OGB health plan, the surviving spouse's choice of health plan, the surviving spouse's coverage level, and the surviving spouse's Medicare status. The participating agency with whom the surviving spouse is employed and enrolled with OGB as an active employee will no longer pay the state share of the surviving spouse's premiums as an active employee. So, while one participating agency may see an increase in premiums paid, another may see a decrease unless the current participating agency is the same as the one from which the deceased spouse retired in which case the amounts may offset within the agency's budget.

There may be minimal one-time costs associated with required programming updates by OGB's vendor. These costs will be performed by a vendor already contracted with OGB at the previously agreed upon rate and are estimated to cost between $615 and $1,320.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

OGB does not expect an increase or decrease in revenues as a result of this rule change.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule change will benefit a small number of state employees by making them eligible for surviving spouse health coverage.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule change is not expected to have an effect on competition or employment.

Heath C. Williams
Chief Executive Officer
2409#038

Patrice Thomas
Deputy Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Office of the Governor
Division of Administration
Office of Group Benefits

Primary Plan of Benefits and
Additional Plans and Operations
(LAC 32:III.105, and V.203, 303, and 503)

Editor's Note: The following Notice of Intent is being repromulgated to add the effective date and to correct technical errors. The original Notice of Intent can be viewed in the July 20, 2024 *Louisiana Register* on pages 1044-1048.

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., as authorized pursuant to R.S. 42:801 and 42:802, the Office of the Governor, Division of Administration, Office of Group Benefits, proposes to amend Chapter 1 of LAC 32:III., Primary Plan of Benefits, and Chapters 2, 3, and 5 of LAC 32:V., Additional Plans and Operations. The revisions amend the Out-of-Pocket Maximums to comply with the federal Inflation Reduction Act (IRA) which limits plan participants with Medicare Part D coverage to a maximum out-of-pocket amount of $2,000 for prescription drugs. The revisions also amend these rules to create a division between medical and prescription maximum out-of-pocket amounts to comply with the IRA. The effective date of the proposed Rule change is January 1, 2025.

Title 32
EMPLOYEE BENEFITS
Part III. Primary Plan of Benefits
Chapter 1. Operation of Primary Plan
§105. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	**Non-Network**
Individual:		
Active Employee/Retirees on or after March 1, 2015	$3,500	No Coverage
Retirees prior to March 1, 2015	$2,000	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	$6,000	No Coverage
Retirees prior to March 1, 2015	$3,000	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	$8,500	No Coverage
Retirees prior to March 1, 2015	$4,000	No Coverage

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

Out-of-Pocket Maximum[1] Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	**Non-Network**
Individual:		
Active Employee/Retirees on or after March 1, 2015	Medical: $1,500 Prescription: $2,000	No Coverage
Retirees prior to March 1, 2015	Medical: $500 Prescription: $1,500	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for One):		
Active Employee/Retirees on or after March 1, 2015	Medical: $4,000 Prescription: $2,000	No Coverage
Retirees prior to March 1, 2015	Medical: $1,500 Prescription: $1,500	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: $2,000 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $0 Prescription: $1,500 per participant	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for One):		
Active Employee/Retirees on or after March 1, 2015	Medical: $6,500 Prescription: $2,000 per participant	No Coverage

Out-of-Pocket Maximum[1] Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
Retirees prior to March 1, 2015	Medical: $2,500 Prescription: $1,500 per participant	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: $4,000 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $1,000 Prescription: $1,500 per participant	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for Three):		
Active Employee/Retirees on or after March 1, 2015	Medical: $2,500 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $0 Prescription: $1,500	No Coverage

