Office of Group Benefits awaits ruling on Act 479 implementation

The Office of Group Benefits is waiting for a federal court to decide whether the agency will be required to contract with Louisiana-based companies to provide additional health insurance plans to state workers and hold a second annual enrollment period beginning September 17, as mandated by a new state law.

Both Humana and UnitedHealthcare filed challenges in federal court to prevent implementation of Act 479, which took effect July 17. Judge Ralph Tyson has scheduled a hearing on September 14.

Earlier this year, OGB signed contracts with both companies to administer statewide health plans. Utilizing a competitive bid process required by state law, OGB solicited bids from companies in Louisiana and elsewhere to provide self-insured plans in each of the state's nine regions. Humana submitted the lowest bid for the HMO plan in all regions. United was the low bidder for the EPO plan in all regions. OGB's PPO plan is self-administered.

For the past seven years, OGB contracted with Monroe-based Vantage to provide a fully-insured HMO plan in the Monroe region that covered about 6,000 plan members. Vantage was among the companies that did not submit a bid this year.

Statewide annual enrollment was held as usual during the month of April. Plan members previously enrolled in the Vantage plan selected other coverage.

Authored by Rep. Charles McDonald of Monroe, Act 479 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 the 2007-08 plan year, which began July 1.

To comply with Act 479, OGB requested proposals from Louisiana HMOs in August for fully-insured plans in all regions. Vantage submitted proposals to offer a fully-insured HMO plan in Regions 6, 7, 8 and 9 (the Baton Rouge, Alexandria, Shreveport and Monroe areas). Vantage also submitted a proposal for a Medicare Advantage plan in Regions 7, 8 and 9 for plan members with both Medicare Part A and Part B. Peoples Health/Tenet Choices, based in Metairie, submitted a proposal to offer a Medicare Advantage plan in Regions 1, 3 and 6 (the New Orleans, Hammond and Baton Rouge areas).

"It is possible OGB will not be able to implement Act 479 until a judgment is rendered by the court and any subsequent appeals are resolved," noted Tommy D. Teague, OGB chief executive officer. "If Act 479 is upheld, OGB will 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 also 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 costs, younger plan members who are typically in better health often join these plans because premiums are lower. 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.