The Health Insurance Market for Employees and Retirees of Kentucky State Government

ADOPTED BY PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

PROGRAM REVIEW & INVESTIGATIONS COMMITTEE STAFF REPORT

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LEGISLATIVE RESEARCH COMMISSION

Committee for Program Review and Investigations

Frankfort, Kentucky

August 12, 1999

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FOREWORD

On April 12, 1999, the Program Review and Investigations Committee directed its staff to prepare a report on the feasibility of reestablishing some form of a self-insured health plan for employees and retirees of the Commonwealth. Staff was instructed to investigate the reasons for the financial demise of Kentucky Kare, the state's previous self-insured plan, and to discuss the conditions under which a new self-insured plan might operate more successfully.

The Program Review and Investigations Committee adopted the staff report and recommendations on August 12, 1999.

This report is the result of dedicated time and effort by Program Review staff, Ginny Wilson, Ph.D., Committee Staff Administrator, Dan Jacovitch and Doug Huddleston, and secretary Susan Spoonamore. LRC intern Cory Birdwhistell, and Tom Hewlett and Alice Hobson, of the Program Review staff, provided valuable assistance with the survey of other states.

Robert Sherman
Director

Frankfort, Kentucky
August 31, 1999

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MEMORANDUM

TO: The Honorable Paul E. Patton, Governor
The Legislative Research Commission, and
Interested Individuals

FROM: Representative H. "Gippy" Graham, Co-Chair
Senator Marshall Long, Co-Chair
Program Review and Investigations Committee

SUBJECT: Adopted Committee Staff Report: The Health Insurance Market for Employees and Retirees of Kentucky State Government

DATE: August 31, 1999

On August 12, 1999, the Committee approved a study of the health insurance market for employees and retirees of Kentucky state government. The Committee had requested that staff review the reasons for the demise of Kentucky Kare and to consider whether it is feasible for the Commonwealth to establish a new self-insured plan to replace Kentucky Kare.

The major conclusion of the study is that Kentucky Kare failed primarily because it attracted a disproportionate share of older enrollees who utilized more, and more expensive, medical services than did enrollees in the regional managed care plans with which it competed. A lack of accurate data about enrollment, premiums, and claims seriously hampered the ability of managers to adequately respond to this situation.

The difficulties of Kentucky Kare were found to be similar to those experienced in the Blue Cross & Blue Shield Key Care plan in 1987 and 1988. That both fully-funded and self-insured state-wide indemnity plans suffered essentially the same fate indicates that, unless structural problems are corrected, a new self-insured state-wide indemnity plan would encounter the same financial problems as Kentucky Kare.

The report also concluded that the current absence of reliable and comparable data on claims patterns among members of the state group seriously hampers the ability to develop and assess major policy changes in the structure of the state group health insurance program. Therefore, the study offered the following recommendations.

- The Commonwealth should assert ownership of all enrollment, premium, and claims data for members of the state group.
- The Commonwealth should quickly develop the capability to analyze the health insurance data on the state group.
- A policy-making board should be created to develop recommendations considered equitable and technically feasible regarding how the state contribution should be structured, the design and implementation of an adequate risk-adjustment mechanism, and the creation of a new self-insured plan.
- The General Assembly should require regular reporting of data and analysis about the performance of the health insurance market for employees and retirees of state government.

Questions or requests for additional information should be directed to Dr. Ginny Wilson, Committee Staff Administrator for the Program Review and Investigations Committee.

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Introduction

The Program Review and Investigations Committee voted at its meeting of April 12, 1999 to have staff prepare a report on the feasibility of reestablishing some form of a self-insured health plan for employees of the Commonwealth. Staff was instructed to investigate the reasons for the financial demise of Kentucky Kare, the state's previous self-insured plan, and to discuss the conditions under which a new self-insured plan might operate more successfully. This report presents staff's response to the Committee's request.

The Committee's strong interest in the matter is understandable. The General Assembly appropriated more than $350 million to defray the cost of health insurance for nearly 132,000 employees and retirees of the Commonwealth in the current fiscal year (Table 1). The withdrawal of Kentucky Kare as a plan option generated strong statements of opposition from groups of education employees, state employees, and covered retirees. The purpose of this report is to provide an overview of issues pertinent to a decision by state policymakers to again self-insure some, or all, of the health insurance plans offered to those employees and retirees.

Source: Agency Reports

TABLE 1
KENTUCKY EXPENDITURES ON HEALTH INSURANCE
FOR THE STATE GROUP
(All Dollars in Millions)

	Active Employees			Retired Employees			
Fiscal Years	State Agencies	Boards of Education	Sub Total	State Agencies	Boards of Education	Sub Total	Grand Total
1992	$70	$115	**$185**	$12	$10	**$22**	**$207**
1993	$78	$136	**$214**	$14	$11	**$25**	**$239**
1994	$77	$133	**$210**	$17	$11	**$28**	**$238**
1995	$78	$170	**$248**	$21	$11	**$32**	**$280**
1996	$83	$170	**$253**	$20	$12	**$32**	**$285**
1997	$89	$191	**$280**	$24	$12	**$36**	**$316**
1998	$94	$207	**$301**	$27	$13	**$40**	**$341**
1999	$101	$214	**$315**	$29	$13	**$42**	**$357**

The report is presented in three sections. The first section gives an overview of the recent history of state employee health insurance in Kentucky, with particular attention devoted to the demise of Kentucky Kare. The second section contains information on the methods other states use to provide employee health insurance. Drawing on the first two sections, the final section offers conclusions and recommendations.

Note that the Committee did not request, nor does this report address, the details of the final financial resolution of Kentucky Kare, or the Health Purchasing Alliance with which it is inextricably bound. Staff had neither the time, access, nor expertise to play a significant role in these matters, which are currently in the hands of the litigators, auditors, and regulators who are attempting to bring them to resolution.

Also, at the time of this writing the Personnel Cabinet is in the final stages of evaluating responses to its request for proposals of insurance offerings for the state group in the upcoming plan year. This staff has not been involved in that process, so this report contains no information about the specifics of that effort.

Description of Health Insurance Plans

It may be helpful to the reader to have a brief explanation of various types of health insurance plans discussed in the report. The two basic distinctions involve responsibility for the financial risks associated with the plan and how much freedom the policyholder is given in choosing particular medical services.

The key difference between a fully-funded plan and a self-insured plan revolves around the matter of who absorbs the risk that medical claims incurred by the employee group will exceed the total premiums paid for the group. In a **fully-funded plan**, a private insurance carrier agrees to provide a specified set of benefits for an employee group at a negotiated monthly premium amount per contract. If the total medical claims of the group exceed the total premiums paid, the insurance carrier suffers the loss. Conversely, if the premiums exceed the claims, the carrier keeps the excess. Thus, in a fully-funded plan, all the financial risk is born by the insurance carrier.

A state government, or other employer, that chooses a **self-insured plan** assumes all financial risks associated with the medical claims of the covered group. If claims exceed anticipated amounts, the employer must allocate the additional funds to pay those claims. If claims are less than anticipated, then the employer gets to keep the extra funds. However, both fully-funded and self-insured plans usually purchase reinsurance to limit the total amount that can be lost.

Another important difference to note is between a traditional indemnity plan and a managed care plan. An **indemnity plan** normally imposes an initial deductible amount, say $300, that a policyholder must incur before the policy begins to cover claims. After the deductible is met, the policy pays a specified share (for example, 80 percent) of allowable charges for medical services. The remaining share (say, 20 percent) is paid by the policyholder and is called co-insurance. After some maximum out-of-pocket expense is incurred by the policyholder (for example, $1,500) the policy pays 100 percent of allowable claims up to a specified maximum (for example, $1 million). The policyholder has complete freedom to choose all health care providers and has unconstrained access to all covered medical services not deemed highly unreasonable by the utilization manager.

Various **managed care plans** impose differing levels of restrictions on a policyholder's freedom of choice in location and amount of medical services, in return for lower out-of-pocket costs and, usually, lower premiums for the same coverage. In **a preferred provider organization (PPO),** policyholder choices are restricted to a specified list of providers. They pay a smaller amount for care delivered by providers on the restricted list. Care received from providers not on the list comes at a higher cost. Otherwise, these plans are similar to indemnity plans.

In a **health maintenance organization (HMO),** policyholders must select a primary care physician. Charges for medical services are only covered if the primary care physician has authorized them, as in the case of a general practitioner referring a patient to a dermatologist. Normally, the primary care physician operates under financial incentives to reduce the policyholder's use of medical services judged to be excessive (for example, a visit to an expensive specialist for a problem that can be adequately managed by a general practitioner). Per-visit co-pays are imposed rather than the deductibles and co-insurance imposed by indemnity plans.

Finally, a **Point-of-Service plan (POS)** is a combination of an HMO and an indemnity plan. If the policyholder uses the HMO network and follows its rules, then the HMO coverage applies. However, the policyholder is given the choice of seeking medical services outside the HMO rules, but must pay deductibles, co-insurance, and maximum out-of-pocket expenses for the out-of-network services received, in a manner similar to an indemnity plan.

Explanation of Adverse Selection

The problems created by adverse selection are a major focus of this report. An explanation of adverse selection and its effect on insurance carriers may clarify the later discussion. Adverse selection can occur anytime policyholders in a particular group may choose among two or more insurance carriers. Adverse selection does occur if one of the carriers is chosen by a disproportionate share of policyholders with higher than average claims.

The simple example shown below shows the dramatic effect adverse selection can have on the financial fortunes of insurance carriers (Table 2). The example lists 10 individuals with equal premiums of $100 per month and varying average monthly claims. The distribution of the claims follows that often found among insurance carriers:

- 20 percent of policyholders account for 80 percent of claims
- 25 percent of policyholders have claims that exceed premiums
- 90 percent of policyholders have some claims
- 10 percent of policyholders pay premiums but have no claims

In the situation with no adverse selection, Carrier A and Carrier B get a proportionate share of premiums and claims. Both have premiums that exceed claims and, if they are efficient, would be likely to cover administration costs and make a small profit. This results in a structurally stable market where carriers can compete on the basis of quality of care and efficiency.

Their respective financial fortunes change dramatically in the presence of adverse selection, as shown in the right-most columns of the example table. By attracting a couple of policyholders whose premiums substantially exceed claims and repelling the small percentage of policyholders (only one in this example) with very expensive claims, Carrier A can achieve significant windfall profits, with premiums increasing to $600 and claims falling to $169. Conversely, Carrier B's premium receipts fall to $400, while claims jump to $818.

Significant adverse selection will result in an unstable insurance market in which carriers have a strong incentive to attract low-cost policyholders and repel high-cost policyholders, even if the total premiums paid by group members is sufficient to cover the claims of everyone in the group. A carrier facing significant adverse selection will be forced to raise premiums to cover the more expensive claims, which will drive away the healthier individuals, who can find cheaper premiums with another carrier. This sets up a classic death spiral for the disadvantaged carrier which, unchecked, leads to financial insolvency. Thus, adverse selection leads to an unstable insurance market in which carriers compete on the basis of their ability to attract relatively healthy policyholders and repel relatively unhealthy policyholders.

TABLE 2

HYPOTHETICAL EXAMPLE OF THE EFFECT OF ADVERSE SELECTION

			No Adverse Selection				Adverse Selection			
Distribution of Claims			Carrier A		Carrier B		Carrier A		Carrier B	
Individual	Premiums	Claims	Premiums	Claims	Premiums	Claims	Premiums	Claims	Premiums	Claims
1	$ 100	$ -	$ 100	$ -			$ 100	$ -		
2	$ 100	$ 2			$ 100	$ 2	$ 100	$ 2		
3	$ 100	$ 5	$ 100	$ 5			$ 100	$ 5		
4	$ 100	$ 8			$ 100	$ 8			$ 100	$ 8
5	$ 100	$ 10			$ 100	$ 10			$ 100	$ 10
6	$ 100	$ 12	$ 100	$ 12			$ 100	$ 12		
7	$ 100	$ 25	$ 100	$ 25			$ 100	$ 25		
8	$ 100	$ 120			$ 100	$ 120	$ 100	$ 125		
9	$ 100	$ 350			$ 100	$ 350			$ 100	$ 350
10	$ 100	$ 450	$ 100	$ 450					$ 100	$ 450
Total	**$ 1,000**	**$ 982**	**$ 500**	**$ 492**	**$ 500**	**$ 490**	**$ 600**	**$ 169**	**$ 400**	**$ 818**

Section 1: State-Employee Health Insurance in Kentucky

The Commonwealth first contributed funds for the health insurance premiums of its employees in 1972. From that time until the mid 1980's, Blue Cross & Blue Shield was the only insurance carrier offered to the state group. After experimenting with two HMO plans in 1981 and 1983, the Personnel Cabinet made more than a dozen additional plans, mostly HMO's, available to employees in 1984. Still, the indemnity plan offered by Blue Cross & Blue Shield was the dominant plan chosen. Of the 90,000 employees eligible for state-provided insurance in 1987, 64,000, or 71 percent, were enrolled in the Blue Cross & Blue Shield Key Care indemnity plan.[1]

Cancellation of the Key Care Plan

On September 14, 1987, Blue Cross & Blue Shield notified state officials of its intention to cancel the Key Care plan on October 15, 1987.[2] This date was the beginning of the second year of coverage that had been contracted for the biennial period. The stated reason for the cancellation was consistently late premium payments by the Commonwealth. However, the only significant delinquency specifically identified by the carrier was a $4 million payment by the Department of Education that was due June 1 but actually paid July 1, because of a budget shortfall at the end of the fiscal year.

Many state officials believed the real reason Blue Cross & Blue Shield decided to cancel the second year of its contract was not because of the payment pattern of the Commonwealth, but because the carrier was losing a substantial amount of money on the contract. According to an independent audit requested by the Commissioner of Insurance and conducted by Arthur Young & Co., Blue Cross & Blue Shield's estimated losses would have averaged approximately $1 million per month on the state contract from January 1985 to October 1988.

In the public documents reviewed, three explanations for the losses were given. First is that they were, in part, intentional. The President of Blue Cross & Blue Shield testified that the corporation's board had made a decision to approve the 1987 – 1988 state contract for the Key Care plan at the negotiated premium, even though it expected claims to exceed premiums by $5 - $6 million a year. The rationale given for this decision was that the corporation was willing to make a $5 - $6 million "investment" in this plan because of the $84 - $96 million per year the corporation realized on the overall state contract.

The Arthur Young & Co. report indicated that the Key Care plan paid $9.3 million more in claims than it received in premiums in 1985, and $5.7 million more in 1986. This loss doubled to $11.7 million in 1987 and, at the negotiated premium, was projected to increase to at least $14.4 million in 1988.[3] Thus, while Blue Cross & Blue Shield entered into the Key Care contract expecting some losses, actual losses turned out to be more than double what was anticipated.

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[1] "Blue Cross cancels state workers' coverage," *Kentucky Post*, September 15, 1987, p.1.

[2] Information on the cancellation of the Key Care plan comes from reports, correspondence, newspaper articles, and committee minutes that are contained in the September 24th meeting folder of the Committee on Appropriations and Revenue.

[3] *Rate Study for Blue Cross/Blue Shield Key Care Program,* Arthur Young & Co., July 1987, Commissioned by the Kentucky Department of Insurance.

Another reason given for the loss was that the wide variety of new, competing plans caused Key Care to lose a significant number of contracts in an unpredictable pattern.

> (Blue Cross & Blue Shield spokesman Tom) Ellis said the problems encountered by Blue Cross/Blue Shield had occurred in the last three years because of changes in the health care industry. State employees were allowed to choose between the Blue Cross/Blue Shield plan selected by the state and plans provided by different companies, including health maintenance organizations. It became very difficult for Blue Cross to predict how many employees would use each plan, he said.[4]

This explanation is supported by Arthur Young & Co. According to its report, Key Care lost 12,000 contracts during the 1986 open enrollment. The loss ratio on the contracts that left the plan was 21% better than on those that remained.[5] Thus, policyholders who left the plan were, on average, healthier than those who stayed.

A third reason offered was that the monthly premiums negotiated by the state were inadequate to fund the stipulated benefits for the group covered.

> In a letter Oct. 1, 1986, to Kentucky Supreme Court Chief Justice Robert F. Stephens, (Blue Cross President) Sutherland stated, "It has been evident for many months the state's benefit expenditures were exceeding the monthly premiums.: Sutherland's letter said the state did not budget enough to pay for the health-insurance contract in early 1986. And later the state asked for a contract that included high benefits and low premiums, the letter stated."It is not a lack of our actuarial abilities or timely reporting that is deficient," Sutherland wrote. "A more meaningful understanding of this situation centers around the unrealistic (bid request by the state) and a lack of commitment by the state to budget necessary funds."[6]

Gil McCarty, then Commissioner of Insurance, concurred in that assessment, publicly stating that "The problem is that state insurance premiums are too low for Blue Cross/Blue Shield and many other insurers to make a profit....I hope somebody has got a lot of money in their pockets if they are going to pick up this coverage at the same rate."[7]

Other than the simple fact that the state's long-time primary insurance carrier decided to cancel its contract, there appeared to be two major factors that caused the greatest concern for state policymakers. First was that losses on the plan reached crisis proportions with little advance warning for public officials. The cancellation notice came as a surprise because state officials had little or no knowledge that the claims of the Key Care group were running so far ahead of premiums. Senator Michael Moloney, then Co-Chairman of the Appropriations and Revenue Committee, acknowledged that state policymakers needed to have much better access to information on the medical costs of state workers.

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[4] Jordan, Jim, "Blue Cross blames changes in health care," *Lexington Herald- Leader*, September 17, 1987, p. 1.

[5] A loss ratio is calculated by dividing total claims by total premiums. Thus, for total claims of $64 million and total premiums of $80 million, the loss ratio is $64 million/ $80 million, or 80%. A loss ration below 100% means that premiums are more than claims, a loss ratio above 100% means that claims are more than premiums. Thus, the loss ratio is a standard measure of the financial health of an insurance plan.

[6] Hershberg, Ben A. and Tom Loftus, "Blue Cross defends canceling state plan," *Louisville Courier-Journal*, September 17, 1987, p. B-1.

[7] Jordan, Jim and Jack Brammer, "Blue Cross faced big loss on contract," *Lexington Herald-Leader*, September 16, 1987, p. 1.

The second major concern was that the cancellation of the policy a mere 30 days before the new contract year was to start put a great deal of pressure on state officials to quickly rebid and select a new contract, a process that normally takes months. State officials were very concerned that 67,000 state employees and their families might have a temporary lapse in health insurance before alternate coverage could be arranged. Some charged that the difficulty of this task led Blue Cross & Blue Shield managers to believe that state officials would agree to their mid-contract request for a 16 percent increase in the negotiated premium of $79.71 per single contract and $190.81 per family contract, rather than allowing the cancellation to proceed.

In the end, state officials did not agree to the 16 percent increase. Blue Cross & Blue Shield agreed to extend the Key Care plan for an additional two weeks and the 1988 state contract was re-bid. New carriers were chosen to provide coverage for state employees for the year, without a lapse in coverage for any policyholders.

Kentucky Kare

Largely because of their experience with Key Care, state policymakers decided they were no longer willing to be completely dependent on private carriers to provide insurance coverage to state employees. The 1988 General Assembly amended KRS 18A.2281 to allow the Department of Personnel to establish a self-insured health insurance plan for state employees. The $5 million left in a reserve fund upon termination of the Key Care contract was transferred to the Kentucky Kare Trust. No other direct appropriations of state funds were made to the Trust.

The plan began operation in October of 1988 and offered a set of benefits similar to the Key Care indemnity plan. The original third party administrator (TPA) of the plan was ICH Corporation, and Health Care Review Corporation provided utilization management. Initial reserves were accumulated, since three months of premiums were received before claims began to come due.

