SOCIETY OF ACTUARIES

Article from:

The Actuary

April 2000 – volume 34 - Issue 4

OPINION

A Retrospective
Health care reform in Kentucky

by Carl Westman

It is always with the best intentions that the worst work is done. — Oscar Wilde

As President Clinton's term draws to an end, many political commentators discuss whether he will have any legacy apart from the scandal that led to his impeachment and subsequent narrow acquittal. One legacy of President Clinton's first term is still playing out in the state of Kentucky, which in 1994 implemented health care reform measures inspired by the unsuccessful attempt at national health care reform in the Health Security Act of 1993.

The measures adopted in Kentucky can be described as a textbook case of how not to engage in health care reform. Proving once again that the law of unintended consequences has not been repealed, the reforms led to the implosion of Kentucky's individual health care insurance market. To this day, the effects are still apparent. Only two companies compete in its individual health insurance market, up from one just a year ago. Although the most onerous restrictions on underwriting and pricing have been repealed, it is still unclear whether some of the 57 companies that left the market during 1994–1998 will return to compete under the remaining restrictions. Looking back at how this situation developed may help us understand what went wrong, and why.

Note: Many of the facts presented here are from a document titled "Health Insurance Reform in the 1990s: A Kentucky Historical Perspective," a surprisingly candid and thorough analysis prepared by the Kentucky Department of Insurance. As of this writing, it is publicly available at their Web site at www.doi.state.ky.us/commoffice/history.pdf. *Many of these facts, in turn, have been confirmed through other publicly available documents and corroborated through interviews.*

Reform history in Kentucky

In 1993, access to health care and affordability of coverage was a concern of many Americans. President Clinton proposed broad-reaching health care reform legislation at the national level, which was ultimately defeated in Congress. However, the political situation varied widely among the individual states. Kentucky's then-governor, Brereton Jones, pushed for legislation that was expected to put Kentucky at the forefront of the states in terms of providing universal access to health care while controlling rapidly escalating health care costs. In 1994, the Kentucky legislature passed H.B. 250, which contained these provisions (among others):

- The creation of the Health Policy Board, which was charged with developing up to five standard plans of coverage
- The creation of the Health Purchasing Alliance, which would negotiate coverage for public employees and allow other individuals to "buy-in"
- Underwriting restrictions, including guaranteed issue and guaranteed renewal
- Pricing restrictions, including a mandate to use modified community rating and a ban on the use of gender, health, and occupation variables as rating factors

By 1996, many problems had surfaced in implementation of the original reforms:

- Ultimately, the Health Policy Board developed — and frequently changed — 28 standard plans. The Board also permitted employees with group health insurance to individually select their own carrier, exacerbating already widespread administrative problems that had affected billing and commissions.
- In October 1995, Governor Jones signed an executive order that permitted state employees to choose their own riders, requiring insurance carriers to price and process riders for each employee individually.
- Rates in the individual and group markets went through cycles of approval and recision, and approved rate methodologies were in flux.
- 43 private insurance carriers exited the Kentucky market between 1994 and 1996.

Naturally, politics played a significant part in the chaos that reigned over the market. Governor Jones was com-mitted to having Kentucky at the fore- front of health care reform and did not want to give up concepts such as man- dated guaranteed issue and the prohibition on health status as a factor in pricing. According to Stuart Rachlin, now a consulting actuary with Milliman & Robertson, but then with Choice Care HMO, insurers felt that the rate approval process favored the achievement of political ends rather than actuarial soundness. Rachlin noted that the political pressure on rates and rate structure extended down "from the governor's office to the insurance commissioner and the [Health Purchasing] Alliance administration, and the situation led us to wonder if our actuarial analyses were even being considered in the overall process."

At the same time, association groups successfully lobbied to be exempt from

the health care reform laws, though they were later put under separate, mild restrictions. Along with the self-insurance option, this provided a way for healthier individuals to find lower-cost means of accessing the health care system.

