State of Louisiana
Office of Group Benefits
P. O. Box 44036
Baton Rouge, Louisiana 70804

September 9, 2014

Honorable James R. Fannin
Chairman
House Committee on Appropriations
Louisiana House of Representatives
P.O. Box 44486
Baton Rouge, LA 70804

Re: Annual Report of the Group Benefits Policy and Planning Board

Dear Representative Fannin:

The attached report is submitted on behalf of the Group Benefits Policy and Planning Board as required by La. R.S. 42:881.

Please do not hesitate to contact me if you have any questions or need additional information.

Sincerely,

Susan T. West, MBA,CRM
Chief Executive Officer

Report to the

House Appropriations Committee and the Senate Finance Committee

From the

Group Benefits Policy and Planning Board

On

Proposed Changes to the Office of Group Benefits

Life and Health Benefits Programs

Pursuant to La. R.S. 42:881, the Group Benefits Policy and Planning Board (the "Board") is charged with the responsibility of submitting an annual report to the appropriate legislative oversight committees concerning any changes to the life and health programs of benefits proposed by OGB. Accordingly, this report is submitted.

The Board met on July 30, 2014, to review and receive changes to the life and health programs proposed by OGB. The OGB Chief Executive Officer advised the Board of proposed changes to the OGB health program[1] with regard to plans administered by Blue Cross Blue Shield of Louisiana (BCBSLA) effective August 1, as follows:

EFFECTIVE AUGUST 1

Prior Authorization Requirements: OGB will begin requiring prior authorization for certain medical procedures and services. A prior authorization is a process used to determine the necessity of a proposed service and is a standard measure for managing health care plans. BCBSLA will send in-network healthcare providers a list of the required prior authorizations. The BCBSLA providers are familiar with this process and have all the information needed to request and obtain approval for medical services. Services that will now require a prior authorization[2] include:

- Cardiac rehabilitation
- CT scans
- Genetic testing
- Home health care
- Hospice
- MRI/MRA
- Orthotic devices
- Outpatient pain rehabilitation/Pain control programs

[1] OGB is making no change to the life insurance program.

[2] Speech therapy will no longer require a prior authorization.

- Physical/Occupational therapy
- Residential treatment centers
- Inpatient hospital admissions (except routine maternity stays)

Application of Standard Benefits Limits: OGB will now follow BCBSLA standard number of visits allowed per benefit period for skilled nursing facilities, home health care services and hospice care services.

• Skilled Nursing Facility	90 days per benefit period
• Home Health Care Services	60 days per benefit period
• Hospice Care Services	180 days per benefit period

MedImpact Formulary: 3-Tier Plan Design: OGB will begin using the MedImpact Formulary to help members select the most appropriate, lowest-cost options. The formulary is reviewed on a quarterly basis to reassess drug tiers based on the current market. Members will continue to pay a portion of the cost of their prescriptions in the form of a co-pay or co-insurance. The amount members pay toward a prescription depends on whether the purchase is for a generic, preferred brand or non-preferred brand name drug. These changes do not affect members with Medicare as their primary coverage.

	Current Benefit	***August 1 Benefit***
Generic	50% up to $50	50% up to $30
Preferred	50% up to $50	50% up to $55
Non-Preferred	50% up to $50	65% up to $80
Specialty	50% up to $50	50% up to $80

Member Out of pocket Costs: The pharmacy out-of-pocket maximum threshold has been changed from $1,200 to $1,500. Once met:

	Current Benefit	***August 1 Benefit***
Generic	$0 co-pay	$0 co-pay
Preferred	$15 co-pay	$20 co-pay
Non-Preferred	$15 co-pay	$40 co-pay
Specialty	$15 co-pay	$40 co-pay

90-day fill option: For maintenance medications, 90-day prescriptions may be filled at retail pharmacies for two and a half times the cost of the co-pay.
Over-the-counter drugs: Medications available over the counter in the same prescribed strength will no longer be covered under the pharmacy plan.

EFFECTIVE JANUARY 1

Additionally, the OGB CEO advised the Board of proposed changes to the OGB health program[3] effective January 1, when OGB members will have six plan options[4]:

1. **Pelican HRA 1000**– Low premiums combined with $1000 in state funding for employee only plans and $2000 for family plans will help members and their families get the health care they need in the Blue Cross nationwide network. The health reimbursement account offers $1000 state dollars for single employees and $2000 for families that can be used to offset the medical deductible. This plan is available for retirees as well as active employees.

Medical Coverage				
	Employee-Only	Employee + Spouse	Employee + Children	Family
Employer Contribution to HRA	$1,000	$2,000	$2,000	$2,000
Deductible (in-network)	$2,000	$4,000	$4,000	$4,000
Deductible (out-of-network)	$4,000	$8,000	$8,000	$8,000
Out-of-pocket max (in-network)	$5,000	$10,000	$10,000	$10,000
Out-of-pocket max (out-of-network)	$10,000	$20,000	$20,000	$20,000
Coinsurance (in-network)	20%	20%	20%	20%
Coinsurance (out-of-network)	40%	40%	40%	40%

[3] OGB is making no change to the life insurance program.

[4] In the past, many members selected plans with higher costs and benefits than were necessary for the typical member's needs. So OGB's goal is to offer a wider range of options to give OGB members a chance to select exactly the right plan. OGB revised the plan names for several reasons: 1) plan benefits changed and 2) to encourage members to review each plan to determine which plan best meets their medical and financial needs.

