



# Office of Group Benefits

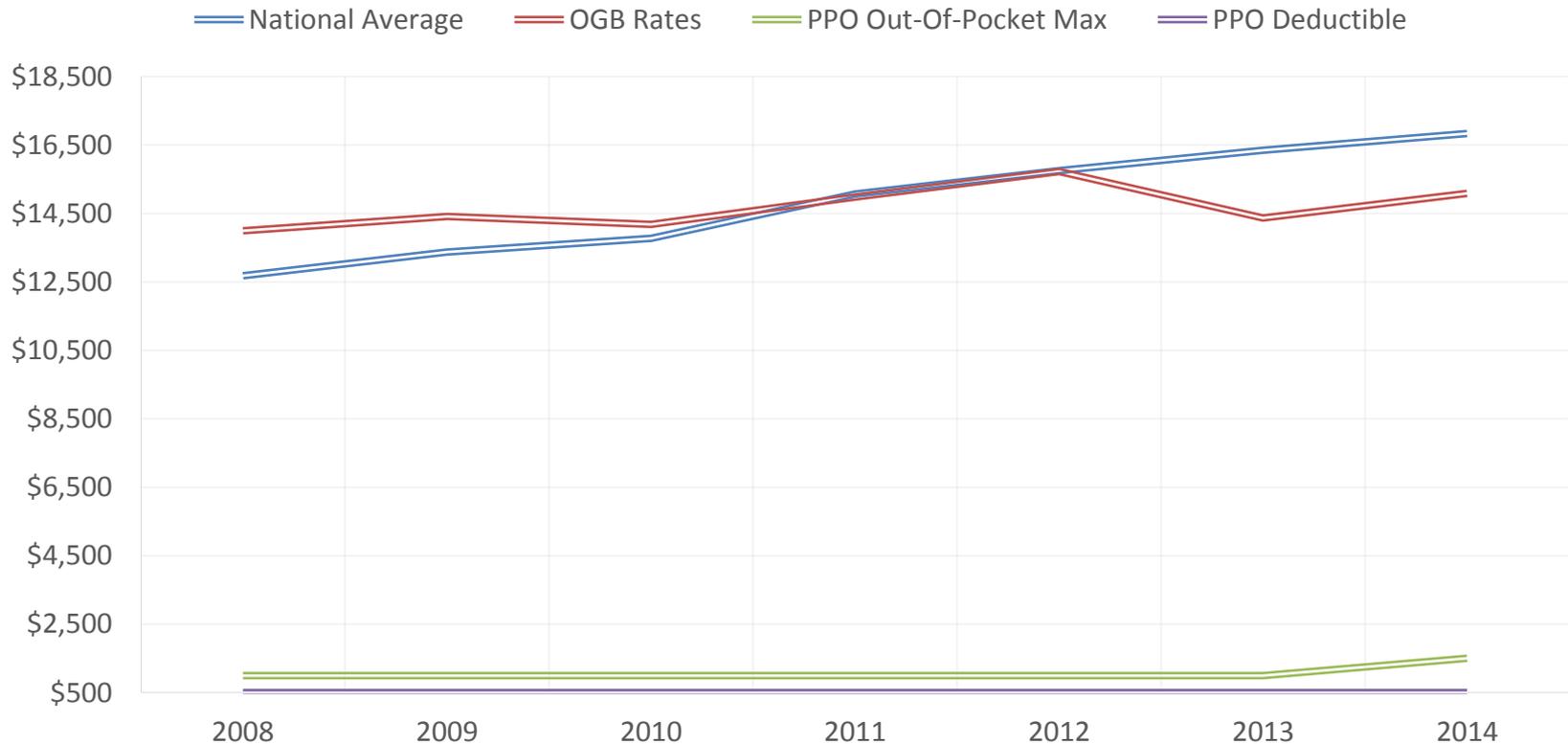
September 25, 2014





# OGB Since 2008

Since 2008, OGB has passed along fewer costs to its members than the rest of the country



# Today

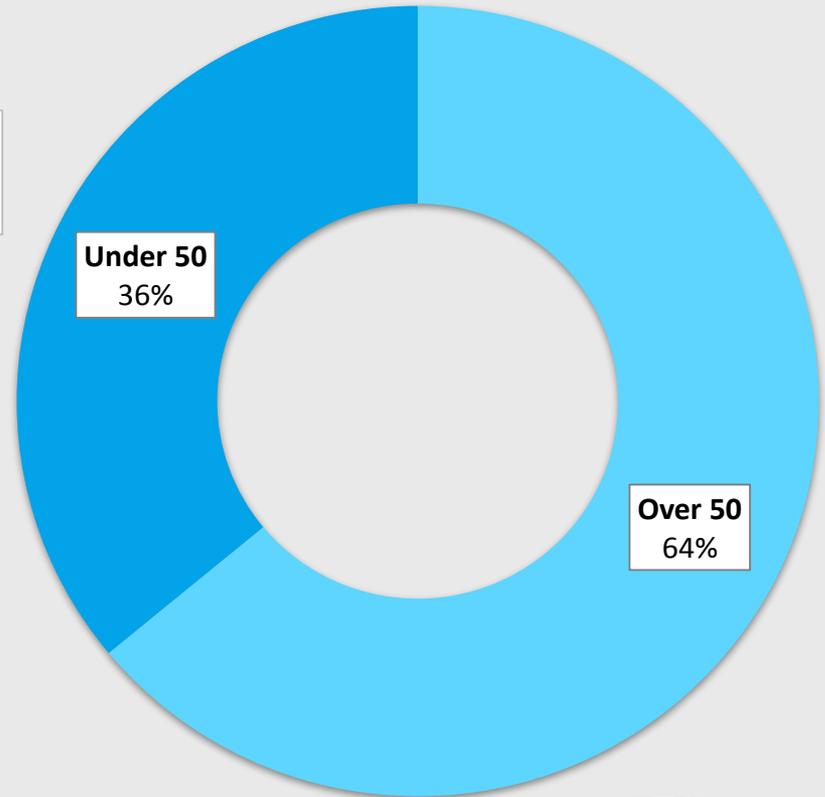
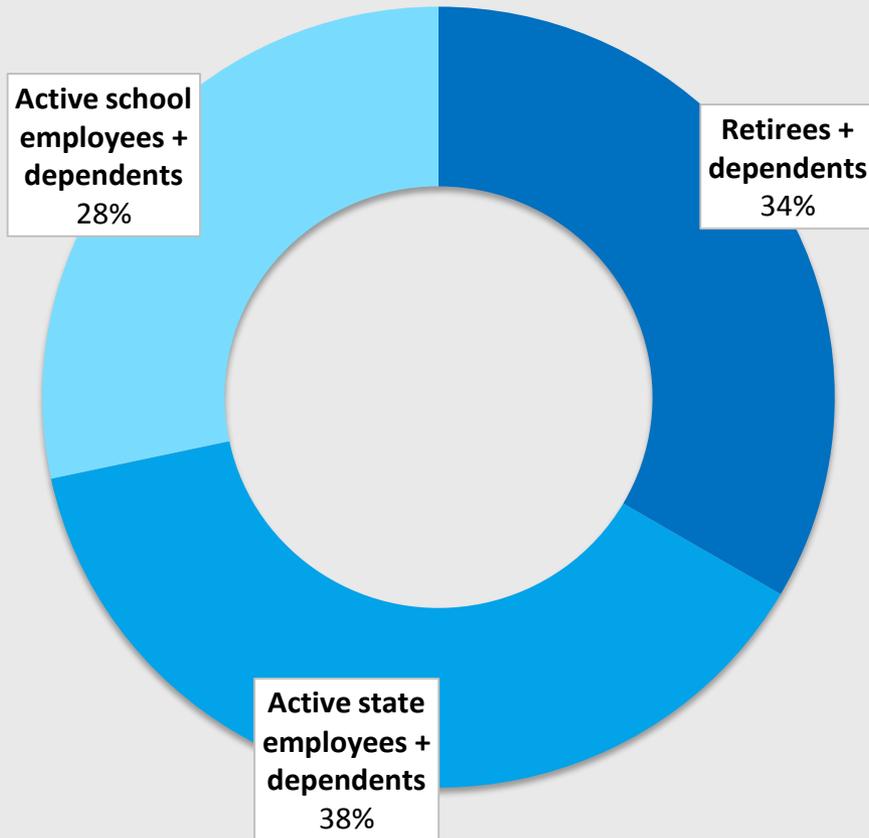
- OGB's HMO plan has the richest benefits in the region
- Premiums are 15% lower than national average
- If no changes are made, claims will outpace revenue by \$16 million each month