As part of extensive changes to health insurance laws adopted in HB 250, the 1994 General Assembly allowed local governments to purchase employee coverage from Kentucky Kare. HB 250 also established the "CommonHealth of Kentucky" program (more commonly known as the "buy-in" program), which allowed any Kentucky resident to purchase health insurance as part of the state employee group. Applications were to be accepted only between the time the law became effective in July 1994 and the time that the Kentucky Health Purchasing Alliance (the Alliance) was to become operational in July 1995. At that time, those in the buy-in group were to be transferred to the individual segment of the Alliance group. Also, in 1995 ICH was replaced by Humana as the TPA.

The 1996 General Assembly mandated that Kentucky Kare offer only standard plans marketed through the Alliance, and that the plans be made available to individual purchasers in the market who were not members of a public-employee group. All premium and enrollment data was now collected by the TPA of the Alliance, originally PlanSource and later, United Chambers.

On January 31, 1997, Governor Patton signed an executive order creating the Kentucky Kare Health Insurance Authority to oversee the operations of Kentucky Kare and hire its executive director, and moved the Kentucky Kare Health Insurance Fund from the Personnel Cabinet to the Finance and Administration Cabinet. HB 315, adopted by the 1998 General Assembly, phased Kentucky Kare out of the private insurance market. Finally, because of declining

enrollments and depletion of the reserve, the Authority voted in September 1998 to not submit a bid to provide a health insurance plan to the state group in 1999, leaving Kentucky Kare in existence as a legal entity but ceasing all health insurance business, save for the payment of outstanding claims.

Table 3 and Figure A display the financial and enrollment history of Kentucky Kare from its first full year of operation in 1990, through 1998.[8] Plan enrollments peaked at 65,500 in 1992, declined slightly to 63,000 by 1994, dropped sharply to 55,000 in 1995 and plunged to 33,000 in 1996. Although enrollments rebounded to 43,000 in 1997, they fell back to 33,000 again in 1998, when the decision was made to take all Kentucky Kare plans off the market. Examination of total premiums versus total claims indicates that premiums exceeded claims until 1995; in subsequent years claims exceeded premiums by an increasing amount.

The difference between total revenues and total expenses in any year, plus retained earnings at the beginning of the year, equals the retained earnings at the end of the year. This is the reserve available to pay unexpectedly large claims and those claims incurred but not yet reported (IBNR). Kentucky Kare's reserves at the end of the fiscal year grew steadily, from approximately $20 million in its first full year of operation to near $90 million in 1994. Reserves at the end of its last year of operation were estimated to be roughly $10 million. Because there is significant dispute as to whether Kentucky Kare is owed money from either the Alliance or its TPAs, due to significant underpayment of premiums and inappropriate payment of claims, and because there is also significant uncertainty about the final dollar amount of IBNR claims, it is unknown at this time whether the final reserve will be sufficient to pay all outstanding financial liabilities.

[8] Financial and enrollment data for plans offered through the Health Purchasing Alliance, including those of Kentucky Kare, is known to be completely unreliable. Even though the reported data is drawn from official publications prepared by the Auditor of Public Accounts (1990 – 1997) or Kentucky Kare (1998), figures for 1996 – 1998 may be significantly adjusted if a full reconciliation is ever achieved. While the figures may not be accurate, they are reported here because they do present a reasonable picture of the demise of Kentucky Kare.

Table 3
Kentucky Kare Financial and Enrollment History

Financial History
$ Millions

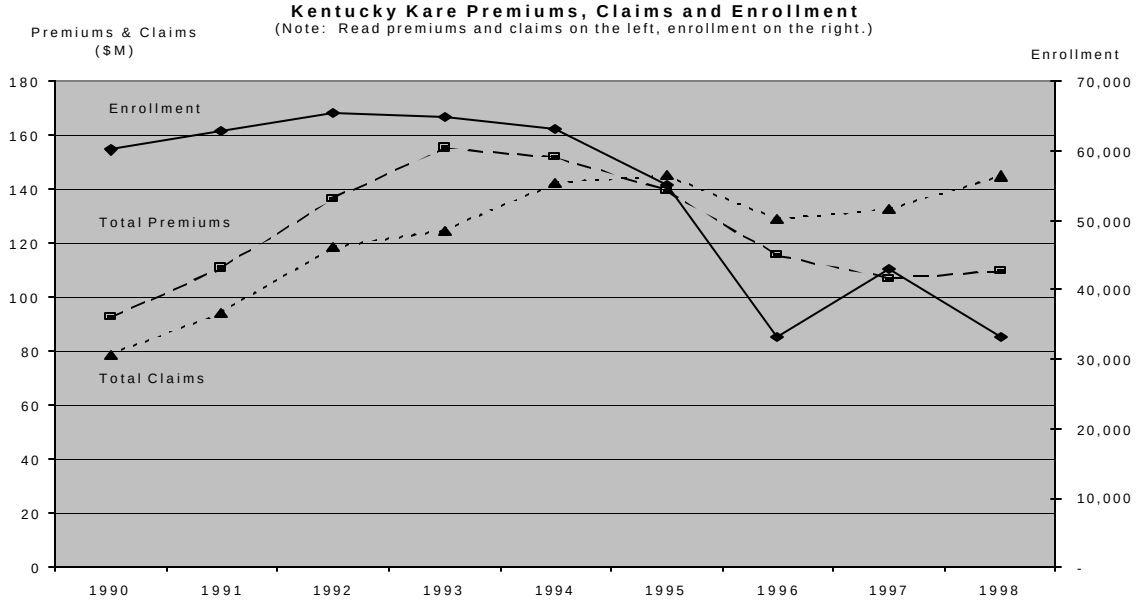
Category	1990	1991	1992	1993	1994	1995	1996	1997	1998
Operating Revenues									
Premium Earned	92.52	111.01	136.64	155.33	151.97	139.53	115.55	107.10	109.75
Interest Earned	2.97	3.45	3.29	3.32	4.10	6.99	6.29	4.64	2.55
Miscellaneous Income							0.05		2.67
Total	**95.49**	**114.46**	**139.92**	**158.66**	**156.08**	**146.52**	**121.89**	**111.75**	**114.97**
Operating Expense									
Interest Expense					0.07	0.18			
Claims	78.87	94.37	118.64	124.87	142.52	145.14	129.02	132.63	145.00
Total	**83.53**	**99.56**	**124.23**	**130.75**	**148.40**	**150.90**	**133.40**	**137.51**	**149.92**
Operating Income	11.95	14.90	15.70	27.90	7.68	(4.38)	(11.51)	(25.76)	(34.95)
Retained Earnings at Beginning of	9.18	21.14	36.03	51.73	79.63	87.31	82.93	71.41	45.65
Retained Earnings at End of Year	21.14	36.03	51.73	79.63	87.31	82.93	71.41	45.65	10.70
Loss Ratio	**85%**	**85%**	**87%**	**80%**	**94%**	**104%**	**112%**	**124%**	**132%**
Admin. As Percent of Expense	**6%**	**5%**	**5%**	**5%**	**4%**	**4%**	**3%**	**4%**	**3%**

Enrollment History

Category	1990	1991	1992	1993	1994	1995	1996	1997	1998
State Employees	16,914	17,608	17,964	16,905	15,391	12,257	5,645	5,372	4,461
Boards of Education	37,467	39,568	41,499	41,648	41,308	35,573	17,931	15,983	12,346
Local Health Departments	1,491	1,694	1,867	1,938	2,036	1,556	3,516	632	460
Retirees	3,794	3,784	3,777	3,945	4,045	3,933	3,245	8,530	8,735
COBRA	457	489	428	442	449	1,752	2,815		
Buy-In								697	605
Universities								265	246
Other Public Sector								465	41
Commercial Small Group								4,275	3,283
Individuals								6,745	3,104
Total	**60,123**	**63,143**	**65,535**	**64,878**	**63,229**	**55,071**	**33,152**	**42,964**	**33,281**
Percent of Total									
Boards of Education	62%	63%	63%	64%	65%	65%	54%	37%	37%
Active Employees	93%	93%	94%	93%	93%	90%	82%	51%	52%
Retirees	6%	6%	6%	6%	6%	7%	10%	20%	26%
Buy-in	0%	0%	0%	0%	0%	0%	0%	2%	2%
Perform Groups (Excluding Buy-in)	0%	0%	0%	0%	0%	0%	0%	27%	20%

1990 - 1997 from the Auditor of Public Accounts; 1998 from Kentucky Kare

Figure A
Kentucky Kare Premiums, Claims and Enrollment
(Note: Read premiums and claims on the left, enrollment on the right.)



Factors Responsible for the Demise of Kentucky Kare

Many reasons have been offered for the demise of Kentucky Kare. Evaluating those reasons is like conducting an autopsy on a victim who has suffered multiple stab wounds. While it may be possible to distinguish between injuries that, taken singly, might have been harmful but not fatal and those serious enough to have been fatal, it is difficult to specify exactly which particular wound was "responsible" for the victim's death. When combined blood loss from all wounds reached a critical level, the victim was lost.

This section evaluates various factors that may have contributed to the financial failure of Kentucky Kare as a self-insured plan for employees of the Commonwealth. Factors are categorized as either less serious or more serious. Less serious factors are those that may have been harmful but, in isolation, would not have been likely to cause the plan to fail. More serious factors are those that, even in isolation, could have been damaging enough to result in financial insolvency.

Less Serious Factors

In the public discussion of the financial problems of Kentucky Kare, many factors have been raised. The ones discussed in this section are not judged sufficient to have brought about the plan's demise in the absence of the more serious factors. Included in this category are management performance, administrative costs, the requirement to offer policies in the private market, standard plans, and flexible spending accounts.

Management Performance. Officials of Kentucky Kare have come under intense criticism for not having been more successful in managing its financial operations. Two particular aspects of management performance, inadequate utilization review and inability to resolve problems with the TPA, allowed serious problems to develop. (These two problems are discussed in the second category of factors.) Staff does not offer an opinion on the overall quality of the management of Kentucky Kare. However, the conclusion is that it is unlikely that managers of any quality could have prevented the financial failure of Kentucky Kare under the conditions in which it operated during the last 5 years.

Two areas in which the management of Kentucky Kare was clearly deficient were in the size of its staff and in its failure to adequately respond to problems that were identified. At its largest, the organization only had 10 employees. For much of its history it operated with significantly fewer than that number. Only after several years of operation was an internal staff person hired to monitor financial transactions: a bookkeeper was hired in 1996, and an accountant in 1997. It is unreasonable to expect that a staff this limited in scope could adequately oversee all aspects of the TPA contracts and evaluate plan data in order to recommend sound financial decisions for a health insurance operation with over $100 million in annual transactions.

Even though it may be understandable that Kentucky Kare managers did not always exercise adequate oversight because of inadequate staffing, once serious problems were identified by outside auditors, managers had the responsibility of seeing that those problems were addressed. Appendix B presents a summary of serious concerns raised by independent auditors in each year of Kentucky Kare's operation. From the beginning, auditors identified weaknesses in the internal control structure for financial, enrollment, and claims data. It was found that, when control procedures were designed into systems, processors sometimes purposely overrode them. A reading of the annual findings portrays a situation where repeated warnings of problems were ignored, and where the scope and seriousness of the warnings escalated over time until they reached crisis proportions.

Costs of Administration. In the early years of operation, administrative expenses accounted for approximately 6 percent of Kentucky Kare's total expenses; they declined to 3 percent by 1998. This is far below the industry norm of around 15 percent. Thus, excessive administrative expenses were not a factor in the plan's financial problems. The real problem with the level of administrative expenses is that they may have been too low. As is discussed below, the problem was that not enough resources were devoted to utilization management, TPA oversight, and data collection & analysis, and this led to the development of some of the more serious problems.

Requirement to Offer to Private Policyholders. Some have blamed Kentucky Kare's demise on health care reform legislation adopted in 1994 (HB 250) and revised in 1996 (SB 343) and 1998 (HB 315). The changes adopted in these pieces of legislation were varied and extensive. However, the one most often mentioned in relation to the failure of Kentucky Kare was the requirement to offer policies to non-governmental employees. These were comprised of three groups – individual policyholders, small employers, and the buy-in group.

Because the premium data from the Alliance is so flawed, it is not possible to calculate a reliable loss ratio for any of these groups. However, the limited information available supports the conclusion that neither the individual nor the small-group policies contributed in any significant way to the losses suffered by Kentucky Kare. As shown in Table 4, individual policies accounted for 12 percent of covered lives, but only 5 percent of claims. Small-group policies accounted for 5 percent of covered lives and 3 percent of claims. These were the only two groups that had a smaller percentage of claims than their percentage of covered lives. Even if it is finally shown that the loss ratios on these groups exceeded 100%, their claims comprised such a small share of the total that they could not have been a major factor in the plan's financial collapse.

Table 4			
Kentucky Kare			
Covered Lives and Claims			
CY 1996			
Group	**Number of Covered Lives**	**Claims ($M)**	**% of Covered Lives**	**% of Claims**
Individual	7,979	$ 5.3	12%	5%
Small Group	3,446	$ 3.2	5%	3%
Buy-In	1,127	$ 4.1	2%	4%
Active State Employees	13,434	$ 21.8	19%	19%
School Employees	35,763	$ 59.7	52%	53%
Other Public Employees	1,696	$ 3.3	2%	3%
Retirees	5,587	$ 15.6	8%	14%
Total	**69,005**	**$ 112.9**	**100%**	**100%**
Source: LRC Staff analysis of data supplied by Humana, Inc., the claims administrator for Kentucky Kare and by PlanSource, former data administrator for the Kentucky Health Purchasing Alliance				

There is no question that the loss ratio on the buy-in group was well above 100 %. They accounted for twice the percentage of claims as they did covered lives in 1996. Kentucky Kare officials estimated that the average monthly loss on a buy-in policy in CY 1997 was $179.13, for an annual average of $2,150.[9] Multiplying by the average buy-in enrollment of 667 for the period July 1996 to December 1997 yields an estimated net loss of approximately $1.4 million per *year* on the buy-in group. While this represents a substantial loss, it pales in comparison to the estimated $2.5 million total Kentucky Kare loss per *month* projected by the Department of Insurance for a similar period.[10]

Standard Plans. Another feature of HB 250 that was retained in SB 343 was the requirement that insurance carriers sell only standard plans. The rationale was that, given a standard set of benefits from which to choose, policyholders would be more likely to choose plans on the basis of quality of services and price, rather than confusing variations in benefits offered.

A comparison of state-employee plan choices before and after the imposition of standard plans supports the hypothesis that standard plans made purchasers more responsive to price differences. Analysis of data on plan selection indicated that, in the year prior to standard plans, price was not a statistically significant factor in predicting the market share of any plan. In the year after the adoption of standard plans, it was determined that a 10% increase in price resulted in a 20% lower market share.

Thus, while standard plans may have had the intended effect, Kentucky Kare was one of the plans that lost significant market share when they were adopted. However, it is unlikely that the imposition of standard plans alone would have killed Kentucky Kare. As will be discussed below, the combination of standardization and a single offering

[9] Finnegan, Robert, "Executive Director's Report" presented to the Kentucky Kare Health Insurance Authority meeting on January 28, 1998.

[10] On February 26, 1996, Kentucky Kare requested a reimbursement of $1 million for losses incurred on the buy-in group under KRS 18A.2251. A one-time payment in this amount was made to the plan. While this reduced the total loss suffered on the buy-in group, it did not completely offset it.

(Anthem's Option 2000 Advantage plan) that was priced substantially below all other plans with the same benefits did result in a major disruption to Kentucky Kare's operations.

Flexible Spending Accounts. In September 1995, Governor Jones announced that, for the first time, employees who chose a plan that was cheaper than the state's contribution for single coverage would be allowed to have the difference deposited in a flexible spending account. Flexible spending accounts allow employees to accumulate before-tax funds and use them to pay for allowable health care expenses not covered by insurance. Here, again, the expected effect would have been to make employees more price-sensitive in choosing plans.

Two additional concerns have been raised regarding the flexible spending accounts. First is that allowing employees who choose plans cheaper than the state contribution to, in effect, keep the difference means that the money can no longer be used to subsidize others who choose more costly coverage. However, that amount was not large. According to 1996 data analyzed by staff, 58,000 public employees chose coverage that was less expensive than the state contribution of $175.50. The average difference was $19, for a total amount of approximately $1.1 million. Since this amount was spread among all plans, the loss of this subsidy opportunity would not have made a significant difference to Kentucky Kare.

A second concern is that, given the option, healthy public employees might waive state-provided coverage and deposit their state contribution into the flexible spending account. This would mean the remaining, less healthy, insured would have higher average claim costs. This does not appear to be a significant problem. First, employees of the state are only allowed to waive coverage if they have alternate coverage. However, employees may choose to waive coverage for dependents.

According to enrollment data analyzed by staff, 8.5 percent of public employees waived dependent coverage in 1997, and approximately 90 percent of them said they did so because the dependent(s) had alternate coverage. Fewer than one-half percent of those who did so said they waived the coverage because they didn't need it. Only if there is some bias that results in healthier people waiving coverage would the average claims experience of the remaining group be worsened.

Absence of Reinsurance. It is normal for insurance carriers to reinsure themselves for large unexpected claims, either for individual claims above a certain amount (say $50,000) or for total claims above a certain amount (say $100 million). Kentucky Kare managers have been criticized for not purchasing reinsurance. However, reinsurance is priced to cover *unexpected* claims on a plan-year basis. Given its continuing problems, it is unlikely that Kentucky Kare could have purchased sufficient reinsurance to mitigate its problems at a price that would have been feasible.

More Serious Factor

Three problems faced by Kentucky Kare were serious enough, by themselves, to cause severe financial difficulty for the plan. These are adverse selection, inadequate premiums, and the absence of timely and reliable enrollment, premium and claims data.

Adverse Selection. As was discussed in the example in the introduction, when policyholders within some group are allowed to choose among more than one plan there is the risk that adverse selection will occur. Adverse

selection occurs when one of the competing plans gets a disproportionate share of policyholders with higher than average claims. This is particularly damaging to the plan that gets the disproportionate share if premiums are paid on a community-rated basis that is not fully adjusted for risk factors, such as age, gender, or health status.

An example of the age and gender effects on claims is shown in Table 5, based on 1996 Kentucky Kare claims. The average claims of women between 21 and 30 were 2.5 times the claims of men in the same age group. Among women, those between 61 and 64 had average claims 2.6 times those aged 21–30. Men who were 61– 64 had average claims 6.7 times those aged 21–30.

TABLE 5
Gender and Age Ratios
Kentucky Kare
Claims Incurred in 1996

	Females				Males				Female to Male Gender Ratio
Age	Covered Lives	Total Claims	Claims per Covered Life		Covered Lives	Total Claims	Claims per Covered Life		
			(A)				(B)		(A/B)
21-30	4,065	$ 4,924,887	$ 1,212	(C)	3,004	$ 1,576,999	$ 525	(E)	2.3
31-40	6,210	$ 9,104,510	$ 1,466		3,628	$ 3,362,796	$ 927		1.6
41-40	10,412	$19,655,735	$ 1,888		6,376	$ 9,510,861	$ 1,492		1.3
51-60	7,710	$19,428,310	$ 2,520		5,094	$13,762,906	$ 2,702		0.9
61-64	2,497	$ 7,840,572	$ 3,140	(D)	1,667	$ 5,863,697	$ 3,518	(F)	0.9
Total	30,894	$60,954,014	$ 1,973		19,769	$34,077,259	$ 1,724		1.1
	Age Ratio	---------->	2.6				6.7		
			(D/C)				(F/E)		

Source: LRC staff analysis of data supplied by Humana, Inc., the claims administrator for Kentucky Kare and by PlanSource, former data administrator for the Kentucky Health Purchasing Alliance.

