KENTUCKY'S

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An analysis of the health insurance market in Kentucky, with summaries of state and national legislative, economic and market issues.

Market Report on *Health* Insurance

Kentucky Department of Insurance
George Nichols III, Commissioner

revised edition

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Contents

OVERVIEW

The issues surrounding various provisions in Kentucky's health care reform laws, HB 250 and SB 343, and their effects on the health insurance market have generated many intense discussions and debates among consumers, providers, industry representatives, legislators, government officials and the media over the past two and one-half years. Interestingly, most of the discussion has centered around specific topics or provisions with little recognition that the overall effect of any one or two provisions on the market is minor until combined with all other provisions. The flaws of the theory, that one or two provisions in the law have led to the current state of the market, are multiplied when this theory is applied to a market about which little is known or understood.

With this document, the Kentucky Department of Insurance presents information about the current market structure and other variables that must be considered in order to comprehend the development of Kentucky's health insurance market under reform and to advance the dialogue of where Kentucky goes from here.

Health insurance is the business of managing risk, financing consumer medical coverage through premiums and developing new products and services. Thus, the future of any health insurance company's business in any state depends on its ability to successfully do these things. It has become clear, as evidenced in the information presented in this report, that a strong health insurance market cannot prevail in Kentucky under the current conditions. The instability of Kentucky's market has serious implications for consumers who want the best health care coverage for their dollar. The challenge is to pull Kentucky's health insurance market out of its current unstable condition that has led to limited choice for consumers, limited competition and company financial concerns. Kentucky cannot sustain its current system in the long term.

The 1994 and 1996 reforms primarily affected the individual and small group markets. Despite good intentions, each of these market segments now has serious issues that must be addressed.

INDIVIDUAL MARKET

Since the reforms were implemented, the individual market has these characteristics:

- 45 companies have withdrawn from the market.

- Financial data shows some companies losing money and others receiving less profitable returns. Financial results are used by companies as they evaluate whether to do business in particular states.

- Only two insurers remain in the market. Because the two operate in different segments of the individual market, no competition exists in the individual market. The two insurers are:
  - Anthem Blue Cross/Blue Shield selling for experience-rated association business and non-Alliance modified-community-rated individual business.
  - Kentucky Kare for the Alliance only modified-community-rated business.
- Both insurers in the individual market experienced financial difficulties in 1996:
  - Anthem reported a $60 million underwriting loss (unaudited by the Department of Insurance).
  - Kentucky Kare has lost more than $30 million over the past 20 months (verified in a preliminary examination by the Department of Insurance).
  - Kentucky Kare requested and received a 28% increase for individuals which will negatively affect consumers.
- The withdrawal of companies from the individual market has eliminated choice for many buyers of individual coverage.
- Because of market conditions, the state made its self-insurance fund, Kentucky Kare, available to the private market. This self-insurance fund is draining its reserves at such a rapid rate, that it is clear that this action is not a sustainable one.
- The Department has taken the additional step of requiring health maintenance organizations (HMOs) to hold open enrollments to provide more choices for consumers in the individual market. However, the impact may be limited because HMOs are not available in all areas.

SMALL GROUP

The small group market also has felt the effects of reform. The problem areas are:

- Consumers (especially healthy ones) may choose to opt out of the modified community rated (MCR) market by buying coverage through an association. Insurers can experience-rate consumers by selling plans through associations and thus have less incentive to sell MCR products.

- Eight to 10 companies are selling products through associations. Those companies can experience-rate those products and can offer lower rates to healthy individuals. Other companies not writing association business will be left with unhealthy groups buying modified-community-rated plans. This trend can escalate quickly in a downward spiral for insurers outside the association market.

- An analysis of the current *reform* market size (about 40 percent of the total insured market including public sector groups) causes concern when coupled with the association exemption. The reform market may never get the numbers needed to distribute costs, a key component of modified community rating (MCR) and necessary to allow rates to level out in such a manner that everyone in the pool can pay a reasonable amount. Further, the experience-rated market will continue to erode the MCR market as healthy groups will find lower rates in the experience-rated market and less healthy groups will find lower rates in the MCR market. As the segmentation of the market continues, the rate differences between the two segments of the market will escalate. MCR rates will be forced upward as the less healthy move to the MCR market. The higher the MCR rates rise, the more the healthy groups will leave the MCR segment in search of lower rates in the experience-rated market.

- HMOs are required to participate in HMO open enrollment under the current market condition, thereby increasing their exposure to more risk.

- A review of the financial data shows the loss ratio of the HMO companies in the small group is slowly increasing. (National data shows this is a nationwide trend. However, current effects of reform are an additional element for Kentucky HMO companies.)

- Some insurers are experiencing financial downturns which caused the Department to initiate closer monitoring of these companies' financial conditions.

EFFECTS OF REGULATION

The reforms were enacted to make health insurance more affordable and more accessible. There was some success in the short term as approximately 5,000 previously uninsured persons obtained insurance through the state buy-in program and approximately 3,300 previously uninsured persons obtained insurance through the Alliance. But in the long term, many of the reforms are expected to have the opposite effect as the young and healthy people leave the market and rates spiral upwards for the remaining pool of sicker persons. (The Department of Insurance acknowledges current data cannot confirm this statement. However, traditional buying patterns would suggest the accuracy of the expectation.)

Although the use of the medical consumer price index plus 3 percent as a test in reviewing rates has effectively placed a cap on rates, it is having an adverse effect on consumer choice. A 1996

study[1] which examined the effects of Washington State's regulation on the health insurance market indicates that

> [i]nitially rate caps may increase affordability of health coverage but at the long term cost of severely curtailed access if rate regulation holds premiums below the competitive level:
>
> - . . . [p]rivate insurers will be unwilling to voluntarily cover applicants with higher claims costs at the mandated premium level.
>
> - Consumers will have fewer product choices as insurers limit their product offerings or exit the state.
>
> - If combined with guaranteed issue, rate caps financially weaken health insurance carriers so that reserves may be insufficient to maintain quality claims service or meet claims obligations.
>
> - As financially strained private insurers exit the market, the state will become the primary insurer for rate regulated coverage. ["The Effects of Regulation on the Health Insurance Market," (pp. 2 and 3)]

The Department is seeing these same developments in Kentucky:

- HMOs are reluctant to participate in open enrollment and voluntarily cover applicants with higher claims.

- Consumers have fewer product choices in the individual market, which is now limited to Anthem Blue Cross/Blue Shield and Kentucky Kare since 45 insurers left that market.

- Recently filed annual statements show that some health insurers have been financially weakened.

- Kentucky Kare, the state self-funded plan, anticipates it will become the primary insurer for rate regulated coverage because of its modified community rate policies

[1] "The Effects of Regulation on the health Insurance Market," dated February 23, 1996, is a study of the effects of the health insurance regulations passed by Washington and other states on the health insurance market. The study was written by Dr. Paul J. Feldstein , who holds the FHP Foundation Distinguished Chair in Health Care Management, University of California, Irvine. The report was funded by Pierce County Medical, a Blue Cross affiliate.

for individuals and its continued payment of commission to agents. Anthem Blue Cross Blue Shield no longer pays commission for this business and has over 90% of the association business all of which may be experience rated and some of which is available to individuals.

The limited numbers of individuals and small groups in the Kentucky insurance market suggest that modified community rating does not have a large enough base of healthy insureds to spread the subsidy of sick insureds. By allowing individuals and small groups to be experience- rated through associations, the current regulatory system shrinks the pool of healthy insureds paying the subsidy and accelerates the collapse of affordable rates for sick persons. As "The Effects of Regulation on the health Insurance Market" describes the cycle:

> The goal of community rating is to promote fairness by equalizing rates for all enrollees and to protect them from sharp premium increases when their health status changes. Initially, high cost enrollees benefit from lower and more predictable premiums, but premiums can quickly escalate as low-cost enrollees depart.
>
> - When rates are equalized, low-cost enrollees subsidize high-cost enrollees. Low-cost groups start to drop insurance or switch to lower premium alternatives such as purchasing groups and self-insurance [and associations, in Kentucky] which are not subject to community rating.
>
> - The remaining enrollees have higher claims costs than those who left, resulting in higher average claims costs in the community rating pool.
>
> - Insurers then seek higher premiums to cover the higher claims costs. The cycle repeats itself as the remaining lower-cost enrollees are asked to subsidize higher-cost enrollees.
>
> - The premium spiral; is exacerbated when guaranteed issue is required. Together, these policies not only drive lower-cost enrollees from the community pool, but allow higher-cost groups to enter.
>
> . . . Combining individual and small group coverage into one community rated pool does not prevent the premium spiral caused by a community rating policy. In contrast, combining the two only drives more small business out of the community rating pool, as they are asked to subsidize higher-cost individuals. [See pages 3 and 4.]

Although this scenario is based on pure community rating, Kentucky's modified community rating along with the richer benefit plans, guaranteed issue, and guaranteed renewal will have the same ultimate effect. Modified community rating has increased premiums for the younger and healthier insureds. Combined with the overall rate increases resulting from the richer benefit plans, guaranteed issue, and guaranteed renewal, numbers of younger and healthier persons have dropped health insurance. Thus, the spiral has begun in the modified community rated market in Kentucky.

Increased regulation of the health insurance market has lessened the insurers' control of their business and their ability to respond to unexpected medical expenses. Thus, 45 companies have exited Kentucky.

Under current law, insurers do not have the necessary flexibility to respond quickly to rate adjustments needed for blocks of business which have higher than anticipated claims expenses because:

- Additional mandated benefits generate medical expenses not considered in existing rates.
- Twelve-month limits on rate increases prevent timely adjustments to stem the influx of persons into plans with inadequate rates.
- The any-willing-provider statute reduces leverage to get significant provider discounts to reduce medical expenses.
- Mandatory rate hearings effectively place a cap on rate increases or delay indefinitely the effective date of the increases.
- Modified community rating requires the young and healthy, through increased premiums, to increase their subsidy of the older and sicker insureds.

As described in the a study of similar regulatory provisions in Washington State, these provisions increase the overall costs of health insurance and, as rates increase, drive out younger and healthier persons. This leaves a shrinking pool of healthy persons to subsidize the sick persons, thus resulting in an ever-accelerating spiral of rate increases.

Based on the information above and the information presented in this white paper, the evidence would suggest that our current system must change. Given the market's current course, it is the conclusion of the Department of Insurance that market issues will get increasingly worse. The July 15, 1997, date (after which date no non-standard plans may be renewed, See KRS 304.17A-160(2)(f)), will begin the decision-making process for many consumers not currently under reform. Remember they have a choice of market segments to meet their financial and health needs. Those choices will have a profound impact on the insurance market.

GENERAL CONSIDERATIONS

Many opinions have been expressed regarding the impact that HB 250 and SB 343 have had on the market that led to the current state of affairs. As the Department of Insurance has sought to provide leadership on this issue, the Department has analyzed factors that impacted the health insurance market and activities that brought Kentucky to this current state. The following information lists the opinions of the Department of Insurance. For ease of presentation the issues are in bullet format. Additionally, the Department recommends review of LRC Research Memorandum No. 474 and LRC Memo to Representative Jim Gooch dated April 3, 1997, as additional considerations.

- **Information about Kentucky's health insurance market was limited when the reforms were developed, including information on:**
    - size of insurance market (by segment, individual group, government, etc.)
    - popular products (what consumers wanted to buy)
    - cost of insurance coverage (what they were actually paying)
    - what companies were in the market place with recognition of
        - their financial condition
        - market strategy (niche players, health insurance primary product, etc.)
        - national trends and market forces in the health insurance industry.
- When insurance reforms were developed, it is difficult to determine that any consideration was given to **anticipated market reaction to comprehensive reforms**, especially by small carriers and the dominant carrier, Anthem Blue Cross Blue Shield, the **impact of market trends** and other forces like income (ability to purchase insurance at any price) and **employer responses.**
- **The nation was preparing itself for federal reform.** The provisions enacted in Kentucky were similar to President Clinton's proposal. If the federal proposal would have passed, all states would be operating under the same system. When the federal government did not pass national reform, Kentucky was one of only seven states at the time to require both guaranteed issue and MCR year-round in the individual market. (The other states were Washington, New York, Vermont, New Hampshire, New Jersey and Maine. In 1996, Massachusetts passed guaranteed issue in the individual market.) In the small group market, only fifteen

(15) states require MCR and guaranteed issue year round. Given the fact that the majority of the potentially insured market was in government (Medicare, Medicaid), self-insured and uninsured status, Kentucky did not have a strong insurance market to support all reform provisions. Further, if the public sector and large employer groups are omitted, Kentucky's small group and individual market is comprised of approximately 503,444 people.

- **Kentucky failed to recognize the complexity of the individual market.** Many companies have made hefty profits on individual books of business as evidenced by their loss ratio. However, this has never been a segment that attracted a lot of carriers due mainly to the risk (which is usually higher than other books of business), the expense to administer the book of business, and the marketing costs. Usually a company needs a large market share and a number of healthy people to stay profitable. Even then, a few high claims could quickly change the bottom line.

- **Kentucky failed to recognize the uniqueness of the small group segment.** This segment has traditionally subsidized the large group segment which has the numbers to negotiate large discounts. Carriers would spread the cost over small groups to assure some margin of return for bigger groups. Also, this group has historically seen yearly double digit increases in premium. To combine this segment with the individual market only increased its exposure for high rates.

- **Health insurance consumers, legislators, and government officials were not fully briefed and aware of the high rates that would come from the reform provisions.** Companies priced conservatively to assure they could cover their anticipated losses after being told they must accept all comers and were prohibited from considering health status. Recognizing that insurance is the business of managing risk, this should have been an expected approach.

- **Limited information was provided that explained the winners and losers under reform.** The rationale behind MCR is that the cost of insuring the "community" is spread over the entire "community". Thus, some would pay a little more for their coverage in relation to their risk and others would pay a little less. The actual changes to Kentucky's system did affect some negatively and others positively but to a much greater degree than explained. In any non-government run system, this is unavoidable.

- **Guaranteed issue addressed the issue of access.** Kentucky correctly acknowledged that guaranteed issue is meaningless without MCR because companies would have the ability to price people out of the market. However, not having enough people to spread cost (which allows MCR to be effective) has the same effect based on consumer responses to rate increases. (There is no data available to support how many people left the market or continue to be uninsured due to the cost of coverage.)

- **MCR was never given ample time to work.** MCR rates became effective in July 1995. By January 1996 the Executive Orders and changes with SB 343 stopped the flow of people into

the MCR market, especially young healthy people. The MCR market can now be viewed as a potential high risk group with rapidly increasing cost. Four tiered pricing redistributed premium cost and caused a substantial increase in family rates. The added rating factors of gender and occupation provided for another redistribution of premium cost which, in turn, had an impact on the rates. Prior to reform, rates could take into consideration gender and occupation. HB 250 did not allow carriers to consider these factors when developing rates. Through amendments to MCR in SB 343, carriers were again allowed to consider gender and occupation as rating factors, however, this again caused certain consumers to experience yet another increase due to the redistribution.

- **The Kentucky Health Policy Board entered into an agreed order through a lawsuit settlement that exempted certain associations from MCR before SB 343 was passed.** So, even without SB 343, risk rated business would exist today.

- **The time line for implementation of HB 250 by the Health Policy Board and the Alliance left little room for error and little time to think and/or act on market forces and company responses.** The Health Policy Board members, while chosen for their quality and dedication, were intentionally selected as to have only limited insurance knowledge with which to evaluate effects.

- **The Department of Insurance had little or no involvement in the implementation of HB 250 other than reviewing rates and standard benefit plans.**

- **Regulatory issues**

    - **The requirement that any proposed rate increases in excess of the medical CPI + 3 percent be subject to a mandatory rate hearing was considered an artificial rate cap.** Downward pressure on rates will put companies at financial risk for short term consumer gain and hurt consumers in the long term because of company exits or premium increases down the road in order to stay financially sound.

    - **Involvement of the Attorney General.** The Department must accept that it lost the trust and confidence of the Legislature and public regarding its ability to effectively regulate the market. Thus, additional oversight of the market from a separate entity should have been expected. However, companies have expressed concern about the Attorney General's role in rate review when its public position has been one of a consumer advocate only. The Department's role is to balance its duty as a consumer advocate with its duty to protect the financial soundness of the market.

    - **The process of approving rates changed considerably in that additional documentation was required to ensure compliance with the rating provisions of HB 250 and SB 343.** Companies systems were not set up to retrieve information and many had little or no experience at MCR pricing. The Department also experienced

internal difficulties in handling the new system because it had not been structured for the new approach (i.e. breakdown, data reporting by provider contracts, administrative expense tied back to financial statements, etc.). The new reporting format seemed logical, but it was not the way the industry had operated prior to reform and it was not the way national carriers are required to operate in the majority of states.

- **No recognition was made of the market dominance of Anthem Blue Cross/Blue Shield and Humana and their anticipated reaction to reform** (i.e. agent commissions, provider reimbursement, their dominance and/or relationships in the association market prior to reform which assured control of the most prominent associations under SB 343 as well as the healthy business in Kentucky thereby making them more dominant in the market place). Company reactions turned into impacts on consumers. This has contributed to the disruption brought about by the actual provisions of reform.

- **The lack of competition in the individual market eliminated the market pressures necessary to drive down the cost.**

- **Misinformation has contributed to consumer confusion.** Agents have said that almost every customer communication they receive is tied to problems with reform. Carrier communications attribute changes and/or problems to reform. In public hearings held by the Department several complaints were made which the consumers attributed to reform. In actuality, the basis of the complaints involved problems that existed prior to reform (i.e. doctors dropping out of the network, balance billing). Yet consumers attributed the problems to reform.

- **The standard health benefit plans all contain comprehensive, rich benefits which contribute to high cost of the plans.**

- **Managed care has not evolved in Kentucky** (especially in eastern and western Kentucky). **Thus, Kentucky has not benefited from some of the cost savings that would come from a true managed care market** (as California, Minnesota and some east coast communities have benefited). With the current any willing provider law, Kentucky may never truly benefit from any savings brought about by managed care.

This document is not a complete picture of health insurance in Kentucky. However, combined with studies and reports assembled by the state Legislative Research Commission, it does provide a snapshot of today and benchmark for future comparisons. Collectively these reports will improve our ability to regulate and set policy. Further, these reports support the conclusions that Kentucky's market is unstable and will not be able to sustain itself over the long term.

Kentucky Department of Insurance

CURRENT MARKET

number of carriers

size of insured market

size of reform market

THE PRIVATE INSURANCE MARKET IN KENTUCKY

DATA GATHERING

As part of the attempt to determine the state of the non-elderly private insurance market, the Department mailed a standard health benefits plan survey to 42 insurance companies identified as involved in the health insurance market in Kentucky. In this survey, the Department requested the companies to provide information concerning premium dollars, number of contracts, and covered lives for standard and non-standard health plans. The information received was analyzed and found to have data inconsistencies in reporting formats. A follow up survey conducted by the Department resolved and clarified some conflicting information as well as obtained additional information. The information obtained from all 42 companies is included in this report.

BREAKDOWN OF THE INSURANCE MARKET

The breakdown of the private insurance market contained in this section is the compilation of information reported to the Department by insurance companies. This information is based on year end 1996 and measures covered lives. These figures are subject to reporting and rounding error and represent what the Department believes to be as accurate as possible the true picture of Kentucky's private non-elderly insurance market as of December 31, 1996.

The non-elderly private insurance market is composed of individuals, small groups, large groups, and associations. Insurance may be purchased in the form of standard plans within the Alliance or standard or non-standard plans outside the Alliance (Alliance membership is only open to individuals, small groups, and public sector employees). The individual and small group markets in Kentucky are controlled by a modified community rating methodology, while associations and large groups may continue to be risk rated. The total number of reported covered lives in the **private non-elderly insurance market** in Kentucky is **1,196,162**.

The individual market in Kentucky is primarily composed of persons who buy their insurance coverage directly from a carrier, rather than through their employer or through an association in which they are a member. The total number of reported covered lives in the **individual market** in Kentucky is **122,738**. This figure includes the reported membership of 24,833 people reported by the Farm Bureau Federation, whose membership is not reflected in the association data.

The small group market is defined as employers with 50 or fewer employees. The total number of reported covered lives in the **small group market** in Kentucky is **231,259**.

The large group market is defined as employers with more than 50 employees. The total number of reported covered lives in the **large group** market in Kentucky is **751,867**. This total includes **257,436** public sector employees which are mandatory Alliance members.

REFORM MARKET

A major component of the health care reform effort was the implementation of modified community rating. Under this concept, the insurance rates of individuals are determined without regard to health status. The theory behind modified community rating is that the costs of providing health care to high risk individuals could be lessened by spreading their expenses across an entire community of insureds. Thus, it is expected that the premium for the young, healthy insureds would increase slightly while the premium for the older, less healthy would decrease slightly.

The reform market is composed of the individual, small group, and association markets. The total number of reported covered lives in the **reform market** is **444,294**. (This number excludes the public sector employees and is broken down as follows: individual - 122,738; small group - 231,259; association - 90,297.) This represents **37%** of the total non-elderly private insurance market in Kentucky.

Because associations are exempted from the modified community rating requirements and are allowed to risk rate, healthy insureds covered through association plans will not be transitioning into the modified community rated market. On the other hand, older and less healthy insureds are likely to move from associations to the modified community rated market. Thus, of the 444,294 people in the reform market, fewer than **353,997** have the potential of participating in the **modified community rated market**. This represents **79%** of the reform market and **31%** of the total non-elderly private insurance market in Kentucky.

Of the 444,294 people in the **reform market**, **176,594** are **currently participating** in the modified community rated market. (This total was arrived at by subtracting from the total number of covered lives in the reform market those covered through non-standard plans. The number is broken down as follows: non-standard plans - 177,404 (individual - 63,344, small group 114,059. This total does not include public sector employees.) This represents **39%** of the reform market and **14%** of the total non-elderly private insurance market in Kentucky.

