For Your BENEFIT
STATE OF LOUISIANA * OFFICE OF GROUP BENEFITS
SUMMER 2003

OGB 101: Introduction to Health Benefit Issues

By A. Kip Wall
Chief Executive Officer

What is the purpose of this report?

The Office of Group Benefits (OGB) is responsible for administering life and health benefits for state employees, participating school boards, and certain political subdivisions. In total, more than 125,000 employees throughout the state are enrolled in OGB sponsored life and health programs. With spouses and dependents included, more than one quarter of a million individuals are covered in the OGB benefit plans.

OGB is not an insurance company. The State of Louisiana offers self-funded and fully-insured health benefit plans for participants. The life insurance program is now fully-insured by Prudential. The fact that OGB is an employer sponsored health plan and is an agency of the State of Louisiana determines how this agency operates. The purpose of this report is to provide information to plan members regarding the OGB health benefit program.

OGB Demographics

	Male	Female	Active	Retired
Members	45,109	81,470	86,385	40,194
Dependents	60,331	57,874	98,642	19,563
Total	105,440	139,344	185,027	59,757

How is OGB funded?

OGB is a money-in – money-out operation. The funding we receive from plan members and participating agencies is used to pay doctors, hospitals, pharmacy benefits, HMOs and for other health care services. Currently, $.96 of every dollar OGB receives is used to pay HMOs, medical expenses, and life insurance claims. The amount of money needed by OGB to pay benefits for members is determined by the amount and costs of services utilized by plan participants.

The administration and the Legislature have directed OGB not to incur future deficits. Therefore, premium rates must be established in order to pay for the cost of the services delivered. In FY 2001-02, OGB generated a surplus of approximately $8 million. For FY 2002-03, OGB is projecting a surplus of approximately $6 million. The combined surplus of approximately $14 million represents less than one percent of the total revenue of $1.5 billion for the respective years.

continued...

INSIDE

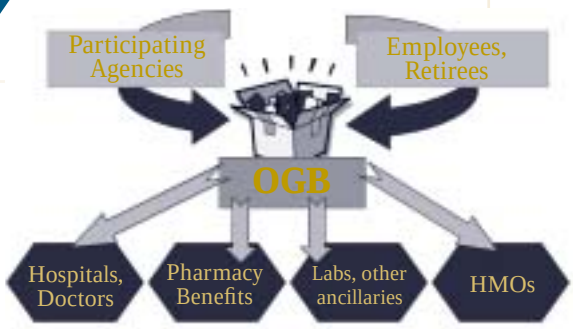
Announcements • 6
Service Offices • 8

From the CEO

Five-Year Surplus/Deficit

		Cumulative Deficit
FY 1997/98	$14,798,643	($30,303,610)
FY 1998/99	($20,133,389)	($50,436,999)
FY 1999/00	($42,569,862)	($93,006,861)
FY 2000/01	$5,215,783*	($87,791,078)
FY 2001/02	$7,947,104	($79,843,974)

*Legislative appropriation of almost $76.4 million



Why are costs increasing?

Currently, health care costs are increasing at double-digit rates across the country and are predicted to continue to increase at that rate for the foreseeable future. One example of the cost increases impacting OGB plan members is prescription drugs. OGB competitively bids for pharmaceutical management services. The price OGB pays for prescription drugs is at or below the cost paid by government employee plans in the surrounding states.

OGB Major Expenses 2001-2002

HMOs	$134,276,100
Health Claims	$410,419,819
Drug Claims	$100,407,426
Mental Health	$6,358,673
Life Claims	$27,387,204
Administrative Costs	$32,368,090
TOTAL	$711,127,312

The surpluses generated in the past two years have been minimal; however, they represent a significant turnaround from prior experience. In 2001 the Legislature authorized more than $90 million in funding to eliminate past deficits of the program. It should be understood that these deficits were incurred in providing health care services to plan members. **OGB is now operating on a fiscally sound basis**.

OGB Drug Expenses

Month	Rx Expense
June-02	$9,324,108
July-02	$9,800,521
August-02	$10,007,248
September-02	$9,974,377
October-02	$10,830,507
November-02	$10,774,348
December-02	$12,899,723
January-03	$11,635,145
February-03	$11,476,219
March-03	$12,939,684
April-03	$13,031,083

Even with competitive bidding, the cost increases for prescription drugs are alarming. In the year ending June 30, 2002, OGB paid slightly more than $100 million for prescription drugs. In 2002-2003, OGB has paid out almost $140 million for drugs.

