

Kentucky

Department of Insurance



Health Insurance Reform in the 1990s: A Kentucky Historical Perspective

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Introduction

Health Insurance Reform in the 1990s:

A Kentucky Historical Perspective

By George Nichols III

Commissioner, Kentucky Department of Insurance

Purpose of this report: As we approach the year 2000 and a new legislative session, we should reflect on how dramatic and challenging the decade of the 1990s was for all of us in Kentucky regarding health insurance.

We recognize the health insurance debate will be prominent during the new session and we hope this historical perspective will help legislators.

This report is intended for legislators. However, we believe anyone interested or directly participating in the debate will benefit from our efforts to chronicle Kentucky's reforms over the past decade.

As I have traveled the state hosting town forums the past three years, I have heard the same concerns you are hearing from constituents.

At a Richmond meeting of the Chamber of Commerce, I heard from the Berea artist struggling to stay in business because insurance in the individual market is so expensive for a self-employed businessman.

In Middlesboro, retirees talked of limited choices for health care, higher costs and lesser coverage.

In Bowling Green and Louisville, conscientious employers worried about how they could continue paying part of the premiums for employees who would go uninsured without their help.

Fewer employers offer insurance

More than half of U.S. businesses with 10 or fewer employees do not offer health insurance as an employee benefit.

In 1988, 68 percent of all employees in the U.S. got their health insurance through their employers.

Small employers are charged up to 25 percent more for health insurance than large employers.

In some regions of the U.S. in 2000, premiums will increase up to 40 percent for small employers.

-- Source: Managed Healthcare News and Employee Benefits Research Institute.

And in western Kentucky, there were concerns about the loss of MedQuest, a financially troubled HMO.

The people we serve faced dramatic increases in premiums and paid much more out of their own pockets to maintain health insurance coverage. A growing number of employers quit offering coverage as an employment benefit, especially as part-time, contract or temporary employees entered the work force.

As a General Assembly since 1994 through 1998, you responded to increasing demands from constituents to do something for people who could not get insurance because of their health status, to increase consumer protections, and to guarantee coverage for specific medical conditions.

The insurance industry changed dramatically, through mergers and acquisitions, and most notably with the rise of managed care and Health Maintenance Organizations (HMOs). At the urging of consumers and lawmakers across the country, insurance companies tried to control costs by directly intervening to decide the number of days of a hospital stay and the types of treatment options a doctor could consider.

Doctors and hospitals went through major changes, feeling threatened by increasing challenges to their medical decisions and fees. In some cases, they walked away from contracts and provider networks, limiting choices and access to patients.

These past 10 years were wrenching and historic for the citizens we serve. There were major changes on all fronts involving health care, medicine and the insurance industry.

For every change we tried as legislators and as a department, the greatest impact has fallen on consumers. Whether our new laws were good or not, each change affected consumers.

We recognize how unique a health insurance contract is, a promise by a company to pay when the consumer is at their most vulnerable point, when they are ill, needing coverage for mounting bills.

As insurance commissioner since April 1996, I continue devoting most of my time to health insurance. The Kentucky Department of Insurance has tried to balance protections for consumers with a good business environment, stability, and solvency for a troubled health insurance industry.

National crisis leads to search for Kentucky solutions. We began the past decade with a national health insurance crisis that would dominate the campaign leading up to the 1992 presidential election of Bill Clinton.

When national efforts stopped short, Kentucky moved into the forefront with its own options.

The changes made in each legislative session of the Kentucky General Assembly throughout the 1990s would have dramatic consequences for good and not so good.

Kentucky consumers would win some of the nation's best patient protections.

The Commonwealth would become one of only eight states with guaranteed access to insurance regardless of health. Kentucky became a national leader, but an unforeseen consequence was the state also became an island where more than 60 health insurance companies abandoned this market for other states due to income, market size, or regulatory and legislative climate.

Guaranteed issue gave everyone the opportunity to have insurance, but affordability remains the greatest obstacle. Even with guaranteed access to coverage, about 14.1 percent, or 545,000, of

Kentucky's residents still have no health insurance.

What happened to health insurance premiums? Many people have tried to simplify this answer by blaming lawmakers, the Department of Insurance or the executive branch for their attempts at regulatory reforms.

Others blame doctors and hospitals for their pursuit of money.

And still others blame the insurance companies.

You cannot give simple answers to a

People without health insurance

Nationwide, 44.3 million people or 16.3 percent of the population are uninsured, an increase of about 1 million since 1997.

Kentucky ranks 28th in the nation, with 545,000 of its 3,865,000 residents uninsured, or 14.1 percent of the population.

This is actually a slight improvement in Kentucky for the first time in many years. In 1997, 587,000 or 15 percent of the population were uninsured.

-- Source: U.S. Census Bureau (10/4/99 report).

complicated, national problem.

Actions by all sides, including consumers, contributed to today's consequences.

More than 60 health insurance companies left Kentucky and many blamed state legislative changes. But it is not fair to put all the blame on lawmakers.

People previously denied any chance for health insurance because of their medical condition would certainly trumpet the courage of Kentucky lawmakers, led by then-Gov. Brereton Jones, regarding guaranteed issue.

Health insurance premiums for California public employees

With 776,000 state and local employees, California is second only to the federal government in its size and clout in negotiating health insurance premiums.

California public employees are on the verge of the biggest premium increase since 1992. The average increase for 2000 is expected to be 9.7 percent.

The increase in 1999 was 7.3 percent.

-- Source: California Public Employee Retirement System.

Gov. Paul Patton continues as an advocate for Kentucky's patient protections, among the best in the United States, while Congress still debates and considers only a portion of what already is law here.

Patients also are accountable for the costs. Demanding Mayo Clinic care when affordable, quality care is possible here certainly influences costs. Ignoring symptoms of poor health and waiting until much more expensive emergency treatment is necessary also has a dramatic impact on rates.

The cost of prescription drugs and national ad campaigns to reach patients

Health insurance premiums for federal employees

Even with the size and bargaining power of the federal government, here is how premiums increased for the nation's largest group of employees:

2000 (estimate): 10 percent.

1999: 10.2 percent.

1998: 8.5 percent.

-- Sources: Office of Personnel Management; the Hay Group; Health Affairs.

directly to promote sales are driving up actual costs. Rate increases sought in recent years by Kentucky insurers document pharmacy costs jumping as much as 15 to 20 percent in just one year.

Overall medical costs have increased 5 to 8 percent a year for HMOs in Kentucky and traditional indemnity insurers report increases up to 15 percent. These medical costs are directly passed on to us through higher premiums.

Guaranteed issue is estimated to have added 10 percent to health insurance premiums because ill, previously uninsured Kentuckians, were now covered for their expenses.

At the same time people complain that they believe doctors are greedy and walking away from contracts because they won't make as much money, there are impressive examples of just how much care doctors provide without reimbursement. The Journal of the American Medical Association reported March 24, 1999, that more than 7,000 of 11,000 doctors surveyed were providing an average of 10 hours a week of charity care. In Kentucky, doctors have organized a program through the Kentucky Medical Association to arrange charity care for indigent patients.

Early history of health insurance.

The national history of health insurance begins in the 1930s when Blue Cross and Blue Shield was created to offer the first health insurance policies.

Insurance became an employment benefit during and after World War II. In 1987, 69.2 percent of employers offered health insurance. That declined to under 60 percent in recent years, according to the Robert Wood Johnson Foundation. *Newsweek* reported Nov. 8, 1999, that employment-based health insurance is at 62 percent today.

Medicare for the elderly and Medicaid for the poor were created in 1965.

In 1995, 60 percent of Americans got their insurance through their employer; 11 percent through Medicaid; 14 percent

Prescription drug costs

Here is how much prescription drug prices increased nationwide each year:

1993: 8.7 percent

1994: 9.0 percent

1995: 10.6 percent

1996: 13.2 percent

1997: 14.1 percent

1998: 18.4 percent

-- Source: Health Care Financing Administration.

through Medicare; and 15 percent were uninsured.

Our aging population will add more pressure to costs as “baby boomers” begin experiencing health problems and need expensive care.

The decade of sweeping changes.

The 1990s began with concerns about the increasing number of uninsured Americans and fewer employers offering health insurance as a benefit.

In March 1992, then-Gov. Brereton Jones established a task force to sample public opinion. Their work was not a scientific sample, but a compilation of issues and views ranging from comprehensive health education, health professional recruitment, medical malpractice reform, tort reform, insurance access and much more.

The task force laid the foundation for a 1993 special session in which the General Assembly debated how to control the cost of health care by using health insurance as the tool.

Gov. Jones wanted sweeping changes in health care, yet his eventual reforms actually focused on the narrower issue of health insurance.

A major shift was happening in the job market, as more jobs shifted from higher-

paying industrial and manufacturing jobs to lower-paying retail and service sector employment.

New medical advances and technology added to the costs, along with an aging population. New medical equipment, research and the impact of litigation and tort reform also had a price tag.

Increasing numbers of Americans below the poverty level, especially children, shifted health care costs.

Kentucky’s relatively high level of health problems, including the costs associated with having the highest percentage of smokers in the United States, also directly affected medical costs and health insurance premiums.

These factors framed health insurance as a national issue, leading up to President Clinton’s election in 1992. State and federal policy makers came under pressure to do something to improve or stabilize the situation.

By 1994, Kentucky lawmakers enacted many of the same laws that would die later the same year in Congress.

This report details what Kentucky did between 1990 and 1999.

The pains and consequences. There is cause for grave concern about the financial

health of the health insurance companies remaining in Kentucky.

In 1998, 9 of 17 HMOs lost money and had to infuse an additional \$71 million in capital to stay afloat.

Despite these losses, Anthem Blue Cross and Blue Shield remains profitable. But those profits are derived from many sources, including substantial investment income.

There is ample proof overall that Kentucky's health insurance companies are not getting fat with increasing premiums.

The MedQuest HMO in Owensboro is a recent example, becoming the first HMO to close in Kentucky in 12 years due to

financial reasons.

The local hospital in Owensboro transferred approximately \$18 million to MedQuest, but finally asked the department to assume day-to-day operations this summer, leading to liquidation on Nov. 1, 1999.

Before major rate increases in early 1999, MedQuest paid \$1.56 for medical claims for every \$1 collected in premiums in 1998. The department closely monitored MedQuest since it began business, keeping it on a monthly watch list as far as its financial condition. Like the hospital, we wanted MedQuest to succeed, offering consumers in Owensboro a competitive

Where Premium Dollar Goes



Source: IQR data reported by all Kentucky Health Plans to Kentucky Department of Insurance

choice for health insurance. The hospital kept adding to reserves each time we raised concerns. We walked a tightrope until the end when it was obvious MedQuest must close.

The department's goal when it reviews requests for rate increases is to tightly control the amount of premium dollars that go to agent commissions, operating expenses to run the insurance company, and for profits. Currently, only about 16 cents of every premium dollar goes to operate the company. The remaining 84 cents goes directly to pay your medical bills. The department only has authority over this 16 cents and we have no control over what providers charge.

Several current HMOs in Kentucky are living on the edge and using almost every penny for medical bills, with little left to assure they can remain in business.

Currently, six companies are on a monthly watch list where we closely monitor their financial performance because of concerns.

Some of the most important factors for escalating health insurance premiums are beyond Department of Insurance control:

1. What a doctor and hospital charge;
2. Contract negotiations between providers and insurance companies;
3. Nationwide inflation in pharmacy and other medical

costs; 4. Lack of population and profitable prospects for carriers in rural areas.

We are watching history in the highly public battle over how insurance companies are trying to hold the line on the health-care costs of doctors, hospitals and pharmaceutical companies. Doctors say they are being squeezed and paid less than their costs for the services.

The Kentucky Hospital Association reported Kentuckians pay less per hospital admission than 44 other states. KHA also states that federal cuts in Medicare will reduce hospital operating margins to only 1.3 percent by 2002, forcing financial losses for one of every two hospitals.

The battle makes market share unstable and uncertain for the insurer, as many doctors walk away and end their contracts.

Aetna/TPI is a recent example where an organized group of doctors in Louisville refused to accept an all or nothing Aetna contract designed to control medical costs. The department had little authority to control contract talks or fee negotiations, but did win significant cooperation from the doctors and the company to give policyholders time to make an informed decision when their coverage expires.

How historic will the 1999 vote of the American Medical Association be to the

history of health care costs? The AMA recommended and voted for unionizing doctors nationwide.

What will happen if the nationwide financial problems of HMOs continue?

Because of all these pressures on price, access to health care in the 1990s is becoming more and more dependent on whether you have coverage.

Then-Gov. Jones and key legislators enacted guaranteed issue when they saw access to health care was becoming more dependent on whether you were insured. They tried to bridge that gap for Kentuckians.

Kentucky hospitals feeling pressure

- *Because of rising costs for doctors and prescription drugs, hospital costs account for a decreasing share of total medical costs.*
- *Medicare payments to Kentucky hospitals will drop by more than \$630 million from 1998-20002 and one of every two hospitals will face financial losses as a result.*

-- Source: Kentucky Hospital Assoc.

The challenge today is how to fill in that gap and deal with affordability of health insurance.

When the proposals of President Clinton and Congress died, Kentucky increased pressure on insurance carriers to hold down costs. Those companies are facing a backlash as they try to restrict the length of hospital stays and challenge medical treatments by doctors.

Where do we go from here to keep the balance of insurance industry solvency and consumer protections?

Rising medical costs are the biggest reason why our premiums are going up, but my department has no authority over what doctors or hospitals charge.

I can tell you that insurance companies are scrutinizing medical costs and treatments like never before, looking at each patient's case to try to control costs and slow down the increase in our premiums. Sometimes the insurance companies go too far, denying legitimate treatment and we have to intervene with consumer protections.

Gov. Patton continues consumer protections. Gov. Patton continues to maintain the consumer protections of the early '90s and led efforts for additional help to Kentuckians.

He has provided the executive, administrative and financial support to this department so we can assume the role as the authority on health insurance.

Gov. Patton was instrumental in helping us establish the Consumer Protection & Education Division, which now fields 2,000 consumer calls per month, most of them related to health insurance problems.

The division's ability to investigate and intervene on behalf of consumers became critical as Kentucky Kare and the Health Purchasing Alliance went out of business.

The division has embarked on a consumer education campaign that has included hosting nearly a dozen Insurance 101 courses to help the public understand the specifics of all forms of insurance, including health.

We did not have the resources and personnel to deal with these pressing issues until Gov. Patton was elected.

Preparing for the year 2000 legislative session. State legislators have faced enormous pressure in each session to do something about the health insurance situation.

The continuing increases in insurance premiums, the loss of MedQuest in Owensboro, and fewer competitors

offering coverage in rural areas of the state are among the troublesome issues facing the 2000 session.

Everyone is looking for the silver bullet to solve all insurance problems. I believe the problems in our market are so fragile that I'm not even sure we have the weapon to fire the silver bullet if we had it.

Stated more directly, our past actions have caused multiple, unanticipated consequences. Yet, I firmly believe the intentions always were to benefit consumers.

The most difficult task for the Department of Insurance and the legislature is helping everyone understand that there are a multitude of things that upset health care coverage, delivery and pricing that go beyond the profits of insurance companies and providers.

If we have learned anything from this past decade of change, I believe we need to consider phasing in changes and new legislation with great caution and study.

We are looking at dynamic problems in our market where if one or two things occur we could see disaster.

With only Anthem and Humana in the individual market, we've got to keep searching for options.

The Department of Insurance will be making recommendations based on what we have gathered by listening to all groups.

We need to maintain a public policy of important consumer protections and get back to some semblance of a viable health insurance market.

But we must remember that for every positive stride there was an unintended negative result. For example, legislative mandates requiring coverage for certain medical conditions increased premiums for all Kentuckians.