# HISTORY



# OGB Members



# How Did We Get Here?

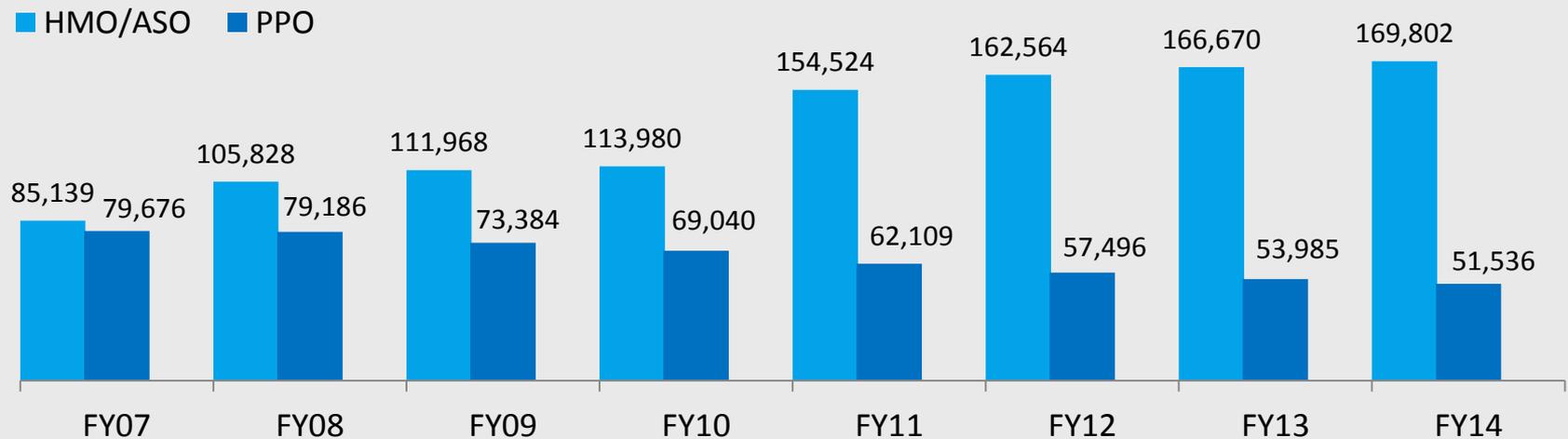
In 2008, OGB eliminated its EPO plan in favor of a new HMO plan

Traditional HMO	OGB HMO
Narrow network	Nationwide network that covers 98.7% of providers used by OGB members
Care driven by primary care physician through referrals and prior authorizations	No prior authorization or referral requirements
Providers incentivized to control utilization and cost	Providers incentivized to increase volume



# Membership in HMO

The design of the OGB HMO incentivized members to join through large provider network, low co-pays and low premiums.

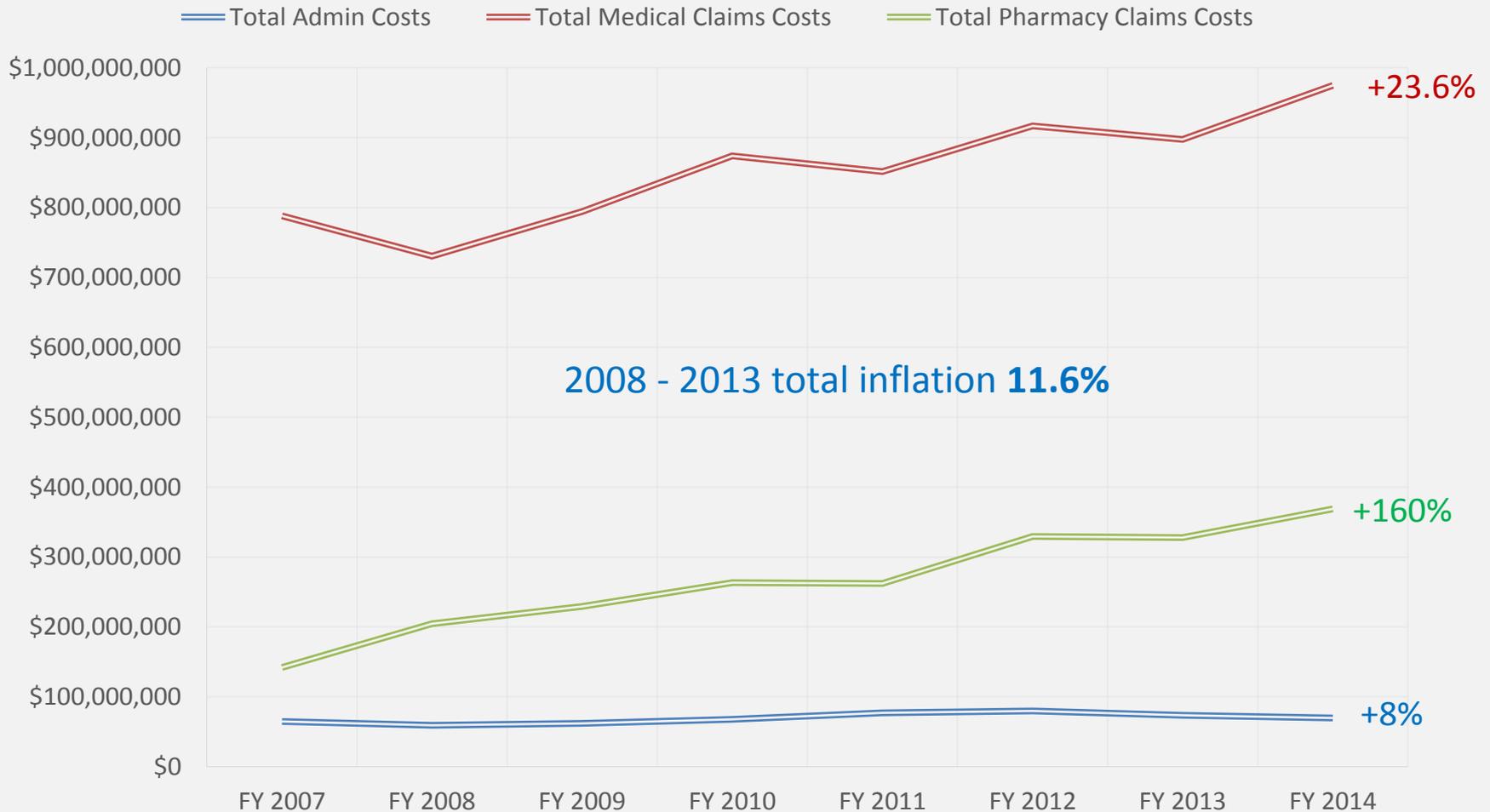


Membership in the PPO declined by 35%  
Membership in the HMO increased by 99%





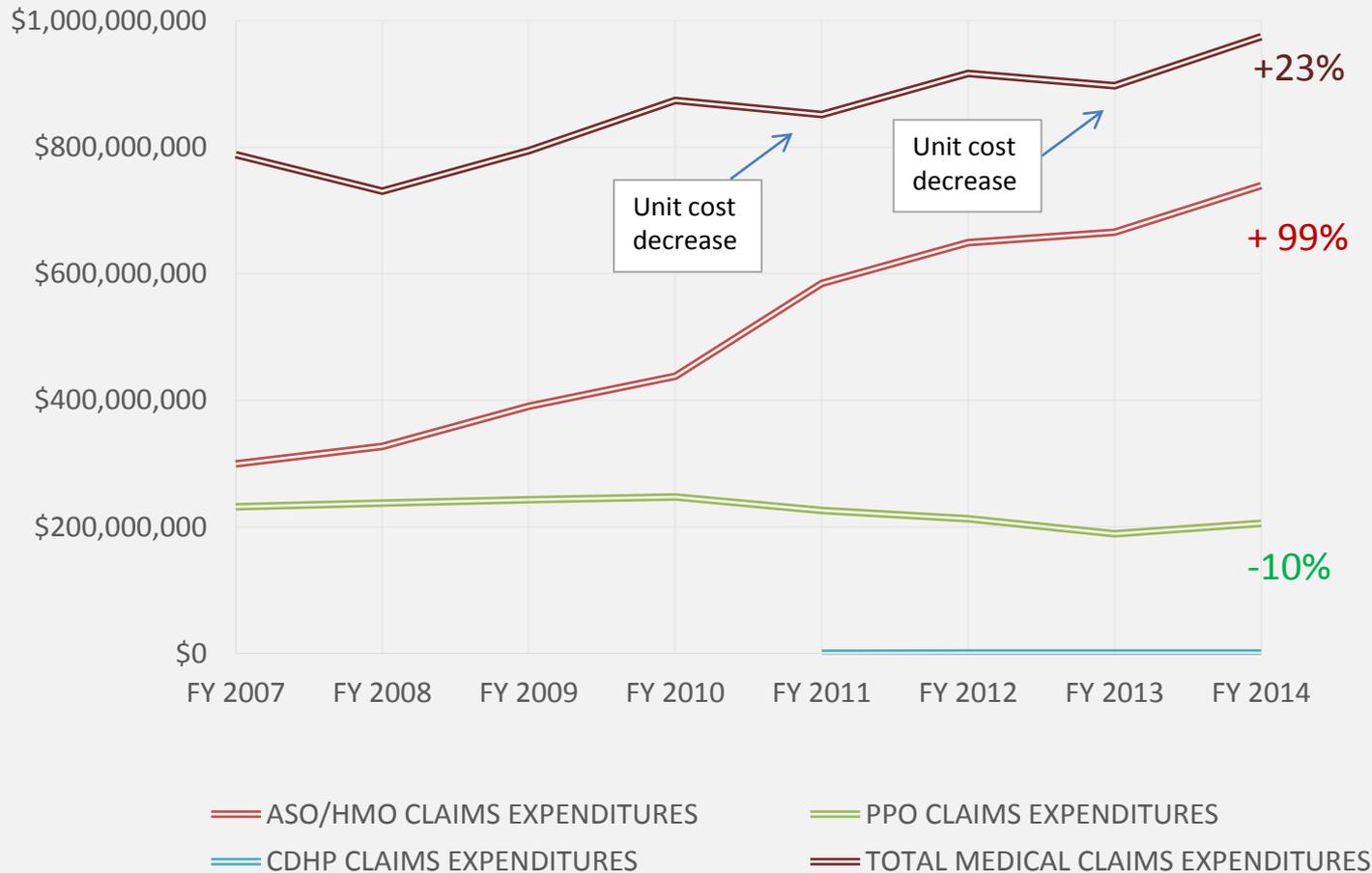
# Expenses 2008-2014





# Medical Claims Breakdown

The biggest increase in expense has come from the HMO plan.