[1] Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

Out-of-Pocket Maximums[1] (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)					
	Active Employee/Retirees on or after March 1, 2015		Retirees prior to March 1, 2015 Without Medicare		Retirees prior to March 1, 2015 With Medicare
	Network	Non-Network	Network	Non-Network	Network and Non-Network
Individual Only	Medical: $1,500 Prescription: $2,000	$4,700	See Subsection A	See Subsection A	Medical: $1,300 Prescription: $2,000
Individual Plus One Dependent (Medicare Paying Primary for One)	Medical: $4,000 Prescription: $2,000	$8,500	Medical: $1,600 Prescription: $2,000	$7,600	Medical: $3,600 Prescription: $2,000
Individual Plus One Dependent (Medicare Paying Primary for Two)	Medical: $2,000 Prescription: $2,000 per participant	$8,500	Not Applicable	Not Applicable	Medical: $1,600 Prescription: $2,000 per participant
Individual Plus Two or More Dependents (Medicare Paying Primary for One)	Medical: $6,500 Prescription: $2,000	$12,250	Medical: $2,900 Prescription: $2,000	$10,900	Medical: $5,900 Prescription: $2,000
Individual Plus Two or More Dependents (Medicare Paying Primary for Two)	Medical: $4,500 Prescription: $2,000 per participant	$12,250	Medical: $900 Prescription: $2,000 per participant	$10,900	Medical: $3,900 Prescription: $2,000 per participant
Individual Plus Two or More Dependents (Medicare Paying Primary for Three)	Medical: $2,500 Prescription: $2,000 per participant	$12,250	Medical: $0 Prescription: $2,000 per participant	$10,900	Medical: $1,900 Prescription: $2,000 per participant

[1]Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:350 (February 2015), effective March 1, 2015, amended LR 43:2153 (November 2017), effective January 1, 2018, LR 49:1377 (August 2023), LR 50:

Part V. Additional Plans and Operations

Chapter 2. PPO Plan Structure—Magnolia Open Access Plan

§203. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

	Active Employee/Retirees on or after March 1, 2015		Retirees prior to March 1, 2015 Without Medicare	
	Network	Non-Network	Network	Non-Network
Individual Only	$3,500	$4,700	$2,300	$4,300
Individual Plus One Dependent	$6,000	$8,500	$3,600	$7,600
Individual Plus Two or More Dependents	$8,500	$12,250	$4,900	$10,900

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:355 (February 2015), effective March 1, 2015, amended LR 43:2155 (November 2017), effective January 1, 2018, amended LR 50:

Chapter 3. Narrow Network HMO Plan Structure—Magnolia Local Plan (in certain geographical areas)

§303. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	**Non-Network**
Individual:		
Active Employee/Retirees on or after March 1, 2015	$2,500	No Coverage
Retirees prior to March 1, 2015	$1,000	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	$5,000	No Coverage
Retirees prior to March 1, 2015	$2,000	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	$7,500	No Coverage
Retirees prior to March 1, 2015	$3,000	No Coverage

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

Out-of-Pocket Maximum[1] Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	**Non-Network**
Individual:		
Active Employee/Retirees on or after March 1, 2015	Medical: $500 Prescription: $2,000	No Coverage
Retirees prior to March 1, 2015	Medical: $0 Prescription: $1000	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for One):		
Active Employee/Retirees on or after March 1, 2015	Medical: $3,000 Prescription: $2,000	No Coverage
Retirees prior to March 1, 2015	Medical: $1,000 Prescription: $1,000	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: $1,000 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $0 Prescription: $1,000 per participant	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for One):		
Active Employee/Retirees on or after March 1, 2015	Medical: $5,500 Prescription: $2,000	No Coverage
Retirees prior to March 1, 2015	Medical: $2,000 Prescription: $1,000	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: $3,500 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $1,000 Prescription: $1,000 per participant	No Coverage
Individual, Plus Two or More Dependents (Three with Medicare Paying Primary):		
Active Employee/Retirees on or after March 1, 2015	Medical: $1,500 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $0 Prescription: $1,000 per participant	No Coverage

[1] Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:359 (February 2015), effective March 1, 2015, amended LR 50:

Chapter 5. PPO/Consumer-Driven Health Plan Structure—Pelican HRA 1000 Plan

§503. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Deductibles, Coinsurance Amounts and Copayments)		
	Network	**Non-Network**
Individual	$5,000	$10,000
Family	$10,000	$20,000

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

Out-of-Pocket Maximum[1] Per Benefit Period (Includes All Eligible Deductibles, Coinsurance Amounts and Copayments)		
	Network	**Non-Network**
Individual	Medical: $3,000 Prescription: $2,000	$10,000

Out-of-Pocket Maximum[1] Per Benefit Period (Includes All Eligible Deductibles, Coinsurance Amounts and Copayments)		
	Network	Non-Network
Family (Medicare Paying Primary for One)	Medical: $8,000 Prescription: $2,000	$20,000
Family (Medicare Paying Primary for Two)	Medical: $6,000 Prescription: $2,000 per participant	$20,000
Family (Medicare Paying Primary for Three)	Medical: $4,000 Prescription: $2,000 per participant	$20,000

[1] Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:364 (February 2015), effective March 1, 2015, amended LR 50:

Family Impact Statement

The proposed amendments are not anticipated to have an impact on family formation, functioning, stability, or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

The proposed amendments are not anticipated to have an impact on poverty, as described in R.S. 49:973.

