Federal judge declares Act 479 unconstitutional, issues permanent injunction barring implementation by OGB

Chief Judge Ralph Tyson of the U.S. District Court for the Middle District of Louisiana has declared a new state law unconstitutional and issued a permanent injunction that prohibits the Office of Group Benefits from implementing it. The ruling bars OGB from awarding additional contracts to Louisiana-based health maintenance organizations and ends preparations for a second annual enrollment period originally set to begin September 17, as mandated by Act 479.

The law was passed by the Louisiana Legislature and took effect July 19 when Gov. Kathleen Blanco signed it. Its constitutionality was subsequently challenged by UnitedHealthcare and Humana. The companies currently have contracts with OGB to administer health plans in all nine regions of the state for the 2007-08 plan year, which began July 1.

In a 24-page decision dated October 31, Tyson held that those contracts are non-exclusive and are not impaired by Act 479. However, he ruled that the law "clearly violates" the U.S. Constitution by "favoring in-state economic interests" and "directly discriminates against interstate commerce...solely on the basis of residence," thus preventing Humana and United from fairly competing with Louisiana insurers and resulting in "irreparable harm" to the companies.

Authored by state Rep. Charles McDonald of Monroe, Act 479 directed OGB to contract with up to three Louisiana-based companies in each region to provide fully-insured HMO plans in addition to the self-insured EPO, PPO and HMO plans OGB now offers for state workers and retirees. The new law also directed OGB to reopen annual enrollment within 60 days. The additional 30-day enrollment period would have given 138,000 state workers, school employees and retirees another chance to choose a health plan for 2007-08.

In a competitive bid process mandated by state law, OGB solicited bids this spring from companies in Louisiana and outside the state for the administration of self-insured plans in each region. Humana was awarded contracts in all regions for the HMO plan and the Medicare Advantage HMO plan. United was the successful bidder in all regions for the EPO plan. OGB's PPO plan is self-administered.

Monroe-based Vantage Health Plan was among companies that did not submit bids to administer self-insured plans for the current plan year. For the past seven years, OGB contracted with Vantage to provide a fully-insured HMO plan in the Monroe region that covered about 6,000 plan members. These members selected other coverage during regular statewide annual enrollment in April.

"As always, OGB will continue to operate in compliance with court mandates and state and federal laws, as we did this summer by preparing to implement Act 479," noted Tommy D. Teague, OGB chief executive officer. "The judge's decision means the month-long annual enrollment period for Medicare Advantage plans will take place as scheduled in November for plan members who have Medicare Part A and Part B. Any plan changes they choose to make will take effect January 1 on schedule. There will be no additional annual enrollment period for all OGB plan members."

OGB's mission is to help plan members get the most value for every health care dollar they spend on insurance premiums by offering the best possible health insurance. Keeping costs down without reducing benefits is a difficult and constant challenge. Across America, health care costs continue to rise annually. South Louisiana still faces shortages of doctors and other medical professionals because many left the state after Hurricanes Katrina and Rita damaged or destroyed hospitals, medical facilities and their homes.

Self-Insured vs. Fully-Insured -- What's the Difference?

Self-insured describes a group health insurance plan in which the organization offering the plan assumes all liability for payment of all claims for health care services rendered to plan members and sets premium rates at levels projected to generate adequate revenue to cover the costs of administering the plan and paying claims. Rates are more affordable because they are based on the characteristics and projected health care costs of the total risk pool, which includes a wide variety of plan members--young, old, active employees, retirees, healthy members who rarely need medical care and members with health problems who regularly visit doctors and hospitals and take prescription drugs. Using a shared risk pool for all plan members enrolled in each self-insured plan enables the organization to keep costs as low as possible. Any cost savings realized are used to offset the ever-increasing costs of health care and offset rising premium rates.

Fully-insured describes the way insurance companies typically do business in a free market environment. The insurance company assumes all liability for payment of all claims for health care services rendered to plan members. However, premiums are based on many factors, including the cost of providing health care to plan members, administering the plan and a profit margin. Funds remaining after payment of claims and administrative expenses are kept by the company as profit rather than being returned to plan members in the form of lower costs for health care or smaller increases in premium costs. Because many fully-insured plans offer lower benefits at lower premiums, younger plan members who are typically in better health often join these plans. They are no longer part of the shared risk pool for the self-insured plans, which causes the cost of health care for all self-insured plan members to rise.