## HMO Growth

2008:	8%
2009:	16%
2010:	11%
2011:	25%
2012:	10%
2013:	2%
2014:	10%

## PPO Growth

2008:	2%
2009:	2%
2010:	2%
2011:	-9%
2012:	-6%
2013:	-13%
2014:	8%

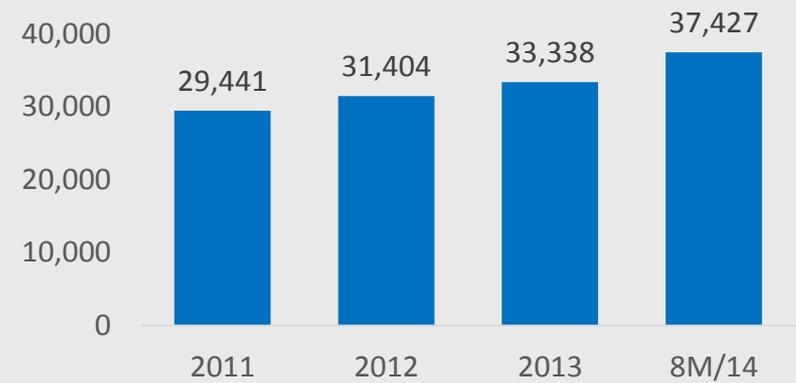
# Utilization vs. Unit Cost

There are two factors that determine claims expenses: unit cost and utilization

HMO Unit Cost

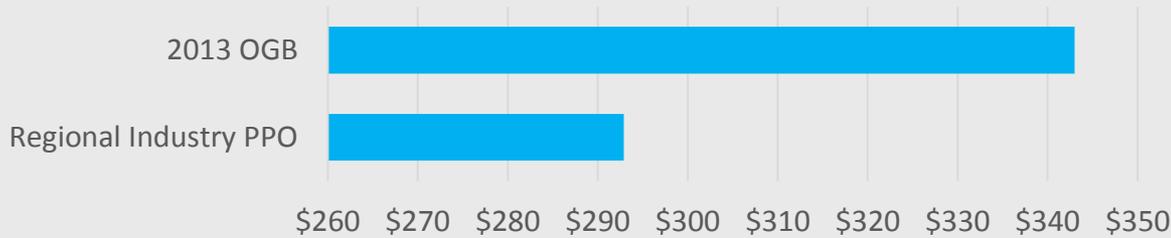


HMO Utilization



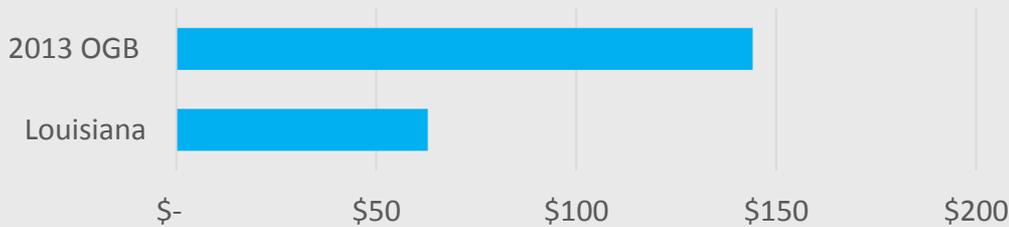
# Utilization

## Total Medical Claims PMPM



OGB's total medical claim cost per member per month is **17% higher** than the regional benchmark.

## Total Pharmacy Claims PMPM



OGB's rate of pharmacy claims is **129% greater** than the Louisiana benchmark.

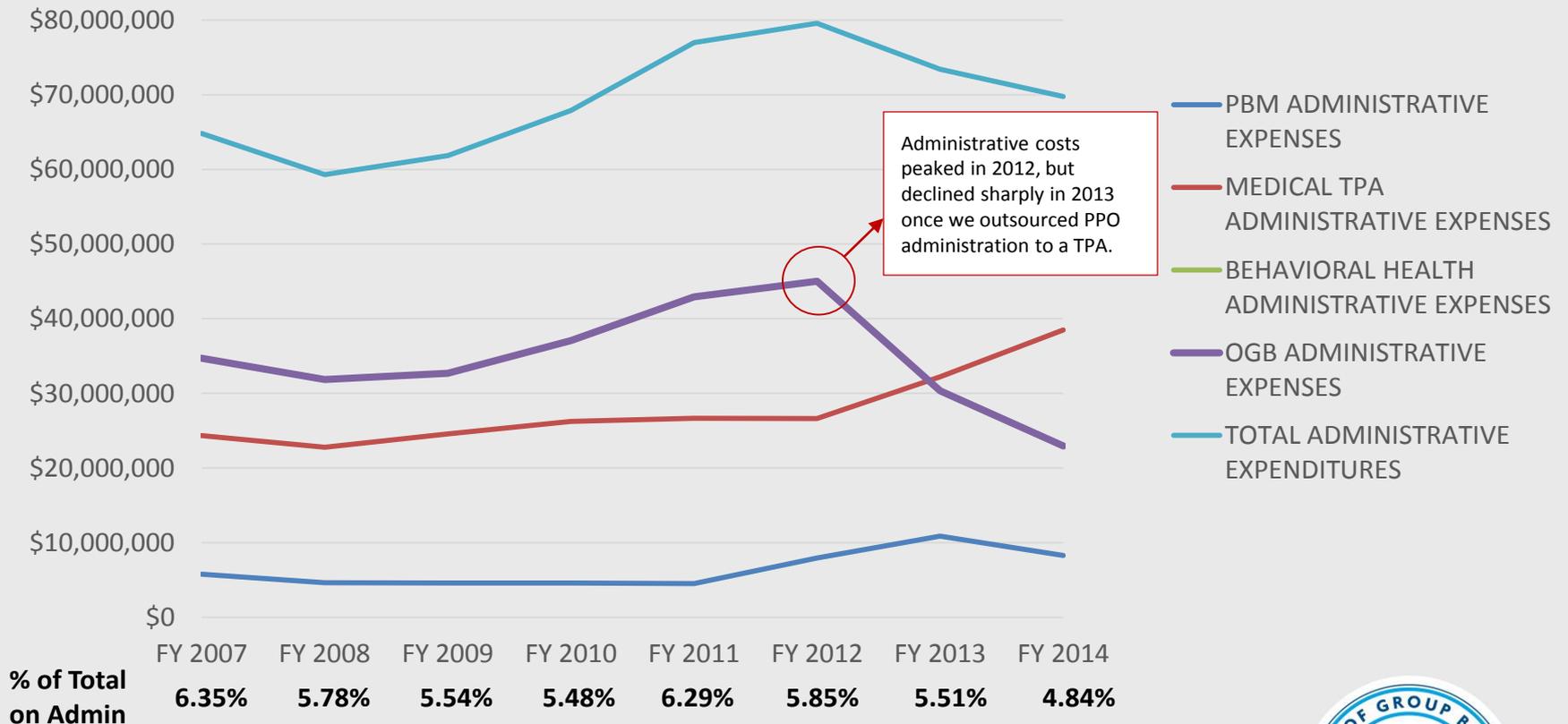


# OUTSOURCING



# Why Change?

## Administrative Expenses Peaked in 2012



# Third-Party Administrator

After a competitive bid process, Blue Cross and Blue Shield of La. was selected in 2011 to administer the HMO benefit plan, and PPO in 2013.

- Today Blue Cross serves as a Third Party Administrator (TPA) by providing a provider network, customer service, and processing claims.
- The TPA contract expressly prohibits Blue Cross from playing a role in benefit design.
- OGB is rebidding the TPA agreement in 2015 for a new agreement beginning 1/1/16.
- The new TPA will be required to provide TPA services, plus enhanced analytics and population health management.



# Savings

Blue Cross and Blue Shield took over claims administration for the PPO plan in January 2013.

### Total PPO Medical Expenses



### Administrative Costs



# 2011 vs. Today

	2011	2014
Medical Claims	\$851 million	\$974 million
Pharmacy Claims	\$262 million	\$368 million
Administrative Costs	\$67.8 million	\$69.7 million
Administrative %	5.5% of total expenses	4.8% of total expenses
Premiums for individual member in HMO	\$139.30	\$140.28



# CASH BALANCE



# Cash Balance

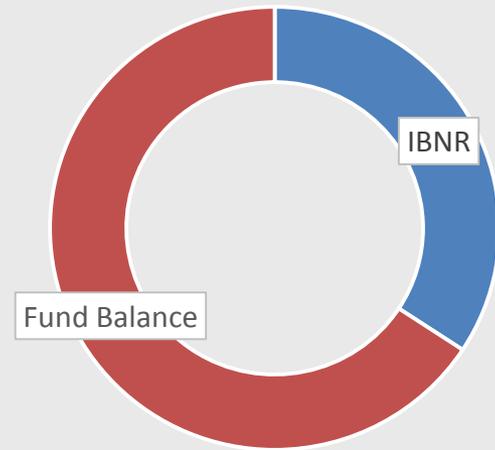
## Year-end Cash Balance



# What is the Cash Balance?

- Cash balance is all cash on hand
- Fund balance is all cash - IBNR
- IBNR is an estimate of incurred but not reported claims

CASH BALANCE



# Target Balance

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. The target balance falls between \$113 and \$226 million.