What is being done?

OGB, the administration, and the Legislature realize the negative impact that the current inflationary cycle in health care has on plan members. Since 1998, three study commissions have been empanelled to review the operations of OGB. To the extent possible, these recommendations have been adopted by OGB or enacted in law.

One of the recommendations issued by the study commissions is that OGB participants be provided with health plan options. For the FY 2003-04 plan year OGB members are able to select from four health plans. Those health plans are the PPO, EPOs, HMOs, and the MCO. With the exception of the PPO, all of the plans will be administered by private insurance carriers or third-party administrators.

Three of the health plans, the PPO, EPO, and MCO, are part of a single risk pool. This means that the cost and utilization of those individuals who participate in these plans are combined. Therefore, the premiums for these three plans are actuarially established in order to meet the health care costs of the entire group. The HMOs, Ochsner and Vantage, are fully-insured programs. For these plans, OGB collects the premium and transfers it to the HMOs.

How does this impact OGB plan members? The HMOs attract younger, healthier members leaving the older, less healthy population in the self-funded EPO, PPO, and MCO programs. For years, the PPO has provided coverage to the highest cost population of OGB.

Average Age of Plan Members

	EPO	HMO	PPO	Total
Members	47.6	45.7	57.4	52.2
Dependents	26.8	24.5	37.0	30.8
Total	36.7	35.0	48.3	41.8

How are premiums set?

The challenge faced by OGB, as well as by insurance companies and HMOs in the private sector, is to effectively spread the cost of those who need health care services across the total membership of the plan. Simply eliminating or substantially increasing the costs of the PPO program would not solve the problems presented. If the PPO program were eliminated, or if premium costs for the PPO were substantially increased, the high cost plan members in the PPO would move to the EPO, HMO, or MCO programs which would in turn increase the cost of those plans. **The cost of the sicker – less healthy members will not disappear**.

The problems relating to adverse selection in the PPO are not new. For several years, the former SEGBP charged plan members enrolled in HMOs the same amount as paid by participants enrolled in the PPO even though the HMO premiums were lower. The additional revenue generated from the HMO plan members was used to subsidize individuals in the PPO who had higher health care costs.

Last year, OGB recommended that the HMOs operate on a self-funded basis instead of on a fully-insured basis. If the HMOs were moved to a self-funded operation, the employees who select HMO coverage would be included in the overall risk pool.

continued...

From the CEO

Unfortunately, Ochsner Health Plan would not agree to participate on a self-insured basis and threatened to withdraw as a provider for OGB plan members. As a result, due to plan member demand, Ochsner Health Plan and Vantage continue to operate on a fully-insured basis. Currently, neither of these plans is sharing the cost of the older, less healthy population in the self -insured program.

Cost to the plan = Cost to the plan member

It has been suggested that state employees in the self-funded programs are being overcharged for their health insurance. In order to avoid future deficits, this group must generate sufficient premiums to pay for the cost of services that are provided. Do some employees pay more in premiums than they receive in benefits? Yes, they do. That is how health insurance works; healthy people pay for sick people. In order to avoid these types of problems, many employers offer only one option to employees. While it is more efficient to administer a single health plan, such a program prevents plan members from selecting options that may better suit their needs.

As described above, OGB is required to generate sufficient premium income to cover the cost of health care expenses. Using actuarial guidelines, OGB is projected to require as much as $937 million to pay for plan member benefits for the plan year beginning July 1, 2003. This projection includes the cost of the PPO, EPO, HMO, MCO, and life insurance programs and factors in how plan members will utilize their benefits.

How are premium costs allocated?

After the projected cost has been determined, establishing premium rates for the various plans is governed by policy and statutory provisions. The following steps are followed in developing the final premium rate:

Participating agencies pay 75 percent of the premium for an active employee for all products which cost the same as, or less than, the PPO. For each premium tier the maximum allowable contribution for the PPO is applied to any products that cost more than the PPO. At this time, OGB only has one product, the EPO, which costs more than the PPO.

This premium subsidy system resulted from recommendations by the second study commission. The actual recommendation was that participating agencies be required to pay 75 percent of the lowest cost health care product offered by OGB. This would have resulted in a reduction in benefits to plan participants. For this reason the administration and the Legislature have elected to pay 75 per cent of the premium up to 75 percent of the cost of the PPO.

As discussed above, HMO costs are a pass-through. OGB collects the premium as set by the HMO and passes that premium on to plan members and participating agencies.