Insurers estimate the 1998 mandates alone added up to 2 percent in costs. Kentucky has created new mandated benefits 23 times since 1968, adding up to 10 percent in costs overall, according to national studies.

Since 1994, high-cost patients were able to get insurance, a significant and compassionate achievement. It also resulted in added expenses being paid by all insurers and ultimately by all Kentuckians.

We need to approach the 2000 session by carefully sorting out all the options, searching for what has greater benefits and lesser negative consequences.

My best analogy is that you may start with a harmless chemical, but, as soon as you mix a new ingredient, you may have an explosive recipe.

Remember how good it sounded to hold Kentucky Kare's premiums at below market rates? Reserves were spent so rapidly that a once-stable alternative for health insurance was bankrupted and shut down.

The department and I will be pursuing a moderate course in our legislative proposals in 2000, seeking to balance insurance solvency with consumer protections and options.

We want to raise the bar and increase the capital surpluses maintained by insurers, avoiding financial instability.

We favor a new external appeals process in health insurance disputes. We need rapid, medically sound decisions on care when the insurer disputes coverage. The independent review actually would protect policyholders, providers and insurers from inappropriate decisions involving the health of consumers. This will remove unnecessary delays in treatment and lead to more consistent guidelines for what is covered and what is not by a health insurance policy.

Health insurance premiums are going to continue to increase. The number of uninsured will increase as employers try to get out of these burdens of increasing costs. An aging population and increasing demands for health care will be one of the biggest factors. Providers will face more pressure to become the safety net and to care for the working poor and the uninsured.

Lack of options and a choice of insurance companies will remain critical for us in the next decade.

Anthem and Humana are the only options in the individual market. And choices are limited in the small-group markets and even the major markets for public employees. A retired school teacher at a Middlesboro town forum noted CHA was her only realistic choice for insurance in southeastern Kentucky.

I firmly believe any effective impact on health insurance will require a coordinated effort by state and federal lawmakers.

We also plan a series of administrative rules and regulations that will simplify important patient protections contained in HB 315.

It is important that these regulations closely follow your intent as legislators

and work within the framework of enacted laws like HB 315.

The goal is to write departmental regulations that are administratively simple and cost-effective for insurance companies, while clearly defining the benefits and protections all of us have enacted for consumers.

Here are highlights of the regulations we are proposing:

- Explain and simplify what documents insurance companies should provide to the department proving they have procedures in place to guarantee quality management. Lawmakers defined quality management as documenting required policies and procedures for utilization review, grievance and appeals.
- Offer clear guidelines for how carriers should disclose to their policyholders any changes in drug formularies. We do not want to change how these lists of recognized prescription drugs are decided, added or deleted, but we do want clear rules assuring consumers are informed.
- We want clear disclosure in contracts with providers that an

HMO cannot bill policyholders for the balance of medical bills when a doctor or hospital charges more than the HMO has authorized to pay within the network. We want to work out how these “hold harmless” terms are disclosed to consumers who stay in the network or go out of the network of providers.

- When coverage is denied, we need clear language of what members should be told. Consumers deserve to know what medical service is being denied, how to appeal, and the date of the decision. All companies are issuing denial letters as required by HB 315, but we want to simplify and resolve confusion about what details should be included.
- Separate from these patient protections, we want to create an advisory panel that can hear from the public and medical experts about existing and possible future mandated benefits. The panel also should consider publicly any issues or proposals regarding health benefit plans and coverage. This study group should gather expert

information on costs and the need for any changes in mandated benefits or health benefit plans.

Five goals for 2000 session.

This report spells out what happened in one decade. But where do we go next, starting with the 2000 session?

I believe we should specifically focus on these five goals:

1. Maintain the consumer protections.

We have some of the nation’s best patient protections, especially with guaranteed issue. We should maintain these for all Kentuckians.

2. Stabilize the market. Kentucky

made so many sweeping and untested changes that we created confusion and drove too many carriers out of the state. We must carefully research and document any future change so we’re more informed about the potential consequences.

3. Choice. The individual market is almost down to only one choice, Anthem. We must open up more options for the market.

4. Comply with federal law. Some changes are necessary because of federal law.

5. Address geographic issues. We continue to worry about whether rural Kentuckians will even have a choice of carriers for health insurance. Added to the problem in rural areas is the lack of large employers most likely to offer health insurance as a benefit. We may need to pay much more attention to the geographical differences rather than statewide solutions in future legislation.

1990 – 1993

Years Leading Up to Reform

Health care and insurance were rising as national issues and would become an important plank of the 1992 presidential campaign of Bill Clinton.

Being able to afford insurance was becoming a bigger obstacle to the uninsured.

Kentucky began moving to the national forefront with its proposed health insurance changes, beginning in 1992 when then-Gov. Brereton Jones established a task force searching for public opinion and possible solutions.

Gov. Jones started with sweeping ideas dealing with health care, but health insurance would be used as the vehicle to bring changes.

Gov. Jones' proposals led to a 1993 special session and HB 4, which didn't pass, but laid the foundation for the 1994 General Assembly's enactment of HB 250.

Problems of the uninsured and the cost of health care were gaining increasing national attention as the 1990s began. Health care would become a key issue in the successful election campaign of President Bill Clinton in 1992.

While these issues were reaching a national pitch, however, states across the nation already were confronting the complex problems. Kentucky was among the states proposing and testing innovations for health care reform and ultimately leading sweeping changes in health insurance.

On the eve of President Clinton's 1992 victory, election surveys showed health care reform trailed only the economy as the major priorities of American voters. Clinton's campaign advisor James Carville kept the election effort focused with the slogan, "It's the economy, stupid." Yet the cost of health insurance and health care followed just behind that issue.

There were many facets to the problem of the uninsured:

- Approximately 429,000, or 12% percent of all Kentuckians, were estimated to be uninsured. Nationally, that number was 34 million. The number was continuing to grow. The

Congressional Budget Office projected the number of uninsured would swell to approximately 39 million in the year 2000.¹

- An array of barriers existed to prevent the uninsured from obtaining health insurance.
- Indirect methods of paying for the uninsured had contributed to an unsatisfactory health delivery and financing system.
- The rising costs of health care contributed to an increasing number of uninsured people, generating negative effects on the economy in general and specifically on state and federal budgets.

Health care spending in the U.S. continued to increase in the early 1990s at an alarming rate, and the number of uninsured people continued to grow as well. In 1992, about \$800 billion, or 13.6% of the gross domestic product, was spent on health care services. Lawmakers were told that if spending continued to increase at that rate, it could reach as high as 18% of the gross domestic product by 2000.

¹ Congressional Budget Office, "Projections of National Health Expenditures," October 1992, page 4.

As dollars for health care increased, there were fewer state and federal dollars for non-health spending, such as education, roads, housing, and urban development. Federal spending on Medicaid and Medicare were the principal reasons for anticipated increases in the federal deficit to more than \$500 billion by the year 2002.

Kentucky had experienced increases in the state's contribution to the Medicaid program of 300 percent over the 10-year period ending in 1992.

A number of factors contributed to this unacceptable problem, including rising health care costs, increasing numbers of Americans below the poverty level (particularly children), and increasing premium costs, which inhibited employers and employees from purchasing health insurance, particularly those in small businesses. The use of practices such as experience rating and underwriting of subgroups by insurance companies had resulted in increasing numbers of uninsured because high-cost people were excluded.

Medicaid programs across the nation had long served as the primary safety net program for providing health care to people who met the guidelines.

Kentucky's Medicaid program served

approximately 500,000 residents in 1993, an increase of over 21% in the eligible population over an approximate two-year period. The increase in people eligible for Medicaid in Kentucky was primarily due to federally mandated expansions in the program to cover poverty level children and pregnant women.

Even with these significant expansions, there were an estimated 176,000 Kentuckians, approximately one-third of whom were children, without health insurance under the poverty level. Another 213,000 uninsured Kentuckians had incomes of more than 100% but less than 200% of the poverty level. Another 40,000 or so uninsured Kentuckians had incomes above 200% of the poverty level.² Many of these could have afforded an average premium price to obtain insurance, but could not get coverage because of pre-existing conditions or they were high-cost individuals and could not afford the price.

Beyond the safety net programs, people generally obtained health care coverage through employment. Many businesses, particularly small businesses, were unable to provide health insurance to their employees because of underwriting

² Kentucky Health Care Reform report issued by Gov. Brereton Jones, Feb. 26, 1993, Attachment F.

practices, firm size and high risk employees, high administrative costs per employee, and higher employee turnover and higher risk for adverse selection.

It was estimated that approximately 191,000 of the uninsured that were age 18 or older were employed in some sort of job.

As health care costs and the number of uninsured throughout the nation continued to grow, states like Kentucky were in search of solutions to remove the barriers to reasonable access to health care for every citizen.

In March 1992, then-Gov. Brereton Jones issued Executive Order 92-261 establishing the Task Force on Health Care Access and Affordability. The 48-member task force was composed of representatives from a wide spectrum of consumers, providers and advocacy groups, as well as citizens at large. The task force was charged with the dual role of educating the public on the issue of health care reform, as well as taking the pulse of consumers and providers as to their views on health care policy. This information was secured through a series of 15 regional town meetings held across the Commonwealth during the month of May 1992.

A report was issued in June 1992 containing the synthesis of the opinions gathered at the town meetings. Since the report contained survey information that was not gathered using accepted survey techniques, it could not be viewed as a scientific sampling, but rather as a compilation of the views of those who chose to participate. Issues and views varied and covered such topics as comprehensive health education, professional education, establishment of integrated delivery networks, health professional recruitment, quality, certificate of need, medical malpractice reform, tort reform, insurance access and barriers to access, and insurance reform.

While consensus was not achieved, input from these individuals and groups played a role in developing Gov. Jones' plan for restructuring Kentucky's health care financing and health care delivery system. It also led to major drafts of legislation necessary to enact the total reform plan.

A special session for the spring of 1993 was envisioned to deliberate the issue. The governor's plan was released in February 1993. Fundamental to the goals of the governor's proposal was to stop the rapid increase in health care costs and assure that

all citizens of the Commonwealth were able to secure quality health care at an affordable cost. These goals were to be accomplished by:³

- Controlling the cost of health care.
- Providing universal access to medically necessary care.
- Restructuring the health care delivery system.
- Defining and maintaining high standards of quality health care.
- Emphasizing primary care services.
- Assuring that everyone pays his or her fair share.

In a special session of the General Assembly, which began May 10, 1993, Governor Jones supported HB 4, which would have:

- Created the Health Policy Board.
- Created a large purchasing pool (a pool that could include the uninsured, public employees, public retirees and had the potential to hold Medicaid eligibles, Medicare eligibles,

and private business employees).

- Set provider rates, as well as premium rates.
- Mandated insurance for all citizens.
- Prohibited exclusions for pre-existing conditions and mandated community rating.
- Provided subsidies to small businesses with low net profits and low annual payroll, and many other provisions.

Gov. Jones wanted sweeping changes in health care, yet his eventual reforms actually focused on the narrower issue of health insurance. Gov. Jones started with major initiatives proposed in HB 4, which laid the foundation in 1993 and ultimately led to passage of HB 250 by the General Assembly in 1994.

What resulted was a huge impact on health insurance coverage and a dramatic change in the industry and market. While all effort was focused on health care, the actual reforms dealt with a restructuring of the private health insurance sector.

One example of trying to use health insurance regulation to achieve changes in what doctors and hospitals charged was to challenge insurance rates so carriers had to

³ Kentucky Health Care Reform plan issued by Gov. Brereton Jones, Feb. 26, 1993.

reach down and equally challenge providers. Private sector insurers were used as the tools or road toward clamping down on providers.

The reform proposal offered by Gov. Jones in February 1993 shows how sweeping the goals were, speaking almost exclusively of health care and such things as a mandated seat-belt law in more than 20 pages of his plan. Only a few pages dealt with health insurance, including community rating ideas and prohibiting pre-existing condition exclusions.

The eventual changes, however, dealt

COBRA: *The federal law assuring employees could still get health insurance coverage after their employment ended with employers of 20 or more people.*

COBRA is the acronym for the law known as the Consolidated Omnibus Budget Reconciliation Act.

Kentucky actually adopted patient protections like this before the federal government passed COBRA, allowing people to continue or convert coverage.

with health insurance and not health care and were sweeping. These changes came without a thorough study of the potential impact on the market and consumers.

While a comprehensive health care reform bill did not pass in the 1993 Special Session, a bill did pass creating a 25-member Task Force on Health Care Reform. The Task Force on Health Care Reform met from June to September 1993, and many of its findings resulted in provisions in HB 250, passed in 1994.

At the federal level, the federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act) was passed to assure employees (of employers with 20 or more employees) could get health insurance coverage after their employment.

Also during this era, the Family Medical Leave Act was passed in 1993 to require companies with more than five employees to allow up to 12 weeks of leave during any year for personal illness, birth, adoption, or illness of a spouse, child or parent. Employers were required to pay the health insurance premiums of the employee on leave, but not their salary.

In 1993, President Clinton created a task force to address the health care crisis. This task force debated many months before producing a voluminous plan known as “the Clinton Plan.”

Congressional committees and the Clinton Administration would debate the proposal for several months into 1994 and beyond.

Kentucky deliberately decided to be at the forefront of the growing national debate about health insurance. State lawmakers got ahead of Congress.

Kentucky would ultimately pass comprehensive changes, including guaranteed issue to any resident regardless of health. The state expected President Clinton to win passage of his plan in Congress and to be that much further ahead when that time came.

But Kentucky got out front and nobody followed. HB 250 passed in April 1994. Clinton's national plan died in Congress in November 1994.

In just one historic year, 1994, Kentucky became a national leader in health insurance changes – and an island, too.

Family Leave: *Congress passed the Family Medical Leave Act in 1993. Employers with more than five employees were required to give up to 12 weeks of leave during any year for personal illness, birth or adoption of a child, or illness of a spouse, child or parent.*

Employers did not have to pay the employee's salary during the leave, but were required to keep paying health insurance premiums.

1994-1995

By the end of 1994, President Clinton's proposed national health care plan was clearly not going to pass. But the 1994 Kentucky General Assembly had already acted, passing dramatic changes of its own in HB 250.

The law created a powerful Health Policy Board and the Health Purchasing Alliance where public employees would be among the members.

A rush to make such dramatic changes, and confusion over all the new reforms, led a number of health insurance companies to announce they were withdrawing from the Kentucky insurance market.

Consumers gained significant protections from Kentucky that Congress wouldn't give to the rest of the nation in the Clinton Plan, including guaranteed access to insurance coverage regardless of health. But there were other consequences, too, including higher rates and fewer choices.

Kentucky became a national leader – and an island – in these same historic years.

Gov. Jones was the driving force behind passage of HB 250 in the 1994 legislative session. The law was effective on July 15, 1994, but the actual implementation was not until July 15, 1995.

One of the key provisions of HB 250 was the creation of a powerful and independent Health Policy Board. This full-time, paid board of five members would become responsible for even more sweeping and dramatic changes in health insurance.

But there were built-in obstacles for this board. Members were given very little time to make such dramatic changes. And, by law, three of the five members could have no expertise or background in insurance matters.

Among key duties of the Health Policy Board was to collect information that would become the basis for later policy decisions. As a quasi-state agency, the

Members of Health Policy Board could have no insurance expertise:

“Three members shall be persons who do not hold, and have not held, any full-time employment with a facility and who are not, and have not been licensed providers.”

-- HB 250.

board answered only to the General Assembly.

Gov. Jones intended the board to begin collecting more and more data for future proposed reforms in health insurance. Jones’ focus was on health care, but he used health insurance coverage as his instrument for change.