**\$113 million**

(highest monthly disbursement  
over last six months)

**OGB  
Fund  
Balance**

**\$226 million**

(two times the average  
monthly disbursement over the  
last six months)



# Rate Decrease

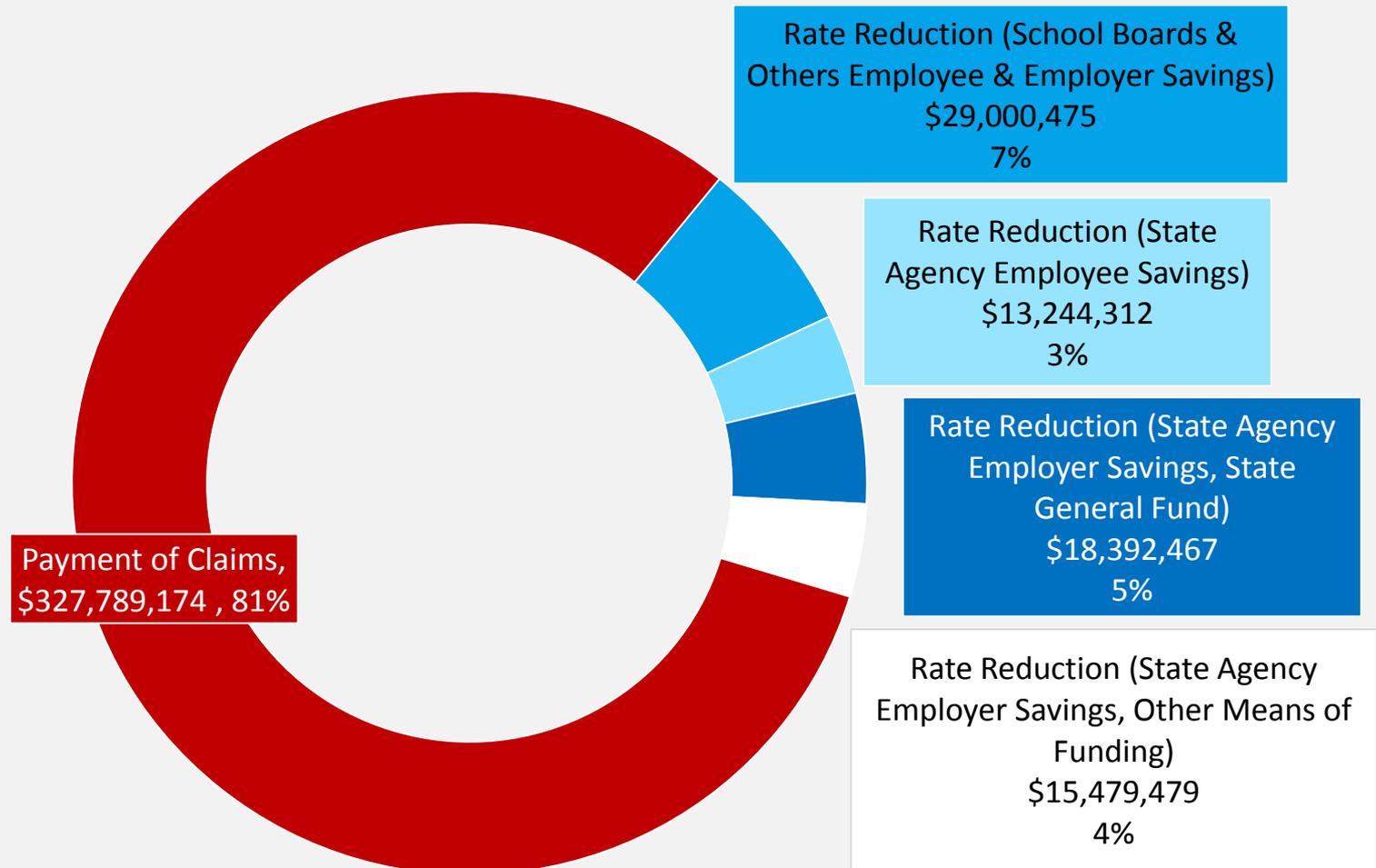
In 2011, our year-end cash balance was \$595.4 million and fund balance was \$499.8 million. **326%** above its current target.

- OGB's actuary recommended lower rates.
- Most state employees had not received merit increases in several years.
- Lowering rates in 2012 and 2013 gave families enrolled in OGB plans an additional \$500 each year.





# Where Did the Reserves Go?



*At the same time, other revenues increased which offset the effect of premium decreases by \$29M.*

# What if these plans are not implemented?

By the end of fiscal year 2015, OGB will have only \$8 million in reserves. It will have two options:

Immediately raise premiums by 37%  
for all members

OR

Immediately raise premiums by 25%  
for all members

*AND*

Implement \$145 million in plan  
changes. (For reference, the 2015  
plan changes will save \$130 million)



**TODAY**



# State by State Plan Comparison

Many states contribute one rate to the employee and the employee must “buy up” both plan and family members.

- Not all offer HMO plans
- Most are introducing CDHPs



# Plan Richness

**Pew Study** - Only calculated plan contribution on premium and claims. OGB plans were just below the national average, but still would be considered a Platinum Plan on the healthcare exchange.

**Buck Analysis** - Analyzed plan designs and compared benefits to benefits for southern states. **OGB HMO carries the highest Actuarial Value of any other plan in the south.** PPO was average.

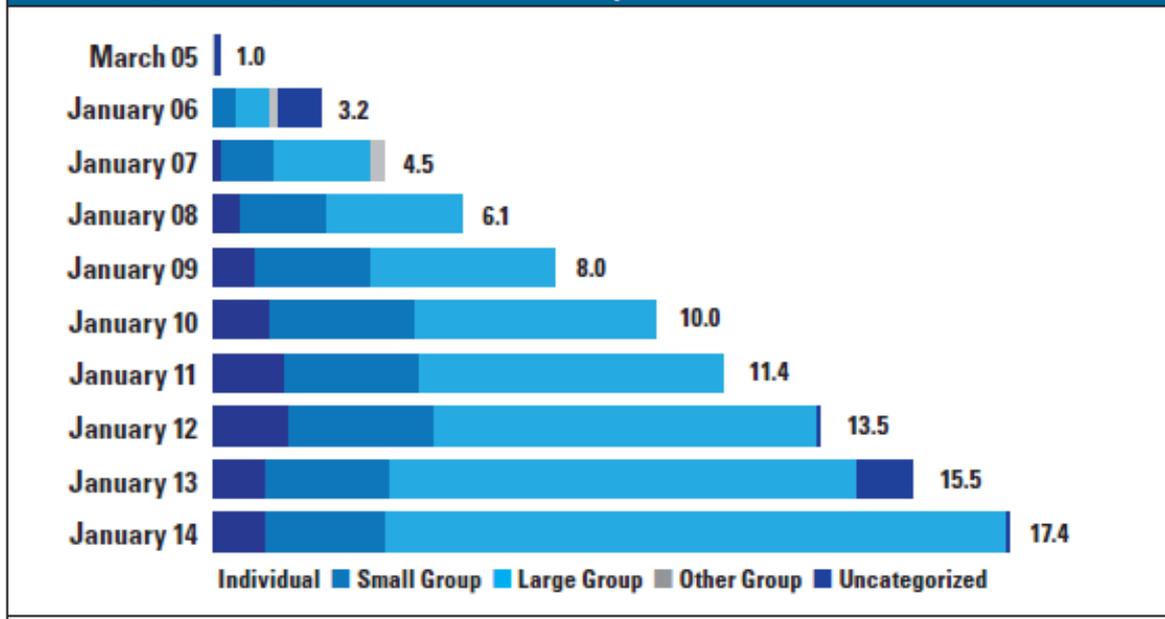
State	Plan	RelVal
LA	HMO	1.08
LA	PPO	1.00
AL	PEEHIP-PPO	0.94
AL	VIVA Health Plan	0.95
AR	Gold	0.97
AR	Silver	0.89
AR	Bronze	0.85
FL	Health Investor HMO	0.75
FL	Standard HMO	1.06
FL	Health Investor PPO	0.82
FL	Standard PPO	0.97
MS	Base	0.84
MS	Select	0.86
TN	Partnership PPO	0.96
TN	Standard PPO	0.88



# The Move to Consumer-Driven Plans

As of January 2014, nearly 17.4 million people were enrolled in HSA/HDHPs. This represents an increase of approximately 2 million enrollees since January 2013, 4 million since January 2012, and 6 million enrollees since January 2011 (see Figure 1 and Table 1).

