DECLARATION OF EMERGENCY

Office of the Governor
Division of Administration
Office of Group Benefits

General Provisions
Prior Authorization Requirements, Benefit Limits, Pharmacy Benefits Formulary
(LAC 32: I.1701)

Pursuant to the authority granted by R.S. 42:801(C) and 802(B)(6), vesting the Office of Group Benefits (OGB) with the responsibility for administration of the programs of benefits authorized and provided pursuant to Chapter 12 of Title 42 of the Louisiana Revised Statutes, and granting the power to adopt and promulgate rules with respect thereto, OGB, hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

OGB finds that imminent peril to the public health, safety, or welfare requires it to revise and amend certain of its General Provisions including to prior authorization requirements, benefit limits, and the pharmacy benefits. La. R.S. 42:803(B) grants authority to OGB to establish a self-funded health benefits program and establish plan(s) of benefits for employees under the direction of the Commissioner of Administration. The Plan documents in effect for OGB self-funded plans (PPO, HMO, and CDHP) and the LAC Part III, §423 (PPO) state that changes shall be made from "time to time" to the plans and "such modifications will be promulgated subject to the applicable provisions of law." While no applicable law expressly requires promulgation for such changes to be effective between enrollees and OGB, this rule is being promulgated due to the imminent peril of financial exposure of the State, OGB, its plan enrollees, and other State programs resulting from a threat of litigation that rules are required to be promulgated by law. According to OGB, the OGB fund balance will be as low as $8 million by July 2015 if these and other changes are not implemented. The OGB fund, in the absence of these changes through December 2014, will be depleted by $194,300 per day and $231,819 per day from January to June 2015. This daily loss causes an imminent peril by accelerating the need to impose increases of 18% or greater in premiums according to the LFO. These and other resulting costs to enrollees could become so burdensome for enrollees that they drop their health coverage. The fund is now facing the imminent peril of becoming actuarially unsound and unstable. Moreover, if the OGB fund goes into a deficit, then taxpayers are statutorily required to pay the costs of any increase in premiums to enrollees. Consequently, other State programs will be impacted through the resulting budget cuts to higher education and health care which will result in a reduction in critical services for all citizens of the state. Accordingly, the following Emergency Rule, revising and amending the General Provisions, is effective September 30, 2014, and shall remain in effect for a maximum of 120 days, or until a final rule is promulgated, whichever occurs first.

Title 32
EMPLOYEE BENEFITS
Part I. General Provisions
Chapter 17.

§1701. Prior Authorization Requirements, Benefit Limits, Pharmacy Benefits Formulary

A. Changes for the PPO, HMO, and CDHP 2014 plans of benefits have been adopted which affect medical and pharmacy benefits and drug utilization.

B. Medical Benefits

1. A prior authorization is a process used to determine the necessity of a proposed service or procedure and is a standard means used by health plans to manage health care utilization. To avoid extra costs, enrollees should always ensure that their health care providers obtain a prior authorization when necessary for a covered benefit.
2. In addition to any services previously identified in the 2014 plan documents or these rules, services that will now require prior authorization, include, but are not limited to:
   a. Cardiac rehabilitation
   b. CT scans
   c. Genetic testing
   d. Home health care
   e. Hospice
   f. MRI/MRA
   g. Orthotic Devices
   h. Outpatient pain rehabilitation/Pain control programs
   i. Physical /Occupational Therapy
   j. Residential treatment centers
   k. Inpatient hospital admissions (except routine maternity stays)
3. An updated Summary of Benefits and Coverage (SBC) with a complete list of services and procedures requiring prior authorizations shall be available to OGB enrollees through its third-party administrator (TPA) and the OGB website.
4. In addition to any limits previously identified in 2014 plan documents or these rules, OGB self-funded plans will follow the pharmacy benefit formulary's standard for number of visits allowed per benefit period for skilled nursing facilities, home health care services and hospice care services. An updated Summary of Benefits and Coverage (SBC) shall be made available to enrollees through the OGB TPA and through the OGB website.

C. Pharmacy Benefits Formulary

OGB shall have discretion to adopt its PBM pharmacy benefits formulary or other drug formulary. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time, subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether a generic, preferred brand, non-preferred brand name, or

specialty drug is obtained. Formulary changes for members with Medicare as their primary coverage shall be effective January 1, 2015. For maintenance medication, 90-day prescriptions may be filled at retail pharmacies for two and a half times the cost of the co-pay. Medications available over-the-counter in the same prescribed strength, are no longer covered under the pharmacy plan. The pharmacy co-payment threshold is changed from $1,200 to $1,500. Additional changes include:

	Prior Benefit	New Benefit
Before co-payment threshold satisfied:		
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
After co-payment threshold satisfied:		
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

D. Drug Utilization Management

1. Clinical Utilization Management through prior authorizations for certain medications, the use of step therapy and quantity limitations to promote appropriate utilization of prescription medications and use of generic medications.
2. High Cost Compound Management to promote the use of commercially available, lower cost, individual compound medications instead of high cost compound medications.
3. Medical Foods exclusion as the FDA does not currently have safety or efficacy evaluation standards for them as they are not regulated as drugs.
4. Review the usage of narcotic medications such as opiates and Acetaminophen to prevent their over and/or improper usage.
5. Polypharmacy Management identification and case management for members receiving multiple prescriptions to ascertain and implement appropriate consolidation of medication therapy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C), 802(B)(6).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits.

Susan T. West
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Ruth Johnson
Deputy Commissioner
of Administration

Provider Impact Statement

The Emergency Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.