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TO: The Honorable James R. Fannin, Chairman Joint Legislative Committee on the Budget (JLCB)
The Honorable Jack Donahue, Vice Chairman Joint Legislative Committee on the Budget (JLCB)
Honorable Members of the Joint Legislative Committee on the Budget (JLCB)

FROM: John D. Carpenter, Legislative Fiscal Officer
J. Travis McIlwain, Section Director

DATE: August 11, 2014

SUBJECT: Office of Group Benefits (OGB) Update

The Legislative Fiscal Office (LFO) attended the OGB Policy & Planning Board meeting held on July 30, 2014. Along with multiple presentations from various vendors and the swearing in of new board members, OGB presented to the board the proposed health plan changes effective August 1, 2014 and January 1, 2015. A detailed explanation of the health plan changes and the fiscal impact of the changes are discussed below.

Since the FY 14 fiscal year's accounting cycle is not completed (August 15th is the deadline), the LFO has no additional OGB financial information to report to the committee relative to OGB's current fund balance. However, OGB's contract actuary provided a report to the OGB Policy & Planning Board that indicated the anticipated FY 14 ending year OGB fund balance to be approximately $218.4 M.

Note: Page 7 of this document includes a complete listing of health insurance terms utilized throughout this document.

HEALTH PLAN CHANGES

In order to slow the current OGB monthly "burn rate" of spending $16.1 M more than monthly revenue collections, OGB is modifying the health plan options for all state employees (and participating school board employees) and anticipating these changes to result in $44.7 M in overall expenditure savings and the prescription drug changes to result in an additional $69 M in expenditures savings all in FY 15.

The significant changes to the health plans include:

1. ***Significantly increasing the out-of-pocket maximum for all health plan options;***
2. ***Increasing deductibles for all health plan options;***
3. ***Increasing co-pays 100% for those proposed health plans with co-pays;***
4. ***Increasing the out-of-pocket maximum for the prescription drug benefit by $300 from $1,200 to $1,500 (20% increase);***
5. ***Subjecting the prescription drug benefit to a drug formulary with various drug categories that will result in an increased cost for preferred and brand name drugs and a decreased cost for generic drugs;***
6. ***Implementing other various prescription drug benefit changes including high compound management, over utilization management and the exclusion of medical foods;***
7. ***Requiring prior authorizations for certain medical procedures;***
8. ***Eliminating the out-of-network benefit for some health plan options, which could result in balanced billing for some OGB members depending upon the new health plan choice;***
9. ***Application of standard benefit limits (Blue Cross Blue Shield standard) for skilled nursing facilities, home health care services and hospice care services;***
10. ***Removing all vision coverage from the health plan options;***
11. ***Implementing the Live Better Louisiana wellness initiative;***
12. ***Decreasing premiums for the proposed HRA/HSA compared to the current Consumer Driven Health Savings Account (CDHSA) health plan option.***

The health plan and prescription drug plan policy changes listed above will shift more of the costs from the state (OGB Health Plan) to the OGB plan member and as mentioned above will save the state at least $44.7 M for health plan changes and at least $69 M for prescription drug plan changes in FY 15.

Along with premiums, the major costs incurred for medical services by an OGB plan member will be deductibles, co-payments and coinsurance. Table 1 on the next page is a brief summary

