

COMPARISON BETWEEN STATE EMPLOYEE GROUP BENEFIT PLANS AND BETWEEN STATE PLANS AND INSURANCE PROVIDED BY LARGE MONTANA EMPLOYERS

A Report Prepared for the
Legislative Finance Committee

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INTRODUCTION

The Legislative Finance Committee (LFC) work plan for the 2017 interim included developing an understanding of the financial condition of the state employee and Montana University System (MUS) group benefit plans. The state employee group benefit plan (SEGBP) experienced large cost increases for medical claims in the previous biennium. The higher than anticipated costs lowered the fund balance of the SEGBP below the level recommended by the plan actuaries. As part of the state employee pay plan for the 2017 biennium the executive requested and received increases of 10.0% in FY 2016 and 8.0% in FY 2017 in the state share contribution to employee health care costs. The higher costs resulted in the decision by the legislature to study the benefit plans over the interim.

As part of its study of the group benefit plans the LFC requested a report comparing the two state health plans and comparison between state health plans and large private employers health care insurance. The purpose of this report is to provide the LFC with a comparison of:

- Premium costs and employer contributions to those costs in 2016;
- Statutory requirements, both federal and state;
- Medical benefits provided under each plan in 2016;
- Deductibles for employees and families;
- Coinsurance and copayments;
- Maximum out of pocket expenses that employee may incur in 2016;
- Differences in network and types of reimbursement agreements included in the network;
- Impacts of potential changes to reimbursement under the SEGBP.

PLANS USED FOR COMPARISON

The state employee group benefit plan provides health insurance benefits for employees of the Legislative, Executive, and Judicial Branches including elected officials. Similarly, the MUS group benefit plan provides health insurance benefits to employees of MUS including professors, administrators, and other employees working within the system.

Large employers in Montana are defined by the Department of Labor and Industry as those employers having more than 1,000 employees. Both MUS and Montana state government are considered large employers. According to the Research and Analysis Bureau within the Department of Labor and Industry, there were 18 private employers with more than 1,000 employees in 2013. For a listing see Appendix A.

The Legislative Fiscal Division (LFD) used the list of 18 private employers to research information on large private employer health benefits provided to employees. As part of the comparison of required benefit, deductibles, copayments and coinsurance, and maximum out of pocket, the LFD included three of the large private employers. Employers were selected if information was available on the employer's website or available from employees. Premium costs for the employer were not available from either source. However, national data is available and is provided for comparison purposes as part of the report.

Data from the health insurance marketplace was not used for comparison purposes in this report because penalties contained in the Patient Protection and Affordability Care Act (ACA) make it cost effective for large employers to provide health insurance through either self-insurance or purchasing a health policy rather than using the health insurance marketplace.

EMPLOYEE COSTS FOR HEALTH INSURANCE

Private insurers collect premiums for health insurance. Self-insured plans collect contributions for health insurance costs. The following figure shows monthly premium costs for the state plans for single employees, employee and spouse, and employee and family.

Premiums for State Insurance Plans						
Plan Year 2016						
	Single Employee	% Difference from SEGBP	Employee & Spouse	% Difference from SEGBP	Employee & Family	% Difference from SEGBP
SEGBP	\$11,556		\$14,196		\$15,120	
MUSGBP - Allegiance	7,488	35.2%	11,148	21.5%	14,136	6.5%
MUSGBP - Blue Choice	7,320	36.7%	10,908	23.2%	13,836	8.5%
MUSGBP - Pacific Source	8,184	29.2%	12,192	14.1%	15,468	-2.3%

As shown, using SEGBP as the baseline for comparisons, premium price differences narrow as the number of individuals covered through the plan increase. Premium costs for private employers were not provided. MUSGBP began setting explicit subsidization targets for dependent premium tiers and retirees seven years ago. The changes were made to meet the Cadillac tax requirements and the ACA requirements for affordability. MUSGBP sets the dependent and retiree subsidies and then determines the single rate necessary to meet revenue needs. Currently, SEGBP sets contribution rates to link the amount of the state share contribution to equal the employee only contribution.