CONCLUSIONS

Identifying those people covered in the market segments targeted by reform (individual and small group, whether their health benefit plan was purchased through the Alliance, Non-Alliance, or association market) provides a picture of the size of the anticipated reform market in Kentucky.

The analysis of the available data supports the expectation that given the option of voluntarily opting out of the reform, healthy individuals would choose associations plans. This opt out would result in the inability of the modified community rated market to provide a sufficient critical mass of healthy individuals to sustain itself in the long term.

INDIVIDUAL COVERED LIVES (policyholder plus any dependents)
Market Totals for Calendar Year 1996

Standard Plans (plans issued after July 15, 1995)	**Number**	**Percent of individual market**	**Premium**	**Percent of individual market**
Alliance	20,776	17%	$ 15,563,584	10%
Non-Alliance	38,618	31%	$ 56,611,032	36%
Subtotal	59,394	48%	$ 72,174,616	46%
Non-Standard Plans (plans issued prior to July 15, 1995)	63,344	52%	$ 83,893,563	54%
TOTAL (standard and non-standard)	122,738	100%	$ 156,068,179	100%
Percent Total Market	10%		10%	

SMALL GROUP COVERED LIVES (employee plus any dependents)
Market Totals for Calendar Year 1996

Standard Plans (plans issued after July 15, 1995)	Number	Percent of Small Group Market	Premium Amount	Percent of Small Group Market
Alliance	32,063	14%	28,238,907	10%
Non-Alliance	85,137	37%	106,080,213	37%
Subtotal	117,200	51%	$ 134,319,120	47%
Non-Standard Plans (plans issued prior to July 15, 1995)	114,059	49%	152,220,704	53%
TOTAL (standard and non-standard)	231,259	100%	$ 286,539,824	100%
Percent Total Market	19%		18%	

LARGE GROUP COVERED LIVES (employee plus any dependents)
Market Totals for Calendar Year 1996

Standard Plans (plans issued after July 15, 1995)	Number	Percent of Large Group Market	Premium Amount	Percent of Large Group Market
Alliance	257,436	34%	349,881,770	34%
Non-Alliance	100,551	13%	164,552,225	16%
Subtotal	357,987	48%	$ 514,433,995	50%
Non-Standard Plans (plans issued prior to July 15, 1995)	393,881	52%	524,674,608	50%
TOTAL (standard and non-standard)	751,867	100%	$ 1,039,108,603	100%
Percent Total Market	63%		65%	

ASSOCIATION GROUP COVERED LIVES
Market Totals for Calendar Year 1996

Standard Plans (plans issued after July 15, 1995)	Number	Percent of Large Group Market	Premium Amount	Percent of Large Group Market
Alliance	-	0%	-	0%
Non-Alliance	6,386	7%	3,196,574	3%
Subtotal	6,386	7%	$ 3,196,574	3%
Non-Standard Plans (plans issued prior to July 15, 1995)	83,911	93%	102,652,771	97%
TOTAL (standard and non-standard)	90,297	100%	$ 105,849,345	100%
Percent Total Market	8%		7%	

TOTAL COVERED LIVES FOR ALL MARKET SEGMENTS
Market Totals for Calendar Year 1996

Standard Plans (plans issued after July 15, 1995)	Number	Percent of Total Market	Premium Amount	Percent of Total Market
Alliance	310,276	26%	393,684,261	25%
Non-Alliance	230,691	19%	330,440,044	21%
Subtotal	540,966	45%	724,124,305	46%
Non-Standard Plans (plans issued prior to July 15, 1995)	655,195	55%	863,441,646	54%
TOTAL (standard and non-standard)	1,196,162	100%	1,587,565,951	100%
Percent Total Market	100%		100%	

TOTAL COVERED LIVES IN MCR MARKET
Market Totals for Calendar Year 1996

Standard Plans (plans issued after July 15, 1995)	**Number**	**Percent of MCR Market**	**Premium Amount**	**Percent of MCR Market**
Alliance	52,840	15%	43,802,491	10%
Non-Alliance	123,754	35%	162,691,245	37%
Subtotal	176,594	50%	206,493,736	47%
Non-Standard Plans (plans issued prior to July 15, 1995)	177,404	50%	236,114,267	53%
TOTAL (standard and non-standard)	353,997	100%	442,608,003	100%
Percent Total Market	30%		28%	

ASSOCIATION DATA

The 1996 General Assembly passed SB 343 which exempted qualifying associations that sell insurance to their members from the modified community rating requirements imposed on the small group and individual markets. An emergency regulation was promulgated requiring all associations to file specific information regarding membership and health insurance offerings. This information was required on a monthly basis from January 1996 through September 1996. The associations also were required to file quarterly updates with demographic data related to their insurance membership.

Information received through the reports and from discussions with association representatives as well as some of the third party administrators indicated difficulty in retrieving the breakdown of demographic data requested in the regulation. The demographic information received was provided by only a small percentage of the associations and therefore is not useable.

Due to the number of associations not reporting any information and the small number of associations providing a demographic breakdown, the Department decided to rely instead on the information reported by the insurance carriers for an assessment of the total association market (See Current Market Statistics - Section 1).

The information provided in the subsection of Section 1 entitled "The Private Insurance Market In Kentucky" lists the number of covered lives in the association market as **90,793**. This number was reported by the insurance carriers and represents the number of covered lives as of December 31, 1996. The information contained in Appendix A indicates that the number of covered lives in the association market totals **151,332**. This number was reported by the associations in response to 806 KAR 18:080E and represents the number of covered lives as of March 31, 1997.

These numbers, if correct, suggest that the association market has grown considerably over a three month period, and that the numbers contained in this report may be understated.

Kentucky Department of Insurance

RATING ISSUES

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summary of SB 343 rate filings

analysis of MCR rates

SB 343 Rate Filing Requirements

Senate Bill 343 passed by the 1996 General Assembly included significant new requirements for insurers and HMO's in regard to rates for health benefit plans effective July 15, 1996. The rate filing provisions of Senate Bill 343 applied to all health benefit plans, i.e., pre-standard plans, standard plans, large groups and association business. The following areas were addressed:

- Rate guarantee of twelve months;
- Rate filing frequency limitation of twelve months;
- Automatic public hearings for requested rate increases more than 3% in excess of the change in medical CPI for urban South region consumers, as published by the Bureau of Labor Statistics;
- Small groups definition reduced from 100 to 50 eligible employees;
- Modified community rating;
    - Rating for industry and/or occupation with the highest factor no more than 15% of the lowest factor;
    - Rating for gender (with 50% limitation);
    - Overall maximum ratio for rates based on all case characteristics of 5:1;
    - Association business exempted;
- Allowed for a phase-in of rates into new rating methodology by allowing a +/-30% variation from the index community rate between July 15, 1996 and June 30, 1998; +/-20% on July 1, 1988; +/-10% in 1999 and zero variation in the year 2000, and
- Significantly expanded information in the actuarial certification made on behalf of the insurer regarding expenses, detailed explanation of rate development, provider discounts, etc.

Emergency regulation 806 KAR 17:140E was promulgated by the Department of Insurance effective August 23, 1996 containing the requirements for submitting health insurance rates to the Department.

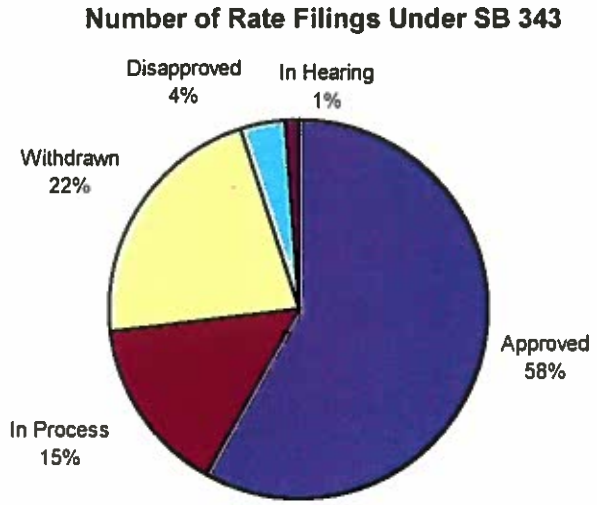
NUMBER OF RATE FILINGS UNDER SB 343

There have been 143 health insurance rate filings from approximately 35 different health insurers for rates filed to be effective July-December, 1996. In addition, there have been 28 such filings for rates filed to be effective in 1997. Some of these represented filings from four companies that had not filed during the last half of 1996.

This rate filing activity is summarized as follows:

	1996	1997	Total
Approved	62% (88)	41% (11)	58% (99)
In process	8% (11)	55% (15)	15% (26)
Withdrawn	25% (36)	4% (1)	22% (37)
Disapproved	4% (6)	0% (0)	4% (6)
In hearing	1% (2)	0% (0)	1% (2)

While there were some delays initially in reviewing and acting upon rate increases (some up to 6 months), the review process used by the Department has been streamlined with decisions currently occurring within 30 to 60 days once information required by the regulation is submitted by the insurer or HMO.

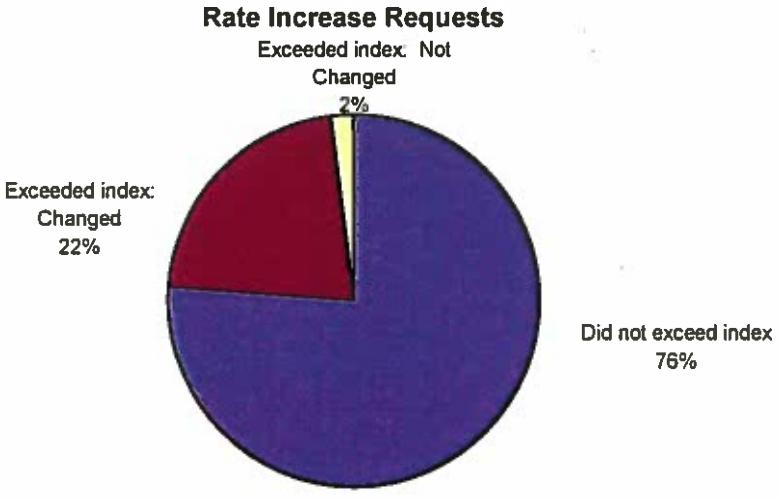


Rate Increase Requests in Relation to Automatic Hearing Trigger

Excluding the filings that were withdrawn as well as those that are still being processed, the following summarizes the filings according to whether they were initially filed with a composite rate (a weighted average rate, for a schedule of rates, based on an assumed distribution of the insured population among the rate cells) increase not greater than the increase in the statutory index (medical care consumer price index for all urban consumers for the South region as published by the federal Bureau of Labor statistics) margin. The filings requesting increases greater than the statutory index increase margin are split between those that were changed not to exceed the index margin and those that were not changed (i.e. those filings subject to automatic hearing). Twelve of the filings were for new products and, therefore, not subject to statutory index test. For two filings that were disapproved the composite increase was not determinable.

Rate Increase Requests

	1996	1997	Total
Did not exceed index	74% (62)	100% (12)	76% (71)
Exceeded index: Changed	24% (20)	0% (0)	22% (20)
Exceeded index: Not Changed	2% (2)	0% (0)	2% (2)



Rate Increases Approved

Appendix B is a listing of the 1996 and 1997 rate filings made by companies reflecting the company name, the product, the approved composite rate increase or decrease and trend factors approved, if applicable.

While the rate increases approved after reform appear to be moderate, there isn't data on pre-reform rates to analyze how insurers rates increased or decreased due to reform. Any significant change in rating methodology can be expected to result in a general increase in the overall rate level with subsequent adjustment as actual experience identifies the true cost of benefits. This is magnified with the sweeping changes in insurance accessibility and portability, as well as rating restrictions, introduced with HB250.

Rate Analysis of Most Popular Modified Community Rated Health Products Under Reform

INTRODUCTION

The following health benefit plan rate filing data represents an initial attempt by the Department of Insurance to present the increases or decreases in rates after the Health Care Reforms of 1994 were implemented and subsequently amended by SB 343 of the 1996 General Assembly. Because it was determined to be of extreme interest to the public as well as to policy-decision makers, the Department decided to gather and analyze data on the "most popular plans" initially, and to conduct a similar analysis on all rates at a later date. Hopefully, this will provide useful information from which a baseline can be established in order to answer questions about the trends in health insurance rates after reform. Since there is no pre-reform baseline data on rates, this analysis focuses strictly on rate trends beginning with reform.

As indicated above, the Department collected data for purposes of this report on the "most popular plans" being sold in the market based on rate filings submitted for approval during the period of July 1996 - December 1996. For purposes of this analysis, a "most popular plan" was defined by the Department as any rate filing with a proposed effective date between July 1, 1996, and December 31, 1996 which indicated that there were 1,000 certificate holders or more.

Unfortunately, since there is no baseline data to compare to, it is difficult to determine exactly what the effects are of guarantee issue, standard benefit plans, and any shifts in the way in which particular market segments were subsidizing or were subsidized prior to reform.

The Department recognizes the inherent limitations of the data presented here, but believes that it represents a beginning in the effort to collect data and monitor trends in health insurance premiums for Kentucky's citizens. The collection of premium and benefit data in the future will clarify the current uncertainty about the sufficiency or deficiency of premiums.

DATA COLLECTION METHODOLOGY

For inclusion in this report, the Department reviewed all health insurance modified community rated filings for standard benefit plan products submitted for review by insurers and HMO's with proposed effective dates of July 15, 1996 through December 31, 1996. Rate filings which were disapproved or were withdrawn are not included since our goal was to identify changes in actual rates used in the market. However, two rate filings which are not yet approved but are currently in hearing status have been included, because they represent products which have significant numbers of certificate holders in certain market segments.

The Department reviewed all rate filings to determine number of certificate holders the insurer or HMO reported as being covered by the product.[1] If the number of certificate holders was equal to 1,000 or more, this product was selected for inclusion in the analysis. While some might argue that the selection of 1,000 certificate holders was an arbitrary number, the Department, through trial and error, determined that a lower threshold did not produce a significant difference until the number was reduced to about 500 and a higher threshold did not allow for enough products to be included in the report to make analysis meaningful.

If the rate filing met this 1,000 certificate holder criteria, then any rate filing under reform either prior to or after the July 1996 - December 1996 rate filing period for this same product was obtained and information pulled from the filing. Modified community rating filings were first received in July 1995. It is important to point out that during this twenty-two (22) month period, the requirements for rate filings changed frequently. Therefore, information contained in the July 1996 - December 1996 rate filing period may not have been provided as a part of prior filings for the same product. Also, it should be noted that SB 343 instituted significant changes, effective July 1996, in the rating factors which could be considered. Some of these differences are quite apparent in the rate data displayed by product.

Since our interest was in analyzing patterns of increases or decreases in the rates of products affected by the 1994 and 1996 reform legislation, we focused only on modified community rated filings for small groups and individuals. Rate filings for products sold to large groups and associations are not modified community rated, but rather use experience rating methodologies. For large groups, including associations, the rate filings contain the rating formula used by the insurers that is applied to the experience of the group. Since an actual rate for a group depends on the previous claims experience, there is no way to determine any group's rate from data in the filing. For these reasons, large group product filings were not included in this analysis.

There are limitations in the data which could be obtained from the rate filings. For example, the filings may have been submitted in July or August of 1996 but were proposed to become effective in November 1996. The number of certificate holders reported in many cases was the last month's enrollment available to the company's actuary from several months prior to the proposed effective date. Therefore, significant changes in these numbers could have occurred from the time rates were proposed and the time they became effective in the marketplace. For this reason, the number of certificate holders reported in the rate filings was only used to determine if the product should be selected for analysis. Any other assumptions, calculations, etc. used in this analysis involving number of certificate holders were derived from up-to-date sources such as a survey of companies or from the Kentucky Health Purchasing Alliance.

However, while other sources were more current, other limitations were inherent in that data as well. Numbers of certificate holders obtained from the Alliance used in calculating the average premium rate by product type, while being more up-to-date than information from the rate filing,

[1] Carriers/insurers were not required to provide information as to the number of certificate holders as a part of the rate filing until August 23, 1996.

had a combined enrollment count including both HMO and POS. The Department developed the percentage of a company's business between HMO and POs based on the information in their July 1996-December 1996 rate filing and then applied these percentages to the Alliance enrollment counts as necessary.

The rate information shown in the January 1997 period may not represent a new filing. Effective July 15, 1996, insurers could only file for rate increases once in a twelve (12) month period. However, the Department interpreted this to mean that insurers could propose a rate increase for the first six (6) months and then use a trend factor to update rates for the second six month period. This prevents insurers from front-loading annual increases at the beginning of the rate period. In allowing the use of a trend factor, the increases over the entire twelve (12) month period must meet all requirements under the law. If a trend factor was used, the trend rate was applied to the rate for the first six months to obtain the rate for January 1997.

There are only two (2) products currently being sold in the individual market. Kentucky Kare in the Alliance (the only individual product in this analysis) and Anthem's Option 2000 and Option 2000 Advantage products outside the Alliance. Unfortunately, Anthem's products are not included in the analysis as the rate filings for these products were submitted and withdrawn.

The Department matched rate filings over a twenty-two month period to a particular company's products to the extent possible, however, companies sometimes referred to the same product differently from one rate filing to the next, making it difficult to track what a company was doing with its rates over the period.

ANALYSIS

A total of twenty-two (22) health insurance products are analyzed in this report. Since actuarially there is a difference in the cost of a benefit plan between the four (4) types of products, i.e., HMO, POS, PPO and Fee-for-Service, the twenty-two (22) products were segregated by type of product. Also, products were segregated into Alliance versus non-Alliance filings.

As a condition of doing business, insurers must issue the Basic Plan. Rates analyzed in this report were rates for the Standard High benefit plan.

The Department selected the under age 30 and the 60-64 age bands for analysis, as these age bands would reflect the age bands most affected by the rating limitations based solely on age, and the age band 30-39 because it is a highly populated age band. The rates analyzed are the male and female rates, as well as the tier rates that must be filed (single, couple, parent-plus and family).

For non-Alliance filings, the premium rates for each cell in the selected age bands were listed for each filing period, i.e., July 1995, January 1996, July 1996, and January 1997. The percentage increase or decrease in the rate from each period to each subsequent period was calculated and is displayed in the worksheets provided at the end of this analysis.

Alliance filings were separated into the rating periods used for state employees (January of each year) and non-state employee groups (July of each year). Alliance rates are negotiated every six months. Because state employee rates are adjusted in January of each year and represent the majority of Alliance enrollment, changes in rates for Alliance products sold to state employees were measured from January 1, 1996 to January 1, 1997. These filings are referred to as "Public" to denote the general characteristics of the population to which the rate would be applicable. A small number of non-state public and private employer groups and individuals would also use these rates as well.

The Alliance July 1995 and July 1996 rates would be used only for non-state public and private employees and individuals buying or renewing coverage during the months of July through December and therefore, these filings are separated from the rates used predominantly by state employees. These filings are referred to as "Private."

It is important to explain here that rates presented in this report are the monthly list bill rates for the selected rate cells. For Alliance products, these monthly list bill rates for January 1996 and January 1997 are not the rates charged to state employees. The Alliance uses these rates to create composite rates by tiers, using the distribution of state employees in each rating cell. Compositing the rates in this manner produces a standard rate for each product. State employees are charged the same composite rate by tier classification (single, couple, parent-plus and family).

At the end of each product type, the weighted average premium rate for each rate cell for each product is calculated for the July 1996 and January 1997 periods. The rate is weighted by that product's proportion of certificate holders to the total number of certificate holders for the product type. For example, for all Alliance HMO products, the weighted average premium rate for female single coverage under age 30 is $115 for the July 1996 period and $121 for January 1997, as shown in the rate worksheet contained in this analysis.

FINDINGS

Analysis of the most popular plans shows that insurers generally made adjustments in their rating methodologies as permitted by SB 343. For example, when premium rates could be varied by gender, comparisons between the unisex rates for a particular age group and gender-rated rates for the same age group reflect that rates for females in the child- bearing ages went up significantly while rates for males in the same age groups were reduced significantly. Eight Alliance HMO products were analyzed. The range of increase in rates for the females in the under-30 age group was a low of 0.0% (on a base of $113) to a high of 21.7% (on a base of $109), while the range of rate reductions for males in the under age 30 category varied from a low of a 19.16% decrease (applied to a rate of $106) to a high of a 37.86% decrease (applied to a rate of $140). The same comparison for the 30-39 age category reflects generally the same outcome, that is the range of increases for females was from a low of a 0.0% increase (on a base rate of $145) to a high of a 28.95% increase (on a base rate of $114). For males in this age group, the range of decreases was from a low of a 10.24% decrease (on the base of $127) to a high of a 30.83% decrease (on a base of $133). In the 60-64 age category, the impact of gender rating is more moderate and shows that females received moderate decreases while male rates

increased in the 60-64 age group from the previous unisex rate. Most insurers increased the male rates in the 60-64 age group from the previous unisex rates. Traditionally, one could have expected the rates for females ages 60-64 to decrease, and rates for males age 60-64 to increase.

ALLIANCE HMO RANGE OF PERCENTAGE CHANGE

Age Band	Females	Males
Under 30	0.0% to +21.7%	-19.1% to -37.86%
30-39	0.0% to +28.95%	-10.24% to -30.83%
60-64	+2.16% to +17.98% or -2.03 % to -10.32%	+.41% to +26.04% or -.65% to -16.57%

The Alliance POS products reflect the same patterns as the HMO products discussed above.