Finally, budget considerations play a role in determining premiums for the various products. As the premium cost for the PPO and lower priced products are increased, the subsidization by participating agencies also increases.Therefore, there are limits to how much these products can be increased, especially when local and state agencies are struggling to fund current obligations.

What are premium tiers?

In addition to the considerations above, premium cost to plan members is also impacted by cost within the four premium tiers. The four premium tiers are single, member and spouse, member and children, and family. When premiums are calculated, the cost of services provided within each of the premium tiers is evaluated as part of the premium rate determination process.

The premium category "single" is predominantly comprised of younger – healthier individuals. This group generally has lower utilization of health care services and, as a result, lower health care costs. In our program, the "member and spouse" category is mainly comprised of older couples without children. These participants tend to be age 50 and older and are reaching a point at which they are experiencing an increase in the use of health care services. As a result of this experience, the health care costs for this group tend to be higher.

The third category is "member and children". The employees in this category tend to be younger, and children, after reaching age two, generally have lower health care cost. For this reason, cost for the "member and children" category is slightly higher than the "single" category, but lower than the "member and spouse" and "family" categories.

The "family" category is primarily comprised of child-bearing age employees. The cost of child bearing and the associated health care costs of children in their early years are the primary drivers of premium cost for this group. As a result, this group has the highest health care costs of the four premium tiers.

How are providers paid?

Another area that significantly impacts cost to OGB plan members is provider reimbursement. Each year physicians and hospitals seek increases in the amount they are paid for services provided. Any increases in cost charged by health care providers must ultimately be paid by plan members and participating agencies.

OGB has standardized reimbursement for physicians and hospitals. Both physicians and hospitals are compensated based on Medicare reimbursement rates. For procedures which are considered as management and evaluation, generally offices visits and related services, OGB pays 155 percent of Medicare. This means that for every dollar Medicare would pay for the procedure, OGB pays $1.55. For services which are procedural in nature, OGB pays 180 percent of Medicare; again, this would mean that OGB would pay $1.80 for every procedure for which Medicare pays $1.00.

Hospitals are reimbursed according to the case mix rating, a value they are assigned by Medicare for inpatient services. Medicare evaluates the type and severity of cases handled by different facilities and assigns the rating. There are five tiers within the OGB reimbursement schedule. Hospitals that handle the largest number of severe cases are placed in the highest reimbursement tier. For outpatient services, hospitals are reimbursed at approximately 200 percent of what Medicare pays hospitals for such services.

With only two exceptions throughout the state, Our Lady of the Lake and Woman's Hospital in Baton Rouge, hospitals have accepted the reimbursement offered. Additional funding would be required in order to increase reimbursement rates for hospitals. **The only source for additional funding is plan participants and participating agencies**.

Louisiana, like most other states, is facing significant budget challenges. The cost of providing life and health benefits to participants in the OGB program will represent almost $1 billion of the state's budget of approximately $17 billion. Benefits for state employees are very important, but the cost of those benefits must be balanced against the many other responsibilities of the state. This very difficult task is even more challenging when health care costs are increasing at double-digit rates annually.

We ask that you visit our website at www.groupbenefits.org regularly for updates and more information concerning your life and health benefits.

Announcements

Helpful

DIVORCE = INELIGIBILITY

Divorced spouses are not eligible for coverage. If you divorce you must let us know immediately. Coverage for a former spouse ceases the last day of the month following the divorce. To notify us, complete an Enrollment/Change form (GB01). Active members submit the GB01 through their agencies. Retirees may submit the form or a letter directly to the Eligibility section of the OGB. There are significant financial consequences of late notification, including:

- Premium overpayments – You will have paid premiums for coverage you do not have.
- Flexible Benefits plan members – You will not be refunded the difference in sheltered premiums, even though you do not have coverage for the former spouse.
- Obligation to pay for services – We will require that claim payments made on behalf of the ineligible ex-spouse be refunded to the OGB. You may be responsible for these expenses.

Please remember to notify the OGB promptly. Flexible Benefits plan members must submit a Change in Status form in addition to the GB01.

Note: divorced spouses are eligible for 36 months of continuing coverage through COBRA. The 36 months begin the first day of the month following the divorce. The ex-spouse must apply for coverage within 60 days from the date of the divorce and pay the full premium. The state does not subsidize the premium.