PREMIUM COSTS

According to the Kaiser Family Foundation report, “2015 Summary of Findings”, virtually all employers with 1,000 or more workers offer coverage to at least some of their employees. In 2015, 83% of large employers partially or completely self-funded their health insurance. In 2015 for all plan types, the average single worker contributed \$1,071 toward premiums while the employer contributed \$5,179 or a ratio of 17.2% of costs paid by the employee and 82.8% by the employer. Family insurance premium contributions averaged \$4,955 for employees matched by \$12,591 for employers. The ratio of employee costs increases for families to 28.2% of the total average premium paid by the employee and 71.8% paid by the employer.

According to information from the Kaiser Family Foundation, recent trends in employer-sponsored health insurance include increases in average premiums for single and family coverage. The following figure shows the changes in the average annual premiums between 2004 and 2014.

Average Annual Premiums for Single and Family Coverage						
	2004	2006	2008	2010	2012	2014
Single	3,695	4,242	4,704	5,049	5,615	6,025
% Change from previous		14.8%	10.9%	7.3%	11.2%	7.3%
Family	9,950	11,480	12,680	13,370	15,745	16,834
% Change from previous		15.4%	10.5%	5.4%	17.8%	6.9%

Source: Kaiser Family Foundation analysis, Recent Trends in Employer-Sponsored Insurance.

Plans increased premium costs for health coverage at all levels. Over the 10 year period the average annual costs for a single employee increased between 2004 and 2014:

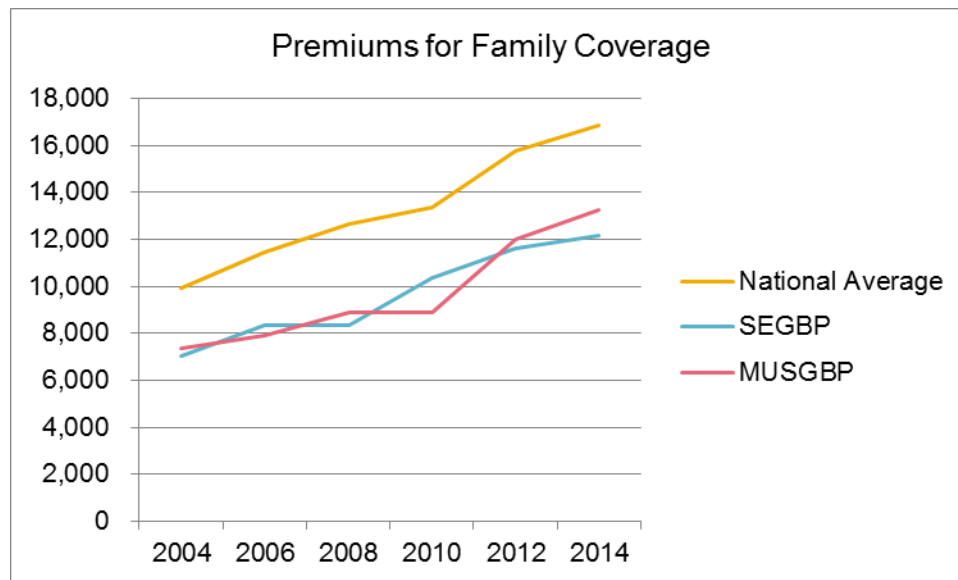
- 63.1% using the national level;

- 45.8% for MUSGBP;
- 92.1% for SEGBP.

During the same period the average annual cost for family coverage included increases of:

- 69.2% using the national level;
- 80.0% for MUSGBP;
- 73.3% for SEGBP.

The figure below contrasts the costs of average annual premiums for family coverage between the national average, the MUSGBP, and SEGBP between 2004 and 2014.



For the MUSGBP and SEGBP, the percentage of single only coverage is about 50%. The other 50% are in rate tiers comprised of employees that cover spouses and or families. To compare the aggregate premium of both the plans to the national average the following uses a weighted calculation combining the single and family coverage increases in premium costs from 2004 through 2014. This shows:

- National level – 66.1% premium increase;
- SEGBP – 82.7% premium increase;
- MUSGBP – 62.9% premium increase.