ALLIANCE POS RANGE OF PERCENTAGE CHANGE

Age Band	Females	Males
Under 30	+ 5.9% to +19.8%	-18.4 % to -37.50%
30-39	+ 0.67% to +19.51%	-18.6% to - 31.4%
60-64	+13.1% to +16.1% - 2.4% to -22.0%	+1.4% to +23.2% (One decreased 16.9%)

Analysis of all of the remaining products types generally reflects the same increases to females of child bearing age and decreases to males as shown above.

The change in rates is calculated for each product type and presented in the worksheets at the end of this section.

TIER RATIO RELATIONSHIPS

Another basis for comparing the consistency of rate factors among products is that used for determining tier rates. The four tier rating structure (single, couple, parent-plus and family) has been a long standing, generally accepted practice for large employer groups, but not as much so for individuals and small groups, and had not been utilized for the state employee group until mandated by HB 250. With the requirement of HB 250 that modified community rating be presented in the four tiers, the adjustment forced a redistribution of rates in that the previous practice, especially for small groups, was to establish the single rate in such a manner as to subsidize couples and families. Due to reform, rates for couple, parent plus, and family tiers were higher, indicating a reduction in the subsidy. As an example, for the state employee group which makes up a significant portion of the Alliance, the redistribution was felt initially by families in January 1996, and by couples in January 1997.

The average weighted rate tier ratios for the various product types are shown in the following table. In the younger age brackets the male ratios for couple and family are significantly higher than the female ratios because the male rates for single are significantly less than female single rates. This also means that the female parent-plus rates in the young age brackets are significantly higher than the male parent-plus rates.

This variation between male tier ratios and female tier ratios occurred with the onset of gender rating, as the single rate for females is higher than the single rate for males, requiring an adjustment to the ratios for the two genders to reflect the costs in couple, parent-plus and family tiers in relation to the single rate.

January 1997 Small Group and Individual Average Weighted Rate Tier Ratios

GROUP		FEMALE Single	Couple	P-Plus	Family	MALE Single	Couple	P-Plus	Family
Alliance HMO	Under 30	1	2.0	2.0	2.9	1	2.8	2.0	4.1
	30-39	1	1.8	1.9	2.7	1	2.5	2.0	3.7
	60-64	1	2.2	1.4	2.5	1	1.9	1.3	2.2
Alliance PPO	Under 30	1	2.1	2.1	3.1	1	2.7	2.1	4.2
	30-39	1	1.7	1.9	2.8	1	2.3	2.0	4.0
	60-64	1	2.1	1.5	2.7	1	1.8	1.3	2.3
Alliance POS	Under 30	1	1.7	1.7	2.4	1	2.6	2.0	3.6
	30-39	1	1.7	1.8	2.5	1	2.5	2.2	3.7
	60-64	1	2.1	1.3	2.3	1	2.0	1.2	2.2
Alliance FFS	Under 30	1	1.8	1.7	2.5	1	2.5	1.9	3.4
	30-39	1	1.8	1.6	2.3	1	2.6	1.8	3.3
	60-64	1	2.2	1.3	2.5	1	2.0	1.3	2.3
Non-Alliance HMO	Under 30	1	1.9	2.0	2.7	1	3.0	1.9	4.3
	30-39	1	1.7	1.9	2.6	1	2.6	2.0	4.0
	60-64	1	2.2	1.4	2.5	1	1.8	1.3	2.2
Non-Alliance PPO	Under 30	1	2.5	2.0	3.3	1	2.9	1.8	3.9
	30-39	1	2.0	1.9	2.5	1	2.4	1.7	3.2
	60-64	1	2.3	1.6	2.5	1	1.7	1.2	2.0
Hearing Status [1]									
Non-Alliance PPO	Under 30	1	1.7	1.8	2.9	1	1.7	1.8	2.9
	30-39	1	1.7	1.6	2.5	1	1.7	1.6	2.5
	60-64	1	1.7	1.6	2.5	1	1.7	1.6	2.5
INDIVIDUAL									
Alliance FFS	Under 30	1	1.8	1.7	2.5	1	2.5	1.9	3.4
	30-39	1	1.8	1.6	2.4	1	2.5	1.8	3.3
	60-64	1	2.2	1.3	2.5	1	2.0	1.3	2.3

[1] Average Weighted Tier Rate Ratios for Option 2000 and Option 2000 Advantage for July 1996

PREMIUM ALLOCATION

In submitting rates to the Department of Insurance for approval, insurers and HMO's are required to provide an explanation of the load factors used in pricing, including any assumptions made that affect pricing. By load factors it is meant the administrative expenses (which include marketing, advertising, customer service costs, costs of issue, billings, rent, salaries, etc.), commissions (assumption of commission structures used and the average commission percentages paid for prior periods), taxes (city, county, state and other premium taxes included in the cost of the product), and profits (profit margins included in the rate from all sources and actual profits for prior periods). These load factors are then expressed as a percentage of the total premium requested in the rate filing. The total of these load factors, which are sometimes collectively referred to as administration and profit, is the proportion of the premium which is not anticipated to be used for actual medical claims.

The percentage of the total premium which is anticipated to be used to reimburse providers for medical claims is referred to as the medical loss ratio. On a pricing basis, the sum of the administration and profit load and the medical loss ratio combine to establish the total premium.

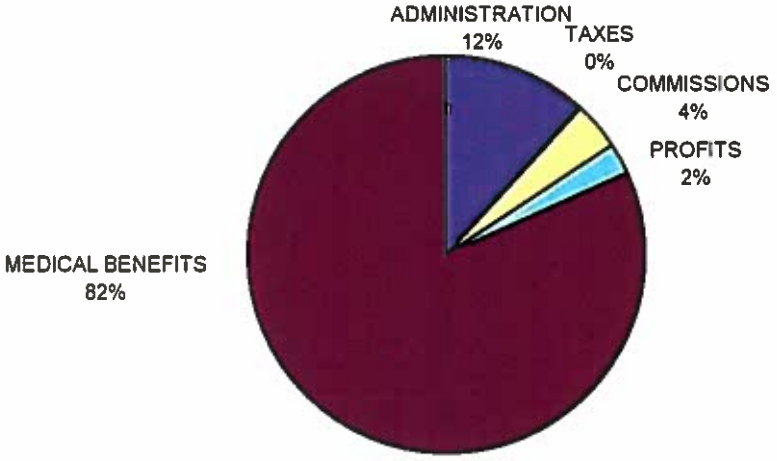
For analysis purposes, using rate filings of the 22 most popular plans, the statistics were combined for the load factors and medical loss ratios for all rate filings for product types HMO and POS and reported in the following tables and chart as "Managed Care". Reported as "Indemnity" are statistics for Fee-for-Service and PPO product types. To reflect any differences in pricing for market segments by the insurers, the statistics are further separated by Alliance versus Non-Alliance filings, and small group versus individual business. Finally, the requested premium split for the two rate filings in hearing status are included, again because they represent large numbers of certificate holders. The statistics presented are the average of all rate filings in that product type.

The following chart summarizes the average percentage found in the rate filings for administration, taxes, commissions, and profit margin. The total administration and profit column is the sum of the first four columns. This total percentage is subtracted from 100% to obtain the medical loss ratio anticipated in the filings.

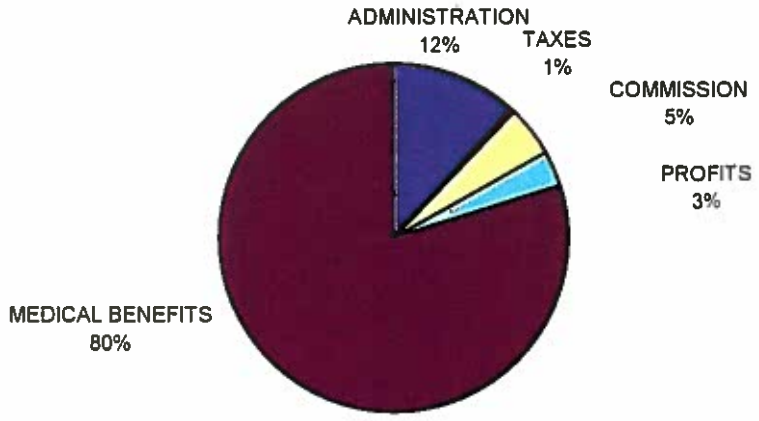
Average Percentage Load by Product Type by Market Segment

Product Type	Administration	Taxes	Commissions	Profits	Total Admin .& Profit	Medical Loss Ratio
Alliance- Group-Mgd. Care (HMO & POS)	11.7%	.35%	3.82%	2.45%	18.32%	81.68%
Non-Alliance-Group-Mgd. Care (HMO & POS)	11.56%	.56%	4.89%	3.19%	20.2%	79.8%
Alliance-Group-Indemnity (FFS & PPO)	8.81%	.47%	2.5%	2.75%	14.53%	85.47%
Non-Alliance-Group-Indemnity (FFS & PPO)	13.78%	0%	4.97%	4.0%	22.75%	77.25%
Alliance-Individual-Indemnity (FFS & PPO)	4.91%	1.25%	5.0%	0%	11.16%	88.84%
Hearing Status Non-Alliance-Group (PPO)	13.81%	0%	6.38%	4.0%	24.19%	75.81%

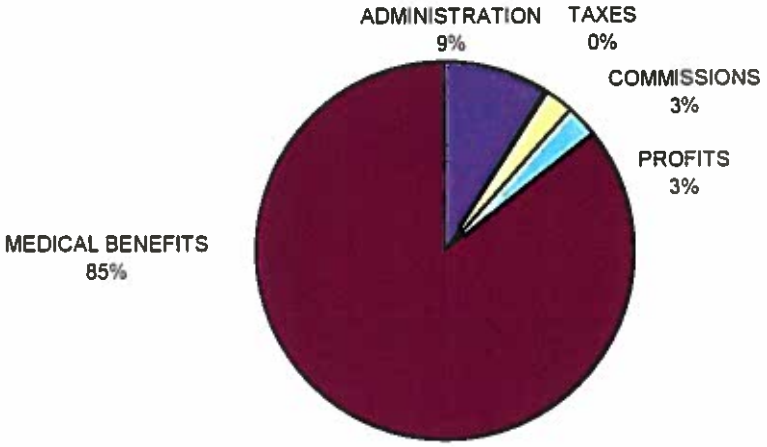
1997 ALLIANCE GROUP MANAGED CARE - HMO & POS



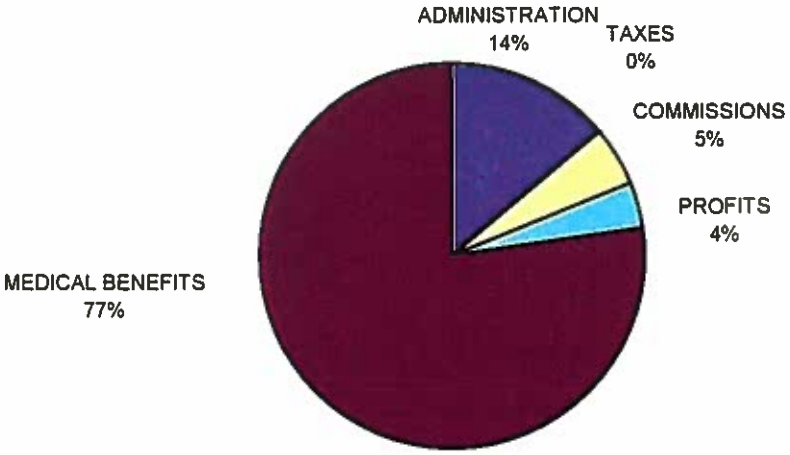
1997 NON-ALLIANCE MANAGED CARE (HMO&POS) PREMIUM



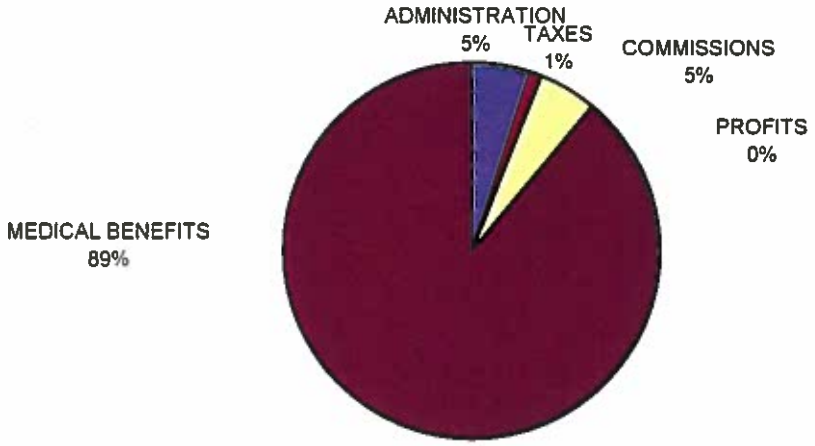
1997 ALLIANCE GROUP INDEMNITY (FFS & PPO) PREMIUM



1997 NON-ALLIANCE SMALL-GROUP INDEMNITY (FFS&PPO)



1997 ALLIANCE INDIVIDUAL - FFS & PPO PREMIUM



This means that a male, age 35, who purchases family coverage in January 1997 through the Alliance as a part of an employer group would pay $373 monthly for a "popular" HMO product. Of the $373 monthly premium, the average percentage of the premium which is used for administration and profit is 18.32% of the "average" HMO Alliance product for his age group which would be $68.33 ($373 monthly premium multiplied by .1832). The remaining amount ($373 less $68.33) of $304.67 is what would be paid out in medical claims.

CONCLUSIONS

From the rate analysis, the following conclusions can be reached:

- Product premium allocations analyzed are consistent with state and national trends.
- Significant redistribution of rates occurred among different age bands and by gender.
- Reform caused a significant redistribution in rates among the single, couple, parent-plus and family tiers.

Again, baseline data does not exist to allow for comparisons of pre-reform rates to rates after reform. While the data reveals some general trends, a more extensive analysis will be made as additional rate information becomes available to determine other trends in progress.

ALLIANCE HMO GROUP

Co.	Final Composite	1997 Trend	Net Composite Change 1/96 to 1/97	Cert hkd 7/96	Weight 7/96 %	Cert hkd 1/97	Weight 1/97 %	Effect. Date	LIST MONTHLY BILL RATES — ATTAINED AGE 30-39 — FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	ATTAINED AGE 40-54 — FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	ATTAINED AGE 55-64 — FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family
A								Private																						
	-4.51%	1.40%	-3.17%	148	9.24%			7/95	$113	$227	$189	$308	$113	$227	$189	$308	$133	$268	$223	$363	$133	$268	$223	$363	$265	$533	$445	$723	$265	$533	$445	$723
								7/96	$120	$197	$218	$293	$80	$230	$145	$333	$137	$221	$243	$342	$92	$238	$171	$370	$247	$510	$319	$601	$269	$515	$348	$603
									6.19%	-13.22%	15.34%	-4.87%	-29.20%	2.64%	-23.28%	8.12%	3.01%	-17.54%	8.97%	-5.79%	-30.83%	-11.19%	-23.32%	1.93%	-6.79%	-4.32%	-28.31%	-16.87%	1.51%	-3.38%	-21.80%	-16.00%
								Public																						
								1/96	$109	$223	$186	$307	$100	$221	$186	$307	$129	$264	$220	$363	$129	$264	$220	$363	$250	$525	$438	$722	$250	$525	$438	$722
						13,736	19.75%	1/97	$122	$200	$221	$297	$81	$230	$147	$338	$139	$224	$246	$347	$93	$241	$173	$375	$250	$517	$323	$609	$273	$522	$353	$611
									11.63%	-10.42%	18.85%	-3.22%	-25.58%	5.05%	-20.95%	9.99%	7.69%	-15.12%	12.00%	-4.47%	-27.68%	-8.59%	-21.18%	3.36%	-2.10%	-1.50%	-26.15%	-15.59%	0.55%	-0.53%	-19.44%	-15.31%
B																														
				Cert hkd 7/96	Weight 7/96 %	Cert hkd 1/97	Weight 1/97 %	Private 7/95	$120	$203	$220	$345	$120	$203	$220	$345	$148	$251	$239	$375	$146	$251	$239	$375	$325	$552	$511	$802	$325	$552	$511	$802
	-1.98%	8.50%	-10.31%	315	19.69%			7/96	$125	$310	$254	$405	$90	$270	$169	$377	$153	$304	$291	$375	$114	$272	$194	$366	$318	$741	$510	$791	$337	$578	$410	$681
									4.17%	55.67%	15.45%	17.39%	-20.00%	37.44%	-23.10%	9.28%	3.38%	21.12%	21.76%	0.00%	-22.97%	8.37%	-18.83%	-2.40%	-2.15%	34.24%	-0.20%	-1.37%	3.69%	4.89%	-19.77%	-14.71%
								Public 1/96	$118	$273	$246	$399	$118	$273	$246	$399	$130	$297	$263	$425	$130	$297	$263	$425	$297	$630	$527	$879	$297	$630	$527	$879
						22,005	31.65%	1/97	$114	$289	$232	$371	$88	$255	$155	$345	$140	$278	$266	$343	$104	$249	$178	$335	$291	$678	$407	$724	$308	$530	$375	$626
									3.07%	5.91%	-5.52%	-7.12%	-25.56%	-8.49%	-37.14%	-13.55%	2.94%	0.34%	1.24%	-19.26%	-20.30%	-16.20%	-32.51%	-21.20%	-2.03%	8.61%	-11.45%	-17.66%	3.82%	-16.70%	-28.81%	-28.80%
C																														
				Cert hkd 7/96	Weight 7/96 %	Cert hkd 1/97	Weight 1/97 %	Private 7/95	$101	$220	$165	$303	$101	$220	$165	$303	$114	$250	$187	$344	$114	$250	$187	$344	$258	$563	$421	$774	$258	$563	$421	$774
	3.40%	2.69%	6.00%	40	2.50%			7/96	$112	$189	$191	$267	$70	$189	$155	$267	$127	$214	$231	$318	$87	$214	$191	$318	$278	$567	$345	$634	$289	$567	$350	$634
									11.89%	-14.09%	15.76%	-11.88%	-24.75%	-14.09%	-6.06%	-11.88%	11.40%	-14.40%	23.53%	-7.56%	-23.68%	-14.40%	2.14%	-7.56%	7.75%	0.71%	18.05%	-18.09%	12.02%	0.71%	-15.44%	-18.09%
								Public 1/96	$101	$220	$165	$303	$101	$220	$165	$303	$114	$250	$187	$344	$114	$250	$187	$344	$258	$563	$421	$774	$258	$563	$421	$774
						3,685	5.30%	1/97	$115	$194	$196	$274	$78	$194	$159	$274	$130	$220	$237	$327	$89	$220	$196	$327	$285	$582	$354	$651	$297	$582	$360	$651
									14.87%	-11.78%	18.87%	-9.51%	-22.73%	-11.78%	-3.53%	-9.51%	14.40%	-12.10%	26.85%	-5.07%	-21.03%	-12.10%	4.89%	-5.07%	10.65%	3.42%	-15.85%	-15.88%	15.03%	3.42%	-13.16%	-15.88%

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Co.	Final Composite	1997 Trend	Net Composite Change 1/96 to 1/97	Cert Mkt 7/96	Weight 7/96 %	Cert Mkt 1/97	Weight 1/97 %	Effect Date	LIST BILL MONTHLY RATES — ATTAINED AGE < 30 — FEMALE Single	FEMALE Couple	FEMALE Parent	FEMALE Family	MALE Single	MALE Couple	MALE Parent	MALE Family
D				Cert Mkt 7/96	Weight 7/96 %	Cert Mkt 1/97	Weight 1/97 %	Private 7/95	$92	$185	$194	$240	$92	$185	$194	$240
	3.04%	2.50%	5.62%	485	30.27%			7/96	$102	$188	$198	$284	$70	$192	$163	$284
									10.87%	1.62%	2.06%	18.33%	-23.91%	3.78%	-15.98%	18.33%
								Public 1/96	$95	$200	$181	$248	$95	$200	$181	$248
						3,994	5.74%	1/97	$105	$193	$203	$291	$72	$197	$167	$291
									10.05%	-3.65%	12.13%	17.38%	-24.47%	-1.60%	-7.69%	17.38%
E				Cert Mkt 7/96	Weight 7/96 %	Cert Mkt 1/97	Weight 1/97 %	Private 7/95	$140	$322	$252	$392	$140	$322	$252	$392
	1.26%	2.70%	3.99%	259	16.19%			7/96	$128	$236	$248	$359	$87	$240	$203	$359
									9.57%	20.71%	-1.59%	-8.42%	-37.86%	-25.47%	-19.44%	-8.42%
								Public 1/96	$115	$229	$233	$345	$115	$229	$233	$345
						13,272	19.03%	1/97	$131	$242	$255	$369	$89	$240	$208	$369
									14.31%	5.84%	9.31%	6.87%	-22.31%	7.03%	-10.52%	6.87%
K				Cert Mkt 7/96	Weight 7/96 %	Cert Mkt 1/97	Weight 1/97 %	Private 7/95	$109	$200	$245	$414	$109	$200	$245	$414
	2.94%	2.77%	5.79%	7	0.44%			7/96	$132	$245	$278	$403	$88	$245	$205	$403
									21.10%	-5.77%	13.47%	-2.66%	-19.27%	-5.77%	-16.33%	-2.66%
								Public 1/96	$123	$241	$227	$375	$123	$241	$227	$375
						3,916	5.63%	1/97	$136	$252	$286	$414	$90	$252	$211	$414
									10.79%	4.48%	25.86%	10.44%	-26.47%	4.48%	-7.19%	10.44%