To stem the chaos over coverage, billing, and administration, incoming Governor Paul Patton issued executive orders early in 1996 that permitted Kentuckians with individual coverage to renew pre-reform policies for a period of time. However, by this time, only two carriers were left serving the individual health insurance market in Kentucky: Anthem and Kentucky Kare, the self-insured fund for state employees. Kentucky Kare was seriously depleted by high medical costs incurred following mandated open enrollments (at standard rates) to the uninsured. (Kentucky Kare was eventually forced to cease operations in September 1998 following its financial collapse.)

In 1996, the legislature passed S.B. 343, abolishing the Health Policy Board and permitting gender and occupation to be included in modified community rating (though not without some level of cross-subsidy). Despite this concession, the law required the insurance commissioner to hold a hearing if newly proposed rates exceeded the regional CPI plus 3%. As could be expected, hearings on health insurance rates became very frequent.

Recent changes, current proposals

In 1998, Kentucky-based Humana committed to the legislature to participate in the individual market should new legislation H.B. 315 pass, which it did. This provided an alternative to Anthem, which was soon to be the only carrier left with the imminent demise of Kentucky Kare.

The new legislation abolished the Health Purchasing Alliance, and changes continued to be made to approved rate methodologies, the rate approval process, and standard plans.

In the individual market, the number of standard plans dwindled to only one, and for a time, not only was that standard plan required to be offered, it was the only plan that could be offered. This caused more administrative headaches, as carriers had to convert their insureds to the standard plan. Later, this restriction was eased, and more administrative work was to be found in allowing insureds to "unconvert" from the standard plan.

H.B. 315 permitted health status to be reflected in premium through rate bands of plus or minus 35% around the index rate. H.B. 315 also created another arrangement called the Guaranteed Acceptance Program (GAP), which mandates participation by carriers with 25% or more market share. According to Mark McGuire, an actuary at the Kentucky Department of Insurance, GAP required the carriers to accept certain high-cost individuals, specifically, those who had one of 28 listed high-cost conditions and those who failed to meet an insurer's underwriting guidelines. GAP provided a mechanism for the carriers to be reimbursed for their losses on such policies according to the diagnosis and severity level of the condition. With GAP, rates charged to individuals could be up to 50% greater than the index rate, depending on whether the individual had "creditable coverage" in the 63-day period immediately preceding the GAP policy.

McGuire describes the workings of GAP to be confusing to many carriers. "They were asking, 'why don't we do what 28 other states do and establish a risk pool for the uninsurable?'" A bill currently before the Kentucky Legislature (H.B. 617) would do just that, eliminating GAP and the guaranteed issue mandate in favor of a risk pool called "Kentucky Access." According to McGuire, this pool would be funded initially by money from the settlement between the various states' attorneys general and the tobacco industry. A critic would say that H.B. 617 still includes an undesirable combination of mandated benefits, price controls, and underwriting restrictions. However, it is hoped that by adopting a less destabilizing approach than previous legislation, carriers might be willing to return to compete in Kentucky's health insurance market.

Conclusion

There is little argument that Kentucky's health care reforms were intended to broaden access to and affordability of health insurance. However, as is too often the case, lawmakers and policy analysts failed to understand the dynamic between risk classification and consumer choice in voluntary insurance systems.

Future attempts at reforming health care insurance must recognize the concept of adverse selection. So long as alternatives to a state-mandated rating and underwriting system exist, there will be limits on how much cross-subsidy between risk groups can be achieved. And should these limits be exceeded, we can expect more unintended consequences.

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Disciplinary Action

At a meeting of the Committee on Discipline on November 22, 1999, the committee indefinitely suspended Eugene Boudreault of Montreal, Canada, from membership in the Society of Actuaries. After March 4, 2001, however, Boudreault may apply for reinstatement of membership, and reinstatement of membership in the SOA will be subject to Boudreault meeting all membership requirements of the SOA. This notification to SOA members is made under the provisions of Article XIII of the SOA By-Laws.