For the same year it was determined that 20 percent of policyholders accounted for 80 percent of total claims. Among all individuals covered, one percent accounted for 29 percent of total claims. If these distributions are similar to that for all policyholders in the group, it is clear that a disproportionate distribution of even a small number of policyholders, if they are in the higher-cost groups, would have a large negative financial effect on the carrier that got the disproportionate share.

Note that, in Kentucky Kare's case, it is not the conditions normally considered "high-cost" that accounted for most of its claims. In 1996, the five specific diagnoses accounting for the largest amount of total payments were coronary atherosclerosis, back problems, gall bladder disease, breast cancer, and heart attack – conditions normally associated with those middle aged and beyond. Together, these diagnoses accounted for $16.5 million in payments. This is compared to less than $1 million for payments for diabetes mellitus, epilepsy, cystic-fibrosis, multiple sclerosis, Parkinson's disease, HIV and Aids, all combined. Thus, diseases associated with aging accounted for a much larger share of total claims than those often defined as high-cost.

Table 6 shows the share of the total number of contracts in the state group held by Kentucky Kare, compared to its share of total contracts from employees of state agencies and boards of education, and from retirees. Since its

inception, Kentucky Kare held a disproportionate share of retiree contracts and a less than proportionate share of contracts from state agencies. Until 1997, Kentucky Kare's share of contracts from employees of boards of education has remained roughly 4 percent above its share of total contracts education has remained roughly 4 percent above its share of total contracts.

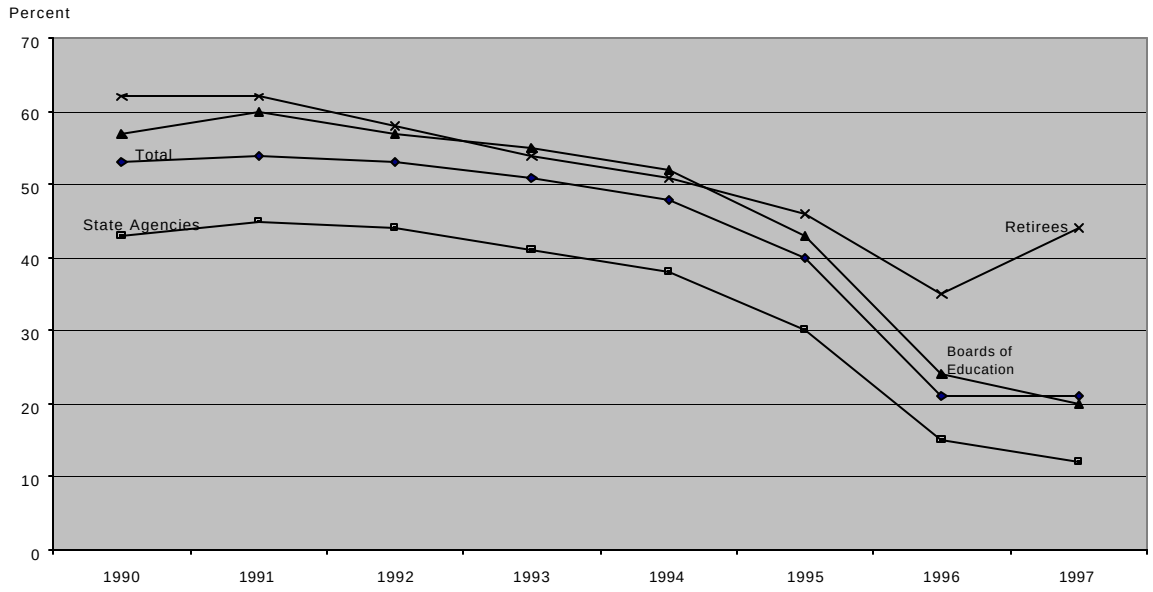
Table 6

Kentucky Kare Enrollment as a Percent of Enrollment of all Carriers

Years	Percent of Total Enrollment of All State Contracts	Employees of State Agencies	Employees of Boards of Education	Retirees
1990	53%	43%	57%	62%
1991	54%	45%	60%	62%
1992	53%	44%	57%	58%
1993	51%	41%	55%	54%
1994	48%	38%	52%	51%
1995	40%	30%	43%	46%
1996	21%	15%	24%	35%
1997	21%	12%	20%	44%

There are two other important points to note from Table 6. First is that Kentucky Kare's market share began a slow decline in 1993 – well before the market changes from major legislative initiatives were implemented. Second, as shown in Figure B, that decline was roughly proportionate for all three groups, until 1995. Between then and 1997, the shares of total contracts, and those of state agencies and boards of education were roughly halved, while the share of total retiree contracts rebounded to close to the 1995 level.

Figure B
Kentucky Kare's Share of Total Contracts in the State Group



Data shown in Appendix A indicates that, among active employees, the greatest movement of Kentucky Kare policyholders from 1995 to 1996 was for single coverage in enhanced high and standard high policies. In fact, for these two levels of coverage, nearly 15,000 employees switched to managed care policies while fewer than 13,000 stayed with Kentucky Kare. The average age of those leaving was about 4 years less than those staying.

A more detailed picture of this group is reflected in Table 7, which compares the age and gender distributions of those who stayed in Kentucky Kare in 1996, those who left Kentucky Kare for a managed care plan, and those who were in a managed care plan but did not come from Kentucky Kare. Of the employees with single enhanced high or standard high policies that stayed with Kentucky Kare, 42 percent were age 50 or more, compared to 29 percent for the former Kentucky Kare members who went to managed care. The gender breakdown shows that single enhanced high and standard high policies are predominantly held by females, and there was a slightly higher share of females in the group that stayed with Kentucky Kare. In both age and gender, the composition of people leaving Kentucky Kare to go to managed care mirrors that of all others already under managed care.

Table7
Single Coverage, Enhanced High and Standard High Plans
Active State Employees
1996

		In Managed Care	
	Stayed With KY Kare	**Came From KY Kare**	**NOT From KY Kare**
Number of Policies	12,580	14,570	46,731
Age distribution			
Age 50 or more	42%	29%	30%
Under age 50	58%	71%	70%
	100%	100%	100%
Gender distribution			
Female	75%	70%	71%
Male	25%	30%	29%
	100%	100%	100%

Source: LRC Staff analysis of data provided by PlanSource, third party administrator for the Health Purchasing Alliance.

In 1997, while the loss of existing enrollees continued somewhat, retired teachers were added to the groups eligible for coverage. The addition of this older group paired with declines in younger members was the primary reason that Kentucky Kare's claims began to exceed premiums so greatly.

Figure C graphically shows the dramatic realignment of market shares among the plans offered to public employees. In 1995, Kentucky Kare held 40 percent of the contracts in this group, Humana held 29 percent, and Healthwise held 13 percent, for a combined total of 82 percent. Anthem and its associated plan, Alternative Health Delivery Systems (AHDS), held a combined 11 percent. In 1996, Anthem offered its Option 2000 Advantage POS policy at a single rate far below that charged for competing plans. As noted above, the advent of standard plans and the flexible spending account option likely made employees even more responsive to the large price advantage of the plan. As a consequence, the Anthem/AHDS total market share jumped to 42 percent, while the combined Kentucky Kare, Humana and Healthwise shares were cut in half.

Claiming that it lost a great deal of money, Anthem dropped the Option 2000 Advantage POS offering in 1997. Even with that move, the combined Anthem/AHDS market share only declined to 32 percent, while the former market leaders made no recovery at all. By 1999, Kentucky Kare was out of business, Healthwise (now wholly owned by United Healthcare) no longer offered a policy to the state group, and Humana's market share had only recovered to 14 percent. The Anthem/AHDS share also fell, to 22 percent, leaving CHA and Bluegrass Family Health to pick up much of the slack.

FIGURE C
Insurance Carriers' Share of Public Employee Market
1990-1999

Insurance Carrier	1990	1991	1992	1993	1994	1995	1996	1997	1998 *	1999
Kentucky Kare	53	53	53	51	48	40	21	21		
Humana	30	30	29	27	26	29	10	11		14
Healthwise	10	10	11	12	12	13	11	10		
Alternative Health Delivery Systems	4	4	4	6	7	8	5	16		11
Anthem BC/BS					1	3	37	16		11
Lexington Health Advantage/ Advantage Care					2	4	7	10		3
CHA							3	9		24
Bluegrass Family Health							1	2		26
Other	3	3	3	3	3	3	5	5		11

*** -** Comparable data was not available for 1998.

Sources: 1990-95 Monthly Membership Reports provided by Kentucky Kare; 1996-97 Health Purchasing Alliance; 1999 provided by Personnel Cabinet.

There are three conclusions drawn from this analysis. First is that loss of market share and adverse selection were growing problems for Kentucky Kare even before 1996. As shown in Figure A, total enrollment and total premiums began to decline after 1993, even though total claims were still growing at a healthy pace. Second is that the accelerated pace of adverse selection that occurred in 1996 put Kentucky Kare into a classic death spiral whereby the increased premiums needed to cover claims caused adverse selection to worsen, leading to a need for increased premiums, and so on, until the plan was no longer financially viable. Third is that, if adverse selection was the wound that bled Kentucky Kare, then Anthem's Option 2000 Advantage POS product was the instrument that enlarged the wound to quickly fatal proportions.

Within any group, the only cure for the problems caused by adverse selection is a fully functioning risk adjustment mechanism – insurance carriers who get a smaller share of policyholders with higher than average claims must financially compensate carriers who get a larger share. Although a Demographic Risk Adjustment Fund and a High-Cost Case Fund were created, they did not become operational quickly enough, nor were they broadly defined enough, to significantly affect Kentucky Kare's outcome. Kentucky Kare received $2.3 million from the Demographic Risk Adjustment Fund for the period May 1996 through May 1997. This represented about one twelfth of the plan's losses for the fiscal year ending June 30, 1997. As noted above, the list of conditions eligible for reimbursement from the High-Cost Case Fund did not capture the largely age-related conditions that represented the bulk of Kentucky Kare claims. The plan received a payment of $3 million from the fund for calendar year 1996 claims, against total claims of $116 million.

Managed Care versus Indemnity Policy

For all practical purposes, Kentucky Kare was the only indemnity policy chosen by members of the state group. All of the competing plans incorporated some form of managed care. Three aspects of this had negative impacts for Kentucky Kare.

Requirement for State-Wide Coverage – Unlike any other carrier at the time, Kentucky Kare was required to offer policies in all 120 counties. It is understandable that some carrier(s) had to offer in all counties because the Commonwealth has employees in every one. However, forcing Kentucky Kare to be the only one to offer a policy in areas where managed care networks were not developed, while other carriers were allowed to concentrate in areas with well-developed networks, exposed it to higher costs. Table 8 indicates in which regions Kentucky Kare was heavily chosen by active state employees as of March 1996. At the top of the list is Region 5 (Christian County), with 72 percent of active state employees choosing Kentucky Kare. This is in stark contract to the urban regions around Jefferson, Fayette, and Boone Counties, where the comparable percentages were 3, 6, and 8 percent, respectively.

Table 8
Active State Employees
Enrolled in Kentucky Kare
as of March 1996

Region	Number of Policies	Share of Region Total	Counties in Region
5	1,347	72%	Christian
4	2,264	64%	Henderson and Daviess
1	1,051	33%	Greenup, Carter, and Boyd
7	18,489	25%	All other counties
2	544	8%	Boone, Campbell, Kenton, Gallatin, Grant, and Pendleton
6	773	6%	Scott, Bourbon, Woodford, Jessamine, Madison, Clark, and Fayette
3	513	3%	Jefferson, Oldham, and Bullitt
Statewide	**24,981**	**21%**	

Adverse Selection Revisited - Research has demonstrated that, when given the choice, policyholders who are older and have chronic health conditions are more likely to select an indemnity policy because of the lack of restrictions on their access to medical services.[11] [12] In a study of changes in pricing rules for employees of Harvard University, Cutler and Reber concluded that, without adequate methods for risk adjustment among competing carriers, plans offering characteristics desired by those with high expected claims, such as the unregulated access to care inherent in the Kentucky Kare indemnity policy, would be unlikely to survive long-term. The authors argued that those with higher expected claims are attracted to plans with generous benefits and greater freedom of choice.

One might wonder whether our results about adverse selection are unique to Harvard, or whether they apply to multiple-choice insurance arrangements more generally. While we do not have definitive evidence on this question, we suspect that our findings are quite general. Harvard is not alone in finding difficulty maintaining more generous (indemnity) plans. Stanford University and the State of Minnesota, for example, also moved to equal contribution rules and were forced a few years later to discontinue their most generous plans. There is a suggestion in each case that adverse selection was to blame. Similarly, the Massachusetts Institute of Technology also moved to an equal contribution rule in the 1980's and was forced in 1997 to discontinue its indemnity policy.[13]

Utilization Management - In addition to their propensity to lead to adverse selection, indemnity plans are simply more expensive. Once deductibles and maximum out-of-pocket expenses are met, the financial incentive for both the policyholder and the provider is to increase the number and specialization of medical services delivered. Kentucky Kare officials noted that they had instituted per-visit fee schedules (including a restriction on balance billing)

[11] Homan, Rick K., Gerald L. Glandon, and Michael A. Counte, Perceived risk: the link to plan selection and future utilization, *Journal of Risk and Insurance*, Vol. 60, No. 2, 1998, p.300.
[12] Marquis, M. Susan, Adverse selection with a multiple choice among health insurance plans: a simulation analysis, *Journal of Health Economics*, Vol 11, 1992, p. 129.
[13] Cutler, David M. and Sarah J. Rebner. "Paying for health insurance: The trade-off between competition and adverse selection," *Quarterly Journal of Economics*, May 1998, v113, n2 p433 (34).

and utilization review.[14] However, per-visit fee schedules are largely ineffective in controlling costs in the absence of restrictions on the number of visits.

Also, utilization review was obviously not effective. According to minutes of the Kentucky Kare Health Insurance Authority, as late as June 1998, the executive director noted that the plan's "experience in hospitalization, number of admits and average length of stay is extremely high."[15] It was noted that 70 percent of the plan's hospital admissions were through the emergency room. This compares to 2 percent nationally. Pharmacy costs were $29 per member/per month, compared to $14.50 for HMO's and $21 for indemnity plans, nationally.[16]

Inadequate Premiums / Insufficient Appropriations

No matter how high total claims, if total premiums are sufficient then no financial problem develops. Obviously this was not the case for Kentucky Kare. Three aspects of decisions about premiums are relevant to the plan's financial problems.

Policy Decision to Restrict Premiums – In 1993, Kentucky Kare had an $80 million reserve and an 80 percent loss ratio. The plan appeared to be so strong financially that policymakers decided to place a moratorium on premium increases until the reserve was reduced by about $50 million. As one aspect of this plan, the Department of Education was to withhold $17 million in premiums due Kentucky Kare in FY 1994. Only after the Auditor raised a concern about the failure to properly account for the receivable and the Attorney General raised a concern about the legality of the actions taken, was a $17 million transfer made from the General Fund Surplus to the Kentucky Kare Trust Fund. What seemed reasonable decisions to restrict premiums at the time were, unfortunately, made without the benefit of crystal ball. Figure D shows the plan's loss ratio plotted against total enrollment and the share that various groups comprised of that enrollment.

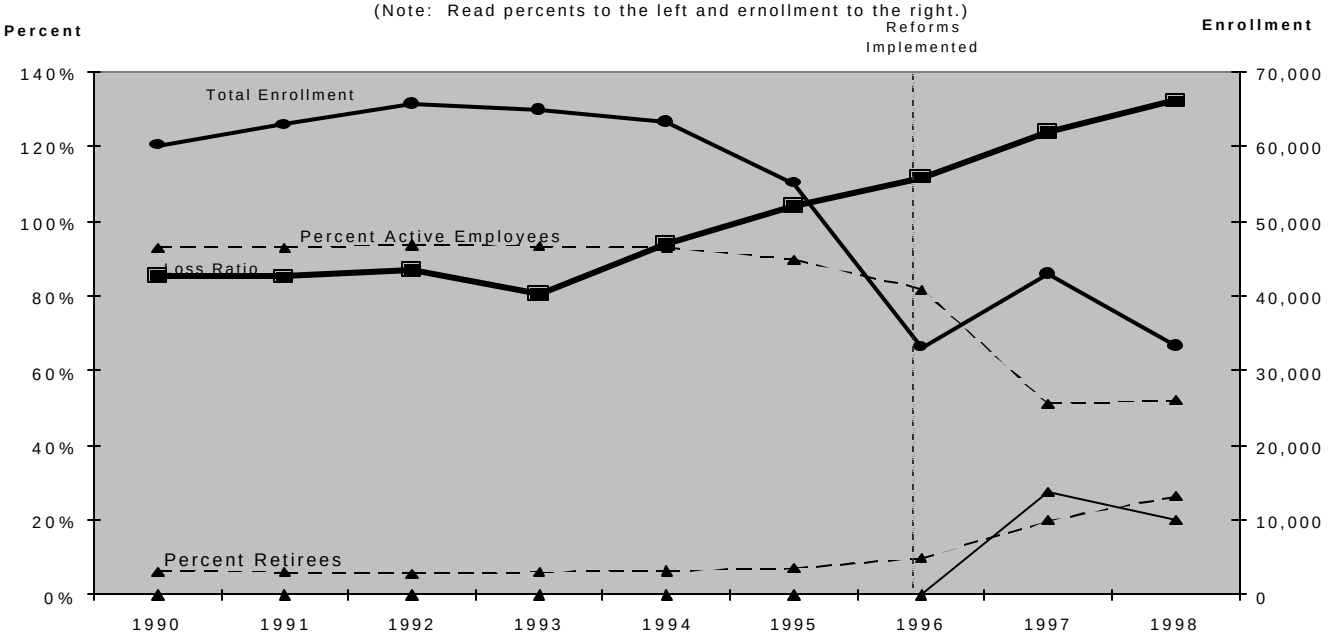
The policy decision to hold the line on premiums is clearly portrayed in the upward shift in the loss ratio that occurred between 1993 and 1994. It is assumed that the intent was to level out the loss ratio at somewhere around 94 percent, to leave money for the customary 6 percent administrative expense. Unfortunately, market changes already underway (declining enrollments and adverse selection) combined with events put in motion by HB 250 (Option 2000 Advantage POS, standard plans, modified community rating) to prevent managers from holding the loss ratio below 100 percent.

It is unlikely that the additional reserves that would have been available if the premiums had been allowed to grow on trend in 1994 would have "saved" Kentucky Kare. At best, they might have bought more time for managers to develop a managed care approach that could have been viable for the 1999 plan year.

[14] Staff interview with E. Jerry Philpot, July 14, 1999.
[15] Finnegan, Robert, "Kentucky Kare Situation Report," an Addendum to the Executive Director's Report to the Kentucky Kare Health Insurance Authority," June 23, 1998.
[16] Minutes of the December 16, 1997 meeting of the Kentucky Kare Health Insurance Authority Strategic Planning Committee.

However, given the abysmal absence of data on premiums and claims, it is doubtful that a successful change could have been made.

Figure D
Kentucky Kare Loss Ratio
Total Enrollment
And Group Percents of Total Enrollment
(Note: Read percents to the left and ernollment to the right.)



The point to be drawn from this situation is that it is risky to impose political considerations on decisions about the management of a large health insurance carrier. Blue Cross & Blue Shield suffered for this in 1987 and Kentucky Kare suffered for it just a few years later. No matter the apparent reasonableness of a policy decision from a political or equity standpoint, it should not be made without an understanding of the market forces that will determine its outcome.

Adverse Selection, Again – Adverse selection sets up a difficult Catch-22 in the setting of premiums. Lowering premiums makes an indemnity plan even more attractive to those with higher cost claims, and leaves the plan with fewer resources to cover the claims. Raising premiums tends to drive away those who are not willing to pay the increased premiums, usually leaving a higher concentration of high utilizers. This can lead to a classic death spiral from leaving the premiums of fewer policyholders to cover the claims of those who are very expensive.

