



OGB Hot Topics

Frequently Asked Questions

ANNUAL ENROLLMENT

Q: When and how can members enroll?

A: Annual enrollment begins October 1 and ends October 31. Employees and retirees can enroll in one of three ways:

1. By visiting the online enrollment portal
2. By completing a paper enrollment form
3. By contacting human resources if you are an active employee or OGB if you are a retiree

Q: What happens if members don't enroll?

A: Current OGB members who don't enroll in a 2015 plan will be enrolled in the Pelican HRA 1000 – a new, low premium plan that offers employer funds to offset out-of-pocket costs.

It's important that you take the time to review each of the 2015 offerings to ensure you are selecting the right coverage for your circumstances. The out-of-pocket cost calculator can help active employees and retirees without Medicare see how each plan could affect their out-of-pocket costs depending on the type of care needed.

Q: Is OGB forcing members to move plans?

A: OGB is still offering HMO, PPO and consumer-driven health plans in 2015. While none of the 2015 plans are exactly the same as the plans offered in 2014, some of the choices are very similar. Because we are offering new options, we are requiring that all OGB members make a plan selection for 2015. If you are currently enrolled in a plan and do not make a selection by the end of the enrollment period, you will be moved into the Pelican HRA 1000 – a new, low premium plan that offers a nationwide network and an employer contribution that can be used to offset out-of-pocket costs.

Q: Why do the plans have new names?

A: As OGB added more plan offerings of the same plan type (multiple HMO plans, multiple CDHPs), it became confusing to name them the way we did in the past (HMO, PPO, CDHP). This year we categorized them and offered more details about plan specifics in the name. For example, the Pelican HRA 1000 offers a \$1000 employer contribution into a health reimbursement account.

It's important that you take the time to review each of the 2015 offerings to ensure you are selecting the right coverage for your circumstances. The out-of-pocket cost calculator can help you see how each plan could affect your out-of-pocket costs depending on the type of care you need.

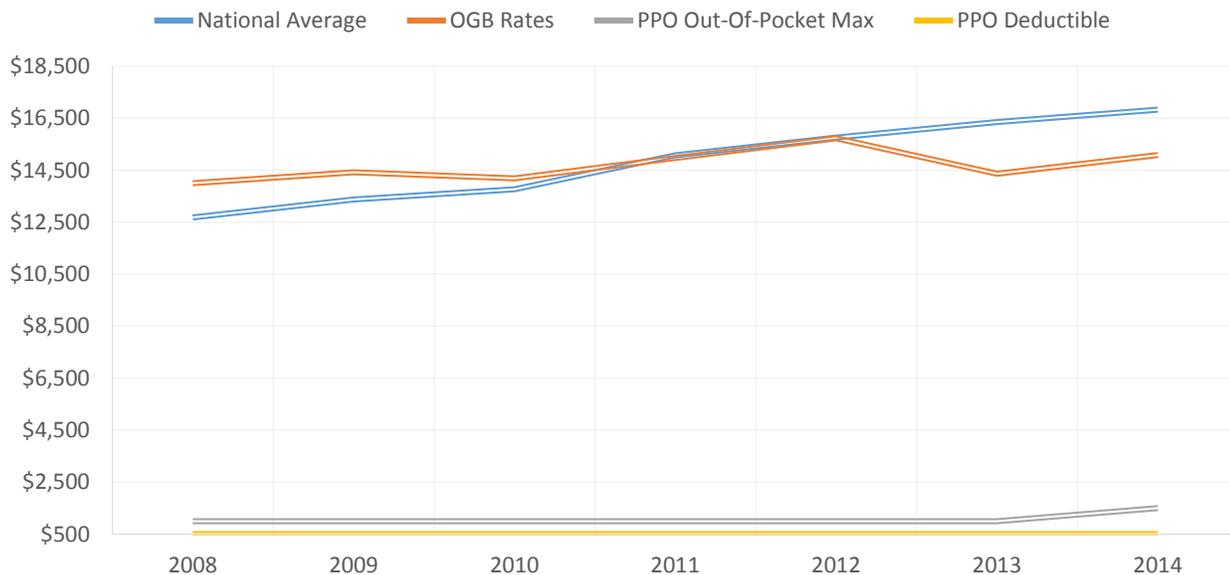
Q: Why must things change?