LIFE INSURANCE

All correspondence about your life insurance must be made through your agency's benefits office. Whether you are actively employed or retired, your agency will help you:

- Get answers to your questions
- Change your beneficiary
- Report name and address changes
- File claims

All interaction with The Prudential Life Insurance Company of America should be made through your agency. The Office of Group Benefits does not handle life insurance changes.

OVER-AGE DEPENDENTS

Eligibility for coverage for dependents normally ends when the dependent reaches age 21. Coverage for a dependent who is unable to work due to mental retardation or physical incapacity can be continued. The Office of Group Benefits must be notified before the dependent's 21st birthday. We cannot continue coverage if we receive notification on or after that birthday. We require a letter from the doctor to document the incapacity.

Dependents age 21 through 23 may continue coverage if they are full-time students. A letter from the school's registrar verifying full-time status is required each semester. Please make sure that the name and Social Security number of the person carrying coverage with Group Benefits is on the front of the letter from the registrar's office.

Information

PRESCRIPTION DRUG PROGRAM FOR PPO AND EPO

A reminder about the prescription drug program: The maximum co-payment for up to a 34-day fill is $50; for 35-68 days, $100; for 69-102 days, $150.

After a member has incurred $1,200 in eligible expenses, generic drugs have no co-payment. Brand name drug co-payments are $15 (1 – 34 days), $30 (35-68 days), and $45 (69-102 days).

The Office of Group Benefits plans to start sending you a prescription drug Explanation of Benefits. This EOB will tell you what you have paid in co-payments and what the OGB has paid on your behalf. You have a lifetime maximum benefit of $250,000.

This will help you keep track of your costs and how you benefit by finding the pharmacy with the lowest cost for the medication you require. For example, if you have reached the $1,200 threshold, you will pay only $45 for a 102-day supply of a brand name drug. But Pharmacy A may charge us $200 for the prescription while Pharmacy B charges us only $150. The total pharmacy charge is included in your lifetime maximum, so finding the least expensive pharmacy will make your lifetime benefit last longer.

OPPOSITION

OGB has been requested to advise plan members that the following boards and offices opposed the increase in prescription drug cost that became effective July 1, 2003:

The Office of Group Benefits Policy and Planning Board

The Division of Administration

The Office of Governor

The Louisiana Legislature

MCO NEWS

The Office of Group Benefits now offers a managed care option. This program offers basic health coverage at a low cost. The MCO is a cost-effective program for those who need basic coverage. Members should be aware that the MCO has strict limitations.

- Prescription drug formulary: The MCO pays only for drugs on the MCO list. The list consists mainly of generic drugs. There are no benefits for drugs that are not on the list.
- Out-of-network service: There are no benefits for services from non-network providers. Members should verify that each provider is in the network. This is especially important when one provider "sends" you for tests, lab work, etc.
- Emergency service out-of-network is covered only if the emergency is life or limb threatening.

M. D. ANDERSON CANCER CENTER

The Office of Group Benefits is pleased to announce that the University of Texas M. D. Anderson Cancer Center is now part of our PPO and EPO networks. M.D. Anderson is renowned for providing top quality comprehensive care for cancer patients. PPO and EPO plan members will be able to seek care and pay in-network costs.

Service Offices

Area Customer Service Offices

Alexandria
900 Murray Street, Room F-100
Alexandria, LA 71301
318.487.5731
800.813.1578

Baton Rouge
5825 Florida Boulevard
Baton Rouge, LA 70806
225.925.6625
800.272.8451

Lafayette
825 Kaliste Saloom Road
Building II, Suite 101
Lafayette, LA 70508
337.262.1357
800.414.6409

Lake Charles
710 West Prien Lake Road
Suite 114
Lake Charles, LA 70601
337.475.8052
800.525.3256

Metairie
3421 North Causeway
Suite 400
Metairie, LA 70002
504.838.5136
800.335.6208

Monroe
1400 North 19th Street
Monroe, LA 71201
318.362.3435
800.335.6206

Shreveport
1525 Fairfield Avenue
Room 670
Shreveport, LA 71130
318.676.7026
800.813.1574

TDD (hearing impaired)
225.925.6770
800.259.6771

This document was published at a total cost of $10,153.01 for 133,000 copies. This document was printed by LSU Graphic Services, under authority of the Division of Administration, to inform state employees about their benefits. This information was printed in accordance with the standards for printing by state agencies established pursuant to R.S. 43:31.

Office of Group Benefits
State of Louisiana
P. O. Box 44036
Baton Rouge, LA 70804-4036

Pre-Sorted
Standard
US Postage Paid
Baton Rouge, LA
Permit 266