**Figure 1. Growth of HSA-Qualified High-Deductible Health Plan Enrollment, (Millions), March 2004 to January 2014**





# Today at OGB

OGB is in the same situation as other employers across the country:

- Health care costs rising at 6% a year
- The Affordable Care Act will cost \$24 million a year starting in 2015
- The ACA includes the possibility of the “Cadillac Tax” of \$31 million in 2018
- The cash balance is at its target level and can no longer be used to offset member costs

# Cost Management Options

1. Raise premium rates
2. Adjust benefits
3. Increase member cost share
4. Reduce administrative costs
5. Lower provider reimbursement
6. Improve health of members





# OGB Plan

- Rates went up for the first time in nearly three years in July. They will NOT go up again in January. Administrative savings are expected by reducing central office expenditures and by continuing to partner with a health plan
- New wellness program designed to help members focus on health and prevention
- Some benefit changes to HMO and PPO in January, along with new lower cost offerings

# STRATEGIC CHANGES



# Redesigned Strategic Direction

Old OGB	New OGB
Acted like insurance company	Employer who strategically manages employee benefit plan offerings
Processed claims	Manages vendor partnerships
No big picture claims analytics	Strategic utilization management
Excessive span of control	Functional organization with technical expertise
Communication inefficiencies	Improved communication and technology
Inefficient	Efficient



# Reorganization

OGB's new role and commitment is to manage benefit plans and to achieve maximum efficiency while considering best practices. In order to leverage vendor partnerships, OGB's organization will be streamlined to allow for the blending of functions, the re-alignment of employee skills and the maximization of efficiency and productivity.

- Two positions have been created to focus on wellness - OGB plans to hire from within the organization.
- One position has been created in budget to allow for greater oversight of the budgetary process and actuarial analysis.



# PLAN CHANGES



# Where are we now?

July 1, 2014	January 1, 2015
Four plans for active employees, retirees without Medicare and retirees with Medicare (as secondary plans)	Six plans for active employees, retirees without Medicare and retirees with Medicare (as secondary plans)
Two co-pay plans, two deductible and co-insurance plans available	Three co-pay plans, three deductible and co-insurance plans available
Routine vision include in two plans	Routine vision included in one plan
Multiple Medicare Advantage plans as alternatives for Medicare eligible	Multiple Medicare Advantage plans as alternatives for Medicare eligible



# What's really different?

HMO Plan = Magnolia Local Plus	
July 1, 2014	January 1, 2015
Primary care co-pay = \$15 Specialty care co-pay = \$25	Primary care co-pay = \$25 Specialty care co-pay = \$50
ER co-pay = \$100	ER co-pay = \$150
Out-of-network coverage available	No out-of-network coverage available <i>(Last year, 98.7% of providers were covered in-network)</i>
Out-of-pocket max = \$1000	Out-of pocket max - \$3000
Deductible = \$0	Deductible = \$500
New Option – Magnolia Local	
July 1, 2014	January 1, 2015
Not available	Baton Rouge, New Orleans and Shreveport networks available
Not available	Access to Blue Cross's Blue Connect and Community Blue networks

# What's really different?

PPO Plan = Magnolia Open Access	
July 1, 2014	January 1, 2015
Deductible = \$500 (active employees) Deductible = \$300 (retirees)	Deductible = \$1000 (all individual plans)
Out-of-pocket max = \$1500	Out-of-pocket max - \$3000

CDHP = Pelican HSA 775	
July 1, 2014	January 1, 2015
Monthly premium = \$115.28	Monthly premium = \$56.99

New Option – Pelican HRA	
July 1, 2014	January 1, 2015
Not available	Monthly premium = \$98
Not available	\$1,000 - \$2,000 in employer funding that offsets half of the deductible

# What's really different?

15% of members account for **77%** of claims expense

Average spend:

- Employee Only HMO: \$250
- Employee + : \$466
- Employee Only PPO: \$664
- Employee + : \$1,170

*Does not mean all members will see an increase  
Cost can decrease based on individual choice*



# Member Outreach and Education

- Decisions guides mailed to homes
- Reminder postcards
- Extended customer service hours
- 43 statewide meetings
- 16 live webinars
- Recorded webinars
- Email
- Website
- HR reps
- Retirement associations
- Public service announcements

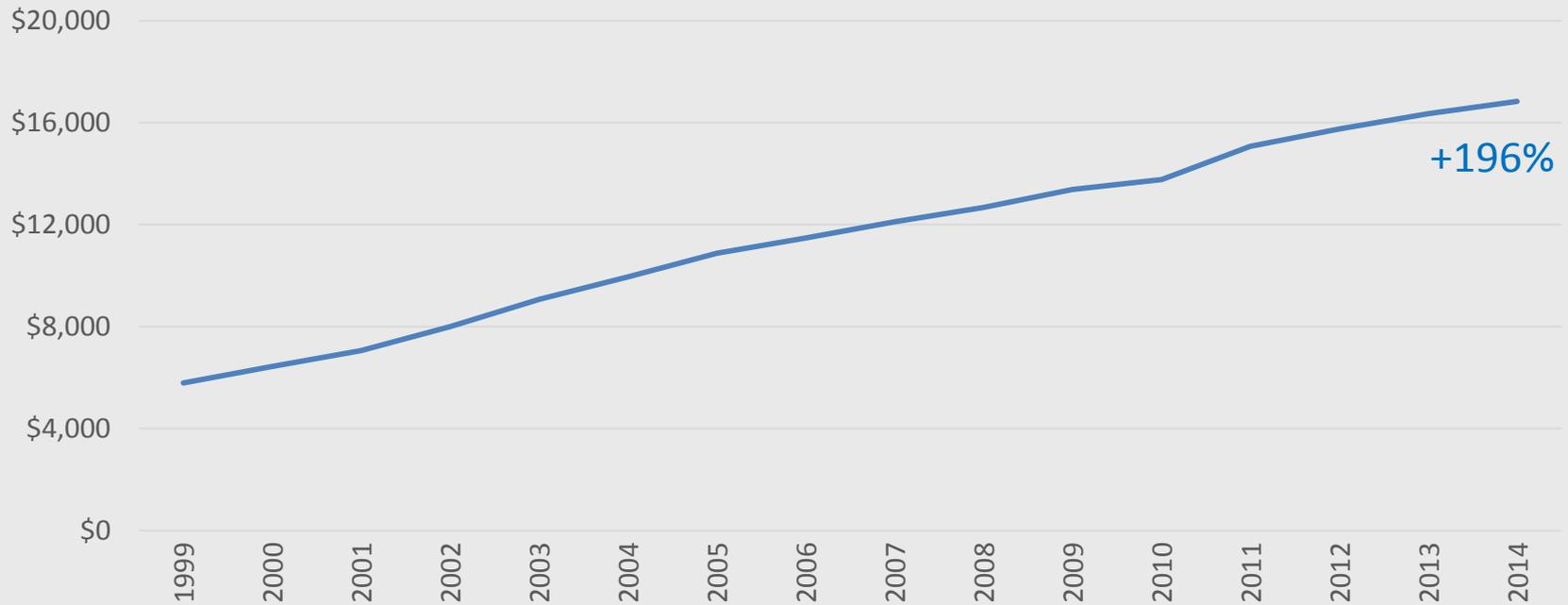


# APPENDIX



# The State of the Industry

Since 1999, the cost of health care has increased by 196%



# When is the HMO the Right Choice?

## Service Estimates:

Estimate the **anticipated** number of **visits per year** to the following for **you and/or your dependents**:

Preventive/Wellness Care (per year) [What are these?](#)

Primary Care Physician (per year) [What are these?](#)

Specialty Care Physician (per year) [What are these?](#)

Urgent Care Center (per year) [What are these?](#)

Emergency Room (per year)

Inpatient Hospital Visits (assumes a three day hospital stay) (per year)

Outpatient Surgeries (per year)

## Prescription Drugs:

Estimate how many different types of the following prescription drugs **you and/or your dependents** are taking **per month**? (This number will be calculated as an annual cost)

**Note:** For a listing of medications and their associated tier, please view the current full formulary lists for the [Pelican HRA 1000 & Magnolia plans](#) or the [Pelican HSA 775](#).