The reason for the mass exodus from Kentucky Kare's enhanced high and standard high single coverage by active employees can be seen in the lower average premium prices under managed care -- $24 per month lower for the enhanced high, and $8 lower for standard high (Appendix A). This translates to a realized aggregate savings of over $330,000 per month for these two groups alone. Where similar price relationships exist in the other types and levels of coverage, the same large numbers leaving relative to those staying can be seen.

It is interesting to note that Kentucky Kare compared favorably on average premium price for all cases of the three levels of coverage below standard high – standard low, economy low, and budget high. Also, all levels of

Kentucky Kare's family coverage had lower average premium prices. For these categories, although the numbers leaving were not as great relative to those staying, people still left Kentucky Kare to opt for a more expensive managed care product. Thus, although the monthly premium is an important factor, it appears that many were willing to pay extra each month in order to eliminate the deductible, co-insurance, and maximum out-of-pocket expenses associated with the indemnity product and replace them with known co-pays – even in the face of the restrictions imposed by managed care.

Inadequate Appropriations - There are two possibilities to consider in understanding why Kentucky Kare lost money. The one discussed above focuses on the inadequacy of Kentucky Kare's premiums in covering the associated claims. A more global question that can be asked is whether any carriers were able to make money, given the set of benefits mandated and the pressure to bid a premium close to the state contribution.

According to information reported to the Department of Insurance by carriers which account for approximately 90 percent of the state group, the overall loss ratio for this market was just over 90 percent for calendar year 1997. This means that total premiums were 10 percent greater than claims. While this is good news compared to the recent history of Kentucky Kare, it should be remembered that administrative expenses must also be covered by premiums. For carriers that actively manage utilization, administrative expenses often average around 15 percent of claims. Further, those carriers that projected final loss ratios for calendar year 1998 all projected loss ratios above 100 percent.

If these data are accurate, it would mean that only the most efficient carriers, or those who benefit from adverse selection against the others, would have any chance of making a profit on the state group. Of course, given that the data were submitted by those seeking to increase premiums, and were not independently verified, the figures should be used with great caution. Still, they highlight the need for additional analysis to determine whether the benefits offered can be purchased for close to the state contribution for a group with the particular demographic and utilization profile of the state group.

Inadequate Data

It would be difficult to overstate the negative effect that data problems had on the ability of Kentucky Kare's managers to successfully negotiate the treacherous conditions they faced. They were like physicians who have reason to believe that a patient is losing blood, without access to any information about the location of the wound or the amount of blood being lost.

With the advent of the Alliance, all premium and enrollment data for Kentucky Kare was processed by the Alliance TPAs, first PlanSource, then United Chambers. A flavor for the quality of this work is given in a report on procedures conducted by the state auditor. The following are quotes from that report.

- PlanSource bank reconciliations – Due to the large volume of missing documents, unanswered questions, and unexplained variances, we could not complete this work.
- The (United Chambers) system allowed Plan participants to enroll in plans not offered, converted inactive groups from PlanSource into active groups, and did not allow United Chambers' employees to view information needed to answer enrollment questions.
- United Chambers did not institute procedures which ensured every individual or group received a bill.

- Because of the condition of billing records, the Alliance would not permit United Chambers to terminate any enrollee from coverage until May 1998.
- Billing registers and bills could not be re-run even if an error had been noted.
- United Chambers did not base payments to (carriers) on the amount due. Instead, the payments were based on the availability of cash and statements from (carriers) or an actuarial study.
- United Chambers did not have sufficient preparation time to assume responsibilities as the third party administrator.
- United Chambers' computer system was not user-friendly. Initially, customer service representatives at United Chambers could not quote to a Plan participant the amount of a bill, how much had been paid, how much had been posted to the system, or how much remained outstanding.
- United Chambers did not have sufficient personnel to handle the volume of deposits.[17]

What this means is that, during the period when they faced significant changes in business conditions, managers of Kentucky Kare did not have access to reliable data on two of the three most basic business questions: How many customers do we have ? How much are they paying us? For example, the Executive Director of Kentucky Kare presented the following information to the Authority in January 1998.

> Based on information received from United Chambers, we were carrying about 44,000 contracts when we actually had about 38,000. Therefore we paid claims on persons who were not eligible which cost Kentucky Kare about $1 million.[18]

Data on the third basic question – How much does it cost to provide our product? – was also difficult to obtain. Humana was the TPA responsible for processing claims for Kentucky Kare. In April 1998, the Director made the following report to the Authority Board.

> In January of 1998, Humana reformatted their entire group identification system and changed all group numbers for their business including Kentucky Kare's group numbers. As a result of this change, they have been unable to produce any membership breakdown reports since the first of the year…

Apparently, there continues to be some question as to whether claims data on Kentucky Kare members can be reliably separated from the claims of Humana members. Whether they can or not is somewhat of a moot question now. The fact remains that when the data was needed most – at the point which a decision had to be made about options for continuing Kentucky Kare or closing it – there was no current and reliable data on the number enrolled, how much they had paid in premiums, or what they had incurred in claims. It is not difficult to understand that the decision to close was judged more prudent than one to proceed blindly forward.

Note that the problems with enrollment and premium data affected all carriers offering policies through the Alliance, so these were not unique to Kentucky Kare. However, other carriers at least had some confidence in their ability to access and analyze claims data. Kentucky Kare was particularly disadvantaged in this respect.

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[17] Hatchett, Jr., Edward B., *Independent Auditor's Report on Procedures Performed as Part of a Consulting Engagement for the Kentucky Health Purchasing Alliance for the Period July 1, 1997 through April 30, 1998,* Kentucky Auditor of Public Accounts.
[18] Finnegan, Robert, Minutes of the Kentucky Kare Health Insurance Authority Board Meeting, January 28, 1999.

Also note that the Department of Personnel is similarly hampered by data unavailability and inconsistency in its current evaluation of proposals for the next plan year and in its planning for future options. Table 9 shows claims data for the state group submitted by carriers as part of the current RFP process. Examination of the data indicates that no two carriers in the group submitted comparable sets of claims data. Some included prescription drug claims, others did not; some estimated incurred but not reported claims, others did not; some included the capitation fees paid to providers, others did not; and some included the claims paid on riders to policies (such as vision and mental health riders), while others did not. This isn't just like comparing apples and oranges, it's like comparing apples and oranges and bananas and watermelons. Using these data, there is no reliable way to estimate the total claims experience of the state group. Without that information it is very difficult to assess the reasonableness of bids in relation to the state contribution.

Conclusion about the Demise of Kentucky Kare

The conclusion is that Kentucky Kare failed because of the adverse selection created when it offered a state-wide indemnity plan that competed against regional managed care plans. The problems created by this adverse selection were greatly exacerbated by artificial limits on premiums and inadequate utilization management. A complete absence of reliable data about enrollments, premium receipts and incurred claims made adequate response to these problems all but impossible.

TABLE 9

CLAIMS INFORMATION SUBMITTED ON THE STATE GROUP

Carrier	Non-RX Claims	Rx Claims	Capitation Charges	Total	Reflect IBNR[a]	Reflect RX	Reflect Capitation Charges	Rider Claims Included
Aetna	$ 16,271,331	x	x	x	**no**	**no**	**no**	yes
Alternative Health	$ 38,298,887	$ 10,076,299	$ 1,161,075	$ 49,536,261	yes	yes	yes	**partial**[b]
Blue Grass Family	$ 24,129,965	$ 6,867,803	$ 2,145,849	$ 33,143,617	**no**	yes	yes	yes
CHA	$ 91,693,915	$ 21,516,565	x	$ 113,210,480	**partial**[c]	yes	**no**	yes
Humana	$ 63,527,013	x	$ 4,082,914	$ 67,609,927	yes	yes	yes	yes
Kentucky Kare	x	x	x	$ 110,518,122	**no**[d]	yes	none	yes
Medquest	x	x	x	$ 5,061,681	**no**	**no**	**no**	**no**

a - incurred but not reported claims
b - not mental health and prescription drugs
c - non-prescription drug included; prescription drug IBNR not included
d - paid not incurred

Source: Carrier submissions for the 2000 RFP for state employee insurance.

Section II: State-Employee Health Insurance in the U.S.

Given the trouble Kentucky has experienced in the last 10 years in its state-employee health insurance program, it may be instructive to examine how other states organize their programs. All 50 states offer some form of health insurance coverage to full-time permanent employees of state agencies. However, the ways they choose to do that are varied.

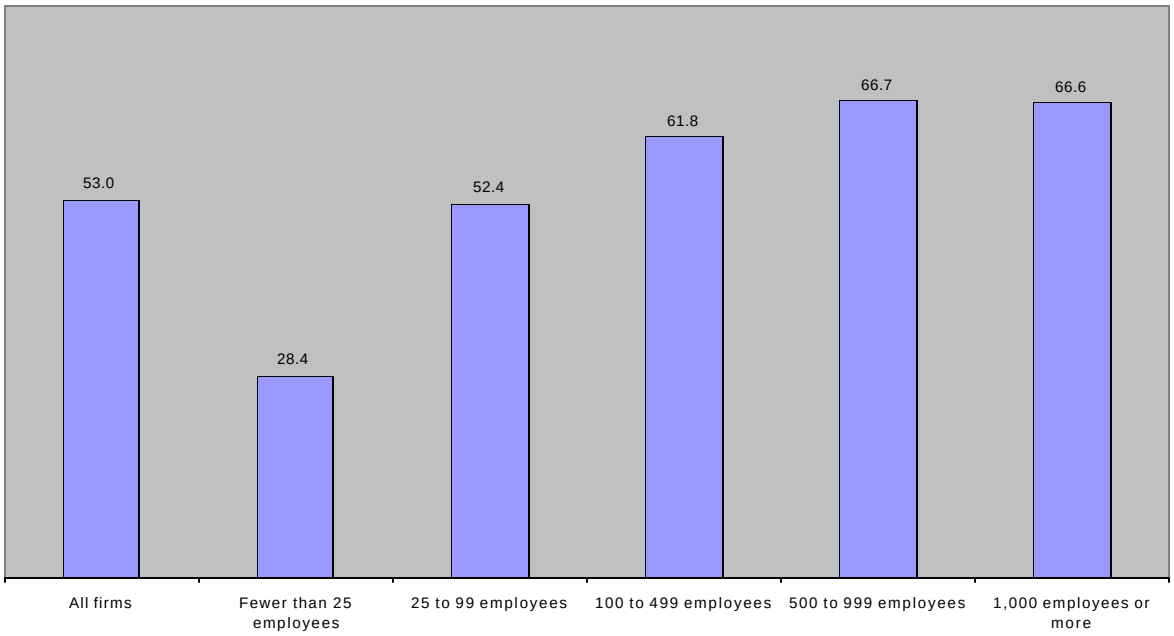
This section consists of three parts. The first provides a general overview of employer-provided health insurance. The second presents current information on health insurance provided by each of the 50 states. The third

discusses particular issues, such as the setting of state contributions and responses to adverse selection, in the context of decisions of specific states. As requested by the Committee, attention is given to self-insured arrangements throughout the section.

Overview of Employer-Provided Health Insurance

Employer provision of health insurance benefits first became prevalent during World War II as one attempt to circumvent a wage freeze imposed by the federal government. By 1997, over 61 percent of the U.S. population was covered by employer-sponsored health insurance. The likelihood that an employer will offer health insurance benefits to its employees varies by size (Figure E). Two-thirds of those working in firms with 1,000 or more employees have employer-based health insurance.[19]

Figure E
Percent of U.S. Workers with Employment- Based Health Insurance by Firm Size



While the focus of this report is on employer-sponsored health insurance, it is important to remember that health insurance benefits are one part of the total compensation package that employers use to attract and retain productive workers. According to the Bureau of Labor Statistics, in March 1999 health insurance comprised 5.4 percent of the total compensation paid by private industry and 7.6 percent of that paid by state and local governments[20] (Table 10). Between 1981 and 1992, employee health insurance costs increased at three times the rate of increase in wages & salaries and more than double the rate of increase in other benefits. Conversely, between December 1992 and September 1998, employer health insurance costs increased 15%, compared to 21% for wages & salaries and 19% for other benefits.[21]

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[19] Bennefield, Robert L., *Health Insurance Coverage, 1997*, U.S. Census Bureau, P60-202, September 1998.
[20] *Employment Cost Trends for March 1999*, Bureau of Labor Statistics, June 1999.
[21] Schwenk, Albert E., Trends in health insurance costs, *Compensation and Working Conditions Online*, Bureau of Labor Statistics, Vol. 4, No. 1, Spring 1999.

Table 10		
Components of Total Compensation		
Private Industry and State and Local Governments		
March 1999		
	Percentage of Total Compensation	
Component	**Private Industry**	**State & Local Governments**
Wages & Salaries	73.0	70.6
Total Benefits	27.0	29.4
Categories of Benefits		
Paid Leave	6.3	7.8
Supplemental Pay	2.9	0.9
Life Insurance	0.2	0.2
Health Insurance	5.4	7.6
Disability Insurance	0.3	0.1
Retirement	3.0	6.8
Social Security	6.1	4.7
Federal Unemployment Insurance	0.2	0.0
State Unemeployment Insurance	0.5	0.1
Worker's Compensation	1.9	1.1
Other	0.2	0.1
Source: Employment Cost Trends, Bureau of Labor Statistics, June, 1999.		

The periods of slow increases were due in part to employer efforts to contain health care costs, including cost shifting to employees. The share of employees whose health insurance premiums are wholly paid by employers has declined sharply since 1980. Of full-time workers in medium and large private establishments who participated in medical care plans, 21 percent had individual coverage wholly financed by their employer in 1997, down from 72 percent in 1980. The comparative rates for family coverage were 20 percent in 1997 and 51 percent in 1980.

> Other cost containment strategies used by employers included changing health plan design to heighten employer's control over the type or delivery of health care services; instituting major medical deductibles and coinsurance payments; eliminating basic coverage for certain types of care; and shifting to managed care programs or self-funded plans.[22]

In 1992, 52 percent of employees had an indemnity plan obtained through work, compared to only 15 percent in 1997. With 85 percent of covered employees, managed care plans now dominate the market for employer-provided health insurance.[23] The reason for that shift can be seen in the difference in the average total cost of each plan per employee. In 1997, the average annual cost per employee for an indemnity plan was $3,759, compared to $3,307 for an HMO plan, $3,518 for a PPO plan, and $3,588 for a POS plan. Since 1987, there has been an increase, from 56

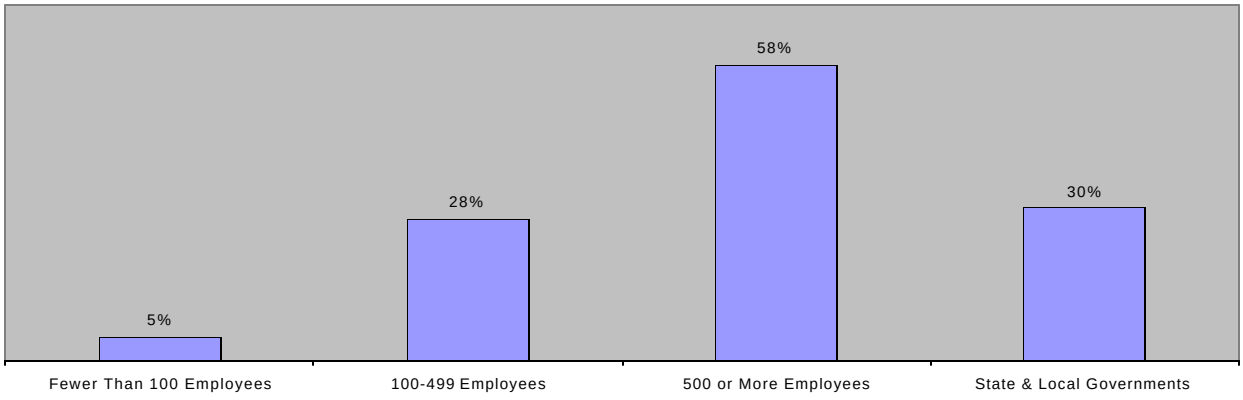
[22] Health care costs fluctuate with employer cost-containment efforts, *MLR: The Editor's Desk*, Bureau of Labor Statistics, April 8, 1999.

[23] Fronstin, Paul, Features of employment-based health plans, Employee Benefit Research Institute, Issue Brief No. 201, September 1998.

percent to 63 percent, in the share of employees who must contribute some amount to the premium cost for their coverage; however, the portion of the total premium they must contribute has not changed.[24]

The adoption of self-insured plans has not been as universal as the adoption of managed care, varying significantly by firm size and governmental status. Well over 50 percent of the employees of large private firms are covered under a self-insured plan, compared to 5 percent of those in small firms and 30 percent of the employees of state and local governments (Figure F). Employers with more than 200 employees who adopt HMO plans are much less likely to self-insure those plans than if they adopt plans with less stringent management of care (Figure G). Evidence exists that the percentage of self-insured firms declined between 1993 and 1997, as firms adopted fully-funded HMO plans.[25]

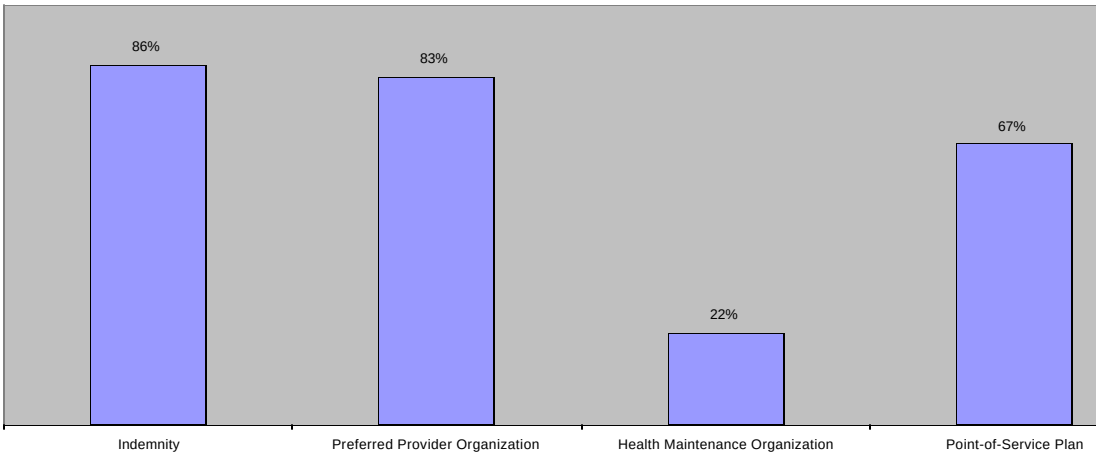
Figure F
Percentage of Participants in Employment-Based Self-Funded Plans by Firm Size 1996



Thus, the indication is that fully-funded HMO plans and self-insured indemnity, PPO, and POS plans are, at this stage, two alternate approaches employers have chosen to reduce their health insurance costs. In areas with a strong HMO presence, significantly fewer firms choose to self-insure than in areas with a weak HMO presence.[26] Employers have not yet demonstrated a great willingness to organize the provider networks and directly impose the restrictions on access to medical services that would be required to self-fund an HMO plan.[27]

[24] Fronstin, Paul, Features of employment-based health plans.
[25] Marquis, M. Susan and Stephen H. Long, Recent trends in self-insured employer health plans, *Health Affairs*, Vol. 18, No. 3, May/June 1999, p. 161.
[26] Marquis, M. Susan and Stephen H. Long, Recent trends in self-insured employer health plans.
[27] Although it is becoming more common for HMOs to "rent" their networks to self-funded employers, this practice has not yet yielded a large rush for employers to self-insure HMO plans.

Percentage of Employees in Self-Funded Plans
by Plan Type
for Employers with 200 or More Employees
1998



The Health Care Financing Administration is projecting that the annual rate of increase in private health insurance expenditures will be more than double in 2001 (7.9%) what it was in 1996 (3.6%).

