REPORT OF THE SUBCOMMITTEE ON HOUSE BILL 207

RESEARCH MEMORANDUM NO. 449

LEGISLATIVE RESEARCH COMMISSION

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Foreword

The 1990 Kentucky General Assembly passed House Bill 207 which directed the Legislative Research Commission to study the feasibility of requiring Kentucky health insurers and health maintenance organizations to offer their coverage statewide. It also directed that the study review cost savings resulting from HMO use as opposed to traditional insurance. The study was assigned to the Interim Joint Committee on Banking and Insurance which created a special subcommittee to undertake the study. The subcommittee met six times between November 14, 1990 and September 18, 1991.

The subcommittee narrowed its focus to the state health benefits plan since that plan seemed to be the source of HB 207 and to show the inequities in the plan when HMOs operate in limited service areas.

The subcommittee was assisted by Greg Freedman, Banking and Insurance Committee Administrator and Linda Attkisson, Committee Secretary.

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Unit 1
Overview of Health Insurance 1940 to Present

The years from 1940 to 1970 were marked by dramatic increases in the number of persons covered by private health insurance, the number of physicians, hospital construction, and the roles of state and federal government in making health care accessible. Medical expenditures soared throughout the period and Congress reacted with enactment of the Health Maintenance Organization (HMO) Act of 1973. Despite the ambitious goals of the HMO Act, health care costs have continued to increase. In 1971, national spending for health care accounted for 7.5 percent of the Gross National Product (GNP), but by 1989 that had increased to 11.6 percent and amounted to $604.1 billion.

The Commonwealth of Kentucky's expenditures for a health benefits plan for state employees reflects the national trend of spiraling health care costs. From 1980 to present, the state's contribution has risen from $28.86 per month per employee to $150. This increase of more than 400 percent has occurred while employees have had out-of-pocket expenses increase in the form of deductibles and co-payments. The rising costs of the state health benefits plan is an increasing burden on the state as well as state employee households. And it is a burden not shared equally by all state employees.

Chapter 1.1
Development of Health Insurance 1940-1970

Increase in Number of Insureds

In 1940 less than 10 percent of the U.S. population had health insurance. But two things occurred during World War II that changed the health insurance business. Toward the end of the war, employers' contributions to health insurance for employees were treated as a nontaxable element of compensation, exempt from wage controls. Then, the U.S. Supreme Court ruled that under the National Labor Relations Act health care is an appropriate subject.[1]

By 1950, 50.7 percent of the population had hospital insurance. Ten years later, 68.3 percent had coverage, and by 1970 the percentage had risen to 77.9.[2]

While the percentage of Americans covered by health insurance rose, so did personal medical care expenditures. In 1950, expenditures totalled $10.9 billion, in 1960 they amounted to $23.7 billion, and by 1970 they had ballooned to $65.1 billion.[3]

How Americans perceived health insurance also changed during this period. A mid-1950s survey found that 37 percent of those without health insurance felt they were just as well off without it. By 1974, only 10 percent of the uninsured felt they were just as well off.[4]

Supply of Physicians

Another change that occurred was the increased supply of physicians. Through the 1950s and early 1960s, there were 141 physicians per 100,000 persons. During this same period,physicians' incomes were rising, as was the number of medical school applicants. The increasing availability of health insurance and the enactment of Medicare and Medicaid increased the demand for physicians. This led to an increasing number of foreign medical school graduates coming to the United States. This immigration trend and the limited number of medical school spaces in the United States resulted in enactment by Congress of the Health Professions Educational Assistance Act (HPEA) in 1963. The Act brought expansion of existing medical schools and construction of new ones. By 1980, there were 200 physicians per 100,000 persons, which was an increase of nearly 50 percent from the early 1960s.[5]

Hospital Construction

Hospital construction also increased from the 1940s to the 1970s. Congress passed the Hill-Burton Act, which, from 1947 to 1974, authorized disbursement of more than $4.1 billion in grant funds and $1 billion in loans to hospitals, which financed more than 496,000 beds. The funds created excess beds in hospitals and added to the dramatic rise in hospital costs.[6]

Medicare and Medicaid

Medical expenditures skyrocketed, particularly after 1966, when Medicare and Medicaid were enacted. In 1965, 80 percent of medical expenditures were privately financed, but by 1985 that number had declined to 60 percent. Medicare and Medicaid provided the elderly and poor with medical care, hospitals were paid according to their costs, and physicians were paid their usual and customary fees. In 1965, the federal government spent $3.6 billion on personal medical services; by 1975 it spent $31.4 billion, in 1980, $62.5 billion, and in 1985, $112 billion. States spent $4.3 billion under Medicaid in 1965 and in 1985 they spent $35 billion. While government expenditures rose, private sector expenditures went from $31 billion in 1965 to $250 billion in 1985.[7]

Changes from 1940 to 1970

Between 1940 and 1970 health insurance changed dramatically. The percentage of the population with health insurance rose from less than 10 percent to almost 78 percent, as more and more workers insisted on health insurance as a fringe benefit. By the 1970s, fringe benefit programs providing health care for employees were established by most major employers and governmental bodies. With more physicians, hospital beds, and private insurance available, and with the government taking an active role in making health care accessible through enactment of Medicare and Medicaid, few constraints existed to hold down the use of services, or the prices charged by the increasing number of providers. As a result, medical expenditures climbed dramatically.

Chapter 1.2
HMO's 1971 to 1991

The Rising Cost of Health Care

In 1971, President Nixon addressed the rising inflation in the country by imposing a wage and price freeze. The Nixon Administration also endorsed the HMO (Health Maintenance Organization) concept in 1971, as a way to constrain the rising cost of health care. Elliot Richardson, Secretary of Health, Education, and Welfare, stated that "the goals of the Administration are to develop 450 HMOs by the end of fiscal year 1973." This figure was to increase to 1,700 by the end of fiscal year 1976, and by the end of the decade there were to be "a sufficient number of HMOs to enroll 90 percent of the population if they [desire] to enroll."[8]

The term Health Maintenance Organization (HMO) is attributed to Paul M. Ellwood, Jr., of InterStudy, who used it in 1970 in advocating competition among alternative health-care systems as more beneficial to the public than more government regulation. The major prototype of the HMO, Kaiser-Permanente, developed from a system serving workers building the Los Angeles Aqueduct in 1933. By 1945 the system was opened to public enrollment. The Group Health Cooperative of Puget Sound was formed in 1946 and the Health Insurance Plan of Greater New York was established in 1947.[9]

HMO Act of 1973

Although the Nixon Administration backed off its advocacy of the HMO concept after pressure from some members of the medical profession and the health insurance industry, Congress enacted in 1973 the HMO Act, 42 USC 300e. The Act authorized grants, loans, contracts, and loan guarantees to HMOs. Employers with 25 or more employees were required to offer their employees an HMO if a qualified HMO was available in the area. The Act also provided that federally qualified HMOs were exempt from restrictive state laws, regulations, and practices that would prevent the HMOs from operating in accordance with the HMO Act.

