

Group Benefits Policy and Planning Board

Meeting Summary – January 23, 2012

The Group Benefits Policy and Planning Board met January 23, 2012, with only 7 members present: Dr. Merline Broussard, Rikki Nicole David, Nancy DeWitt, Kenneth Krefft, James Lee, Janet Lorena and Jackie Self.

Without the necessary 8 members needed to constitute a quorum, board members took no action, but listened as information was presented and discussed various issues:

Tom Tomczyk of Buck Consultants presented an actuarial report.

- The Office of Group Benefits ended the short, 6-month 2011 plan year on December 31 with a loss of about \$18 million.
- A loss of about \$14.5 million is projected for the 2012 plan year, which will lower OGB's fund balance to approximately \$466 million by December 31.
- A fund balance equal to 4 to 6 months of expenses is considered an adequate contingency fund by industry experts. OGB's current fund balance, which slightly exceeds the 4-month mark, is now trending downward.
- OGB has been working for the past several years to achieve a generic drug utilization rate for OGB health plans of around 70 percent. OGB's generic drug utilization rate now stands at 69 percent for the HMO health plan (administered by Blue Cross and Blue Shield of Louisiana) and 66 percent for the PPO health plan (self-administered by OGB). Although the cost of generic drugs has increased significantly over the past year – about 17 percent, generic drugs are still more cost-effective.
- A financial report now being prepared by contractor Morgan Keegan regarding potential privatization of OGB's self-administered PPO health plan is “a work in progress.”

OGB general counsel Tommy Benoit provided an update regarding contractual issues.

- A notice of intent to contract (NIC) was issued by OGB for the standard HMO health plan on January 20. An emergency contract with Blue Cross for administration of the plan remains in effect through March 2012. OGB will move to dismiss an appeal of a judgment rendered in a 2010 lawsuit, which required OGB to reissue the NIC for administration of the HMO plan, after OGB's recent actions rendered the issue moot.
- A class action lawsuit was recently filed, alleging that OGB has unwittingly overcharged PPO plan members but OGB has not been served with notice yet to appear in court. OGB is reviewing the concerns raised in the lawsuit but will not comment on pending litigation.

OGB chief operating officer Brenda St. Romain gave a report on OGB operations.

- OGB enrollment is stable.
- Increased costs in 2011 were due largely to expanded coverage mandated by the federal Affordable Care Act and a short 6-month plan year with no re-set of deductibles or out-of-pocket maximums, which was the equivalent of an 18-month plan year.

Ms. DeWitt raised the issue of the high-income surcharge that must be paid by retired OGB members with incomes that exceeded certain levels who were automatically enrolled in OGB's new Medco Medicare Part D prescription drug plan. She urged OGB to disseminate information to members who are potentially affected by the surcharge to explain the additional cost.

Mr. Krefft pointed out that smoking increases health care costs and praised OGB's efforts to promote the Department of Health and Hospitals' new tobacco cessation pilot program for state employees.

Ms. DeWitt called attention to the board's ongoing difficulties in attaining a quorum necessary to take action and said it is “unconscionable for board members not to attend meetings.” She noted that the board had tried unsuccessfully since August to confirm the attendance of enough members to constitute a quorum on various meeting dates. Mr. Krefft suggested changing state law to allow attendance via phone or video camera to facilitate board members' attendance.

Frank Jobert, executive director of the Retired State Employees Association, addressed the board briefly during the public comments segment at the end of the meeting.

Board members set the next meeting for Wednesday, February 15 at 10 a.m.