The Health Purchasing Alliance was another creation of HB 250. The alliance was promoted as a way to create a large, affordable group of people who would have the size and leverage to create an affordable pool for insurance coverage.

The alliance also became a way to bring the public marketplace together with the private, non-Medicaid and non-Medicare market.

The theory was that an alliance with many public and private employees as members would drive competitive pricing because of its size and leverage. At first, Gov. Jones mandated all public employees as members, including state, local, county, school and university employees, as well as public retirees. The private sector could voluntarily join the alliance, including private individuals and small-group employers with up to 100 employees.

The alliance also was a quasi-state agency answering to the legislature on all

substantive matters and to the Health Policy Board on administrative matters. The alliance board was voluntary and its original members came from the same groups represented, including public employees at universities, cities, schools and one member was from the private sector.

The alliance also had unrealistic timelines, including an unreasonably short period of time to prepare to enroll 300,000 people by the first day of implementation.

Gov. Jones was committed to making sure Kentucky offered one of the nation's top consumer protections, believing in guaranteed issue, where nobody should be denied insurance because of health status. That was the basis of his eventual health insurance reforms.

In 1994, when HB 250 was enacted, Jones expected long-term that everybody would buy through the alliance. But he knew it would take time to establish it. He devised a more immediate compromise, by allowing those with health problems and needing immediate insurance relief to "buy in" to the alliance. The "buy-in program" was available to any Kentucky resident. They could buy an individual policy from any carrier already offering coverage to state employees in July 1994. More

significantly, they were able to get their insurance at the same premium as the larger, healthier pool of state government employees.

By 1995, 5,148 people were enrolled in the "buy-in program." Because of the high loss ratios that resulted, it is a safe assumption that many people in this program previously were uninsured because of their poor health.

HB 250 also created sweeping changes in the health insurance provisions of the Insurance Code.

Four main consumer protections related to the purchasing and renewing of health insurance were created:

- **Guaranteed issue:** Insurers were required to issue a policy to everyone. Health conditions could no longer be used as a reason for denying coverage
- **Guaranteed renewal:** Insurers must renew all health plans except for non-payment of premium, fraud or misrepresentation, non-compliance with plan provisions, or if the insurer ceases doing business in Kentucky.

Guaranteed issue and guaranteed renewal: These were among the most significant consumer protections passed by Kentucky lawmakers during the decade.

Under guaranteed issue, everyone was eligible for health insurance in Kentucky regardless of medical condition. Guaranteed renewal meant coverage could not be dropped because of developing medical problems.

Ultimately, only eight states in the United States would require health insurance in this way.

Then-Gov. Brereton Jones and key legislative leaders were instrumental in passing this law, HB 250 in 1994, which came about in Kentucky after similar proposals by President Clinton died at the federal level.

Proponents considered this a powerful and compassionate consumer protection for ill Kentuckians previously denied access to health insurance.

Critics complained it added to overall health insurance premiums for all Kentuckians and drove many insurers out of state and to more profitable markets.

- Limitations on exclusions for pre-existing conditions - Previously, an insurance carrier could refuse to cover a patient for a specific pre-existing condition. Under HB 250, pre-existing conditions (conditions which an insured sought or received treatment for within the last six months) could not be excluded from coverage for more than six months.

- Portability - Closely related to pre-existing exclusions is the concept of “portability.”

HB 250 required insurance companies to give credit for prior coverage against any pre-existing condition regardless of a

policyholder changing jobs or insurance policies.

In addition to these consumer protections, HB 250 provided for major changes in the way rates were developed and in the benefit plans that could be offered in Kentucky.

As part of HB 250, health plans were required to use “modified community rating” for individuals, employers with 100

Portability: *The consumer protection where an employee receives credit for health insurance coverage when changing jobs. If the person was covered for a sufficient period of time under the first policy, benefits for a pre-existing condition could continue under the subsequent policy.*

or fewer employees and Alliance members. Modified community rating (“MCR”) required premiums to be based solely on age, geography, number of family members, type of benefit plan, cost containment provisions (such as an HMO

Modified community rating:

Modified community rating is a way to distribute the costs of insuring a pool of people. It is a middle-of-the-road way to rate a group of people.

In traditional, experience-rated insurance, everyone pays a premium based on what their own costs are anticipated to be, such as for a costly medical condition or a pregnancy.

On the other end of the spectrum is pure community rating where costs are estimated for an entire group and everyone pays the same premium to cover that projection.

Modified community rating is somewhere in the middle of these two theories. MCR allows rates to vary for such factors as age, gender, occupation, and where a person lives. All insureds with the same demographic characteristics are rated the same. Differences in premium for an insured's health status, however, are not allowed.

product vs. traditional insurance), and limited discounts for healthy lifestyles.

Rate variations for age could not be more than 300 percent from the lowest to the highest rate. For example, if the youngest person in a specific health plan is charged \$100, an insurance carrier could not charge more than \$300 for the oldest policyholder.

Insurers could not use gender, health, or occupation as rating factors. Single individual, couple, single parent families and two parent tiers were established.

HB 250 also repealed the use of guaranteed loss ratios. Previously, an insurance company could file and use rates with the guarantee that they would pay a specific ratio in medical expenses. If they did not meet that amount, they promised to refund the difference to policyholders.

HB 250 created the Health Policy Board and asked it to establish a way to reimburse carriers for unpredictable or disproportionate risks because of the

Loss Ratio: *An insurance company's estimate of how much money it will pay in claims compared to how much money it will receive from premiums charged to policyholders.*

legislative changes.

For example, carriers were not allowed to base rates on a person's gender.

However, claims experience shows young women are more expensive to insure than young men. A carrier insuring a larger number of young women than another insurance company might sustain disproportionate claims. The board created a Demographic Risk Fund to reimburse a carrier in this type of situation.

All carriers were required to offer the same standard plan of health benefits.

Under HB 250, the Health Policy Board was required to define up to five such standard plans.

One of the standard plans was required to match Kentucky Kare benefits offered as of Jan. 1, 1994.

All insurers were required to offer the standard plans at the time of renewal.

The law required each standard plan to be offered in two forms: As a traditional indemnity plan and as a managed care plan.

In addition, each standard plan was required to provide for two levels of cost sharing. For example, one of the low plans had a \$500 deductible and one of the high plans had a \$1,000 deductible.

The plans varied according to the amount of deductibles and co-payments that policyholders were willing to choose. The benefits and services covered also varied according to the plans, which ranged from what were called enhanced, standard, economy and budget plans.

Ultimately 28 benefit plans were designed for health insurers to choose to offer. All had to offer a basic plan (at least one of the 28 designs).

For example, certain plans governed HMOs. But all had to offer a basic plan.

By July 1995, HB 250 begins implementation. The reality of this new law hits, as carriers realize just how directly they are being told who to cover, how to write coverage and what to charge.

The law called for changes in rates and the standard plans that could be offered. Regulations tied to implementation of the law were in chaos as well.

Earlier, in April 1995, the Health Policy Board approved a standard plan. However, companies said they couldn't offer this standard plan in time for the massive number of policyholders who would renew coverage in July.

In May 1995, however, the Health Policy Board adopted even more plans and

determined how to rate associations and exempted union plans.

In June 1995, the board again changed standard plans and permitted the plan year to change to a calendar year.

Adding to the complexity, the board also determined that each employee of an employer could choose their own insurance carrier through the alliance. Rather than one employer making the decision on behalf of all employees, the alliance was faced with processing the choices of every single employee at a company. Five employees could choose five different carriers. The board created a billing nightmare for companies at exactly the time they were processing their biggest

wave of renewals.

Plan Source, serving as the administrator handling the bills, claims and paperwork for the alliance, didn't get its first set of premium rates from the accountable health plans until the beginning of July. There was another major hitch, however; the Department of Insurance had not yet approved those rates and each company reported their rates in a different way because there were no directions for how to follow the new law.

As a result, also in July, the first companies began serving notice that they would be leaving Kentucky. Guaranteed issue, standard plans and modified community rating were listed as the

1994-1995 Timeline of Key Events

7/15/94: HB 250 passes General Assembly.

11/94: Five-member, voluntary Health Purchasing Alliance Board appointed. In the next eight months, the board must have the entire program in operation, find an executive director, and be ready to enroll at least 250,000 people.

3/95: Alliance board names executive director responsible for daily operations. Only four months to go until opening the doors and beginning enrollment.

5/19/95: Contract with third-party administrator, Plan Source, which was responsible for having all computers, paperwork and staff in place to handle enrollment, billing and claims when operations begin in just 58 days.

7/17/95: Health Purchasing Alliance begins operations and enrollment.

specific reasons for departure. By this point, carriers could now sell and renew only five standard plans and the board was still writing and rewriting what those plans would be. At this point, the board had only written four of the five.

The insurance companies were being asked to drop their previous plans and switch policyholders to new plans that still weren't finalized. Everyone in Kentucky had to switch over.

From July 15 to Aug. 21, 1995, the alliance received 27,000 calls, but the alliance didn't have staff in place and was still hiring.

In late August, the Department of Insurance adopted the rates for all the health insurance carriers.

By Sept. 1, there were only 300 people enrolled with the alliance because of all the implementation problems. The HMO Association sued the alliance, challenging the alliance for offering Kentucky Kare to individuals and small group employers in the private sector when it previously was available only to public employees.

By October, Gov. Jones issued an executive order saying state employees could choose their riders, or special amendments to insurance coverage, creating more hardship for the insurance

companies. Each employee essentially could write their own coverage and somehow carriers had to process and price this. By the end of October, the riders had to be rewritten because they didn't correctly address prescription drug co-payments.

Standard Plan Timeline

7/15/94 – With enactment of HB 250, Health Policy Board given authority to develop standard health benefit plans to be the only plans issued or renewed in Kentucky after 7/15/95.

4/21/95 – Health Policy Board approved standard plans.

5/16/95 – Health Policy Board adopted a motion allowing carriers the option of extending the renewal date of current policies through the end of the calendar year, without a rate increase.

5/30/95 – Health Policy Board issued additional changes to standard plans and exempted Taft-Hartley plans.

6/30/95 – Health Policy Board made additional changes to standard plans.

7/15/95 – Carriers required to have printed, and ready to market, all changes necessary to implement standard plans.

Open enrollment for state employees already was delayed from the norm of September and this major new requirement about the riders was already being added a month late. The department continued to receive notice that up to 45 carriers were going to leave Kentucky because of all of this.

On Oct. 16, a temporary restraining order was issued, preventing the alliance from enrolling the mandatory public employees. Just days later, the order was lifted partially, saying public employees could use the alliance but they must enroll with Kentucky Kare.

In addition to all these changes and confusion, every insurance company had its own computer system trying to talk to the computer system of Plan Source, the alliance's administrator. The incompatibility of these computers made it difficult to process applications.

By early November, the Department of Insurance was receiving consumer complaints that premiums weren't being billed accurately. Agents also complained that commissions were incorrect.

On Nov. 9, DOI rescinded approval of all the rates and issued a new method of determining rates.

Confusion over Rates

7/15/94 – HB 250 enacted, requiring modified community rating for all individual and small group products (a sweeping change in rating methodology.)

5/19/95 – the DOI provided regulator guidance on interpretation of how to calculate rates based on MCR

5/30/95 – Health Policy Board made a determination of how to rate associations.

7/15/95 – HB 250 takes effect; all carriers required to have all rates in compliance with the standard plans.

8/24/95 – Health Policy Board adopted additional rating changes.

11/9/95 – DOI rescinded approved rates and issued new methodology for rates.

11/16/95 – Health Policy Board adopted additional changes affecting Alliance and non-Alliance rates, effective 1/1/96.

12/7/95 – Health Policy Board issued additional changes for rates effective 1/1/96.

12/11/95 – Governor issues warning to carriers to comply with new rating methodology.

On Nov. 16, the Health Policy Board wanted alliance and non-alliance rates, a change that led to more difficulties.

The board discovered that alliance rates were higher than non-alliance rates and that's what led to this action. These findings were in direct conflict with Gov. Jones' key goal of having a large alliance forcing competitive and presumably cheaper rates.

On Nov. 28, mandatory group enrollment was completed for all public employees in the alliance. Total enrollment was 138,000, compared to only 300 in September.

The Health Policy Board issued additional changes to the rates on Dec. 7. These were for rates effective Jan. 1, less than 30 days away. These changes were made as a result of two different actuarial studies within the Department of Insurance, noting that all of these legislative changes were having a major rate impact beyond what the board had anticipated.

On Dec. 11, outgoing Gov. Jones called a news conference saying insurance companies are gouging the public. Paul Patton was the incoming governor, with his term beginning in January 1996.

1996

The year is marked by more changes as SB 343 is enacted, changing some earlier reforms of HB 250. Many carriers in the insurance industry abandon the Kentucky market.

SB 343 abolished the Health Policy Board and exempted associations from modified community rating. Local governments and universities are no longer required to be in the alliance and Gov. Jones' global idea of a purchasing alliance is getting smaller.

Kentucky Kare, the self-insured health plan for state employees, is in financial crisis. By the end of the year, Kentucky Kare asks for a 28 percent rate hike to stop the drain on reserves.

This is also the year that Congress enacted legislation guaranteeing coverage to small groups of 50 or fewer employees and giving credit for previous insurance when changing jobs (known as HIPAA for Health Insurance Portability and Accountability Act).

The year began with the new administration of Gov. Paul Patton who was committed to studying the issues in the health insurance market and to maintaining consumer and patient protections.

The year also began with a regular session of the General Assembly; lawmakers were ready to make major changes to HB 250.

In anticipation of changes to the health insurance laws, three executive orders were issued delaying implementation of HB 250.

The orders issued on Jan. 29, Feb. 29 and April 19 allowed Kentuckians with health insurance to renew their pre-reform policies through July 15 (the anticipated effective date of new legislation).

Although carriers were permitted to increase rates for these policies, in anticipation of rating changes, rates were not increased.

Various bills were debated during the session.

The original SB 343 incorporated recommendations from Gov. Patton. Other versions considered wide ranging proposals, from a risk pool to slight modification of HB 250.

The result was a substitute SB 343, enacted on April 4, with limited input from the Department of Insurance.

As with HB 250, much of the debate reflected the General Assembly's ongoing concern with rate increases and a lack of trust of health insurance carriers and the Department of Insurance at that time.

For example, one provision required the insurance commissioner to review all rates filed by insurers for health benefit plans during the period of July 15, 1995, through July 15, 1996, to determine whether rates were excessive and benefits were no longer reasonable in relation to the premiums or fees charged.

An insurer whose rates were found to be excessive was required to make refunds within 60 days of notification of the commissioner's findings.

(The department's subsequent review of the rates did not find any large group rate filing to be excessive. The department did identify other filings in other market segments to be excessive or inadequate.)

Another example of the lack of trust was the expansion of the role of the Attorney General in rate hearings and creation of the Health Insurance Advisory Council. The Health Insurance Advisory Council pulled together the industry,

providers and consumers to advise the commissioner on health insurance issues.

Members of HIAC were asked to review the following:

- Design of the standard health benefit plans.
- Rate filing process for all health benefit plans.
- Definition of high-cost conditions.
- Administrative regulations to be promulgated concerning KRS 304.17A.
- Other issues at the request of the commissioner.

One of the major changes of SB 343 was to abolish the Health Policy Board. Its insurance-related responsibilities were transferred to the Department of Insurance and its duties related to health care were transferred to the Cabinet for Human Resources (now the Cabinet for Health Services).

Major changes were also made to the Kentucky Health Purchasing Alliance during the 1996 legislative session.

- University employees and local government employees were permitted to be "voluntary" members of the alliance as opposed to "mandatory" members.

- Kentucky Kare, the self-insured health plan for state employees, became another option for members of the alliance to choose.
- The alliance was attached to the Department of Insurance for administrative purposes.
- Small groups continued to have the option of joining the alliance, but the size of these groups was amended to 50 employees or less compared to the previous 100 or less.

