Policy Brief
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A Better Plan for Group Benefits

The state Office of Group Benefits could use a dose of financial stability, accountability and transparency

The recent controversies over the Office of Group Benefits reveal the need for a long-term fix. PAR recommends a third-party actuarial review for determining future premiums. The current decision-making system is too vulnerable to the expediencies of the state budget. This change would put Group Benefits on a path of better long-term financial stability and provide a more accountable and transparent process.

This policy brief provides a basic guide to the state's system of providing health insurance to government employees and retirees. It identifies problems and recommends changes in policy and the state's decision-making process.

Background

Recent controversies call for a re-examination of how financial decisions are made for the Office of Group Benefits. The office's surplus in 2011 of over $500 million has been substantially reduced and, according to some projections, will be close to zero at the end of this fiscal year if changes are not made. The administration's proposed changes would shift costs to employees and retirees by increasing their co-pays and deductibles. (See sidebar on page 6.) In light of the magnitude of these changes, Group Benefit's financial health and decision-making processes should be evaluated.

Group Benefits is responsible for providing health insurance to state employees and retirees, as well as their dependents. While the office offers fully insured policies, most of its members are enrolled in one of the self-insured policies. The self-insured plans are the Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) plans. Group Benefits also offers a Consumer Driven Health Plan (CDHP) with a related Health Savings Account (HSA). In the past fiscal year, Group Benefits had 131,511 members paying premiums, which covered 232,609 people including dependents.

For the self-insured plans, Group Benefits has the ultimate responsibility to pay any and all claims and must have sufficient funds to do so. To make certain it can meet that obligation, Group Benefits collects a premium from employers (state agencies and some school boards), employees and retirees. If the funds from those premiums are more than what was necessary to pay for claims in a given year, the surplus is added to the OGB Reserve Fund. If premiums are not sufficient to cover the cost of claims in a given year, the Reserve Fund is used to cover those additional expenses.

Each year the premiums are adjusted to cover the expected cost of care. This decision is made by Group Benefits and the Division of Administration in consultation with their actuary. The actuary looks at factors such as the demographics of the plan members, expected utilization rates and the projected cost of healthcare services. The actuary may recommend a new level of premiums but is not the final decision maker.

According to the Legislative Fiscal Office, the OGB Reserve Fund balance at the end of fiscal year 2008 was $270 million.[1] It increased to $500 million by the end of fiscal year 2011. Following a series of premium reductions, the Reserve Fund fell to $207 million at the end of fiscal year 2014. In a report this summer, the Fiscal Office projected a fund balance of about $6 million by June 30, 2015, the end of the current fiscal year. Group Benefits is proposing program changes that would prevent fund depletion and leave an estimated fund balance of $113 million at the end of this fiscal year.

Group Benefits' finances are under pressure from rising healthcare costs and Affordable Care Act mandates. One of the reasons behind the reduced Reserve Fund balance is the decision to set premiums below the level needed to cover the costs.

OGB Reserve Fund Balance

Fiscal Year	Premium Change	End of Year Fund Balance
2008	+6.0%	$270m
2009	+3.7%	$398m
2010	0.0%	$456m
2011	+5.6%	$500m
2012	+8.1%	$483m
2013	-7.0%	$401m
2014	-1.8%	$207m
2015	+5.0%	$6m - $113m*

*Source: Legislative Fiscal Office. *In its July 2014 report, the LFO estimated a $6 million fund balance at the end of fiscal year 2015. Due to potential plan changes, this projection is likely different now. Prior authorization and formulary changes were made in August and other proposed changes could take effect in 2015. OGB's estimate for the fiscal year-end 2015 fund balance is $113 million. The cash balance estimate is $227 million.*

Why was the premium reduced?

Under Louisiana Law, the state must pay 75% of the healthcare premium for each employee. That person picks up the remaining 25% if he or she is an active employee of the state. The premium share paid by the state for dependents of employees is 50%. The state match for retirees is based on the number of years the person was a member of Group Benefits. The employer share of the premium comes from the budget of the agency where the employee works. For example, a state prison guard would pay 25% of the premium and the Department of Corrections would pay 75%.

If premiums go up, the state agencies have to dedicate more money from their budgets to pay for employee health insurance. Agencies do not necessarily receive any increase in state funding to cover rising premium costs. They often are expected to come up with the money to cover those increases from their existing funding. Conversely, if premiums are reduced, that frees up funds at each state agency that otherwise would have gone to Group Benefits in the form of premiums.

After several years of increases, premiums were reduced 7% in fiscal year 2013 and 1.8% in fiscal year 2014. These premium reductions made the job of balancing the budget easier for state agencies in those years by reducing their employer contribution costs. Although the OGB Reserve Fund was not directly raided the same way other state funds have been swept to help balance the state budget, the premium reductions made the job of balancing the budget easier. Administration officials knew that if costs to Group Benefits exceeded expenses due to decreased premium-based revenue, the money for those extra costs could be drawn down from the OGB Reserve Fund. It should be noted that employees and retirees shared in the premium reduction because their premium costs decreased as well.