As stated, premium cost increases between plan year 2014 and 2015 for SEGBP were driven by higher than anticipated health care costs in 2014. According to SEGBP minutes from August 18, 2014 the factors that contributed to the high costs included:

- 100% coverage of preventative care as required in the Patient Protection and Affordable Care Act (ACA) and increased participation in health screenings that identified previously undiagnosed health conditions;
- Open enrollment in plan year 2014 that increased enrollees by about 500. Some of the members had cancer and other chronic diseases resulting in increased costs of \$1.1 million;
- Increased costs from providers, primarily outpatient hospital services which increased \$8.0 million as of June 2014. Costs were driven by cancer and circulatory system diseases;

Further examination of the costs by the contracted actuary also identified:

- Number of claims above \$100,000 increased by 33.4% and the aggregated costs for large claims increased by \$4.3 million above projections;
- Expanded access to health care services due to health centers increases of \$4.5 million;

- Average claim lag increased from 1.35 months to 2.42 months. This resulted in \$9.6 million more in costs than were previously identified;
- Implementing a mental health capitation program whereby an annual fee is paid for each participant in a health plan costing an additional \$1.5 million.

According to MUSGBP staff, increases in MUSGBP premiums during the last five years were the result of:

- Hospital costs increasing. While utilization is decreasing, the cost per service continues to increase, driving costs higher than in total;
- Pharmacy specialty drug costs which has increased 30.0% to 35.0% in five years;
- Elimination of lifetime limits as required by the Patient Protection and Affordable Care Act (ACA). Prior to the change in FY 2014 the plan had only had one claim over a \$1.0 million. In FY 2015 the plan had four claims over \$1.0 million including one over \$4.3 million. MUSGBP negotiated the costs from \$4.3 million down to \$2.3 M. MUSGBP staff indicate that part of the reason for the increase is changes in practice patterns whereby expensive care is utilized for high risk individuals that may not have been afforded those options when there were lifetime limits for health care coverage.

The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured, a report conducted by researchers from various research facilities including Yale University, University of Pennsylvania, and Carnegie Mellon, discusses the results of a study of insurance claims data for 27.6% of individuals with private employer-sponsored insurance in the U.S. between 2007 and 2011. According to the report, hospitals represent 31.0% of health care spending, with the average prices of an inpatient admission in 2011 of \$12,976. The report reaches the following conclusions:

- Health spending on the privately insured varies by more than a factor of three across the 306 hospital referral areas in the U.S. According to the *Dartmouth Atlas of Health Care 1999*, a hospital referral area is defined by documenting where patients were referred for major cardiovascular surgical procedures and for neurosurgery. Montana has three referral areas Missoula, Great Falls, and Billings. See Appendix B for a map of the Rocky Mountain hospital referral region;
- Being for profit, having more medical technologies, being located in an area with high labor costs, being a bigger hospital, being located in an area with lower income, and having a low share of Medicare patients are all associated with higher hospital prices. In addition, the researchers estimate that “monopoly hospitals” have 15.3% higher prices than markets with four or more hospitals. It should be noted that Montana hospitals are considered “monopoly hospitals” as cities within the state do not have four or more hospitals within each market;
- Hospital transaction prices play a large role in driving inpatient spending variation across hospital referral regions;
- Hospital negotiated transaction prices vary substantially across the nation and also occurs across and within geographic areas. For example, the report found within hospital referral regions, the most expensive hospital had a MRI negotiated transaction price twice as large as the least expensive hospital.

A study conducted by Allegiance and confirmed by a third party analyst in 2012 and again in 2014 compared Medicare pricing to the contracted amount Allegiance paid for inpatient and outpatient hospital costs. The study showed that inpatient costs ranged between 191% and 322% of Medicare rates. Outpatient services ranged between 239% and 611% of Medicare rates. These costs would be considered hospital transaction prices.

SEGBP is working with its new third party administrator, Allegiance, to address the increasing costs of both inpatient and outpatient hospital services. The LFD prepared a memorandum on reference based pricing, one of the options under consideration that can be found [by clicking here](#).