Co.	ATTAINED AGE 30-39 — FEMALE Single	FEMALE Couple	FEMALE Parent	FEMALE Family	MALE Single	MALE Couple	MALE Parent	MALE Family	ATTAINED AGE 60-64 — FEMALE Single	FEMALE Couple	FEMALE Parent	FEMALE Family	MALE Single	MALE Couple	MALE Parent	MALE Family
D																
	$110	$220	$230	$285	$110	$220	$230	$285	$252	$505	$530	$656	$252	$505	$530	$656
	$113	$215	$226	$328	$80	$215	$199	$328	$226	$499	$290	$563	$241	$465	$305	$520
	2.73%	-2.27%	-1.74%	15.09%	-21.82%	-2.27%	-13.48%	15.09%	-10.32%	-1.19%	-45.28%	-14.18%	-4.37%	-7.92%	-42.45%	-19.51%
	$113	$238	$215	$295	$113	$238	$215	$295	$242	$507	$459	$628	$242	$507	$459	$628
	$116	$220	$232	$336	$88	$220	$204	$336	$232	$511	$297	$577	$247	$477	$313	$541
	2.50%	-7.41%	7.74%	13.97%	-21.99%	-7.41%	-5.13%	13.97%	-4.28%	0.88%	-35.24%	-8.11%	2.08%	-5.99%	-31.89%	-13.82%
E																
	$145	$333	$261	$405	$145	$333	$261	$405	$356	$818	$640	$996	$356	$818	$640	$996
	$145	$276	$290	$421	$111	$270	$256	$421	$278	$613	$357	$693	$297	$571	$375	$649
	0.00%	-17.12%	11.11%	3.95%	-23.45%	-17.12%	-1.92%	3.95%	-21.91%	-25.06%	-44.22%	-30.42%	-16.57%	-30.20%	-41.41%	-34.84%
	$127	$254	$258	$383	$127	$254	$258	$383	$242	$483	$490	$727	$242	$483	$490	$727
	$149	$283	$298	$432	$114	$283	$203	$432	$286	$630	$367	$712	$305	$586	$385	$607
	17.26%	11.60%	15.44%	12.89%	-10.24%	11.60%	1.90%	12.89%	17.98%	30.34%	-25.10%	-2.10%	26.04%	21.41%	-21.40%	-8.32%
K																
	$114	$252	$250	$406	$114	$252	$250	$406	$232	$464	$368	$618	$232	$464	$368	$618
	$147	$255	$283	$422	$98	$255	$223	$422	$237	$497	$361	$666	$255	$497	$378	$666
	28.95%	1.19%	13.20%	3.94%	-14.04%	1.19%	-10.60%	3.94%	2.16%	7.11%	-1.90%	7.77%	9.91%	7.11%	2.72%	7.77%
	$129	$234	$232	$368	$129	$234	$232	$368	$261	$429	$341	$559	$261	$429	$341	$559
	$151	$262	$291	$434	$101	$262	$229	$434	$244	$511	$371	$684	$262	$511	$388	$684
	17.11%	11.99%	25.36%	17.85%	-21.93%	11.99%	-1.22%	17.85%	-6.68%	19.06%	8.80%	22.44%	0.41%	19.06%	13.92%	22.44%

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LIST BILL MONTHLY RATES

Co.	Final Composite	1997 Trend	Net Composite Change 1/96 to 1/97	Cert hldr[1] 7/96	Weight 7/96 %	Cert hldr[1] 1/97	Weight 1/97 %	Effect. Date	Attained Age < 30 Female Single	Female Couple	Female Parent	Female Family	Male Single	Male Couple	Male Parent	Male Family	Attained Age 30 - 39 Female Single	Female Couple	Female Parent	Female Family	Male Single	Male Couple	Male Parent	Male Family	Attained Age 60 - 64 Female Single	Female Couple	Female Parent	Female Family	Male Single	Male Couple	Male Parent	Male Family
N				Cert hldr[1]	Weight	Cert hldr[1]	Weight	Private																								
				7/96	7/96 %	1/97	1/97 %	7/95	$109	$260	$245	$414	$109	$260	$245	$414	$114	$252	$250	$406	$114	$252	$250	$406	$232	$464	$368	$618	$232	$464	$368	$618
	3.31%	2.00%	0.20%	34	2.12%			7/96	$125	$231	$263	$381	$83	$231	$194	$381	$139	$241	$267	$399	$93	$241	$211	$398	$224	$469	$341	$629	$241	$469	$357	$629
									14.68%	-11.15%	7.35%	-7.97%	-23.85%	-11.15%	-20.82%	-7.97%	21.93%	-4.37%	6.80%	-1.72%	-18.42%	-4.37%	-15.60%	-1.97%	-3.45%	1.08%	-7.34%	1.78%	3.88%	1.08%	-2.99%	1.78%
								Public																								
								1/96	$118	$234	$218	$361	$118	$234	$218	$361	$124	$225	$223	$354	$124	$225	$223	$354	$251	$413	$328	$538	$251	$413	$328	$538
						6,489	9.33%	1/97	$129	$237	$270	$392	$85	$237	$199	$392	$143	$248	$274	$410	$96	$248	$217	$409	$230	$482	$351	$647	$248	$482	$367	$647
									8.90%	1.48%	24.02%	8.50%	-27.69%	1.48%	-8.52%	8.50%	15.24%	10.11%	23.08%	15.87%	-22.90%	10.11%	-2.73%	15.58%	-8.26%	10.74%	6.87%	20.19%	-1.30%	10.74%	11.89%	20.19%
L				Cert hldr[1]	Weight	Cert hldr[1]	Weight	Private																								
				7/96	7/96 %	1/97	1/97 %	7/95	$113	$192	$208	$326	$113	$192	$208	$326	$140	$237	$225	$353	$140	$237	$225	$353	$306	$521	$482	$757	$306	$521	$482	$757
	1.03%	1.50%	-0.49%	313	18.55%			7/96	$113	$285	$229	$366	$87	$252	$153	$341	$138	$275	$263	$339	$103	$240	$176	$331	$287	$669	$461	$715	$304	$523	$370	$618
									0.00%	48.44%	10.10%	12.27%	-23.01%	31.25%	-26.44%	4.60%	-1.43%	16.03%	16.89%	-3.97%	-20.43%	3.80%	-21.78%	-6.23%	-6.21%	28.41%	-4.36%	-5.55%	-0.65%	0.38%	-23.24%	-18.36%
								Public																								
								1/96	$106	$239	$215	$349	$100	$239	$215	$349	$119	$260	$230	$372	$119	$260	$230	$372	$260	$557	$461	$769	$260	$557	$461	$769
				0	0	2,437	3.51%	1/97	$111	$281	$226	$361	$80	$248	$151	$336	$136	$271	$259	$334	$101	$242	$173	$326	$283	$659	$454	$704	$299	$515	$364	$609
									5.00%	17.40%	4.91%	3.30%	-19.16%	3.86%	-29.90%	-3.76%	14.23%	4.18%	12.63%	-10.24%	-14.74%	-6.80%	-24.63%	-12.36%	8.73%	18.31%	-1.50%	-8.42%	15.17%	-7.51%	-20.94%	-20.84%
				1,602	100.00%	69,534	100.00%																									
				Weighted Average Total[2]			Private:	7/96	$115	$242	$227	$339	$83	$233	$168	$332	$134	$255	$259	$357	$100	$245	$200	$357	$268	$600	$383	$666	$285	$523	$350	$608
							Public:	1/97	$121	$245	$237	$350	$85	$241	$172	$349	$140	$258	$267	$371	$101	$251	$202	$373	$270	$594	$387	$676	$288	$533	$368	$632

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CD.	Final Composite	1997 Trend	Net Composite Change 1/96 to 1/97	Cert Mkt 7/96	Weight 7/96 %	Cert Mkt 1/97	Weight 1/97 %	Effect Date	LIST ATTAINED AGE <30 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	BILL MONTHLY RATES ATTAINED AGE 30-39 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	ATTAINED AGE 60-64 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family
A								Private																								
								7/95	$119	$239	$199	$324	$119	$239	$199	$324	$140	$282	$235	$382	$140	$282	$235	$382	$279	$561	$468	$760	$279	$561	$468	$760
	-4.50%	1.40%	-3.16%	13	9.51%			7/96	$120	$207	$220	$308	$84	$245	$152	$351	$145	$232	$255	$359	$90	$251	$160	$389	$259	$545	$335	$632	$283	$542	$366	$634
									5.88%	-13.39%	15.08%	-4.94%	-29.41%	2.51%	-23.62%	8.33%	3.57%	-17.70%	8.51%	6.02%	-31.43%	-10.99%	-23.40%	1.83%	-7.17%	-2.85%	-28.42%	10.84%	1.43%	-3.39%	-21.79%	-16.58%
								Public																								
						4,194	10.24%	1/96	$115	$235	$190	$323	$115	$235	$196	$323	$135	$277	$231	$382	$135	$277	$231	$382	$269	$552	$460	$759	$269	$552	$460	$759
								1/97	$128	$210	$202	$312	$85	$248	$154	$350	$147	$235	$259	$364	$97	$255	$183	$394	$263	$553	$349	$641	$287	$550	$371	$643
									11.10%	-10.68%	18.47%	-3.31%	-25.93%	5.71%	-21.36%	10.19%	8.91%	-15.07%	11.94%	-4.71%	-27.89%	-8.12%	20.99%	3.26%	-2.37%	0.11%	-20.15%	-15.57%	6.68%	-0.44%	-19.32%	-15.30%
C				Cert Mkt 7/96	Weight 7/96 %	Cert Mkt 1/97	Weight 1/97 %	Private 7/95	$102	$223	$167	$307	$102	$223	$167	$307	$116	$253	$189	$348	$116	$253	$189	$348	$261	$570	$426	$784	$261	$570	$426	$784
	0.90%	2.69%	3.68%	103	76.06%			7/96	$119	$200	$202	$283	$81	$200	$104	$283	$135	$227	$245	$337	$92	$227	$202	$337	$295	$601	$365	$672	$306	$601	$377	$672
									16.67%	-10.31%	20.90%	-7.82%	-20.59%	-10.31%	-1.80%	-7.82%	16.38%	-10.28%	29.63%	-3.16%	-20.69%	-10.28%	6.88%	-3.16%	13.03%	5.44%	-14.32%	-14.29%	17.24%	5.44%	-11.50%	-14.29%
								Public																								
						9,476	81.20%	1/96	$102	$223	$167	$307	$102	$223	$167	$307	$116	$253	$189	$348	$116	$253	$189	$348	$261	$570	$426	$784	$261	$570	$426	$784
								1/97	$122	$205	$207	$291	$83	$205	$168	$291	$139	$233	$252	$346	$94	$233	$207	$346	$303	$617	$375	$690	$314	$617	$387	$690
									19.80%	-7.90%	24.21%	-5.34%	-18.45%	-7.90%	0.85%	-5.34%	19.54%	-7.86%	33.12%	-0.56%	-18.56%	-7.80%	9.75%	-0.56%	16.07%	8.27%	-12.01%	-11.98%	20.40%	8.27%	-9.12%	-11.98%
E				Cert Mkt 7/96	Weight 7/96 %	Cert Mkt 1/97	Weight 1/97 %	Private 7/95	$144	$332	$260	$404	$144	$332	$260	$404	$149	$343	$269	$418	$149	$343	$269	$418	$368	$847	$663	$1,031	$368	$847	$663	$1,031
	0.89%	2.70%	3.61%	20	14.43%			7/96	$132	$243	$256	$370	$90	$248	$209	$370	$150	$285	$300	$435	$114	$285	$264	$435	$287	$633	$369	$715	$300	$589	$387	$670
									4.13%	26.81%	-1.54%	8.42%	-37.50%	-25.30%	-19.62%	8.42%	0.67%	16.91%	11.52%	4.07%	-23.49%	-16.91%	-1.86%	4.07%	22.01%	25.27%	-44.34%	30.65%	-18.85%	-30.46%	-41.63%	-35.01%
								Public																								
								1/96	$120	$240	$244	$361	$120	$240	$244	$361	$133	$266	$270	$401	$133	$266	$270	$401	$255	$509	$217	$766	$255	$509	$217	$766
				0	0	999	8.56%	1/97	$136	$250	$263	$380	$92	$255	$215	$380	$154	$293	$308	$447	$117	$293	$271	$447	$295	$650	$379	$734	$314	$605	$397	$688
				135	100.00%	11,669	100.00%		12.97%	3.98%	7.75%	5.26%	-22.98%	6.12%	-12.03%	5.26%	15.03%	10.04%	14.11%	11.41%	-11.07%	10.04%	0.42%	11.41%	15.59%	27.72%	74.64%	-4.14%	23.24%	18.84%	83.16%	-10.17%
			Weighted Average Total					Private: 7/96	$122	$207	$212	$298	$83	$211	$169	$302	$138	$236	$254	$353	$90	$238	$209	$356	$290	$600	$363	$674	$304	$594	$377	$668
								Public: 1/97	$124	$210	$215	$300	$84	$214	$171	$305	$141	$238	$257	$357	$97	$240	$210	$360	$298	$613	$372	$689	$311	$609	$386	$685

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Co.	First Composite	1997 Trend	Net Composite Change 1/96 to 1/97	Cert Mkt 7/96	Weight 7/96 %	Cert Mkt 1/97	Weight 1/97 %	Effect. Date	LIST ATTAINED AGE < 30 FEMALE Single	FEMALE Couple	FEMALE Parent	FEMALE Family	MALE Single	MALE Couple	MALE Parent	MALE Family	BILL MONTHLY RATES ATTAINED AGE 30-39 FEMALE Single	FEMALE Couple	FEMALE Parent	FEMALE Family	MALE Single	MALE Couple	MALE Parent	MALE Family	ATTAINED AGE 60-64 FEMALE Single	FEMALE Couple	FEMALE Parent	FEMALE Family	MALE Single	MALE Couple	MALE Parent	MALE Family
D								Private:																								
								7/95	$90	$164	$177	$278	$96	$164	$177	$278	$119	$203	$192	$302	$119	$203	$192	$302	$262	$445	$412	$647	$262	$445	$412	$647
	3.32%	2.50%	5.90%	46	30.36%			7/96	$105	$266	$214	$342	$81	$235	$143	$318	$129	$257	$240	$317	$90	$230	$164	$309	$268	$625	$431	$667	$284	$488	$346	$577
									9.38%	62.20%	20.90%	23.02%	-15.63%	43.29%	-19.21%	14.39%	8.40%	26.60%	28.13%	4.97%	-19.33%	13.30%	-14.58%	2.32%	2.29%	40.45%	4.01%	3.09%	8.40%	9.66%	-16.02%	-10.82%
								Public:																								
								1/96	$94	$218	$197	$319	$94	$218	$197	$319	$109	$238	$210	$340	$109	$238	$210	$340	$238	$509	$422	$704	$238	$509	$422	$704
						3,243	30.25%	1/97	$108	$273	$219	$351	$83	$241	$147	$326	$132	$263	$252	$325	$98	$230	$168	$317	$275	$641	$442	$684	$291	$500	$355	$591
									14.49%	25.07%	11.35%	9.89%	-11.60%	10.49%	-25.60%	2.18%	21.31%	10.68%	20.07%	-4.43%	-9.72%	-0.95%	-19.95%	-8.05%	15.42%	25.86%	4.69%	2.89%	22.31%	-1.73%	-15.96%	-15.99%
F																																
				Cert Mkt 7/96	Weight 7/96 %	Cert Mkt 1/97	Weight 1/97 %	Private:																								
								7/95	$100	$255	$220	$398	$100	$255	$220	$398	$108	$233	$215	$376	$108	$233	$215	$376	$241	$511	$368	$654	$241	$511	$368	$654
	-2.50%	1.34%	-1.19%	107	69.64%			7/96	$112	$197	$231	$332	$75	$197	$108	$332	$124	$188	$237	$378	$83	$188	$183	$375	$219	$431	$314	$630	$244	$431	$338	$590
									12.00%	-22.75%	2.21%	-16.58%	-25.00%	-22.75%	-25.66%	-16.58%	14.81%	-19.31%	0.85%	0.53%	-23.15%	-19.31%	-22.13%	-0.27%	-9.13%	-15.66%	-14.67%	-3.67%	1.24%	-15.66%	-8.15%	-9.70%
								Public:																								
								1/96	$108	$233	$200	$355	$108	$233	$200	$355	$118	$213	$214	$335	$118	$213	$214	$335	$262	$466	$335	$583	$262	$466	$335	$583
				0	0	5,234	61.75%	1/97	$114	$200	$234	$336	$78	$200	$170	$336	$126	$191	$240	$383	$84	$191	$185	$380	$222	$437	$318	$638	$247	$437	$313	$598
									5.09%	-14.32%	13.04%	-5.23%	-29.62%	-14.32%	-17.35%	-5.23%	6.49%	-10.55%	12.23%	14.35%	-28.72%	-10.55%	-13.34%	13.44%	-15.29%	-6.27%	-5.01%	9.51%	-5.62%	-6.27%	2.25%	2.56%
				153	100.00%	8,477	100.00%																									
			Weighted Average Total:					Private:	$110	$218	$226	$335	$77	$209	$160	$328	$120	$209	$240	$359	$87	$201	$177	$355	$234	$490	$350	$641	$250	$440	$340	$586
								Public:	$111	$228	$228	$342	$79	$215	$161	$332	$128	$218	$245	$361	$90	$208	$179	$356	$242	$515	$365	$656	$264	$461	$347	$585

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Co.	Final Composite	1997 Trend	Net Composite Change 1/96 to 1/97	Cert Adj 7/96	Weight 7/96 %	Cert Adj 1/97	Weight 1/97 %	Effect Date	LIST BILL MONTHLY RATES — ATTAINED AGE < 30 — FEMALE Single	FEMALE Couple	FEMALE Parent	FEMALE Family	MALE Single	MALE Couple	MALE Parent	MALE Family
1								Private								
								Adj								
	[illegible]	[illegible]	0.00%	[illegible]	[illegible]			7/96	$101	$211	$161	$241	$101	$211	$161	$241
								Public								
								1/96	$101	$211	$161	$241	$101	$211	$161	$241
	[illegible]	2.5%	6.80%	0	0	30.632	100%	1/97	$115	$211	$193	$289	$87	$214	$165	$292
									13.86%	0.00%	19.88%	19.92%	-13.86%	1.42%	2.48%	21.16%
				1.163	100.0%	30.632	100.0%									
			Weighted Average Total					Private: 7/96	$101	$211	$161	$241	$101	$211	$161	$241
								Public: 1/97	$115	$211	$193	$289	$87	$214	$165	$292

Co.	BILL MONTHLY RATES — ATTAINED AGE 30-39 — FEMALE Single	FEMALE Couple	FEMALE Parent	FEMALE Family	MALE Single	MALE Couple	MALE Parent	MALE Family
1								
	$120	$253	$193	$289	$120	$253	$193	$289
	$120	$253	$193	$289	$120	$253	$193	$289
	$136	$243	$214	$320	$97	$247	$174	$324
	13.33%	-3.95%	10.88%	10.73%	-19.17%	-2.37%	-9.84%	12.11%
	$120	$253	$193	$289	$120	$253	$193	$289
	$136	$243	$214	$320	$97	$247	$174	$324

Co.	ATTAINED AGE 60-64 — FEMALE Single	FEMALE Couple	FEMALE Parent	FEMALE Family	MALE Single	MALE Couple	MALE Parent	MALE Family
1								
	$257	$539	$411	$616	$257	$539	$411	$616
	$257	$539	$411	$616	$257	$539	$411	$616
	$238	$523	$315	$600	$259	$520	$337	$598
	-7.39%	-2.97%	23.36%	-2.60%	0.78%	-3.53%	-18.00%	-2.92%
	$257	$539	$411	$616	$257	$539	$411	$616
	$238	$523	$315	$600	$259	$520	$337	$598

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Co.	Final Composite	1997 Trend	Net Composite Change 1/96 to 1/97	Cert Hdl 7/96	Weight 7/96 %	Cert Hdl 1/97	Weight 1/97 %	Effect. Date	LIST ATTAINED AGE < 30 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	BILL MONTHLY RATES ATTAINED AGE 30-39 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	ATTAINED AGE 60-64 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family
J								Private 7/96																								
	81%	81%	0.00%	1.685	100.00%			7/96	$138	$254	$232	$347	$105	$257	$198	$350	$163	$291	$257	$384	$116	$296	$209	$389	$285	$627	$378	$720	$311	$624	$404	$718
								Public 1/96	$128	$268	$204	$306	$128	$268	$204	$306	$153	$321	$244	$367	$153	$321	$244	$367	$320	$684	$521	$781	$320	$684	$521	$781
	28.38%	2.69%	31.87%			3.210	100.00%	1/97	$177	$325	$297	$445	$134	$329	$254	$449	$210	$373	$329	$493	$149	$379	$268	$499	$365	$804	$485	$923	$399	$801	$518	$920
					100.00%		100.00%		30.08%	21.27%	45.59%	45.42%	4.69%	22.76%	24.51%	46.73%	37.25%	16.20%	34.84%	34.33%	2.61%	18.07%	9.84%	35.97%	11.96%	17.54%	6.91%	18.18%	22.39%	17.11%	0.58%	17.80%
				Weighted Average Total				Private 7/96	$138	$254	$232	$347	$105	$257	$198	$350	$163	$291	$257	$384	$116	$296	$209	$389	$285	$627	$378	$720	$311	$624	$404	$718
								Public 1/97	$177	$325	$297	$445	$134	$329	$254	$449	$210	$373	$329	$493	$149	$379	$268	$499	$365	$804	$485	$923	$399	$801	$518	$920