> Recent stronger growth in real per capita income is expected to boost underlying demand for medical services, and higher medical inflation is expected to fuel increasing health-spending growth. An anticipated slowdown in the growth of private-sector managed care enrollment and a pause in the downward trend for private health insurance coverage also are expected to contribute to the acceleration in health spending growth.[28]

The fastest growing components of medical expenditures between now and 2007 are expected to be prescription drugs and personal health care services.

It is doubtful that managed care plans will offer the savings in the future they have in the past. The remaining markets without managed care penetration likely have barriers that prevent development of practice networks. Many managed care insurers have held premiums artificially low to gain market share.[29] These premiums will have to be adjusted upward to more accurately reflect the costs of delivering care. Also, the current policy debate about consumer and provider acceptance of managed care restrictions may lead employers to change coverage options or lead elected officials to pass patient protection legislation that increases costs for managed care entities.

A nationwide survey found that 55 percent of consumers with a managed care plan were at least "somewhat worried" that their health plan would be more concerned about saving money than delivering the best care if they got sick. This compares to 34 percent of consumers with an indemnity policy.[30] This concern is apparently shared by physicians and nurses as well.

> Many doctors – between a third and two-thirds, depending on the type of denial – also reported that (in their judgement) health plan denials of drugs, hospital stays, diagnostic tests or referrals to specialists or

[28] Smith, Sheila, Mark Freeland, Stephen Heffler, David McKusick, and the Health Expenditures Projection Team, Health Affairs, Vol. 17, No. 5, September/October 1998, p. 128.
[29] Ginsburg, Paul B. And Jon R. Gabel, Tracking Health Care Costs: What's New in 1998?, Health Affairs, Vol. 17, No. 5, September/October 1998, p. 141.
[30] Is there a managed care backlash?, Kaiser Family Foundation with the Harvard School of Public Health, November 1997.

mental health services resulted in adverse health consequences for their patients. About half of nurses (48%) said that within the last two years a health plan decision has resulted in a decline in health for their patients.[31]

In its annual survey of HMOs, the National Committee on Quality Assurance found that 26.5 percent of patients of the reporting HMOs said they had trouble getting the medical care they thought they needed.[32]

It should be remembered that none of these surveys speaks to the essential question of whether consumers enrolled in an HMO have different survival or treatment results than consumers enrolled in other types of plans, after controlling for differences in risk factors. However, this high a level of consumer and provider dissatisfaction is likely to result in industry changes, either voluntary or mandated. It is unlikely that those changes will lead to a further decline in premiums in these products. Therefore, it is expected that employers will continue to experiment with methods to limit their exposure to a new round of increases in health insurance expenditures.

Employee Health Insurance Provided by State Governments

Given the changes in the general market for employer-provided health insurance, it is not surprising that states have begun to pay close attention to the health insurance they provide to their own employees. The National Conference of State Legislatures (NCSL) began tracking state employee health insurance as a separate topic in 1999. According to information provided on NCSL's online Health Policy Tracking Service, eighteen states identified state employee health insurance as a priority for the 1999 legislative session. This emphasis resulted in the introduction of over 30 bills related to the topic by March of this year. Most of the bills were either concerned with changes in benefits, including mandating particular benefits, or controlling costs.

All 50 states provide a contribution for health insurance premiums for employees of state agencies. Most provide a contribution for retirees who are not yet eligible for Medicare, and some make contributions for other groups as well. The total expenditure on state employee health insurance premiums in 1997 is presented in Table 11. Note that this only includes data on the premium contributions for employees of state agencies. Other groups that may be covered in state plans, such as teachers, retirees, and local government employees, are excluded for the sake of comparability. The total state government contributions for premiums were divided to get a per-employee monthly amount, for comparison among states. Total contributions were also divided by the total state budget for a measure of the share of the total budget devoted to state employee health insurance. Finally, total health care expenditures in the state in 1995 were divided by the total state population to give an indication of relative magnitude of purchases of health services in each state.

According to this data, the average monthly per-employee contribution for their employees' health insurance among all states was $289, which represented about 1.3 percent of total state budgets. The per capita total health expenditure in all states was $2,896 for 1995. Kentucky had the 7th lowest per-employee monthly contribution for health insurance for state employees, at $147, and the 2nd lowest share of its total budget devoted to this use, at one-

[31] New survey shows that providers and health plans clash often over patient care, Kaiser Family Foundation with the Harvard School of Public Health, July 1999.
[32] *The State of Managed Care Quality 1999*, National Committee for Quality Assurance, July 1999.

half of one percent.[33] The fact that Kentucky ranked 23rd lowest on total per capita health expenditures makes it unlikely that its low rankings on the other two indicators can be explained by unusually lower health care costs or health service utilization, compared to all other states.

In order to provide information about the use of various types of health insurance plans offered to state employees. LRC staff conducted a telephone survey of state employee health insurance officials in all 50 state group (excluding dependents), the number of HMO, PPO/POS, and indemnity plans offered, the number of each of those plans that are self-insured, and the total number of contracts in the self-insured plans, but many were reluctant to provide specific information about that issue.

The results from that survey are shown in Table 12. According to this data, nearly 5 million employees and retirees are included in state group insurance plans, not including dependents. Forty-four states offer at least one HMO plan, 34 offer a PPO or POS plan, and 30 offer an indemnity plan. Only 4 states offer a single choice of plan type. The remaining 46 states offer multiple plan choices to at least some employees.

[33] The $148 calculated here is not exactly equivalent to the $185 per month actually appropriated for the employee contributions. The $148 refers to actual expenditures, which, on average, would be lower than the appropriated amount because of factors such as partial-year employment.

TABLE 11
State Expenditures for State Employee Health Insurance - 1997

	State	Total State Budget $M	Number of State Employees	Total State Employee Health Insurance Premiums $ M	Monthly Premium Expense Per Employee	Rank (1=lowest)	Premium Expense as % Total Budget	Rank (1=lowest)	Total State Population	Total State Per Capita Health Expenditure	Rank (1=lowest)
1	Alabama	$ 11,852	35,741	$ 158.4	$ 369.32	36	1.3%	29	4,319,154	$ 2,792	29
2	Alaska	$ 4,242	14,967	$ 59.3	$ 330.17	30	1.4%	32	611,300	$ 2,573	17
3	Arizona	$ 13,808	39,321	$ 130.3	$ 276.15	22	0.9%	15	4,554,966	$ 2,335	7
4	Arkansas	$ 8,271	44,582	$ 97.3	$ 181.87	13	1.2%	22	2,509,700	$ 2,435	11
5	California	$ 96,251	271,966	$ 959.7	$ 294.06	24	1.0%	18	32,383,000	$ 2,908	32
6	Colorado	$ 9,266	67,242	$ 40.1	$ 49.70	2	0.4%	1	3,896,000	$ 2,584	19
7	Connecticut	$ 13,737	50,570	$ 348.2	$ 573.79	45	2.5%	45	3,269,858	$ 3,736	49
8	Delaware	$ 4,049	25,992	$ 114.7	$ 367.74	35	2.8%	48	731,581	$ 3,089	43
9	Florida	$ 40,101	125,401	$ 353.0	$ 234.58	20	0.9%	12	14,783,236	$ 3,031	42
10	Georgia	$ 19,824	62,203	$ 272.3	$ 364.80	34	1.4%	30	7,353,225	$ 2,734	25
11	Hawaii	$ 6,317	44,232	$ 178.1	$ 335.54	31	2.8%	47	1,186,185	$ 2,938	35
12	Idaho	$ 2,963	16,309	$ 37.8	$ 193.14	15	1.3%	25	1,210,000	$ 1,882	1
13	Illinois	$ 28,163	67,134	$ 555.3	$ 689.29	50	2.0%	40	11,895,849	$ 2,921	33
14	Indiana	$ 15,212	36,594	$ 150.4	$ 342.50	32	1.0%	16	5,803,000	$ 2,826	30
15	Iowa	$ 9,407	27,828	$ 100.9	$ 302.15	26	1.1%	20	2,852,000	$ 2,574	18
16	Kansas	$ 7,884	44,165	$ 157.8	$ 297.75	25	2.0%	41	2,582,492	$ 2,673	22
17	Kentucky	$ 11,983	33,832	$ 59.9	$ 147.54	7	0.5%	2	3,860,219	$ 2,690	23
18	Louisiana	$ 14,733	83,840	$ 218.6	$ 217.28	18	1.5%	35	4,352,000	$ 2,990	38
19	Maine	$ 3,950	12,774	$ 67.8	$ 442.30	41	1.7%	37	1,242,051	$ 2,764	26
20	Maryland	$ 15,054	71,468	$ 326.3	$ 380.47	38	2.2%	42	5,042,438	$ 3,005	40
21	Massachusetts	$ 20,942	65,900	$ 481.4	$ 608.75	48	2.3%	43	6,118,000	$ 3,828	50
22	Michigan	$ 30,619	54,623	$ 444.6	$ 678.29	49	1.5%	34	9,773,892	$ 2,776	28
23	Minnesota	$ 15,545	34,358	$ 120.6	$ 292.51	23	0.8%	7	4,734,830	$ 2,998	39
24	Mississippi	$ 7,699	31,381	$ 50.5	$ 134.10	4	0.7%	4	2,730,000	$ 2,266	6
25	Missouri	$ 12,974	55,656	$ 113.6	$ 170.09	12	0.9%	10	5,402,058	$ 2,952	36
26	Montana	$ 2,370	10,200	$ 26.5	$ 216.50	17	1.1%	21	890,000	$ 2,363	8
27	Nebraska	$ 4,546	15,648	$ 46.8	$ 249.23	21	1.0%	19	1,652,093	$ 2,663	21
28	Nevada	NA	13,116	$ 69.9	$ 444.11	42	NA	50	1,781,750	$ 2,103	4
29	New Hampshire	$ 2,306	11,181	$ 77.2	$ 575.38	46	3.3%	49	1,177,000	$ 2,933	34

30	New Jersey	$ 23,422	68,628	$ 445.9	$ 541.45	44	1.9%	39	8,052,849	$ 3,197	45
31	New Mexico	$ 6,616	23,215	$ 62.1	$ 222.92	19	0.9%	14	1,720,000	$ 2,255	5
32	New York	$ 66,929	223,543	$ 1,029.4	$ 383.74	39	1.5%	36	18,137,000	$ 3,696	47
33	North Carolina	$ 20,693	243,925	$ 109.6	$ 37.44	1	0.5%	3	7,427,480	$ 2,456	12
34	North Dakota	$ 1,997	11,697	$ 19.9	$ 141.77	5	1.0%	17	643,539	$ 3,140	44
35	Ohio	$ 32,834	64,743	$ 241.2	$ 310.46	29	0.7%	5	11,200,000	$ 2,987	37
36	Oklahoma	$ 8,567	39,114	$ 78.1	$ 166.39	11	0.9%	13	3,317,000	$ 2,424	10
37	Oregon	$ 12,895	43,956	$ 185.0	$ 350.73	33	1.4%	33	3,236,000	$ 2,472	13
38	Pennsylvania	$ 33,209	85,500	$ 441.3	$ 430.12	40	1.3%	28	12,056,122	$ 3,444	46
39	Rhode Island	$ 3,609	15,269	$ 85.1	$ 464.45	43	2.4%	44	923,929	$ 3,710	48
40	South Carolina	$ 12,499	68,292	$ 154.0	$ 187.92	14	1.2%	24	3,776,000	$ 2,391	9
41	South Dakota	$ 1,718	12,325	$ 14.8	$ 100.07	3	0.9%	9	737,973	$ 2,646	20
42	Tennessee	$ 14,750	48,200	$ 121.4	$ 209.89	16	0.8%	8	5,368,198	$ 3,018	41
43	Texas	$ 39,855	268,955	$ 521.3	$ 161.52	10	1.3%	26	19,513,000	$ 2,553	15
44	Utah	$ 5,504	19,700	$ 72.0	$ 304.57	27	1.3%	27	2,048,753	$ 2,010	2
45	Vermont	$ 1,658	6,994	$ 12.4	$ 147.75	8	0.7%	6	584,711	$ 2,564	16
46	Virginia	$ 18,081	92,253	$ 158.6	$ 143.27	6	0.9%	11	6,734,000	$ 2,477	14
47	Washington	$ 18,651	93,682	$ 348.9	$ 310.36	28	1.9%	38	5,606,800	$ 2,698	24
48	West Virginia	$ 5,309	31,157	$ 141.3	$ 377.92	37	2.7%	46	1,815,717	$ 2,862	31
49	Wisconsin	$ 17,939	35,700	$ 250.0	$ 583.57	47	1.4%	31	5,192,298	$ 2,774	27
50	Wyoming	$ 2,012	12,500	$ 23.8	$ 158.67	9	1.2%	23	479,743	$ 2,080	3
	Total	**$ 782,815**	**2,977,572**	**$ 10,333.4**	**$ 289.20**		**1.3%**		**267,268,989**	**$ 2,896**	

Note: Does not include education employees or retirees. Total budget not provided for Nevada.

Source: Milbank Memorial Fund, NASBO, the Reforming State Group, 1997 State Health Care Expenditure Report

TABLE 12
State Employee Health Insurance Plans - 1999

	State	Number of Employees Covered	Total Number of Plans Offered (including self-insured)			Number of Self Insured Plans			Number of Employees Self-Insured	Self- Insured as Percent of Total Covered
			HMO	PPO/POS	Indemnity	HMO	PPO/POS	Indemnity		
1	Alabama	48,457	2		1			1	48,009	99%
2	Alaska	12,000			2			2	12,000	100%
3	Arizona	51,382	5		1				-	0%
4	Arkansas	60,000	4		1	4		1	29,594	49%
5	California	1,063,638	15	2	3		2		183,690	17%
6	Colorado	30,000	5		2	3			19,000	63%
7	Connecticut	57,000	10	1	1				-	0%
8	Delaware	32,000	2		3	2		3	32,000	100%
9	Florida	164,610	7	1			1		94,226	57%
10	Georgia	225,000	4		2				-	0%
11	Hawaii	49,167	2		1				-	0%
12	Idaho	18,200		2	2				-	0%
13	Illinois	242,809	11	3	1			1	149,264	61%
14	Indiana	36,345	7	2			2		9,323	26%
15	Iowa	30,000	12	1	1				-	0%
16	Kansas	43,948	7	1	2			2	31,323	71%
17	Kentucky	131,000	9	9					-	0%

18	Louisiana	117,000	3	1		1	1		87,000	74%
19	Maine	22,300		1					-	0%
20	Maryland	93,206	7	5			5		40,585	44%
21	Massachusetts	138,398	6	1	1		1	1	78,887	57%
22	Michigan	40,000	18		1			1	26,400	66%
23	Minnesota	45,000	5	1		1	1		20,000	44%
24	Mississippi	126,000		1			1		126,000	100%
25	Missouri	56,000	15	5					-	0%
26	Montana	14,000	2		2			2	11,000	79%
27	Nebraska	15,350	1	1						0%
28	Nevada	28,000	3	1			1		19,600	70%
29	New Hampshire	11,000	1	1					-	0%
30	New Jersey	78,000	14	1	1		1	1	71,670	92%
31	New Mexico	22,000	1	1		1	1		22,000	100%
32	New York	197,772	24	1					-	0%
33	North Carolina	359,441	10		1			1	273,618	76%
34	North Dakota	20,534	1	1					-	0%
35	Ohio	62,000	10	1			1		20,000	32%
36	Oklahoma	37,500	5		1			1	19,500	52%
37	Oregon	39,000	6	6					-	0%
38	Pennsylvania	85,000	20	5	1	20	5	1	85,000	100%
39	Rhode Island		4	3	1					0%

		24,000							-	
40	South Carolina	217,201	3		1			1	188,111	87%
41	South Dakota	11,985		1	3		1	3	11,985	100%
42	Tennessee	64,055	8	4		1	4		47,014	73%
43	Texas	257,744	14	1		1	1		138,317	54%
44	Utah	17,835	1	1	1	1	1	1	17,835	100%
45	Vermont	9,400	3		2			1	5,570	59%
46	Virginia	111,206	6	1		1	1		78,654	71%
47	Washington	144,000	15		1			1	37,000	26%
48	West Virginia	107,278	5	2			1		45,317	42%
49	Wisconsin	70,000	22	2	2		1	2	13,000	19%
50	Wyoming	14,000			2			2	14,000	100%
	Total	######	**335**	**71**	**44**	**36**	**33**	**29**	######	**43%**

Source: LRC staff telephone survey of state employee health insurance officials, conducted July 1999.

Thirty-four states have at least one self-insured plan. Forty three percent of all state policies are self-insured. In those states offering self-insured plans, 53 percent of all policies are in the self-insured options. Eleven states have developed at least one self-insured HMO, 20 states self-insure a PPO or POS plan, and 20 offer a self-insured indemnity plan. Of the 34 states with a self-insured plan, eleven reported that the plans were losing money in various amounts. Seventeen respondents characterized their plans as "breaking even" or better, and the remaining respondents were unable to provide the requested information. Kentucky and Colorado were both in the process of closing self-insured plans because of mounting losses.

Unlike employers in general, states are apparently increasing their use of self-insured plans, while maintaining a strong commitment to offering HMOs. A 1994 survey of states found 25 with self-insured plans versus the 34 in 1999.[34] Forty-one states offered at least one HMO in 1994, compared to 44 in 1999. There has been virtually no change in the number of states offering at least one indemnity plan, at 31 in 1994 and 30 now.

Issues Relating to State Self-Insured Plans

It is interesting to note that private employers and state government employers are moving in different directions with regard to self-insuring employee plans. A major reason for this is that, other than seeking cost reductions, private employers and state governments have very different incentives for self-insuring.

There are three major differences between private employers and state government employers that affect their incentives to self-insure – regulatory differences, geographic differences, and political differences. One of the major incentives for private employers is that private self-insured plans are regulated under the federal Employee Retirement Income Security Act of 1974 (ERISA). Because of this, they are not subject to either state regulations or state premium taxes. Private employers who operate facilities in multiple states argued that this would allow them to standardize employee health insurance operations for greater efficiency. Since state governments are not subject to state insurance laws and premium taxes, this absence of regulation would have no effect on their decisions to self-insure.

Although private employers may operate in various locations, they generally face health insurance markets in a fairly small set of locations that are often relatively distant from each other. Particularly if they include teachers, state governments must cover employees in every area of a state and, in the case of retirees, areas outside the state. This requirement to offer a health insurance plan that is workable in every market condition is a difficult problem for state governments that is rarely faced by either private or local government employers.

Another major difference between private employers and state government employers is the ability of state employees to exert significant influence on management decisions, even in non-unionized states. Subject to the need to attract and retain a productive workforce, private employers have a fair amount of latitude in making health insurance decisions that reduce costs. In contrast, state policymakers are constrained by the fact that they owe their jobs to the electorate. Within an increasingly disengaged electorate, state employees often represent an organized group of active voters who understand how the system works. This, coupled with the fact that the media usually covers issues

[34] Maciejewski, Matthew, Bryan Dowd, and Roger Feldman, How do states buy health insurance for their own employees?, *Managed Care Quarterly*, Vol. 5, No. 3, 1997, p. 11.

that affect large numbers of state employees, means that policymakers have to tread carefully around sensitive issues like health insurance.

While state policymakers might look to private employers for particular ideas about cost containment practices, because of the significant differences outlined above, private employers are not judged a good source of strategies for developing the overall structure of state employee health insurance plans. Therefore, in the discussion of particular issues relating to employee health insurance, the practices of state governments are referenced as the relevant case studies.

The major issues relevant to the establishment of a self-insured state-employee health insurance plan are discussed in turn. These include the need to offer state-wide coverage, solutions to the problem of adverse selection, development of adequate utilization management, data requirements, and location of administration responsibilities. A final consideration of the decision to self-insure concludes the section.

