

Group Benefits Policy and Planning Board

Meeting Summary – July 24, 2012

The Group Benefits Policy and Planning Board met July 24, 2012, with 9 members present: Barry Blumberg, Dr. Merline Broussard, Nancy DeWitt, Kenneth Krefft, James Lee, Melissa Lee, Janet Lorena, Jackie Self and Sen. Gregory Tarver.

Board members approved minutes of the May 23, 2012, meeting and elected new officers. James Lee was re-elected as chairman. Nancy DeWitt was elected as vice-chairman and Janet Lorena was elected as secretary.

Tom Tomczyk of Buck Consultants presented an actuarial report.

- The Office of Group Benefits fund balance was \$498,549,700 as of April 30, 2012. The historical fund balance is expected to continue downward through the end of the year.
- A \$17 million surplus is expected for the first half of the year. Due to the 7 percent premium reduction, a \$62 million deficit is expected for the last six months, leaving a \$45 million deficit for the year ending December 31, 2012.
- Projections for the 2013 fiscal year are underway.
- Health care cost trends are higher for the PPO health plan than for the HMO health plan, partly due to the increasing average age of PPO plan members, but mainly due to the extended plan year in 2011.
- The generic prescription drug utilization rate is 68 percent for the PPO plan, and nearly 70 percent for the HMO plan.
- The cost per prescription continues to rise by approximately 14 percent for brand-name drugs. Pharmaceutical companies have raised prices for some brand drugs in anticipation of the expiration of patents and availability of generic versions.
- Nexium and Lipitor are the drugs most frequently prescribed for HMO plan members. Plavix, Nexium and Lipitor are the top drugs prescribed for PPO plan members. These drugs saw significant cost increases in the last year.

Mr. Lee suggested offering an incentive for mail order prescriptions since member utilization is low. Sen. Tarver recommended looking into adding natural and homeopathic drug options to the plan of benefits, noting they work well for him.

OGB chief operating officer Brenda St. Romain provided highlights of OGB operations.

- Membership in OGB health plans remains about the same.
- As of July, the average age of enrollees is 66.62 for the PPO plan, 49.18 for the HMO plan and 46.65 for the Medical Home HMO plan. The average age of plan members in all OGB Medicare Advantage plans combined is 70.5.

Responding to a question from Mr. Lee about the OGB weight loss program underway at Pennington Biomedical Research Center, OGB contract manager Rusti White told the board about 30 bariatric surgeries had been performed so far and all were successful. She said many OGB members indicated interest in participating, and potential participants now exceed program funds for bariatric surgeries. The program also includes a separate intensive medical management component.

In old business, board members asked about the one-year contract awarded to Blue Cross Blue Shield of Louisiana to administer OGB's self-insured health plans (the PPO, HMO and Consumer Driven plans), with options to renew for two 12-month periods. Mr. Tomczyk said the selection process focused on discounts and administrative fees and a qualitative network review because OGB wanted to minimize disruption in provider networks now utilized by plan members. Dr. Broussard asked about performance guarantees and expressed concern about customer service quality. OGB general counsel Tommy Benoit said plan members will be notified of all changes and customer service contact information. Mr. Lee explained that the PPO plan of benefits will not change. Dr. Broussard asked when the contract will be available for review and whether premiums will change. Mr. Benoit said it may take some time to write the contract, partly due to possible protests by other companies that submitted proposals. He said the plans are self-insured, so OGB sets premiums, which are not expected to change in 2013. Ms. DeWitt asked that board members be well-informed by OGB about what is going on "and make sure we understand" to aid the board in fielding calls from concerned constituents.

Mr. Benoit noted that OGB is still operating under a voluntary delay in a class action lawsuit alleging the agency unwittingly overcharged PPO plan members. He said OGB "should know soon whether the issue can be resolved without further litigation."

Turning to new business, a motion by Mr. Krefft to implement a policy for best practices regarding the OGB fund balance was unanimously approved. Ms. DeWitt recommended this be done by October 2012.

Mr. Krefft made a motion to conduct a study of the plausibility and cost benefit of implementing a non-smoker benefit by October 2012 and Mr. Self offered an amendment to make it a non-tobacco-user benefit. The motion passed unanimously.

There were no public comments from the audience. The next board meeting is set for Wednesday, August 22 at 10 a.m.