

MINUTES

POLICY AND PLANNING BOARD MEETING OFFICE OF GROUP BENEFITS

December 11, 2002

CALL TO ORDER

Mr. Hubert Lincecum, vice chairman, called the meeting of the Policy and Planning Board to order.

ROLL CALL

Members Present

Mr. Charles Castaing
Dr. Barbara Cicardo
Mr. Russell Culotta
Mr. Charles Lazare*
Mr. James Lee
Mr. Hubert Lincecum
Mr. Richard O'Shee
Representative Tank Powell
Senator Tom Schedler*
Mr. Jackie Self

Members Absent

Dr. Merlin Broussard
Dr. James Calvin
Mr. John Warner Smith
Mr. Aubrey Temple

Roll call indicated eight board members present, representing a quorum.

*Mr. Lazare and Sen. Schedler arrived after roll call.

APPROVAL OF MINUTES OF OCTOBER 30, 2002 BOARD MEETING

The minutes of the October 30, 2002, board meeting were presented for approval.

A motion was made by Mr. Lee, seconded by Rep. Powell, to accept the minutes as presented. There being no objection, the minutes were approved.

2003-04 PLAN OF BENEFITS

OGB Newsletter

Mr. Culotta stated that the OGB newsletter sent out to all members failed to report that the Board did not recommend some of the proposed changes being considered by the

Office of Group Benefits. He indicated this will mislead plan members in believing that the Board is in support of all of the proposed changes.

Board Report

Mr. Lincecum stated that Ms. Sharon Runyan, OGB Communications Director and Mr. Aubrey Temple, Chairman, drafted the report from the previous meetings held by the Board.

Mr. O'Shee recommended that the Chairman of the Policy and Planning Board sign the report instead of having all Board members sign. He stated that as a matter of law he could not sign any report where the Department of Insurance representative is a non-voting member. The proper procedure is for the chairman to sign the report stating that this was the recommendation of the Board. Mr. Benoit reported that the Board acts a body and not as individual members. A majority vote of the members of the Board to adopt this report makes it the report of the Board. If there are individual members who disagree with some parts of the report and want to make other comments, they are free to submit those comments to the Legislative Oversight Committees on their own authority. Mr. Lincecum stated that the report would be redrafted to reflect the officers-of-the-Board's signatures.

The report will be submitted to the House Appropriations Committee and the Senate Finance Committee from the Office of Group Benefits Policy and Planning Board on the FY 2003-04 Plan of Benefits.

**Report to the
House Appropriations Committee and the Senate Finance Committee
From the Office of Group Benefits Policy and Planning Board
on the
Fiscal Year 2003-04 Plan of Benefits**

Pursuant to LSA-R.S. 42:881 the Office of Group Benefits (OGB) Policy and Planning Board (the "Board") is charged with the responsibility of submitting an annual report to the appropriate legislative oversight committees concerning the plan of benefits proposed by OGB. This report is submitted as specified by statute.

The chief executive officer of OGB advised the Board of proposed modifications to the plan of benefits for Fiscal Year 2003-04, and sought comments and suggestions. The Benefits Committee of the Board met on several occasions to receive and review modification recommendations. The Board met on October 30, 2002, to review the recommendations of the Benefits Committee.

The Board has considered the proposed modifications for Fiscal Year 2003-04 and recommends the following as appropriate and necessary to maintain

operation of the program on a fiscally responsible basis. The Board understands that health care rates in Louisiana and across the country continue to increase at double-digit rates for the foreseeable future. Accordingly, OGB and other employers face a significant challenge in maintaining viable benefit programs at affordable cost.

Options considered by the Board and pertinent comments are provided below.

Plan Administration

The Board agrees with the recommendation to solicit programs, on both a self-insured and fully-insured basis for EPO and HMO benefits on a statewide and regional basis. The Board realizes that current HMO contracts expire June 30, 2003, and that the OGB needs to explore and evaluate available alternatives in the delivery of health care services.

Agency-Retiree Premium Subsidy

The Board agrees with the recommendation to clarify the rule regarding retirees who return to work. This will require that once an individual retires, he/she will be treated as a retiree for all future purposes and that future premiums for him/her will be paid by the agency from which he/she retires.