EMPLOYER CONTRIBUTIONS TO EMPLOYEE HEALTH INSURANCE COSTS

One of the benefits provided to state employees, including those within the Executive, Legislative, and Judicial Branches and MUS is a contribution to a share of the employee benefit costs, \$887 a month in FY 2015 or \$10,644 a year. This flat amount of employer contribution allocated across the plan to employees, regardless of whether they cover dependents or not, is a defined contribution health benefit plan. It differs from other commonly used contribution allocation methods used by employers. The two most common are a proportional cost split or a percentage of salary. Both these methods are defined benefit contribution which are tied to increases in the cost of health care premiums. The majority of the contribution is used to provide health insurance coverage through the self-insured group benefit plan

During the 2017 biennium state and university employees received increased state share contributions approved by the legislature. State employees' contribution increases in January of each fiscal year to correspond with the plan year. For state employees the increases were:

- \$89 a month or 10% in FY 2016 at a cost of \$1,068 a year per employee
- \$78 a month or 8% in FY 2017 at a cost of \$936 a year per employee

The MUS plan year begins July of each year corresponding with the fiscal year. MUS employees did not receive an increase in state share contributions in FY 2016. Based on their 2015 census of 8,409 employees, this amounted to \$8.9 million in FY 2016 state share that was not appropriated in HB 2. In FY 2017 the state share contribution for benefits increased 18.8% from \$887 a month to \$1,054 or \$167 a month and \$2,004 a year per employee.

One of the impacts of the state share contribution is that both plans charge a higher amount for a single employee's premium than may be required using insurance pricing principles. One of the impacts of the current pricing methodologies is that individuals subsidize the costs of providing insurance for dependents and retirees. To mitigate this, the MUSGBP has gradually been restructuring its pricing to more closely align the premiums to the costs of the plan for the individual. SEGBP is looking at making similar changes in its pricing structure in the next plan year.

It should be noted that according to statute each state agency shall make an employer contribution for group benefits. This directs the funding to the state employee group benefit plan, not to the employee. If health benefit costs for an individual employee are below the amount provided by the state employer share the balance would be paid to the SEGBP or the MUSGBP, not to the employee.

Increases in premium costs are driven by the total cost of medical services provided to employees including:

- Types of services covered under the health plan;
- Utilization of services by employees;
- Severity of the medical conditions requiring medical services;
- Provider charges for services.

DO REQUIREMENTS UNDER FEDERAL AND STATE STATUTES IMPACT PREMIUMS?

This section discusses federal and state requirements related to the provision of health benefits. All plans, whether self-funded or purchased from an insurer, must comply with the following federal statutes:

- Health Insurance Portability and Accountability Act (HIPPA);
- Consolidated Omnibus Budget Reconciliation Act (COBRA);
- Patient Protection and Affordability Care Act (ACA);
- Genetics Information Non-Discrimination Act (GINA);

- Americans with Disabilities Act (ADA);
- Pregnancy Discrimination Act;
- Age Discrimination Act;
- Civil Rights Act.

Impacts on premiums due to changes contained in these acts have largely been absorbed, with the exception of the ACA. Changes in the ACA that have recently been implemented and impact premium costs include:

- Elimination of lifetime limits, this may lead to changes in practice patterns;
- Elimination of copayments and deductibles for preventative care;
- Comparative effectiveness fee – fee is \$2 per average number of members between 2014 through 2019, it is eliminated after 2019;
- Guarantee issue meaning there are no exclusions for pre-existing conditions. In addition rate discrimination based on health conditions or other factors is also eliminated. This results in reduced premium variance within the various plans;
- Reinsurance fee – in 2014 the fee was \$63 per covered life, in 2015 it was \$44 per covered life, and in 2016 it is \$27 per covered life. The fee is eliminated after 2016;
- Expanded coverage for dependents to the age of 26;
- Employer shared responsibility requirements;

The employer shared responsibility requirements were enacted in 2015. Under ACA's shared responsibility requirements for large employers, an employer must offer either minimum essential coverage that is "affordable" and that provides "minimum value" to their full-time employees who are employed at least 30 hours per week on average and their dependents, or potentially be required to make an employer shared responsibility payment to the Internal Revenue Service. An employer can be subject to the payment if:

- The employer does not offer health coverage, or offers coverage to fewer than 95% of its full-time employees and the dependents of the employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on the health insurance marketplace. The penalty is calculated based on the number of full-time employees less 80 multiplied by \$166.67 per employee per applicable month in 2015. The penalty is indexed by the premium adjustment percentage for the calendar year
- The employer offers health coverage, or offers coverage to fewer than 95% of its full-time employees and the dependents of the employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on a health insurance marketplace because the employer did not offer coverage to that employee or because the coverage the employer offered to employees was either unaffordable to the employee or did not provide minimal value

Minimum value is defined as covering at least 60% of the total allowed cost of benefits that are expected to be incurred under the employers' plan. Affordability is determined using an employees' wages, rate of pay, or the federal poverty line.

The additional requirements for employer shared responsibility have the potential to increase the number of employees covered under the state's plan. For example, every other year the Legislative Branch hires a number of employees for the legislative session. A typical session requires about 100 additional employees to provide staffing support working varying hours between the end of December and the beginning of May, about 19 weeks. If individuals work more than 1,040 hours in that period, the state must provide health insurance benefits or make an employer shared responsibility payment. A number of the positions such as the Sergeant at Arms of the House and Senate, the Chief Clerk of the House, and the Secretary of the Senate need to begin working prior to the end of December and often continue into May, potentially requiring the Legislative Branch to pay health insurance benefits for them. Seasonal employees are also found within the Departments of Fish, Wildlife, and Parks, Natural Resources and Conservation, and Transportation.

Another category of employee that may be subject to the impacts of the employer shared responsibility is interns, typically hired for a limited term of employment. Agencies will need to closely monitor the number of hours each intern works to ensure they are complying with the share responsibility requirements. These same requirements are applicable to the large employers included in Appendix A of this report.

One major driver of premium increases is the cost of providing medical benefits to employees. The next section of the report discusses medical benefits provided by the various plans.

MEDICAL BENEFITS

Since the implementation of the ACA insurers are required to provide a minimum of 10 essential health benefits. These include:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventative and wellness services and chronic disease management;
10. Pediatric services, including oral and vision care.

Montana has adopted an essential health benefits plan which further refines the benefits included as essential health benefits for health insurance plans offered in Montana. These include:

- Hospice care excluding services that do not require skilled nursing care including custodial care or care for the convenience of the patient or family member;
- Infertility treatments excluding in vitro fertilization;
- Home health care services excluding maintenance or custodial care visits, domestic or housekeeping services, "Meals on Wheels" or similar food;
- Skilled nursing care coverage excluding custodial care;
- Chiropractic care limited to \$600 maximum per benefit period for treatments and \$100 maximum for office visit and x-rays;
- Radiation therapy;
- Chemo-therapy;
- Infusion therapy;
- Renal dialysis/Hemodialysis;
- Alternative medicine excluding acupuncture, homeopathy, hypnotherapy, Rolfing, and holistic medicine;
- Allergy treatment excluding experimental or investigational procedures, transplants of nonhuman organ or artificial organ implant or donor searches.

In addition Montana statutes require provision of benefits including:

- Minimum hospitalization after childbirth;
- Post-mastectomy care;
- Coverage for mental illness, alcoholism, and drug addiction;
- Autism spectrum disorders;
- Mammography screenings;
- Well-child care;
- Outpatient diabetes management;
- Reconstructive breast surgery after mastectomy;

- Treatment for inborn metabolism errors;
- Coverage for severe mental illness;
- Diagnosis and treatment of Down syndrome.

While the self-insured plans are exempted from a number of the requirements, they are required to provide coverage for autism spectrum disorders, diabetes outpatient management, post-mastectomy care, and diagnosis and treatment of Down syndrome.