The HMO Act established organizational and operational requirements that an HMO must meet to be federally qualified. These include specified basic health services provided or arranged through one of four models: staff, medical group or groups, individual practice association, or direct service contracts. The Act specified methods of payment and required a community rating system. Each HMO must have a fiscally sound operation and administrative and managerial arrangements. When the HMO Act was enacted there were few states with enabling legislation. That circumstance, along with the advantages of federal qualification, caused most new HMOs to seek that qualification.

Enactment of the HMO Act in 1973 caused new HMOs to be established with the support of federal loans and grants available under the Act. Through fiscal year 1981, 657 grants, totaling $145 million, were given. Through May 1983, $203 million was loaned to 102 qualified HMOs. From 1974-1982 HMO enrollees increased 15 percent, as the number of plans increased from 142 to 265. In 1983, however, federal loans to HMOs were discontinued. HMOs continued to grow, despite the loss of the funding. Between December 1983 and March 1988, HMO enrollment rose from 13.7 million to 31 million, with an annual average increase of 25 percent.[10]

By 1988 employers were complaining that their health care costs were rising, due to regulations on payments to HMOs. There was also displeasure with the HMOs community rate, as exceeding the HMOs revenue requirements. The Administration believed the HMO Act had achieved its purpose and wanted it repealed. Congress refused to repeal the law, but instead amended it.

1988 Amendments

Among other things, the 1988 amendments allowed a federally qualified HMO to offer a preferred provider organization (PPO), an insurance plan, or a non-qualifiable HMO. Reimbursement of members for services received outside the HMO was authorized if at least 90% of the physician services of the HMO were provided through providers affiliated with the HMO. Adjusted community rating was added, to allow an HMO to set rates for a group, prospectively based on the revenue requirements of the HMO for providing services to the group. Another change in 1988 prohibited an employer's contribution to an HMO from financially discriminating against employees choosing an HMO. However, the amendments end the ability of HMOs to

mandate employer participation, effective October 24, 1995, and to receive equal dollar employer contributions.

Distribution of HMOs

Today, HMOs cover approximately 14 percent of the total U.S. population and 17 percent of individuals with health insurance. That is far less than the prediction in the early 1970's that by 1980 HMOs would be available to 90 percent of the population. HMOs are distributed unevenly across geographical areas and segments of the population. According to the Group Health Association of America, 70 percent of all HMO enrollees reside in the 27 largest metropolitan areas. Twenty-five percent of HMO enrollees live in either the Los Angeles or San Francisco markets, although those areas account for only 10 percent of the U.S. population.[11]

Chapter 1.3
Health Care Expenditures from 1971 to 1989[12]

Percent of GNP

In 1971 national spending for health accounted for 7.5 percent of the gross national product (GNP). Wage and price controls from 1971 through 1973 stabilized the rising costs of health care. By 1976 Medicare had been expanded to cover the disabled and health care spending rose to 8.5 percent of the GNP. From 1976 to 1979 hospital costs and physician fees were voluntarily controlled. In 1982 health care costs were 10.2 percent of the GNP and Congress enacted legislation that established a prospective payment system (PPS) for Medicare. Since 1987 health care spending as a percentage of the GNP has increased each year.

Health Care Spending in 1989

In 1989, health care spending was 11.6 percent of the GNP and amounted to $604.1 billion. On average, this meant $2,354 was spent for each person in the United States. The major national health expenditures in 1989 were:

Hospital Care	$232.8 billion
Physician Services	117.6 billion
Pharmaceuticals	44.6 billion
Nursing Home Care	47.9 billion
Dentist Services	31.4 billion

In 1989, consumers paid $124.8 billion in out-of-pocket expenses and $199.7 billion for insurance. Government programs paid $253.3 billion.

Burden of Health Care

The rising cost of health care becomes more of a burden when growth in income and revenue lags behind growth in health care costs. In 1970, government spent 5 percent of its revenues on health care, but in 1989 it spent 14.8 percent. In 1970, households spent 4.1 percent of adjusted personal income, while in 1989 that figure had risen to 5.1 percent. Between 1970 and 1989 it was business that was hardest hit. In 1970, business health spending as a percent of corporate profits after taxes was 36.1 percent. In 1989, that figure had increased to 100.5 percent.

Chapter 1.4
State Health Benefits Plan

The 1990-91 Plans

In 1990-91 the state health benefits plan consisted of three state self-insured free-choice plans and seven HMO plans. The HMOs operated only in a 55-county area. State employees who reside in the other 65 counties were restricted to one of the three free-choice plans and had no HMO options.

Increase in Premiums

Kentucky Kare, the state's self-insured plan, has provided state employees with a free-choice plan since 1988-89. Prior to that time, Blue Cross/Blue Shield of Kentucky held the contract to provide a traditional free-choice insurance plan for state employees. The total premium for single coverage under BC/BS in 1980-81 was $28.86 per month and for family coverage it was $72.06. The total premium for single coverage under Kentucky Kare Standard for 1991-92 will be $150 per month and for family coverage it will be $315. That is an increase over the period of more than 400 percent for single coverage and more than 300 percent for family coverage.

HMO Options

In 1980-81 state employees had two HMO options to the BC/BS free-choice plan. In 1981-82 there were no options. In 1982-83 there were again two options and in 1983-84 there were none. Since 1985-86 state employees have had HMO options each contract year. In 1986-87 state employees could chose from 14 alternatives to the BC/BS plan. The following year those options had decreased to 10. In 1988-89, the first year of the state's self-insured plan, there were 9 options to the self-insured plan. In 1989-90 there were 8 alternative plans and in 1990-91 there were 7.

Burden of Health Care

The rising cost of health care to state employees has exceeded the salary increases appropriated, which have generally been 5 percent or less per year. The state contributes an amount equal to the total premium for single coverage for each employee. That contribution has gone from $28.86 per month in 1980-81 to $150 in 1991-92. An employee with single coverage pays no premium, while those with family coverage pay the difference between the state's contribution and the premium for family coverage. A state employee with family coverage will have to pay premiums out of his or her paycheck in an amount from $165 to $200.92 per month under one of the free-choice plans in 1991-92. The range of out-of-pocket premiums under the 7 alternative plans will be from $149 to $294.92 per month. That means a state employee will spend from $1,800 to $3,500 a year on premiums for family coverage. When deductibles and co-payments are added, it is clear, the state health benefits plan is becoming an increasing burden on state employee households, even as the state's contribution continues to increase.

Unequal Burden

The burden of health care is not shared equally by all state employees. Health care expenditures of $3,000 for insurance premiums, deductibles, and co-payments is about 17 percent of a take-home salary of $18,000, but only about 8 percent of a take-home salary of $36,000. This is an unavoidable inequity among persons earning different salaries and it will continue unless state contributions to premiums are varied according to income levels. It is seen to be even more of an inequity when one compares the out-of-pocket premium expenditures of the $18,000 employee with family coverage to those of the $36,000 employee with single coverage. But that is an issue beyond the scope of this subcommittee's assignment. The inequity raised by HB 207, however, is that the burden of health care on state employee households is unequal among members within the group, in large part, because of an employee's place of residence.

