Federal court order suspends OGB implementation of Act 479

To comply with a September 10 federal court order, the Office of Group Benefits has postponed awarding contracts to Louisiana-based companies to offer additional health insurance plans for state workers and retirees and suspended preparations for a second annual enrollment period beginning September 17, as mandated by a new state law. A hearing on the matter is slated for September 14.

The temporary restraining order was issued by U.S. District Judge Ralph Tyson of the Middle District of Louisiana after Humana and UnitedHealthcare challenged the constitutionality of Act 479, which took effect July 17. Humana and United contracted with OGB to administer health plans in each of the state's nine regions for the 2007-08 plan year, which began July 1.

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

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

Monroe-based Vantage was among companies that did not submit bids to provide self-insured HMO 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.

"OGB cannot implement Act 479 until the judge renders a decision and any subsequent appeals are resolved," noted Tommy D. Teague, OGB chief executive officer. "If Act 479 is upheld, OGB will award contracts and reopen annual enrollment, and changes in coverage will take effect January 1."

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 increase annually. South Louisiana still faces shortages of doctors and other medical professionals because many left the state after Hurricanes Katrina and Rita damaged and destroyed hospitals, medical facilities and their homes.

After all legal issues are resolved and any required additional annual enrollment period has ended, OGB plans to mail directories and other printed materials to PPO plan members. Other OGB plans will also send out information to their plan members.

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

Self-insured describes a 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 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.