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Co.	Final Composite	1997 Trend	Net Composite Change 1996 to 1997	Cert holders	Weight 1996 %		Effect Date	LIST ATTAINED AGE < 30 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	BILL MONTHLY RATES ATTAINED AGE 30-39 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	ATTAINED AGE 60-64 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family
A							7/95	$111	$223	$186	$302	$111	$223	$186	$302	$131	$263	$219	$356	$131	$263	$219	$356	$260	$523	$436	$709	$260	$523	$436	$709
							1/96	$100	$217	$181	$299	$100	$217	$181	$299	$125	$257	$214	$353	$125	$257	$214	$353	$249	$511	$426	$702	$249	$511	$426	$702
	4.50%	1.40%	2.75%	12755	73.94%		7/96	$122	$215	$239	$319	$81	$255	$153	$304	$145	$241	$265	$372	$95	$260	$180	$404	$268	$565	$318	$656	$291	$563	$379	$658
						Percentage Change	1/97	-4.50%	-2.69%	-2.69%	-0.99%	-4.50%	-2.69%	-2.69%	-0.99%	-4.58%	-2.28%	-2.28%	-0.84%	-4.58%	-2.28%	-2.28%	-0.84%	-4.23%	-2.29%	-2.29%	-0.99%	-4.23%	-2.29%	-2.29%	-0.99%
								13.21%	-2.30%	30.39%	5.35%	-24.53%	15.67%	-16.57%	20.07%	14.40%	-7.39%	21.96%	3.97%	-24.00%	-0.39%	-14.49%	12.75%	6.02%	9.00%	-19.48%	-7.83%	16.47%	8.61%	-12.21%	-7.55%
								1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%	1.40%
D							7/95	$92	$183	$192	$238	$92	$183	$192	$238	$109	$218	$229	$283	$109	$218	$229	$283	$250	$501	$520	$651	$250	$501	$520	$651
							1/96	$97	$195	$185	$253	$97	$195	$185	$253	$116	$231	$220	$301	$116	$231	$220	$301	$246	$493	$468	$641	$246	$493	$468	$641
	3.17%	2.50%	5.75%	4205	6.92%		7/96	$102	$188	$198	$284	$71	$192	$162	$284	$113	$214	$226	$327	$87	$214	$200	$327	$226	$498	$290	$564	$242	$465	$305	$528
							1/97	$105	$193	$203	$231	$73	$197	$166	$291	$116	$219	$232	$335	$89	$219	$205	$335	$232	$510	$297	$578	$248	$477	$313	$541
						Percentage Change		5.43%	6.50%	-3.65%	6.30%	5.43%	6.50%	-3.65%	6.30%	6.42%	5.96%	-3.93%	6.36%	6.42%	5.96%	-3.93%	6.36%	-1.60%	-1.60%	-11.03%	-1.54%	-1.60%	-1.60%	-11.03%	-1.54%
								5.15%	3.59%	7.03%	12.25%	-26.80%	-1.54%	-12.43%	12.25%	-2.59%	-7.36%	2.73%	8.64%	-25.00%	-7.36%	-9.09%	8.64%	-8.13%	1.01%	-38.03%	-12.01%	-1.63%	-5.68%	-34.83%	-17.83%
								2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
M							7/95																								
							1/96	$95	$181	$175	$275	$95	$181	$175	$275	$118	$200	$190	$298	$110	$200	$190	$298	$258	$439	$406	$638	$258	$439	$406	$638
	2.20%	2.50%	4.76%	1267	7.34%		7/96	$93	$250	$201	$321	$78	$220	$134	$298	$121	$241	$231	$297	$90	$215	$184	$270	$262	$586	$404	$626	$268	$458	$324	$541
							1/97	$101	$256	$206	$329	$80	$226	$137	$305	$124	$247	$237	$304	$92	$220	$189	$277	$269	$601	$414	$642	$275	$469	$332	$555
								4.21%	55.28%	14.86%	16.73%	17.89%	30.65%	23.43%	8.36%	2.54%	20.50%	21.58%	0.34%	-23.73%	2.50%	-3.16%	-9.40%	1.55%	33.49%	-0.49%	-1.88%	-3.88%	4.33%	-20.20%	-15.20%
								2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
L							7/95	$97	$163	$210	$323	$97	$183	$210	$323	$132	$220	$229	$353	$132	$220	$229	$353	$347	$581	$509	$785	$347	$581	$507	$785
							1/96	$101	$171	$186	$291	$101	$171	$186	$291	$125	$212	$201	$316	$125	$212	$201	$316	$274	$466	$431	$677	$274	$466	$431	$677
	3.25%	2.50%	5.83%	2023	11.73%		7/96	$108	$273	$249	$350	$83	$241	$146	$326	$132	$263	$252	$324	$98	$235	$188	$317	$275	$640	$441	$684	$291	$400	$354	$591
							1/97	$111	$280	$224	$359	$85	$247	$150	$334	$135	$270	$258	$332	$100	$241	$193	$325	$282	$656	$452	$701	$298	$410	$363	$606
								4.12%	4.91%	11.43%	9.91%	4.12%	4.91%	11.43%	9.91%	-5.30%	-3.64%	-12.23%	-10.48%	-5.30%	-3.64%	-12.23%	-10.48%	-21.04%	-19.79%	-15.32%	-13.76%	-21.04%	-19.79%	-15.32%	-13.76%
								6.93%	59.65%	17.74%	20.27%	-17.82%	40.94%	-21.51%	12.03%	5.60%	24.06%	25.37%	2.53%	-21.60%	10.85%	-6.47%	8.32%	0.36%	37.34%	2.32%	1.03%	-6.20%	-14.16%	-17.87%	-12.70%
								2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
				17250	100.00%																										
						Weighted Average Total	7/96	$110	$220	$229	$317	$80	$243	$150	$345	$138	$239	$255	$354	$94	$248	$185	$374	$262	$565	$355	$644	$285	$523	$363	$626
							1/97	$118	$224	$233	$323	$81	$247	$152	$351	$140	$244	$260	$360	$96	$252	$188	$380	$267	$574	$361	$655	$290	$532	$369	$636

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Co	Final Composite	1997 Trend	Net Composite Change 1.96 to 1.97	Cert holders	Weight 7.96 %		Effect Date	LIST ATTAINED AGE < 30 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	BILL MONTHLY RATES ATTAINED AGE 30-39 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	ATTAINED AGE 60-64 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family
B							[illegible]	$82	$138	$178	$275	$82	$138	$178	$275	$112	$187	$195	$300	$112	$187	$195	$300	$295	$493	$433	$667	$295	$493	$433	$667
							1996	$95	$162	$175	$275	$95	$161	$175	$275	$118	$200	$190	$298	$118	$200	$190	$298	$259	$440	$407	$639	$259	$440	$407	$639
	1.00%	2.50%	1.47%	4262	100.00%		1996	$107	$273	$219	$350	$83	$240	$146	$325	$132	$263	$251	$324	$98	$235	$168	$316	$274	$639	$440	$683	$290	$499	$353	$590
							1997	$110	$280	$224	$359	$85	$246	$150	$333	$135	$270	$257	$332	$100	$241	$172	$324	$281	$655	$451	$700	$297	$511	$362	$605
								15.85%	17.39%	-1.69%	0.00%	15.85%	16.67%	-1.69%	0.00%	5.36%	6.95%	-2.56%	-0.67%	5.36%	6.95%	-2.56%	-0.67%	-12.20%	-10.75%	0.00%	-4.20%	-12.20%	-10.75%	-0.00%	-4.20%
								12.63%	68.52%	25.14%	27.27%	-12.63%	49.07%	-18.57%	18.18%	11.86%	31.50%	32.11%	8.72%	-16.95%	17.50%	-11.58%	6.04%	5.79%	45.23%	8.11%	6.89%	11.97%	13.41%	13.27%	-7.67%
								2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
				4262	100.00%	Weighted Average Total	1996	$107	$273	$219	$350	$83	$240	$146	$325	$132	$263	$251	$324	$98	$235	$168	$316	$274	$639	$440	$683	$290	$499	$353	$590
							1997	$110	$280	$224	$359	$85	$246	$150	$333	$135	$270	$257	$332	$100	$241	$172	$324	$281	$655	$451	$700	$297	$511	$362	$605

NON ALLIANCE PPO GROUP

Co.	Final Composite	HEARING STATUS 1997 Trend	Net Composite Change 1996 to 1997	Cost Holders	Weight 1996 %		Effect Date	LIST BILL MONTHLY RATES ATTAINED AGE < 30 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	ATTAINED AGE 30 - 39 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family	ATTAINED AGE 60 - 64 FEMALE Single	Couple	Parent	Family	MALE Single	Couple	Parent	Family
G							7/95	$112	$187	$241	$372	$112	$187	$241	$372	$151	$254	$264	$406	$151	$254	$264	$406	$399	$666	$587	$903	$399	$666	$587	$903
		6.00%	6.00%	7168	51%		7/96	$99	$168	$182	$285	$99	$168	$182	$285	$122	$208	$197	$309	$122	$208	$197	$309	$268	$456	$422	$663	$268	$456	$422	$663
							7/96	$99	$168	$182	$285	$99	$168	$182	$285	$122	$208	$197	$309	$122	$208	$197	$309	$268	$456	$422	$663	$268	$456	$422	$663
								-11.61%	-10.16%	-24.48%	-23.39%	-11.61%	-10.16%	-24.48%	-23.39%	-19.21%	-18.11%	-25.38%	-23.89%	-19.21%	-18.11%	-25.38%	-23.89%	-32.83%	-31.53%	-28.11%	-26.58%	-32.83%	-31.53%	-28.11%	-26.58%
								0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
H							7/95	$99	$165	$214	$329	$99	$165	$214	$329	$134	$224	$233	$359	$134	$224	$233	$359	$353	$591	$518	$799	$353	$591	$518	$799
		6.00%	6.00%	7403	49%		7/96	$86	$146	$158	$248	$86	$146	$158	$248	$106	$180	$171	$269	$106	$180	$171	$269	$233	$396	$367	$575	$233	$396	$367	$575
								-13.13%	-11.52%	-26.17%	-24.62%	-13.13%	-11.52%	-26.17%	-24.62%	-20.90%	-19.64%	-26.61%	-25.07%	-20.90%	-19.64%	-26.61%	-25.07%	-33.99%	-32.99%	-29.15%	-28.04%	-33.99%	-32.99%	-29.15%	-28.04%
				15181	100.00%			0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
						Weighted Average Total	7/96	$93	$157	$170	$267	$93	$157	$170	$267	$114	$191	$184	$289	$114	$194	$184	$289	$251	$427	$395	$620	$251	$427	$395	$620

LIFE & HEALTH DIVISION
HEALTH RATE FILING LEGEND

1.	A	ADVANTAGE CARE
2.	B	ALTERNATIVE HEALTH
3.	C	CHA
4.	D	FHP
5.	E	HEALTHWISE
6.	F	HUMANA PPO
7.	G	SOUTHEASTERN UNITED MEDIGROUP - PPO OPTION 2000 - HEARING S
8.	H	SOUTHEASTERN UNITED MEDIGROUP - PPO OPTION 2000 ADVANTAGI
9.	I	KENTUCKY KARE GROUP
10.	J	KENTUCKY KARE INDIVIDUAL
11.	K	HUMANA HMO - KPPA
12.	L	SOUTHEASTERN UNITED MEDIGROUP - HMO KY
13.	M	SOUTHEASTERN UNITED MEDIGROUP - COMMUNITY SELECT
14.	N	HUMANA HMO - MBP

Footnotes

1. Rates reflected on 1/97 rate lines are the 7/96 rate filing data trended forward at the "1997 Trend" rate identified in the third column.

   Rates shown generally reflect a carriers' rates in Region 6. If the insurer does not offer the product in Region 6, Region 2 or 3 was selected.

2. The product's "Weighted Average Total" rate is the weighted average rate based on the number of certificate holders for the selected rate cells for all selected products in its class.

3. The " Certificate Holders" data source was the rate filing for all products except for Alliance rate filings. For Alliance rate filings, data was obtained from the Alliance to reflect estimates of certificate holders at the beginning of the period for which rates became effective.

4. Rate filings are in hearing status and have not yet been acted upon by the Department of Insurance. Rates for the 7/96 period reflect existing rates that were previously approved.

5. The "Final Composite" represents the percentage change in rates for 7/96 rate filings compared to existing rates based on a composite weighting according to an assumed population distribution among all the rate cells.

Kentucky Department of Insurance

FINANCIAL ANALYSIS

FINANCIAL ANALYSIS OF THE HEALTH INSURANCE INDUSTRY IN THE COMMONWEALTH OF KENTUCKY

There are approximately 1500 insurers licensed in Kentucky. Over 600 of these insurers are traditional life and health companies and approximately 800 insurers are traditional property and casualty companies. The 100 other insurers include approximately 20 health maintenance organizations (HMOs).

Historically, health insurance was sold by life and health insurance companies and property and casualty insurance companies. The broad classification of health insurance products included plans such as group or individual medical expense indemnity, dental, disability income, dreaded disease, workers' compensation, etc. The marketplace is expanding with HMOs, provider sponsored networks, and other limited health service type of insurers. With this market expansion has come custom-designed health products evolving from expense reimbursement plans to managed care/cost containment plans.

The industry is changing and redefining itself every day. This creates enormous difficulties for accountants, actuaries, financial analysts, and regulators who try to measure this moving target. In addition, it is extremely difficult to anticipate what data and in what formats all these different companies with their wide variety of products should be reporting to the Department.

Therefore, it should not be surprising that the information and formats required from the different kinds of insurers is sometimes reported by line of business and sometimes reported by type of health care services, but it is never reported by specific plan. Furthermore, certain information by specific policy or plan is proprietary. For these reasons, it is difficult for Department analysts to determine the profitability of a particular product of an insurer.

The 1996 aggregate statistics will not be available for some time. For 1995, the traditional life and accident and health insurers doing business in Kentucky had premiums of approximately $767 million and claims of approximately $530 million for a claims to premium ratio of 68.84%. For 1995, the traditional property and casualty insurers doing business in Kentucky had premiums of approximately $45.6 million and claims of approximately $40.6 million for a claims to premium ratio of 88.91%. However, these figures are inclusive of all accident and health lines, and it should be further noted that it is not possible from the life and accident annual statement or property and casualty annual statement to delineate premium and claim information for the standard plans under HB 250 or as later amended under SB 343.

Today in the Commonwealth of Kentucky, most hospital and medical insurance is being written by health maintenance organizations. The Department has extracted premium and claims information from the HMO annual statements of HMO insurers licensed in Kentucky from 1991 through 1996. For comparability purposes, premiums are total revenues minus investments and

other revenues. The following chart summarizes premiums, claims and claims ratios for years 1991 through 1996 for HMOs licensed in Kentucky on a nationwide and Kentucky-only basis. The detail information by company can be found in Appendix C.

Premium and Claims Statistics For Licensed HMO's

For the Years 1991 through 1996

Year	Premiums Nationwide Business	Premiums Kentucky-only Business	Claims Nationwide Business	Claims Kentucky-only Business	Claims/Premiums Nationwide Business	Claims/Premiums Kentucky-only Business
1991	1,941,451,167	719,399,138	1,767,391,880	587,878,207	91.03%	81.72%
1992	2,530,561,776	773,061,043	2,279,292,599	613,848,260	90.07%	79.40%
1993	3,259,919,634	1,054,288,448	2,733,856,985	844,629,459	83.86%	80.11%
1994	3,925,355,316	1,260,260,957	3,231,858,233	970,099,502	82.33%	76.98%
1995	4,626,532,794	1,354,828,261	4,006,655,927	1,146,085,687	86.60%	84.59%
1996	6,280,311,990	1,559,221,920	5,534,688,275	1,365,888,485	88.13%	87.60%

Generally, the Profit of an insurance company is determined as total revenues, including investments, less claims, commissions, administrative expenses, and taxes. In 1996, the gross profit margin (i.e. net premiums after claims and before commissions, administrative expenses, and taxes) for nationwide business is 11.897% and for Kentucky-only business is 12.40%.

In Kentucky, HMO premiums have increased from approximately $720 million in 1991 to approximately $1.6 billion in 1996, an increase of 117%. In Kentucky, HMO claims have increased from approximately $590 million in 1991 to approximately $1.4 billion in 1996, an increase of 132%. The Kentucky-only ratio of claims to premiums went from 81.72% in 1991 to 87.60% in 1996. It can be noted for Kentucky-only business, the rate of growth in premiums is slower than the rate of growth in claims.

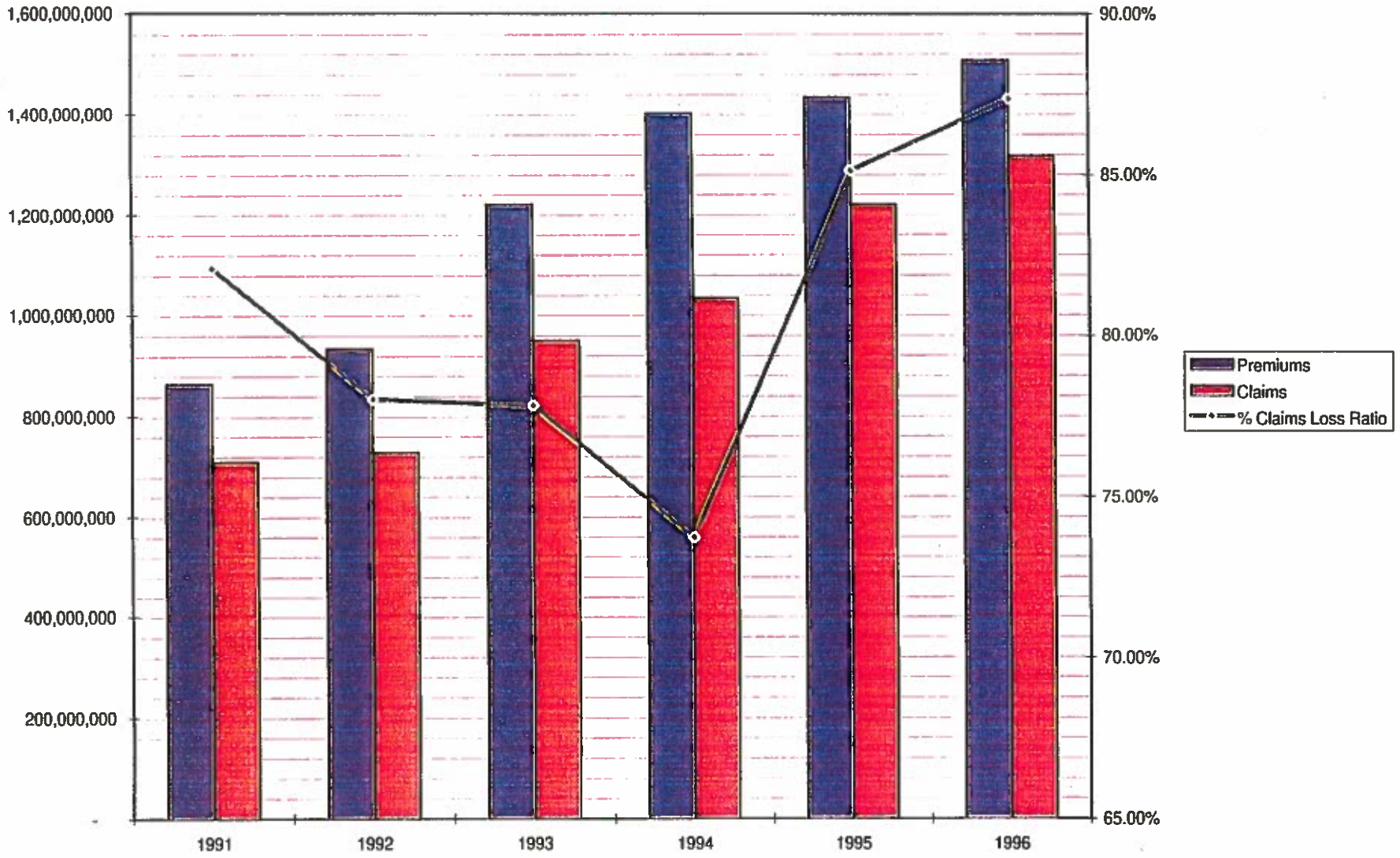
Comparing to the licensed HMOs' nationwide business, HMO premiums have increased from approximately $1.9 billion in 1991 to approximately $6.3 billion in 1996, an increase of 223%. Nationwide HMO claims have increased from approximately $1.8 billion in 1991 to approximately $5.5 billion in 1996, an increase of 213%. The nationwide ratio of claims to premiums went from 91.03% in 1991 to 88.13% in 1996. It can be noted for nationwide business, the rate of growth in premiums is faster than the rate of growth in claims. The nationwide trends are opposite from experience of HMO Kentucky-only business.

Prior to 1994, the year of reform, Kentucky health premium income was increasing. For most of the companies selling individual coverage, there is a downward trend in total health premium income beginning in 1994. With the exception of United Wisconsin Life Insurance Company, which only entered the Kentucky health insurance market in 1993, the bulk of the increases in total premium income in 1996 were experienced by the Kentucky Blue Cross Blue Shield companies. It can be assumed from the data that the Blue Cross Blue Shield companies

experienced significant increased enrollment by those insureds which had to seek coverage elsewhere as companies exited the market. Companies such as Golden Rule, Principal Mutual Life Insurance Company, and Time Insurance Company, for example, experienced a 50% or more decrease in total health premiums beginning in 1994, and extending through 1996. The remaining companies either show decreases or a leveling off in the total health premium during this period. In conclusion, the individual market today has been reduced to two (2) insurers; Blue Cross Blue Shield and Kentucky Kare (a self-insured plan for state employees). The details for companies can be found in Appendix D.

With regard to claims loss ratios, it is evident that from 1991 to 1994 claims loss ratios were decreasing. Beginning in 1994, the year of reform and in subsequent years, the companies experienced significant increases in their claims loss ratios. These trends are reflected in the following chart.

