added to the formulary as other drugs are replaced. A new drug will sometimes be *non-formulary* when first filled and *formulary* at first refill. Formulary drugs may be removed as generic equivalents become available. Many of our members have called Helena or Eckerd requesting the complete formulary list, thinking that that is the most effective way of keeping track. There are two problems with this. First, the formulary is very, very long and most of the drugs on the list will not apply to you. Second, the list will be obsolete by the time it reaches you. The better strategy is to visit Eckerd's website at *www.ehs.com* and enter the name of your medication or to call them at 1-888-645-9303 and ask about your prescription. You can even do these things from your doctor's office. Your local network pharmacy also has access to the formulary.

Non-covered and Limited Drugs - Certain drugs such as Viagra for sexual disfunction and Rogaine for hair loss are not covered by the plan at all. The plan document has the details. Other drugs such as Prozac weekly, Proscar, Wellbutrin-SR, Remicade, growth hormones, and ADHD drugs require a letter of medical necessity from the doctor. Some drugs are restricted by quantity. Many drugs are safe and effective when they are used for short periods of time (Toradol). But because these medications can be overused, quantity limits are put in place and adjusted by Eckerd. Other drugs are subject to a contingent therapy protocol designed to ensure that members received the most cost effective and efficacious drugs. Celebrex, Vioxx and Bextra, for example, are part of this program.

Costs - What does all of this business about *formularies, generics, brand names*, etc. have to do with the bottom line? In actuality, a great deal. The least expensive option for you and the plan is to use a generic when available. Next you should try to use a drug on the formulary whereever possible to see if it is tolerated and effective. The most expensive option is to use a non-formulary drug or a brand name when a generic equivalent exists. This last option may still be appropriate in your situation. Drug tolerances vary from individual to individual and you should never override your physicians directives. Ask about generics or ask to try a drug on the formulary first, but in every case follow your physician's best judgement. The ultimate goal is your good health and not just saving yourself and the plan a few dollars.

The Plan Structure - Using a network pharmacy will result in immediate savings for you. Most Montana pharmacies are in the network. If you use a non-network pharmacy, you must pay the total charges up front and then file a claim with Eckerd for reimbursement. There is a $100 deductible per member and $200 deductible per family for the network pharmacy plan. For up to a 30 day supply of medications you pay a $10 copayment for generics, $15 for formulary drugs, and $25 for non-formularies. Your out-of-pocket costs after the deductibles are met are capped at $700 maximum per individual and $1400 per family. For maintenance drugs the mail order plan is **always** your least expensive option. You pay no deductibles. A 90 day supply of a generic drug costs $15, a formulary drug $30, and a non-formulary drug $50.

Eckerd's Role - Eckerd is our Pharmacy Benefit Manager. Eckerd's role is to partner with pharmacists and doctors to achieve the best drug therapy for our members. Because of the enormous breakthroughs made with science and medicine doctors now have the ability to choose from a large variety or prescription drugs for the treatment of various diseases. However, with all the medications to choose from now, drugs have the potential to be used improperly. As a result, serious problems for the patient may develop. For these reasons MUS has contracted with Eckerd to manage our drug program and insure that your drug therapy is safe, effective, and follows FDA guidelines. Granted that those letters and phone calls can be annoying at times, but they are done to protect you from adverse drug reactions and to save money for the plan. Not always will your physician or pharmacist know every medication you take or every possible drug interaction. We ask Eckerd to manage the plan for your benefit and safety.

Proposed Plan Changes - Once again the InterUnits Committee struggles to keep or drug costs under control. The following proposed changes were suggested by Eckerd and will likely be implemented next year. The pharmacy plan copays will go from a flat rate basis to a percentage basis: 20% or $10 for generics (whichever is greater), 30% or $20 for formulary drugs, and 40% or $30 for non-formulary drugs. Members will pay the price difference between a brand name drug and a generic equivalent where one exists. The maximum out-of-pocket costs will be raised to $800 per individual and $1600 per family. The fees in the mail order program will be increased to $20 for a 90 day supply of a generic drug, $40 for a formulary drug, and $60 for a non-formulary drug. No deductibles will apply to the mail order plan.

The InterUnits Committee understands that these proposed changes will once again raise the out-of-pocket costs for our members. Maintaining an affordable drug plan without bankrupting the entire program has become an increasingly difficult challenge in the recent era of 20% plus inflation in our drug costs. The Committee feels that it only fair that a portion of those increases be transferred to those actually using the drug plan. The intent is not punishment for those requiring drugs but solvency for the plan as a whole. We appreciate your continuing understanding and good will. ■

Editor's Note - By the time you read this, all of the proposed plan changes will have been reviewed on the campuses and the InterUnits Committee will have met to make the final decisions for next year. We will summarize all of these changes in the May issue of Choices.

Classified Retirement Choices - Part IV

We have reached the end of this series of articles on the choice of retirement plans facing our classified employees and are now ready to offer some guidelines to assist you in your final decision. You may wish to review the previous three articles published in the May, September, and December 2002 *Choices Newsletters*. All are available online at *www.montana.edu/choices*.