Need to Offer State-Wide Coverage

No state offers just an HMO option to its employees and retirees. It is likely the need to provide insurance coverage in every part of a state, and even out of state for retirees, that prevents states from experimenting with full use of this option. The limitation, of course, is that HMOs have not generally formed in rural areas, and employers have not been successful in fostering their creation.

A recent study concluded that managed care penetration into an area is significantly more likely the greater the number of physicians in group, rather than single practice, the more competition that exists among hospitals, and the lower the average hospital occupancy rate. It was also determined that areas with a greater number of large non-governmental employers, a higher population density, and a higher percentage of college-educated individuals were more likely to have higher managed care penetration into the market for health insurance.[35] Another study noted that, although there has been a significant increase in the percentage of rural counties across the U.S. that are listed in the service area of at least one HMO, this has not translated into actual rural enrollment, which has remained very low.[36]

The factors that foster development of viable managed care networks are not likely to exist in rural areas and are not generally under the control of state governments. This means it is very difficult for states to create or rent managed care networks in rural areas to provide health insurance for state employees. South Dakota first attempted to develop a state-wide managed care network, to be anchored by its state employee group, but which would also be open to private groups. It quickly became apparent that this task was too large and difficult to accomplish in one effort, so the decision was to implement the plan only in the capital city of Pierre, which had 2,400 state employees out of a total population of 10,000. Although the plan became operational in 1994 and enrolled 74 percent of the eligible employees, state officials found that that it was difficult to implement a typical managed care model in the rural setting. The rural physicians rejected a capitated fee system and the single local hospital refused to join the network. Reviewers of the effort offered three lessons from South Dakota's experience.

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[35] Danrove, David, Carol J. Simon, and William D. White, Determinants of managed care penetration, *Journal of Health Economics*, No. 17, 1998, p. 729.

[36] Moscovice, Ira, Michelle Casey, and Sarah Krein, Expanding rural managed care: enrollment patterns and prospects, Health Affairs, Vol. 17, No. 1, January/February 1998, p. 172.

1. "Without supportive market pressures, the success of ambitious managed care initiatives in rural areas, particularly when collaborative relationships among employers are sought, depends crucially on strong leadership. But, leadership of this type may be difficult to sustain."

2. "Where there are not significant market pressures for the adoption of managed care, rural providers are in relatively strong positions to influence the ultimate form of managed care initiatives."

3. "Contracting with individual provider groups to establish provider networks for employees is administratively time consuming and challenging for rural employers."[37]

The areas of greatest government influence over the development of managed care networks in the future are in Medicaid and Medicare. Those efforts have not yet gotten off the ground in rural Kentucky. Also, the high percentage of employees who enroll in managed care plans when given the choice indicates that the fixed co-pays and absence of a deductible are attractive, even with the associated limits on freedom of choice. It is unlikely that employees who prefer the fee structure of a managed care plan would welcome a return to a non-managed care fee structure. Therefore, the conclusion is that Kentucky officials will, for the foreseeable future, face two distinct health insurance markets for state employees – an urban market with significant managed care penetration and a rural market with few established provider networks. The task will be to take advantage of the savings available in each market, without letting either unfairly disadvantage the other.

Adverse Selection

Any time participants in a health insurance group are free to choose among more than one plan, adverse selection is a possibility. If the market for health insurance were uniform throughout the state, officials would have the option of keeping the group together under one carrier, either fully-funded or self-insured, and not have to worry about a disproportionate distribution of claims. However, the conclusion that Kentucky state employees will continue to be distributed into two distinct health insurance markets means that designers of the structure of options available to state employees must incorporate adequate controls for adverse selection, or risk continued instability and price spikes for certain segments of the insured group.

There are two categories of adverse selection to consider – that *between* categories of plans (HMO, PPO, indemnity) and that between particular plans *within* a category (such as between two HMOs.) As was the case with Kentucky Kare, the adverse selection that can develop when some employees choose an HMO plan, while others choose an indemnity plan, can quickly cost millions of dollars and disrupt insurance markets in large geographic areas.

There are four major reasons that the cost structures of managed care and indemnity plans are different. Indemnity plans tend to be disproportionately selected by policyholders who are more likely to need medical care. Because of the absence of utilization controls, policyholders tend to use more medical services, and those services are

[37] Christianson, Hon B. And J. Patrick Hart, Importing employer-based managed care initiatives to rural areas: the experience of the Sough Dakota state employees group, *Journal of Rural Health*, Vol. 13, No. 2, Spring 1997, p. 145.

more likely to be higher-cost specialty services. Also, because of the absence of capitation and network price agreements, providers tend to charge higher prices to patients with indemnity coverage.

This difference in cost structures can have significant implications for the setting of state contributions and premium rates when employees have access to managed care and non-managed care options. The state contribution amount becomes somewhat of a target for carriers. On average, they don't want to set a premium significantly lower than the state contribution so that they can capture all of the profit available in that contribution, even if it means enriching the level or quality of services offered. They also don't want to set a premium much higher than the state contribution, because, in the face of large monthly out-of-pocket costs, employees will seek alternate plans. When the indemnity plan is self-insured, there is often strong political pressure to hold premiums to an amount close to the state contribution.

If the state makes a fixed-dollar contribution for all employees, and this amount is close to the average cost of a managed care plan, then the indemnity carriers will be forced to have significantly higher premiums or lose large amounts of money. On the other hand, if the fixed- dollar contribution is close to the average cost of an indemnity plan, then managed care plans will reap large windfall profits. Neither of these situations is desirable.

In deciding how to set its contribution policy, a state must consider what it is trying to achieve. As noted above, contributions for health insurance are part of the total employee compensation package. An equal fixed-dollar contribution for each employee delivers the same addition to total compensation for all employees. This may be intended as an equitable arrangement. The problem is that a fixed-dollar contribution greatly accelerates the pace at which adverse selection will destabilize the health insurance arrangement when both managed care and indemnity plans are offered. Various states have used different approaches to reduce this effect.

Unequal Contributions. Some states contribute more for plans that cost more, to protect employees from the extra cost. For example, New Jersey contributes $86 per month for its self-insured indemnity plan and $78 per month for its self-insured POS. The problem with contributing more for more expensive plans is that it gives employees an incentive to choose the most expensive plans, thus raising aggregate state costs and removing the incentive for plans to control costs.

Recent research indicated that companies who contributed more for higher-priced plans, usually in an attempt to sustain a self-insured indemnity plan, were found to experience higher growth in premiums than companies who did not. In effect, these employers "paid more twice" by giving the extra contribution and by reversing the incentive for employees and providers to move to lower-cost coverage.[38] One way that New Jersey attempted to reduce this effect was by imposing an employee contribution of $31 per month on the indemnity plan, with zero employee contribution for the other plan.

In an opposite approach, some states preserve the incentive for employees to move to lower cost plans by contributing more for them and less for higher-cost plans. For example, Virginia contributes $304 per month for its self-insured POS plan, compared to $205 per month for its self-insured indemnity plan. While this sets up the incentive for employees to select the lower-cost plans, it may raise equity concerns. Employers do not require a higher contribution for insurance from female employees, or those who are older or have chronic health conditions. This is seen as

[38] Hunt, Kelly A., Sara J. Singer, Jon Gavel, Derek Liston, and Alain C. Enthoven, Paying more twice: when employers subsidize higher-cost health plans, Health Affairs, Vol 16. No. 6, November/December 1997, p. 150.

inequitable. However, charging more for the indemnity plans, which these individuals are most likely to choose, in one sense, does exactly that. That is why it is important to consider the reasons indemnity plans are more expensive.

An argument can be made that it is unfair to require employees to pay more for insurance because of factors mostly beyond their control, such as age, gender and health status.[39] It may also seem unfair to impose higher costs on employees who live in rural areas that do not meet the conditions for development of managed care. On the other hand, it may seem unfair to give an extra contribution to those who simply prefer to be unfettered by the restrictions on access to specialty care faced by those in managed care plans. Also, much of the additional cost for indemnity coverage actually accrues to providers who charge more to those not covered by network agreements.

In most states, the state contribution covers most of the cost of single employee coverage. Employee contributions are relatively low; however, research has shown that employee choices are sensitive to relatively small differences in out-of-pocket costs.[40] In this situation, the state could impose small employee contributions as an incentive to select cheaper plans, then allocate its contributions in whatever manner achieves the lowest total cost. The problem with this approach is that many employees are still faced with out-of-pocket costs for dependent coverage. The total allocation that is least costly for the state may impose higher costs on some employees for dependent coverage.

To get around this problem, some states make significant contributions for dependent, as well as employee coverage. For example, Arizona, Connecticut, Massachusetts, Oklahoma, Florida, Michigan, Washington, Virginia, New Jersey, and North Carolina are all among the states that contribute most, or all, of the cost of dependent coverage for at least one of the plans offered. Tennessee pays 80 percent of the employee and dependent cost of its highest priced plan. This means that employees who choose the higher priced indemnity plans pay 20 percent of the monthly cost, while those who choose the lower priced HMO plans pay only about 15 percent. Because employees are not subject to significant out-of-pocket costs from the state's management of its insurance options, these states have more flexibility in solving the problems associated with adverse selection.

However, this solution also raises concerns, both about equity and labor market effects. Health insurance contributions are one part of the total compensation package. Labor economists would argue that the amount of compensation paid any employee should be related to the productivity of that employee in achieving the employer's goals. Making an additional contribution for dependent health insurance coverage, in effect, gives an across-the-board raise to employees who choose to cover their dependents under a state insurance plan, while denying that raise to those who either don't have dependents, or who choose to cover them elsewhere.

Unless there is some reason to believe that employees with dependents in a state insurance plan are more productive than those without, then the contribution for dependent coverage can distort the labor market for state jobs. By offering a contribution for dependent coverage, the state will attract applicants who want dependent coverage and, all else equal, will not attract employees without dependents. The state will pay considerably more for its insurance offerings, and will not necessarily attract the most productive employees. Also, under this arrangement private

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[39] Although many make a strong case that individuals do have significant control over their own health status, the tradition has not been for employers to impose higher insurance contributions on employees with conditions such as cancer or heart disease.

[40] Buchmueller, Thomas C., Does a fixed-dollar premium contribution lower spending?, Health Affairs, Vol.17, No. 6, November/December 1998, p. 228.

employers are able to shift some of their insurance costs to the state. For example, say a state employee has a spouse working for a private employer who offers insurance. If the state pays for dependent coverage, the private employer can develop an incentive for the spouse to seek coverage as a dependent on the state policy, rather than on the employer's policy.[41] These types of problems are a major reason that some large private employers have adopted a "cafeteria" style approach to benefits. They offer a set contribution for all benefits, then let employees allocate that total amount among leave time, retirement options, and health insurance coverage according to their individual priorities. State governments have not generally adopted this approach.

There are several conclusions from a review of this issue. First is that employees are very responsive to the incentives that exist in a state's contribution arrangement. Second is that the way these incentives are structured can have profound financial impacts on individual employees, on the competing insurance plans and on the state itself. Third is that decisions about contribution arrangements must incorporate *both* equity and technical considerations that interact in very complex ways. Thus, the decision cannot be made simply by technicians. It must be made by policy makers who are informed about the technical consequences of the various options they consider as they seek an arrangement considered equitable.

Risk Adjustment. Adverse selection is not simply a phenomenon that occurs between managed care and indemnity plans. Any time policyholders can choose among more than one plan there is the chance that one of the plans will get a disproportionate share of policyholders with higher than average claims. The plan with the greater share of such policyholders will have higher average costs, while the plan with the smaller share will have lower average costs. This represents a significant incentive for plans to attempt to attract low-cost policyholders and repel high-cost policyholders. If some plans are successful in this attempt, they can force the other plans into an adverse selection death spiral. This creates market instability and can impose a harsh financial burden on policyholders in the disadvantaged plan.

The most common tool for minimizing this incentive is to apply a risk adjustment mechanism, whereby plans with a less than proportionate share of expensive policyholders pay some of their premiums to the plans with a greater than proportionate share of expensive policyholders. The state of Washington has been a leader in developing and using a risk adjustment mechanism.

The state of Washington implemented a risk adjustment mechanism in its state employee health insurance market in 1988. Initially, the payment adjustments for plans were calculated on the basis of various demographic characteristics of enrollees. These included age, gender, member status, family type, COBRA status, and retiree status. Recently the state has begun a phase-in of a "health status-based risk adjustment approach which will expand the risk calculation to include a measure of health status based on enrollees' recent diagnostic experience."[42] The stated policy objectives for this move are as follows.

1. "Providing a level playing field via equitable reimbursement. Our interest is in providing reasonable payment to health plans based on the predictable differences in the health risk of their enrollees. Risk adjustment is an approach that increases the sensitivity of health plan payments to the treatment needs,

[41] This could be in the form of a negative incentive, such as requiring a significant employee contribution for the private employer's plan, or a positive incentive, such as offering a cash payment to the employee for not choosing to enroll in the private employer's plan.
[42] Washington Health Care Authority, *Annual Report to the Legislature*, January 1998, p. 3.

and therefore costs, of enrollees with different risk profiles, without undermining the insurance aspect of managed care plans."

2. "Encouraging the management of care, not the management of risk. Risk adjustment is one tool to provide an incentive to health plans to enroll any individual, regardless of illness burden. The tool is particularly geared to provide an incentive to enroll and care for, rather than avoid, individuals who have a chronic illness and who carry a higher than average illness burden."

3. "Increasing the accuracy of health plan bids. The Washington Health Care Authority believes that, in the long run, reducing uncertainty about the risk profile of a population allows health plans to be more confident in their bid calculations and therefore lessens their need to 'guess conservatively' (i.e., higher)."

4. "Enhancing the Health Care Authority's opportunity to understand the unique health care needs of its population and use that information in designing appropriate benefit coverage."[43]

The key features of the Washington risk adjustment method are the mandatory participation of all plans offered to the state group, that funds are shifted among plans based on their mix of risks relative to the average for the whole group, and that the total amount paid by the state is not affected by the risk adjustment process. In a simulation of the mechanism on actual prior year data, about 5 percent of total premium payments were redistributed among plans because of unequal distribution of risks. Data on actual transfer amounts during the first year of operation have not yet been published.

Note that risk adjustment is important whether one of the plans is self-insured or whether all of the plans are fully-funded. Left unaddressed, adverse selection can destabilize the insurance offerings to any group, possibly until only one viable carrier is left.

Utilization Review

In order to be able to afford to offer non-managed care options to certain segments of its employee group, a state must impose some kind of adequate management of costs in those options. This is particularly true if the non-managed care plan is self-insured. The absence of the provider networks and capitation arrangements does not mean that the state cannot impose some control on the costs of claims.

Analysis of its employee claims by officials in Massachusetts showed that employees in the self-insured indemnity plan were charged significantly more for the same procedure requiring the same length of stay in the hospital than were employees in a managed care plan. For example, the claims data indicated that the state plan was charged an average of $19,700 for a hip replacement, compared to $7,500 in an HMO, even though the hospital stay was the same.

[43] Wilson, Vicki M., Cynthia Smith, Jenny Hamilton, Corolyn Madden, Susan Skillman, Bret Mackay, James Matthisen, and David Frazzini, Case study: the Washington State Health Care Authority, *Inquiry*, Vol. 35, Summer 1998, p. 178.

> The indemnity plan has been paying an average of $18,268 to treat a heart attack while a managed care plan pays an average of $8,168 for the same care. The indemnity plan pays 123% more. The indemnity plan pays an average of $7,277 for maternity services, while other plans pay $4,659 on average, a difference of 59%.[44]

State officials reasoned that, given the large penetration of managed care arrangements, those costs should be defined as the "reasonable and customary" indicator of the cost of services. Therefore, they specified that their self-insured indemnity plan would adopt a reimbursement schedule tied to the average payments received from managed care plans. According to a state official, this saved the plan over $20 million in one year.[45]

Data Systems

The one constant among states that are attempting to gain control of costs in their employee health insurance plans is a focus on developing the ability to monitor and analyze claims data. Several states assert ownership of the claims data of policyholders in their groups, and require any carriers that provide coverage to agree to submit the claims data to state officials. Access to complete and accurate enrollment and claims data is critical if state officials want to offer their employees adequate and equitable insurance coverage at a reasonable cost.

[44] Massachusetts Group Insurance Commission, home web page, accessed and printed on July 15, 1999.
[45] Telephone conversation with Helena Rubinstein, Massachusetts Group Insurance Commission, July 30, 1999.

Administration of Self-Insured Plans

The issue of who does the enrollment processing, claims-processing and utilization review for a state self-insured plan is actually fairly simple. The entity(s) that can deliver adequate quality service at the least cost should be chosen. Most states contract with one or more outside firms to complete these tasks, while a few complete the tasks in-house. For example, the Group Benefits Program of Louisiana uses approximately 300 state employees to do all enrollment and claims processing, audits, and analysis. In Pennsylvania, the Commonwealth and the state employee union jointly administer the Employees Benefit Trust Fund. In this self-insured plan, when accumulated reserves exceed three months of claims, a moratorium on monthly premium collections is instituted until reserves fall back to the target level.

Three mistakes can be made in the process of selecting an administrator. First is selecting an administrator who has even the appearance of a conflict of interest in processing the claims data for the state's plan. If competing carriers are used for this purpose, the question of a conflict of interest will be raised any time difficulties occur, even if they are entirely innocent. This issue is compounded for an administrator who also provides medical services to enrollees. A provider charged with processing its own claims payments would have to continually deliver error-free audits to allay the perception of self-interest. A more reasonable course would be to choose non-competitors and non-providers as the plan administrator.

The second serious mistake is to choose the administrator on any criteria other than technical competency and price. Given the critical importance of accurate claims data in managing the insurance program, technical competency should be weighted more heavily and evaluated more stringently than any other criterion.

The third serious mistake in the process is for state officials to fail to impose adequate oversight on administrators. No matter who completes the administration of enrollment, claims, and utilization review, state officials should regularly expose all aspects of their operations to independent audit review and data validation, and should require that problems be corrected when they are found.

Self-Insured Versus Fully-Funded Plans

A final point to note is that much of the discussion about the problems created by adverse selection, insufficient state contributions, poor utilization review, and inadequate data analysis applies whether a state chooses to self-insure its employees or contracts with private insurance carriers for coverage. These problems can cause disruption in the state employee insurance market for any carrier. A state cannot trade these problems away simply by contracting with a private carrier, because the carrier will either fail or drop the contract, leaving the state to find alternate coverage under difficult conditions. Nor will the problems be solved simply by self-insuring. States may be able to absorb some losses associated with a self-insured plan, but when those losses start to mount by the tens of millions, they cannot be ignored.

A decision about whether to self-insure or fully-fund any of the plans offered to state employees is not terribly complex. It should be made on the basis of a technical assessment of who can provide the desired coverage in the most cost-efficient manner. The major difference between the two approaches is who bears the risk for unexpectedly large claims. Since some form of reinsurance usually covers these, the real difference comes down to who can deliver the best product at the least administrative cost.

The most important, but difficult, decisions involve how to organize a state employee health insurance market that

- is stable and has adequate protections against adverse selection
- attracts productive employees
- is efficient and provides accountability in the use of tax dollars
- equitably balances the needs of urban and rural employees
- equitably balances the costs of employees who have few medical expenses and those who have many
- equitably balances the preferences of employees who would choose the fee structure of a managed care plan and those who would choose fewer restrictions on access to medical services.

If these conditions are met, the program will be a success whether it is self-insured or fully-insured. If these conditions are not met, employees will face continuing disruption in their health insurance coverage, and policymakers will face continuing controversy.