Small Business Analysis

The proposed amendments are not anticipated to have an adverse effect or economic impact on small businesses in accordance with the Regulatory Flexibility Act.

Provider Impact Statement

The proposed amendments are not anticipated to have an impact on providers of services funded by the state as described in HCR 170 of the 2014 Regular Legislative Session.

Public Comments

Interested persons may submit written comments about the proposed Rules to the Office of Group Benefits, Attn.: Margaret A. Collier, P.O. Box 44036, Baton Rouge, LA 70804. The deadline for receipt of written comments is Monday, August 12, 2024 by 4:30 p.m.

Public Hearing

A public hearing on the proposed amendments may be held on Wednesday, August 28, 2024, beginning at 9 a.m., in the Louisiana Purchase Room (Room 1-100) on the first floor of the Claiborne Building, located at 1201 North Third Street, Baton Rouge, LA 70802, if such a hearing is requested by Monday, August 12, 2024 by 4:30 p.m.. All interested persons will be afforded an opportunity to submit data, views, or arguments, orally or in writing, at the hearing. For assistance in determining if a hearing will be held, please call OGB Customer Service at 225-925-6625, or at 1-800-272-8451.

Heath Williams
Chief Executive Officer

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Primary Plan of Benefits and Additional Plans and Operations

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed changes modify the out-of-pocket maximums set forth in LAC 32:III.105, LAC 32:V.203, LAC 32:V.303, and LAC 32:V.503. Changes are mandated by the federal Inflation Reduction Act (IRA) which limit the maximum out-of-pocket amount (MOOP) for prescription drugs to $2,000 for plan participants with Medicare Part D.

The IRA's mandates are expected to decrease the Office of Group Benefits' (OGB) expenditures for its self-funded plans by approximately $6.2M in Fiscal Year Ending (FYE) 2025 and $6.1M in FYE 2026, but increase expenditures by $8.3 M in FYE 2027. These values are an estimate of expenditures under the IRA compared to estimated costs without the expected impacts of the IRA, and rely upon values provided by OGB's Pharmacy Benefit Manager (PBM) and Actuary. Some federal Medicare Part D subsidy amounts for 2025 have still not been released by the Centers for Medicare & Medicaid Services (CMS); any deviations between the Medicare Part D subsidy estimates provided by OGB's vendors and the subsidy payments OGB actually receives will impact the estimates provided.

The IRA also mandated those providing Medicare Part D coverage make available the Medicare Prescription Payment Plan (M3P). M3P is a program that requires OGB to offer Medicare paying primary plan participants the option to pay out-of-pocket prescription drug costs in the form of capped monthly installment payments instead of all at once at the pharmacy. This program assists Medicare enrollees by allowing them to defer the cost of their prescriptions and pay a monthly amount instead. This means that a plan participant who purchases a prescription drug on January 1st will not have to pay their share of the cost on January 1st if they enroll in the program. Instead, the plan participant can spread their prescription cost across monthly payments for the remainder of the plan year. Despite payments being spread out, the plan participant's prescription costs will still accrue to meet their MOOP. This federal requirement will cause an increase of $9 per member per month (PMPM) in 2025 for those members who participate in the program. This administrative fee will be paid by OGB to the prescription drug administrator and covers the cost of administering this program.

The cost estimates presented on the prior page do not include any potential impact of the M3P program, the cost of which will depend on the number of participants who enroll and the period they remain enrolled in the program. If every eligible participant enrolled in this program for 12 months, the annual cost to OGB would be $4.8M. If OGB were to incur the maximum cost for this program, this increase in administrative cost would reduce the expected decrease in expenditures.