In addition to the above requirements the MUSGBP includes the following benefits:

- Naturopathic;
- Medical massage therapy;
- Acupuncture;
- Chiropractic care limited to 30 visits a year which may be higher than required in the essential benefits plan.

The SEGBP provides the following additional benefits:

- Dietary or nutritional counseling maximum 3 days a plan year;
- Chiropractic care limited to 20 days a plan year which may be higher than required in the essential benefits plan;
- Acupuncture.

While health benefits offered to employees are a part of the components behind the increases, the utilization of the benefits based on the overall health condition of the employees is another part of health care costs.

STATE HEALTH PLAN RISK COMPARISONS

In addition to the benefits offered, health plan costs are driven by the overall health of the insured population. The LFD and Health Care Benefits Division (HCB) are working with the Montana Association of Health Care Purchasers to provide health risk scores for state employees and their dependents compared to other Montana employers included in the MAHCP data. The data has not yet been received or analyzed. The LFD will continue to work with HCB on the risk score data. Once the data has been received and analyzed, a separate report will be prepared for the June LFC meeting.

EMPLOYEE COST SHARING

It is generally acknowledged that those required to participate in their own health care costs make better consumer decisions in terms of costs than those that do not have to pay a portion of their health care costs. Most plans require employees to participate in the costs of the plan through deductibles, coinsurance and copayments. The next section of the report discusses deductibles, coinsurance and copayments, and the maximum out of pocket required in 2016. The LFD was able to get information to compare the deductibles, coinsurance, copayments, and out of pocket costs for three large private employers in addition to the state employee group benefit plans.

DEDUCTIBLES

For the most part benefits provided by the two state plans and the large private employers included in this report are similar. The remainder of the report compares the deductibles, coinsurance and copayments required under each plan.

A deductible is the amount owed for covered health care services before a health insurance plan begins to pay. Screenings, immunizations, and other preventative services are paid by the health insurance plan without deductibles being imposed as required by federal law.

At the national level, according to the Kaiser Family Foundation, the average deductible amount for single coverage was \$1,105 for workers in large firms in 2015. In this case large firms are defined as 200 or more workers. Deductibles for all firms have increased, from an average of \$496 in 2006 to \$971 in 2014 or 48.9% over eight years. According to Kaiser, looking at the increase in deductible amounts over time does not capture the full impact for workers because the share of covered workers in plans with an annual deductible as increased significantly, from 55% in 2006 to 81% in 2015. The figure below shows the deductible for the employers included in this report.

Plan Deductibles				
	In Network		Out of Network	
	Single Individual	Family	Single Individual	Family
SEGBP	\$1,000	\$1,000 per member	\$2,500	\$2,500 per member
MUSGBP - Allegiance	750	1,500	1,250	2,750
MUSGBP - Blue Choice	750	1,500	1,250	2,750
MUSGBP - Pacific Source	750	1,500	1,250	2,750
Employer 1 - Health savings medical plan - high deductible*	1,500	3,000	1,500	3,000
Employer 1 - Health reimbursement medical plan*	1,150	2,300	1,150	2,300
Employer 2 - Basic Plan	1,500	3,000		
Employer 2 - Premium Plan	1,000	2,000		
Employer 3 - Health savings account based medical plan	2,000	3,800	4,000	7,600

* Employer provides a health incentive to offset costs of \$700 per individual and \$1,400 per family
 ** Employee can earn up to \$1,600 from the employer if complete health and wellness activities

The SEGBP deductible is slightly lower than the national average for a single employee while MUSGBP is 55% below the national average. Two of the private employers offer health savings account based medical plans which are considered high deductible. Both provide employees opportunities for monetary incentives for medical costs as a part of the plans.

COINSURANCE AND COPAYMENTS

Once the deductible costs have been met, most insurance plans require the employee to pay a portion or percentage of certain medical costs. The ACA requires that services defined as preventative care be provided without deductibles, coinsurance, or copayments.

Coinsurance is a share of the costs of health care service, usually a percentage of the amount allowed for the charged service. Copayments are a fixed amount you pay for covered health care services such as \$15 per doctor visit.