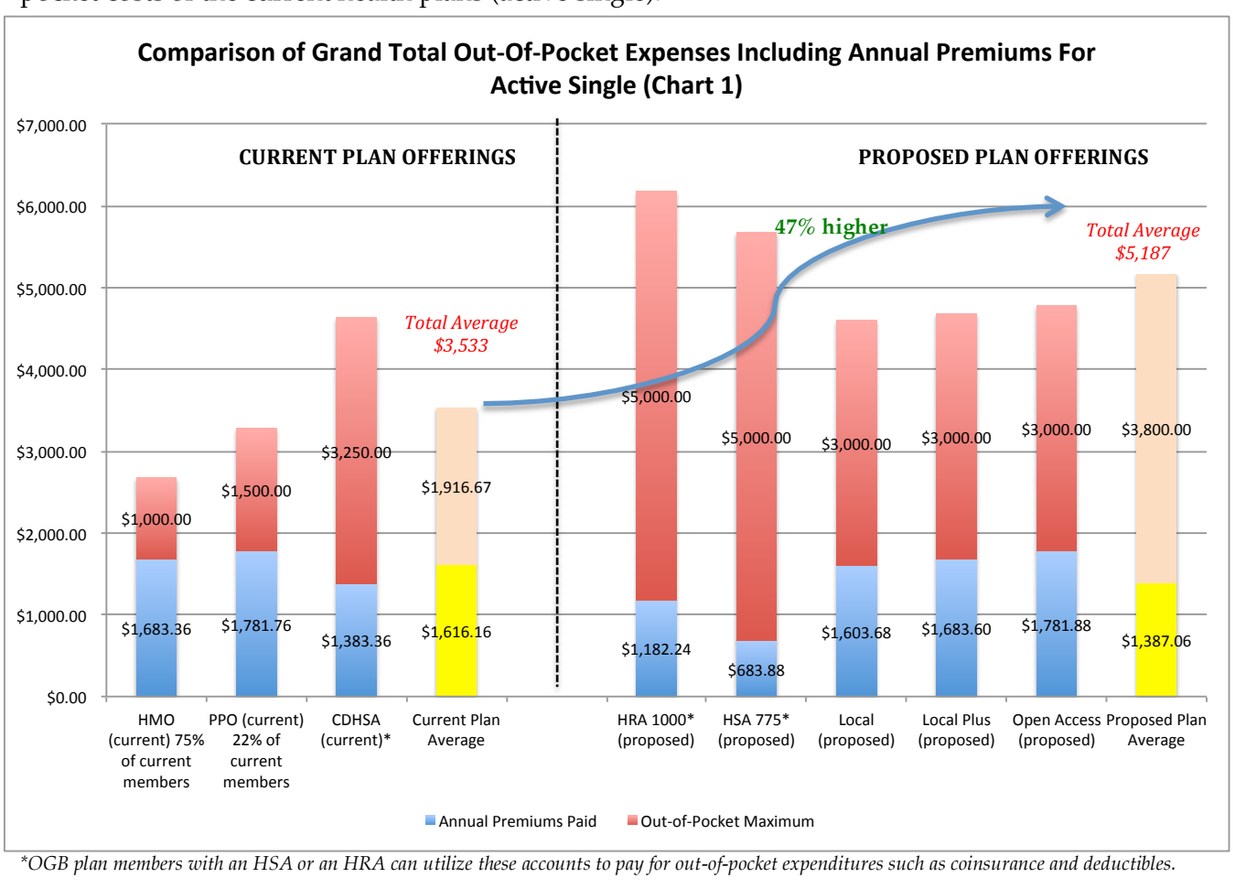
TABLE 1								
CURRENT OGB PLAN OFFERINGS				PROPOSED OGB PLAN OFFERINGS				
ACTIVE SINGLE	PPO	HMO	CDHSA	HRA 1000	HSA 775	Local	Local Plus	Open Access
Deductible*	$500	$0	$1,250	$2,000	$2,000	$500	$500	$1,000
Co-Pays	$0	$15/$25	$0	$0	$0	$25/$50	$25/$50	$0
Coinsurance	10%	$0	20%	20%	20%	$0	$0	10%
OOM (in-network)	$1,500	$1,000	$3,250	$5,000	$5,000	$3,000	$3,000	$3,000
OOM (out-of-network)	$3,500	$4,000	$3,250	$10,000	$10,000	N/A	N/A	$4,000
Out-of-Network Benefit	30%	30%	30%	40%	40%	N/A	N/A	30%

**The deductible listed in the Table 1 for the proposed plans is for in-network providers. There is a separate and higher deductible for out-of-network providers under the proposed health plans. The same is true for the out-of-pocket maximum.*

comparing the costs of the current major OGB health plan offerings to the proposed OGB health plan options for a Single Active Employee. Based upon Table 1, by adding and/or increasing deductibles, increasing the out-of-pocket maximum and increasing co-payments and coinsurance, the new health plan offerings will significantly reduce the cost to OGB, while the OGB member pays more for their medical services. As shown in Table 1, all new health plan options will have a deductible increase *(PPO plan currently has a $500 deductible for active single)*, an out-of-pocket maximum increase, a copay increase or incur the additional cost of having a deductible that currently does not exist for most OGB members. Of the total OGB population, 75% are currently enrolled in the HMO plan, which currently has a $0 deductible. Thus, the majority of OGB plan participants will be subject to a deductible and coinsurance whereas most are currently only subject to fixed co-pays.

Note: *Based upon Table 1 above, it appears there is not much difference between the current CDHSA plan and the proposed HRA 1000 and HSA 775 health plan choices. However, as of the latest OGB enrollment information, there are approximately 350 total covered lives (223 OGB members) that are currently covered by the current CDHSA plan. This represents 0.15% of the total OGB member population. Since the majority of OGB's member population is either in the PPO Plan (22%) or HMO Plan (75%), comparing the current CDHSA health plan to the new health plans will not illustrate the complete fiscal impact to the OGB program and its membership.*

Chart 1 below compares the total out-of-pocket costs (true costs) including annual premiums paid (denoted in the blue bars below) and the out-of-maximum (total amount member must pay before health plan pays 100% denoted in the red bars below) for all current and proposed health plans. The average out-of-pocket costs for all proposed health plans are 47% higher than the average out-of-pocket costs of the current health plans (active single).



**OGB plan members with an HSA or an HRA can utilize these accounts to pay for out-of-pocket expenditures such as coinsurance and deductibles.*

Based upon the new health plan offerings, the diagram on the next page is an illustration of how deductibles, coinsurance and out-of-pocket maximums work in relation to the new OGB health plan options that have deductibles and coinsurance. Due to the majority of OGB members being in the HMO plan without deductibles and coinsurance, these individuals will likely choose a plan with deductibles and coinsurance if the member wants a similar plan structure to the current HMO plan.

DURING OGB PLAN YEAR (JANUARY 1 THROUGH DECEMBER 31)

How Deductibles, Coinsurance and Out-of-Pocket Maximums will work for the proposed HRA 1000, HAS 775 and Open Access Plan members.