Companies Selling Individual Health Coverage Prior to HB 250



Kentucky Department of Insurance

Regulatory Environment

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filing frequency

prior approval

modified community rating

effects of regulation

REGULATORY ENVIRONMENT

House Bill 250 and Senate Bill 343 contained many additional regulatory provisions for health insurance rates, filing procedures, and benefit plans. This shifted the environment of health insurance from market control towards regulatory control. Understanding how the industry reacted and is likely to react is important in any search for solutions. The regulatory changes with the most impact on insurers are summarized below.

RATES

HMO Filings Prior to Reform

Prior to House Bill 250, a HMO could file rates anytime it chose. The HMO only had to demonstrate the rates were within the broad parameters of the law: not excessive, not inadequate, and not unfairly discriminatory. According to regulation, that meant demonstrating the rate would not result in a glut of reserves, would not cause the HMO to be statutorily insolvent, and would not treat enrollees in similar situations differently.

Further, rates could be deemed approved 60 days after filing unless, during that period, the Department disapproved the rates, scheduled a hearing, or extended the period an additional 30 days. Although rate hearings were an option, in practice there were no hearings because of the expense and length of time required for an administrative hearing. As a result, if the rate increase was not justified, the HMO could choose to modify or withdraw the filing. Otherwise, the Department disapproved the filing.

Each rate filing was required to include:

- cover letter outlining the scope and reason for filing;
- actuarial certification;
- capitation rates and formula, if community rating;
- HMO's budget;
- recent financial data; and
- any other supporting data the Department deemed necessary.

Community rating was not mandated, but HMOs which used another rating system had to be prepared to demonstrate the system was not unfairly discriminatory.

Indemnity Insurer Filings Prior to Reform

An indemnity insurer before reform had to file its rates for **individual policies** but did not have to have the rates approved if there was no increase or if the insurer guaranteed the loss ratio. By guaranteeing the loss ratio, the insurer promised that if the projected medical payments for the block of business were greater than the actual medical payments, each policyholder would receive a refund for his share of the excess.

Filings with increases but without a guaranteed loss ratio had to be approved before use. In approving or disapproving the filing, the Department considered

- whether the benefits were reasonable in relation to the premium;
- previous premiums; and
- the effect of the increase on policyholders.

Before reform, the law did not divide the group market into small group and large group. In addition, rates for **group policies** of indemnity insurers were neither required to be filed nor required to be approved -- there was no regulatory oversight of group rates. Rather, market competition controlled rates in this segment of the indemnity market.

HMO and Indemnity Filings During Reform

Current law subjects all health insurers to the same requirements and restrictions of health insurance reform. Therefore, the comments in this section concerning health insurers include both HMOs and indemnity insurers.

FILING FREQUENCY

Under reform, a health insurer is limited to filing for rate increases no more frequently than every 12 months. In addition, the filing must be held for a 30 day waiting period. These provisions lock-in the rate for at least a 12 month period (a 13 month period under an alternate interpretation) during which the insurer is required to issue and renew policies at the approved rate. On top of this, each policy has its own 12 month premium guarantee because of industry practice and standard plan terms. The premium guarantee in the policy delays the application of any premium increase to an existing policy until the policy is renewed.

This means that the rate must be structured for use for a bare minimum of 23 months, or 25 months if a hearing is required for the next rate. This lengthy projection in an environment of expanding mandated benefits, eroding managed care capabilities, and rising medical cost trends force insurers to seek greater rate increases than they would if there was a possibility of filing more frequently.

PRIOR APPROVAL

Rates must be filed with and approved by the Department before use. Unless the Department disapproves the rates, schedules a hearing or extends the period of consideration 30 more days, rates may be deemed approved 30 days after filing.

Before a filing may be approved or allowed to be deemed approved, the Department makes a thorough review of the filing to ensure it meets the strict standards of Senate Bill 343:

- whether the benefits are reasonable in relation to the premium;
- whether the provider fees are reasonable in relation to the premiums;
- previous premiums;
- effect of the increase on policyholders;
- whether the premium is excessive;
- whether the premium is inadequate;
- whether the premium is unfairly discriminatory ; and
- other factors deemed relevant by the commissioner.

Under reform, each rate filing must contain more detailed information to demonstrate it meets the statutory standards and copious documentation to support its actuarial justification. The specifics are set out in 806 KAR 17:140 and include

- Product Information Form - summary of filing with explanation of type of product;
- Income and Expense Worksheet - breakdown into detailed categories;
- Actuarial Memorandum - details of rate development; and
- Annual Report - information provided to shareholders or policyholders.

In addition to this information, modified community rate filings must also contain

- Premium Parameter Worksheets - demonstration of the filings' relation to standardized guidelines used by the Department; and
- Modified Community Rates on diskette and in print.

Indemnity insurers no longer have the option of filing individual policy rates with guaranteed loss ratio and using those rates without prior approval.

Prior approval of rates causes uncertainty and delay in the implementation of rate increases which may create unacceptable business conditions for insurers. As a result, prior approval may lessen competition as it drives insurers from the market and discourages others from entering the market. For example, Contennial Life Insurance Company, being unable to meet the standards for prior approval, said it left the Kentucky market because it could not get timely rate relief.

MEDICAL CONSUMER PRICE INDEX PLUS 3%

Rate increases greater than the medical consumer price index plus 3% are subjected to mandatory public hearings with the Attorney General as a required party. Rate increases in excess of this amount can be granted if the increases are justified under the standards set out in the previous subsection. However, the expense and delay inherent in the public hearings procedure, effectively turn the medical consumer price index plus 3% into a cap on rate increases.

During the period from July through December of 1996, insurers withdrew 37 filings which exceeded the medical consumer price index plus 3% because the companies wished to avoid the delay of public hearings. Fourteen of the filings were refiled with a rate increase less than the medical consumer price index plus 3%.

MODIFIED COMMUNITY RATING

As explained in a prior subsection, health insurance reform treats all insurers the same. However, health insurance reform treats certain insureds differently. For example, the rate structure for an insurer is determined by whether the insured is in a small group (an employer group with 50 or fewer employees), in a large group, or in an association.

The rates for small groups, as well as for individuals and Alliance participants, are based on a modified community rating methodology, must provide for four family compositions, and have limited spreads from the highest premium to the lowest. Modified community rating is determined solely on the basis of:

- age
  - with premium variations no more than 300%
- gender
  - with premium variations no more than 50%
- occupation or industry
  - with premium variations no more than 15%
- geography

- within Department established guidelines

- family composition
  - for single individuals
  - for couples
  - for single-parent families
  - for two-parent families
- benefit plan design
- cost containment provisions
- whether the product is offered through the Alliance

The rates may provide for discounts up to 10% for healthy lifestyles. But, using all of the case characteristics, the ratio from the highest premium to the lowest cannot exceed 5 to 1.

On the other hand, large groups and associations - including small groups and individuals covered through associations - are not subject to modified community rating but are allowed to be experience rated.

FORMS

In the past, an insurer could issue whatever health policies it chose as long as the forms were filed with and approved prior to use, the policies contained the applicable mandated benefits, and the policies did not contain prohibited terms. Further, any limit on the insurer's right to cancel or nonrenew a policy was set out in the policy, not in the law. An insurer could select its customers by underwriting and choose for itself which segments of the market it wished to service.

An insurer presently may offer only the five standard plans and must offer the basic plan. Guarantee issue and guarantee renewal prevent the insurer from selecting its customers and, to some extent, dictate which segments of the market the insurer must serve. In addition, House Bill 250 and Senate Bill 343 added more mandated benefits:

- Additional treatments for breast cancer;
- Inclusion of adopted children; and
- Required maternity coverage
  - 48 hours hospital stay after vaginal delivery
  - 96 hours hospital stay after Cesarean section.

MISCELLANEOUS

Prior to House Bill 250 and Senate Bill 343, an insurer had considerable freedom in determining which types of providers and which individual providers would be eligible for reimbursement under its policies. For individual policies, pre-existing condition exclusion was allowed up to two years. For other polices, pre-existing condition exceptions were set by market demand.

Now the any willing provider and primary chiropractic provider statutes require the insurer to accept certain types of providers and certain individual providers into its network. Furthermore, an insurer participating in the Alliance must require the insurer's network providers to report medical outcome information to the Department. Also, all health insurers must report to the Department various data that was not required before. For example, the insurer must report demographic and high-cost case data as part of the risk adjustment process. Finally, pre-existing conditions limitations are currently set by law.

COMPARISON OF PROVISIONS

A chart outlining the major regulatory provisions prior to House Bill 250 and the regulatory provisions currently in effect are set out in the following chart. Note that prior to House Bill 250, HMO's, Indemnity Individual Plans, and Indemnity Group Plans were each regulated differently. Under current law, all three are subject to the same regulatory provisions.

REGULATORY ENVIRONMENT

CURRENTLY	***PRIOR TO HB 250***		
HMOs, Indemnity Individual, and Indemnity Group	HMOs	Indemnity Individual	Indemnity Group
RATES Rate Filing [KRS 304.17A-095] • File and approve prior to use • 30 day waiting period • Deemed approved after 30 days *30 day extension option • Mandatory Hearing if increase greater than MCPI +3% *Attorney General required party • Standards for approval *not excessive *not inadequate *not unfairly discriminatory *benefits reasonable in relation to premium *provider fees reasonable in relation to premium *previous rate *effect of increase on policyholder	Rate Filing [KRS 304.38-050] • File and approve prior to use • Deemed approved after 60 days *30 day extension option • Standards for approval *not excessive *not inadequate *not unfairly discriminatory (these standards are defined in 806 KAR 38:070 Section 2)	Rate Filing [KRS 304.17-380 and 304.17-383] • File prior to use • Approval prior to use if increase • Deemed approved if guaranteed loss ratio • Hearing Optional *Attorney General participation optional • Standards for approval *benefits reasonable in relation to premium *previous rates *effect of increase on policyholder	(No Filings Required)

*other factors deemed relevant by commissioner • Filing frequency *decrease: file anytime *increase: no more often than every 12 months • May withdraw approval if benefits no longer reasonable in relation to premium *after hearing *may require appropriate refund of premium • Required information and supporting documentation [806 KAR 17:140] *product information *income and expense *actuarial memorandum *premium parameters worksheet *modified community rate diskettes *standard industry codes *discounts *load factors *provider fee information	• May withdraw approval • Required information and supporting documentation [806 KAR 38:070] *letter of explanation *certification by actuary *capitation rates and formula *HMO's budget *recent financial data *other supporting info	• Filing frequency *decrease filed anytime *increase no more often than every 6 months • May withdraw approval if benefits no longer reasonable in relation to premium • Required information and supporting documentation [806 KAR 17:070] *all forms *rate sheet *actuarial memorandum *comparison with same filing in other states	

Modified Community Rating [KRS 304.17A-120] • Modified Community Rating applies to *individuals *employers with 50 or fewer employees *Alliance participants • Rate determined solely on *age *gender *occupation or industry *geography *family composition *benefit plan design *cost containment provisions *whether or not offered through Alliance *life style discounts up to 10% • Bands for variations from lowest to highest price *age: up to 300% *industry or occupation: up to 15% *gender: up to 50% *total of all case characteristics: 5 to 1			

• Required Family Compositions *single individual *couple *single parent family *two parent family with children • Optional Phase In of MCR *7/15/96 to 6/30/98: + or - 30% of index community rate *7/1/98 to 6/30/99: + or - 20% of index community rate *7/1/99 to 6/30/2000: + or - 10% of index community rate *7/1/ 2000 forward: no deviation from index community rate ***FORMS*** • Standard Plans [KRS 304.17A-160] • Issue only Standard Plans • Renew only Standard Plans after 7/15/97] • Must offer Basic Health Benefit Plan	• Form Filings [KRS 304.38-050]	• Form Filings [KRS 304.14-120]	• Form Filings [KRS 304.14-120]

• File and approve before use • Coordination of benefits required • Providers listed in network must be under contract	• File and approve before use • Deemed approved after 60 days *30 day extension option • May withdraw approval • Must contain complete and clear statement of *health care services *any limitations *co-pay and deductible *how services may be obtained *any other provisions for delivery of services • Ads to be filed and in compliance with Department guidelines [KRS 304-38:030]	• File and approve before use • Deemed approved after 60 days *30 day extension option • May withdraw approval [KRS 304.14-130] *30 days after notice unless hearing requested *if in violation of code *if inconsistent, ambiguous, or misleading *if substantially illegible *if excludes HIV coverage *if benefits unreasonable in relation to premium	• File and approve before use • Deemed approved after 60 days *30 day extension option • May withdraw approval [KRS 304.14-130] *30 days after notice unless hearing requested *If in violation of code *if inconsistent, ambiguous, or misleading *if substantially illegible *if excludes HIV coverage *if benefits unreasonable in relation to premium

MISCELLANEOUS • Breast Cancer additional treatments *bone marrow and stem cell transplantation [KRS 304.17A-135] • Adopted children inclusion [KRS 304.17A-140] • Maternity Coverage [KRS 304.17A-145] *48 hours hospital stay after vaginal delivery *96 hours hospital stay after Cesarean Section • Any Willing Provider [KRS 304.17A-110(3)] • Primary Chiropractic Provider [KRS 304.17A-171] • Guarantee Issue [KRS 304.17A-160(2)] *after 12 month residency • Guaranteed Renewal unless [KRS 304.17A-110(1)] *non-payment of premium *fraud or misrepresentation *intentional and abusive non-compliance with plan provisions		• Renewable by terms of policy [KRS 304.14.240] *if no term, at option of insurer	• Renewable by terms of policy [KRS 304.14-240] *if no term, at option of insurer

*insurer no longer doing business in Kentucky 12 months prior notice to policyholder and Department 5 year ban from State *individual becomes eligible for employer group plan	• Cancellation of enrollee's coverage [806 KAR 38:060] *non*payment of premium *misrepresentation in application *dependent child canceled when marries attains limiting age termination of legal residence no longer totally disabled enrollee's coverage terminates termination of dependent status *Spouse cancelled when legally divorced from enrollee *Group contract terminated *Voluntary termination *Medicare eligibility *Move out of service area *Disregard plan rules		

• Pre-existing condition limitation [KRS 304.17A-110(2)(a)] *12 month exclusion for condition manifested 12 months before coverage • Credit for prior coverage if lapse not more than 60 days [KRS 304.17A-110(2)(b)]			

Kentucky Department of Insurance

SELECTED PROVISIONS OF HB 250 AND SB 343

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risk adjustment

standard plans

buy-in program

RISK ASSESSMENT / RISK ADJUSTMENT

Coopers & Lybrand L.L.P. (C&L) serves as Risk Adjustment System Administrator for the Kentucky Department of Insurance. The Risk Assessment/Risk Adjustment (RARA) process, promulgated under Kentucky Regulation 909 KAR 1:090 (Regulation), is intended to equalize risk imbalances between insurers in Kentucky's guaranteed issue and modified community rating environment. Specifically, C&L administers the Demographic Risk Fund (DRF) and the High Cost Case Fund (HCCF). RARA governs only those policies written under the Kentucky Modified Community Rating (MCR) Rules since July 15, 1995

Demographic Risk Fund

The Demographic Risk adjustment process is based on a calculation of the differences in expected health care costs that result from demographic and premium characteristics, and for which rating differences are not permitted under Kentucky's MCR rules. For policies issued or renewed from July 15, 1995 through July 15, 1996, these rules allow for rating by age, geography, family size, and benefit plan. During this period, premium rates were not allowed to vary based on gender, industry, continuation status, or retiree status. Subsequent to July 15, 1996, MCR rules also permit rating, within certain tolerances, for gender and industry.

Prospective Risk Adjustment Factors (PRAF), which represent the expected cost relatively by age, gender, family size, continuation status or retiree status for the MCR population, serve as the basis for Demographic Risk adjustment. These PRAF's are applied to plan-specific premium and demographic data to calculate the difference in expected costs for each carrier as compared to the average among all carriers.

Funding for the DRF is based on the results of the quarterly calculations discussed above. Insurers deemed to have a relatively low risk MCR population are required to submit payment to the DRF. Once these funds are received, they are redistributed to those insurers with a disproportionately high risk population.

HIGH COST CASE FUND

The HCCF is designed to limit the liability of the insurers experiencing a disproportionate share of high cost cases. The HCCF is created so that a carrier can be partially reimbursed if its experience of caring for high cost cases is greater than the state average. Tables 2 and 2A of the Regulation list nine specific procedures/diagnoses that are deemed to be "high cost cases" for the purposes of this program.

The Regulation states that payment to insurers from the HCCF shall be based on the amount that each insurer's per enrollee payments for high cost cases, adjusted for statewide average payments per month of exposure, exceeds the statewide average per enrollee payments for high cost cases, subject to the amount collected in the Fund throughout the time period.

Funding for the HCCF was provided by all the insurers writing policies under the Kentucky MCR rules. On a quarterly basis, all insurers were to remit to C&L an amount equal to 1.00% of the total premium received during the previous calendar quarter to be held in the High Cost Case Fund. This Fund represents the only money available to compensate insurers who have a disproportionate share of high cost cases.

	1995 HCCF Payouts		1996 HCCF Payouts	
Carrier	Amount Reimbursed to "Eligible Insurers"	Funds Remitted to "Eligible Insurers"	Amount Reimbursed to "Eligible Insurers"	Funds Remitted to "Eligible Insurers"
Advantage Care		$260.19		$131,987.49
Aetna ALIC		$136.35		$19,843.47
Aetna HMO		$136.95		$17,478.44
Allianz		$1.35		$842.24
Allmerica		$0.00		
American Chambers		$0.00		$30.08
Anthem (formerly Home Life)		$39.62		$1,939.12
Bankers Life		$0.00		
Bankers Multiple				
AHDS		$914.44		$95,893.67
BCBS - Community Select	$71,051.22	$3,978.56		$1,117,120.80
BGFH		$238.64	$88,423.46	$28,832.36
Centennial		$284.48		$25,284.99
Central Benefits		$178.45		$1,640.36
CHA Health		$103.90		$40,431.73
ChoiceCare		$187.44		$8,368.38
CIGNA		$0.00		
CNA		$0.00		
Continental General				
Continental Life		$0.00		
CUNA Mutual		$64.85	$53,860.46	$1,481.92
EHI		$155.86		$9,493.30
FHP		$335.53	$93,265.70	$57,867.95
General American		$17.17		$2,284.48
Great West		$0.00		
Guardian		$14.56		$4,999.91
Healthwise		$67.00		$154,470.03
HMO KY - BCBS	$15,527.49	$172.46		
Humana		$161.00	$731,697.64	$211,336.56
Jefferson-Pilot		$0.00		
John Alden		$671.32		$11,455.03
John Deere Health Care		$56.14		$1,590.72
John Deere HMO (Her. Nat'l)		$0.00		$1,938.58
John Hancock		$0.00		
Kentucky Kare		$0.00	$2,681,733.47	$364,774.54
MEGA Life (United Ins. Co.)		$92.43		$2,611.76
Mid-West National Life				$1,436.43
Nippon				

PFL		$141.35		$4,881.25
Pioneer Financial (PFS)		$0.00		$2,347.98
Principal Financial		$0.00		$0.00
Prudential HealthCare		$0.00		$6,695.68
Prudential Ins. Co. of Amer.				$2,850.44
Southwestern				
State Mutual		$0.00		
Trustmark		$119.29		$1,888.29
UNICARE (fka Mass Mutual)		$0.00		$420.89
Union Bankers				
United Health (fka (Metra Health)		$0.00	$50,545.40	$2,519.57
United Wisconsin		$3,274.21	$184,484.88	$50,205.80
Washington National		$0.00		
TOTAL	86578.71	11803.54	3884011.01	2387244.24

Carrier	DEMOGRAPHIC RISK FUND		
	Payment to/(from) DRF Quarter Ending November 15, 1995	Payment to/(from) DRF Quarter Ending February 15, 1996	Payment to/(from) DRF Quarter Ending May 15, 1996
Advantage Care	($1,722.48)	$5,254.22	$10,605.48
Aetna ALIC	($783.68)	($7,519.41)	($43,277.96)
Aetna HMO	$5,412.19	$13,166.67	($43,612.02)
Allianz		$1,980.14	($1,846.03)
Allmerica			
American Chambers			$59.72
Anthem (formerly Home Life)	$1,056.05	$4,180.52	($6,381.06)
Bankers Life			
Bankers Multiple			
AHDS	($2,204.05)	($26,457.96)	$98,377.50
BCBS - Community Select	$2,168.81	$48,330.34	($424,503.76)
BGFH	($3,218.23)	($12,257.47)	$30,421.03
Centennial	($2,036.38)	$30,684.32	($89,290.19)
Central Benefits	($1,516.76)	$2,002.52	($3,732.61)
CHA Health	($2,036.70)	($4,894.53)	$19,185.22
ChoiceCare	($801.51)	$12,124.85	($42,128.98)
CIGNA			
CNA			
Continental General			
Continental Life			
CUNA Mutual	($2,725.93)	($3,381.20)	$3,825.12
EHI	$544.66	$10,536.72	($16,758.23)
FHP	$1,377.88	($30,868.22)	$45,054.53
General American	($49.18)	$3,615.28	($4,911.17)
Great West			
Guardian	$724.65	$4,010.33	($4,089.49)
Healthwise	($2,103.02)	($102,473.24)	$246,210.96
HMO KY - BCBS	$159.46	$15,834.88	($70,846.82)
Humana	$1,059.05	$24,471.39	$35,225.80
Jefferson-Pilot			
John Alden	$10,073.35	$94,819.13	($121,202.04)
John Deere Health Care	$4,680.71	$11,354.79	($29,401.46)
John Deere HMO (Her. Nat'l)		($139.43)	$208.16

John Hancock			
Kentucky Kare		($258,610.78)	$659,211.07
MEGA Life (United Ins. Co.)	$1,953.02	$8,017.07	($15,526.24)
Mid-West National Life			
Nippon			
PFL	$3,916.65	$17,825.04	($45,278.54)
Pioneer Financial (PFS)			($8,158.08)
Principal Financial			
Prudential HealthCare		($1,393.66)	$6,641.83
Prudential Ins. Co. of Amer.		($19,121.42)	$38,275.27
Southwestern			
State Mutual			
Trustmark	$2,183.46	$7,972.97	($7,891.89)
UNICARE (fka Mass Mutual)		$1,080.88	($2,889.67)
Union Bankers			
United Health (fka (Metra Health)			($622.35)
United Wisconsin	($15,842.02)	$149,855.25	($210,953.10)
Washington National			
TOTAL PAYMENT TO CARRIERS	35309.94	467117.31	1193301.69
TOTAL PAYMENT FROM CARRIERS	-35039.94	-467117.32	-1193301.69

STANDARD HEALTH BENEFIT PLANS

Through HB 250, the 1994 Kentucky General Assembly provided for the creation of standard health benefit plans[1]. The theory behind standardization of health benefit plans was to allow consumers an opportunity for an "apples to apples" comparison of health insurance policies. As the benefits offered under the policies are required to be identical, consumers only have to consider premium rates, quality of the carrier, and physician networks when making a decision on which policy to purchase. Further, standardization of benefits forces insurance carriers to compete on price and quality, which ultimately benefits the consumer.