Again referring to information from Kaiser, a large majority of covered or insured workers pay a portion of the cost of physician office visits. Almost 68% of covered workers pay a copayment with a smaller share of workers paying coinsurance for primary care office visits (23%) or specialty care office visits (24%). The average coinsurance for office visits is 18% and is 19% for specialty care. 65% of covered workers have coinsurance for hospital visits with the average coinsurance rate of 19%. Another 14% of covered employees have copayments with the average copayment of \$308 per hospital admission. For outpatient surgery 67% of covered workers have coinsurance requirement averaging 19%. Another 15% have copayments with an average copayment of \$181.

The figure below shows the coinsurance percentages for the employers included in this report.

Coinsurance				
	In Network		Out of Network	
	Single Individual	Family	Single Individual	Family
SEGBP	25%	25%	35%	35%
MUSGBP - Allegiance	25%	25%	35%	35%
MUSGBP - Blue Choice	25%	25%	35%	35%
MUSGBP - Pacific Source	25%	25%	35%	35%
Employer 1 - Health savings medical plan - high deductible*	ranges between 10 - 25%	ranges between 10 - 25%	ranges between 10 - 25%	ranges between 10 - 25%
Employer 1 - Health reimbursement medical plan*	ranges between 10 - 25%	ranges between 10 - 25%	ranges between 10 - 25%	ranges between 10 - 25%
Employer 2 - Basic Plan	N/A	N/A	N/A	N/A
Employer 2 - Premium Plan	N/A	N/A	N/A	N/A
Employer 3 - Health savings account based medical plan	20%	20%		

* Requires a \$25 copayment unless a specialist, specialists require a \$50 copayment but no coinsurance payments
** Requires a \$20 copayment unless a specialist, specialists require a \$40 copayment but no coinsurance payments

With the exception of Employer 3, all employers examined in the report require employees to pay for a percentage of their medical care through coinsurance payments. The percentage of coinsurance is higher for state employees than the other two private employers.

MAXIMUM OUT-OF-POCKET

The ACA required that non-grandfathered plans include an out-of-pocket maximum to limit the cost sharing that a worker must pay in a policy period, generally a year. Once the maximum has been hit the insurer pays 100% of the allowed amount for covered services. In 2015 the maximum was \$6,600 for a single employee and \$13,200 for family coverage. In 2015, 98% of covered workers have an out-of-pocket maximum according to the Kaiser Family Foundation. The maximum increases under the ACA to \$6,850 for single employees and \$13,700 for family coverage in 2016.

The figure below shows the maximum out of pocket costs for the employers included in this report.

Annual Out-Of-Pocket Maximum				
	In Network		Out of Network	
	Single Individual	Family	Single Individual	Family
SEGBP	\$4,000	\$8,000	\$8,950	\$18,900
MSUGBP - Allegiance	4,000	8,000	10,000	19,000
MSUGBP - Blue Choice	4,000	8,000	10,000	19,000
MSUGBP - Pacific Source	4,000	8,000	10,000	19,000
Employer 1 - Health savings medical plan - high deductible*	3,500	7,000	3,500	7,000
Employer 1 - Health reimbursement medical plan*	3,300	6,000	3,300	6,000
Employer 2 - Basic Plan	4,000	8,000		
Employer 2 - Premium Plan	3,000	6,000		
Employer 3 - Health savings account based medical plan	3,000	5,700	6,000	11,400

* Employer provides a health incentive to offset costs of \$700 per individual and \$1,400 per family
** Employee can earn up to \$1,600 from the employer if complete health and wellness activities

The maximum out of pocket amounts for both state employee group benefit plans are equal to or above the other employers examined in this report.

OTHER DIFFERENCES

Additional differences exist between the two state employee group benefit plans including:

- MUSGBP offers employees a choice of three plans. The benefits, copayments, coinsurance, deductibles, and out-of-pocket maximums are the same for all three plans. The difference is the providers within the networks and the premium costs for each plan;
- SEGBP provides state employee health clinic services to state employees in Helena, Missoula, Billings, Miles City, Butte, and Anaconda. Services provided to the employees include primary care visits, flu shots and other vaccinations, health screenings, laboratory services, diagnostic services referrals, and health coaching. Employees receiving medical services provided by the health clinics are not required to make copayments and those referred for x-rays and ultrasounds have no out-of-pocket costs for the services.