The Board understands that this clarification specifies that any future retirement subsidies are the responsibility of the employer from which an individual retires and prohibits employees from participating in the program if they were not members of OGB during retirement, before returning to work as an active employee.

The Board concurs that this recommendation is intended to promote adequate funding of the OGB health plan, properly allocate subsidy costs, and deter adverse selection from individuals who were not formal participants in the program.

Alignment of Plan Year and Deductibles

The Board agrees with this proposal to align the plan year and the deductible year. In order to accomplish this goal, the current deductible year will be extended until June 30, 2003. The Board understands that this will result in a loss of the offset of deductibles during the period of January 1, 2003 – June 30, 2003.

Wellness Benefits

The Board agrees that this proposal will simplify the wellness benefit for plan members. This would eliminate the provision of one physical examination

during an eligibility period and allow instead a maximum benefit amount of \$200 during this same period.

Morbid Obesity

The Board agrees with the recommendation to develop a program for the surgical treatment of morbid obesity at a center of excellence. This would apply to a limited number of patients with a Body Mass Index of 40 or more, and would not pay for reversal of the procedure nor for additional occurrences. This program will study the relative benefits of this surgical treatment and will serve as a pilot program.

It is important to note, however, that the Board disagrees with two proposed recommendations. These options and pertinent comments are provided below.

Prescription Drugs

The Board does not agree with the proposal to increase the maximum cost for a single prescription from \$40 to \$50 and to increase the maximum out-of-pocket limit from \$1,000 to \$1,200. The Board recommends that the prescription drug program remain as it is.

Although the Board acknowledges that OGB spent almost \$101 million on drugs in 2001-2002, and will spend almost \$120 million in 2002-2003, it believes additional drug co-payments will be too difficult a burden to bear. This burden will be even more overwhelming for fixed-income retirees and for active workers earning less than \$18,000 annually.

The Board understands, but declines to accept, the necessity of increasing plan member drug costs in order to maintain an affordable benefit program.

Genetic Testing

The Board does not agree with the proposal to research the advisability of providing coverage for genetic testing to detect tendencies for certain diseases such as breast and colon cancer.

It is also important to note that the Board submits one additional recommendation not included in the plan of benefit modifications proposed by OGB. This option and pertinent comments are provided below.

Retirees with Medicare

The Board proposes that retirees with Medicare should not have to pay the co-payment for hospital stays. The Board believes the co-payment of \$50 per day

for the first five days should be waived for retirees with Medicare, parts A and B, who are admitted to OGB-contracted hospitals.

Although the Board realizes that this proposal will cost an estimated \$1.3 - \$1.7 million, it nevertheless believes that this co-payment places an unfair burden on an estimated 27,000 Medicare retiree population that can ill afford it.

Finally, the Board -- through its Benefits Committee -- considered numerous modification proposals. After due study and diligence, the following were not accepted:

- Exempt retirees with Medicare from the \$300 deductible
- Change the deductible for the first two visits to the emergency room to \$100/visit; subsequent visits would remain at \$150
- Increase the wellness benefit to \$300
- Apply co-payments to deductibles
- Physician assistant visits should have a lower co-payment
- Remove the deductible from ancillary services
- Re-institute the provision allowing for a 90-day supply of a prescription drug for one co-payment
- Have the state pay 100 percent of the premium
- Establish a family co-payment in lieu of individual co-payments on family coverage
- Eliminate plan member paid administrative fee for flexible spending account programs
- Increase lifetime maximum for prescription drugs
- Retirees and active plan members earning less than \$18,000 should not pay for any increases in costs to the program. The state should fund these increases.

The information provided herein constitutes the report of the Board to the Legislature as prescribed by statute.

Mr. Culotta stated that the report does not mention rate structure. He asked if it would be appropriate to have in the report. Mr. Lee stated that the rate increase is a separate issue. The rate increase will not be determined until February or March 2003. Mr. Lincecum explained that the statute states that the Board is charged with making a recommendation on the plan of benefits.

A motion was made by Mr. Lee, seconded by Rep. Powell, to adopt the report and have the proper signatures of the chairman and the secretary of the Board and the report be properly delivered to Legislative Oversight Committee.