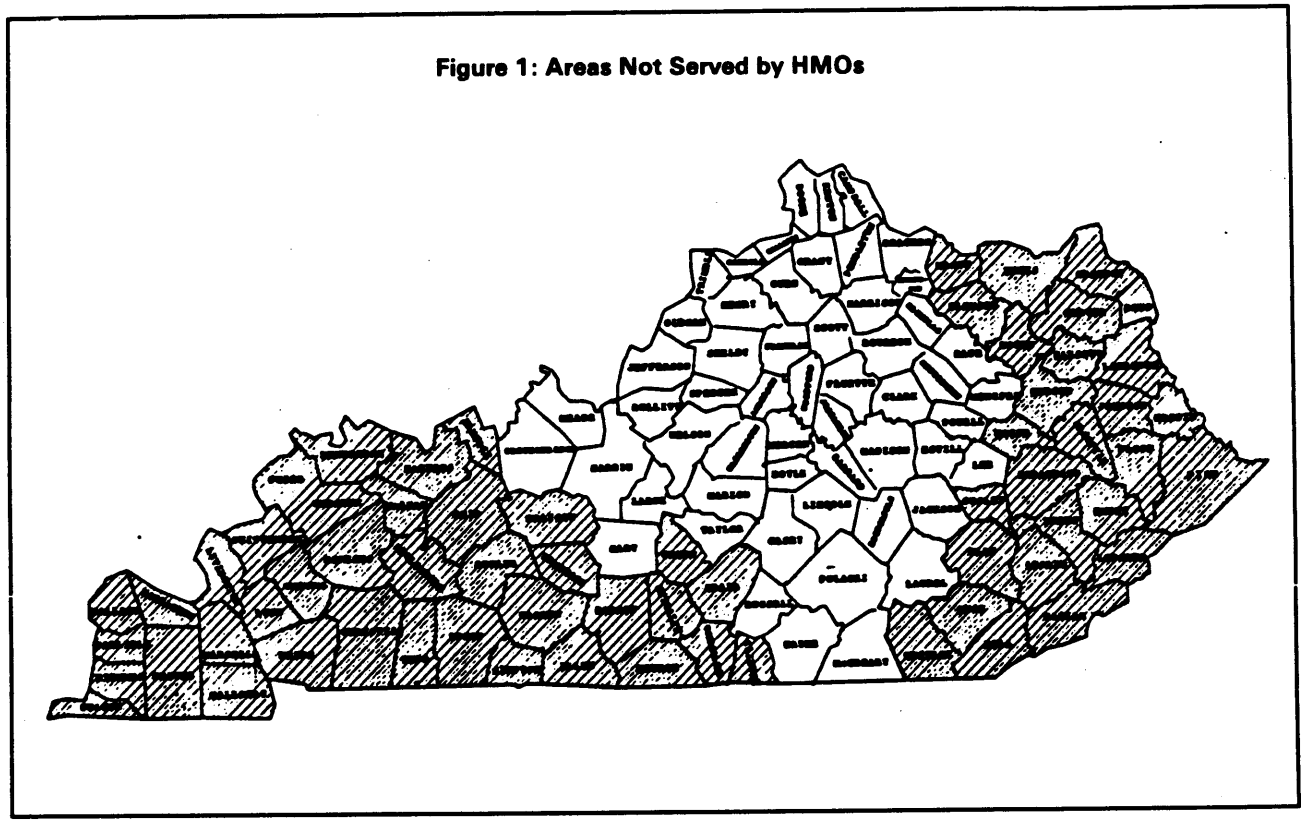

Figure 1: Areas Not Served by HMOs.
The 65 shaded counties do not have an HMO option under the state health insurance plan.

Unit 2
Issues Raised by HB 207

HB 207 raises two issues for consideration by the General Assembly. The first is the feasibility of requiring HMOs and other managed care plans to offer their coverage statewide. The second addresses the cost savings resulting from the use of HMOs and other managed care plans, as opposed to traditional health insurance. These two issues originated with concerns raised by state employees who reside in the 65 eastern and western Kentucky counties in which HMO coverage, under the state health benefits plan, is not an option. HB 207 was enacted by the General Assembly to address these concerns.

Chapter 2.1
Feasibility of Requiring HMOs to Operate Statewide

Distribution of HMOs

The distribution of HMOs throughout Kentucky under the state health benefits plan reveals a concentration in the middle of the state. The highly populated areas of Louisville, Lexington and Northern Kentucky are the bases for the HMOs. As noted earlier, 70 percent of HMO enrollees nationally reside in 27 metropolitan areas. Thus, the uneven distribution of HMOs in Kentucky reflects what is happening nationally.

A major way HMOs control costs is by contractual agreements with health care providers to render services to subscribers at a discount. This practice requires an adequate number of health care providers and a large customer base. Providers agree to discounts when increased volume can be shown to result. In rural areas, where there are fewer providers and less population, volume is less of a selling point. The state requires that HMOs have agreements with providers within 50 miles or 30 minutes of the subscriber's work place or residence. HMOs cannot enter a sparsely populated region and require health care providers to contract to provide services at a discount.

Population of Counties

Of the 65 counties without an HMO option, 34 have a population of 16,000 or less and 22 have populations between 16,001 and 40,000. There are, however, three two-adjoining-county areas that each have populations in excess of 115,000.

Hopkins/Christian	115,067
Floyd/Pike	116,169
Daviess/Henderson	130,233

These three areas would thus appear to have potential as bases for HMOs. Volume is not the only consideration, however. There must be providers who are willing to contract to render services at a discount. In testimony before the Subcommittee, hospital administrators from Henderson County and Floyd County said their hospitals have refused to provide a discount to state employees covered by Kentucky Kare. The reasons given were that discounts have only a one-year impact, that it is hard to justify a discount to one payor and not to others, and that discounts result in cost shifting.

HMO Association of Kentucky

In testimony before the Subcommittee,[13] the Health Maintenance Organization Association of Kentucky (HMOAK) stated that requiring HMOs to provide coverage statewide "would severely impact our industry." It would "likely have the affect of reducing, if not totally eliminating HMO options for Commonwealth employees because most Kentucky HMOs could not realistically offer statewide coverage."

HMOAK said the reason for this is:

> the financial and administrative resources necessary to develop and maintain a statewide network of hospitals and physicians are beyond the capabilities of most Kentucky Health Maintenance Organizations. A provider network is the critical component of an effective Health Maintenance Organization and the resources involved in its initial development and ongoing support are significant.

Commissioner Elizabeth Wright, Department of Insurance, also told the Subcommittee that such a requirement would not be feasible. She testified:

> Health insurers (i.e., insurance companies) have statewide certificates of authority and usually, but not necessarily, write health coverage over the entire Commonwealth. However, health insurers have different levels of expertise on how to control costs. Each insurer may or may not enter into discount contracts with health care providers and may operate under varying degrees of managed care. Although cost containment measures such as

preauthorization are common in commercial insurance contracts, insureds have a freedom of choice among providers and can elect to receive care from providers which have not entered into discount agreements. With this freedom of choice scenario, health insurers generally do not have the capability to manage health care and its costs as well as HMOs.

