Federal judge extends order halting OGB implementation of Act 479; trial continued until October 11

At a September 25 hearing, U.S. District Judge Ralph Tyson again extended a September 10 temporary restraining order that bars the Office of Group Benefits from implementing Act 479 until he rules on the constitutionality of the new state law. Trial of the case, which began September 14, is scheduled to resume October 11 in the Middle District Court of Louisiana in Baton Rouge.

To comply with the court order, OGB delayed awarding additional contracts to Louisiana-based health insurance companies and suspended preparations for a second annual enrollment period, originally set to begin September 17.

The case stems from legal challenges to Act 479 filed by Humana and UnitedHealthcare. The companies 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. The new law took effect July 17.

Act 479 directs 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 law also directs OGB to reopen annual enrollment within 60 days. The additional 30-day enrollment period would give OGB's 138,000 plan participants another chance to choose a health plan for 2007-08.

In a competitive process required by state law, OGB solicited bids last fall from companies in Louisiana and elsewhere to offer self-insured plans in each region for the 2007-08 plan year. 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 for 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. Those members selected other coverage during OGB's 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. The effective date of changes in coverage will necessarily depend on the timing of the judge's ruling."

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.