A: Since 2008, claims grew from \$993 million to \$1.37 billion in 2014 — a 28 percent increase. In that same time period, OGB's premiums grew less than eight percent. Health care costs across the country are rising at six percent a year. In addition to that, the Affordable Care Act will cost OGB \$24 million each year, with the potential for a \$31 million penalty in 2018 if no changes are made.

Q: Who decided to make these changes?

A: Every year, OGB works with its actuary and health care providers to review claims trends and costs. If we are paying more in claims than we take in from premiums, we have to make changes to ensure we can operate responsibly. Traditionally, claims have risen by about six percent a year. Through a combination of administrative savings and benefit changes, OGB has been able to maintain affordable coverage for its members without significantly increasing costs to members.

COST GROWTH: OGB VS. NATION 2008-2014



OUT-OF-POCKET COSTS

Q: Is it true that costs are rising by 47%?

A: No. That number is from an LFO report that mistakenly referred to the out-of-pocket maximums as the "out-of-pocket cost". Out-of-pocket maximums refer to the potential cost a member could pay if they fully utilize the benefits available. At OGB last year, less than three percent of members enrolled in the HMO plan did that. The average member enrolled in an employee-only plan only paid \$250 out-of-pocket last year, while the average family paid \$466, far below the current and future maximums. So, while the maximum amount a member could potentially pay is increasing, most members will not be affected by the change.

Q: How will these changes affect the average member?

A: Most members who choose to stay enrolled in the plan closest to their current plan will see few changes. The largest change to the plans offered in 2015 is the increase to the out-of-pocket maximum. Less than three percent of members in OGB's HMO plan reached the out-of-pocket maximum last year. That means that for most members, the increased maximum won't affect their bottom line.

The other major change is the addition of a \$500 deductible to the HMO plan (the Magnolia Local Plus). While the deductible only applies when a co-pay doesn't, members in that plan will have to reach the deductible before the plan will pay a larger portion towards care.

However, in 2015 OGB will also offer new plan options that preliminary calculations show can save the majority of members money in premiums and other out-of-pocket expenses compared to their current coverage. So, members who change plans could see significant savings.

Q: Are premiums increasing?

A: No. Premiums increased for the first time in nearly three years in July and will not increase again in January. In fact, premiums for the CDHP (Pelican HSA 775) will decrease by 50%. One of the new plan options - the Pelican HRA 1000 - will also offer premiums 30% lower than today's HMO plan option.

Q: What's changing?

A: Co-pays and deductibles within the HMO plan (Magnolia Local Plus) are changing. The cost of caring for OGB members has risen by 28% since 2008. While OGB has been able to shield its members from the majority of that cost - increasing premiums by less than 8% in the same time period - it must make some changes to plans to continue to operate.

In 2015, a \$500 deductible has been added to the HMO plan. Co-pays in that plan have increased from \$15 to \$25 for primary care visits.

For many members currently enrolled in the HMO, it may be possible to save money in out-of-pocket costs by moving into one of the new Pelican plans. Those plans offer employer funding that offsets out-of-pocket costs.

Q: What does it mean when there is no out-of-network coverage available?

A: Out-of-network coverage is coverage outside of your available network. OGB's plans offer Blue Cross's nationwide network, making it easy to stay in-network for your care. 98.7% of all providers used by OGB members enrolled in the HMO plan last year were covered in the Blue Cross network.

OGB VS. OTHER PLANS

Q: How do OGB plans rank against the rest of the country?

A: Last year OGB's actuary, Buck Consulting, performed an analysis to determine the Actuarial Value of OGB's plan offerings compared to those in the southern states. They compared each plan's design to determine relative value. This type of analysis is similar to the method used when plans are compared on the federal healthcare exchange. Buck determined that OGB's HMO plan offered the highest value among its peer group and 8% higher than the average.