When health insurers apply for a certificate of authority they are required to submit a plan of operation which includes a marketing plan. Marketing plans state what types of insurance (i.e., Medicare supplement, group or individual policies); the segment of the population they are targeting; and they may, but are not required to, project the amount of business they plan to write over the first few years. Frequently companies start writing in the more heavily populated areas in order to acquire business quickly.

HMOs were established in response to escalating health care costs. HMOs can be more cost efficient within a specific area because they contract with a limited number of providers and facilities. Like insurers, HMOs differ in their level of care management. However, they are more uniform than insurers due to their geographic and provider limitations. When an HMO provides a service outside its service area, it is much less able to manage costs.

All managed care plans depend upon selective contractual arrangements with efficient providers who must be willing to participate in the plan. Requiring an HMO or other managed care insurance plan to operate statewide rather than within an area served by such providers would defeat the managed care concept.[14]

The uneven distribution of HMOs participating in the state's health benefits plan has meant that in state employees in eastern and western Kentucky are unable to participate fully in the state's health benefits plan. It is not feasible to require HMOs to operate statewide at this time. HMOs rely on volume and tend to locate in highly populated areas. The uneven distribution across the Commonwealth represents on a smaller scale the operation of HMOs nationally. This failure of HMOs to penetrate less populated counties outside the Louisville, Lexington, Northern Kentucky area has created an inequity in plan choices for state employees under the state's health benefit plan.

Chapter 2.2
Cost Savings

HMO Studies

There have been a number of studies on claims that HMOs save employers money, as compared to the traditional fee-for-service system (FFS). In testimony before the Subcommittee, the Health Maintenance Organization Association of Kentucky cited a 12-year, $80 million study by RAND Corporation that found that HMO members have up to 40 percent fewer hospital admissions and save up to 28 percent on health care costs, compared to FFS plans.[15] Other studies have shown the total cost of medical care for HMO enrollees to be 10 to 40 percent lower than for persons under FFS plans. Also, there are approximately 30 percent fewer hospital days for HMO enrollees.[16]

1989 Survey

However, employers have expressed dissatisfaction with the savings realized by HMO plans. A 1989 survey by benefit consultant A. Foster Higgins and Co. Inc. found that 32 percent of employee benefit managers did not believe HMOs were effective in controlling costs, 35 percent of employers were ambivalent about HMOs' potential, and 54 percent said their HMO rates were the same as or higher than indemnity plan rates.[17]

1991 Survey

A 1991 survey of employers conducted by Hewitt Associates found that 31 percent said HMO premium increases were rising more slowly than indemnity plan increases. Thirty-seven percent of employers with HMOs said HMO premium increases exceeded those charged by indemnity plans.[18]

State Health Benefits Plan

Notwithstanding the findings of studies and national surveys, under the state health benefits plan for 1990-91, it appears that the benefits of most, if not all, of the seven alternative coverage providers save employees more money than the three free-choice plans. In general, the alternative coverage providers have lower deductibles and require lower out-of-pocket expenditures for hospital charges, office visits, and prescription drugs. Non-hospital diagnostic tests, chiropractic coverage, maternity care, well baby care, and tubal ligation require generally lower out-of-pocket expenses under the alternative plans than the free-choice plans. Birth control pills, vision coverage, and audiometric exams are not covered by the free-choice plans, but the majority of alternative plans do provide coverage.

Uniform Contribution

The state contributed $124.27 per month per employee for health insurance coverage during contract year 1990-91. Four of the seven alternative plans charged exactly that much for their single coverages. That means state employees in 65 counties were subject to more out-of-pocket expenses per state contribution than those employees in the other 55 counties who opted for one of the alternative plans.

Shadow Pricing and Inequity in Benefits

Since 1985-86, Humana has always charged exactly what the state contributes, so that the state employee pays no premium for single coverage. HealthWise did the same for contract years 1986-87, 1987-88, and 1988-89. In 1989-90, HealthWise charged $3.94 more than the state contribution and in 1990-91 it charged $2.98 more. Alternative Health Delivery System (AHDS) charged the same for single coverage as the state contribution in 1986-87, 1987-88, 1988-89, 1990-91. The only year AHDS didn't charge the same amount was 1989-90, when it charged $7.87 more than the state contribution. (See Appendix B.)

Two HMO plans have charged the same as the state contribution only in their initial contract year, 1986-87. Since then, Choice Care and Lincoln National Health Plan have charged more than the state contribution. In 1990-91, state employees had to pay $45.67 more for the single coverage under Choice Care, and that will remain the same in 1991-92. In 1990-91, Lincoln National charged $12.17 more for single coverage and will charge $9.73 more in 1991-92.

"Shadow pricing" is the term used to refer to HMO charges which are the same or near the same price as the free-choice plan offered by the employer. Shadow pricing is not unique to HMOs participating in the state health benefits plan. It is the pricing

strategy of many HMOs. An HMO that uses less hospital care can produce services at a lower cost. However, these savings are not passed on to the employer as long as the employer makes a uniform contribution to both the HMO and free-choice plans. The HMO passes the savings to its subscribers in the form of increased benefits, in order to increase its market share over the free-choice plan. The result is that employers do not realize savings they expected and their uniform contribution to both types of plans creates an inequity in benefits.

Unit 3
Inequities in the State Health Benefits Plan

State employees in 65 counties face inequities in choice and in benefits under the state health benefits plan. The issues raised by HB 207 are based on these two inequities, which have taken on greater significance with the increase in the health care burden on households.

Inequity in Plan Choices

Kentucky's state health benefits plan provides three free-choice plans and seven HMO plans. Employees in 55 counties can chose from at least one of the HMO plans, in addition to the free-choice plans, while those in 65 counties are restricted to the three free-choice plans. This inequity in the availability of choices is due in part to the state's interest in providing employees with as many choices as possible, the failure of HMOs to expand into less populated areas of the state, and federal law that requires health benefits plans to include the option of membership in federally qualified HMOs.

Inequity in Benefits

In addition to the inequity in availability of plan choices, there is an inequity in benefits. Part of this inequity is inherent in the plans. HMOs restrict choices of hospitals and physicians, which allows them to control costs through contractual arrangements with health care providers. Free-choice plans lack these cost-controlling restrictions. There is, however, another reason for the inequity in benefits, which is being addressed by the state in its current requests for bids. It is the state's method of determining its contribution to plans.

The state contributes the same amount per employee to the plan selected by the employee. On the surface that appears fair. However, when adverse selection and shadow pricing are considered, it becomes apparent that HMO enrollees benefit more by the uniform state contribution than free-choice enrollees.