What is the right fund balance? How much is too much?

Part of the justification for the premium reductions was that the OGB Reserve Fund balance was too high. The fund balance exists to help offset unexpected costs. An argument can be made that an OGB Reserve Fund with $500 million is more than is needed for an agency that has annual expenditures of $1.5 billion. The risk is low that the state would need half a billion dollars to cover unexpected costs in a single year. On the other hand, a fund depletion to near zero dollars would be far too low a level.

The challenge for decision-makers is to determine a healthy and balanced level of reserves for the fund. The proper amount for the fund is fundamentally a question of risk tolerance. That is a question that actuarial science can be helpful in answering. Actuaries can consider several potential minimum standards for the Reserve Fund. For example, they could figure an amount that is enough to cover expenses that have been incurred but not reported, usually abbreviated as INBR. Or they could allow for two to three months of average expenses, or an amount equal to the two highest months expenses, and so on. Because the OGB Reserve Fund is ultimately backed by the state, one could argue that the fund needs only enough to cover cash flow expenses.

Group Benefits recently created a financial standard for the fund balance. Working with the consulting firm Alvarez and Marsal, the administration developed a methodology under which Group Benefits would compute a Targeted Fund Balance Range.[2] If faithfully implemented, this new standard would be a positive step forward.

The continuing problem is that the state does not have consensus or a transparent system for deciding the level of risk tolerance or for choosing a method of appropriate fund level calculation. Decisions are too likely to be influenced by short-term concerns over the state budget rather than by a long-term strategy for ensuring the stability of the Reserve Fund and the health of the Group Benefits financial system.

Recommendations

A minimum standard or target range should be set for the OGB Reserve Fund balance and that standard should be approved by an actuarial committee.

The standard should be clearly stated. It should be based on actuarial principles. The approval process should be designed to resist the temptation to lower the standard whenever budget pressures increase.

The actuarial committee could be similar to the Public Retirement Systems Actuarial Committee (PRSAC), if not PRSAC itself. PRSAC already serves a similar role in the setting of retirement contribution rates. Each year the state retirement systems propose what they think the retirement contribution rates should be. The contribution rates become effective only when approved by PRSAC.

As a body, PRSAC is unique. It is staffed by the Legislative Auditor's actuary, who reviews the retirement system proposals and, in some cases, makes recommendations. The members of PRSAC are the Commissioner of Administration, the State Treasurer, the Legislative Auditor, one member from both the House and Senate and two actuaries appointed by the retirement systems.

PRSAC is certainly not immune to politics or state budget concerns, but its focus tends to be on the actuarial assumptions at hand. The committee has reluctantly reduced the estimated actuarial return for the state's pensions, perhaps with regard to the near-term budget impact of those reductions.

Still, even with these shortcomings, PRSAC or a committee similar to PRSAC would make the Group Benefits decision-making process more apparent and accountable. A public body would be making decisions in public meetings, with input from stakeholders and independent experts. The critical decision-making would no longer be vested purely by administration insiders operating with no transparent process.

While PRSAC is one model for this type of actuarially informed decision making process, the solution for Group Benefits would not have to be this same entity. The actuaries who sit on PRSAC are retirement specialists rather than health insurance specialists. The state could create another PRSAC-like committee to deal with Group Benefits issues or simply change out the membership of PRSAC when dealing with Group Benefits. For example, the health insurance actuaries on the new committee could be appointed by the Department of Insurance.

Premiums should be set with the standard for the Reserve Fund balance in mind and should be approved by an actuarial committee.

Instead of setting a premium that covers the cost of benefits in a given year, the standard for the OGB Reserve Fund balance should be included in the calculation of annual premium costs. If the OGB Reserve Fund is less than the target as previously set, premiums should be increased in order to move the Reserve Fund closer to where it should be. Similarly, if the OGB Reserve Fund is overfunded, premiums could be reduced, or at least not increased as much as a simple annual calculation of costs would dictate. Much like the standard for what the OGB Reserve Fund amount should be, the premium levels should also be subject to approval by an actuarial committee.

Did privatization cause the problem with the Group Benefits Fund?

Starting in January 2013, the Office of Group Benefits outsourced a number of administrative duties to Blue Cross Blue Shield of Louisiana. In light of the reduced OGB Reserve Fund balance, a number of employees and legislators have questioned this move out of concern that such outsourcing contributed to depletion of the Reserve Fund.

Blue Cross is paid on a "per member per month basis" that will equal $25.50 per person per month as of January 2015. As the administrator of the claims, Blue Cross is not ultimately responsible for the cost of the health services provided. That cost is ultimately borne by the state. The amount of money in the Reserve Fund, the costs of premiums and the benefit plans can be changed to ensure the solvency of the system without affecting Blue Cross's ability to serve as a plan administrator.