Another recent report - "State Employee Health Plan Spending" report released in August by the Pew

Charitable Trusts and MacArthur Foundation - showed that our premiums are 15% lower than the average rates across the country.

Q: How do OGB plans rank against LSU First?

A: LSU First plans are both high deductible, co-insurance plans with offsetting employer funding, similar to the new Pelican plans OGB will offer in 2015. A lot of the complaints about OGB's new plans revolve around the addition of a deductible to the HMO plan. However, both LSU First Options offer deductibles. Their deductibles are actually higher than OGB's, but once you factor in their employer funding, you end up with a \$500 and a \$1500 deductible for the LSU First Options. OGB offers deductible options at \$500 and \$1,000.

LSU First does not offer co-pay plans comparable to OGB's HMO offerings.

HISTORY

Q: When is the last time you've made these kinds of changes?

A: OGB changes its plans every year. But, the last major change was probably the addition of the current statewide HMO plan in 2008. Today, 75% of our members are enrolled in that plan.

When the HMO was launched in 2008, premiums for a single employee were \$130.18. In 2015, that plan will offer premiums of \$140.38. That's a little more than a 7.5 percent increase over a seven year period. In that same seven year period, premiums across the country rose by 31 percent.

OGB's claims rose in that time period as well. Since the HMO was introduced, claims grew from \$993 million to \$1.37 billion in 2014 – a 28 percent increase. However, OGB was able to shield its members from the majority of those increases through its shift to third-party administration and by using a portion of the fund balance to cover the increased costs.

MEMBER OUTREACH

Q: How are you educating your members on the changes?

A: In a variety of ways:

- Active employees and retirees are invited to attend any of 41 meetings around the state to get more information on the new plans and answers to any questions.
- Active employees and retirees are invited to attend any of twelve live webinars throughout September and October.
- All members will receive a full decision guide and annual enrollment form in the mail.
- The annual enrollment website provides detailed information about plan choices, the ability to enroll online, and an out-of-pocket cost calculator that will help members select the right plan.
- Customer service hours will be expanded to better serve members.
- OGB is working with retiree associations to get information to their members and attending the RSEA and LTRA conferences in October.
- OGB is training all agency human resource departments to ensure everyone who works with members is fully trained and able to answer questions on the new plan offerings.
- Members who have not enrolled by the middle of October will receive calls and reminder notices from OGB.

Q: What about members without an internet connection?

A: OGB is mailing decision guides to all member homes. Members will also receive a printed invitation to attend any of the 41 meetings scheduled around the state. The guides include a paper form that can be mailed back to OGB with the member's plan selection. Additionally, as the enrollment period progresses, OGB and HR liaisons will call members who haven't yet enrolled to remind them about annual enrollment. And finally, OGB is running public service announcements all over the state to ensure members without internet access are aware of the enrollment period.

Q: What about retirees?

A: Retirees will be notified in the following ways:

- Retirees are invited to attend any of 41 meetings around the state to get more information on the new plans and answers to any questions. (see p. 5 for dates)
- Retirees are also invited to attend any of twelve live webinars throughout September and October.
- Retirees will receive a full decision guide and annual enrollment form in the mail by October 1.
- The annual enrollment website launching 9/15 will provide detailed information about plan choices and the ability to enroll online.
- Beginning 9/15 customer service hours will be expanded to 7 a.m. - 7 p.m. Monday - Saturday to better serve retirees.
- OGB is working with retiree associations to get information to their members and attending the LTRA and RSEA conferences in October.
- Public service announcements will run on state-wide radio and TV networks starting 9/15.
- Members who have not enrolled by the middle of October will receive calls and reminder notices.

Q: What about teachers?

A: Teachers will receive communications from OGB in all the ways listed above as well as through targeted communications just for them. OGB is emailing 38,000 teachers with information on its plans and working with the retired teachers association to schedule other communications. Webinars were scheduled with teachers in mind at 4:30 p.m. throughout September and October.