First of all, let's do a quick review of the basics. The decision you make is irrevocable and you and your dependents must live with its consequences the rest of your lives. Next, be sure you know your anniversary date of first hire and your years of service. If you are facing a 5, 10 15 or 20 year anniversary date and are considering one of the two defined contribution programs, make your decision and file your election before that date. If you are not facing an anniversary date, wait until early June to file the election; you will receive a guaranteed 8% return on your transferred funds and that is a very good deal considering current market conditions. **Do not, however, forget to file.** See Part I of this series for details.

Understand also the concept of *vesting*, your rights to the employers contribution and accruals. Vesting comes after 5 years in the PERS Defined Benefit (DB) and Defined Contribution (DC) plans; vesting is immediate in the TIAA-CREF Optional Retirement Plan (ORP). Furthermore, your vesting rights transfer; if you are currently vested in the PERS DB plan, you will continued to be fully vested in either DC plan.

You should know where you stand with regards to full retirement eligibility in your current DB plan. You must meet one of the following three criteria: age 60 with 5 years of service, age 65 still in active service, or 30 years of service at any age in order to qualify for the full benefit. There are provisions for early retirement at a reduced benefit. See your PERS manual for details. Furthermore, weigh the following factors in making your final decision: your age, anticipated years to retirement, your spouse's work history and retirement plan, your health and family health history, ages of dependents and their health and needs, your overall financial situation, your knowledge of investments, risk tolerance and willingness to manage a retirement portfolio.

With all of these considerations in mind we can look at some general principles and guidelines to aid you in your decision making. The ultimate goal is to maximize the amount of the retirement benefit for you, your dependents, and heirs. At the same time, you want to minimize taxes paid and gain maximum access to the employers contributions and accruals. That said you must realize that there well may be several different paths to these same goals.

Remember that the guidelines that follow are just that, suggestions appropriate to perhaps the majority of people in a certain category but definitely not all. Individual circumstances could well dictate a different conclusion. Guideline No. 1 will provide our principal example that nothing is 100%:

Guideline 1 - Do not cash-out your retirement plan upon leaving MUS employee. If anything can be said with certainly, it is this. You give up all of your vesting rights (access to the employer's contributions), pay income tax on all of your contributions and accruals in a single tax year, and pay a 10 % tax penalty besides. Most importantly, you jeopardize your long term financial security in retirement for a short gain. Yet even here there may be the occasional but rare situation where cashing out might be necessary. If this step would keep you out of bankruptcy court, for example, it might be a prudent thing to do. No guideline can possibly apply to all individuals and all circumstances.

Guideline 2 - If you are certain that you will be leaving MUS employ before you are vested (5 years service credit), choose the TIAA-CREF ORP. It the only option that will allow you to take a portion of the employer's contributions with you. Even a relatively small amount left in your retirement account when you are young can grow to a sizable amount at retirement through the magic of compound interest.

These first two guidelines can be stated with some certitude. The situations get much more complex after this point and the logic somewhat fuzzier. The problem is that no one knows how financial markets will perform in the future and most of us cannot be totally certain of where our careers will lead us. I am afraid that we will be casting our die before June 30th based on incomplete knowledge and an inability to know the future with any kind of certainty.

Guideline 3 - Most long-term employees who anticipate finishing their careers in the MUS system are probably better off staying with the PERS Defined Benefit plan. This is especially true of older employees. There are two basic reasons for this. As you approach retirement, you want to take less risk with your funds and being exposed to the financial markets is far riskier than following a guaranteed formula. The second reason has to do with the nature of defined benefit plans. DB plans are structured in such a way that long-term employees gain the most at the end of their careers. Unlike DC plans the benefit growth in DB plans is not linear over time, but increases significantly at the end. You do not want to miss this final bump in benefits as you approach the end of your career.

Guideline 4 - Younger employees especially those who have a high probability of advancing their careers elsewhere might want to consider one of the two defined contribution programs. Time is on your side when you are early in your career. Risk is spread out over many years and you have time to recover from any market falls. Defined contribution plans work best when compounding can work its magic over the years and decades. A dollar invested in your 20's could well be worth more than $10 invested in your 40's. In addition, DC plans tend to be more portable. The PERS DC plan has some portability within the State if you continue as a State employee after leaving the University System. You can continue to participate in TIAA-CREF nationwide at most institutions of higher education and at some non-profits as well. The two DC plans are compared in Part III of this series (December 2002). Use that article to guide you in choosing between the two plans.

Guideline 5 -If you are an older worker approaching retirement age but with only a small number of years of service (less than say 15), you will probably find that staying in the DB plan will yield a higher benefit. The reasons are similar to those stated above. If retirement is fast approaching, time is no longer on your side., portability is not an issue, and you will get the final bump that only DB plans offer. Crunch the numbers to be sure by using a financial calculator or financial software such as *MS Money* or *Quicken* or go