Analysis from the Legislative Fiscal Office indicates that the overall administrative costs (both internal Group Benefit costs and the fees paid to Blue Cross) have decreased since privatization began. For example, the total administrative costs for Group Benefits decreased by approximately $10 million (from $79.6million to $67.3million) between fiscal years 2012 and 2014. By this measure the privatization seems to have saved money.

This initiative would give greater transparency to the process and give stakeholders greater confidence that the numbers used in the decision making process had been seriously reviewed.

Examine the cost effectiveness of a reinsurance policy

A reserve fund helps Group Benefits and the state mitigate risk of unexpected costs. If things go wrong, the fund is supposed to be the cushion that softens the blow. Another tool that can be used to mitigate risk is reinsurance. With a reinsurance policy, Group Benefits could pay a premium to an outside insurance company. In return, the company would cover losses beyond certain parameters. For example, if claims exceeded projections by more than $200 million, the outside insurer could cover half or even all of the cost. The larger the reinsurance policy, the smaller the need for a reserve fund. PAR is not recommending this course of action at this time but does suggest that a study of this option would be instructive.

Summary

These recommended changes will not solve the short-term problems facing the Office of Group Benefits. To prevent the OGB Reserve Fund from falling into a deficit posture in the near term, the state will have to add more revenue (probably through premium increases) or reduce benefits, or implement some combination of the two.

The PAR recommendations in this report will put Group Benefits on a path to better long term stability. By bringing this discussion in front of a public, deliberative body with expertise, Group Benefits members and others will be better informed of the need for potential future changes and premium increases.

1.One potential source of confusion over the status of the OGB Reserve Fund is the difference between a fund balance and a cash balance. In reference to the OGB reserve fund, the cash balance is all cash on hand. The fund balance is the cash balance minus an estimate of claims that may have been incurred in a certain period but have not been reported. This estimate is called "incurred but not reported" or INBR for short.

2. This range would have a low end equal to the highest monthly disbursement during the past six months and a high end of two times Group Benefits' average monthly disbursements during the past six months.

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New plans cope with rising health care costs

One of the ways that Group Benefits can help control the cost of providing health insurance is to adjust its coverage plans in ways that incentivize better personal health, disease prevention and fewer unnecessary trips to the doctor. Shifting costs to plan members helps reduce the state's coverage expenses while at the same time placing financial burdens on some beneficiaries, especially retirees. These are hard choices.

The state's Group Benefits plans have been relatively generous to members compared to coverage commonly offered to employees of private companies. To cope with rising health care costs and slow the increase in premiums, many private employers have adjusted their employee health plans to require larger patient co-pays for doctor visits, higher deductibles and other changes. Many of these changes have shifted more health care costs to the employees. By private industry standards, Louisiana government has been slow to adjust its insurance plans to cope with rising costs.

To reduce insurance costs, the Office of Group Benefits is changing its healthcare plan options. The current plans -- the PPO, HMO and CDHP – will be replaced sometime in 2015 by a Health Reimbursement Account (HRA), Health Savings Account (HSA), Magnolia Local, Magnolia Local Plus and Magnolia Open Access plans. Some of the new plans closely track older ones. For example, the Magnolia Local Plus is similar to the current HMO plan except it has a higher out-of-pocket cost for typical employees (a deductible, higher co-pays, and greater maximum out of pocket limits). The HRA and the Magnolia Local are new.

The administration argues that these changes bring Group Benefits in line with national trends. Group Benefits has not required prior authorization standards or referral processes for certain visits. The out-of-pocket maximums, co-pays and deductibles had not been adjusted in many years. The administration contends the current plans' minimal constraints drive excess utilization in the long run that have little impact on improving members' health. When the new plans were first announced, critics said the cost-shifting was too much too fast and could seriously jeopardize the finances of retirees on fixed incomes. Group Benefits then revised its original plan to remove the negative impact on retirees and lessen the impact on current employees.

There is disagreement between the Legislative Fiscal Office and the Division of Administration on how much more the new plans will cost OGB members. Based on the administration's original plan, the Fiscal Office said the total maximum out-of-pocket expense would increase 47%. The administration has stated that several members could realize a savings from the new plans. In fact, both are correct in their own ways. By acquiring additional options, certain members could see their total cost decrease. Group Benefits has provided an online cost calculator to help members select the plan that best fits their situation. The Fiscal Office also is correct in predicting that total potential costs will increase overall and in some cases substantially. The Fiscal Office is describing the maximum expenditure exposure, or the worst-case scenario, of a plan member.

It is difficult to say how these changes will affect a "typical" member because situations vary from one household to the next. Overall, employees and retirees clearly will be paying more for their healthcare with these new plans.

Group Benefits anticipates that these health plan changes will save the state millions of dollars in the first year. Savings will depend on the effective date and the final form of the changes. This is in addition to savings from changes to the prescription drug program. These savings will be achieved through lower utilization of healthcare services and by shifting some costs to the employees and retirees.