Pursuant to the provisions of HB 250, the Kentucky Health Policy Board was authorized to create no more than five standard health benefit plans. Four plans of varying benefit levels were created: budget, economy, standard, and enhanced. Each plan was offered with a high and low deductible level. Additionally, the plans were offered in four product types: fee for service (FFS), preferred provider organization (PPO), health maintenance organization (HMO), and point of service (POS)[2]. As a requirement of doing business in Kentucky, health insurers were required to issue the basic plan (defined as the Standard High and Standard Low plans). Insurers could, at their option, offer any of the other three standard health benefit plans.

After July 15, 1995, no insurer doing business in Kentucky was permitted to issue health benefit plans other than the standard health benefit plans. Although HB 250 prohibited carriers from renewing pre-standard health benefit plans after July 15, 1995, two Executive Orders permitted the extension of pre-standard plans (at the option of the insured) until July 15, 1996. Further, SB 343 (effective July 15, 1996) allowed for the renewal of pre-standard policies until July 15, 1997.

The provisions regarding standard health benefit plans were amended slightly in 1996 by SB 343. The authority over the plans was given to the Department of Insurance. In addition, the Department was authorized to create an unlimited number of standard health benefit plans.

To date, the Department has made minimal changes to the standard health benefit plans originally created by the Kentucky Health Policy Board. The Standard Health Benefit Plan Subcommittee, a Subcommittee of the Health Insurance Advisory Council, has been created to review the standard health benefit plans. Their purpose is three-fold: (1) to review requests for specific benefits to be added to the standard health benefit plans; (2) to compare the current standard health benefit plans with the most popular pre-standard plans to determine what amendments, if any, need to be made to the current standard plans; and (3) to review requests for

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[1] This standardization did not affect policies covering only accident, credit, dental, disability income, fixed indemnity, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, workers' compensation coverage, automobile medical-payment insurance, student health insurance, individual limited guaranteed renewable hospital or medical expense policies issued prior to January 1, 1994, and conversion policies existing on January 1, 1994 (KRS 304.17A-100(4)(b)).

[2] The budget high and low plans are not available as a point of service plan, and the budget low plan is not available as a preferred provider organization plan.

the creation of additional standard health benefit plans. All requests are considered in light of their rate impact, benefit to all Kentuckians, and viability in the insurance market.

The Department has created one additional standard health benefit plan which was approved on December 6, 1996. The plan was designed as a catastrophic, high deductible plan which meets the requirements for participation in the federal medical savings account pilot program under the Health Insurance Portability and Accountability Act of 1996. As a result of input from agent forums the Department held across the state of Kentucky as well as input from the Standard Health Benefit Plan Subcommittee, the Department will be developing a second catastrophic plan with higher deductible levels.

A copy of the benefits currently available through each of the standard health benefit plans is included as Appendix E.

According to the Department's survey of all insurance carriers marketing standard health benefit plans in either 1995 or 1996, the most popular standard health benefit plan in 1995 and 1996 was the standard high plan. This is likely due to the fact that insurers are required to offer the standard high (and standard low) health benefit plan as a condition of doing business in Kentucky. The following table represents the order of popularity of the plans for 1995 and 1996. Inconsistencies in the reporting of information have prevented including enrollment numbers by plan type.

1995	1996
standard high	standard high
enhanced low	**enhanced high**
enhanced high	**enhanced low**
economy high	**standard low**
standard low	**budget high**
budget high	**economy high**
economy low	economy low
budget low	budget low

The most popular delivery system for the standard plans in 1995 was a HMO followed by PPO, FFS, and POS. In 1996 the most popular delivery system for the standard plans was also HMO followed by PPO, POS, and FFS.

At the end of 1996, 540,966 individuals were covered through standard health benefit plans (whether through individual, small group, large group, or association policies). This number represents 42% of the total nonelderly private insurance market (753,712 individuals were covered through non-standard plans). Pursuant to SB 343, any policy issued or renewed on or after July 15, 1997, must be a standard health benefit plans. Thus, by July 15, 1998, all health benefit plans will conform to the standard health benefit plans.

Reaction from the insurance carriers to the standard health benefit plans has been mixed. In general, carriers are supportive of standardization to a degree. However, carriers have expressed that because no other plans may be issued, there should be some flexibility, at least at the cost sharing level. If no flexibility in the standard health benefit plans is allowed, then carriers should be allowed to market plans in addition to the standard plans. Additionally, carriers have expressed that standardization is not necessary for the large group market as larger groups typically have benefit coordinators to help compare benefit policies and make a decision as to which policy best suits their needs.

The current standard health benefit plans are all comprehensive plans which contain a high level of benefits. The high benefit levels, combined with pre-defined cost sharing levels, the fact that carriers must only offer the standard health benefit plans and are required to take all comers (guaranteed issue), have been cited as reasons that carriers have withdrawn from the market.

BUY-IN PROGRAM

KRS 18A.2251 permitted Kentucky residents to purchase health insurance coverage under the same terms and conditions as the coverage provided to state employees. The rates for high risk individuals (as determined by the Kentucky Health Policy Board) for this coverage could not exceed 200% of the premium charged to state employees. This "buy-in" program was intended to provide access to health insurance for medically uninsurable individuals during the interim period following the effective date of HB 250 (July, 15, 1994) and the date the Kentucky Health Purchasing Alliance became operational (July 15, 1995). Policies purchased under the buy-in program were to be effective for one year after which time insureds would become eligible for participation in the Alliance. Due to the two Executive Orders issued by the Governor and the extension on pre-standard health benefit plans in SB 343, the buy-in participants were entitled to renew these policies until July 15, 1997.

The statute provided for an assessment on all health insurers doing business in the Commonwealth of Kentucky to recoup any losses experienced by insurance carriers as a result of buy-in participation. In July 1996, the Department of Insurance sent a survey to all health insurers licensed to do business in Kentucky requesting the following information:

- total health insurance premium
- total enrollment in the buy-in program
- actual claims experience from the buy-in program
- premium collected from the buy-in program, and
- administrative expense associated with the buy-in program.

This information was collected by the Department and forwarded to Coopers & Lybrand for calculation of the assessment.

Pursuant to the survey responses, the following carriers participated in the buy-program.

- Alternative Health Delivery Systems
- Bluegrass Family Health, Inc.
- Choice Care Health Plans, Inc.
- FHP of Ohio, Inc.
- Healthwise of Kentucky, Inc.
- Humana, Inc.
- Kentucky Kare
- Anthem Blue Cross Blue Shield (Southeastern United Medigroup/Southeastern Group, Inc.)

The report of Coopers & Lybrand, based on the survey responses, indicated that the total enrollment in the buy-in program (from 7/14/94 - 12/31/95) was **5,148.** The Alliance reported

that as of March 1997, the buy-in enrollees totaled **2,147**. There is no information available on the current insurance status of the 3,001 enrollees no longer enrolled in the program.

In regard to premium, due to inconsistencies in premium and claims reported by the insurers, the Department is unable to provide accurate data. The Department is continuing to collect and analyze necessary data with assistance from Coopers & Lybrand.

Pursuant to KRS 18A.2251, carriers will be reimbursed for any loss they experienced through an assessment on all health insurance carriers. Any assessment on the participating carriers will be offset by the amount of their loss to arrive at the carriers' net amount received or owed. No carrier participating in the buy-in program will be penalized in the event that their collected premium is greater than their claims experience under the buy-in program.

Kentucky Department of Insurance

HEALTH PURCHASING ALLIANCE

THE KENTUCKY HEALTH PURCHASING ALLIANCE

The Kentucky Health Purchasing Alliance was established by the 1994 Health Reform Act to enhance the health insurance purchasing power of small employers and individuals by allowing them to join forces with a very large pool of public sector employees. In the past, small employers and individuals were often denied health insurance if they had any chronic conditions or major adverse health events. Although the Health Reform Act's market-wide requirements have greatly improved access to coverage, individuals and small employers would still have less bargaining power than larger purchasing groups if they were not able to pool their purchases with those of hundreds of thousands of state, local, and educational employees. Several other states have public or private purchasing pools, but Kentucky's Alliance is unique in combining the public and private sectors.

STATUTORY STRUCTURE

The Kentucky Health Purchasing Alliance operates under a detailed statutory structure set form in KRS 304.17A-010 through 304.17A-070. In addition, the general provisions of the Kentucky Insurance Code, KRS Chapter 304, govern Alliance business to the extent that they relate to health insurance and HMOs.

- Several specific legal requirements and restrictions have broad-ranging effects on the Alliance (the following selection is not exhaustive). There is only one Alliance that operates state-wide. KRS 304.17A-020(1), (2).

- The Alliance can only offer fully insured benefits through certified accountable health plans and is prohibited from contracting directly with health care providers. KRS 304.17A-020(a); see also KRS 304.17A-010(1) (defining "accountable health plan"), (12) (defining "health insurer"), (13) (defining "health benefit plan"), and 304.17A-070 (setting forth conditions for accountable health plan certification).

- Alliance membership is limited to qualified individuals and to persons entitled to health insurance benefits through the state, school systems, local and district health department, judicial system, Kentucky Retirement System, Teachers' Retirement System, cities, counties, special districts, state universities, employers of 50 or fewer eligible employees, and associations with 50 or fewer eligible members; Alliance members must meet several other participation criteria KRS 304.17A-010(17) (defining "mandatory Alliance member"), (23) (defining "voluntary Alliance member"), 304.17A-020(3) (limiting Alliance membership to mandatory and voluntary members), and 304.17A-040 (setting forth conditions for Alliance participation).

- The Alliance is a state agency under the administrative auspices of the Dept. of Insurance with a voluntary Board of Directors appointed by the Governor, and Directors cannot have ties with the health care or health insurance industries. KRS 304.17A-020(1), (4); 304.17A-050, 060.

- The Alliance must review proposals from insurers and HMOs that seek to participate as accountable health plans and determine whether they meet detailed certification criteria. KRS 304.17A-070.
- The Alliance must select accountable health plans from among those that meet certification criteria and negotiate rates for Alliance members aggressively. The Alliance must offer all plans that are selected to members who live within the plans' service areas. KRS 304.17A-030(4).
- The Alliance must use modified community rating for all groups within its membership, regardless of size. KRS 304.17A-120(1).

CHALLENGES

Association Exemption

The statutory exemption of associations from the rating requirements of the Health Reform Act seriously jeopardizes the integrity of the Alliance's individual market segment. If associations can charge high-risk members higher rates than those members would pay for an Alliance plan, these individuals will obviously be motivated to buy in the Alliance. As more high-risk than low-risk individuals enroll, rates are likely to increase even more than at present, forcing the low-risk enrollee to look elsewhere for coverage. Likewise, if a small employer is quoted a high risk-based rate for an association plan, they will be likely to bring their high-risk group into the Alliance. Although this danger exists for non-Alliance plans offered other than through associations, many carriers can balance the added risk by doing business in the association market as well.

Market Instability

The atmosphere of instability created by frequent changes, rumors of changes, and lobbying for changes in the laws governing Alliance operations is a constant challenge. The appeal of insurance is its ability to reduce the unpredictable risk of loss to a predictable monthly payment. Consumer confidence is eroded when the health insurance structure appears to be in perpetual flux. Insurance carriers have enormous power to create the appearance of instability, for example by changing provider networks, delaying the issuance of identification cards, delaying claims payment, or giving incorrect or conflicting information. Even in the absence of such provocations, however, an atmosphere of legislative uncertainty undermines the very value that consumers seek when they buy insurance.

Loss of Mandatory Membership

Senate Bill 343 removed municipal and university groups as mandatory members and added significant variation and complexity to the previous rating structure, resulting in major increases in composite rates for the older group of state employees who were enrolled as couples. Groups of more than 50 employees can be experience rated outside the Alliance, but the Alliance must

use the same rates for them as for the smallest groups, placing the Alliance at a competitive disadvantage for larger public sector groups.

Statistics

Exhibit A: Enrollment data by accountable health plan, benefit level, and family.

Note: The apparent decline in small group enrollment is attributable to a change in designation of small public sector groups. These groups were originally categorized with private sector employer groups, and are now included in the public sector figures. On the other hand, the decline in individual enrollees is real, and reflects the decision by Anthem to withdraw its individual offerings from the Alliance, leaving only Kentucky Kare as an option for the individual enrollee. A significant number of Anthem individual enrollees chose to renew their Anthem plans outside the Alliance rather than change to Kentucky Kare.

Exhibit B: Alliance enrollees by employment category

Exhibit C: Alliance voluntary public sector enrollees (larger groups)

Exhibit D: Alliance enrollment by market segment

EXHIBIT A

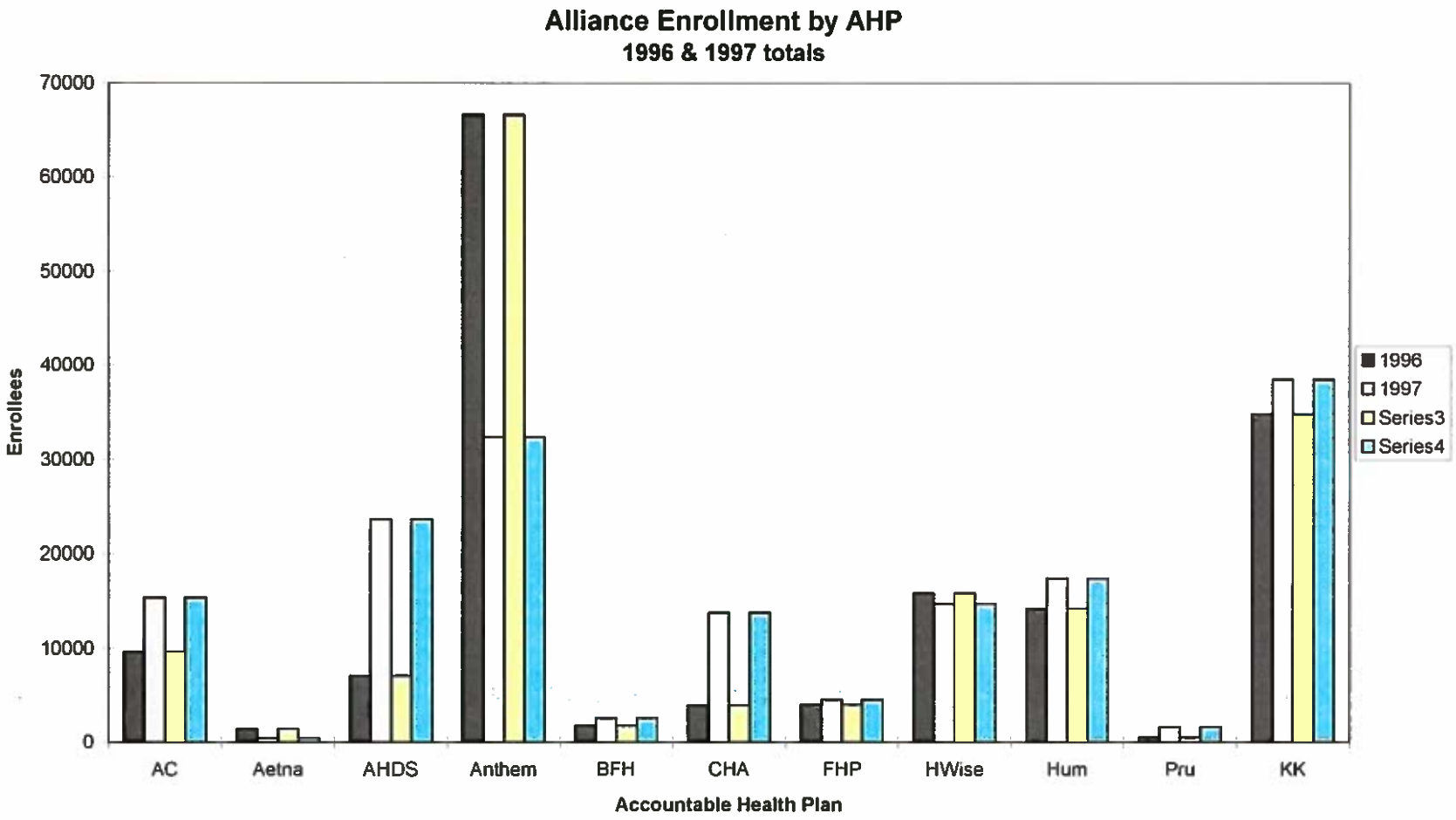

Alliance Enrollment by AHP
1996 & 1997 totals
Enrollees
70000
60000
50000
40000
30000
20000
10000
0
AC
Aetna
AHDS
Anthem
BFH
CHA
FHP
HWise
Hum
Pru
KK
Accountable Health Plan
1996
1997
Series3
Series4

EXHIBIT B

ALLIANCE ENROLLEES BY EMPLOYER

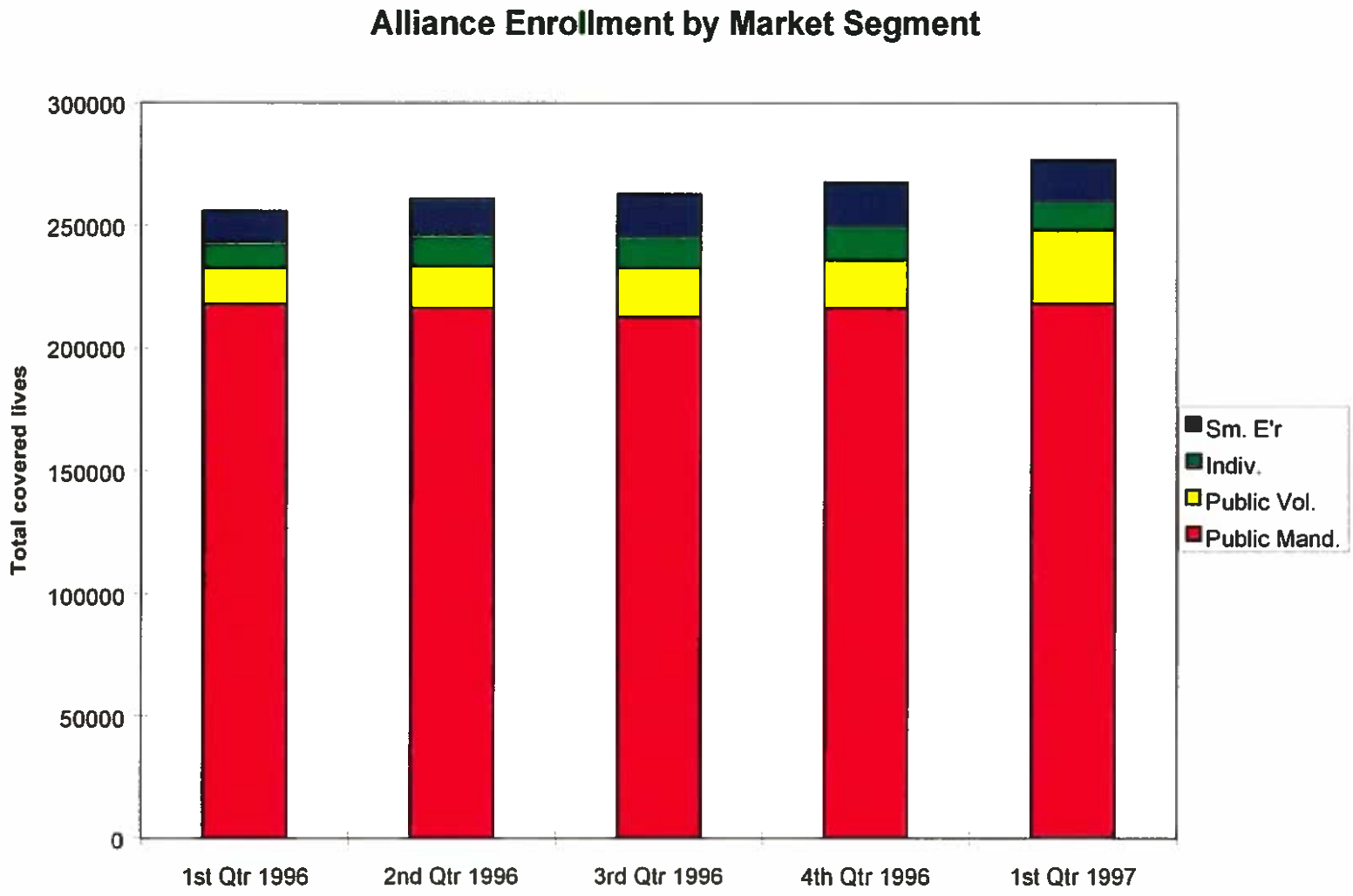
State	38,333
School systems	75,427
Kentucky Retirement Systems	10,023
Teacher Retirement System	8,726
Health Departments	2,752
Buy-in Enrollees	2,147
Universities	6,277
Cities, Counties, Special Districts	4,231
Small employers	9,370
Individuals	7,283
TOTAL	168,800

Exhibit C

Alliance Voluntary Public Sector Member Activity (groups over 50 enrollees)

Group	Enrollees	Date of entry	Date of renewal
Teacher Retirement System	8,726	January 1, 1997	
Western Kentucky Univ.	1,470	January 1, 1997	
University of Louisville	4,950	January 1, 1996	January 1, 1997
Northern Ky. University	950	January 1, 1996	January 1, 1997
Pike County Fiscal Court	180	April 1996	April 1997
Campbell/Kenton Sanitation Dist.	135	January 1996	January 1997
Barren County Fiscal Ct.	94	October 1995	October 1996
Fayette County Sheriff	91	January 1996	January 1997
Hopkins County Fiscal Ct.	118	January 1996	January 1997
Kenton County Water Dist.	100	January 1996	January 1997
MH/MR Board/Adanta Group	375	January 1996	January 1997
City of Fort Thomas	70	February 1996	February 1997
Carroll County Fiscal Court	60	March 1996	March 1997
City of Jeffersontown	103	March 1996	March 1997
Oldham County Fiscal Court	125	March 1996	March 1997
Knott County Fiscal Court	77	April 1996	April 1997
Housing Authority of Louisville	300	May 1996	
Fleming County Hospital Dist.	110	June 1996	
Breckenridge County Fiscal Court	69	July 1996	
City of Bardstown	95	July 1996	
City of Danville	125	July 1996	
City of Florence	116	July 1996	
City of Maysville	100	July 1996	
Madison County Fiscal Court	136	July 1996	
Marion County Fiscal Court	62	July 1996	
Ohio County Fiscal Court	60	July 1996	

EXHIBIT D


Alliance Enrollment by Market Segment
Total covered lives
300000
250000
200000
150000
100000
50000
0
1st Qtr 1996
2nd Qtr 1996
3rd Qtr 1996
4th Qtr 1996
1st Qtr 1997
Sm. E'r
Indiv.
Public Vol.
Public Mand.