These changes further fragmented the market and eroded the initial goal of Gov. Jones to have a powerful, influential purchasing alliance that would spark competitive premiums.

Once SB 343 was in effect, only two carriers were left in the individual market, Anthem and Kentucky Kare, and the latter was in serious financial trouble.

The common area of agreement in 1996 was that all Kentuckians should continue to have access to health insurance. To maintain this goal, the four consumer protections originally enacted in HB 250 were maintained:

- Guaranteed issue.
- Guaranteed renewal.

- Limitations on exclusions for pre-existing conditions.
- Portability.

There were slight modifications to these protections, including a 12-month residency requirement before guaranteed issue applied.

The definition of "pre-existing condition" was changed to include conditions that were discovered or treated during the year before the insured's coverage started (as opposed to 6 months in HB 250).

Other insurance-related changes brought about by SB 343 included:

- The definition of small group was changed from 100 employees or less to 50 employees or less.
- Large groups were exempted from the standard plan requirements; they could develop their own unique plans.
- Two additional factors were added to how rates could be calculated under modified community rating methodology: gender and occupation.
- The Department of Insurance could now create an unlimited number of additional standard health benefit plans. The original plans developed

by the Health Policy Board were maintained. In addition, the department created one additional standard health benefit plan meeting the federal requirements for a catastrophic plan to be used in conjunction with a medical savings account.

The most substantial insurance-related changes brought about by SB 343 affected rating.

With the abolishment of the Health Policy Board, the Department of Insurance was again responsible for the approval of health benefit plan rates. However, several "safeguards" were included in legislation to ensure that the Department of Insurance acted fairly in both its review and approval of rates and to ensure that the consumer's interest was considered in the evaluation.

Insurers were required to file all rates for health benefit plans with the Department of Insurance for approval before the rates could be charged.

Each rate must be filed with the department for a minimum of 30 days before the department could approve or disapprove the filing. The waiting period could be extended for another 30 days if the Department of Insurance gave appropriate notice.

If the commissioner did not affirmatively act on the filing within the waiting period, or extended waiting period, the filing was deemed approved.

In reviewing a rate filing, the commissioner was required, by statute, to consider the following:

- Whether benefits are reasonable compared to premiums charged.
- Whether fees paid to providers for the covered services are reasonable in relation to the premiums charged.
- Previous premium rates or fees for the policies or contracts to which the filing applies.
- Effect of the rate increase on policyholders.
- Whether rates, fees, dues, or other charges are excessive, inadequate, or unfairly discriminatory.

In acting on the filing, the commissioner could choose to approve or disapprove the filing or hold an administrative hearing. If an administrative hearing was held, the commissioner was required to hold the hearing within 30 days of receiving the filing or during an additional 30-day extension, and was further required to issue an order approving or disapproving

the filing within 30 days following the conclusion of the hearing.

The commissioner was required to hold a hearing if the proposed rate increase exceeded the insurer's existing rates by a certain percentage. This percentage was determined by how much the consumer price index had increased for all urban consumers in the South regions, as published by the U.S. Bureau of Labor Statistics, plus 3 percent.

During any administrative hearing on a health benefit plan rate filing, the Attorney General was required to participate as a representative of health insurance consumers.

Finally, the law permitted the commissioner to withdraw approval of a rate at any time after a public hearing if benefits were no longer reasonable in relation to the premiums or fees charged. The commissioner also could order a refund to policyholders, enrollees and subscribers.

The other major rating impact of SB 343 involved the exemption of association plans from the modified community rating requirements. Although the Health Policy Board had previously permitted the exemption of certain associations from the MCR requirements through an agreement,

SB 343 permitted a broader exemption through statute.

The provisions allowed associations to apply to the Department of Insurance to become an "eligible association."

Associations existing before Jan. 30, 1996, could offer health benefit coverage to their members by Sept. 1, 1996, and now be exempt from modified community rating.

What this meant was an association's rates could be based on actual or projected claims experience of the association.

This exemption worked to narrow the number of people under modified community rating. It also worked to segregate the healthy and unhealthy. Healthier insureds sought coverage through associations (which were rated according to the actual claims experience of their members). Conversely, unhealthy insureds selected coverage in the standard market, which rated insureds the same, regardless of their health status.

With these new requirements, the department anticipated many rate hearings. Instead, the unanticipated result was that carriers held rates artificially low to avoid automatically triggering hearings. This would have financial implications later.

Other provisions of SB 343 worked to further delay the full implementation of the standard health benefit plans and the modified community rating requirements.

For example, SB 343 contained a provision, similar to the executive orders, permitting carriers to keep renewing non-standard plans through July 15, 1997.

Additionally, carriers wanting to withdraw from Kentucky's market were required to give a 12-month notice before canceling an insured's policy. This period was intended to provide an insured with adequate time to shop for a new carrier. It also delayed adding individuals to standard plans rated under modified community rating.

All these delays, while well-intended, kept the number of those already in the "reform pool" small. This did not allow the reform pool concepts to reach their full potential.

It also shielded individuals and small groups from the initial rating effects of the reform laws. Unfortunately, when those individuals and small groups transitioned into the reform plans, they were met with the rating impact of the reforms (10%) and the increase required after rates were held artificially low for as much as two years.

The 1996 legislative changes did little to stop the exodus of insurers. The coverage provided by those carriers that previously gave their notice of withdrawal (in 1995) was now being canceled. People had to find new coverage through the remaining carriers.

However, the number of active carriers continued to dwindle as 10 additional carriers gave notice that they were leaving the Kentucky market.

Although the alliance survived the legislative session, problems with its third-party administrator continued. In May, the alliance started to consider terminating its contract with Plan Source because of all the administrative, billing and enrollment problems.

There was also continued concern over the decision to allow Kentucky Kare (a self-insured plan created for state employees) to offer coverage to members of the alliance that were not state employees.

The main concern was the financial condition of Kentucky Kare and its ability to accept new members. This was enhanced by the fact that Kentucky Kare would be one of only two carriers in the individual market.

In 1993, Kentucky Kare appeared to be so financially strong that a decision was made to leave rates unchanged until the reserve levels were reduced.

However, by June 1996, the Department of Insurance began a financial examination of Kentucky Kare showing a loss of more than \$30 million over a 20-month period.

In July, SB 343 became effective. The law was intended to stabilize the market, but the new regulatory environment drove carriers out of Kentucky.

The crisis was felt most by the individual market because the only choices were Anthem or Kentucky Kare.

Anthem offered a managed care plan (with a network of providers) outside the alliance.

Kentucky Kare offered an indemnity plan with the freedom to choose any provider within the alliance. The indemnity coverage provided by Kentucky Kare attracted those who lived in rural areas and were less healthy.

Neither plan competed against the other.

There were many unanticipated consequences and market reactions that affected an individual's choice of coverage.

In September 1996, Anthem announced that it would only pay a commission of \$5 to agents for individual health benefit plans. On individual plans written through an association, however, the commission was not altered. Kentucky Kare continued to pay 5% commissions on its individual products. Consequently, agents sought to place coverage either through Kentucky Kare or in association plans.

Another change in September further affected the regulatory process. The federal Health Insurance Portability and Accountability Act was enacted by Congress. This law required, among other things, access and renewal of coverage issued to small groups and specific individuals.

Kentucky already had laws in place that complied with most of the federal requirements. One major area of flexibility, however, dealt with access for individual coverage. With the continued instability in the market and the opportunity for change under the federal law, the debate over Kentucky's health insurance market began again.

The main focus continued to be cost. The public began demanding information on rate development to understand why

their rates were increasing even after the law had been "reformed."

On Oct. 25, 1996, a public hearing was held for the alliance to explain how its composite rates were developed. The focus was on development of rates for couples (a new tier) versus family rates.

With its continued financial losses, Kentucky Kare asked for 28 percent rate hike to try and stop the drain on its reserves. A hearing was eventually held on this issue in March 1997. Following the hearing, the department endorsed the rate increase and it was approved by the alliance.

Although there were many anecdotes about what was happening to consumers in the market, there was no solid data. Information was lacking on solutions for the problems.

In December, the department formed a task force to study the individual market crisis. Consumers, the insurance carriers, insurance agents, associations, the provider community and legislators were represented.

The guiding principles for the task force were to:

- Focus on the best interest of all consumers and preserve the four consumer protections of guaranteed

issue, guaranteed renewal,
limitations of exclusions for pre-
existing conditions and portability.

- Re-establish a competitive individual health insurance market in Kentucky.

The department envisioned all groups interested in the health care of Kentuckians working together to find a common solution to the issues.

However, in late December, the consumer advocates publicly announced that they did not feel they could work with the insurance industry in studying the market issues and developing a solution.

The task force divided into two separate groups, one for the industry and one for the consumer/provider, each with their own separate missions going into 1997.

1997

Although consumers and the industry split into two separate task forces, there was consensus that Kentucky still had a health insurance crisis and key consumer protections should remain in force.

The department generated detailed documentation and published a “white paper” leading to a special session of the General Assembly. However, key recommendations sought by the department to stabilize the market failed by one vote.

Problems continued at the Health Purchasing Alliance, even after another third-party administrator was hired.

Also during the year, Congress passed legislation creating the CHIP, or Children’s Health Insurance Program.

Although the task forces for the insurance industry and for consumers/providers were splintered, they continued to meet individually from January through May.

Represented on the task forces were insurance carriers, insurance agents, the Health Purchasing Alliance, health care providers, legislators, the Attorney General, consumers, and associations.

They heard testimony from all constituencies about the problems in the market.

Public forums also were held to hear directly from health insurance consumers.

The department issued its “white paper” to the task forces, giving them the most detailed and comprehensive actual data compiled on the status of Kentucky’s health insurance market.

By June, the Consumer/Provider Task Force issued these key recommendations:

- Retain the current consumer protections.
- Provide for adequate data collection.
- Opposed to rating based on health status; but if it is re-enacted, then there should be restrictions.

- Phase out ratings based on gender over a five-year period.
- Remove the association exemption.
- Require all insurers to write in the individual market or to pay an assessment to underwrite losses of insurers who "play."
- Require a minimum of three standard plans; carriers can write other plans with a form comparing plans being offered to the standard plans.
- Remove the automatic hearing trigger.
- Allow carriers to file for a new rate within six months of the previous increase; rates must be guaranteed to an individual for 12 months.

The separate Industry Task Force recommendations were released on July 3 and there was common ground on one, critical point of wanting to keep consumer protections in place under existing laws.

However, there were these distinctions sought by the industry:

- Keep one standard benefit plan.
- Allow health status to be permitted as a rating factor within reasonable limits.
- Streamline the rate approval process.

- Remove the limit on one rate filing per 12 months.
- Remove the rate hearing trigger.
- Offer limited amnesty.
- Enact a proven mechanism for insuring high-cost individuals.
- After an appropriate transition time, allow Kentucky Kare to cover only state employees.
- Allow for voluntary competing alliances.
- Require cost analyses for any mandated benefits.

For the first time under the reform laws, all HMOs were encouraged to have open enrollment for individuals.

The enrollment was held in May. HMOs that had been in operation for at least two years and demonstrated the financial strength to insure open enrollment participants were required to provide individuals with insurance coverage without regard to health status.

Seven carriers participated:

1. Alternative Health Delivery System (now fully owned by Anthem).
2. Aetna US Healthcare.
3. ChoiceCare (now Humana Health Plan of Ohio).
4. FHP of Ohio, Inc. (now Pacificare).
5. Humana Health Plan, Inc.

6. PruCare.

7. United Healthcare of Kentucky.

Anthem didn't participate because the company already offered year-round guaranteed issue to individuals.

Six of these plans asked to limit the number of individuals they were required to enroll. None reached that capacity.

During the 30-day open enrollment, the basic standard health benefit plan (commonly called the Standard High and the Standard Low plan) was offered. Only HMO coverage was offered.

Although only 237 policies were issued for 328 people, the significance was that this was a preliminary test of an "all markets" or "pay or play" approach. In other words, carriers that didn't normally participate in the individual market were required to cover individuals.

It's important to note that prior to this time individuals only had two choices: Anthem and Kentucky Kare.

Considering the numbers enrolled, open enrollment did not have a large impact on the number of individuals covered.

The department attempted a survey to determine why people applied for coverage, but no conclusive data was obtained.

Problems continued at the alliance, with United Chambers replacing Plan Source as the new third-party administrator.

As summer approached, several events converged to prompt Gov. Patton to call a special session on health insurance.

Among the factors: both task forces had issued their recommendations; the new law was not working; and the department's data and white paper provided specific ideas for action.

The department convinced lawmakers to focus on the specifics of health insurance and not the general concept of health care reform.

It helped move the debate directly to what was needed in the insurance market.

The department presented an alternative to the crisis, addressing the overall market and not just the individual market.

The department also emphasized the value of gathering data and documenting any reasons for change.

Going into the special session, these were the department's objectives and proposed solutions:

- Maintain the four consumer protections regarding guaranteed issue, guaranteed renewal, pre-

existing conditions and portability. (DOI proposed minor changes to the definition of "pre-existing condition" to comply with federal law).

- The main change was the focus of guaranteed issue – all 12-month Kentucky residents were guaranteed coverage either in the standard market or through a risk pool.
- The risk pool was also proposed as Kentucky's alternative mechanism for ensuring access to HIPAA-eligible individuals.
- Comply with federal law.
- Bring stability to the market.

The DOI hoped to address stability and competition by amending Kentucky's laws to bring them more in line with laws in surrounding states. (i.e. similar rating structure and approval process; open market to plans other than the standard plan; allow access for high-cost individuals through a risk pool with losses funded through a broad-based subsidy).

Eight carriers agreed to return to the market under DOI's proposal.

The department's plan lost by one vote. (Full details of the proposals are in the Appendix, comparing SB 1 (a risk pool

approach) and HB 3 (a "pay or play" approach).

When a final plan failed to emerge from the special session, other problems developed.

A previous series of executive orders had delayed implementation of HB 250 and SB 343, in recognition that there were problems with the laws and that changes were likely.

When the special session failed to resolve these issues, delays in implementation came to a critical juncture.

Executive orders had delayed transition of all policies into standard health benefit plans. The full rate impact of these reforms also had been delayed, due to the difficulty in having rates approved, the requirement of the executive orders that plans be renewed at the same rate, and the exemption of associations from modified community rating.

For these reasons, when the crisis began, there was still an opportunity to make changes to the law.

That opportunity was lost with the failed special session.

With the decision to move forward under SB 343, we went down a one-way road.

1997 Timeline

2/10/97 - Alliance Board requests bids for new administrator.

3/21/97 – Kentucky Kare receives 28% rate increase.

4/97 – DOI suggests Alliance Board obtain audit of Plan Source.

4/97 – DOI releases "Market Report on Health Insurance" leading up to special session.

5/1/97 – United Chambers becomes alliance's new third-party administrator.

6/97 – Recommendations received from Consumer/Provider Task Force.

6/5/97 – Executive order extends non-standard plans to 10/15/97.

7/97 – DOI announces mandatory open enrollment by HMOs for individuals.

7/3/97 – Recommendations received from the Industry Task Force.

10/97 – Special session on health insurance.

10/17/97 – Executive order extends non-standard plans through 12/1/97.

1998

The full impact of health insurance rates and full implementation of the reforms of 1994 and 1996 hit consumers and the industry hard.

It was no longer possible to delay the laws any further by executive order and the failed special session of 1997 put significant pressure on all public officials in 1998.

Some carriers had not adjusted their rates in 18 months and the full consequence of this was about to hit.

HB 315 would result from the regular session of the 1998 General Assembly.