STEP 1

Deductible

OGB member pays 100% of the healthcare costs up to the amount of deductible. Deductibles range from $500 to $8,000 depending upon health plan choice, plan type (single, family) and if the deductible applies to an in-network or out-of-network provider.

Note: If the OGB member has the HRA 1000 or HSA 775 plans, the resources in their HSA or HRA can be utilized to pay the deductibles and coinsurance.

Note: There are different out-of-pocket maximums and deducitibles for the out of network benefit portion of the health plan.

STEP 2

Coinsurance

After the deductible is met, the OGB member will pay coinsurance % up to the out-of-pocket maximum. Coinsurance costs range from 80/20 to 90/10 depending upon health plan choice. For example, 80/20 coinsurance means the OGB member will pay 20% of the contracted rate while the health plan pays 80%. Proposed out-of-pocket maximums range from $3,000 to $20,000 depending upon health plan choice and plan type (single, family).

Note: There are some health plan choices that do not have coinsurance and only have co-pays (Local/Local Plus)

Note: Along with the conisurance and co-pays, deductible payments go toward out-of-pocket maximum.

STEP 3

100% Paid by Health Insurance Plan

After the OGB member has met the out-of-pocket maximum (through deductible, co-pay & coinsurance), the health insurance plan will pay 100% of the medical costs.

Note: The pharmacy benefit has a separate out-of-pocket maximum, which is being increased by $300 from $1,200 to $1,500 effective August 1, 2014 for all active and Non-Medicare Retirees. The prescription drug out-of-pocket maximum for Medicare Retirees will be effective on January 1, 2015.

VARIOUS OGB SCENARIOS

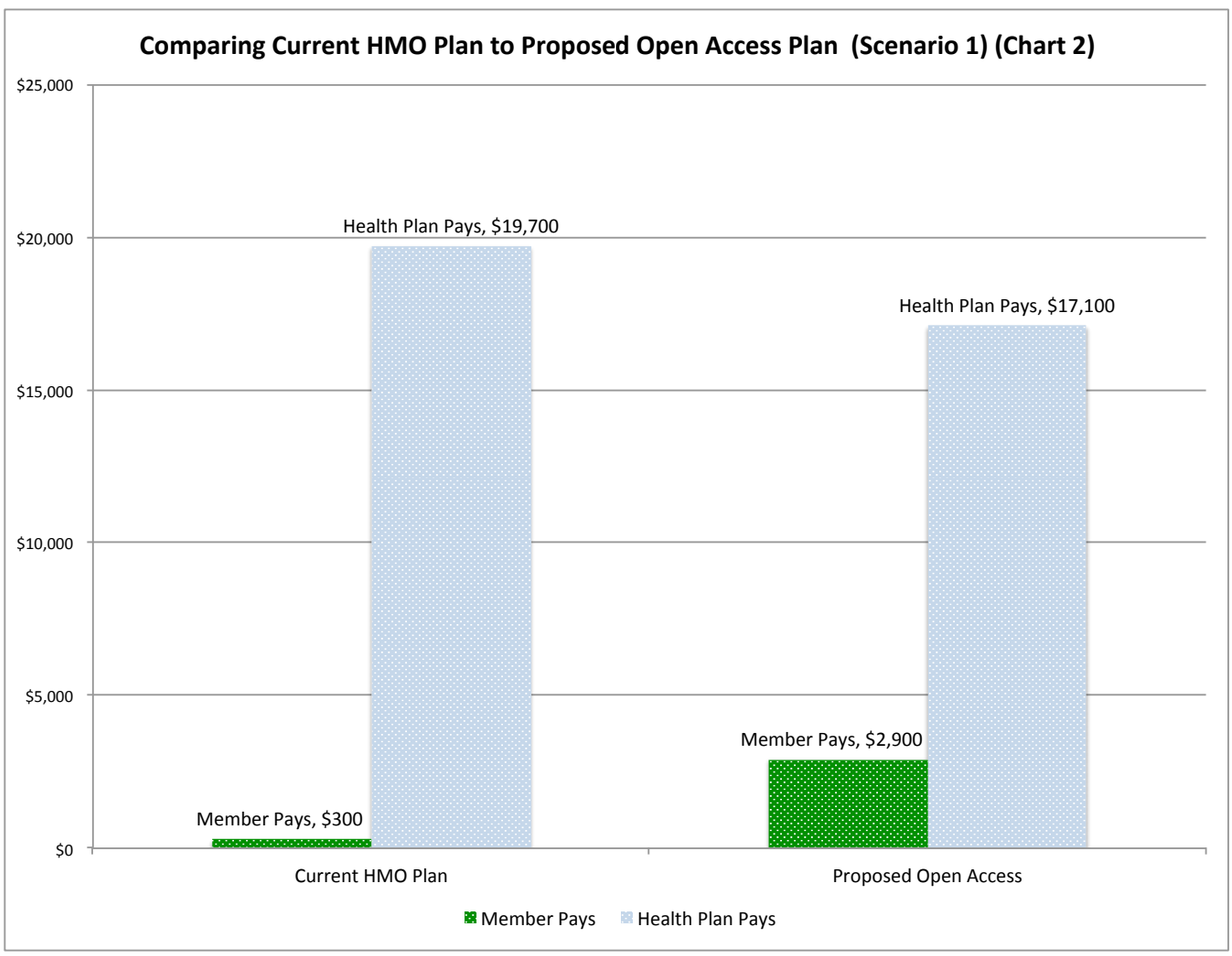
After reviewing the new health plan offerings presented to the board, the LFO has created a few scenarios to illustrate the cost saving potential to the OGB of the new health plan options compared to the existing plans. **These scenarios are based upon assumptions of the total contracted rate costs and assume all providers are in-network providers and facilities (hospitals) of the current Blue Cross Blue Shield Provider Network**.