Adverse Selection. One function of insurance underwriting is to prevent adverse selection. It occurs when above-average-risk applicants purchase insurance at average rates. The state's contribution is based on the experience of the employees in its free-choice plans. It has been shown in studies that younger employees are less concerned about freedom of choice and are more likely to join an HMO at a lower premium. If younger, healthy employees leave the free-choice plan, adverse selection occurs, in that the proportion of older, higher-risk employees in the free-choice plan increases. The result is that the premium for the free-choice plans is inadequate and will have to be increased. HMOs, on the other hand, find their premiums more than adequate and may lower premiums or increase benefits. This creates a situation where HMOs become more attractive and the free-choice plans less so.

While the state continues to increase its premiums to meet the rising claims of its increasing pool of high health care utilizers, it continues to contribute the same amount per employee to HMOs. The HMOs, with this guaranteed state contribution, have no incentive to lower premiums. The HMOs engage in shadow pricing by charging at or near the same premium established for the free-choice plan. With this more than adequate premium, HMOs increase benefits, making their plans more attractive. Thus, the state's equal contributions per employee creates an inequity in benefits.

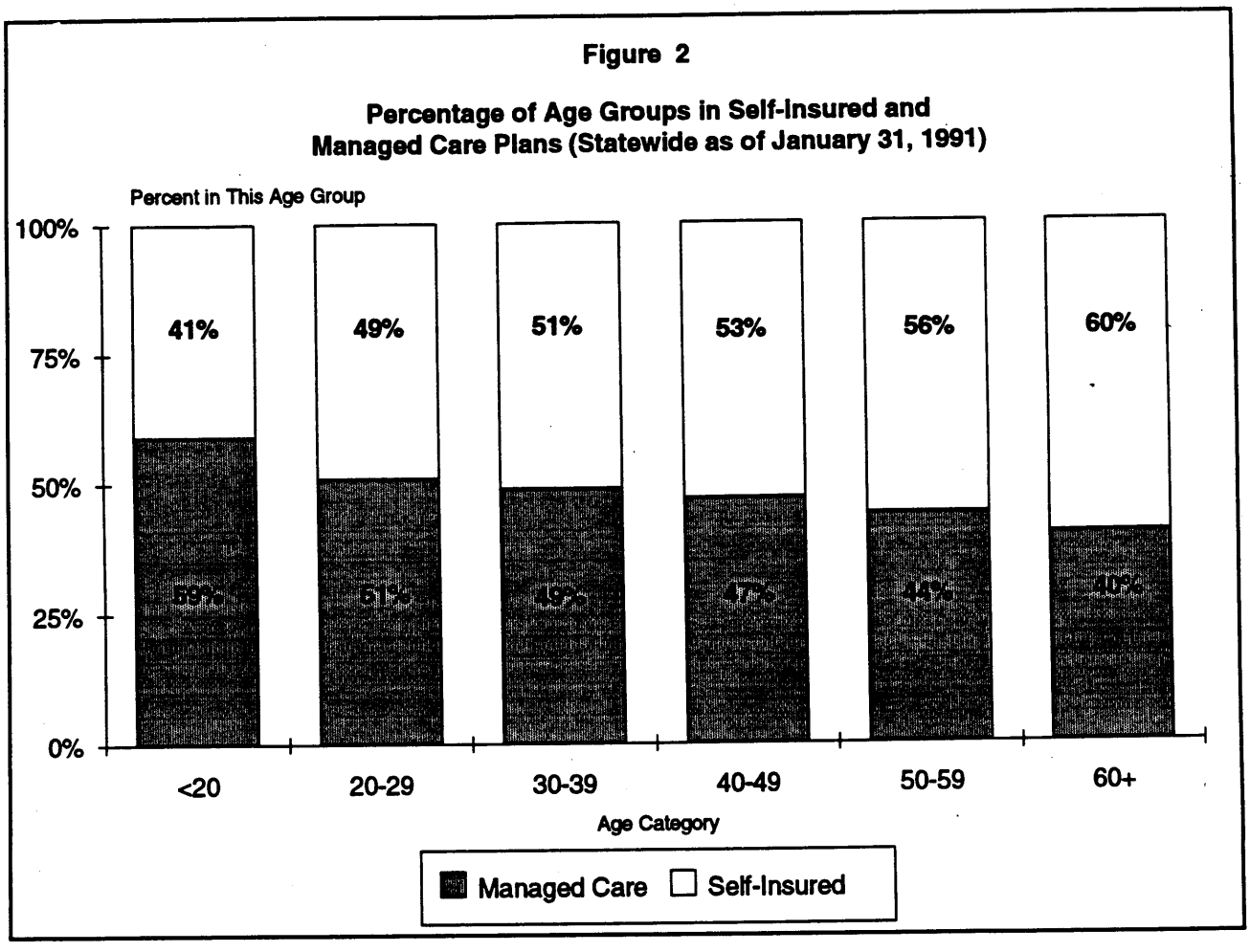

Figure 2. Percentage of the Age Groups in Self-Insured and Managed Care Plans. (Statewide as of January 31, 1991)
Source: Kentucky Department of Personnel

Unit 4
Recommendations

The inequities in the state health benefits plan create two classes of state employees, based on where employees reside. All state employees work for the same employer. The option to make choices between different plans offered by that employer should not be determined by place of residence. If the employer has no choice, every effort should be made to alleviate that inequity to the maximum extent possible. Health insurance is a fringe benefit that the state provides to all its employees. That benefit should be distributed fairly and equally across the Commonwealth. Health insurance is as much a necessity for an employee in Letcher County as it is for an employee in Franklin county. Each state employee works for the same employer, is paid by the same employer, and should have equal access to the same employment benefits.

1. **A Single State Plan.** If there were a single health insurance plan available to state employees, the problem of inequity would be eliminated. There would be no distinctions based on place of residence, benefits would be the same, shadow pricing would not exist, and costs to the state could well be less.

The major obstacle to a single plan is federal law. Section 300e-9(a)(1) of the United States Code Annotated requires the state to include in any health benefits plan the option of membership in federally qualified HMOs which provide basic health services in HMO service areas in which at least 25 state employees reside. Two of the HMO's participating in the state plan are federally qualified.

The state must allow those HMOs to participate. Although the other three HMOs are not federally qualified, if there isn't going to be a single plan, they should be retained, so that as many choices as exist should be made available to state employees. This obstacle shouldn't exist after 1995, when this federal law sunsets. In the meantime, the state should evaluate the advantages and disadvantages of providing a single plan for state employees after the expiration of the federal law.

2. **Expansion of Service Areas.** A means of reducing the number of counties without HMO options is to require HMOs that seek to expand their service areas to include several counties or all counties in a region when they expand. The state is currently doing this by dividing the 65 counties without HMO options into 11 regions. An HMO that desires to expand into any of the 65 counties must take all counties within the region in which that county is located. (See Figure 3.)

When this subcommittee asked four participating HMOs about this proposal, none rejected it outright. One suggested it could be workable if the regions are determined after taking into account existing referral patterns, travel and geographic circumstances, and the geographical size of the regions.

Rather than designating specific regions, an alternative approach would be to require that all counties bordering the expansion county be included. Or, it could be required that a minimum number of counties adjoining the expansion county be included.