The Guaranteed Acceptance Program (GAP) was among several significant highlights of HB 315, as well as major mandated benefits for hospice, diabetes, cancer drugs, women's health, autism and cochlear implants.

HB 315 also abolished the Health Purchasing Alliance and established the department's Consumer Protection and Education Division, which now helps at least 2,000 Kentuckians each month.

The consequences of so many changes, proposals, new laws and delays finally hit in full force in 1998.

The failed special session of 1997 led to full implementation of the previous reforms.

Because the expected changes weren't enacted in the special session, an executive order was necessary to give insurance carriers more time to implement all of the previous reform laws.

People also started seeing large rate increases, for a number of reasons, as follows:

- Rates were now based on modified community rating and not actual claims experience.
- The various reforms, such as guaranteed issue, were estimated to add 10 percent to premiums.
- Many carriers had not raised rates in almost 18 months, meaning rates had held at artificially low levels.

Health insurance again would dominate another session of the General Assembly.

The result was enactment of HB 315, which made numerous changes to the previous reforms.

Perhaps the most significant was the decision to create something no other state

had, a Guaranteed Acceptance Program known as GAP.

GAP was a much different way of spreading the risk for people with high-cost conditions and was nothing like SB 1 from the year before.

Under the failed legislation of SB 1 in the special session of 1997, eight companies were committed to returning to Kentucky.

Why didn't they return with HB 315 in 1998? GAP is still an exclusive idea of Kentucky and companies did not want to come back under an experiment.

It was difficult implementing GAP provisions of HB 315 because there was nothing like it.

For example, ICD-9 codes were used in the medical profession as the measurement for high-cost medical conditions.

But these codes were intended to categorize diseases for billing purposes. They were not a good model for deciding the severity of illness for people seeking insurance.

In essence, Kentucky officials now were saddled with having to create a new type of national underwriting guideline where none existed before.

Individual market. The Home Team was a powerful influence fighting on this issue.

The companies criticized the most have always been and continue to be the ones providing individual coverage on a statewide basis, for every state in the country.

Dominant players are Blue Cross and national indemnity carriers. All of us failed to recognize our individual coverage would come from the companies being treated as adversaries.

Some companies did return but only to small and large group markets, not to the individual market.

Patient protections and new relationships between providers and insurers. HB 315 created key patient protections and added an important public service.

The department's Consumer Protection and Education Division was created. The division now fields 2,000 calls per month, mostly involving health insurance. The legislation also created the position of ombudsman.

But HB 315 also changed relationships between providers and insurers.

This was highlighted later in 1999 with Aetna/TPI and Anthem's coronary network.

Under HB 315, each managed care plan must demonstrate an adequate number of providers.

The provider network also must be within 30 miles or 30 minutes of each member's residence, as long as those services are available.

The law also allowed "any willing provider" to participate in a plan's network if they were willing to meet the terms and conditions.

Market continues to fragment. Gov. Jones' vision of a powerful purchasing alliance was continuing to fragment. As associations and smaller groups found their own ways to purchase insurance, a large purchasing alliance with leverage to compete for the best rates and coverage was unraveling.

The gradual erosion occurred over a period of years, including the exemption of associations in 1996, and continuing with HB 315 and the ability to self-insure and get out of the market in 1998.

The creation of more and more special groups also was troubling Congress at the national level.

Rate Approval Process. The 1998 General Assembly amended the rate approval process to allow carriers to use their rates upon filing with the department.

After filing, the department completes an actuarial review of the rates within 60 days.

If the department has taken no action within those 60 days, the rates will be deemed approved.

The commissioner maintains the right to subsequently disapprove the rates and order retroactive refunds of any premium determined to be unreasonable.

The factors for consideration of a rate remained the same as those enacted in 1996, plus the effect of GAP assessment on rates.

The Attorney General is provided a copy of all rate filings by the insurer and may request, in writing, that the commissioner hold a hearing. If the Attorney General requests a hearing, the commissioner must hold one.

At the conclusion of the hearing, the commissioner must either approve or disapprove the requested rate. The Commissioner has no authority to amend the filing.

Rate methodology. The modified community rating requirements for

individuals and small groups were repealed. Insurers are now permitted to consider health status and claims experience when developing rates for individuals, small groups and associations.

However, the amount an insurer could charge a person based on health status was limited.

Also, limits were set on how much an insurer could increase premiums when an individual renewed coverage.

With limits to the differences in rates, carriers were allowed to consider the following when developing rates: age, gender, occupation/industry, and geographic area.

Rates for health benefit plans issued to individuals with a high-cost condition were restricted. This applied to anyone with a high-cost condition after July 15, 1995.

The limits were defined in HB 315 and were not to exceed previous rates by more than 25 percent for the first two renewal periods. The total increase couldn't exceed 35 percent.

Associations meeting the definition of "employer-organized associations" may be rated according to their own experience rather than the experience of the entire association market segment.

Alliance abolished. The Kentucky Health Purchasing Alliance was abolished by the 1998 General Assembly.

No coverage could be issued or renewed after June 1, 1998, and alliance activities must end by June 30, 1999.

For the first time this year, and before HB 315 passed, the alliance fell under the supervision of the Department of Insurance.

Eventually, a lawsuit was filed against United Chambers, alleging problems in its role as third-party administrator for the alliance.

Ending the alliance has not ended the woes for consumers, however. Overwhelming billing and administrative problems unnecessarily exposed consumers to unpaid medical claims and disputes over coverage and these problems continue through 1999.

Portability and pre-existing conditions. Federal HIPAA requirements regarding portability and pre-existing condition exclusions were enacted into state law.

For groups, insurers are permitted to impose an exclusion period for pre-existing conditions. However, that period cannot be longer than 12 months, unless you are a late enrollee in which the pre-

existing period can be 18 months. (Same as previous law.)

The statute regarding portability essentially remained the same.

Standard plans. The number of standard plans was decreased to one. The department maintained authority over the design of the plan with the advice of the Health Insurance Advisory Council.

Insurers must offer the standard plan in the small group market and the individual market if the insurer participates in those markets and in the same product types (HMO, POS, PPO, FFS) in which it offers other coverage.

A benefits comparison form, comparing the standard plan to the plan being offered, must be provided to an individual applicant and any non-employer small group applicant.

The form compares benefits, exclusions and premiums.

Patient protections.

HB 315 made a number of changes regarding providers and quality of service.

Highlights included:

- Disclosure of benefits, exclusions and financial incentives between the insurer and participating providers.

- The right to appeal and the procedure for appealing a decision of the insurer.
- An insurers' procedures to ensure confidentiality of medical records and personal information.
- Managed care plans must have a quality assurance program.
- Coverage for emergency room screening and stabilization without prior authorization.
- Drug utilization review programs to ensure appropriate drug therapy and education for consumers.
- Time frames and procedures for denial of coverage.
- Procedures to ensure continuity of care.
- Adequate, accessible network of providers.

1999

MedQuest in Owensboro became the first HMO to fold in Kentucky in 12 years, as HMOs nationwide continued to struggle financially.

The Health Purchasing Alliance ceased operations during the year, pursuant to 1998 passage of HB 315. Lawsuits continued against third-party administrator, charged with much of the paperwork nightmares involving the Alliance.

The department reorganized its life and health divisions and named a new deputy commissioner of health insurance to address the rising challenges in that area.

The first action is taken to enforce the “any willing provider” law involving a hospital contract dispute in western Kentucky.

MedQuest HMO in Owensboro became the first Kentucky HMO to go out of business in 12 years for financial reasons.

Nationwide, 56 percent of the HMOs in the U.S. reported losses exceeding \$400 million in the past year.

HMOs in Kentucky lost more than \$70 million in the previous year and six companies remained on an internal and confidential monthly watch list.

Alliance. The Health Purchasing Alliance closed for business on June 30, 1999, pursuant to 1998 legislation of the General Assembly. Lawsuits remain pending regarding paperwork problems alleged against the third-party administrators.

Aetna/TPI. The changing relationship between insurance carriers and providers was highlighted in a Louisville contract dispute.

Approximately 2,000 Louisville doctors announced in the spring of 1999 that they were going to drop out of the Aetna network because of a dispute over future contract terms. The group of doctors was known as The Physician Inc. (TPI).

The department intervened in the Aetna/TPI dispute because tens of thousands of residents in the Louisville

Fee for service plan (FFS): *A type of traditional insurance where the policyholder can go to any doctor or hospital and the insurance carrier offers a specific payment for the service provided. For example, the insurance company would pay \$50 toward an office visit and any remaining expense is up to the patient.*

HMOs: *A Health Maintenance Organization provides health care in return for predetermined monthly premium payments. Most HMOs provide care through a network of doctors, hospitals and other medical professionals that their members must use in order to be covered for that care.*

PPOs: *Preferred Provider Organizations use a network of doctors and hospitals providing care at a lower cost than traditional insurance. PPO members get more benefits when they use the PPO network and pay higher out-of-pocket costs when they go outside the network.*

POS: *Point of Service plans are a type of HMO coverage allowing members to choose to receive services in or out of an HMO provider network. For out of network care, members pay deductibles and a percentage of the costs of care. Most POS plans require patients to coordinate their care through a primary care physician.*

metro area would see a substantial decline in their options for choosing a doctor in the network. Furthermore, the dramatic changes in the number of doctors in the network would have occurred during consumers' policy year.

The department ultimately was able to mediate an agreement where Aetna and TPI agreed to delay these changes until the next policy year for consumers so the public could make an informed choice at the time they renewed their health insurance coverage.

Consumers. During the year, the department's Consumer Protection and Education Division began teaching its newly designed Insurance 101 courses, including specific classes dealing with health insurance. For the third consecutive year, Commissioner Nichols hosted town forums statewide to hear concerns of the general public. The forums were held in 15 communities.

The department ordered Anthem to refund money to 827 policyholders regarding premium increases implemented during the policyholders' one-year policy term. The department and Anthem disputed when rate increases under HB 315 could take effect. The contested case went to hearing before the attorney general's

office in September and was still pending in late 1999.

The department's Life and Health divisions were reorganized into separate units of the Department of Insurance.

Recognizing the growing issues and concerns with health insurance, Gov. Patton and Public Protection and Regulation Cabinet Secretary Secretary Ronald McCloud authorized Commissioner Nichols to name a new deputy commissioner of health insurance.

Consumers continued to experience problems presented by confusion over records and unpaid bills involving closure of Kentucky Kare and the Health Purchasing Alliance.

The Health Insurance Advisory Council and the Home Team continued to meet, monitoring implementation of HB 315 and the latest status of GAP.

This was the first year that state employees were back under the authority of the Personnel Cabinet with the end of the Health Purchasing Alliance and the first year without Kentucky Kare.

Legislators began discussing the possibility of self-insuring the state and the cost of coverage for out-of-state retirees.

There also was a class action lawsuit filed in Pikeville in 1999 regarding the

lack of a fee-for-service (FFS) product for state employees.

General Assembly’s special subcommittee on health insurance.

The General Assembly was not in session in 1999, but interim joint committees continued to meet during the year. Members of the joint House and Senate Banking and Insurance Committee and the health subcommittee held hearings with insurance carriers to study what factors would encourage them to return to Kentucky and compete in the health insurance market.

The department continued to advocate for an independent appeals board for review of disputed medical claims.

Early in 1999, the department urged HMOs to develop their own voluntary system of external appeals.

Among pre-filed bills were proposals creating an external appeals process when health insurance claims are in dispute between policyholders and health insurers.

Legislators heard emotional testimony in September from Monica and Steve Whitaker who testified about difficulties getting coverage for treatments for their young son. Mrs. Whitaker told committee members that her son has a congenital condition affecting his facial appearance

but also causing physical challenges to his mouth and eye.

The Whitakers testified their son was covered previously by Kentucky Kare but not by a new private carrier they had to switch to when Kentucky Kare went out of business.

During the interim of 1999, lawmakers also received a detailed report from Chief Economist Ginny Wilson, of the Legislative Research Commission, regarding all the factors leading to the financial collapse of Kentucky Kare.

Provider network. An initial review of each managed care plan’s provider network was completed in February 1999.

The review analyzed access to and adequacy of the provider networks specific to primary care doctors, hospitals and six specialties (cardiology, OB/GYN, pediatrics, ophthalmology, surgery and orthopedics.

The review also analyzed whether policyholders were within 30 miles of providers, another requirement of the law, and substantial compliance was determined.

Any willing provider. The Department of Insurance issued the first sanctions under the “any willing provider law” when Bluegrass Family Health didn’t

offer similar terms and conditions to Lourdes Hospital in western Kentucky.

The department issued fines and an order against the Lexington health carrier. Bluegrass eventually offered a contract that the department deemed met the requirements of the law.

GAP. By June 1999, 1,443 were enrolled in GAP, the Guaranteed Acceptance Program reimbursing carriers for losses sustained while covering people with high-cost medical conditions.

Preliminary calculations showed the assessment on health benefit plan premiums would raise just over \$4 million, adding to the one-time appropriation of \$10 million by the legislature.

Congress began debating a variety of proposals offering patient protections and a “Patient’s Bill of Rights.” Debate continued but no legislation was passed by the fall of 1999.

Debate also continued in Congress regarding the right to sue HMOs.

Preparing for 2000 session of General Assembly.

This report is our view of the health insurance changes in Kentucky for the decade of the 1990s. As we begin a new decade and a new century in the 2000 session, we need to carefully consider the

lessons learned and the consequences of any additional reforms.

As mentioned in the introduction, I believe we should specifically focus on these five goals:

1. Maintain the consumer protections.

We have some of the nation’s best patient protections, especially with guaranteed issue. We should maintain these for all Kentuckians.

2. Stabilize the market. Kentucky

made so many sweeping and untested changes that we created confusion and drove too many carriers out of the state. We must carefully research and document any future change so we’re more informed about the potential consequences.

3. Choice. We need more choices in the health insurance market.

4. Comply with federal law. Some changes are necessary because of federal law.

5. Address geographic issues. Rural Kentuckians have fewer choices for health insurance. Future legislation must recognize the difference between rural, urban and statewide solutions.

Appendix

These topics are dealt with in greater detail, as follows:

- *History of Mandated Benefits: 1990-1999.*
- *SB 1 and HB 3: 1997 Special Session.*
- *Guaranteed Acceptance Program (GAP) 1998.*
- *National Legislative Initiatives: 1990-1999.*
- *Market Trends: 1990-1999.*
- *History of Kentucky Health Carriers: 1990-1999.*
- *History of Kentucky Kare: 1990-1999.*
- *History of Provider Issues: 1990-1999.*
- *History of Health-Related Litigation: 1990-1999.*

History of Mandated Benefits

1990 - 1999

Mandated offerings are benefits that an insurer must offer in an insurance contract, but consumers do not have to buy the coverage.

Prior to 1990, mandated offerings were limited to a short list of five items. For example, insurers were mandated to cover newborns, congenital defects and birth abnormalities, effective 1976. Ambulatory surgical centers

also were included, effective 1978.

Specifically, these pre-1990 mandates stated that the same procedures by a dentist, optometrist or osteopath that were covered by insurance also were covered if provided by any other physician.

Also mandated was coverage for treatment at an ambulatory surgical center

if the same coverage was provided at a hospital.

Here are highlights of some of these mandates prior to 1990:

Mandated benefits: *Mandated benefits generally are regarded as specific coverage or medical services that a health benefit plan must offer to any policyholder. Mandates can also require specific procedures offered by certain providers, such as a dentist, optometrist or osteopath. State laws specifying certain optional benefits are also considered mandated benefits, although the policyholder makes the ultimate decision of whether they want that coverage for an additional amount of premium.*

1. Five days of nursery care for newborns that are well.
2. Offer benefits for mental illness equal to the benefits for physical illness (sometimes referred to as “mental parity”). For example, if a health plan provides for in-patient hospital coverage for a

physical illness, the plan must provide similar in-patient hospital coverage for mental illness.