Note: *For purposes of simplicity, all scenarios presented are for an active single member. A detailed and specific health plan comparison cannot be completed until the OGB/DOA releases the official proposed health plan documents of all five health plan options, which will not be made available until annual enrollment begins in October 2014. These scenarios are meant to assist in explaining the differences between the current plans and the proposed plans based upon OGB's presentation to the OGB board on July 30, 2014 and are in no way actuarially sound.*

***Scenario 1*:** At the beginning of the health plan year, an individual (active single) breaks his foot and has to have emergency surgery. Due to the complexity of the procedure, the individual is required to stay in the hospital for 3 days following surgery and requires the assistance of home health services upon hospital discharge. For this scenario, the total cost of these medical services is $20,000, which is broken down as follows:

- $17,000 – emergency room plus 3 days inpatient hospital bill
- $3,000 – home health bill
- $20,000 – Total

Based upon the proposed health plan offerings for this scenario, the OGB program will save significant medical claim expenditures. See Chart 2 below that compares the current HMO plan to the proposed Open Access heath plan option. ***Note:*** *These two plans were picked for comparison because the majority of OGB members (75%) have the HMO Plan and the Open Access Plan is the only proposed health plan option that is a traditional health plan that also has an out-of-network benefit like the current HMO plan.*



Note: The current HMO plan requires co-payments while the proposed Open Access plan has deductibles and coinsurance.

Based upon Chart 2 above, the OGB health plan will decrease its financial expenditures from paying 98% of the medical costs to paying 86% of the medical costs. In this scenario, this represents a 13% decrease in OGB health plan expenditures, but also represents a significant out-of-pocket increase for OGB plan members.

***Scenario 2*:** An individual (active single) visits an ENT (Specialist) on January 2, 2015 for treatment of a severe sinus infection. Due to January 2 being the second day of the new health plan year, the entire cost of the doctor visit (assuming $600 for an ENT visit with in-house lab work) will be borne by the OGB plan member (dependent upon health plan choice), which will result in expenditure savings to the overall OGB program. See Table 2 that compares scenario 2 costs under current health plan options to proposed health plan options.

$600 ENT DOCTOR VISIT ON JANUARY 2nd (SCENARIO 2) (TABLE 2)								
	PPO	**HMO**	**CDHSA****	**HRA 1000****	**HSA 775****	**Local*****	**Local Plus*****	**Open Access**
Deductible	$500	$0	$1,250	$2,000	$2,000	$500	$500	$1,000
Copays	$0	$25	$0	$0	$0	$50	$50	$0
Coinsurance*	90/10	$0	80/20	80/20	80/20	$0	$0	90/10
ENT Visit Costs	**$600**	**$600**	**$600**	**$600**	**$600**	**$600**	**$600**	**$600**
Member Pays (deductibles, copays, coinsurance)*	($510)	($25)	($600)	($600)	($600)	($50)	($50)	($600)
Health Plan Pays	($90)	($575)	$0	$0	$0	($550)	($550)	$0

Coinsurance for the current **PPO plan is 90/10 once the deductible is met. Thus, under this scenario, a current PPO plan member would be responsible for paying the $500 deductible as well as 10% coinsurance of the remaining doctor visit cost, which equates to $10 in this scenario (10% of $100 = $10).*