Tier 1 Generic (per month)

Tier 2 Preferred (per month)

Tier 3 Non-Preferred (per month)

Tier 4 Specialty (per month)

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Tier 1 Generic (per month)

Tier 2 Preferred (per month)

Tier 3 Non-Preferred (per month)

Tier 4 Specialty (per month)

	Pelican		Magnolia		
	HRA 1000	HSA 775	Local	Local Plus	Open Access
Plan Design	PPO	PPO	HMO	HMO	PPO
Employee Monthly Premium Contribution	\$98.52	\$56.96	\$133.64	\$140.28	\$148.48
Additional Employer Contribution <a href="#">What are these?</a>	\$1,000.00	\$775.00	—	—	—
Maximum Medical and Pharmacy Out of Pocket Cost	\$5,000.00	\$5,000.00	\$3,000.00	\$3,000.00	\$3,000.00
Your Estimated Total Medical and Pharmacy Expenses <a href="#">How is this calculated?</a>	\$720.00	\$100.00	\$995.00	\$995.00	\$1,450.00
Employee Annual Premiums	\$1,182.24	\$683.52	\$1,603.68	\$1,683.36	\$1,781.76
Additional Employee Contribution <a href="#">What is this?</a>	—	\$575.00	—	—	—
<b>Your Estimated Total Annual Expenses <a href="#">How is this calculated?</a></b>	<b>\$1,902.24</b>	<b>\$1,358.52</b>	<b>\$2,598.68</b>	<b>\$2,678.36</b>	<b>\$3,231.76</b>
Your Rollover Account for Next Year's Expenses	\$270.00	\$0.00	—	—	—
Your 2016 Beginning Account Balance	\$1,270.00	\$1,350.00	—	—	—

	Pelican		Magnolia		
	HRA 1000	HSA 775	Local	Local Plus	Open Access
Plan Design	PPO	PPO	HMO	HMO	PPO
Employee Monthly Premium Contribution	\$98.52	\$56.96	\$133.64	\$140.28	\$148.48
Additional Employer Contribution <a href="#">What are these?</a>	\$1,000.00	\$775.00	—	—	—
Maximum Medical and Pharmacy Out of Pocket Cost	\$5,000.00	\$5,000.00	\$3,000.00	\$3,000.00	\$3,000.00
Your Estimated Total Medical and Pharmacy Expenses <a href="#">How is this calculated?</a>	\$3,466.00	\$3,116.00	\$1,295.00	\$1,295.00	\$2,693.00
Employee Annual Premiums	\$1,182.24	\$683.52	\$1,603.68	\$1,683.36	\$1,781.76
Additional Employee Contribution <a href="#">What is this?</a>	—	\$575.00	—	—	—
<b>Your Estimated Total Annual Expenses <a href="#">How is this calculated?</a></b>	<b>\$4,648.24</b>	<b>\$4,374.52</b>	<b>\$2,898.68</b>	<b>\$2,978.36</b>	<b>\$4,474.76</b>
Your Rollover Account for Next Year's Expenses	\$0.00	\$0.00	—	—	—
Your 2016 Beginning Account Balance	\$1,000.00	\$1,350.00	—	—	—

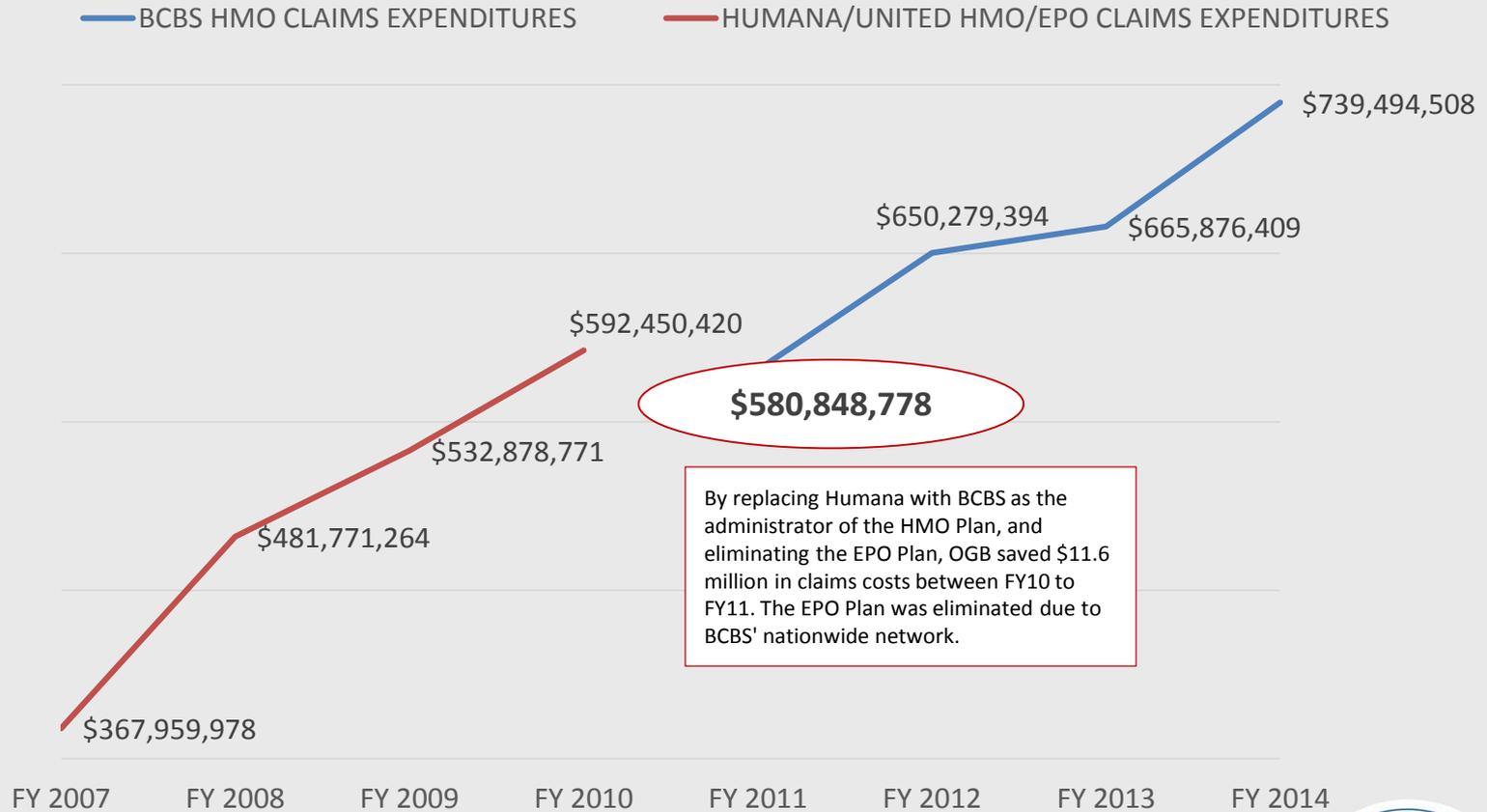


# OGB vs. LSU First

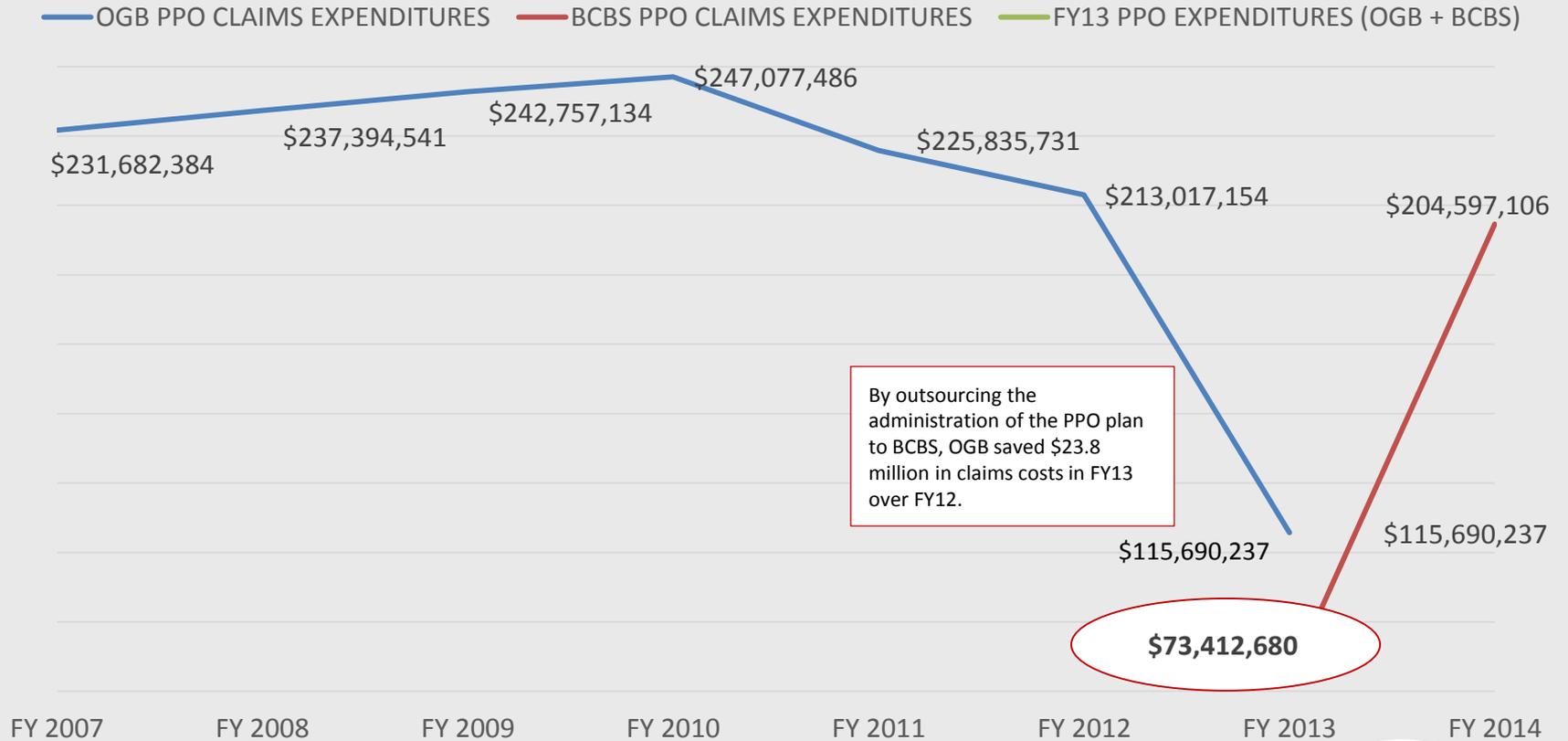
	LSU First	OGB
# of Options	2	6 (active employees) 5 (retirees)
# of High Deductible Options	2	2 (active employees) 1 (retirees)
# of HMO Options	0	3
Lowest Deductible Available	\$1,500	\$500