LOOKING AHEAD

As discussed earlier in the report, one of the cost containment measures being considered by the SEGBP is referenced based pricing. Impacts of referenced base pricing include limited networks and higher costs for employees because they can be balanced billed for the remainder of the costs.

Balance billed is not considered part of out-of-pocket expenses and the employee is responsible for the difference.

APPENDIX A

PRIVATE EMPLOYERS WITH MORE THAN 1,000 EMPLOYEES IN MONTANA

According to the Research and Analysis Bureau within the Department of Labor and Industry the following were large employers in Montana in 2013:

- Albertson's;
- Benefis Health System;
- Billings Clinic;
- BSNF Railway Company;
- Bozeman Deaconess Hospital;
- Cenex Harvest States Cooperative;
- Costco;
- First Interstate Bank;
- Kalispell Regional Hospital;
- Missoula Community Medical Center;
- Montana Rail Link;
- Northwestern Energy;
- St Patrick Hospital;
- St. Peter's Hospital;
- St Vincent's Hospital;
- Town Pump;
- Wal Mart;
- Wells Fargo Bank.

Hospital Service Areas in the United States

The documentation of the patterns of use of hospitals according to Medicare enrollee ZIP Codes during 1992-93 led to the aggregation of approximately 42,000 ZIP Codes into 3,436 hospital service areas. In each area, more Medicare patients were hospitalized locally than in any other single hospital service area. The propensity of patients to use local hospitals is measured by the localization index, which is the percentage of all residents' hospitalizations that occur in local hospitals (the number of local hospitalizations of residents divided by all hospitalizations of residents). This index varied from a low of 17.9% to over 94%. More than 85% of Americans lived in hospital service areas where the majority of Medicare hospitalizations occurred locally. More than 51% lived in areas where the localization index exceeded 70%.

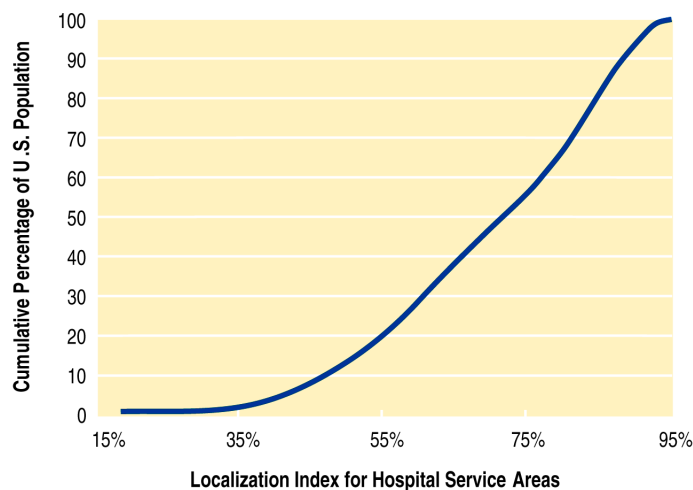


Figure A. Cumulative Percentage of Population of the United States According to the Hospital Service Area Localization Index (1992-93)

The localization index is the proportion of all hospitalizations for area residents that occur in a hospital or hospitals within the area. The figure shows the localization index for Medicare patients in 3,436 hospital service areas, according to the cumulative proportion of the population living in the region. Most of the population lived in regions where more than 50% of hospitalizations occurred locally.

In 1993, most Americans lived in hospital service areas with three or fewer local hospitals. Eighty-two percent, or 2,830, of all hospital service areas, which comprised 39% of the population in 1990, had only one hospital. Four hundred twenty-eight hospital service areas, which comprised 23% of the United States population, had either two or three hospitals. One hundred seventy-eight, or less than 6% of hospital service areas, had four or more local hospitals and comprised about 37% of the population of the United States.