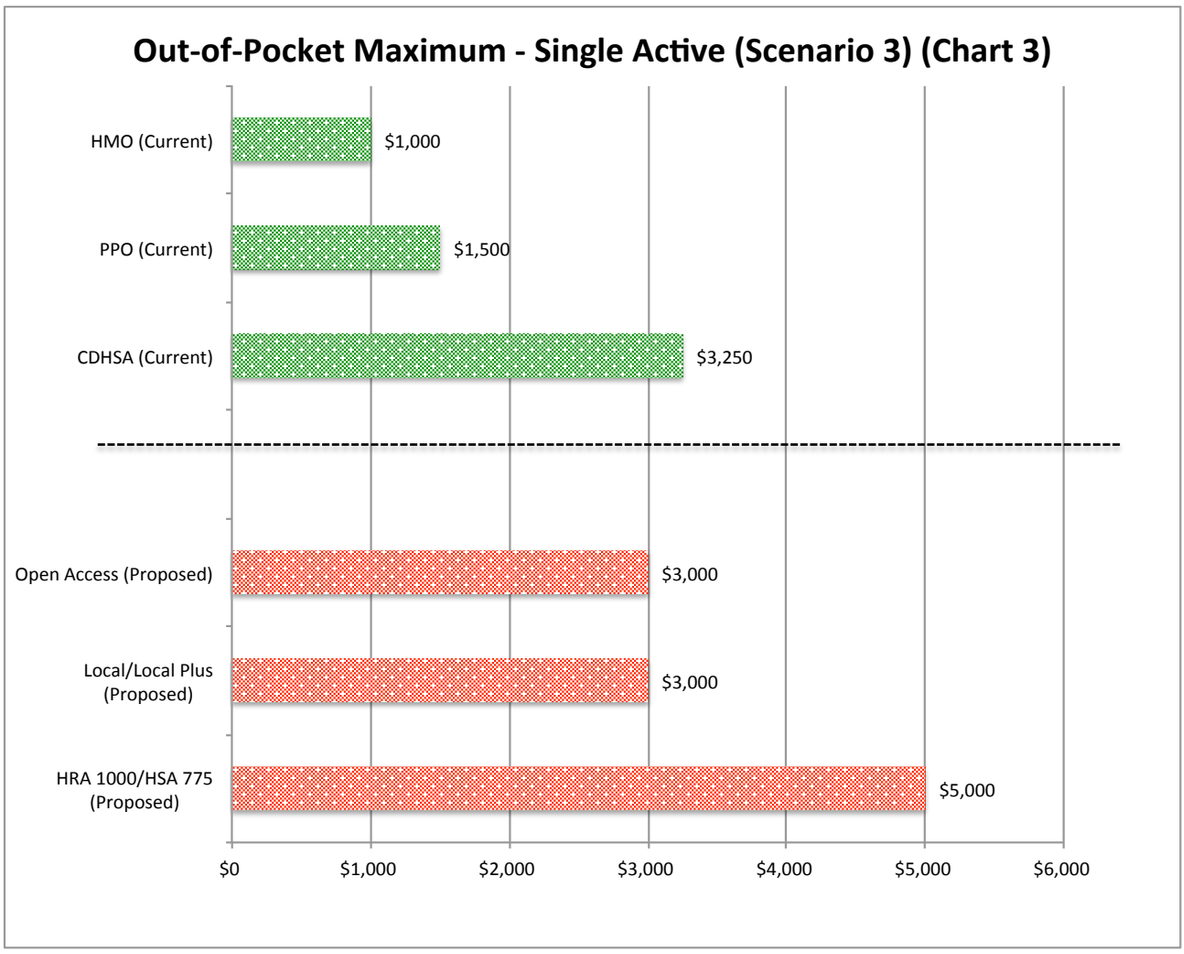
***If the OGB member has the HSA 775 or HRA 1000, the $600 ENT visit could be funded with resources contained within the members' HSA or HRA account. This is currently the case for those members who have the CDHSA account. There is currently 0.15% of OGB's member population who has the CDHSA plan.*

****These health plans only have an in-network benefit and no out-of-network benefit, which could result in the OGB member being **balanced billed** for medical services provided by providers outside the Blue Cross Blue Shield nationwide network for Local Plus plan option or the Blue Cross Blue Shield community network (Baton Rouge, Shreveport, New Orleans areas only) for the Local plan option. Balanced billing is the practice of an out-of-network provider billing the health plan member the difference between the amount the health insurance plan pays (only if there is an out-of-network benefit) and the total medical services costs. If a health plan has an out-of-network benefit, it will only pay a percentage of what is known as the "reasonable and customary" amount. **If your health plan does not have an out-of-network benefit, the health plan member would be responsible for the entire medical service cost of the out of network provider. See Table 3 below for an out-of-network benefit comparison of the health plan choices compared to current plans.***

TABLE 3		
Health Plans	**Out-of-Network Benefit (Yes or No)**	**Out-of-Network Benefit**
HMO Plan (Current)	YES	30% of fee schedule up to out-of-pocket maximum of $4,000 (individual) or $12,000 (family)
PPO Plan (Current)	YES	30% of fee schedule up to out-of-pocket maximum of $3,500 (individual) or $12,700 (family)
CD-HSA (Current)	YES	30% of fee schedule up to out-of-pocket maximum of $3,250 (individual) or $11,000 (family)
Local/Local Plus (Proposed)	NO	No Out-of-Network Benefit
Open Access (Proposed)	YES	$1,000 deductible (single), $3,000 deductible (family), 30% coinsurance up to out-of-pocket maximum of $4,000 (individual) or $12,000 (family)
HRA 1,000/HSA 775 (Proposed)	YES	$4,000 deductible (single), $8,000 deductible (family), 40% coinsurance up to out-of-pocket maximum of $10,000 (individual) or $20,000 (family)

***Scenario 3*:** The same individual (active single) visits the ENT (Specialist) again on December 30, 2015 for treatment of a similar severe sinus infection. Due to December 30th being at the end of the health plan year, the $600 visit (with in-house lab work) could be completely covered 100% by the health plan, if the active single individual has met the out-of-pocket maximum of the health plan. See Chart 3 on the next page that compares the out of pocket maximums for the current health plan options to the proposed health plan options before the plan covers 100% of an in-network providers' costs.