The state's designation of expansion regions is a good step toward reducing the number of counties without HMO options. It should be monitored and refined, if necessary, to be certain that it accomplishes its objective without undermining HMO financial performance or quality of service.

3. **Two Rates of State Contribution.** Because of adverse selection and shadow pricing, it is arguable that HMOs under the state health benefits plan have a built-in profit margin that is more than adequate. Figure 2 shows that the older state employees are more likely to choose one of the free-choice plans, while younger employees choose an HMO. This leaves the free-choice plans with a higher percentage of high health care users than HMOs. Because the state makes the same contribution per employee to all plans and bases that contribution on costs under

the free-choice plans, the result is that the uniform contribution provides the HMOs with a wider profit margin than the free-choice plans. HMOs are then able to increase their benefits for their enrollees more than the free-choice plans could. This inequity compounds the inequity in plan choices for those employees in the 65 counties without options. The effect is that the state and those employees in the 65 counties paying for family coverage are indirectly subsidizing those employees in 55 counties with a choice.

One way to address this problem is to establish one contribution rate for the free-choice plans and a lower rate for the HMO plans. Exactly what the differential would be must be determined after analysis of HMO experience. What is the average cost per employee under HMO plans compared to free-choice plans? How much is being paid in claims as a percentage of premiums? This is data that the state should have access to in order to determine fair and adequate rates.

The uniform contribution defeats one of the purposes of the HMO concept, namely, to save employers money through cost control measures. It is arguable that the uniform contribution on a health benefit plan that includes free-choice plans and HMO plans is actually costing the state money.

4. **Subscribers Outside HMO Service Areas.** The subcommittee asked four participating HMOs about the feasibility of allowing state employees who reside in counties outside the service area of the HMO to subscribe to the HMO. None of the HMOs ruled this out. They mentioned inconvenience to state employees, the need to contract with additional providers, and penalties for failure to use the HMO network.

One HMO suggested that 40 to 45 miles or 1 hour should be the limit on travel time. A subscriber beyond those limits may have to use a non-HMO provider. Use of the non-HMO provider would limit the HMOs ability to control costs and could require the subscriber to pay for the services out-of-pocket.

This does seem to be a viable option for a limited number of employees outside HMO service areas. Guidelines designating who qualifies and the effect of using a non-HMO provider would need to be established by the Department of Personnel. Such an option should be explored by the Department during the remainder of the 1991-92 fiscal year.

5. **Preferred Provider Organization.** A PPO is an organized system under which selected health care providers agree to provide specified health care services subject to certain utilization and cost containment procedures. Providers are paid on other than a traditional fee-for-service basis. They are assured of prompt payment and an increase in patient market share. PPO's retain the freedom of choice concept in a restricted form. Insureds may use a non-preferred provider but will have to pay higher out-of-pocket expenses if they do.

A PPO established by the state, if made available on a statewide basis, would alleviate some inequities in the current system. The state has taken steps in that direction by negotiating discounts with hospitals for persons enrolled in the free-choice plans. As the Department of Personnel told this subcommittee, a PPO would require the state to select some hospitals over others. Those excluded could suffer substantial income losses. Although the state has an interest in providing its employees with affordable health care coverage, it also has an interest in not harming existing businesses.

For fiscal year 1991-92, the state will offer Kentucky Kare Premiere for state employees in Allen, Butler, Edmonson, Logan, Simpson, and Warren counties. Contracts with hospitals, physicians, and pharmacists in these six counties have been obtained. State employees in those counties were restricted to the free-choice plans prior to the creation of this PPO by the Department of Personnel. Its success will have broader implications for establishment of PPOs by the state in areas where HMOs fail to penetrate.