Section III: Conclusions and Recommendations

The Program Review and Investigations Committee instructed staff to evaluate the reasons for the demise of Kentucky Kare and to assess the feasibility of the Commonwealth's establishing another self-insured plan to provide health insurance to state employees and retirees. This section presents the conclusions regarding these issues and offers recommendations intended to improve the stability and equity of the market for state employee health insurance.

Conclusions

- **Kentucky Kare failed because of the adverse selection created when it offered a state-wide indemnity plan that competed against regional managed care plans. The problems created by this adverse selection were greatly exacerbated by artificial limits on premiums and insufficient utilization management. A complete absence of reliable data about enrollments, premium receipts and incurred claims made adequate response to these problems all but impossible.** Adverse selection occurs when one of two or more insurance plans offered to a group attracts a disproportionate share of policyholders with higher than average claims. Evidence exists that Kentucky Kare was faced with rapidly declining total enrollment and was retaining policyholders who were older and had higher average claims than the policyholders it was losing. Policy decisions to restrict premium increases added to the plan's financial problems. Insufficient utilization management, which allowed 70 percent of hospital admissions to occur through the emergency room, caused claims losses to mount much more quickly. Enrollment, premium and claims data was either unavailable or completely unreliable, to an extent that managers did not know how many policyholders they had, what their total premium receipts were, nor what their claims costs were.

- **The problems experienced by Kentucky Kare were larger in magnitude, but similar in nature, to those which caused Blue Cross & Blue Shield to suddenly withdraw its Key Care indemnity plan for state employees in 1987.** Blue Cross & Blue Shield gave a 30-day notice that it was canceling its indemnity plan with the state group for the second year of a two-year contract. The official reason given for the termination was late premium payments by the Department of Education. However, the cancellation notice came immediately after state officials refused to agree to a 16 percent increase in premiums. An independent audit commissioned by the Department of Insurance indicated the plan had lost nearly $50 million in the previous three years, and that the rate of losses was increasing. Shortly before these losses began to accrue, the Department of Personnel had opened the state employee market to over a dozen competing HMO plans. Also, at the time of the crisis, state officials raised serious concerns about inadequate premiums and insufficient data on which to make decisions.

- **That such similar problems occurred in both a fully-funded plan and a self-insured plan, and over a significant period of time, indicates that the Commonwealth has a structural instability in its state employee health insurance market that must be addressed.** The instability in the market primarily comes from these circumstances: the Commonwealth attempts to seek equity by setting a single state-wide contribution and benefit policy, when employees are distributed into (at least) two distinct health insurance markets – an urban market, with significant managed care penetration, and a rural market, with little managed care penetration. Even within the urban market some policyholders, particularly those with chronic health conditions, prefer to chose health plans with fewer restrictions on access to care. There is significant pressure on all plans offered to the state group to bid a premium somewhere close to the state contribution. If that contribution is set closer to the average costs of a

managed care plan, the non-managed care plans will lose large amounts of money. If that contribution is set closer to the costs of a non-managed care plan, then the managed care plans will reap windfall profits.

- **There is little expectation that penetration of managed care into rural areas will increase significantly in the foreseeable future. This means that state officials must devise methods to ensure equitable treatment of employees in each of the different markets.** Managed care penetration into an area is more likely when

  - physicians are organized into group practices
  - there is competition among hospitals
  - hospital occupancy rates are low
  - the area's population has a high proportion of college graduates
  - there are many large non-governmental employers.

These conditions are largely out of the control of state officials. Neither of the governmental managed care initiatives, in Medicaid and Medicare, has yet been implemented in rural Kentucky, so they are not expected to change the current situation soon.

- **Employees, retirees, and insurance carriers respond to the incentives that exist in the structure of the health insurance program. How the incentives are designed can have a significant financial impact on individual policyholders, insurance carriers, and the state itself.** Policy makers will be under pressure to develop a state contribution policy that is perceived to be fair and equitable to both taxpayers and employees. However, the contribution policy must also promote stability, rather than instability, in the multiple markets for state employee health insurance. Decisions about this policy must take into consideration a technical assessment of the likely effects of the policy on the operation of these markets.

- **Risk adjustment is a valuable tool for addressing the problem of adverse selection among plans.** A risk adjustment mechanism takes some premium income from plans that attract fewer than the average number of higher-cost policyholders and reallocates it to plans that attract more than the average number. A successful risk adjustment mechanism reduces the incentive for plans to make money by avoiding policyholders with chronic health conditions. This adjustment helps to stabilize the market for all carriers. However, the task of constructing and implementing an adequate risk adjustment mechanism is technically complex and will require significant time and expertise.

- **Compared to those of other states, Kentucky's premium contribution per employee is low.** Data was obtained that showed the total appropriation for health insurance premiums for employees of state agencies in every state in FY 1997. This was divided to get a monthly per-employee appropriation in each state. The total amount appropriated for health insurance was also divided by the total state budget to get the share of the total budget devoted to this use. Kentucky had the 7th lowest monthly per-employee appropriation for health insurance, and the 2nd lowest share of the total budget devoted to this use. Since the state as a whole had the 23rd lowest per capita health expenditures, it is not likely that average lower cost or lower utilization of medical services in the state accounts for these results.

- **In the future, it should be entirely feasible for the Commonwealth to establish a self-insured plan. However, this step alone will not solve the structural problems that exist in the markets for state employee health insurance.** Thirty-four states operate self-insured plans. Most of these are for plans with fewer managed care features than a traditional HMO. These plans insure about 43 percent of the employee groups insured by all state governments. Whether this will be a preferred approach for Kentucky primarily reduces to the question of who can administer the program most cheaply. Neither a fully-funded plan nor a self-funded plan will be able to long absorb the losses if the problems of adverse selection, utilization management, insufficient premiums, and poor access to reliable claims data are not adequately addressed.

- **We do not currently have adequate data to allow state officials to make reliable decisions about how to best change the structure of the state employee health insurance market.** Reliable decisions about the best ways to structure the program to provide health insurance to state employees and retirees depends critically on access to valid and complete enrollment and claims data. Decisions about how to change the market should depend on a good understanding of the ways employees and retirees sort themselves among the various plans they are offered, and the patterns of costs they incur as they seek covered medical care. Data for those purposes is not currently available.

Recommendations

Based on the above conclusions, the following recommendations are offered.

Recommendation 1: The state should assert ownership of all the enrollment and claims data for the policyholders in the state group. As noted in the conclusions, this data is critical in any effort by state policymakers to efficiently and equitably manage the health insurance options provided to state employees and retirees. As a condition of offering a plan to this group, insurance carriers should be required to provide complete and detailed enrollment and claims data on a timely basis.

Two points should be made. First, it is not necessary to impose uniform data systems or formats on all carriers. Competent data analysts should be able to take individual-level claims data from various sources and make the adjustments necessary to combine them into a usable master data set. However, it *is* important that all carriers be required to report comparable types of data that are unique to the state group. For example, an inability to separate pharmacy costs for state-group policyholders from those in other books of business, or an inability to incorporate incurred-but-not-reported claims as part of the total reported for any period, should be considered unacceptable.

Second, concerns about confidentiality of the medical claims data for individual employees are not difficult to address. It should be a fairly direct procedure to develop a unique identifier for each claimant that is stripped of any information that would allow analysts to determine his or her identity, but still allow analysis of claims on the basis of factors such as age, gender, and location. Encryption technology can be used to provide a secure ability to link the anonymous data back to particular individuals for the purposes of data validation or other legitimate needs that arise.

Recommendation 2: Immediate priority should be given to two parallel efforts that will improve the Commonwealth's ability to manage its state employee health insurance options. The first effort should target an

improvement in data handling and analysis capabilities, and the second effort should target creation of a group charged with making the difficult policy choices in balancing questions of equity and cost.

Recommendation 2A: The Commonwealth should invest adequate resources in the development of sufficient technical capabilities to monitor and analyze state employee health insurance data. It will take some time to develop a working system for the collection, validation, and analysis of enrollment and claims data for the whole state group. However, that capability is considered necessary to provide policymakers with the data they need to make informed decisions. Development of this capability should begin immediately and be given a top priority.

One of the continuing failures of both Kentucky Kare and the Health Purchasing Alliance was the inability to adequately oversee the operations of their third party administrators, due to a lack of staff resources and expertise. Therefore, even if the Commonwealth chooses to hire outside contractors to do the bulk of the required data analysis, sufficient technical capabilities and staff resources should be maintained in-house to provide independent verification and oversight of results submitted by contractors.

Recommendation 2B: A board should be established to make the complex policy decisions pertaining to the provision of health insurance to state employees and retirees. Suggested membership of the board includes:

- Secretary of the Finance and Administration Cabinet
- Secretary of the Personnel Cabinet
- State Budget Director
- Auditor of Public Accounts (Ex-Officio)[46]
- Commissioner of Insurance (Ex-Officio)
- Representative for active employees of state agencies and boards of education
- Representative for retired employees of state agencies and boards of education.

The board should reconsider the manner in which the state contribution is set, should evaluate the possibility of incorporating an improved risk adjustment mechanism into the process, and should determine whether another self-insured plan ought to be established. The alternatives considered for each of these decisions will have different effects on various groups of policyholders, insurance carriers, and taxpayers. Determining what is an equitable distribution of costs and benefits is a matter for policymakers. However, decisions on these matters should be informed by sound technical information about the likely market consequences of each alternative. Therefore, if this recommendation is implemented, it is also recommended that the policy-making board be supported by a staff with expertise in employee benefit design, analysis of health insurance markets, estimation of actuarial risk,

[46] There may be a concern about a possible conflict of interest in having the Auditor of Public Accounts serve, even as an ex-officio member, of a board that makes policy decisions for an entity that he or she may later have to audit. However, the long history of this office in raising repeated warnings about problems with both Kentucky Kare and the Health Purchasing Alliance, indicates that the Auditor could play a valuable role in designing a successful and accountable program. If the possible conflict is considered a serious problem, an outside auditor could be used to complete any required independent audits.

prudent financial management, and appropriate accounting protocols. Even if outside contractors are hired to do major components of the required technical analysis, the board should have a regular staff who are familiar enough with the technical details to provide independent clarification and verification of technical conclusions.

Recommendation 3: The General Assembly should expand its oversight of the management of the state employee health insurance program. In particular, the General Assembly should require regular and detailed reporting on the distribution of enrollment, and claims, and on the financial stability of the program. There are two reasons for this recommendation. First, when there were problems in the program in the past, members of the General Assembly were in a position of having to conduct policy deliberations and respond to constituent concerns without adequate information on program operations. Regular reporting would reduce the chance that legislators will remain uninformed of problems until a crisis develops, and may allow them to require earlier corrective action. Second, the existence of a requirement for regular and detailed reporting of information to the General Assembly will necessitate the creation and maintenance of the critical data systems specified in Recommendation 2A. A regular reporting requirement will reduce the likelihood that commitment to the effort would wane.

Recommendation 4: Entities that provide either health insurance products or covered medical services to the state group should not be selected as administrators or contractors for the program, unless there is some overriding reason for an exception. There is no reason to believe that contractors and administrators with no connection to the program would necessarily provide higher quality service than those who do have a connection to the program. No matter who manages them, complicated information processing systems rarely run perfectly. Problems often develop, usually because of the complexity of the system and because of a nationwide shortage of skilled personnel to maintain such systems. However, if the administrator has even an indirect financial interest in the operation of the program, it is difficult to allay the suspicion that, when problems occur, they were somehow intentional.

Recommendation 5: The 2000 General Assembly should not expect to solve the structural problems in the state employee health insurance program during the upcoming Regular Session, but should understand that a long-term commitment to developing a solution is needed. It will take considerable time and effort to fully assess the current status of the program, much less evaluate the impact of major changes. Given current dissatisfaction with their health insurance options on the part of many members of the state group, policymakers may be under significant pressure to make major changes during the 2000 Session of the General Assembly. Unfortunately, there are no quick or cheap solutions to the problems facing the state employee health insurance program. The lack of data and the need for a thorough evaluation of options will make it difficult for the 2000 General Assembly to develop a long-term solution. It is entirely reasonable to adopt short-term measures to temporarily address some of the more pressing financial and equity concerns. However, unless policymakers make a long-term commitment to resolving the underlying structural problems, they will be faced with periodic variations of the crises caused by the withdrawal of Key Care and the demise of Kentucky Kare. Band-aids won't cure a patient in need of major surgery.

APPENDIX A
Alliance Policies for Active State Employees -- State Agencies, Teachers, and Health Departments

		Single					Couple					Parent Plus					Family					
		Enhanced High	Standard High	Standard Low	Economy Low	Budget High	Enhanced High	Standard High	Standard Low	Economy Low	Budget High	Enhanced High	Standard High	Standard Low	Economy Low	Budget High	Enhanced High	Standard High	Standard Low	Economy Low	Budget High	Totals
Kentucky Kare policies																						
Kentucky Kare listed as prior coverage (stayed with Kentucky Kare)																						
	Number of policies	9,663	2,889	106	21	159	939	311	50	16	31	1,538	326	84	15	15	2,376	1,395	224	13	142	**20,153**
1	Monthly premiums	$ 1,772,408	$ 451,493	$ 14,030	$ 2,295	$ 12,001	$ 295,200	$ 99,476	$ 13,548	$ 1,296	$ 4,790	$ 397,514	$ 69,262	$ 15,115	$ 1,697	$ 1,642	$ 1,030,840	$ 487,996	$ 69,355	$ 3,206	$ 25,072	$ 4,821,552
	Average premium	$ 186	$ 156	$ 132	$ 107	$ 76	$ 378	$ 320	$ 271	$ 220	$ 165	$ 252	$ 212	$ 180	$ 146	$ 108	$ 434	$ 366	$ 310	$ 251	$ 177	
	Average age	47.4	44.5	41.9	40.8	40.5	54.1	50.2	46.1	43.5	41.7	41.7	40.6	40.0	39.9	37.7	44.6	42.9	39.8	40.8	39.9	
Non-Kentucky Kare plan listed as prior coverage (indicated they were new with Kentucky Kare)																						
	Number of policies	1,090	429	27	9	56	99	69	21	4	10	280	80	26	2	15	310	287	146	13	155	3,353
2	Monthly premiums	$ 203,680	$ 67,044	$ 3,574	$ 966	$ 4,227	$ 37,695	$ 16,872	$ 5,699	$ 879	$ 2,781	$ 73,068	$ 16,997	$ 6,296	$ 312	$ 1,539	$ 134,397	$ 104,910	$ 45,205	$ 3,206	$ 27,357	$ 758,426
	Average premium	$ 186	$ 156	$ 132	$ 107	$ 76	$ 379	$ 320	$ 271	$ 220	$ 165	$ 252	$ 212	$ 180	$ 146	$ 103	$ 434	$ 366	$ 310	$ 251	$ 177	
	Average age	44.8	43.5	43.0	45.8	41.5	51.4	45.0	45.0	36.0	44.2	40.3	39.2	39.3	52.5	41.1	43.4	41.7	39.7	38.2	39.5	
No prior coverage listed																						
	Number of policies	717	279	12		8	69	19	10	1	2	126	34	12	1	2	222	117	23	2	20	1,675
	Monthly premiums	$ 132,889	$ 43,602	$ 1,586		$ 604	$ 26,174	$ 5,757	$ 2,709	$ 220	$ 309	$ 31,747	$ 7,224	$ 2,159	$ 146	$ 205	$ 96,246	$ 42,768	$ 7,121	$ 502	$ 3,631	$ 406,609
	Average premium	$ 185	$ 156	$ 132		$ 75	$ 379	$ 320	$ 271	$ 220	$ 165	$ 252	$ 212	$ 180	$ 146	$ 103	$ 434	$ 366	$ 310	$ 251	$ 177	
	Average age	45.6	41.8	41.5		40.9	53.0	48.7	43.6	42.0	48.5	41.7	45.6	37.2	42.0	45.0	44.3	41.4	42.6	45.5	41.1	
Managed care policies																						
Kentucky Kare listed as prior coverage (left Kentucky Kare to go to managed care)																						
	Number of policies	13,810	1,113	43	44	28	1,033	266	45	44	15	2,423	665	60	65	4	788	534	116	109	10	**20,786**
3	Monthly premiums	$ 2,163,276	$ 186,115	$ 5,688	$ 6,188	$ 1,774	$ 339,292	$ 76,644	$ 12,495	$ 10,897	$ 2,406	$ 596,573	$ 148,586	$ 11,995	$ 10,084	$ 576	$ 368,881	$ 229,012	$ 44,823	$ 34,246	$ 2,251	$ 4,209,381
	Average premium	$ 161	$ 149	$ 137	$ 139	$ 89	$ 336	$ 303	$ 277	$ 249	$ 165	$ 247	$ 223	$ 200	$ 160	$ 144	$ 454	$ 412	$ 386	$ 342	$ 225	
	Average age	43.5	40.1	37.7	44.2	45.8	50.6	44.9	37.3	36.1	39.6	40.9	39.8	38.6	38.4	38.0	43.1	41.1	39.9	39.0	34.4	
Non-Kentucky Kare plan listed as prior coverage (did not indicate any association with Kentucky Kare)																						
	Number of policies	40,294	3,962	157	125	39	3,853	766	125	132	33	9,749	2,374	258	300	14	4,136	2,753	697	630	54	**70,757**
4	Monthly premiums	$ 6,689,529	$ 618,322	$ 22,752	$ 16,954	$ 3,314	$ 1,260,693	$ 242,035	$ 35,533	$ 32,039	$ 6,760	$ 2,409,669	$ 573,301	$ 66,206	$ 39,097	$ 1,940	$ 1,868,548	$ 1,139,749	$ 364,656	$ 204,106	$ 12,350	$ 15,829,694
	Average premium	$ 166	$ 156	$ 145	$ 136	$ 85	$ 328	$ 316	$ 284	$ 243	$ 174	$ 253	$ 214	$ 214	$ 164	$ 138	$ 449	$ 414	$ 388	$ 340	$ 229	
	Average age	43.7	40.2	39.0	43.0	39.2	50.4	44.0	40.4	39.4	38.0	40.4	39.0	38.3	38.6	43.1	43.2	41.0	40.9	39.5	40.2	
No prior coverage listed																						
	Number of policies	2,648	552	18	19	3	227	50	13	21	3	492	194	17	22	3	295	136	35	39	2	4,779
	Monthly premiums	$ 446,710	$ 82,511	$ 2,675	$ 2,436	$ 267	$ 75,621	$ 15,628	$ 3,498	$ 4,866	$ 645	$ 124,376	$ 46,099	$ 3,749	$ 4,273	$ 430	$ 128,036	$ 56,201	$ 13,466	$ 13,609	$ 432	$ 1,025,651
	Average premium	$ 169	$ 149	$ 149	$ 128	$ 89	$ 333	$ 311	$ 269	$ 236	$ 182	$ 253	$ 238	$ 221	$ 194	$ 143	$ 436	$ 413	$ 385	$ 349	$ 216	
	Average age	41.9	39.6	37.2	39.8	28.3	48.0	48.6	33.2	39.7	31.7	39.0	38.9	37.8	36.0	24.0	43.4	40.7	38.5	38.8	33.0	
Other indemnity policies																						
Kentucky Kare listed as prior coverage																						
	Number of policies	19	23		1	1	6	1			1	6					1	1			4	64
	Monthly premiums	$ 3,895	$ 4,030		$ 160	$ 100	$ 2,399	$ 341			$ 172	$ 1,998					$ 547	$ 478			$ 1,061	$ 15,133
	Average premium	$ 205	$ 175		$ 160	$ 100	$ 395	$ 341			$ 172	$ 332					$ 547	$ 478			$ 265	
	Average age	46.6	40.3		32.0	46.0	57.8	28.0			51.0	40.3					44.0	44.0			37.5	
Non-Kentucky Kare plan listed as prior coverage																						
	Number of policies	7	5	1	2		1	1				1	1								3	22
	Monthly premiums	$ 1,433	$ 875	$ 152	$ 266		$ 391	$ 341				$ 336	$ 276								$ 790	$ 4,858
	Average premium	$ 205	$ 175	$ 152	$ 133		$ 391	$ 341				$ 336	$ 276								$ 263	
	Average age	42.1	35.0	29.0	33.0		56.0	43.0				51.0	27.0								41.0	
No prior coverage listed																						
	Number of policies	2	1										1								1	5
	Monthly premiums	$ 425	$ 174										$ 275								$ 271	$ 1,145
	Average premium	$ 212	$ 174										$ 275								$ 271	
	Average age	39.5	63.0										43.0								39.0	

APPENDIX B

Summary of Independent Auditor Reports on the Operation of Kentucky Kare

Statewide Single Audits

Statewide single audits dating from 1990 through 1997 have reported problems with internal controls and lack of oversight of the Kentucky Kare Plan. The Auditor of Public Accounts (APA) performs a statewide single audit of the Commonwealth annually in conformance with generally accepted government auditing standards and the Single Audit Act of 1984. The Kentucky Kare Plan is part of the statewide effort. Each year the APA report contained financial statements and an opinion of the Kentucky Kare Plan. The supplemental report also contained reports on the internal control structure and compliance with laws and regulations.