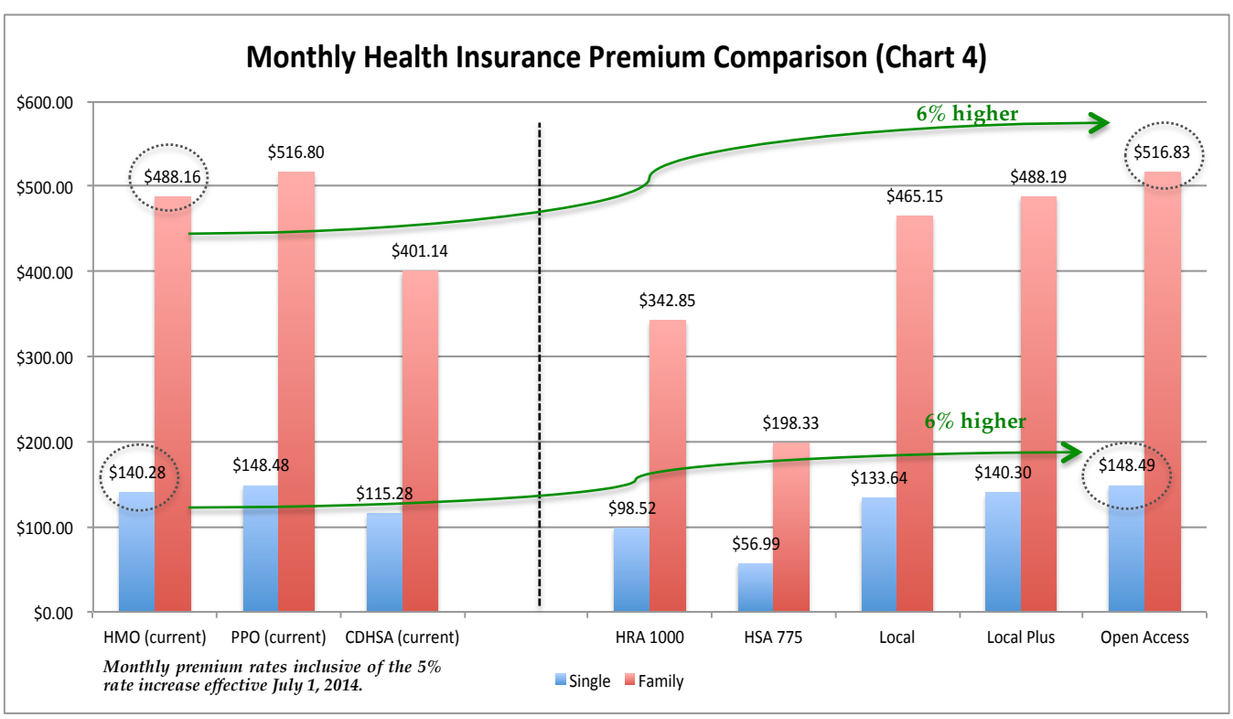
Based upon Chart 3 on the next page, the $600 ENT visit at the end of the health plan year will be 100% covered if the out-of-pocket maximum is reached. **The out-of-pocket maximums for OGB plan members are significantly increased ranging from 54% increase (comparing current CDHSA to proposed HRA 1000/HSA 775) up to a 300% increase (comparing current HMO to proposed Open Access and Local Plus). This change will result in significant cost savings to OGB.**



HEALTH PREMIUMS

Other than the HRA 1000 and HSA 775 (premiums will be lower than current CDHSA), the health premiums for the new health plan options will remain unchanged for January 1, 2015. **However, due to the majority of the current OGB plan members (75%) being under the HMO Plan, those individuals that choose the Open Access Plan, which is the only traditional health plan with both an in-network and out-of-network benefit like the current HMO plan, will pay approximately 6% more in premiums beginning January 1, 2015. Due to the 5% premium increase that was effective July 1, 2014 these specific OGB members will be subject to a total premium increase of 11% in FY 15 (See Chart 4 Below).** The Open Access plan premium mirrors the current PPO plan premium, which is currently 6% higher than the current HMO plan premium. OGB members who have the PPO plan and who pick the Open Access Plan would see no change in premium payments. See summary bullets and Chart 4 below.

- Proposed HRA 1000 and HRA 775 premiums are significantly lower than the current CDHSA plan option;
- Proposed Local Plus premiums are the same as current HMO plan option;
- Proposed Open Access premiums are the same as current PPO plan option.



PRESCRIPTION DRUG CHANGES

Effective August 1, 2014, the prescription drug benefit changed for all current (active/non-Medicare retirees) OGB plan members. The prescription drug benefit will be subject to a tiered drug formulary and the out-of-pocket maximum will increase $300 from $1,200 to $1,500 (20% increase). The OGB anticipates these changes, along with other prescription drug changes, will result in overall OGB expenditure savings in the amount of $69 M in FY 15.

A drug formulary is a list of medications available to health plan members under the health plan's drug benefit. The formulary consists of 4 different drug categories: generic drug, preferred brand drugs, non-preferred brand drugs and specialty medications. Table 4 below is comparison of the prescription drug benefit prior to the August 1st changes and after the August 1st changes.