2. **Pelican HSA 775** – A strong, stable network combined with a health savings account and matching state dollars allows members and their families to save money in an interest-bearing account that can be rolled over each year if not used. A health savings account offsets much of the plan's deductible, and rolls over each year. Money that isn't used earns interest and can be withdrawn at retirement to use for other expenses.

Medical Coverage				
	Employee-Only	Employee + Spouse	Employee + Children	Family
Employer Contribution to HSA	$200, plus up to $575 more dollar-for-dollar match of employee contributions			
Deductible (in-network)	$2,000	$4,000	$4,000	$4,000
Deductible (out-of-network)	$4,000	$8,000	$8,000	$8,000
Out-of-pocket max (in-network)	$5,000	$10,000	$10,000	$10,000
Out-of-pocket max (out-of-network)	$10,000	$20,000	$20,000	$20,000
Coinsurance (in-network)	20%	20%	20%	20%
Coinsurance (out-of-network)	40%	40%	40%	40%

3. **Magnolia Local** – This local plan varies based on your location. Shreveport, New Orleans and Baton Rouge networks are available for members who want low premiums and don't have needs that will take them out of the local area. This local coordinated care network product is designed for **Baton Rouge communities** (East & West Baton Rouge and Ascension Parishes), **Shreveport communities** (Caddo and Bossier Parishes) and **Orleans and Jefferson Parishes** in the Greater New Orleans area. This is a great health plan for people who want local access, a new approach to health and a lower priced insurance plan.

Medical Coverage				
	Employee-Only	Employee + Spouse	Employee + Children	Family
Employer Contribution to HRA/HSA	$0	$0	$0	$0
Deductible (in-network)	$500	$1,500	$1,500	$1,500
Deductible (out-of-network)	No coverage	No coverage	No coverage	No coverage
Out-of-pocket max (in-network)	$3,000	$9,000	$9,000	$9,000
Out-of-pocket max (out-of-network)	No coverage	No coverage	No coverage	No coverage
Co-Payment (in-network)	$25 / $50	$25 / $50	$25/$50	$25/$50
Co-Payment (out-of-network)	No coverage	No coverage	No coverage	No coverage

4. **Magnolia Local Plus**– This option offers the same benefits as the Magnolia Local plan, with an expanded network. This type of plan offers predictable co-payments that make this option attractive for members who need a larger coverage area.

Medical Coverage				
	Employee-Only	Employee + Spouse	Employee + Children	Family
Employer Contribution to HRA/HSA	$0	$0	$0	$0
Deductible (in-network)	$500	$1,500	$1,500	$1,500
Deductible (out-of-network)	No coverage	No coverage	No coverage	No coverage
Out-of-pocket max (in-network)	$3,000	$9,000	$9,000	$9,000
Out-of-pocket max (out-of-network)	No coverage	No coverage	No coverage	No coverage
Co-Payment (in-network)	$25 / $50	$25 / $50	$25/$50	$25/$50
Co-Payment (out-of-network)	No coverage	No coverage	No coverage	No coverage

5. **Magnolia Open Access** – Navigate a wide network with the open access plan, which provides coverage in and out of the Blue Cross nationwide network. This traditional plan offers the widest options for active employees and retirees. Low deductibles make it a good option for anyone who needs a broad network.

Medical Coverage				
	Employee-Only	Employee + Spouse	Employee + Children	Family
Employer Contribution to HRA/HSA	$0	$0	$0	$0
Deductible (in-network)	$1,000	$3,000	$3,000	$3,000
Deductible (out-of-network)	$1,000	$3,000	$3,000	$3,000
Out-of-pocket max (in-network)	$3,000	$9,000	$9,000	$9,000
Out-of-pocket max (out-of-network)	$4,000	$12,000	$12,000	$12,000
Co-Insurance (in-network)	10% (active) 20% (retiree)*	10% (active) 20% (retiree)*	10% (active) 20% (retiree)*	10% (active) 20% (retiree)*
Co-Insurance (out-of-network)	30% (active) 20% (retiree)*	30% (active) 20% (retiree)*	30% (active) 20% (retiree)*	30% (active) 20% (retiree)*

*Retiree with Medicare

6. **Vantage Medical Home HMO** – OGB will continue to offer the regional Medical Home HMO plan from Vantage now in all regions of Louisiana.

Medical Coverage				
	Employee-Only	Employee + Spouse	Employee + Children	Family
Employer Contribution to HRA/HSA	$0	$0	$0	$0
Deductible (in-network)	$500	$1,500	$1,500	$1,500
Deductible (out-of-network)	$1,500	$3,000	$3,000	$3,000
Out-of-pocket max (in-network)	Tier I: $3,000 Tier II: see below	Tier I: $9,000 Tier II: see below	Tier I: $9,000 Tier II: see below	Tier I: $9,000 Tier II: see below
Out-of-pocket max (out-of-network)	None	None	None	None
Co-payment (in-network)	$0/$35 $10/$45	$0/$35 $10/$45	$0/$35 $10/$45	$0/$35 $10/$45
Co-payment (out-of-network)	50% subject to deductible	50% subject to deductible	50% subject to deductible	50% subject to deductible

- **Tier I Providers**
  Most participating providers are Tier I providers. Members seeing Tier I providers pay the Tier I co-pays, co-insurance and deductibles as listed in the Certificate of Coverage. (Affinity *Health Network Providers*)

- **Tier II Providers**
  Tier II providers are participating providers whose cost may be higher than other similar participating providers. Members who choose to see these providers will have to pay an additional 20% coinsurance in addition to their Tier I cost share. There is no out-of-pocket maximum for Tier II services.

The information provided herein constitutes the report of the Board to the Legislature as prescribed by statute.

Nancy ~~DeWitt~~
Chairman