# HMO Medical Expenses



# PPO Medical Expenses



# Timeline

- Oct 1 – Annual Enrollment Begins
- Oct 15 – Medicare Advantage Open Enrollment Begins
- Oct 31 – Annual Enrollment Ends
- Nov 14 – Deadline for agencies to enter all plan changes made during Annual Enrollment period
- Dec 7 – Medicare Advantage Open Enrollment Ends
- Jan 1 – 2015 plan year begins



# Comparing Apples to Oranges

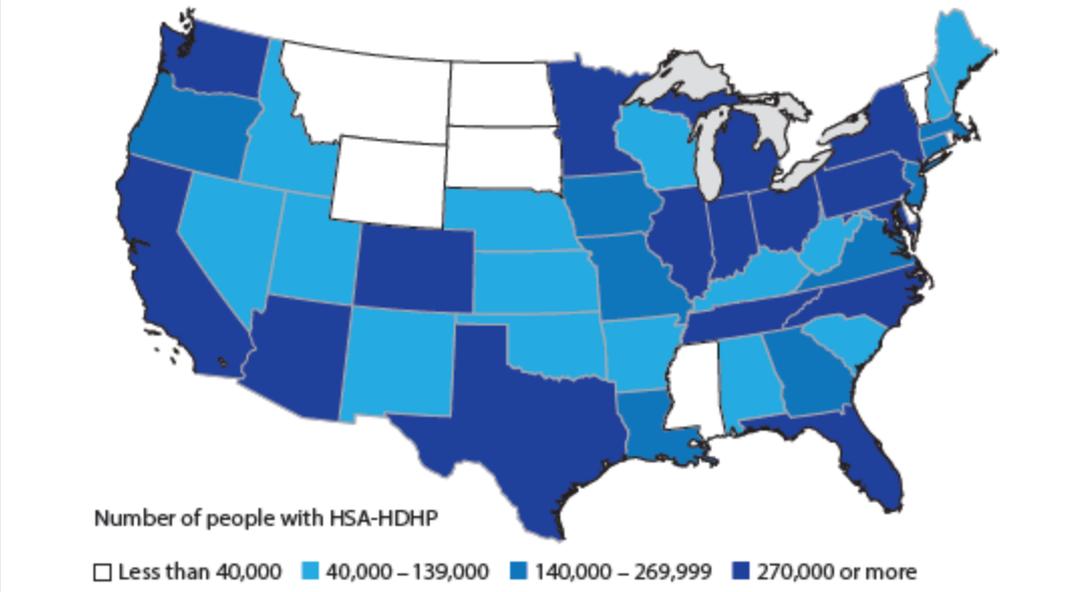
	Alabama SEHIP	Arkansas - Classic	Miss - Select	Louisiana HMO	BCBSLA - High Ded Average	BCBSLA – PPO Average	BCBSLA – HMO Average
<b>Plan Type</b>	PPO	HMO	PPO	HMO	PPO	PPO	HMO
<b>Employee Risk Factor</b>	?	?	?	?	?	?	?
<b>State Cost Index</b>	?	?	?	?	?	?	?
<b>Employer Contribution</b>	64%	EE - 87%; Family 71%	Legacy 95% EE. 65% Family	75%			
<b>Premium EE contribution – Single</b>		\$46	\$20/\$38	\$140	\$321	\$376	\$443
<b>Premium EE Contribution- Family</b>		\$306	\$667/\$685	\$488			
<b>Deductible</b>	\$300/person 3 max	\$1000S/ \$2000F	\$1,000	\$500 EE/\$1500 Fam (non-copay)	\$2,645	\$1,119	



# Today

Employers across the country are shifting to consumer-driven plans

**Figure 7. Number of Enrollees in HSA-Qualified High-Deductible Health Plans, by State, January 2014**



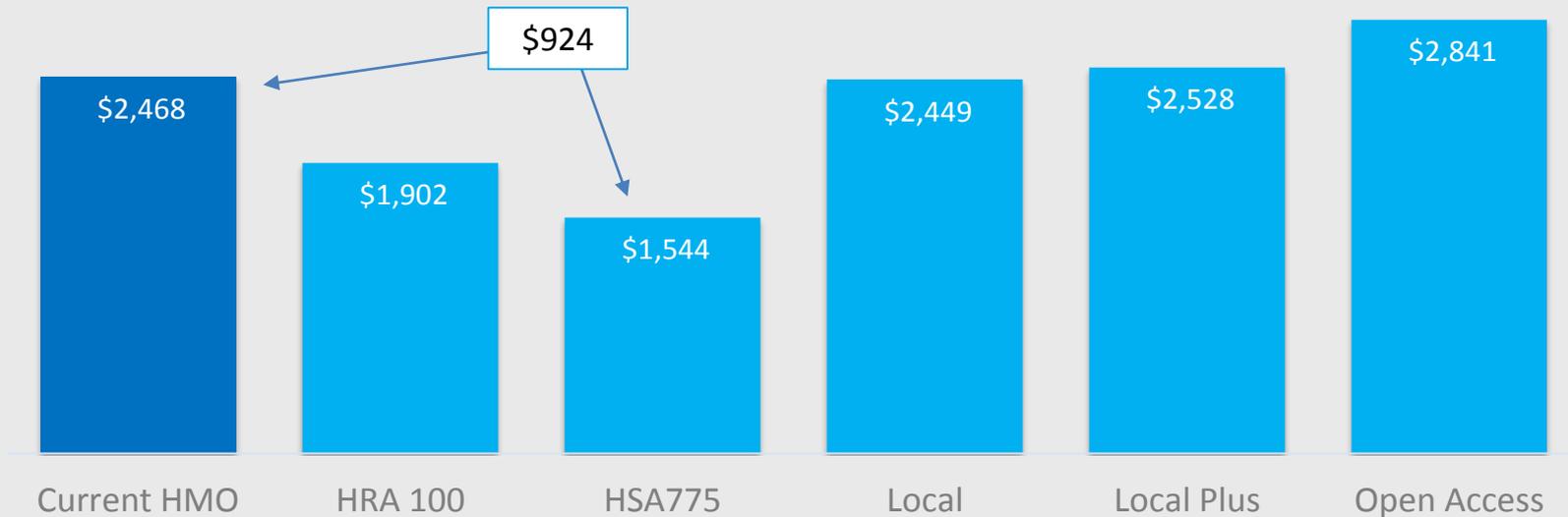
# What if these plans are not implemented?

If the January 1 changes are not implemented and OGB builds its reserves up to 2011-2012 levels, it would take even more drastic increases.



# Scenario: Employee Only

Employee Only Scenario I: 1 wellness, 1 PCP, 1 SCP, 1 UCC, 1 Generic, 1 Tier II, plus employee premium



Difference between current HMO to Magnolia Local Plus is \$60



# Scenario: Employee Only 2

Employee Only Scenario II: 1 wellness, 2 PCP, 2 SCP, 2 UCC, 1 ER, 1 Generic, 1 Tier II, plus employee premium

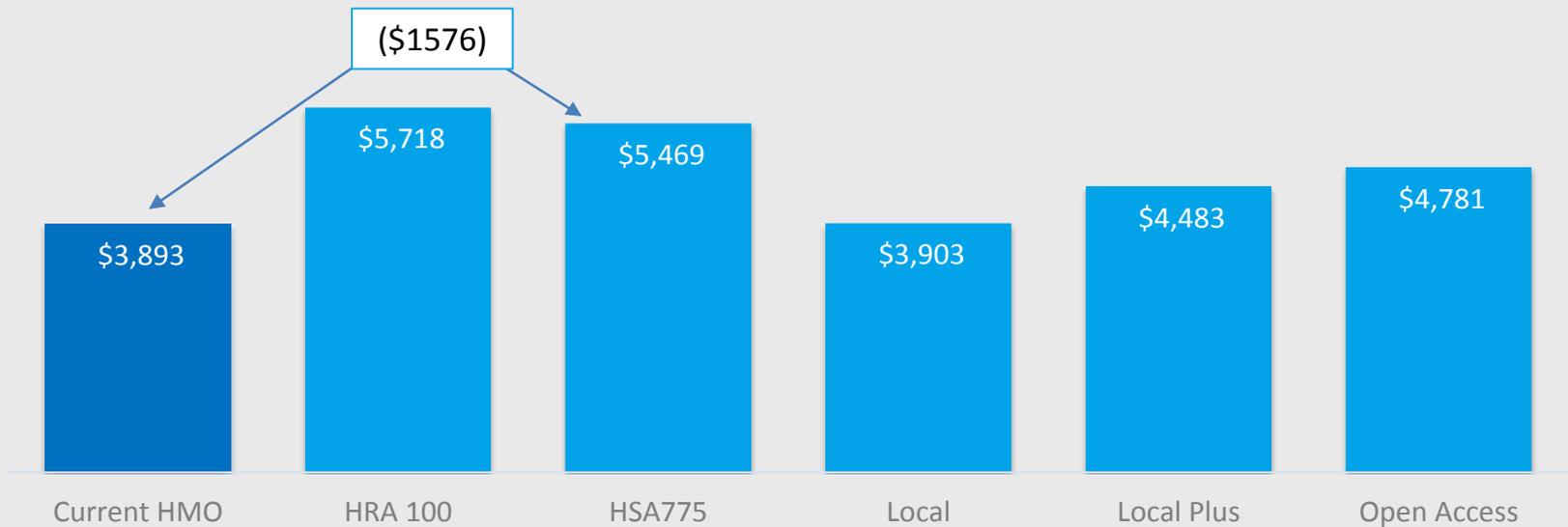


Difference between current HMO to Magnolia Local Plus is \$170



# Scenario: Employee Only 3

Employee Only Scenario III: 1 Hospital Visit, 1 wellness, 2 PCP, 2 SCP, 2 UCC, 1 ER, 1 Generic, 1 Tier II, 1 Tier 3, plus employee premium