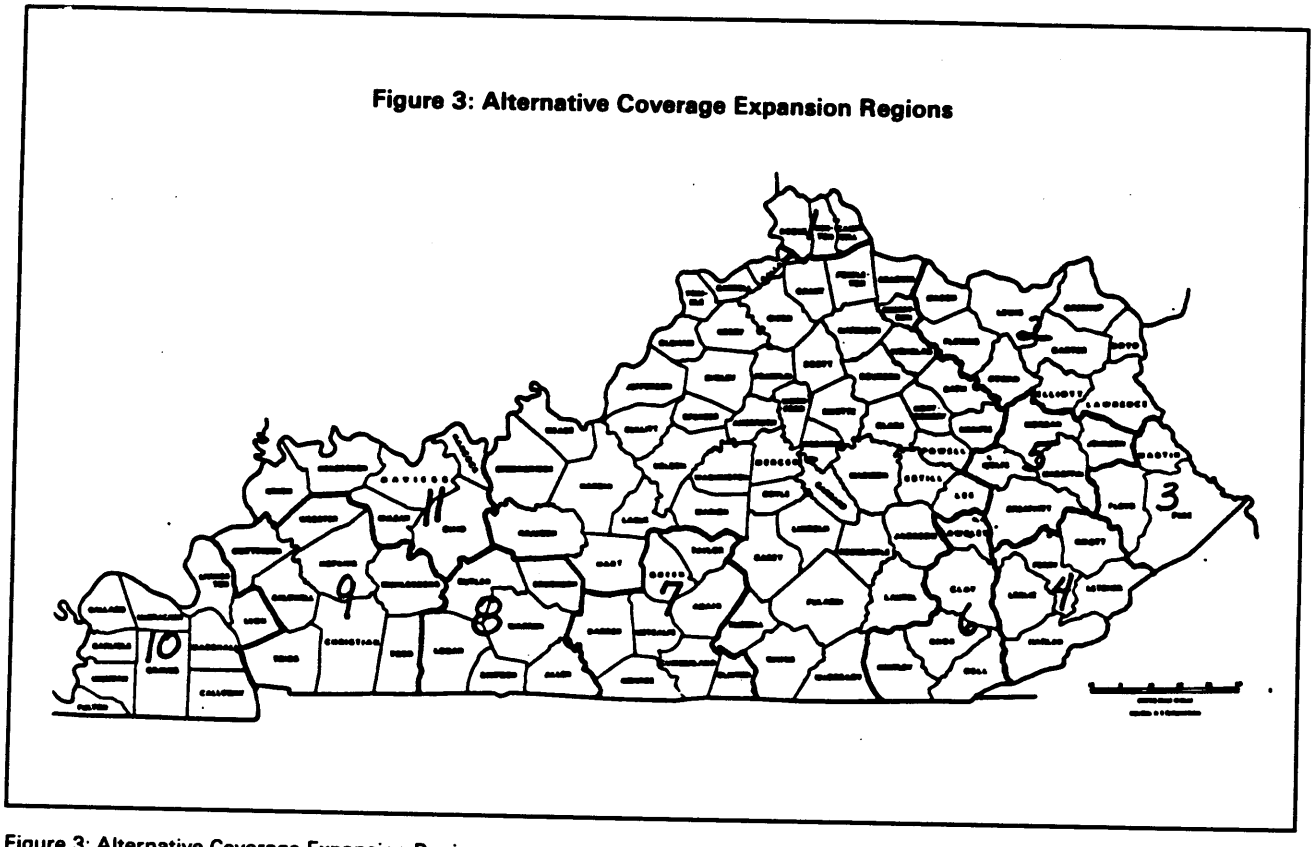

Figure 3: Alternative Coverage Expansion Regions

Footnotes

1. Ernest W. Saward and Scott Fleming, "Health Maintenance Organizations," *Scientific American*, October 1980, p. 48.
2. Paul J. Feldstein, *Health Care Economics* (New York: John Wiley and Sons, 1988), p. 155.
3. Ibid., p. 2.
4. Ibid., p. 124.
5. Ibid., p. 309.
6. Dustin L. Mackie and Robert L. Biblo, "HMO Development: Threat Or Opportunity For Hospitals?" *American Journal of Law and Medicine*, Vol. 6, No. 1, p. 30.
7. Feldstein, pp. 3, 308.
8. Saward, pp. 48, 50.
9. Ibid., pp. 47-48.
10. Jack F. Monahan and Michael Willis, "Special Legal Status For HMOs: Cost Containment Catalyst Or Marketplace Impediment?" *Stetson Law Review*, Vol. XVIII, 1989, pp. 356, 360.
11. Adriene C. Locke, "HMOs Stong in Cities," *Business Insurance*, January 21, 1991, p. 3.
12. K.R. Levit, H.C. Lacenby, S. W. Letsch, and C.A. Cowan, "National Health Care Spending, 1989," *Health Affairs* Spring 1991, pp. 117-130.
13. Meeting of the Subcommittee on HB 207, November 14, 1990.
14. Ibid.
15. Ibid.
16. Feldstein, p. 331.
17. Jerry Geisel, "Few Employers See HMO Cost Savings," *Business Insurance*, November 6, 1989.
18. Christine Woolsey, "Firms Seeking PPOs, New Options: Hewitt," *Business Insurance*, March 11, 1991, p. 3.

Appendix A
HB 207

AN ACT relating to insurance.

WHEREAS, state employees, teachers, and others have expressed dissatisfaction over the limited availability of coverage by health maintenance organizations in certain regions of the state; and

WHEREAS, some legislators have proposed that insurance and health maintenance organization coverage should be offered statewide whenever they are offered in Kentucky; and

WHEREAS, such a requirement should be carefully studied, since it carries the potential for disruption of the insurance industry; and

WHEREAS, health maintenance organizations and other managed health care options account for an ever-increasing share of the health insurance coverage possessed by Kentuckians; and

WHEREAS, these options are intended to save money for individuals and employers, but there is debate on their efficiency as alternatives to traditional health insurance;

NOW, THEREFORE,

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

Section 1. The Legislative Research Commission shall study the feasibility of requiring Kentucky health insurers, health maintenance organizations, and other managed care plans to offer all their coverage statewide, and shall further study the cost savings to Kentuckians resulting from the use of health maintenance organizations and other managed care options as opposed to traditional health insurance.

Section 2. This report shall be submitted to the Kentucky General Assembly no later than September 1, 1991.

Section 3. Staff services to be utilized in completing this study are estimated to cost ten thousand dollars ($10,000).

These staff services shall be provided from the regular Commission budget and are subject to the limitation and other research responsibilities of the Commission.

Approved March 21, 1990

Appendix B

		1988-89			1989-90			1990-91			1991-92		
		Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays
Kentucky Kare Standard	S	89.07	89.07	-0-	102.96	102.96	0.00	124.27	124.27	0.00	150.00	150.00	0.00
	PP							185.86	124.27	61.59	223.78	150.00	73.78
	F	213.77	89.07	124.70	241.66	102.96	138.70	261.97	124.27	137.70	315.00	150.00	165.00
	CR	213.77	178.14	35.63	241.66	205.92	35.74	261.97	248.54	13.43	315.00	300.00	15.00
Kentucky Kare Select	S	98.07	89.07	9.00	111.96	102.96	9.00	134.72	124.27	10.45	159.60	150.00	9.60
	PP							202.11	124.27	77.84	239.40	150.00	89.40
	F	235.37	89.07	146.30	265.69	102.96	162.73	312.87	124.27	188.60	340.16	150.00	190.16
	CR	235.37	178.14	57.23	265.69	205.92	59.77	312.87	248.54	64.33	340.16	300.00	40.16
Kentucky Kare Essential	S							139.45	124.27	15.18	165.20	150.00	15.20
	PP							209.17	124.27	84.90	247.80	150.00	97.80
	F							320.21	124.27	195.94	350.92	150.00	200.92
	CR							320.21	248.54	71.67	350.92	300.00	50.92
Kentucky Kare Premier (PPO)	S										159.60	150.00	9.60
	PP										239.40	150.00	89.40
	F										340.16	150.00	190.16
	CR										340.16	300.00	40.16

PP = Parent Plus

		1985-86			1986-87			1987-88		
		Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays
Blue Cross/ Blue Shield	S	53.82	53.82	-0-	69.79	69.79	-0-	79.71	79.71	-0-
	F	134.74	53.82	80.92	166.79	69.79	97.00	190.81	79.71	111.10
	CR	134.74	107.64	27.10	166.79	139.58	27.21	190.81	159.42	31.39
HMO Kentucky, Inc.	S	52.55	52.55	-0-	75.60	69.79	5.81	92.23	79.71	12.52
	F	112.00	52.55	59.45	180.10	69.79	110.31	219.72	79.71	140.01
	CR	112.00	105.10	6.90	180.10	139.58	40.52	219.72	159.42	60.30
Humana Care Plus (Humana)	S	50.07	50.07	-0-	59.44	59.44	-0-	77.42	77.42	-0-
	F	109.09	50.07	59.02	115.42	59.44	55.98	154.83	77.42	77.41
	CR	109.09	100.14	8.95	115.42	115.42	-0-	154.83	154.83	-0-
Independence HealthPlan of Kentucky	S	59.65	53.82	5.83	65.28	65.28	-0-			
	F	149.33	53.82	95.51	163.86	65.28	98.58			
	CR	149.33	107.64	41.69	163.86	130.56	33.30			
HealthAmerica of Kentucky	S	62.67	53.82	8.85	65.80	65.80	-0-			
	F	162.94	53.82	109.12	171.09	65.80	105.29			
	CR	162.94	107.64	55.30	171.09	131.60	39.49			
HealthAmerica of Covington	S				64.29	64.29	-0-			
	F				172.01	64.29	107.72			
	CR				172.01	128.58	43.43			
Mountain Trails 400	S				67.00	67.00	-0-			
	F				188.84	67.00	121.84			
	CR				188.84	134.00	54.84			
Mountain Trails 801	S				69.50	69.50	-0-			
	F				235.38	69.50	165.88			
	CR				235.38	139.00	96.38			
Southeastern United Medigroup	S				64.76	64.76	-0-	82.83	79.71	3.12
	F				155.42	64.76	90.66	212.68	79.71	132.97
	CR				155.42	129.52	25.90	212.68	159.42	53.26
Metlife Healthcare *(HMO)*	S				59.48	59.48	-0-	83.71	79.71	4.00
	F				154.48	59.48	95.00	234.45	79.71	154.74
	CR				154.48	118.96	35.52	234.45	159.42	75.03