TABLE 4		
Co-pay Before Out-Of-Pocket Is Met	**Prior to August 1st**	**Change**
Generic	50%, maximum $50 per month's supply	50%, maximum $30 per month's supply
Brand	50%, maximum $50 per month's supply	50%, maximum $55 per month's supply
Non-Preferred Brand	50%, maximum $50 per month's supply	65%, maximum $80 per month's supply
Specialty	50%, maximum $50	50%, maximum $80
Co-pay After Out-Of-Pocket Is Met	**Prior to August 1st**	**Change**
Generic	$0 per month's supply	No change
Brand	$15 per month's supply	$20 per month's supply
Non-Preferred Brand	$15 per month's supply	$40 per month's supply
Specialty	$15	$40

Based upon Table 4, the new prescription drug benefit changes incentivize OGB health plan members to purchase generic drugs as opposed to brand and/or non-preferred brand drugs.

Note: *The drug benefit changes effective August 1, 2014 will only impact Actives and non-Medicare retirees. The drug benefit changes will impact Medicare Retirees on January 1, 2015.*

Other prescription drug changes
In addition to implementing a tiered drug formulary and increasing the out-of-pocket maximum $300, OGB is implementing other prescription drug changes. OGB is anticipating the drug formulary changes to result in $43.2 M of FY 15 savings and the remaining $25.8 M in savings (for a total of $69 M) will come from the significant items listed below.

- *Clinical Utilization Management* – Require prior authorizations and quantity limits on prescription drugs ($10.8 M);
- *90 Day Fill Option* – For maintenance medications, 90-day prescriptions fills for 2.5 times the cost of your co-pay with a maximum of $75 ($9 M)
- *High Cost Compounds* – Require prior authorizations on high cost compounds over $400 ($3.4 M);
- *Over Utilization Management* – Identify OGB members receiving an equivalent greater than 120 mg/day of morphine or other narcotics being prescribed by multiple doctors and filled at multiple pharmacies ($1.2 M);
- *Acetaminophen Management* – Identify OGB members receiving more than the FDA recommended dose ($1.1 M);
- *Polypharmacy Management* – Identify OGB members receiving multiple prescriptions and determine if alternative options are available ($0.1 M);
- *Excluding Medical Foods* – The FDA does not have safety guidelines for these types of foods ($0.2 M).

LIVE BETTER LOUISIANA WELLNESS INITIATIVE

Although the costs for medical services will continue to increase, OGB is anticipating the Live Better Louisiana wellness initiative will assist in reducing future medical costs of the overall member population. This initiative encourages members to focus on preventive health including the use of the online personal health assessment tool and preventive onsite health checks. OGB anticipates this initiative will improve the OGB member future health outcomes that may result in reduced future medical expenditures of the overall program. Since the program's launch on May 30, 2014, there have been at least 280 members that have had a clinic check up of which 31% were identified as pre-hypertension and 14% were identified as pre-diabetic. OGB's remaining calendar year 2014 goal is to have 25% of the total member population screened.

HEALTH INSURANCE DEFINITIONS

Based upon research, the LFO has provided definitions of commonly used health insurance terms that are utilized throughout this document. The source of the prescription drug terms is from MedImpact's presentation to the OGB board on July 30, 2014. MedImpact is OGB's pharmacy benefit manager.

- ***Premium*** *– Amount of money a member pays monthly for health insurance.*
- ***Deductible*** *– Amount of money a member pays for eligible medical expenditures. After the deductible is met, the health plan pays 100% or the member shares the costs (coinsurance) with the health plan up to the out-of-pocket maximum (like the proposed OGB health plan options). The deductible is typically different for in-network and out-of-network providers. All new health plan options have different deductibles for in-network and out-of-network, excluding the Local/Local Plus health plans which have no out-of-network benefit at all.*
- ***Coinsurance*** *– Health cost sharing between the OGB member and the health plan. Cost share ranges included in the new OGB plan offerings range from 90/10 to 80/20, whereby the health plan pays either 90% or 80% of the medical service cost and the member pays the balance up to the out-of-pocket maximum.*
- ***Out-of-pocket Maximum*** *– The maximum amount of money an OGB member pays out-of-pocket for medical services in a health plan year. Under the OGB health plan offerings, co-pays, coinsurance and deductibles are all included in the out-of-pocket maximum calculation. The out-of-pocket maximum typically varies for in-network and out-of-network providers.*
- ***Health Savings Account (HSA)*** *– A savings account that is utilized in conjunction with a high deductible health insurance policy that allows an individual to save money tax-free in an account for medical expenses. Depending upon the employer policy, contributions are made to the account by the employer and employee and these funds can follow the employee.*
- ***Health Reimbursement Arrangement (HRA)*** *– An employer funded account that reimburses employees for out-of-pocket medical expenses. HRAs are notional accounts and the funds cannot follow the employee. In addition, only the employer can contribute to the account.*
- ***Generic Drugs*** *– Identical to a brand name drug in dosage, strength, effectiveness and safety.*
- ***Preferred Brand Drugs*** *– Drugs that have been on the market and do not have a generic equivalent available.*
- ***Non-preferred Brand Drugs*** *– Higher-cost medications that have recently come on the prescription drug market.*
- ***Specialty Medications*** *– Brand or generic drugs that cost over $600 and typically treat specific diseases such as Cancer, Multiple Sclerosis and Rheumatoid Arthritis.*
- ***Balanced Billing*** *– The practice of an out-of-network provider billing the health plan member the difference between the amount the health insurance plan pays (only if there is an out-of-network benefit) and the total medical services costs. If a health plan has an out-of-network benefit, it will only pay a percentage of what is known as "reasonable and customary" amount. If the health plan does not have an out-of-network benefit, the OGB member would be responsible for the entire medical costs of the out-of-network provider.*

In addition to the health and prescription drug changes, other topics of note related to OGB include the OGB Policy & Planning Board, the staff augmentation contract with Alvarez & Marsal (A&M) and the recently approved State Civil Service layoff plan.