Following discussion of the motion a roll call vote was taken with the following result:

<u>Yeas</u>	<u>Nays</u>
Mr. Castaing	
Dr. Cicardo	
Mr. Culotta	
Mr. Lazare	
Mr. Lee	
Mr. Lincecum	
Rep. Powell	
Sen. Schedler	
Mr. Self	

With nine (9) yeas, and no (0) nays, the motion passed.

CEO REPORT

Mr. Wall reported that the \$93 million deficit has been reduced to \$8 million and by the end of the year it should be gone. The only issue that will impact this would be rolling the deductible forward so that deductibles align with the plan year. This will cost the program money and may cause a small deficit.

Mr. Wall provided the report on *Where the Money Goes* for review. Mr. Wall stated that the conversion process to the claims adjudication software has gone well.

Mr. Wall reported that the program's drug costs are increasing 20%. The program will have spent approximately \$120 million on drug costs this year.

OLD BUSINESS

Morbid Obesity

Mr. Wall provided the Board a copy of the Notice of Intent to Contract the program issued on Morbid Obesity. He stated that this issue has been pending for over a year. When it was originally considered, an interagency agreement with LSU was considered. Questions came from the Board and the Division of Administration regarding the cost effectiveness of the contract with LSU. It was requested that a survey be done on the types of service for the surgical treatment of morbid obesity. Responses are due early in January 2003.

Dr. Ciardo asked about the 120-day prescription issue that requires a new prescription to refill. If you have a 90-day prescription and it is not refilled in 120-days then you are required to get a 34-day supply first and then the next time it can be filled for a 90-day supply. She asked if AdvancePCS receives an additional administrative fee. Ms. Wendy See, AdvancePCS, explained that every time a claim is submitted by the

pharmacy to AdvancePCS, an administrative fee is charged to OGB. Mr. Benoit stated that it was fifteen cents per claim.

NEW BUSINESS

Dr. Cicardo stated that she received the LSU healthcare network directory was pleased to see Lafayette and Lake Charles areas were in it. She stated that it contains erroneous information. Mr. Wall stated it was a publication issued by LSU.

Mr. Wall provided to the Board for informational purposes an article regarding the Tower Perrin's study based on than analysis of 358 responses. The survey found that the average cost of employers' health benefit plans will rise 16% in 2003.

Mr. Benoit reported that the public hearing is scheduled for January 8, 2003, at the State Police auditorium on Independence Boulevard. The OGB will submit its report to the Legislative Oversight Committee within a couple of days after the public hearing and that will conclude the comment period on the rules that have been proposed. Once the Legislative Oversight Committee receives the report, it has 30 days to determine whether it will allow the rules to go into affect without a hearing or to conduct a hearing.

Mr. Lee asked if this plan year would be extended or would it be next year to align the deductibles. Mr. Wall stated that this plan year would be extended.

Mr. Culotta inquired about the date and time of the next scheduled OGB Study Commission meeting. Mr. Lincecum stated that the next meeting date has not been determined. He stated that the executive order has been amended to extend the study commission. The report to the governor has been extended from December 5, 2002, to January 15, 2002.

PUBLIC COMMENTS

Ms. Kathleen Miller asked what information would be available to the public before the public hearing on January 8, 2003. Will the public be educated on the proposed plan and what decisions will have already been made? Will rates be a consideration at the hearing? Will the public comments made at the public hearing be used? Mr. Lincecum stated that the comments made at the public hearing taken in written or verbal comments would be included in the report that goes to the Legislative Oversight Committee.

Ms. Miller asked about the primary reason in the NIC for administrative services only HMOs. Mr. Wall explained that the program asked for options across the state both on self-funded and fully-insured, HMO and EPO, regional and statewide to see what was available to make a recommendation regarding coverage for next year. Ms. Miller asked if the recommendations would be made on bottom line cost or if consideration would be given for quality services and reputable companies. Mr. Lincecum stated that

all issues would be considered. She stated that many plan members are concerned that there will be no HMO offerings next year.

ADJOURN

There being no further business to discuss, a motion was made by Mr. Castaing, seconded by Rep. Powell, to adjourn. With no opposition, the motion was unanimously adopted.