Q: Can members call OGB for help?

A: Yes. The customer service line is open from 7 a.m. to 7 p.m. Monday through Saturday. We are asking all of our members to evaluate a new set of plan options for 2015 and it's critical that we provide resources to help them make the best choice possible for their situation.

Q: Did you hire an outside firm to help support your customer service center?

A: Yes. The \$1.36 million contract with AnsaFone includes call center support from September 15 through November 15 to include the weeks surrounding the October annual enrollment period. AnsaFone has experience working with benefit enrollment and its staff has been fully trained on OGB's history, product offerings, and member concerns.

Q: How long does the contract last?

A: The contract extends from August 28 through November 30, 2014.

Q: Was the contract competitively bid?

A: Yes. OGB solicited bids from four vendors and evaluated them based on price and service. Ansafone was selected based on its price, experience, and level of service.

Q: Why didn't you hire a Louisiana company?

A: Working with a Louisiana-based company was a priority. Unfortunately, none of the Louisiana-based companies solicited could meet our service needs in the timeframe specified. Due to the complexity of the decisions facing our customers, it was imperative that a company knowledgeable in the the health insurance benefits industry be available quickly to allow members the maximum amount of time and information necessary to make an informed decision.

THE FUND BALANCE

Q: Why has the fund balance declined?

A: In years past, OGB's reserve balance reached more than double the target reserve balance. It was unnecessary to keep a reserve fund at that level, so over the last several years, we made adjustments and kept premiums low to reduce the burden on members and get our fund balance to an appropriate level. Now that we've reached our target reserve balance, we're making changes that allow us to keep plans affordable for our members.

Q: What's the target balance?

A: OGB and its actuary have developed a formula for calculating an appropriate target balance. A variety of factors were used in the calculation and the recommendation was based on best practices of funds maintained by other insurance entities and the National Association of Insurance Commissioner's risk based capital standards for health insurance companies. Using those standards, an appropriate balance falls between the highest monthly disbursement during the past six months and two times OGB's average monthly disbursements during the same period. That puts a target balance currently at somewhere between \$113 million and \$226 million.

Q: A recent editorial said OGB's fund balance would have a zero balance by the end of the year. Is that true?

A: No. OGB's actuary predicts that OGB will have a \$118 million fund balance and a \$243 million cash balance at the end of FY15. That number is within OGB's target range for a healthy balance and is entirely appropriate for a plan of OGB's size.

Q: What's the difference between cash balance and fund balance?

A: It's different from the cash balance, which is all cash on hand. The fund balance is all cash on hand, minus an actuarially determined amount set aside for claims that may not have been reported.

Q: Was the fund balance used to balance the budget?

A: The money in the fund balance is only used to pay for health care claims and OGB administrative expenses. It has never been moved or used anywhere else.

Q: What's the current fund balance?

A: At the end of FY14, it was \$207 million.

PRIVATIZATION

Q: Are plans changing because of the Blue Cross privatization?

A: No. OGB's Blue Cross plans are self-insured, meaning that claims payments come from OGB's budget. OGB maintains responsibility for plan design and benefit controls while Blue Cross manages its network and the administration of claims payments.

When OGB partnered with Blue Cross and Blue Shield of Louisiana in 2013 for administration of its PPO plan, the HMO plan – with nearly 75% of OGB members enrolled – had already been administered by a third-party since 2007.

The partnership with Blue Cross was intended to save money on administrative costs while providing members with Blue Cross' nationwide network and rich plan offerings. The partnership has been very successful and has saved OGB nearly \$40 million on administrative costs and claims costs.

THE AFFORDABLE CARE ACT

Q: Are these plan changes because of ACA?

A: Some plan changes are required by ACA, including preventive services for women and covering pre-existing conditions. Additionally, fees and plan changes related to the ACA will cost OGB \$24 million each year, requiring OGB to make changes that offset those costs.