OTHER OGB ISSUES

Office of Group Benefits Policy and Planning Board
Pursuant to R.S. 42:881, the OGB Policy & Planning Board shall review life and health benefit programs offered to eligible employees. In addition, the statute provides that the CEO shall submit any proposed changes to the life and health benefit programs to the board for review prior to the final adoption of the plan. The OGB board met on July 30, 2014 and the CEO presented to the OGB board the major health plan changes that will be effective on January 1, 2015 and the health plan changes that were effective August 1, 2014.

Although R.S. 42:802(B)(6) and R.S. 42:802(B)(7) authorize the OGB to establish premium rates and establish benefit plans under the direction of the commissioner of administration, it is unclear if the health plan and premium changes implemented by OGB in the middle of a plan year require official OGB board approval or if changing the health plan in the middle of the plan year is contradictory to the argument that the annual enrollment documents may be considered an annual contract between the health plan and the member. Also, pursuant to R.S. 42:881, the OGB shall submit a written report to the appropriate legislative oversight committees, including any comments and recommendations regarding modifications to proposed health plans. To date, this written report has not been completed. OGB's legislative oversight committees are the House Appropriations Committee and the Senate Finance Committee.

According to the Division of Administration (DOA), pursuant to federal law ***(26 CFR 54.9815-2715 – Summary of Benefits and Coverage and Uniform Glossary, paragraph (b) – Notice of Modification)*** if a group health plan makes any material modification, it must provide notice of the modification to enrollees no later than 60 days prior to the effective date change. OGB notified all plan members on June 3, 2014 of the August 1, 2014 health plan changes, which is within the 60-day requirement outlined in the federal law.

Note: *Prior to the July 30, 2014 OGB board meeting, the last OGB board meeting was held in February 2013.*

During that time frame, some of the significant changes that have been put in place include a health premium decrease (August 2013) and a health premium increase (July 2014).

A&M Staff Augmentation Consulting Services Contract
On December 19, 2013, the State entered into a $4.2 M contract with Alvarez & Marsal (A&M) for consulting services relative to finding efficiencies in state government, which resulted in the production of the Governmental Efficiencies Management Support (GEMS) Report. The contract was amended on January 27, 2014 increasing the contract by $794,678 for staff augmentation support of OGB's *Acceleration of Benefits Transformation Initiative*. This contract amendment increased the total contract value to $5 M. The *Acceleration of Benefits Transformation* are the A&M recommended changes included in the GEMS Report impacting the OGB including health plan and prescription drug changes as well as recommendations to completely reorganize the entire agency and implementing a wellness program that is anticipated to modify future health outcomes.

As was discussed by the LFO in the January 2014 edition of *Focus on the Fisc (Volume 2, Issue 7)*, the A&M consulting contract included provisions that allow for staff augmentation services. The contract provides for augmentation services to be provided on an hourly basis depending upon the labor category of the work order and project. In May 2014, the DOA and A&M amended the $5 M contract again to include 5 various state agency work orders for staff augmentation services that total $2.4 M of which $199,752 is associated with the OGB. This contract amendment essentially extended the original OGB work order from ending on April 18, 2014 to ending on June 30, 2014. Based upon the contract amendment, the hourly rates charged to the state for OGB staff augmentation services range from $198/hour to $446/hour. Upon approval of the A&M contract amendment of $199,752, <u>the total maximum amount the state will pay to A&M for staff augmentation services will be $994,430</u>.

The specific tasks included in the contract amendment to be provided by A&M for OGB include:

- Supporting leadership changes to OGB including supporting the search for CEO and COO;
- Assisting interim CEO and COO by supporting other OGB executive roles;
- Establishing & supporting a vendor-related strategic timeline and assist in any key vendor transitions;
- Supporting benefit open enrollment;
- Supporting planning and execution for a agency reorganization and implementation of administrative efficiencies;
- Advising and implementing recommendations regarding change management and communication strategies and;
- Other staff support as requested regarding subject matter.

Layoff Plan Approved
The State Civil Service Commission officially approved the OGB layoff plan on July 28, 2014. According to documentation provided to the LFO by OGB, the layoff "is necessary because of a lack of work due to the change in function and structure of the OGB organization." The layoff plan will be effective September 1, 2014 and will impact 24 positions. The 24 positions being laid off impact the following OGB sections: Executive, Administration, Eligibility, Customer Service and Flexible Benefits. After the layoff, OGB will consist of 47 positions. The position reductions are associated with the overall reorganization of the agency, which is a portion of the OGB *Acceleration of Benefits Transformation*. For context, OGB's TO positions were 327 in FY 11.