FY 1990

In 1990, the Kentucky Kare Plan was operated by Department of Personnel and the ICH Corporation, an outside contractor. As the third party administrator, the ICH Corporation was responsible for maintaining eligibility files, issuing bills for premium payments, processing claim payments, producing accounting reports and actuarial data and reconciling bank accounts. The Department of Personnel performed administrative duties, including receiving and depositing premium receipts, investing plan funds and reconciling bank statements.

In the 1990 single audit, the APA noted several weakness in the internal accounting control over the receipt of premiums. Accounting reports by ICH Corporation were not reconciled to bank statements and sufficient follow-up was not performed by the third party administrator to determine whether claims errors detected in the review process had been corrected.

FY 1991

The 1991 single audit reported continued problems with the internal control structure for the Kentucky Kare Plan. The APA reported insufficient accounting procedures pertaining to the financial and membership data. Claims payments were processed inaccurately, and duplicate payment controls overridden. The APA also reported that payments were made to ineligible participants and recommended an accountant be made responsible for implementing proper accounting procedures over the financial and membership data. The procedures at a minimum should have included preparing a monthly trial balance and general ledger from which to prepare the financial statements; developing and documenting a comprehensive understanding of the plan's internal control structure, both in the department and at the third party administrator; establishing standards for documentation; and reconciling membership data.

The APA also recommended that procedures regarding claims payments be improved. During the review of the claims processing system at ICH, the APA noted three areas where errors occurred at a rate requiring management's attention. Errors in the first instance (incorrect calculations) were made by benefit analysts and involved incorrectly applying a participating hospital discount, incorrectly totaling a bill, failing to reject an emergency room deductible, and transposing numbers. Payment and/ or discount for 4 of the 59 tested claims were incorrectly calculated. Errors in the second area (duplicate payments) were made by benefit analysts after examining computer edits for possible duplicate payments. They overrode the computer edit messages and allowed the payments, when further examination would have revealed the duplicate payment. The third area dealt with errors resulting from the Department of Personnel not submitting termination and change information for the nonstate participants to ICH in a timely manner.

FY 1992

The Department of Personnel and three third-party administrators operated the Kentucky Kare Plan in 1992. The ICH Corporation was responsible for maintaining eligibility files, processing medical benefit claim payments, producing accounting reports and actuarial data and reconciling bank accounts. ACMG Incorporated was responsible for processing dental benefit claims payments and producing accounting reports. Healthcare Review Corporation (HRC) was responsible for pre-admission review and weekly reports of approvals.

The 1992 single audit again reported weaknesses involving the internal control structure for the Kentucky Kare Plan. The APA reported that claims processed by the third-party administrator, the ICH Corporation, revealed several payments that were either paid after the uninsured cancellation date or paid for a dependent when the insured had single coverage. Additionally, the APA noted three claims payments, from a sample of 80 possible duplicate payments, that were paid twice. The report went on to state that the duplicate payment errors resulted from the benefit analyst's ability to override the computer's detection and rejection of a duplicate payment. The APA recommended the Department of Personnel inform the third-party administrator of insurance changes within a month of the qualifying event. Also recommended was the possibility of ICH reviewing the claims history file when inputting coverage changes for dependents, to ensure previously paid claims on the dependents were actually eligible when paid. Finally, the APA recommended that the Department of Personnel emphasize to the third-party administrator, ICH, the need for benefit analysts to thoroughly check the medical history of a claim to ensure claims paid are not duplicated before overriding the system.

The APA noted that Kentucky Kare had not developed an accounting system, as recommended in the previous single audit for 1991. The APA noted that improvements in procedures over claims payments had been partially resolved since the 1991 audit, and the quality control follow-up on corrective action for overpayments had not been completely resolved.

FY 1993

In 1993, the Kentucky Kare Plan was operated by the Department of Personnel and the three third-party administrators identified in the 1992 single audit. The APA again identified problems with the accounting system. The APA indicated the Department of Personnel had not established a system to accumulate and control accounting and membership data relative to all facets of the Kentucky Kare Plan. The report indicated there was no centralized system for setting standards for financial records, or for accumulating, safeguarding, monitoring, and recording financial and membership information. Financial and membership data was accumulated by numerous sources within the Department and by third-party administrators. It was then given to an independent contractor who compiled the financial statements. The APA reported that by not having accounting and membership records, management could be without ready access to information necessary for decision making and accurate financial reporting. The APA recommended, as it had in previous years, that accounting information be centrally correlated through an individual knowledgeable about and responsible for the overall accounting control of the plan. The APA further recommended a staff accountant be made responsible for implementing proper accounting procedures over the financial and membership data of the Kentucky Kare Plan. Responsibilities at minimum should have included ensuring the accuracy of recorded receipts and expenses, maintaining a general ledger from which financial statements could be prepared, preparing a monthly trial balance and reconciling membership data between the state and all third-party administrators.

The APA noted several recommendations involving the quality control review at the third-party administrator, ICH. In the department response, it was indicated that the third-party administrator contract would be re-bid to be effective for the plan year beginning January 1, 1995.

FY 1994

The statewide single audit for 1994 continued to cite problems appearing in previous years. The plan continued to operate by the Personnel Cabinet and three third-party administrators, ICH, ACMG and Healthcare Review Corporation.

The APA noted deficiencies in the operation of the internal control structure that could have adversely affected the ability to record, process, summarize and report financial data consistently with the assertions of management in the basic financial statements. The reportable conditions noted that accounting procedures over financial and membership records were insufficient and controls over premium receipts were not adequate to ensure that all premiums due were collected and deposited.

Additionally the APA noted the monthly membership totals used by the third-party administrators to calculate their retention fees did not agree. The Division of Benefit Administration did not monitor this activity or reconcile the membership numbers used by each third-party administrator to calculate retention to verify the appropriateness of the amounts drawn. The APA also reported the

Cabinet did not monitor their third party administrator's procedures for recouping overpayments. No reports were issued from the ICH Corporation showing the status of the overpayments.

The APA reported that during FY 94, ICH Corporation did not require all hospital bills of $10,000 or more to be audited by a registered nurse or qualified professional, as required by their contract. Their most current procedures, for admission dates after January 1, 1993, were to require an audit only when the total ancillary charges (all charges except room and board) exceeded $10,000, except for specified hospitals, for which audits were performed only when the hospital bills' total ancillary charges exceeded $20,000. Although Cabinet officials were able to provide documentation showing approval to perform an audit only when ancillary charges exceeded $15,000, no one in the Cabinet could provide documentation authorizing the raise to $20,000 or to change the audit requirement. Additionally, the single audit revealed that from data obtained from the Claims History File, only .8% of total claims paid during FY 94 was recovered by the ICH Corporation through the coordination of benefits, although the contract stated the contractor must provide coordination of benefits recovery that guarantees the Commonwealth will exceed the national average. A minimum of 3% of total claims paid should have been recovered.

The APA stated there was no evidence for either of the above instances that a change order was executed to officially amend the original contract requirements. As a result, ICH was in violation of their contract with the Commonwealth. Additionally, the Cabinet allowed the noncompliance to continue.

The single audit noted that prior audit comments for the previous year had been partially resolved, with the exception of the accounting system and certain internal control procedures.

FY 1995

The single audit for 1995 reported responsibilities for operation of the Kentucky Kare Plan did not change from the previous year. Executive Order 93-182 gave the responsibility for administering the state employee health insurance program to the newly created Division of Benefit Administration.

The APA again recommended that an accounting system should have been developed to provide control over Kentucky Kare transactions. The report indicated the monthly membership totals used by the third-party administrators did not agree. The report stated without proper monitoring of third-party administrator activity, the possibility of errors being made and going undetected greatly increases. Once again the APA noted there had been no resolve on this issue from previous audits and that it remained unresolved at the time of the report. Additionally, the APA recommended the monitoring of third-party administrators should be increased. The audit indicated the Personnel Cabinet did not monitor their third-party administrator, ICH, during FY 94 for procedures for recouping overpayments. No reports were issued to the department from ICH showing the status of the overpayments. The APA went on to recommend the department require the third-party administrator to issue reports detailing all overpayments and show the status of the recoupment process. The report also recommended the Cabinet establish a written policy concerning the dollar amount of

over/underpayments that the third-party administrator would be required to take appropriate steps to resolve. The report indicated that the third-party administrator (ICH) did not require all hospital bills of $10,000 or more be audited by a registered nurse or qualified professional, as required by their contract. The APA recommended the Department monitor third party-administrators to ensure compliance with contractual requirements. The cabinet, in their response to this recommendation, indicated as of January 1, 1995, the Cabinet had contracted with Humana Health Plans as the third-party administrator.

On January 1, 1995 the Personnel Cabinet changed third-party administrators from the ICH Corporation to the Humana Corporation. ACMG Incorporated and Healthcare Review Corporation continued their contractual relationship with the Personnel Cabinet.

The 1995 single audit listed as a reportable condition that the Division of Benefit Administration did not adequately monitor the expenditures made by the third-party administrator. The material conditions noted were: controls over premium receipts were not adequate to ensure that all premiums due were collected; accounting procedures over financial and membership records were insufficient; and the Cabinet did not obtain assurance that general and application computer controls were operating properly, as verified through an independent audit.

The audit reported that Kentucky Kare's receipt function lacked proper segregation of duties. Eight types of receipts were processed for Kentucky Kare. Rather than assigning duties, so that a specific employee performed certain functions for all types of receipts, thereby establishing a check and balance system, duties were assigned by receipt type. The same individual performed every step of the process for each type of receipt, except in some instances, data entry. The report went on to state that without the proper segregation of duties, the potential for mistakes and fraud to occur and go undetected increases significantly.

The report indicated that bank reconciliation did not include procedures to reconcile the balance per checkbook and the balance per Kentucky Kare's deposit listing to the balance per bank account. Comparing deposit slips retained by the agency to bank statements was the only procedure performed. That procedure was not performed by someone independent of the receipt and check writing functions. As a result of the internal control weakness, the report noted a net difference of $167,329 between the total deposits per books and the deposit per bank. The APA stated that without a reconciliation between the checkbook and the bank statement, it was impossible for management to ensure that all receipts were deposited.

In the agency response, Kentucky Kare indicated an accountant had been hired on November 1, 1995. The accountant was to review information received by the third-party administrator and reconcile information to the bank accounts.

The report indicated the Division of Benefit Administration did not monitor the expenditures made by their third party administrators. The third-party administrators withdrew funds from the Kentucky Kare accounts to pay pharmacy fees, administrative expenses, utilization, subrogation, and

other expenses. The Cabinet did not monitor these withdrawals to ensure the payments were legitimate or for the proper amount. The lack of monitoring led to the following exceptions, according to the APA report:

- Humana assumed the role as third-party administrator effective January 1, 1995. Part of the new contract provided that dental fees that were in the past paid directly to ACMG would now be included as part of Humana's monthly charge. However, from January until they were notified in August, a separate withdrawal was made for the ACMG fees. This resulted in an overpayment of dental fees of $138,718. According to the APA, the Division of Benefit Administration was unaware that this overpayment had occurred.

- In April, Humana submitted a checking account debit draft for $124,735. No one in the Division of Benefit Administration was aware that the withdrawal had occurred or for what purpose.

- The APA recomputed the utilization review retention fees based on monthly membership. The APA computations determined this fee should have been $484,441; yet according to bank statements and third-party administrator records, the actual amount drawn was $612,356.

- Humana provided the APA with a monthly breakdown of fees which should have been paid from the benefit account. For June their computation of fees owed was $497,723: yet $499,364 was withdrawn for the account.

- Humana and ACMG reconciled the Kentucky Kare bank accounts through which the health and dental benefits are paid. The Personnel Cabinet did not review or perform these reconciliations. Allowing third-party administrators to reconcile accounts without monitoring could result in erroneous payments being made without detection.

- The bank statement was not reviewed to ensure bank administration fees were properly charged. A review by a Personnel Cabinet employee in December 1995 indicated the bank had overcharged Kentucky Kare by $20,753.

The report stated failure to adequately monitor the expenditures by the third-party administrator has resulted in duplicate and overpayments and expenditures for which no one knew the cause or reason. This lack of monitoring increased the possibility of errors being made and going undetected.

In response to the APA audit, Humana submitted a check to Kentucky Kare for the $138,718 mentioned above on September 25, 1995. The Cabinet also contended the $124,915 was for claims kicked out of the system and had to be processed manually. The APA stated that even though the $124,915 was an allowable expense, the fact remained that no one was monitoring or verifying withdrawals by the third-party administrator.

FY 1996

The statewide single audit for 1996 identified similar problems that were reported in previous years. The plan continued to operate by the Personnel Cabinet and three third-party administrators, Humana, ACMG and Health Review Corporation.

The APA recommended the Division of Benefit Administration develop procedures to verify payments made by the third-party administrators, and for overpayments to obtain refunds plus interest. Additionally, the APA recommended the Cabinet require the third-party administrator to obtain independent verification of the computerized claims processing system, in accordance with the Statements on Auditing Standards, section AU 324. The audit further recommended the Cabinet incorporate this into the third-party administrator contract.

In response to the recommendation of several previous single audits that the internal controls over receipts and investments be strengthened, the Cabinet hired an accountant who monitored investments and, as a result of the Kentucky Health Care Reform Act, the responsibility for billing and collecting premiums was transferred to the Kentucky Health Purchasing Alliance effective January 1, 1996.

FY 1997

On January 31, 1997, the Kentucky Kare Plan was renamed the Kentucky Kare Health Insurance Fund and transferred from the Personnel Cabinet to the newly created Kentucky Kare Health Insurance Authority, administratively attached to the Finance and Administration Cabinet by executive order 97-146. The Kentucky Kare Health Insurance Authority was operated by four third-party administrators. Three had been mentioned in the previous audit, with Medco Review being added. Medco Review was responsible for performing hospital audits on behalf of the Kentucky Health Insurance Authority.

The single audit identified premium receipts that were not adequate to ensure all premiums due were collected and deposited. The APA recommended Authority personnel develop and implement written procedures to track or monitor the premiums collected by the third-party administrator for the Alliance. The audit report further recommended a reconciliation be performed on the premiums to be collected by the third-party administrator, Plansource, with the actual deposits made by the third-party administrator, and the reconciliation and all supporting documentation retained by Authority personnel. The report further recommended the Authority implement adequate accounting controls relating to the financial and membership data. The APA noted during the course of their audit that controls were not adequate to ensure claim payments were made to eligible enrollees. Data from the claims processing third-party administrator were not being updated in a timely fashion.

The APA also noted that 974 outstanding health claims checks written in prior years (FY95 and 96) were neither written off nor voided by the agency, as well as 84 outstanding dental claims checks written in prior years (FY 94, 95 and 96). The APA recommended the Authority personnel instruct their third-party administrator to write off any outstanding liabilities older than one year or the operating

cycle, whichever is longer. At the time these checks were written, the funds to cover them were deposited into the checking account by Humana/Kentucky Kare.

Report on Claims Audit of Humana, Inc. by Coopers & Lybrand

In June 1998, Coopers & Lybrand (C&L) issued its final report on the claims audit of Humana. The report represented the results of a review of the Kentucky Kare Plan administered by Humana on behalf of the Kentucky Kare Health Insurance Authority. The key objectives of the review were:

- To measure the accuracy of medical claims processing during the period of March 1, 1997 to February 28, 1998;
- To measure the accuracy of processing and to assess the quality of medical case management during the aforementioned period for high dollar claims (payments over $100,000); and,
- To evaluate certain controls in place over the claims processing operation, including medical management.

The extrapolated results indicated Humana was processing claims within acceptable industry standards, although C&L indicated there was room for improvement. Coopers & Lybrand used examples of errors resulting from reimbursement of charges for blood products, a service which is excluded by the contract, as indicators of room for improvement. The report indicated these errors were attributable to processors and suggested that additional training and quality review procedures possibly would be warranted. The report indicated some errors arose from the incorrect application of facility discounts and appeared to be attributable to the incorrect discount amount being loaded to the system. The report indicated a greater concern for errors which may have resulted from failure of the claims system. Humana officials had no ready explanation for the errors; it could not be stated whether such errors were caused by the processor or system malfunction.

Specific areas of concern related to the administration of Kentucky Kare were to determine the status of the tiered facility discount project, enrollment report problems, unbundling issues, and the overall medical management process. Coopers & Lybrand provided brief summaries of each area:

Tiered Discounts – Prior to the C&L on-site review, Kentucky Kare was informed by Humana that tiered facility discounts had not been applied. When questioned by C&L representatives as to why the discounts had not been applied, Humana could not explain why this issue was not addressed for the past two years. However, they were very close to completing the evaluation of discount arrangements and estimated that Kentucky Kare is entitled to approximately $500,000 in retroactive tiered discounts. Humana has begun recouping these amounts through a remit "deduct" arrangement against future charges. Coopers & Lybrand acknowledged that it was not known how long it would take to recoup these funds or if interest would be factored into the recovery amount calculation. Coopers & Lybrand stated it was evident that consideration had not been given to this issue.

Enrollment Reports – In anticipation of assuming billing and eligibility responsibilities from United Chambers, Humana made changes to the Kentucky Kare group structure. The changes made it difficult to identify previously identifiable groups. Humana continued to work at resolving this problem and was hesitant to release enrollment reports in the current format.

Unbundling – Humana utilized a vendor software package that identified unbundling and other issues (e.g., upcoding) from a standpoint of certain provider service codes. However, C&L recommended that Humana determine whether the vendor offers various products that were capable of assessing a wider range of services or supplies that may be billed. If so, Humana was to ensure that it was utilizing the package that was most aggressive in identifying unbundling and upcoding. Coopers & Lybrand stated the software did not appear to be capable of identifying unbundling of supplies that do not have CPT codes. The report indicated that certain services or supplies not included in the HIAA database were determined to be significantly in excess of the usual cost of such items (e.g., such surgical supplies as cotton swabs were valued at approximately $4,000).

Medical Management – Numerous concerns existed about the entire process, including a perceived lack of proactive involvement; concurrent review; and coordination between the utilization review case management areas. In addition to the concerns about the vendor, a complete electronic link did not exist between Humana and the vendor. This situation required most documentation to be conveyed by paper or phone, thus exposing the process to lost documents or misinterpretation, according to the audit.

The report concluded by stating that Humana unwittingly contributed to the medical management problems identified during the audit and the plan design lent itself to cost shifting that was only partially controlled by the use of U &C limitations and system logic designed to identify inappropriate billing or practice patterns. Cost shifting arose from the fact that the plans contained few managed care features that could control overall cost. The report suggested that to the extent possible, Kentucky Kare should consider instituting additional cost control mechanisms in the plans design, such as a PPO component.