PP = Parent Plus

		1985-86			1986-87			1987-88		
		Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays
Choice Care ***(HMO)***	S				69.31	69.31	-0-	91.29	79.71	11.58
	PP									
	F				214.40	69.31	145.09	229.54	79.71	149.83
	CR				214.40	138.62	75.78	229.54	159.42	70.12
Healthwise of KY, Ltd ***(HMO)***	S				59.24	59.24	-0-	75.36	75.36	-0-
	PP									
	F				171.80	59.24	112.56	195.93	75.36	120.57
	CR				171.80	118.48	53.32	195.93	150.72	45.21
Alternative Health Delivery System, Inc. (Partners in Hlth Maint.) ***(HMO)***	S				59.00	59.00	-0-	73.95	73.95	-0-
	PP									
	F				168.00	59.00	109.00	193.39	73.95	119.44
	CR				168.00	118.00	50.00	193.39	147.90	45.49
Lincoln National Health Plan (Peak Health Plan)	S				65.01	65.01	-0-	80.55	79.71	.84
	F				185.28	65.01	120.27	213.70	79.71	133.99
	CR				185.28	130.02	55.26	213.70	159.42	54.28
Humana Max. Plan ***(HMO)*** (Maxicare Ky)	S				66.00	66.00	-0-	79.50	79.50	-0-
	F				177.00	66.00	111.00	220.00	79.50	140.50
	CR				177.00	132.00	45.00	220.00	159.00	61.00
Humana Pref. Plan ***(HMO)*** (Ky. Physicians Plan)	S							77.42	77.42	-0-
	F							158.71	77.42	81.29
	CR							158.71	154.84	3.87

PP = Parent Plus

		1988-89			1989-90			1990-91			1991-92		
		Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays
Metlife Healthcare *(HMO)*	S	88.96	88.96	-0-	109.96	102.96	7.00						
	F	291.74	88.96	202.67	263.90	102.96	160.94						
	CR	291.74	177.92	113.60	263.90	205.92	57.98						
Choice Care *(HMO)*	S	103.99	89.07	14.92	137.91	102.96	34.95	169.94	124.27	45.67	186.67	141.00	45.67
	PP							288.90	124.27	164.63	311.74	141.00	170.74
	F	290.95	89.07	201.88	330.98	102.96	228.02	407.86	124.27	283.59	435.92	141.00	294.92
	CR	290.95	178.14	112.81	330.98	205.92	125.06	407.86	248.54	159.32	435.92	282.00	153.92
Healthwise of KY, Ltd *(HMO)*	S	89.07	89.07	-0-	106.90	102.96	3.94	127.25	124.27	2.98	143.76	141.00	2.76
	PP							224.05	124.27	99.78	248.70	141.00	107.70
	F	262.57	89.07	173.50	256.56	102.96	153.60	305.40	124.27	181.13	345.02	141.00	204.02
	CR	262.57	178.14	84.43	256.56	205.92	50.64	305.40	248.54	56.86	345.02	282.00	63.02
Alternative Health Delivery System, Inc. (Partners in Hlth Maint.) *(HMO)*	S	89.07	89.07	-0-	110.83	102.96	7.87	124.27	124.27	0.00	141.00	141.00	0.00
	PP							186.41	124.27	62.14	211.50	141.00	70.50
	F	256.33	89.07	167.26	265.99	102.96	163.03	298.25	124.27	173.98	327.32	141.00	186.32
	CR	256.33	178.14	78.19	265.99	205.92	60.07	298.25	248.54	49.71	327.32	282.00	45.32
Lincoln National Health Plan (Peak Health Plan)	S	95.87	89.07	6.80	123.86	102.96	20.90	136.44	124.27	12.17	150.73	141.00	9.73
	PP										256.24	141.00	115.24
	F	254.61	89.07	165.54	297.27	102.96	194.31	327.46	124.27	203.19	361.76	141.00	220.76
	CR	254.61	178.14	76.47	297.27	205.92	91.35	327.46	248.54	78.92	361.76	282.00	79.76
Humana Max. Plan *(HMO)* (Maxicare Ky)	S	89.07	89.07	-0-	102.96	102.96	0.00	124.27	124.27	0.00	141.00	141.00	0.00
	PP										211.00	141.00	70.00
	F	230.00	89.07	140.93	247.10	102.96	144.14	278.02	124.27	153.75	338.40	141.00	197.40
	CR	230.00	178.14	51.86	247.10	205.92	41.18	278.02	248.54	29.48	338.40	282.00	56.40
Humana Pref. Plan *(HMO)* (Ky. Physicians Plan)	S	89.07	89.07	-0-	102.96	102.96	0.00	124.27	124.27	0.00	141.00	141.00	0.00
	PP										240.00	141.00	99.00
	F	230.00	89.07	140.93	247.10	102.96	144.14	289.02	124.27	164.75	338.40	141.00	197.40
	CR	230.00	178.14	51.86	247.10	205.92	41.18	289.02	248.54	40.48	338.40	282.00	56.40
Humana Basic Plan *(PPO)*	S	89.07	89.07	-0-	102.96	102.96	0.00	124.27	124.27	0.00	141.00	141.00	0.00
	F	210.00	89.07	120.93	223.50	102.96	120.54	250.84	124.27	126.57	290.00	141.00	149.00
	CR	210.00	178.14	31.86	223.50	205.92	17.58	250.84	248.54	2.30	290.00	282.00	8.00
Humana Opt. Benefit Plan *(HMO)*	S	89.07	89.07	-0-									
	F	208.00	89.07	118.93									
	CR	208.00	178.14	29.86									

PP = Parent Plus

		1980-81			1981-82			1982-83			1983-84		
		Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays	Total Premium	State Pays	Employee Pays
Blue Cross/ Blue Shield	S	28.86	28.86	0.00	39.84	39.84	0.00	46.10	46.10	0.00	49.00	49.00	0.00
	F	72.06	28.86	43.20	99.68	39.84	59.84	115.36	46.10	69.26	122.66	49.00	73.66
	CR	72.06	57.72	14.34	99.68	79.68	20.00	115.36	92.20	23.16	122.66	98.00	24.66
Healthcare of Louisville, Inc.	S	46.19	28.86	17.33				51.56	46.10	5.46			
Plan G	F	92.38	28.86	63.52				128.89	46.10	82.79			
	CR	138.57	57.72	109.71				128.89	92.20	36.69			
Plan C	S	35.00	16.45	18.55									
Hunter Health Plan, Inc.	S	34.00	28.86	5.14				45.72	45.72	0.00			
	F	75.00	28.86	46.14				123.44	45.72	77.72			
	CR	75.00	57.72	17.28				123.44	91.44	32.00			