Additionally, there may be minimal one-time costs associated with required programming updates by OGB's current vendors for medical and pharmacy benefits. Other than

the M3P program, these costs are already provided for in OGB's contracts with the vendors and should not result in additional costs to OGB for programming updates.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

OGB is funded by premiums which are paid partially by participating employers and partially by the plan participants themselves. A change in OGB's costs is expected to result in a corresponding change in plan participants' premium rates. While OGB does not anticipate an increase in expenditures in the first or second year of IRA compliance, due to the expected increase in expenditures in the third year of IRA compliance, OGB anticipates the expenditure increase will require an increase in the premium rates for OGB's self-funded health plans. OGB strives to offset large premium rate increases by spreading the expected impact to the premium rate increases across several years. As such, OGB expects the impact of the IRA in 2025 to yield an increase in premium revenue receipts of $0.4M in FYE 2025 from what was expected without the impact of the IRA in 2025. The comparable increases for FYE 2026 and FYE 2027 are $1.7M and $3.1M, respectively.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NONGOVERNMENTAL GROUPS (Summary)

For OGB plan participants for whom Medicare pays primary, the change implements a $2,000 per Medicare participant MOOP for prescription drug benefits, except for those retired before March 1, 2015 in the Magnolia Local Plus plan (who will have a $1,500 per Medicare participant MOOP for prescription drug benefits) or the Magnolia Local plan (who will have a $1,000 per Medicare participant MOOP for prescription drug benefits). For all plans and tiers, the MOOP for medical and commercial prescription drug benefits was set such that when combined with the Medicare drug MOOPs, the total MOOP is equal to the current plan design to the extent this was possible. These changes affect approximately 44,414 OGB plan participants. These updates are expected to lower prescription drug cost sharing for Medicare participants.

The IRA mandated the M3P program, requiring OGB to offer Medicare paying primary plan participants the option to pay out-of-pocket prescription drug costs in the form of capped monthly installment payments instead of all at once at the pharmacy. This program assists Medicare enrollees by allowing them to defer the cost of their prescriptions and pay a monthly amount instead. This means that a plan participant who purchases a prescription drug on January 1st will not have to pay their share of the cost on January 1st if they enroll in the program. Instead, the plan participant can spread their prescription cost across monthly payments for the remainder of the plan year. Despite payments being spread out, the plan participant's prescription costs will still accrue to meet their MOOP. However, the initial higher out-of-pocket amount can be spread out by the plan participant if they desire to participate in this program. While there is no direct cost for this program to the plan participant, as discussed above, this federal requirement will cause an increase of $9 PMPM in 2025 for those members who participate in the program. This fee will be paid by OGB to the prescription drug administrator and covers the cost of administering this program. If every eligible participant enrolled in this program for 12 months, the annual cost to OGB would be $4.8M.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The effect of the proposed changes on competition and employment is unknown but estimated to be minimal to none.

Heath Williams
Chief Executive Officer
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Patrice Thomas
Deputy Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health
Board of Medical Examiners

Polysomnographic Technologists and Technicians
(LAC 46:XLV.3303, 3339, 3343, 6305, and 6311)

Notice is hereby given that pursuant to the authority vested in it by the Louisiana Medical Practice Act, R.S. 37:1261-1292, and in accordance with the applicable provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Board of Medical Examiners (Board) intends to amend its rules governing Polysomnographic Technologists and Technicians.

The proposed Rule changes revise the definition of "direct supervision", require licensed physicians providing and/or billing for interpretation of home sleep testing to ensure proper follow up, add collaborative practice physicians to the mutual obligations and responsibilities, and correct typographical errors. The proposed amendments are set forth below.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part XLV. Medical Professions
Subpart 2. Licensure and Certification
Chapter 33. Polysomnographic Technologists and Technicians
Subchapter A. General Provisions
§3303. Definitions

A. As used in this Chapter, the following terms shall have the meanings specified.

* * *

Direct Supervision—supervision by a physician, polysomnographic technologist, or registered respiratory therapist with SDS who is currently licensed by the board. The supervising entity must be present in the area where the procedure or service is being performed and be available to furnish assistance and direction throughout the procedure or service as needed.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2861-2870 and 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 39:3278 (December 2013), amended by Department of Health, Board of Medical Examiners, LR 50:

Subchapter F. Advisory Committee on Polysomnography
§3339. Organization and Authority

A. - B.4. …

5. advise the board on issues affecting the licensing and regulation of polysomnographic technology in this state;

B.6. - C. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2861-2870 and 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 39:3278 (December 2013), amended by Department of Health, Board of Medical Examiners, LR 50: