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THE KENTUCKY HEALTH CARE EXPERIMENT: HOW "MANAGED COMPETITION" CLAMPS DOWN ON CHOICE AND COMPETITION

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INTRODUCTION

American taxpayers and state legislators now can discern how key components of President Bill Clinton's failed 1993 Health Security Act would have worked by examining the repercussions of a curiously similar program enacted in the state of Kentucky. In April 1994, the Kentucky General Assembly passed a measure that redefined the state's insurance market, created several new state bureaucracies, and altered the financing of health care for the poor. In many respects, the Kentucky Health Care Reform Act of 1994 is a smaller version of the Clinton Administration's discredited Health Security Act. Moreover, the Kentucky plan, like similar health reform plans in Minnesota and the state of Washington, affords a growing body of case studies that state legislators can use to see for themselves how specific regulatory interventions may affect the efficient functioning of the health insurance market and the cost and access of health insurance for individuals and families.

The excessive regulation embodied in the Kentucky plan has sharply increased health insurance rates, has driven health insurance companies out of the state, and has threatened patient privacy. With each passing day, the crisis in Kentucky's health insurance market deepens and the need to fix the government's mistakes becomes more urgent. Thus far, 45 health insurers have left the individual health insurance market. George Nichols III, the state's Insurance Commissioner, recently remarked, "I think going beyond a year would destroy us."[2] In the individual health insurance market, Kentucky Kare, the major plan that covers state employees and individuals, has lost $30 million during the past 20

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Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

months and continues to lose money at a rate that could exhaust its reserves in 19 more months.[3]

For state legislators around the country, Kentucky is a case study in how *not* to reform health care at the state level. For Members of Congress, developments in Kentucky demonstrate once again why the federal government should refrain from imposing ill-considered mandates on the private health insurance market.

THE KENTUCKY HEALTH CARE REFORM ACT OF 1994

Among features remarkably similar to the 1993 Clinton Health Security Act, the Kentucky Health Care Reform Act of 1994 established:

- **A government-sponsored health insurance network,** a statewide purchasing alliance with mandatory participation by certain groups.
- **A powerful government health care policy board,** the Kentucky Health Policy Board (KHPB), with broad regulatory powers that affect both the nature and the practice of medicine in the state of Kentucky.
- **Government standardization of health care benefits,** including all non-Employee Retirement Income Security Act (ERISA) insurance plans and individual policies offered in the state. The Kentucky plan also makes major changes in the qualifications for purchasing insurance.
- **New taxes,** specifically a "provider tax" on doctors, hospitals, and other health care "providers" ranging from 2 percent to 2.5 percent of the gross revenues of physicians and hospitals. Such taxes, of course, are much like payroll taxes on businesses—invariably passed on to individuals and families in the form of higher health care costs.

Like the Clinton health care plan of 1993, the Kentucky plan stresses a managed care model. It provides for increased numbers of graduates from family practice programs at the state's two medical schools, an aggressive minority recruitment and scholarship program to achieve "diversity" among family practice residents, and caps on specialist programs.

Like the original Clinton plan and similar "managed competition" reforms in Washington state and Minnesota, the complex Kentucky legislation was to be implemented over a considerable period of time. Enacted in 1994, the law called for mandatory conversion to a state-approved insurance plan established by July 15, 1996, a date well beyond the closing date of the next general session of the Kentucky General Assembly.[4] Throughout 1994 and 1995, debate raged among Kentuckians about the impact of the bill. Only now, however, is the proverbial dust beginning to settle on this major piece of health care reform legislation, enabling policymakers in Kentucky and other states to learn from the Kentucky experience.

2 "Insurance Market Problems Attributed to Effects of Reform Law, Report Says," *BNA's Health Care Policy Report*, Vol. 5, No. 17 (April 28, 1997).

3 *Ibid.*

4 The Kentucky Constitution calls for the General Assembly to meet in regular session for 60 days in even-numbered years. Other special sessions may be called by the governor.

Unintended Consequences: Higher Insurance Rates, Lower Coverage

For its supporters, the Kentucky plan's two main goals were to make health care insurance more available and more affordable in the Commonwealth. Governor Brereton Jones, a Democrat, initially insisted on "universal coverage," even suggesting that his administration would be a failure if this were not accomplished.[5]

Not only has the original goal of "universal coverage" not been met, but neither have the more modest objectives of increased availability and affordability for individuals and families. In fact, the problems worsened. Although it is true that those who were very sick were eligible to purchase health care insurance for the first time, the cost of health insurance for individuals and families skyrocketed, forcing many small businesses and healthy individuals out of the market altogether. The result: By January 1996, at the opening of the General Assembly, fewer Kentuckians were covered than before the ambitious reforms were passed.

Even though critics of the Kentucky plan have been concerned about its effect on the state's ability to attract and retain physicians, there is little debate about the effect of the law's regulatory regime on the state's ability to retain insurance providers: Midway through the 1996 General Assembly, the last of over 40 commercial fee-for-service providers pulled out of Kentucky. Only a state-run program is left: Kentucky Kare. With insurance rates at record highs and personal choice of plans at an all-time low, pressure has been growing in the General Assembly to repeal or substantially revise the plan, and there is considerable pressure on the Governor to call a special session on health care reform in 1997.[6]

Kentucky's experience holds valuable lessons for legislators in other states who may be tempted to micromanage the health care system:

- **Incompetent government intervention** drives insurance carriers out of the "managed competition" market, aggravating problems of health care cost and access to medical services through the private insurance system.
- **The individual patient's right to privacy** is not easily balanced with government policy planners' need for accurate health care data—critical for public policy "experts" and corporate managed-care decision makers—in such a highly regulated system.
- **Reforms of the underlying tax treatment** of health insurance, the key source of market distortions in the current health care system, are necessary to prevent a state's health care reform efforts from getting bogged down in administrative and managerial conundrums.

Health care reform initiatives in various states can serve as laboratories to show taxpayers and legislators at the state and federal levels how similar reforms would affect the health care system on a national level. Both supporters and critics of the Clinton Administration's attempt at nationwide health care reform need to understand the origin and provisions of the Kentucky Health Care Reform Act, as well as the controversies that continue

5 Charles Wolfe, "Jones Critical of Backers of Phase-In," *The Kentucky New Era*, May 13, 1993, p. 1.

6 Michael Quinlan, "Kentucky Considers High-Risk Insurance Pool," *Louisville Courier-Journal*, April 7, 1997, p. 1. The creation of a high-risk pool appears to be the remedy *du jour*, attracting supporters on both sides of the political aisle.

to surround it. Moreover, state legislators in other states can learn what they can and should avoid while attempting to "fix" the health care system according to the prescriptions of a highly regulated "managed competition" system.

H.B. 250: A PECULIAR POLITICAL HISTORY

Kentucky's health care reform law has a peculiar political history. Concurrent with the development of the Clinton Health Security Act and the emergence of the national health care debate in Washington, D.C., Governor Jones launched a public debate on health care reform, calling for "universal coverage" and convening a special session of the legislature in May 1993 in hopes of passing his reform measures. Public opinion in Kentucky, however, did not support universal coverage, and even Democrat leaders were hesitant to back such a comprehensive plan. When the special session ended, only a temporary tax on health care "providers" (doctors and hospitals) had been passed. One can only guess that Kentucky legislators somehow assumed that such a tax on the suppliers of medical services would have no adverse effect on the market for medical services.

The Kentucky Health Care Reform Act, known originally as House Bill 250, originated during the 1994 general session of the Kentucky state legislature. Several public hearings were conducted with regard to health care reform, concluding on March 2, 1994.[7] Precipitously, on the same day, H.B. 250 passed the first chamber by a vote of 58 to 41. Remarkably, Governor Jones then began lobbying against the bill. He was disappointed that no compromise had been reached on his major objective: universal coverage. The Senate passed its version by a vote of 21 to 17 on March 22, 1994,[8] and sent it to the House for consideration of its amendments. When the give and take was over, the final version of the bill was passed by the Senate in the early morning hours of April 1, 1994. But the House killed it on a procedural motion. Many observers blamed the Governor's public criticism of the bill for its defeat.[9]

Opponents in the state legislature were satisfied that the Health Care Reform Act had been defeated. The legislators went home on Friday, April 1, with plans to return on April 15 for their 60th day in session—the maximum number of days allowed by the Kentucky Constitution for a general session of the Assembly. Meanwhile, Governor Jones continued to attack the legislature for its failure to pass a health care bill. In a shocking reversal, the General Assembly reconvened on April 15 (referred to as Veto Day because it is reserved for overriding vetoes), reintroduced H.B. 250, and passed the measure.

Passage of the Kentucky plan can be explained by the political resourcefulness of its backers and by the philosophical appeal of the notion of carefully "managing" competition in the health care market, an idea promoted assiduously by influential liberal health care policy "experts" in Washington, D.C., as well as in Kentucky, including experts representing nonprofit foundations.

Nonprofits from every corner of the political landscape labor actively in the field of public policy. They make a valuable contribution to the political debate. When it comes to health care policy, however, the Robert Wood Johnson Foundation (RWJF) stands alone

7 Charles Wolfe, "House OKs State Health Care Bill," *The Kentucky New Era*, March 3, 1994, p. 1.
8 Charles Wolfe, "Health Bill Approved, Governor Is Criticized," *The Kentucky New Era*, March 23, 1994, p. 1.
9 Charles Wolfe, "Governor's Lobbying Brings Defeat of Health Care Bill," *The Kentucky New Era*, April 2, 1994, p. 3A.

among the country's nonprofit public policy foundations.[10] The result of the foundation's work typically is legislation to expand access to basic health care with regulatory authority to control costs. New laws and proposals at the state level generally establish health data collection activities, programs to graduate more primary care physicians, an expanded use of capitated managed care, and community rating and price controls on insurance rates and physician fees.

It is difficult to appreciate fully the depth of this foundation's involvement in the formation of the Kentucky health care plan without knowing more about the recipients of its grants.[11] According to Genevieve Young, a Kentucky-based lawyer specializing in health law issues, in 1994 the RWJF granted money to seven states—Alaska, Kentucky, Maryland, Maine, Missouri, Nebraska, and North Carolina—and to Puerto Rico to promote health reform.[12] Kentucky was awarded a Phase I Planning Grant, the purpose of Phase I grants being "to help states '...develop insurance market reforms, Medicaid reforms, and other significant health care financing and delivery changes.'"[13] In addition, the president of the Institute for Health Policy Solutions, founded by the RWJF and the Kaiser Family Foundation in 1992, received a contract "to draft the Kentucky health reform law for the Kentucky Legislative Research Commission."[14] After the Kentucky law was passed, the Institute for Health Policy Solutions was awarded a second grant to help the KHPB implement the law.[15]

Robert V. Pambianco, a Research Associate at the Capital Research Center, recently reported in *National Review* that

> In Kentucky over the last few years a reform effort reliant on community rating (in which insurers are forced to ignore factors such as age and sex in setting premiums) has tripled the price of premiums and driven every single private health insurer save one (Blue Cross) out of the state. The RWJF provided three grants totaling more than $7 million to support this reform in Kentucky.[16]

Several nonprofit groups, as well as the National Governors' Association, also champion Medicaid waivers to accelerate the enrollment of low-income persons into restrictive managed care plans. The proponents favor such waivers to "allow the states to use federal dollars to expand eligibility for the program and to restrict beneficiaries' health care delivery options by mandating enrollment in managed care."[17] Florida official Nancy Ross

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10 Genevieve M. Young, "Robert Wood Johnson Foundation: One Philanthropy's Web of State Health Care Initiatives," *Organization Trends,* August 1995, pp. 1–4.

11 This was most subtly the case at a public hearing on the impact of H.B. 250 during the 1996 general session of the Kentucky General Assembly. A woman and her son (who suffers from complications of spina bifida) gave moving testimony to the legislature about the benefits they reaped under H.B. 250. She spoke on behalf of the spina bifida support group. After the meeting, in a personal conversation with the author, it was discovered that the organization she represented was funded solely by a grant from the Robert Wood Johnson Foundation. From personal communication from Gail Brown, Family Voices, in Frankfort, Kentucky, January 25, 1996. For other entities involved with the RWJF in health care advocacy, see Young, "Robert Wood Johnson Foundation.".

12 Young, "Robert Wood Johnson Foundation," p. 3.

13 *Ibid.,* p. 2.

14 *Ibid.,* p. 4. Young notes that Rick Curtis, president of the Institute for Health Policy Solutions, also played a key role in health reform as a member of the White House Health Care Task Force.

15 *Ibid.*

16 Robert V. Pambianco, "Hillary-Care Moles," *National Review,* May 19, 1997, pp. 40–42.

called Medicaid waivers a "way to do reform without federal legislation."[18] This convergence of the influence of one of the country's most prominent nonprofit foundations, a governor, and the state's legislative leadership committed to a liberal health policy agenda gave birth to the Kentucky Health Care Reform Act.[19]

THE COMPONENTS OF GOVERNMENT CONTROL

In adopting a highly regulatory "managed competition" model for health care reform, Kentucky's legislators created new agencies and instruments of political and regulatory control over the state's health care system. Fortunately, the key components of this program were subjected to an analysis by Coopers & Lybrand, one of the country's foremost accounting and management consulting firms, and the Kentucky Family Foundation, a conservative think tank. The Coopers & Lybrand report examined each of these major components and identified several problems associated with the reform measures:

- A new government agency, the Kentucky Health Policy Board;
- Mandatory health care data collection;
- A health care purchasing alliance;
- Medical education reforms;
- The provider tax; and
- Medical insurance reforms.

The Kentucky Health Policy Board: Unprecedented Power

The KHPB, a new government agency with an annual budget of $3.2 million,[20] is comprised of five full-time members with considerable authority. The board is mandated to (1) develop standard health benefit plans for individuals and small businesses of 100 or fewer employees; (2) control costs by setting target expenditure levels; (3) collect data on health care providers and insurers; and (4) oversee the health purchasing alliance. The board may develop no more than five plans, with one being equivalent to the Kentucky Kare Standard Plan. As of July 15, 1995, plans must have conformed with these state-approved plans. The KHPB also is charged with establishing cooperatives for the purchase of medical supplies and equipment.

The Coopers & Lybrand study suggested that the KHPB would enjoy unprecedented power over health care delivery. It also expressed concern over the board's rate-setting authority, citing the fact that price controls "are inherently inconsistent with a free market cost discipline which could lead to providers and plans deciding to exit the market, leaving fewer choices for consumers."[21] These words, written in 1994, proved to be particularly prophetic. The KHPB has since been abolished.

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17 *Ibid.*, p. 1.

18 *Ibid.*, p. 5.

19 A summary of provisions of the 1994 H.B. 250 can be found on the Web site of Kentucky's Legislative Research Commission at *http://lrc.state.ky.us/legisltn/94H.B.240.htm*.

20 Gil Lawson, "Plan Targets Reform," *Louisville Courier-Journal*, March 1, 1996, p. A6.

21 Coopers & Lybrand, "Summary of Kentucky House Bill No. 250," May 1994, p. 3.

Mandatory Health Care Data Collection: Privacy Erosion

H.B. 250 calls for the mandatory collection, analysis, and dissemination of data relating to cost, quality, and outcomes of health services. The KHPB is to make an annual report on health care charges and quality, including comparisons for each hospital and ambulatory facility in Kentucky.

The data collection provision raises a serious question about patients' rights to privacy.[22] Under the Kentucky plan, physicians are required to submit to the state information on such subjects as tests administered, diagnoses, and treatment plans without the patients' prior knowledge or consent. Although this information supposedly is transmitted without "patient identifiers," the legislation goes to considerable lengths to specify the penalties for any breach of patient confidentiality. Clearly, there was some concern on the part of the legislature that this possibility exists. The Kentucky Family Foundation was particularly concerned that, because of small sample size in rural areas, it might not be possible to protect the identity of patients with an unusual diagnosis.

It also should be noted that Governor Jones signed an agreement with the RWJF on April 28, 1994, entitled "Health Care Reform in Kentucky."[23] The agreement awarded an RWJF grant to the Office of the Governor of the Commonwealth of Kentucky to "assist with the implementation of HB–250 (signed and enacted 4-15-94)." The agreement specified that "The grantee hereby grants to the Foundation a nonexclusive, irrevocable, perpetual, royalty-free license to reproduce, publish, copy, alter, or otherwise use and to authorize other to use any and all data collected in connection with the grant"[24] for RWJF purposes.[25] Both the monetary value of this information and the propriety of furnishing such data to the RWJF should be of legitimate concern to taxpayers.

Health Care Purchasing Alliance: Market Distortion

A statewide insurance cooperative called the Kentucky Health Care Purchasing Alliance, required to be operational by July 15, 1995, is the only entity permitted to operate as a statewide purchasing alliance. Membership in the alliance is voluntary for individuals and employers with 100 or fewer employees, and mandatory for state employees. The alliance negotiates contracts for health plans, enrolls individuals in qualified programs, collects and distributes premiums, establishes conditions for participation of its members, and ensures that each member has an option of one fee-for-service plan.

Under the Kentucky plan, insurance plans must guarantee renewability except for nonpayment of premium or similar breach of contract, or if the insurer goes out of business in Kentucky. Pre-existing condition provisions are limited to the first six months. Qualified health benefit plans must use a modified community rating system approved by the Health Policy Board, and insurers are prohibited from excluding any eligible person or dependent from a group because of an actual or expected health condition.

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22 Rachel Nave McCubbin, "Health-Care Reform Invaded the Privacy Rights of Patients," *Lexington Herald-Leader*, December 29, 1995, p. A11.

23 Robert Wood Johnson Foundation, "Request for Project Support and Conditions of Grant," April 28, 1994 (modified November 23, 1994). For a list of grants to the states in 1994 for health care reform, see also the RWJF's Web site at *http://www.rwjf.org/library/ann94/p50.html*.

24 *Ibid.*, p. 4.

25 *Ibid.*, p. 2.

The Coopers & Lybrand report reserved some of its strongest criticisms for the Health Care Purchasing Alliance, suggesting that a "voluntary alliance may attract a disproportionate number of high cost individuals" and "could be overwhelmed by the addition of a higher risk population." This is borne out by the experiences of other states in which similar alliances "have yet to succeed in attracting large numbers of enrollees from the business sector or in negotiating significantly lower health insurance premiums."[26]

The Coopers & Lybrand report also addressed the problem of cost-shifting, which, prior to the enactment of H.B. 250, was distributed among all medical consumers in the state, including ERISA consumers. With the current changes, it now falls squarely on alliance enrollees—an expensive blow to individuals and small employers.[27] The Coopers & Lybrand report questioned the negative impact of limiting consumer choice in benefits and health plans as well.

Medical Education Reforms: Doctor Shortages

Under H.B. 250, the state's two graduate schools of medicine—the University of Louisville and University of Kentucky—are subject to several major changes that support the "gatekeeper" theory of managed care. A new agency, the Kentucky Health Service, was created to develop and oversee regional family practice residency programs in community-based sites, with at least six such programs conveniently located in each congressional district. Both schools are required to increase the number of family practice residency positions from their current level to a level sufficient to accommodate the medical students in the family practice track of the Kentucky Health Service. They also must cap their non–primary care residency programs at 1994 levels.

The bill also provides for the recruitment of minority students for training in primary care, including stipends, scholarships, and financial incentives for these recruits to practice in underserved areas. At least five regional training programs were created for advanced registered nurse practitioners and physician assistants, with a mandate that the state graduate at least 160 such students each year.

Coopers & Lybrand suggested that medical education reforms could "negatively impact the influx of physicians into Kentucky and cause residents, especially in border areas, to travel out-of-state for tertiary care."[28] Along with the implementation of the 2 percent tax on the gross income of providers, this increased the risk of physicians' leaving the state.

The Provider Tax: Aggravating the Shortage of Doctors

A temporary provider tax was levied on physicians and hospitals by a 1993 special session of the legislature, but H.B. 250 brought a permanent 2 percent tax on health care providers and a 2.5 percent tax on hospitals. This tax is imposed on gross revenues, not on profits. This method of funding health care reform was a particular favorite of Governor Jones, who once proposed a 3.75 percent payroll tax on every employer in Kentucky to underwrite the cost of universal coverage[29] and favored a "provider tax" that would start at 2.5 percent and go as high as 6 percent.[30]

26 "State Developments in Health Care Reform," State Advocacy Department Practice Directorate Web site at *http://www.apa.org/practice/state.html.*

27 Coopers & Lybrand, "Summary of Kentucky House Bill No. 250," p. 7.

28 *Ibid.*, p. 11.

29 Mark Chellgren, "Special Session Attempted," *The Kentucky New Era*, May 8, 1993, p. 1.

On August 2, 1995, the Kentucky Family Foundation released the results of an attitudinal survey of University of Kentucky and University of Louisville medical students in which 78.5 percent of the respondents stated they were "less likely" to remain in the state after graduation because of health care reforms. Some 86.7 percent of all respondents indicated that they had hoped to remain in the state.[31]

Since the enactment of the Kentucky plan, the negative impact on doctors has emerged as a bipartisan concern. Interestingly, both former Lieutenant Governor Paul Patton, elected governor in 1995, and his opponent, Larry Forgy, spoke out against the provider tax in their campaigns, citing their concern that physicians would leave the state and that it would become increasingly difficult to recruit new physicians.[32]

Medical Insurance Reforms: Higher Health Care Costs

The Kentucky Health Policy Board is charged with creating no more than five standard plans, available in two forms: fee-for-service and an option similar to a health maintenance organization (HMO). No insurance provider in the state may offer anything other than a product that matches the criteria for these plans. By law, these plans must guarantee renewability, except for non-payment of premiums or similar default, and must be guaranteed issue, with restrictions on the coverage of pre-existing conditions limited to a period of six months. Premiums may vary based only on age, geography, family composition, benefit plan design, and cost containment provisions—a qualifier known as modified community rating.

The bill stipulates that any willing provider must be allowed to participate in plans approved by the Kentucky Health Policy Board. It also provides for a pilot project for 24-hour insurance. Such plans typically include health care, automobile, and workers' compensation insurance in one policy—hence, the title "24-hour coverage." As of July 15, 1995, every insurer in Kentucky must offer at least the basic plan. Each plan must include "certain cost containment features such as utilization review, case management benefit alternatives, benefit differentials for participating and non-participating providers, and other managed care provisions."[33]

Medical insurance reforms caused the most immediate and most visible impact on consumers. Coopers & Lybrand argued that guaranteed issue "may increase premiums substantially and result in small employers dropping their current insurance coverage."[34]

Under modified community rating, healthy individuals subsidize the cost of insuring the very sick. The Coopers & Lybrand report cautioned that this might drive healthy individuals out of the insurance market because of cost factors, further diluting the overall health status of the group and increasing prices even further.[35] This is a very real concern for Kentucky Kare, the state-run program that has experienced ever-increasing enrollment of individuals with costly medical requirements.

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30 Mark Chellgren, "House Poised to Develop Health Bill," *The Kentucky New Era*, May 19, 1993, p. 1.

31 Kentucky Family Foundation press release, "Most Medical Students Likely to Leave State to Practice Medicine," August 2, 1995.

32 "Decision 1995: KMN Interviews the Candidates," *Kentucky Medical News*, October 1995.

33 "State Developments in Health Care Reform," State Advocacy Department Practice Directorate Web site, p. 2.

34 Coopers & Lybrand, "Summary of Kentucky House Bill No. 250," p. 10.

35 *Ibid.*

Other changes in the insurance market generated continuing controversy beyond the question of cost. For example, the any-willing-provider provisions were hard-fought at the time of passage, but the comprehensive Workers' Compensation Insurance Reform passed during a December 1996 special session does not include an any-willing-provider clause. State officials, legislators, and lobbyists surely will be debating this discrepancy.

The debate on the Kentucky health insurance market was complicated further by the adoption of the pilot 24-hour insurance project in 1996. With passage of comprehensive Workers' Compensation Insurance Reform, 24-hour plans became permissible. It is not known how many companies will attempt to enter this market.[36] Critics point out that it creates an incentive for the insured to claim work-related injuries when seeking treatment because workers' compensation requires no co-payments or deductibles.

CURBING CONSUMER CHOICE

Between April 1994 and January 1996, health care insurance became a top story in Kentucky. Confining consumers to a maximum of five standard plans (the KHPB eventually settled on four) seriously eroded consumer choice. Many individuals and small business owners who had been perfectly happy with their coverage and their carrier found that they no longer could buy the plan they wanted, and that in some cases their insurer had been turned down by the state or had withdrawn voluntarily from the market. Moreover, even though the original legislation called for an HMO-style option to be available for each of the standard plans, many Kentuckians reside in rural areas without enough physicians to support HMO plans. This means that rural consumers have roughly half as many options as their counterparts in urban areas.

Not only were Kentuckians being limited in their choice of plans, but premiums for the remaining options began to skyrocket. Employers living near the state's borders found they were able to insure employees residing across the border for roughly half the price of insuring an employee with identical requirements living within Kentucky.

The Pressure for Price Controls

As any competent economist would have predicted, the new regulatory impositions led to higher costs, and rates continued to rise through the end of 1995. Lawmakers and editorialists, using the familiar rhetoric that has accompanied the imposition of price controls for over 40 years, responded by blaming the insurance industry for unfair pricing practices, "gouging the public," taking advantage of consumers, and similar offenses.

In the meantime, the Kentucky plan was beset by new administrative difficulties. Kentucky Insurance Commissioner Don W. Stephens announced unexpectedly on November 9, 1995, that he had rescinded a previous approval of insurance policies within the alliance. Alliance Director Helen Barakauskas, confounded by the move, expressed concern that the Commissioner's decision would cause widespread confusion among the more than 130,000 state employees who were rushing to meet mandatory enrollment requirements by the end of 1995, but backers of the Kentucky plan applauded the Commissioner's decision. Representative Ernesto Scorsone (D–Lexington) said, "This is exactly what the legislature intended for the [insurance] department to do—function as a watchdog over what insurance companies do with rates...."[37]

36 Personal communication from Senator Gex Williams, Kentucky State Senate, January 13, 1997.

Predictably, by the end of 1995, Kentucky legislators were pressuring the administration to distort the state's already crippled health insurance market even further, and to step in and force insurance companies to fix their rates. Representative Scorsone, for example, challenged the Department of Insurance to use its temporary powers under the reform law to set group health rates. A legislative subcommittee monitoring the changes approved a resolution asking the department to "reject those health-insurance premiums found to be excessive."[38] The recurrent pattern with these sorts of broad legislative pronouncements is that they do not—because they cannot—indicate what is the "right" price at any given time, so the question of what is or is not excessive becomes a matter for arbitrary bureaucratic determination.

After having set in motion the dynamics that would discourage the supply of insurance in the state, Kentucky's political leaders started to express concerns that the scarcity of remaining insurance providers was driving up the cost of insurance. Thus, in mid-February 1996, newly elected Lieutenant Governor Steve Henry weighed in with a plan that was designed to return considerable leeway to insurers to set premium rates. "We've got insurance companies that are wanting to come back in the state if we can get this bureaucracy off their backs," Henry said. Backers of the Kentucky plan opposed this effort to increase the supply of insurance options, claiming that Henry's proposal gave "major concessions to the insurance industry." Within one short week, the proposal was "changed substantially," according to Henry, and Kentucky again tightened the margins under which insurance companies would be forced to operate.[39]

Once again, the result was predictable for anyone who had even a nodding acquaintance with the interaction of supply and demand. On February 15, 1996, the *Louisville Courier-Journal* reported the pullout of the alliance's last commercial fee-for-service company. Now, the paper noted, "with American Medical leaving, individuals who want to buy traditional fee-for-service plans through the alliance will have only one choice: Kentucky Kare, a state-operated program that previously served only state employees."[40] Before being left with this "choice" of only one option, Kentuckians had been able to choose from more than 40 insurance companies.

Thus, Kentucky has "managed" competition out of existence while destroying consumer choice. Under the terms of the Kentucky plan, after July 15, 1995, all health insurance policies affected by the reform had to be in compliance with one of the standard plans designed by the KHPB. Insurance agents, anticipating the inevitable premium increases, often encouraged customers to renew their policies ahead of their anniversary date. This enabled policyholders to make one last purchase of their preferred policy at the "old" rates, effectively forestalling any premium increases until July 14, 1996, after the close of the next session of the General Assembly. Although this appeared to be an advantage for the consumer, it meant that many constituents who eventually did experience rate increases were not affected by them until the legislature was no longer in session.

37 "Insurance Rates' OK Rescinded: Commissioner Says Premiums for State Health Plan Too High," staff wire reports, *Lexington Herald-Leader*, November 10, 1995, p. A1.

38 Gil Lawson, "High Premiums May Keep Plans out of Insurance Pool," *Louisville Courier-Journal*, December 3, 1995, p.1.

39 Gil Lawson, "Henry Says Changes in Health-Care Reforms Will Lure Insurers Back," *Louisville Courier-Journal*, February 17, 1996, p. B1.

40 "Wisconsin Firm to Leave Insurance Alliance," staff and Associated Press dispatches, *Louisville Courier-Journal*, February 15, 1996, p. A3.

Sticker Shock

Individuals who enrolled in a certified plan early in the process often found dramatic changes in the price of insurance, and were compelled in huge numbers to call their legislators. Many legislators experienced record numbers of constituent phone calls during the 1996 session, most of them driven by the changes in health care insurance. Staff and editorial writers for both major dailies—the *Louisville Courier-Journal* and *Lexington Herald-Leader*—who initially had embraced the comprehensive health care reform law reported that the Kentucky plan's honeymoon with the consumer had come to an end. During the early days of the 1996 General Assembly, *Herald-Leader* writer Jim Warren wrote:

> Two years after it was enacted and just several months after it became fully effective, Kentucky's health care reform law may be on the terminal list in the current General Assembly.... Reform backers who pushed the law through the 1994 legislature are circling their wagons and preparing for a legislative holding action, hoping the law will start to bring down costs—if it can survive.... How did things turn so sour so quickly? The simple answer, everybody agrees, is that insurance rates went up. And up. The reforms were expected to cause some increase, because the law opened the door for many high-risk people who previously could not get coverage. But stories of 60, 70 or even 100 percent increases began to surface.[41]

At the time this article appeared, Kentucky legislators believed that the health care law would be repealed or drastically rewritten. According to House Majority Leader Greg Stumbo, "In my opinion, there's an overwhelming majority of members that would simply repeal the bill and walk away from it."[42]

Backtracking on Managed Competition

Governor Paul Patton, elected in November 1995, inherited a legislature and constituency divided over the law's underlying political philosophy and impact on the health care sector of the state's economy. Reflecting the confusion over health care reform and the changing fortunes of the comprehensive reform measure, his administration took a variety of positions on revision of the Kentucky Health Care Reform Act, ranging from promising to make sound changes in the law to vowing to fight to retain every provision of the original H.B. 250. Governor Patton appointed a task force to look into complaints about the Kentucky plan, and the legislature scheduled public hearings on the reform measures in January 1996. On January 24, 1996, Governor Patton said he hoped these efforts would slow down the snowballing, well-organized opposition to the plan and give its supporters a chance to rally their troops. He also indicated that if he could be assured of political support, he would move to uphold H.B. 250 in its entirety.[43]

But the political momentum had shifted decisively against the Kentucky plan. By March 1996, time was drawing near for the close of the General Session. On March 21,

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41 Jim Warren, "Rates Have Health-Care Reform in Trouble," *Lexington Herald-Leader*, January 17, 1996, p. B1.

42 Chad Carlton and Bill Estep, "Odds Are Law Will Be Repealed or Rewritten, House Leaders Say," *Lexington Herald-Leader*, January 17, 1996, p. A1.

43 Informal remarks by Governor Paul Patton to members of the National Council of Churches in the Capitol Rotunda on January 24, 1996, attended by the author.

the Senate passed its version of health care reform by a margin of 20 to 18, substantially revising the original plan. The Senate bill then was sent to the House Health and Welfare Committee,[44] whereupon Governor Patton immediately threatened a veto on the grounds that the legislation was "unacceptable" and a "two-year suspension" of the earlier reform bill.[45]

On Wednesday, March 27, 1996, the House scrapped the language of the Senate bill and adopted the language of a House Health and Welfare Committee compromise version instead, passing the new measure by a vote of 69 to 30 after four hours of debate.[46] Within 24 hours, the governor had threatened to veto the House version; then, on Saturday, March 30, he announced that a compromise had been reached between representatives of the two chambers and that he would support it. Jim Warren, medical writer for the *Lexington Herald-Leader*, reflected the views of many who gave Governor Patton credit for salvaging most of the 1994 reform: "His key move was to back off his earlier position and agree that insurance shouldn't be based on health."[47]

On April 1, 1996, the compromise bill passed by a vote of 61 to 34 in the House and 23 to 13 in the Senate. The new measure abolished the KHPB and assigned its duties to other agencies; changed the state's rate-setting formula to allow a 5:1 gap between the highest and lowest premium levels within a given plan (widened from 3:1); and allowed a rate-setting formula that includes gender and occupation, but not the health status of the insured. In addition, the new measure preserved the portability of insurance; retained the purchasing alliance (threatened by the House version of the bill); and made participation voluntary for county and local government employees and university employees, but mandatory for state employees. Finally, it extended the pre-existing condition exclusion to 12 months.

Kentucky's Continuing Crisis

One of the largest problems on the horizon for Kentucky is the solvency of Kentucky Kare, the insurance "company" within the state government that was established originally as a self-insurance program for Kentucky teachers. After the reform measure passed, Kentucky Kare applied for permission to offer its plans on the open market to any person or small business qualified to purchase insurance through the Alliance.

Kentucky Kare, of course, is a political creation. Its structure and capitalization are different from those of commercial insurance corporations. Originally, it collected premiums and paid out claims for Kentucky teachers who, as a group, were a fairly healthy population. All of the overhead for its operations came from the state, and it operated as a non-profit organization. Under health care reform, Kentucky Kare's standard plan became the benchmark for measuring commercial plans, even though there were no profit considerations factored into the pricing structure.

In December 1996, Anthem Blue Cross and Blue Shield, one of only two outlets for individual insurance left within the state, declared that it no longer could afford to pay percentage commissions, opting instead for a flat $5 commission. In response, Kentucky

44 Bruce Schreiner, "Senate Narrowly Passed Bill," *The Kentucky New Era*, March 22, 1996, p. 1.

45 Bruce Schreiner, "Patton—Health Care Bill Is Unacceptable," *The Kentucky New Era*, March 23, 1996, p. 1.

46 Bruce Schreiner, "House, Senate Ready to Do Battle over Health Care," *The Kentucky New Era*, March 28, 1996, p. 1.

47 Jim Warren, "Crucial Vote Signaled Hope for Health Law," *Lexington Herald-Leader*, April 7, 1996, p. A13.

Kare sought and received government approval for a 28 percent rate hike. These actions culminated in the appointment of a task force by Commissioner Nichols to study the ongoing economic viability of Kentucky Kare. As of this writing, various factions of that committee are at war with one another, and separate working groups—largely "consumer" populated—have been created and are trying to come to grips with the confusion in Kentucky's health insurance market.[48]

One popular provision of the failed House version of the 1996 bill was the creation of a high-risk pool. Some analysts look for serious consideration of such a pool as a possible remedy for Kentucky Kare's impending shortfall.

Warding off the potential collapse of Kentucky Kare could be accomplished in several politically unpopular ways, including drastic rate hikes and broad-based tax increases on Kentucky's workers and their families. A third option, backed by left-wing health policy specialists, is to pressure the General Assembly to make participation in the alliance (most of which is now done through Kentucky Kare) mandatory for more individuals and groups, if not for everyone in the state. Mandatory participation in government health alliances for large numbers of American citizens was an outstanding feature of the Clinton health care plan. For Kentucky, forced flooding of the pool with healthy individuals could be a backdoor way to bring universal, government-run managed health care coverage to the state.

Another potential source of legislative contention is the application of "any-willing-provider" laws. Such laws allow any doctor or other health care "provider" who is willing to abide by the terms and conditions of a managed care contract to be admitted to the managed care network. Kentucky's new workers' compensation legislation, for example, does not restrict policies to the any-willing-provider clause mandated by health care reform. Patients may be limited to specific providers for coverage of workers' compensation claims. The any-willing-provider clause is a key area of debate, and battle lines are drawn among competing lobbyists and factions on their application.

Commissioner Nichols is concerned that private insurance companies will vanish from the state. It is still possible that a special session of the legislature could address the loss of market competition in the insurance industry, but a political power play in the state Senate on January 7, 1997,[49] has diminished Governor Patton's political strength, and it is doubtful that he will call a special session unless he is certain he has support for proposed changes.[50]

Kentucky's Lessons for State Reformers

Lesson #1: Excessive regulation raises health insurance rates. Both the 1994 Health Care Reform Act and its subsequent revision have, at their core, a re-definition of the word "insurance." Insurance companies doing business in Kentucky are given the option of working within these parameters or not participating in the market. Even the concept

48 "Turmoil Within Insurance Market Prompts Examination of State Fund," *BNA's Health Care Policy Report*, Vol. 5, No. 1 (January 6, 1997); available at *newstand.lotus.com.*

49 Al Cross, "Rebel Democrats, GOP Overthrow Senate Leader," *Louisville Courier-Journal*, January 8, 1997, p. 1. On this date, five Senate Democrats joined with all but one of the Senate's Republicans to elect Democrat Larry Saunders President of the Kentucky Senate, ousting long-time President and health care reform advocate Eck Rose. This has left the Senate in an uproar during a year in which there is no general session.

50 Personal communication from Senator Gex Williams.

of "portability," which enjoys nearly universal popularity, forces the insurance companies into a corner. Rather than being able to rate a policy on group experience, insurers will have to look at each policyholder as an individual who is working temporarily within a group. This is likely to increase premiums.

Lesson #2: Excessive government regulation drives out health insurance companies. Early critics of high insurance rates in Kentucky alleged that insurers were gouging the public. If that had been the case, one would have expected a flood of opportunistic carriers into the state. Instead, the "giant sucking sound" Kentuckians heard was the rush of insurers leaving the state.

Alliance Director Helen Barakauskas believes that high premiums reflect an "overreaction by insurance companies forced to compete in a reshaped market," while the previous insurance commissioner told a House committee that health insurance rates did not appear excessive. An independent actuary hired by the state insurance department said that, as rates were brought down for the elderly and became affordable for the sick, the shifting of costs to the young and healthy was necessary.[51]

State-based health care reform cannot be implemented in a geographic vacuum. The United States, despite the heavy regulation of insurance in virtually every state of the Union, is still a market economy. As long as private health insurance companies are free to sell their products in other markets with an expectation of reasonable profit, there is absolutely no incentive for them to remain in Kentucky or any other state with similarly burdensome rules and regulations.

Lesson #3: The creation of a health care database can threaten patient privacy. Policymakers have a growing need for detailed, accurate health care consumption data. The Information for State Health Policy Program (INFOSHP), funded by the RWJF, conducted a study of the top eight or nine officials in each of the states that asked, "How well do state data systems meet state health policy needs?" The eventual goal of the INFOSHP study was to develop "a specific proposal for enhancing an existing data system(s) or creating new one(s) to meet high priority information needs."[52]

This effort led to several interesting conclusions: (1) "[N]o single state appears to have a comprehensive health statistics system that is responsive to policy maker's needs."[53] (2) "[S]tate data systems are not perceived as being well-suited to supporting assessments of program needs or to guiding decisions about restructuring health care systems in a changing environment. This includes information on care in managed care systems."[54] And (3) "Respondents believe that the single most important thing the federal government can do to improve states' ability to generate useful population-based health data is to provide funding to support state efforts. A more coordinated and uniform approach to data collection by federal agencies, including standard definitions and reporting requirements, and technical assistance were also considered important."[55]

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51 Bruce Schreiner, "Study Shows Insurance Firms 'Playing Fair'," *The Kentucky New Era*, March 20, 1996, p. 3.

52 Information from State Health Policy Program Web site: *www2.umdnj.edu/shpp/homepage.htm*, p. 1. (The Information for State Health Policy Program is directed for the Robert Wood Johnson Foundation by Ira Kaufman at the Department of Environmental and Community Medicine, University of Medicine and Dentistry of New Jersey–Robert Wood Johnson Medical School.)

53 *Ibid.*, p. 1.

54 Marsha Gold, "Miss or Match: How Well Do State Data Systems Meet State Health Policy Needs?" Mathematica Policy Research, January 18, 1995, p. 3; funded by Robert Wood Johnson Foundation.

Experience in Kentucky and elsewhere shows that the further government officials venture into the realm of health care administration, the more data they will require in order to micromanage delivery and outcomes. This appetite for data has the potential to become a relatively hungry beast. These databases are also valuable. An organization bidding a managed care contract needs finite information to be competitive. Policymakers inevitably will have to decide whether data collected at the state or federal level should be made available to corporations or foundations intimately involved in health care reform efforts.

Unfortunately, many lawmakers and health care specialists want the federal government to force states into uniform health data reporting requirements. The policy problem, which surfaced during consideration of the Kassebaum–Kennedy bill late in 1996, is whether there is adequate protection of privacy rights when this information changes hands. These ethical questions are inevitable, and should be considered carefully by policymakers in crafting health care reform. One way to protect the privacy of individuals is to make sure that no patient record is transferred from a physician or carrier to any other private or public agency without the express written permission of the patient.

CONCLUSION

The enactment of the Kentucky Health Care Reform Act—so similar to the discredited Clinton health care plan in many of its crucial characteristics—is an excellent case study in the law of unintended consequences. Instead of expanding access to health insurance, the law has left more Kentuckians uninsured today than before it was enacted. Instead of controlling health care costs, its regulatory regime has contributed to their increase. Instead of making more plans available to consumers, it has driven a record number of private insurers out of the state.

Perhaps the chief lesson for state health care reformers is that political attempts to micromanage the financing and delivery of health care can undermine public trust and confidence by making public officials appear incompetent. Instead of limiting consumer choice and competition by trying to establish instruments to control and direct the health care system, state officials should facilitate successful reform of the health insurance market by encouraging Congress to make fundamental changes in the federal tax treatment of health insurance. Congress could do this by giving individuals and families tax relief in the form of tax credits or vouchers, or by allowing them to open medical savings accounts. Such reforms would enable Americans to purchase the kind of health care benefits they want at prices they wish to pay.

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55 *Ibid.*