3. Offer at least 60 days of home health care.
4. Offer certain benefits for the treatment of alcoholism (for groups only.)

In 1990, the Kentucky General Assembly mandated two new medical benefits for people insured in the health market.

Those new mandated benefits provide coverage for mammography screenings and treatment of temporomandibular joint disorders (TMJ) – a disorder involving the jaw.

The **1992** General Assembly enacted no new legislation for additional mandated benefits.

More mandated benefits were enacted in **1994** than any other year.

In various legislation that became law, insurers were mandated to cover:

1. Services provided by podiatrists, psychologists and clinical social workers.
2. Dependents over age 19, with certain disabilities, on individual policies.
3. Legally adopted children must be covered under all health plans covering families.
4. Hospice benefits at least equal to those provided under Medicare were required in the standard health benefit plans.
5. Work-related sickness and accident unless the person is eligible for

benefits under a workers' compensation act.

In 1995, mandated benefits were now part of the standard plan.

The **1996** General Assembly enacted the following mandated benefits:

Chiropractic Services. Any health benefit plans that include chiropractic benefits must also provide coverage for treatment by any licensed chiropractor chosen by the patient and policyholder. The additional requirement was that the chiropractor must be willing to meet the insurance company's terms and conditions to participate in the health plan.

The law also stipulated that the patient could seek treatment from the chosen chiropractor without a referral and insurers must ensure that their networks include an adequate number of primary chiropractic providers.

Treatment of Breast Cancer. Any health insurance policy that provides coverage for the treatment of breast cancer by chemotherapy must also provide other specific coverage. One example is high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation at the same cost-sharing level (co-payment or co-insurance), provided that the institution at which the

treatments are performed complies with certain guidelines.

Maternity Benefits. Any health benefit plan that provides maternity coverage must provide in-patient care for a mother and newborn for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section.

The following mandated benefits were enacted during the **1998** legislative session:

- Hospice Benefits: (HB 315) All health benefit plans must include a hospice benefit equal to the Medicare Benefit. This was mandated originally for standard plans in HB 250, enacted in 1994, and was expanded for all plans in HB 315.
- Diabetes Coverage: (HB 380) All health benefit plans must provide coverage for equipment, supplies, outpatient self-management training and education, and medications for the treatment of diabetes.
- Cancer Drugs: (HB 618) All health benefit plans must include coverage for any cancer drug for a particular indication, regardless of whether the drug has met FDA approval for

that indication. The drug must be FDA-approved for at least one indication.

- Women's Health Initiative: (HB 864) Requires health insurance plans to cover:
 - All stages of breast reconstruction surgery following a mastectomy resulting from breast cancer, if the plan covers mastectomies.
 - Diagnosis and treatment of endometriosis and endometritis if the plan covers hysterectomies.
 - And bone density testing for women age 35 and older.
 - The bill also prohibits insurers from requiring that mastectomies be performed as outpatient procedures.
 - Finally, the bill addresses victims of domestic violence by prohibiting carriers from denying coverage or refusing to renew coverage based on a victim's status and prohibiting carriers from considering domestic violence as a pre-existing condition.

- Autism: (SB 63) Requires all health benefit plans to provide coverage for the treatments of autism, including therapeutic, respite and rehabilitative care, at a maximum benefit of \$500 per month, for children age 2 through 21.
- Cochlear Implants: (SB 135) Requires all health benefit plans to provide coverage for cochlear implants for persons diagnosed with profound hearing loss.

HB 315 also set a new standard for any future mandated benefits. Any sponsor of a bill or amendment proposing a mandated benefit must include a financial impact statement on health insurance rates before the committee can make a final consideration on the bill. The department must review the impact statement, upon request, and provide comments to the standing committee of the General Assembly.

SB 1 and HB 3: 1997 Special Session

During the 1997 special legislative session on health insurance, SB1 and HB 3 received the most attention.

The chart that follows shows the proposed changes in each bill:

Rate Approval

SB 1 (as introduced)	HB 3 (as introduced)
Eliminate the 30-day waiting period and require the commissioner to issue an order approving or disapproving a filing within thirty 30 days; Extensions for an additional 30 days were possible.	Eliminate the 30-day waiting period and require the commissioner to issue an order approving or disapproving a filing within 45 days; no extensions permitted.
Remove the mandatory hearing trigger if a requested rate increase exceeds the percentage change in the medical consumer price index plus 3 percent.	Same.
If the commissioner determines an administrative hearing should be held, require the commissioner to schedule the hearing within 30 days (rather than requiring the commissioner to hold the hearing within 30 days.)	If the commissioner determines an administrative hearing should be held, require the commissioner to hold the hearing within 45 days from the date the filing is received and notify the Attorney General at least 30 days before the hearing.
Required rates for each policyholder to be guaranteed for 12 months from the rate in effect on the date of issue or renewal.	Required rates for each policyholder to be guaranteed for 12 months or the actual contract length, whichever is longer

<p>Maintained the Attorney General as a party to hearings, but if the AG requested a hearing, required the request to include detailed, specific reasons for the request.</p>	<p>Similar.</p>
<p>Allowed carriers the option of using a minimum loss ratio guarantee instead of receiving prior approval. The following minimum loss ratios were proposed:</p> <ul style="list-style-type: none"> ■ 65 percent for individual policies. ■ 65 percent for groups of two to 10. ■ 70 percent for groups of 11 to 50. 	<p>Permitted the commissioner to order a retroactive reduction of rates and make appropriate refunds upon a subsequent finding that the rates were unreasonable</p>

Rate Methodology

SB 1 (as introduced)	HB 3 (as introduced)
<p>Rates for individuals with similar case characteristics could not vary from the index rate by more than 35 percent.</p>	<p>Same.</p>
<p>Renewal rates for individuals (once under the proposed rate methodology for one policy term) were limited to:</p> <ul style="list-style-type: none"> ■ Percentage change in the new business premium rate. ■ Adjustments due to changes in case characteristics. ■ Adjustments for claims experience, health status or duration of coverage, not to exceed 10 percent. 	<p>Similar, except adjustments for claims experience, health status or duration of coverage, not to exceed 5 percent.</p>

<p>Rates phased in for health benefit plans issued to high-cost individuals of 25 percent for the first two renewal periods after the effective date of the act.</p>	<p>No phase-in for high-cost individuals noted.</p>
<p>Small group and association rates for members with similar case characteristics could not vary by more than 25 percent from the index rate</p>	<p>Same.</p>
<p>Renewal rates for small groups and associations (once under the proposed rate methodology) could not increase more than:</p> <ul style="list-style-type: none"> ■ The percentage change in the new business premium rate. ■ An adjustment for changes in case characteristics. ■ An adjustment for claims experience, health status, and duration of coverage, not to exceed 15 percent. 	<p>Same.</p>
<p>The ratio of the highest case characteristic to the lowest characteristic cannot exceed 5:1.</p>	<p>Same.</p>
<p>The index rate for a class of business can not exceed the index rate for another class of business in the same market segment by more than 20 percent.</p>	<p>Separate classes of business may be established.</p>
<p>Associations meeting specific requirements (defined as "employer-organized associations")</p>	<p>Same.</p>

could be rated based solely on the experience of the association, within the limitations applicable for small groups.	
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Guaranteed Issue

SB 1 (as introduced)	HB 3 (as introduced)
<p>Created the Kentucky comprehensive health insurance plan and guaranteed coverage in the plan for the following:</p> <ul style="list-style-type: none"> ■ HIPAA eligible individuals. ■ Or 12-month Kentucky residents who are not covered by other health insurance coverage and who had been rejected by at least two insurers for substantially similar coverage; or had been offered coverage at a rate greater than the plan rate; or had a high-cost condition. 	<p>For HIPAA-eligible individuals and 12-month Kentucky residents, coverage is issued on a guaranteed basis under either the standard health benefit plan or the largest premium volume plan offered to individuals.</p> <p>Coverage is not required to be issued if the individual's most recent coverage was canceled due to fraud or intentional and abusive noncompliance with contract terms.</p>
<p>Insurers must issue coverage to small groups of two to 50 employees on a guaranteed issue basis.</p>	<p>Same, but an insurer may establish contribution or participation rules.</p>
<p>Insurers are not required to issue coverage on a guaranteed basis for large groups of 51 or more employees.</p>	<p>Same.</p>

Risk Adjustment Process – SB 1 proposed a risk pool concept to cover high-cost individuals. The pool was to be governed by a six-member board appointed by the governor with the commissioner as chair. The pool would have been funded through assessments on

all insurers doing business in Kentucky based on a percentage of each insurer's premium.

HB 3 required all insurers to either offer coverage in the individual market or pay an assessment to cover the losses of the participating insurers.

Guaranteed Acceptance Program (GAP)

1998

House Bill 315 was enacted by the General Assembly in 1998. One of the key provisions was creation of the Guaranteed Acceptance Program (GAP).

GAP was created to reimburse insurance companies for losses above the premium collected for insuring people with specified high-cost medical conditions.

There are two ways an individual is eligible to be identified for GAP:

- The insured has a high-cost condition specifically identified in legislation.
- Or the insured fails to meet an insurer's underwriting guidelines, called the alternative underwriting mechanism or AUM.

GAP is funded through a variety of sources including:

- A one-time, \$10 million appropriation from the General Fund.
- An assessment on insurers issuing or renewing health benefit plans, based on market share and premium volume. The rate is set to

raise \$3.9 million for the last six months of 1998.

- If there is a deficit, a second assessment is possible, up to the amount of the first assessment. The total of the two assessments cannot exceed 1 percent of all assessable health benefit plan premiums written during the prior assessment period.
- A 2 percent assessment on premiums for stop-loss coverage

AUM: *The acronym for alternative underwriting mechanism. Under Kentucky's current law, an insurer can no longer deny health insurance to someone because of a medical condition. To compensate carriers for these high-cost conditions, the insurer can compare the individual's condition with an approved set of underwriting guidelines. If the individual would have been denied coverage for health reasons under previous state laws, the carrier can issue the individual a policy through the GAP program and receive reimbursement.*

for health insurance in addition to the other assessments.

- And any amount collected in health insurance premium tax revenue in excess of the amount collected in 1997. For example, if \$12 was raised in taxes in 1998 and \$10 in 1997, the \$2 difference would go to GAP.

All insurers issuing or renewing health benefit plans and all carriers issuing stop-loss coverage for health insurance are "supporting" carriers to GAP and assessed for its operation. Insurers may elect to be "participating" carriers and offer health benefit plan coverage to GAP-eligible individuals.

Participating carriers will be reimbursed each year for the amount of claims in excess of premiums incurred by a GAP-eligible individual to the extent GAP funds are available.

By June 1999, 1,443 were enrolled in GAP, the Guaranteed Acceptance Program reimbursing carriers for losses sustained while covering people with high-cost medical conditions.

Preliminary calculations showed the assessment on health benefit plan premiums would raise just over \$4 million,

adding to the one-time appropriation of \$10 million by the legislature.

National Legislative Initiatives

1990 - 1999

As part of the Congressional Budget Act of **1990**, Congress required Medicare supplement insurance to be offered as one of 10 benefit plans and to be guaranteed renewable.

Congress passed several other bills in 1990 affecting health care. Among them was the landmark Americans with Disabilities Act. The “ADA” expanded protections for the disabled against discrimination or lack of access.

The Older Workers Benefit Protection Act was passed to ensure employers provided older workers with benefits equal to younger workers, unless the cost of providing equal benefits was greater for the older worker.

The Soldiers and Sailors Relief Act was passed to ensure employer-provided health insurance was reinstated when a soldier returned from active duty.

Cost of health care, as well as “access,” was an issue in most elections during the early 1990s.

By **1993**, a newly elected Clinton administration created a task force to

tackle what many called a national health care crisis.

The Clinton task force made more than 1,000 pages of recommendations in 1993.

The resulting plan was called the “Health Security Act,” but it became known as the “Clinton Plan.”

The proposal identified six basic principles:

- Security. Every American should have comprehensive health benefits that could not be taken away.
- Simplicity. Reducing the paperwork was a goal.
- Savings. By increasing the size of insured groups, it was hoped this would spread the risk, increase purchasing power and hold down premium costs.
- Quality. Better health care with emphasis on wellness.

Choice. Preserve people’s right to choose doctors and increase the choice in health plans.

- Responsibility. Proposed that every employee and employer must contribute to the cost of health care.

Congress enacted another major health care initiative in 1993. The Family Medical and Leave Act required companies with more than five employees to allow up to 12 weeks of leave during any year for personal illness, birth, adoption, or illness of a spouse, child or parent. Employers do not have to pay the salary of the person while the employee is on leave, but employers do have to pay the health insurance premiums.

President Clinton's national health care plan continued to be debated in **1994**.

However, by the end of 1994, Congress and the administration had conceded defeat.

The failure of Clinton's proposal was attributed to a combination of factors. Most agree the two largest contributing factors were how complex the proposal was and the fear of government control of the health insurance market.

With the 1994 failure of Clinton's national health care plan, there was continued pressure to enact incremental health care reforms, but nothing of substance emerged from Congress until 1996.

On Aug. 12, **1996**, the U.S. Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). This law affects health insurance issued to small groups and certain eligible individuals, regardless of whether the health plan falls under federal (ERISA) or state insurance provisions. HIPAA provided for guaranteed issue of coverage to small groups of two to 50 employees.

HIPAA also required carriers to guarantee coverage to eligible individuals who met the following requirements:

- Had at least 18 months of prior creditable coverage under a group, government, or church plan. Creditable coverage is defined as a group health plan, health insurance coverage, Medicare Part A or B, Medicaid, CHAMPUS, a medical care program of the Indian health Service or a tribal organization, a state health benefits risk pool, a public health plan, or a health benefit plan under the Peace Corps Act.
- Was not eligible for coverage under a group health plan, Medicare Part A or B; or Medicaid.
- Does not have other health insurance coverage.

- Has not had most recent coverage terminated due to nonpayment of premium, fraud, violation of participation or contribution rules.
- Has exhausted COBRA or state continuation coverage, if offered and elected.
- Guaranteed renewability of all health plans except in the event of nonpayment of premium, fraud, violation of participation or contribution rules, the carrier's withdrawal of a product to all insureds, movement outside of the service area, termination of group membership.
 - Limit of 12 months for any exclusion for pre-existing conditions for health plans issued to small groups and up to 18 months for late enrollees.
 - No pre-existing condition exclusion period for eligible individuals.
 - Credit for any prior creditable coverage against a pre-existing condition exclusion period.

States were required to come into compliance with the federal changes related to small groups by July 1, 1997. States without a regular legislative session before July 1, 1997 (like Kentucky) could

receive an extension to implement the changes to the individual market.

In implementing changes related to guaranteed issue to eligible individuals, states could choose the federal plan specifically covered in HIPAA or could suggest an alternative. Kentucky chose the federal method, guaranteeing eligible individuals a choice of all products offered in the individual market.

Medical Savings Accounts – In addition to the insurance reforms, HIPAA also included a pilot program for medical savings accounts that provided tax incentives through the year 2000 for small employer or individual participants.

Mental Health Parity- The Mental Health Parity Act of 1996 was enacted by Congress on Sept. 26, 1996, and became law more than a year later, on Jan. 1, 1998. The law requires that health plans issued to large groups of more than 50 employees should assure similar benefits for physical and mental health.

For example, if such a plan provided medical and surgical benefits with a lifetime or annual dollar limit, then mental health benefit limits could not be lower than those limits.

An employer would be exempt from mental health parity if it was proven that the health plan cost at least 1 percent more after a six-month period of offering the benefit.

In **1997**, the Children's Health Insurance Program (CHIP) was created as part of a congressional budget bill on Aug. 5, 1997.

CHIP was part of the Balanced Budget Act of 1997 enabling states to create and expand health insurance coverage for uninsured children.

States could create a separate child health insurance program, use the Medicaid program or create a combination of both.

Funding for CHIP would be based on an enhanced match of state expenses beginning Oct. 1, 1997. Federal funds would be given to states with an approved state plan.

The Health Care Financing Administration would regulate the program federally and the Kentucky Department for Medicaid Services at the state level.

In **1998**, various bills were debated in the 105th Congress regarding patient protection issues. Some of the key issues included access to care, including to specialty care such as pediatrics, obstetrics

and gynecology, and emergency care. Also considered were continuity of care requirements, genetic testing issues, and expanded insurance coverage like medical savings accounts.

Quality assurance requirements were considered, along with disclosure requirements, procedures for denial of coverage and appeal of denials, gag-clause restrictions, and provider credentialing and termination procedures.

Women's Health - In October 1998, Congress enacted the Omnibus Appropriations act of 1998 which included a provision requiring all insurers issuing group health plans to provide coverage for reconstructive surgery for women undergoing mastectomies if the policy provided coverage for mastectomies.

In **1999**, Congress began debating a variety of proposals offering patient protections and a "Patient's Bill of Rights." Debate continued but no legislation was passed by the fall of 1999.

Market Trends

1990 - 1999

Consumer Price Index

The 1990s began with consumers seeing an overall break in inflation. But hospital and prescription costs continued to increase dramatically in comparison, hitting double-digit increases in 1990 alone.

The consumer price index increased as follows in **1990**:

- 5.4 percent for all goods.
- 9.0 percent for all medical care.
- 7.1 percent for physician services.
- 6.6 percent for dental services.
- 10.9 percent for hospital services.
- 8.4 percent for medical care commodities.
- 10 percent for prescription drugs.
- 5.1 percent for over-the-counter drugs.

As a comparison, in **1993** the consumer price index increased as follows:

- 3 percent for all items.
- 5.9 percent for all medical care.
- 5.6 percent for physician services.
- 5.3 percent for dental services.
- 8.4 percent for hospital services.

- 3.7 percent for medical care commodities.
- 3.9 percent for prescription drugs.
- 3.3 percent for over-the-counter drugs.

In **1994**, the consumer price index increased as follows:

- 2.6 percent for all items.
- 4.8 percent for all medical care items.
- 4.4 percent for physician services.
- 4.8 percent for dental services.
- 5.9 percent for hospital services.
- 2.9 percent for medical care commodities.
- 3.4 percent for prescription drugs.
- 1.9 percent for over-the-counter drugs.

In **1995**, the consumer price index increased as follows:

- 2.8 percent for all items.
- 4.5 percent for all medical care.
- 4.5 percent for physician services.
- 4.9 percent for dental services.
- 5.0 percent for hospital services.
- 1.9 percent for medical care commodities.

- 1.9 percent for prescription drugs.
- 1.9 percent for over-the-counter drugs.

The consumer price index for all medical care went up 3.5 percent in **1996**, while the CPI for all consumer goods increased only 2.7 percent.

Here are the specifics:

- 2.7 percent for all items.
- 3.5 percent for all medical care.
- 3.6 percent for physician services.
- 4.7 percent for dental services.
- 4.5 percent for hospital services.
- 2.9 percent for medical care commodities.
- 3.4 percent for prescription drugs.
- 1.9 percent for over-the-counter drugs.

The consumer price index increased 2.8 percent for all medical care in **1997**.

The CPI for all consumer goods increased only 1.7 percent.

Here are the specifics:

- 1.7 percent for all items.
- 2.8 percent for all medical care.
- 2.7 percent for physician services.
- 4.0 percent for dental services.
- 3.2 percent for hospital services.
- 2.3 percent for medical care commodities.

- 2.5 percent for prescription drugs.
- 1.1 percent for over-the-counter drugs.

The consumer price index increased 3.4 percent for all medical care in **1998**.

The CPI for all consumer goods increased by less than half that rate, at only 1.6 percent.

Here are the specifics:

- 1.6 percent for all items.
- 3.4 percent for all medical care.
- 3.3 percent for physician services.
- 4.4 percent for dental services.
- 3.1 percent for hospital services.
- 4.1 percent for medical care commodities.
- 4.9 percent for prescription drugs.
- 2.5 percent for over-the-counter drugs.

Health Insurance Rates

The same increases in medical expenses reflected in the consumer price index also began to show up in dramatic premium increases for consumers.

- In 1991, health insurance premiums increased almost 12 percent nationwide.
- In 1992, 11 percent.
- 1993, 8 percent.
- 1994, 5 percent.

- 1995, 2 percent.

Health care dollars

Here is how each health care dollar was spent nationally in **1990**:

- About 47 cents to hospitals.
- 31 cents to doctors.
- 7 cents to pharmaceutical claims.
- About 15 cents to program administration and the cost of private health insurance.

Here is how each health care dollar was spent nationally in **1993**:

- 44 cents to hospitals.
- 33 cents to doctors.
- 7 cents to pharmaceutical claims.
- At least 15 cents for program administration and cost of private health insurance.

Acquired Immune Deficiency Syndrome (AIDS) escalated as a medical expense in the 1990s. The national health insurance industry paid approximately \$550 million for AIDS claims in 1990 and approximately \$650 million for AIDS claims in 1993.

Closer to home, Kentuckians were feeling the same spiral in health care costs.

Here are the kinds of increases seen in Kentucky during the three-year period between 1990 and 1993:

- 9.5 percent for hospital care expenses.
- 6.5 percent for physician care.

In 1993, the average charge for an uncomplicated cesarean delivery was \$8,340 and for an uncomplicated vaginal delivery, \$5,510.

In **1994**, the private health insurance industry paid \$263.4 billion in health care claims nationally. Here is where each health care dollar went:

- 42 cents for hospital claims.
- 35 cents for physician claims.
- 7 cents for pharmaceutical claims.
- About 16 cents for program administration and cost of private health insurance.

Here is where each health care dollar went in **1995**:

- 40 cents to hospital claims.
- 34 cents to doctors.
- 8 cents to pharmaceutical claims.
- About 18 cents for program administration and the cost of private health insurance.

Solvency Issues

In Kentucky, nine of the 17 HMOs lost money in 1998.

Eight of the Kentucky-based HMOs infused a total of \$71 million of additional capital to stay afloat.

Six remain on monthly financial reporting, instead of the normal quarterly reporting, because of department concerns to closely monitor the situation.

The department continues to have concerns about the financial stability of the insurance market and the impact of this instability on consumers.

National financial problems with HMOs were continuing. HMOs in Kentucky lost more than \$70 million in the previous year and several remained on a monthly watch list for careful financial monitoring. Nationwide, 56 percent of the HMOs in the U.S. reported losses exceeding \$400 million.

History of Kentucky Health Carriers

1990 - 1999

1990-1993

Kentucky had 437 companies licensed to sell accident and health insurance. In 1993, direct premiums written were \$692,454,015. The average loss ratio was 90 percent, meaning 90 cents of every \$1.00 collected in premiums went to pay medical claims.

Eleven HMOs were licensed to conduct business in Kentucky at the end of 1993: Advantage Care, Alternative Health Delivery Systems Inc., Bluegrass Family Health, Choice Care, HealthWise of Kentucky, HMPK Inc., Hplan, Inc., Humana Health Plan Inc., Metlife Healthcare Network, PruCare, Southeastern United Medigroup Inc., and TakeCare. A total of 787,423 people were enrolled in HMOs. Direct premiums written were \$773,061,043.

Five of the HMOs were new in Kentucky in 1993. Two of the HMOs were Humana subsidiaries (HMPK, Inc. and Hplan, Inc.) and one was affiliated with Anthem.

Advantage Care Inc. was licensed in 1993, and was owned by the Lexington Clinic. Advantage Care was formerly

known as Lexington Health Advantage and primarily marketed in the Fayette County area. The other HMO licensed in 1993 was Bluegrass Family Health. Bluegrass marketed initially in the Lexington area and is owned by the Baptist Healthcare System.

Who left market: Aid Association of Lutherans was the only company that left the market in 1993.

Mergers & Acquisitions: The largest Kentucky insurance business combination in the early 1990s pertained to the Blue Cross and Blue Shield of Kentucky, Inc. merger with the Indiana Blue Cross and Blue Shield system, The Associated Group, Inc. As part of the business combination, the Kentucky Blues converted to a health maintenance organization and continued to market all types of products under its HMO license.

1994

Who was admitted to market

During 1994, Aetna Health Plan HMO was licensed to sell business in Kentucky. Its primary markets were Northern Kentucky and Louisville. Additionally, the

department licensed American Health Network of Kentucky, Inc., a subsidiary of Anthem.

Additionally, Blue Cross/Blue Shield of Kentucky became known as “Anthem Health Plans.” Lexington Health Advantage became known as “Advantage Care, Inc.” Metlife HealthCare Network merged with Travelers Insurance Co. and became known as MetraHealth Care. TakeCare Health Plan became known as FHP of Ohio, Inc.

Who left market

The following carriers offering health insurance left the market in 1994: Hartford Life and Accident Company and State Farm Mutual Insurance Cos.

1995

Who was admitted to market

Three health insurers entered the market in 1995.

- The Kentucky Department of Insurance licensed CHA HMO, Inc. Initially, CHA was located primarily in the Lexington area and is affiliated with the University of Kentucky.
- The department also licensed Healthsource Kentucky, Inc. It

does business primarily in the western Kentucky area.

- Heritage National Health Insurance Plan was admitted Dec. 8, 1995, as a licensed HMO. They were affiliated with John Deere Insurance Co.

Who left market

The following 31 carriers left the market in 1995 and all were licensed to write health coverage. The carriers covered 29,067 lives previous to their departure from the market.

The list is as follows: American National Insurance Co. of Texas; American Pioneer Life Insurance Co.; American Republic Insurance Co.; Bankers Life & Casualty Co.; Central Reserve Life ; Connecticut Life Insurance Co.; Community National Assurance Co.; Insurance Company of North America; Life of Georgia; John Alden Life Insurance Co.; Life Insurance Co. of North America; Metropolitan Life; Mutual of Omaha; Mutual Life Insurance Co. of New York; New York Life Insurance Co.; National Casualty Co., Nationwide Life Insurance Co.; Pan American Life Insurance Co.; Philadelphia American Life Insurance Co.; Physicians Mutual Insurance Co.; Phoenix Home Life Mutual; PM Group Life

Insurance Co.; Preferred Risk Life Insurance Co.; Pyramid Life Insurance Co.; Provident Indemnity Life Insurance Co.; Security Life Insurance Co. of America; Sentry Life Insurance Co.; Shelter Life Insurance; Union Bankers Insurance Co.; United World Life Insurance Co.; and Washington National Life Insurance Co.

1996

Who was admitted to market

The following were admitted to do business in 1996:

- Owensboro Community Health Plan, Inc. (d/b/a MedQuest HMO) on June 24, 1996. MedQuest initially offered coverage to both small and large groups and associations in Owensboro and surrounding counties.
- United Healthcare of Ohio, Inc. on December 11, 1996. United Healthcare of Ohio also participated in the group markets in the Northern Kentucky area.
- Tripoint Health Plan was admitted on Oct. 14, 1996.

Who left market

The following carriers notified the department of their intent to withdraw from the health insurance market, affecting the following number of people who were covered:

- Celtic Life Insurance Co., 1,122.
- Centennial Life Insurance Co., 4,466.
- Fortis Benefits Life Insurance Co., 12,916.
- General American Life Insurance Co., unknown.
- Golden Rule Insurance Co., 11,738.
- The Guardian Life Insurance Co., 190.
- MidAmerica Mutual Life Insurance Co., 114.
- Nippon Life Insurance Co., 20.
- Principal Mutual Life Insurance Co., 3,354.
- Trustmark Insurance Co., 496.

1997

Who was admitted to market

MSPA Health Plan was admitted as a licensed HMO on Feb. 20, 1997. They are affiliated with the University of Louisville.

Who left market

The following carriers notified the Department of Insurance of their intent to withdraw from the health benefit plan market in 1997:

- Connecticut National Life Insurance Co.
- Cuna Mutual Insurance Society
- John Hancock
- PFL Life Insurance Co.

Mergers & Acquisitions

MetraHealth merged with United Health Care of Ohio in March 1997.

1998

Who was admitted to market

The following carriers notified the Department of their intent to return to the market:

- Fortis Health, individual short-term policies.
- Physicians Mutual Insurance Company, individual short-term policies.
- Fidelity Security Life Insurance Company, individual short-term policies.
- Principal Financial Group, large group and small group health benefit plans.

- American General Insurance Company, large group health benefit plans.
- Nippon Life Insurance Company, large group health benefit plans.

Who left market

The following carriers notified the department of their intent to withdraw from the health benefit plan market in Kentucky in 1998:

- American Fidelity Assurance Co.
- Connecticut General Life Insurance Co.
- Continental Life & Accident Co.
- John Deere Insurance Co.
- Lamar Life Insurance Co.
- National Casualty Co.
- Pioneer Life Insurance Co.
- Tripoint Health Plan Inc.
- United Wisconsin Life Insurance Co.
- Washington National Life Insurance Co.

1999

Who was admitted to market

Principal Mutual Life Insurance Co. filed its policy forms and rates to participate in the small group health insurance market in Kentucky with a

statewide PPO and a traditional insurance product.

Nippon Life Insurance Co. returned to the large group health insurance market and filings for General American Life Insurance Co.'s return was pending.

Fortis Health began offering a short-term health benefit plan during the year.

Specifically, HMPK and HPLAN merged into Humana Health Plan.

Who left market

MedQuest HMO in Owensboro went out of business. The department assumed day-to-day operations of MedQuest, and liquidated the company on Nov. 1.

Mergers & Acquisitions

On Jan. 1, 1999, Southeastern United Medigroup Inc., doing business as Anthem Blue Cross Blue Shield, merged with Southeastern Group Inc., doing business as Anthem Health Plans. The new name for this merged company was Anthem Health Plans of Kentucky Inc. The parent company is Anthem, with headquarters in Indiana.

Also on Jan. 1, Alternative Health Delivery Systems Inc. merged with Anthem Health Plans of Kentucky Inc.

A series of Humana companies also combined their operations in June 1999.

History of Kentucky Kare

1990 - 1999

The state first offered its own self-insured health insurance plan to state employees after the 1988 General Assembly acted.

Kentucky Kare evolved from this legislative action.

The Personnel Cabinet initially managed the transition and began with an initial transfer of \$5 million and started with a reserve generated from the first three months of premiums before the first claims were received.

Kentucky Kare was offered specifically to state employees until 1994, when HB 250 allowed local governments to purchase coverage for their employees.

Individuals outside of government also could “buy in” to Kentucky Kare coverage through the “CommonHealth Program.”

Historically, the General Assembly set premiums for Kentucky Kare. For the first few years, there were two rates: single and family. The total premium needed to pay the medical expenses for state employees under the single plan was less than the combined amount the General Assembly granted for those state employees. This

meant Kentucky Kare received excess funds for the single plans and used the money to subsidize the family rate to keep rates affordable for state employees choosing the family plan.

In 1991, a parent-plus rate (parent and child/children) was offered. The Personnel Cabinet determined that Kentucky Kare rates should be set to only break even since Kentucky Kare was a not-for-profit entity.

With the 1994 General Assembly’s passage of HB 250, local government was allowed to purchase coverage for employees from Kentucky Kare.

Individuals outside of government could also “buy in” to Kentucky Kare coverage.

Kentucky Kare became part of the Alliance in 1994. The HMO Association commenced an action prohibiting Kentucky Kare from being part of the Alliance, but the court ruled in favor of Kentucky Kare.

By 1994, Kentucky Kare’s reserves had reached \$90 million.

At that point any individual who was a member of the Alliance could purchase Kentucky Kare's products.

For the first time, Kentucky Kare began losing money, paying \$1.04 in claims for every \$1 in premiums.

In overall operations, Kentucky Kare collected \$146.5 million and spent \$150.9 million.

Enrollment dropped by almost 10,000, to 55,071, in 1995, according to the Auditor of Public Accounts.

Kentucky Kare sustained considerable losses for its second consecutive year in 1996.

The loss ratio had reached 112 percent, meaning that \$1.12 was spent for every \$1 collected. Specifically, Kentucky Kare collected \$121.9 million and spent \$133.4 million for overall operations.

Although there was previous speculation as to whether Kentucky Kare could be offered to non-state employees, the 1996 legislation specifically permitted Kentucky Kare to be offered to members of the Kentucky Health Purchasing Alliance.

For the year ended June 30, 1996, Kentucky Kare's reported enrollment was 33,152. By December 31, 1996, enrollment totaled 32,545 contracts and

55,977 covered lives for public employees, and 6,721 contracts and 11,506 covered lives in the commercial market.

The 1996 enrollment of 32,545 compared to previous enrollments of 65,535 in 1992, 63,229 in 1994 and 55,071 in 1995, according to the Auditor of Public Accounts.

The 1996 General Assembly ordered Kentucky Kare to offer standard plans and market them through the Health Purchasing Alliance. The Alliance used third party administrators to collect all the premium, enrollment and other related information.

A third consecutive year of losses was having staggering consequences on reserves that once reached as high as \$90 million in 1994. By the end of 1997, reserves were drawn down to \$45 million after one-year losses of almost \$26 million.

Kentucky Kare spent \$1.24 for every \$1 collected during 1997.

In January 1997, Gov. Paul Patton created a new authority to oversee Kentucky Kare, by signing an executive order.

Total covered lives, including dependents, was 73,712 in August 1997. Included in that total were 52,117 public sector employees, dependents and retirees.

The 1998 General Assembly phased Kentucky Kare out of the private market, but left it operational for the public market. No new policies were to be issued or renewed on or after June 1, 1998, with the phase-out to be completed by June 30, 1999.

Kentucky Kare formally ceased operations as a result of a September 1998 vote of the Kentucky Kare Health Insurance Authority to not submit a bid to provide a health insurance plan to the state employee and retiree group for 1999. Kentucky Kare still exists as a legal entity but has ceased to sell health insurance policies to either public or private subscribers.

Kentucky Kare ended 1998 with total operating losses of almost \$35 million. Reserves had declined to less than \$11 million and would rapidly erode when premiums were no longer collected and claims expenses remained to be paid.

During the interim of 1999, lawmakers received a detailed report from Chief Economist Ginny Wilson, of the Legislative Research Commission, regarding all the factors leading to the financial collapse of Kentucky Kare.

History of Provider Issues

1990-1999

Prior to 1994, several bills were introduced to amend the Certificate of Need (CON) bills.

One of the bills was referred to as the Humana bill and was involved in the Boprot investigations.

The federal probe led to convictions of some legislators accused of accepting bribes and influence in support of a bill allowing favorable treatment to Humana's hospital business.

In 1994, HB 250 imposed several taxes on the gross revenues of health care providers.

Hospitals were taxed at a rate of 2.5 percent; physicians, nursing facilities, licensed home health agencies and health maintenance organizations were taxed at a rate of 2 percent and prescription drugs were taxed at a rate of 25 cents per prescription.

HB 250 created a new standard aimed at assuring that doctors, hospitals and other providers were given the chance to participate in any insurance carrier's network.

This provision was known as the "any willing provider" act. The law required an

insurance company to offer the same terms and conditions to any provider who wished to participate in the network within a geographic region.

In addition, a carrier could not exclude a provider if the provider was willing to meet the terms and conditions of the plan.

The Kentucky Health Policy Board was required to develop step-by-step guidelines for treatment of specific ailments, to be used by health care providers.

The intent was to standardize treatment and control costs.

HB 250 transferred the responsibility for administering the certificate of need (CON) law from the Cabinet of Human Resources to the Health Policy Board. A physician's office had to apply for a CON if requesting major medical equipment in excess of \$500,000. Each proposal approved by the Board is subject to biennial budget authorizations.

In 1996, the General Assembly enacted a tax on gross revenues received on physician services. The law, KRS 142.309, covers the period of Aug. 1, 1996, through

June 30, 1999. The tax was phased out according to the following schedule:

- 1.5 percent of gross revenues after July 31, 1996 and until June 30, 1997.
- 1 percent of gross revenues after June 30, 1997, and until June 30, 1998.
- 0.5 percent of gross revenues after June 30, 1998, and until June 30, 1999.

The provider tax on hospitals was unaffected and, therefore, the state continues to collect it.

On Dec. 12, 1996, the Department of Insurance convened the first meeting of the Task Force on Individual Health Insurance.

This task force was comprised of representatives of consumers, providers and the insurance industry (agents and carriers). After comments from the consumer and provider representatives that there was unequal representation on the task force, they divided into two separate task forces: The Industry Task Force on Individual Health Insurance and the Consumer/Provider Task Force on Individual Health Insurance.

The task forces met a total of 13 times between the initial meeting on Dec. 12,

1996, through the last meeting on Apr. 22, 1997.

They heard comments regarding the state of Kentucky's individual health insurance market from the Department of Insurance, carrier representatives, agent representatives, the Health Purchasing Alliance, provider representatives, consumer representatives, and the general public.

Following the meetings, each task force submitted their recommendations to improve the individual health insurance market in Kentucky.

Here are highlights from both task forces:

Consumer protections. Both task forces supported maintaining the consumer protections of guaranteed issue and renewability, of portability and treatment of pre-existing conditions.

Rate review process. Both task forces supported streamlining the rate approval process and removing the requirement for mandatory rate hearings. They differed in how to do this, with the consumer group wanting more “consumer friendly” details released about rate filings.

Standard health plans. The Industry Task Force recommended having only one standard plan while the Consumer/Provider

Task Force favored three plans to give choices to consumers.

The 25-cent tax on prescriptions was scheduled to expire June 30, 1999.

The 2.5 percent tax on hospitals is the only part of the provider tax that remains.

The following provider network initiatives were enacted during the **1998** legislative session (matching proposals considered but not enacted in the 1997 special session on health care):

- Each managed care plan must demonstrate an adequate number of providers.
- Each managed care plan must demonstrate that a provider network is within 30 miles or 30 minutes of each member's residence, as long as those services are available.
- Establishment of objective standards for providers to participate in a plan. Included: Allowing all providers an opportunity to apply at any time during the year or during an open enrollment. Also, provider participation rules must be provided to all applicants.
- Establishment of specific

procedures for removal or withdrawal of network providers.

- Notice to enrollees upon termination of a primary care physician on the provider network.
- Elimination of the "gag clause" regarding a doctor's disclosure of any information relating to an enrollees' medical condition or treatment options.

The following provider quality provisions were enacted during the **1998** legislative session (matching what was proposed but not enacted during the 1997 special session):

- Specific disclosures regarding covered services.
- How covered services may be obtained.
- Limits on covered services,
- Changes in benefits.
- Provider networks and changes to the network.
- Financial incentives between the insurer and participating providers.
- The right to appeal and the procedure for appealing a decision of the insurer.
- An insurers' procedures to ensure confidentiality of medical records and personal information.

- Reasonable standards for waiting times for appointments.
- Coverage for emergency room screening and stabilization without prior authorization based on presenting symptoms.
- Drug utilization review programs to ensure appropriate drug therapy and education for consumers.
- Time frames and procedures for denial of coverage
- Procedures to ensure continuity of care.
- Specific requirements for qualifications and duties of a medical director.
- Comprehensive quality assurance and improvement standards that are available to the public.

In **1999**, approximately 2,000 Louisville doctors announced in the spring of 1999 that they were going to drop out of the Aetna network because of a dispute over future contract terms. The group of doctors was known as The Physician Inc. (TPI).

The department intervened in the Aetna/TPI dispute because tens of thousands of residents in the Louisville metro area would see a substantial decline in their options for choosing a doctor in the

network. Furthermore, the dramatic changes in the number of doctors in the network would have occurred during the policy year of consumers.

The department intervened on behalf of consumers and ultimately was able to mediate an agreement where Aetna and TPI agreed to delay these changes until the next policy year for consumers so the public could make an informed choice at the time they renewed their health insurance coverage.

In a separate dispute, the department took the first enforcement action under the new “any willing provider” law. The department issued fines and an order against Bluegrass Family Health after complaints from western Kentucky doctors and a hospital that the Lexington health carrier was not offering the same terms and conditions to providers wishing to be listed on their network.

Bluegrass eventually offered a contract that the department deemed met the requirements of the law.

An initial review of each managed care plan’s provider network was completed in **February 1999**. The review analyzed access to and adequacy of the provider networks specific to primary care doctors, hospitals and six specialties (cardiology,

OB/GYN, pediatrics, ophthalmology, surgery and orthopedics.

The review also analyzed whether policyholders were within 30 miles of providers, another requirement of the law, and substantial compliance was determined.

The Department of Insurance issued the first sanctions under the “any willing provider law” when Bluegrass Family Health was challenged for not offering similar terms and conditions to Lourdes Hospital in western Kentucky.

History of Health-Related Litigation:

1990 - 1999

In **1990**, the state enacted a law requiring every college student to have minimum health care coverage through a qualifying student health program.

The Franklin Circuit Court ruled the law (KRS 304.18-115) was unconstitutional. Because the ruling was not appealed, the statute essentially was repealed and in 1994 the General Assembly removed it from the books.

In **1994**, the HMO Association challenged implementation of the provider tax to non-staff model HMOs. (A staff model HMO directly employs doctors to provide health care to members and a non-staff HMO contracts independently with doctors.)

The Franklin Circuit Court ruled in favor of the HMO association.

Golden Rule Insurance Co. challenged the constitutionality of HB 250 (the 1994 health care reform legislation). The case went to U.S. District Court, which upheld its constitutionality in 1995. Golden Rule withdrew its appeal from the 6th Circuit.

In **1995**, the Golden Rule Insurance Company challenged the constitutionality of HB 250 (the 1994 health care reform legislation.) The case was filed in U.S. District Court, which upheld its constitutionality in 1995.

Also in 1995, several trade associations sued the Kentucky Health Policy Board in Franklin Circuit Court. The lawsuit sought to exclude associations from the Modified Community Rating provisions of HB 250.

Plaintiffs included: the Kentucky Construction Industry Trust, Kentucky Bankers Association, Kentucky Automobile Dealers Association, Home Builders Association of Kentucky, Kentucky Thoroughbred Owners and Breeders, Kentucky Chamber of Commerce and Kentucky Farm Bureau.

The HMO Association sued on Oct. 5, 1995, in Franklin Circuit Court challenging the Alliance's authority to allow the general public to purchase health insurance from Kentucky Kare.

In **1996**, Golden Rule dropped its appeal to the Sixth Circuit, allowing to

stand the ruling of the U.S. District Court of Eastern Kentucky.

The federal district court upheld the constitutionality of HB 250.

Golden Rule paid the legal expenses of the Kentucky Health Policy Board and the Department of Insurance, as ordered, and then withdrew from the Kentucky health market.

Trade associations' lawsuit. In a separate case in January, the trade associations and the Kentucky Health Policy Board settled the Franklin Circuit Court case by agreeing associations with 100 or more members were exempt from Modified Community Rating.

CHP v. Commonwealth. This was a legal challenge filed by a network of providers who wanted an exclusive contract with Community Health Partners (CHP). The health insurer informed CHP that it could not offer exclusive contracts because of the state's "any willing provider" law.

CHP sued the Commonwealth on Dec. 9, 1996, in the U.S. District Court for the Western District of Kentucky, saying the "any willing provider" law was pre-empted by the federal law known as ERISA (Employee Retirement Income Security Act).

ERISA: *A federal law known as the Employee Retirement Income Security Act.*

This federal law governs large employers who offer their own self-funded health insurance coverage and the Department of Insurance has no jurisdiction.

The state has authority to regulate health insurance companies that provide coverage to Kentuckians.

In a number of cases, lawsuits have been filed to challenge enforcement actions by the state Department of Insurance, with plaintiffs claiming the federal law pre-empts state law.

In a number of important federal cases, the courts have defined where the boundaries are for state and federal regulators.

On June 11, 1998, the district court upheld the "any willing provider" law.

Anthem wins case to hold certain records private in rate hearing. In 1996, the Kentucky Supreme Court said the hearing officer in an Anthem rate case correctly withheld certain company records as private. The attorney general's office had challenged the closed records ruling,

which went all the way to the state's highest court.

Attorney General sues Anthem. In 1997, the Attorney General sued Anthem Insurance Companies to recover for the Commonwealth any charitable assets Anthem received when it merged in 1993 with the non-profit Kentucky Blue Cross/Blue Shield company.

By 1999, the case was in the discovery stage and Anthem had asked the Kentucky Supreme Court to review the Appeal Court's reinstatement of the charge against Anthem for unfair, false, misleading and deceptive practices under the Consumer Protection Act.

Anthem sues Department of Insurance. Anthem and its Southeastern group of companies sued the department in 1997 in Franklin Circuit Court, seeking to prevent further review of the companies' merger in 1993.

The case is still pending in late 1999.

HMO Association sues Nichols. The state's HMOs and their members challenged the "any willing provider" law, saying it was pre-empted by federal law.

The suit, *HMO Association v. Nichols*, was filed April 4, 1997, in U.S. District Court in the Eastern District of Kentucky. (In 1998, both the Eastern and Western

"Any Willing Provider" Law:

This is a state law that seeks to keep health insurance company's contracts open to any doctor or hospital willing to provide similar medical services for similar fees.

The goal of the law was to ensure that policyholders had as many choices as possible for their health care and that provider networks would include as many doctors and hospitals in an area that were willing to meet the insurer's terms and conditions.

Unsuccessful legal challenges arose when some providers sought to arrange for exclusive contracts with insurance companies.

districts had upheld the "any willing provider" law.)

Court upholds "any willing provider" law. The U.S. District Court of Western Kentucky upheld the "any willing provider" law on June 11, 1998, and said it was not pre-empted by the federal law known as ERISA (Employee Retirement Income Security Act.)

The case, *CHP v. Commonwealth*, was filed by Community Health Partners when they contended they could not get their

provider network recognized as an exclusive contract with CHA, a health insurer.

A second federal ruling upholds “any willing provider” law. On Aug. 8, 1998, the U.S. District Court’s Eastern District agreed with the Western District that the “any willing provider” law was not pre-empted by federal law.

This case involved *HMO Association v. Nichols* and was filed by the HMO Association and its HMO members in 1997.

Alliance sues Plan Source. In June 1998, the Health Purchasing Alliance sued Plan Source, alleging breach of contract and negligence. The case is pending in Franklin Circuit Court and alleges problems that occurred when Plan Source handled the paperwork as third-party administrator for the Alliance from July 1995 to June 1997.

In 1999, the Department of Insurance filed suit against United Chambers on behalf of the Health Purchasing Alliance. The suit alleged negligence and breach of contract by United Chambers, and its parent American Chambers, regarding how claims and paperwork were managed when United Chambers served as third-party administrator for the Alliance from July 1997 through December 1998.

The lawsuit also asked Franklin Circuit Court to determine the amount of premiums due and to resolve a financial accounting with all of the accountable health plans.

In separate litigation, the lawsuit continued on the legal test of the any willing provider law. The case, known as *CHP v. Commonwealth and the Kentucky Association of Health plans*, remained pending in the United States Court of Appeals for the Sixth Circuit.