Current HMO to Magnolia Local Plus is \$590\* assumes all \$500 deductible is applied for other services included in hospital stay



# Scenario: Family

Family Scenario I: 4 wellness, 6 PCP, 6 SCP, 6 UCC, 4 Generic, 2 Tier II, plus employee premium

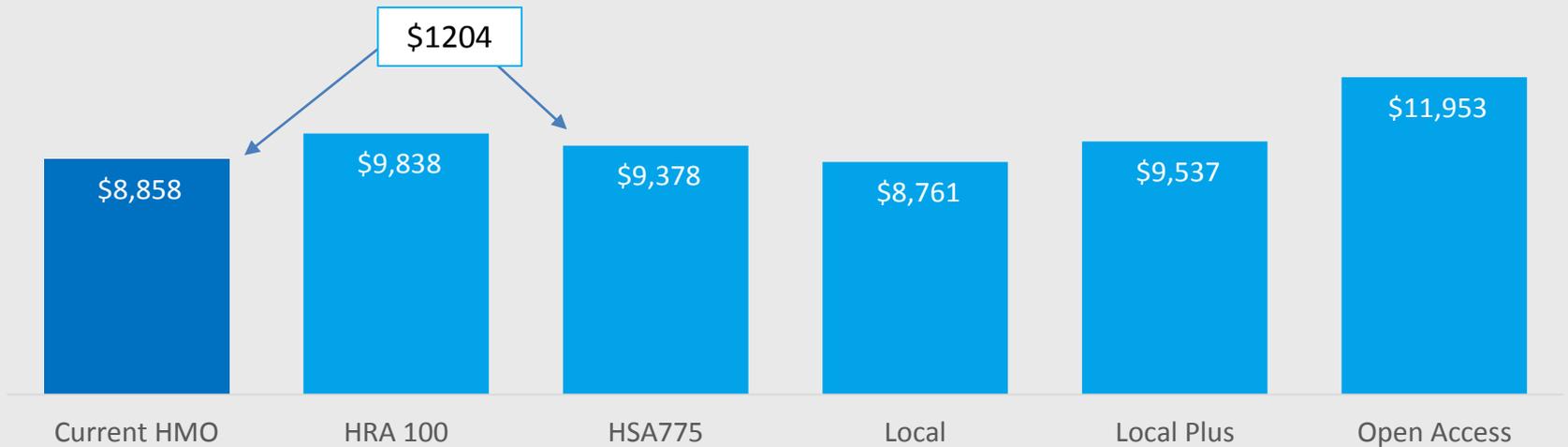


Difference between current HMO and Magnolia Local Plus is \$259



# Scenario: Family 2

Family Scenario II: 4 wellness, 8 PCP, 8 SCP, 8 UCC, 1 ER Visit, 4 Generic, 2 Tier II, plus employee premium

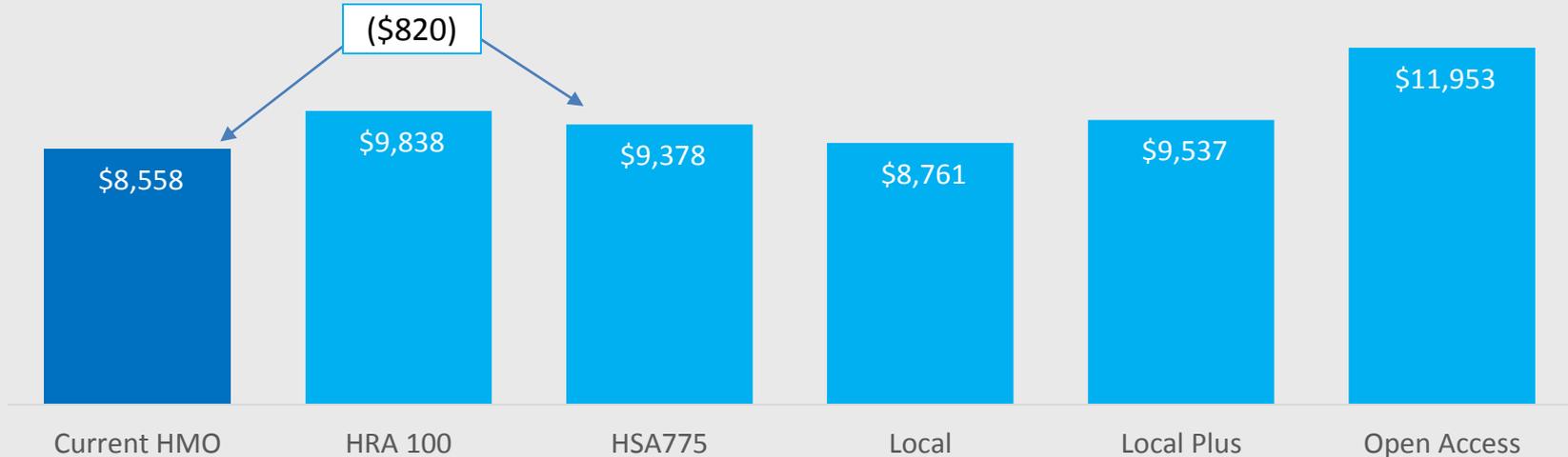


Difference between current HMO and Magnolia Local Plus is \$429



# Scenario: Family 3

Family Scenario III: 1 Hospital Visit, 4 wellness, 8 PCP, 8 SCP, 2 UCC, 2 ER, 4 Generic, 2 Tier II, plus employee premium



Difference between current HMO and Magnolia Local Plus is \$979\*  
assumes all \$500 deductible is applied for other services included in hospital stay



# Frequently Asked Questions

## Are plans changing because of the Blue Cross contract?

No. The reason costs are rising is a rise in utilization, not administrative costs or network changes. We have actually seen our administrative costs and unit cost (network) costs decrease since partnering with Blue Cross. That's part of the reason we've been able to keep rates low for our members over the past few years.



# Frequently Asked Questions

## Can we extend annual enrollment?

State employees pay their premiums one month in advance. So, in December state employees pay their January premiums out of their paychecks. Our annual enrollment period spans the month of October to allow our payroll departments time to process members selections and ensure accurate deductions in January. Extending the enrollment period would mean that members would pay their entire monthly premium out of one paycheck.



# Frequently Asked Questions

## Can I still go to the same hospitals as last year?

Yes. The network has not changed for the plans within the Blue Cross network. We offer one brand new option with a narrow network for people who choose to trade lower premiums for a smaller network. But, it is a new option and not a change to a current plan.

## What does out-of-network mean?

Out-of-network coverage is coverage outside of the plan's covered network of providers. 98.7% of claims paid last year are within Blue Cross's nationwide network.



# Frequently Asked Questions

## What's the difference between a deductible and an out-of-pocket maximum?

**Deductibles** are thresholds that must be met before a change in cost-share occurs. In the PPO plan, if your deductible is \$1,000, you must spend \$1,000 before your insurance will start paying 90% of your cost of care. In the HMO plan, the deductible only applies when the co-pay doesn't. That means that physician visits will still require a co-pay, but you must meet the deductible before your insurance will pay the full cost of dialysis and other more specialized services.

An **out-of-pocket maximum** is the maximum amount you can pay out-of-pocket in one plan year. It means that if the worst case scenario happens, you won't be required to pay more than the maximum.



# Frequently Asked Questions

**How would your cash balance have been affected if you hadn't decreased rates in 2012 and 2013?**

OGB would still have dipped into its reserves by \$100 million and would still need to make changes today.



# Frequently Asked Questions

## Is it true that your reserves will be depleted by the end of the year?

Not as long as these changes are implemented by January 1. OGB's actuary predicts that OGB will have \$243 million in cash on hand (including a \$118 million fund balance) at the end of FY15. The LFO's projections predict \$119 million in the fund balance at the end of the year.

Those numbers are within OGB's target range for a healthy balance.



# Frequently Asked Questions

## Has money been taken from OGB's reserves to balance the budget?

No. 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.



# Frequently Asked Questions

## How does the Affordable Care Act impact costs?

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. An additional \$31 million “Cadillac Tax” could be necessary in 2018 if plans remain the same as they are today.