Kentucky Department of Insurance

State & Federal Reform Initiatives

---

reform provisions

rate bands

population

risk pools

HIPAA

50-state report

ANALYSIS OF FEDERAL AND STATE HEALTH CARE INITIATIVES

States continue to experiment with insurance reforms designed to enhance the availability of health insurance coverage to small employers and individuals. The majority of states have experimented (some more than others) with rating restrictions, guarantee issue, portability, standard benefit plans, and other mechanisms in some portion of their insurance market. It is important that we reflect upon the growing trend of both state and federal initiatives that will have a major impact on the insurance markets in the months ahead.

FEDERAL BUDGET

The President and Congress continue to grapple with how to balance the federal budget and estimate future Medicare expenditure trends, while at the same time accurately estimating cost savings of various Medicare proposals being discussed. It is clear that any significant reductions in these programs to reduce costs will affect providers and insurers. These reductions have a ripple effect on providers and the insurance market as cuts are absorbed or cost shifted to other segments of the population.

MEDICAID PROGRAMS REDUCTIONS

There is continued interest and effort to curb the growth of the budget at both the federal and state levels for this entitlement program. Another emerging trend is states jumping on the bandwagon of Medicaid managed care to achieve savings, help constrain the rate of budget growth, and improve access and care for the Medicaid eligible populations. It is still too early to project with accuracy, however, it can be anticipated that Medicaid managed care programs have been or will be the impetus for increased penetration of managed care into the insurance markets and that this significantly increased penetration and maturation of managed care mechanisms such as capitation, financial incentives for prevention, and other market forces will affect the way in which markets react and behave. While increased experimentation and regulation by states continues, it is important to recognize the natural forces at work in the insurance market.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

This legislation recently enacted by Congress and signed into law by President Clinton signifies an increasing awareness that health insurance access, renewability and continuity present significant difficulties for small employers and individuals that transcends state concerns and has become a growing national concern. This legislation represents a significant action taken by the federal government to provide basic protection to this country's citizens.

A summary of the Health Insurance Portability and Accountability Act of 1996 can be found in Appendix F. A timeline for implementation of the Act can be found on page 7-4.

MANAGED CARE LEGISLATION

There is a growing awareness of the need to set some basic standards with regard to the significant increases in use of managed care health plans in this country. While many purchasers of health insurance have actively embraced managed care plans because of the savings they represent, concerns regarding many of managed care industry's practices are coming under close scrutiny due to what is seen as abusive practices by some HMO's which deny patients' rights to adequate, quality care.

The push for HMO's to improve their bottom line through more efficient operations, increased enrollment growth through expansion or merger and acquisition, and need to maintain steady increases in earnings continue to be challenges for HMO's.

A flurry of activity in states is occurring to develop and enact patient-protection pieces of legislation to ensure that industry standards exist for health plans and providers to work together in the best interest of their patients. Some forty (40) states have either passed or are considering legislation to protect HMO consumers. Some of the issues being addressed legislatively include:

- Physician "Gag" clauses and an array of provider contracting issues
- "Prudent layperson" standard for HMO coverage of emergency services
- Mandatory disclosure of health plan information
- Appropriate appeal and dispute resolution processes
- Drug formulary issues
- Maternity length-of-stays, hospital stays for surgical procedures such as hysterectomies.

Likewise, at the federal level there are currently five (5) or six (6) bills which are in circulation or have been introduced to address patient protections in managed care plans. It is fully to be expected that federal legislation will be enacted in the near future which would have an impact on the managed care segments of the insurance markets.

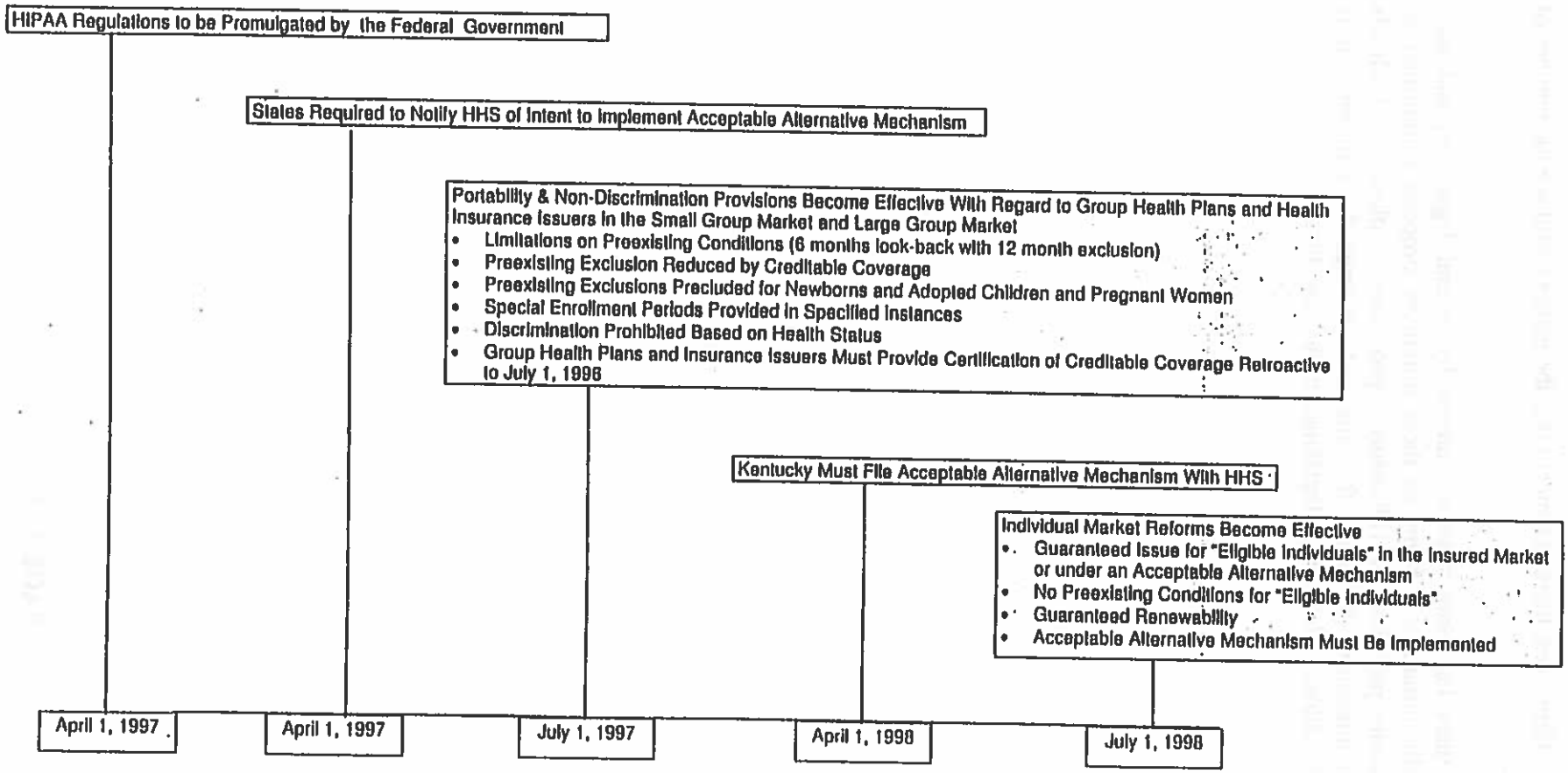
CHILDREN'S HEALTH CARE

In the late 1980's and early 1990's, major strides were made in expanding access to health care coverage to children in the United States. The majority of this coverage resulted from expansions in state Medicaid programs. Beginning in 1983 with the addition of the "Ribicoff Kids" program, millions of children in poor families have received coverage under the Medicaid program. But with the rising costs of health care, state budgets have been stretched to the limit and major new expansions may be difficult to enact. Coupled with the recent change in federal

rules which may reduce the welfare roles, there is concern that the nation could see the number of uninsured children on the rise.

To address these concerns, there has been renewed interest by federal legislators and state lawmakers in children's health initiatives. Many of these initiatives propose a mutlifaceted approach of Medicaid expansions, partnerships with insurers, providers, employers and schools working together to develop innovative programs for universal coverage for children. It is expected that this issue will be addressed by federal legislation in the near future.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT TIMELINE



PROFILES OF 50 STATES: AN ANALYSIS

INDIVIDUAL MARKET REFORMS

Although it was Congress that passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996, state legislatures continue to have the major impact on health insurance markets through legislative mandates, new programs or policies. However, despite much interest and activity, very few states (if any) have pursued reforms that have the far-reaching impact of Kentucky's on the health insurance market.

While 13 states now require guaranteed issue in the individual market and 26 limit exclusions for pre-existing conditions, only 8 states (including Kentucky) require both guaranteed issue and modified community rating in the individual market. The combined reforms have been in place in the individual market no longer than three years in any state, and few are as comprehensive as Kentucky's.

For example, Massachusetts passed the broadest reforms in the individual market in 1996. Its reforms for the individual market are similar to Kentucky's: guaranteed issue, guaranteed renewal, modified community rating and limits on the use of waiting periods for pre-existing conditions. *However, Massachusetts' guaranteed issue provisions do not apply year-round and do not apply to all products. Its law provides residents with guaranteed issue of three standardized products and only during an annual 60-day open enrollment period. In addition, the guaranteed issue provisions do not apply to people who are self-employed* or who are eligible for coverage from an employeer either as an employee or a spouse or dependent of an eligible employee.

Kentucky's guaranteed issue and modified community rating laws apply for all health plans for all individuals all year-round.

Massachusetts' new law has another significant feature that Kentucky's doesn't: *It requires all health plans with 5,000 or more enrollees in the small group market to participate in the individual market.* Other than having the authority under a separate older statute to require HMOs to conduct an open enrollment period, Kentucky placed no provision in its law to require group plans to participate in the individual market.

Also in 1996, Massachusetts repealed a "pay-or-play" mandate on employers. The mandate, which required employers to insure their employees or pay a tax, was a pioneering reform when it was passed in 1988 but it was never implemented.

Massachusetts' new reforms aligned it with Kentucky and six other states as states that have some form of modified community rating *plus* guaranteed issue and limitations on pre-existing conditions in the individual market as well as the small group market. *(See maps 1, 2, 3)*

The other states include:

- **Maine:** guaranteed issue for all individuals year-round for all products. (1993 law) Maine's limits on exclusions for pre-existing conditions are somewhat stricter than Kentucky's -- 12 months' "look back" as opposed to Kentucky's six months' "look back."
- **New Hampshire:** guaranteed issue for all products *only during an annual 60-day open enrollment period,* for individuals who are not eligible for coverage from an employer.
- **New Jersey:** guaranteed issue for five standardized plans for residents who are not eligible for group coverage. (1992 law)
- **New York:** guaranteed issue for all products for all individuals year-round (1992 law)
- **Vermont:** guaranteed issue for all products year-round for all residents who are not eligible for group coverage. (1992 law)
- **Washington**: guaranteed issue for all products for all individuals year-round. (1993 law)

Among these reform states, Washington State has health insurance reforms and demographic characteristics closest to Kentucky's. Like Kentucky, Washington stands alone with *no* neighboring states that have the individual health insurance market reforms of guaranteed issue and modified community rating. Washington State's reforms were passed in 1993. Kentucky's comprehensive reforms were passed in 1994.

Washington State lawmakers now are moving forward with legislation to reduce the guaranteed issue provisions of their law to a once-a-year open enrollment period of 30 days. The bill, passed by the Washington House of Representatives on a vote of 66-32 and approved by two committees of the Senate, was expected to be voted on by the full Senate by April 18. State Rep. Phil Dyer said he introduced the legislation, called the Consumer Assistance and Market Stabilization Act, in response to insurer's complaints of large losses and predictions of premium increases.

Washington's reforms and market are similar to Kentucky's, but with significant differences. It has four dominant carriers still competing in the individual health insurance market. (Kentucky has only Anthem Blue Cross and the state-operated Kentucky Kare plan.) Washington's population is larger at 5.4 million compared to Kentucky's population of 3.9 million, creating a larger health insurance market in Washington State in which insurance carriers can compete. Kentucky's rate of uninsured is 14.6 percent; Washington, which has had a high-risk pool since 1988, has 12.4 percent uninsured. The consumers' ability to afford insurance is very similar:

Kentuckians' average weekly salary is $504; the average weekly salary in Washington State is $489.

The other six states with guaranteed issue and modified community rating provisions in the individual market are clustered in one region, the Northeast. The Northeast is an urban, heavily populated region well penetrated by managed care. The size of the overall health insurance market for that cluster of reform-state neighbors is many times the size of Kentucky's. That market size alone gives health plans reason to continue to compete within the framework of those states' reforms. Kentucky, on the other hand, has a relatively small individual market and stands out like an island with health insurance reforms that reach farther than any of its neighboring states.

A handful of other states have guaranteed issue laws on the books but with provisions that seriously limit the guarantees. For example, Iowa has guaranteed issue year-round *only for individuals who have one year of qualifying coverage within the previous 30 days or a qualifying event in the last 30 days.* (1995 law) Idaho's laws provide for guaranteed issue for all individuals *only during two 45-day open enrollment periods and year-round only for individuals with qualifying previous coverage.* (1994, 1995 laws) In addition, both Iowa and Idaho have bands on rates but *do not have modified community rating in the individual market.*

SMALL GROUP MARKET

In the small group market, insurance reforms that address issues such as access, rating restrictions and limits on exclusions for pre-existing conditions have been in place in some states for a number of years. Small group reforms address rates (with modified community rating or rating bands rules), direct access (guaranteed issue and guaranteed renewal laws) and exclusion clauses for pre-existing conditions. "In fact, only four states have not enacted at least guaranteed renewal, portability provisions or limitations on pre-existing conditions clauses," reports the Health Policy Tracking Service. *(See maps 4, 5, 6)*

As compared to the general experience in the individual market, the small group market presents less unknown risk to carriers. Reforms protecting the group market consumers have been easier for carriers to incorporate in the marketplace. Again, Kentucky's reforms go farther, many combining guaranteed issue, modified community rating and limits on pre-existing conditions.

In the past year or two, a handful of states began struggling with how to expand these reforms to the individual market, which is thought to be about one-tenth the size of the group market. The passage of the Health Insurance Portability and Accountability Act (Kassebaum-Kennedy law) appears to have further spurred states to turn their attention to individual market reforms. The HIPAA also has stirred new interest in high risk pools.

HIGH RISK POOLS, MODEL ACTS, MSAs

The high risk pools are being considered once again by some states, as a way to comply with the new federal reforms. Twenty-six states already have high risk pools. (See table)

States also are more seriously considering the National Association of Insurance Commissioners' Model Acts on Individual Reform and Group Reform. Meanwhile, health purchasing alliances, a concept that was popular a couple of years ago, now are receiving very little attention from legislatures. The experience of the Medical Savings Accounts provisions in the Kennedy-Kassebaum law will be watched by state legislatures, but little change in state laws on MSAs is expected this year.

ANY WILLING PROVIDER LAWS

Any willing provider laws exist in 27 states, although only eight states (including Kentucky) have broad laws that apply to almost any type of medical provider. In most states, the any willing provider laws apply only to limited categories of providers, such as pharmacists. Two to three years ago, legislators and consumers considered any willing provider laws to be consumer-friendly ways to increase provider choice. Insurance carriers and HMOs consider any willing provider laws to be cost drivers, because the laws limit the operations' ability to exclude providers whose practices are not run as effectively and efficiently or whose outcomes fall below a certain range.

The laws traditionally have been supported by most medical providers. However, the popularity of any willing provider laws appears to be diminishing some across the nation as more providers form networks of their own. In addition, any willing provider laws were not the hot topic in legislatures in 1996 that they were in 1994 to 1995.

HEALTH REFORM: PROFILES OF 50 STATES

State	Population[1]	Percent[1] uninsured	Guaranteed issue[2]	Limits & rules of guaranteed issue[3]	Guaranteed renewal[2]	Rating Restrictions[2]	Pre-existing conditions limit[2]	High risk pool[4]	Any willing provider[2]
Alabama	4,246,205	13.5%							Rx only
Alaska	602,545	12.5%	SG		SG	SG-RB	SG-12/6	X	
Arizona	4,305,016	20.4%	SG		SG	SG-RB	SG-12/12		
Arkansas	2,484,761	17.9%			SG	SG-RB		X	broad
California	31,565,480	20.6%	SG		SG	SG-RB	SG-6/6;I-12/12	X	
Colorado	3,747,560	14.8%	SG		SG, I	SG-MCR	SG-6/6;I-12/12	X	
Connecticut	3,270,740	8.8%	SG		SG	SG-MCR	SG-12/6;I-12/12	X	Rx only
Delaware	717,041	15.7%	SG		SG	SG-RB	SG-12/6		Rx only
Florida	14,184,055	18.3%	SG		SG, I	SG-MCR	SG-12/6;I-24/24	X	Rx/AHP
Georgia	7,208,676	17.9%			I	SG-RB	SG-12/NA		
Hawaii	1,179,198	8.9%							
Idaho	1,166,112	14.0%	SG, I	enroll. period (2/45 days)	SG, I	Both-RB	Both-12/6		broad
Illinois	11,790,379	11.0%	SG		SG	SG-RB	SG-12/12	X	
Indiana	5,796,948	12.6%	SG		SG	SG-RB	SG-9/9;I-18/12	X	broad
Iowa	2,843,074	11.3%	SG, I	year round	SG, I	SG-MCR I-RB	SG-12/6;I-12/12	X	
Kansas	2,563,618	12.4%	SG		SG	SG-RB	SG-3/6	X	Rx only
Kentucky	3,856,827	14.6%	SG, I	year round	SG, I	Both-MCR	Both-6/12		broad
Louisiana	4,338,072	20.5%			SG, I	Both-RB	Both-12/12	X	broad
Maine	1,238,572	13.5%	SG, I	year round	SG, I	Both-MCR	Both-12/12		
Maryland	5,038,912	15.3%	SG		SG	SG-MCR	SG-0/0		
Massachusetts	6,071,078	11.1%	SG, I	enroll. period (60 days)	SG, I	Both-MCR	SG-6/6;I-0/0		Rx only
Michigan	9,537,948	9.7%							
Minnesota	4,614,613	8.0%	SG		SG, I	Both-RB	Both-12/6	X	allied
Mississippi	2,696,183	19.7%			SG	SG-RB	SG-12/12	X	Rx only
Missouri	5,319,335	14.6%	SG		SG	SG-RB	SG-12/6	X	

Kentucky Department of Insurance

Sources: 1) U.S. Census Bureau 2) Health Policy Tracking Service 3) Blue Cross/Blue Shield Assn. 4) National Assn. of Insurance Commissioners 5) Communicating for Agriculture

HEALTH REFORM: PROFILES OF 50 STATES

State	Population[1]	Percent uninsured[1]	Guaranteed issue[2]	Limits & rules of guaranteed issue[3]	Guaranteed renewal[2]	Rating Restrictions[2]	Pre-existing conditions limit[2]	High risk pool[4]	
Montana	870,351	12.7%	SG		SG	SG-RB	SG-12/36	X	
Nebraska	1,639,213	9.0%	SG		SG	SG-RB	SG-12/6	X	
Nevada	1,533,478	18.7%	SG		SG	SG-MCR	SG-6/6		
New Hampshire	1,148,244	10.0%	SG, I	enroll. period (60 days)	SG, I	SG-CR, RB, I-CR	Both-9/3		Rx only
New Jersey	7,949,506	14.2%	SG, I	year round	SG, I	Both-MCR	>75,0/0;2-5,6/6 I-12/6		Rx only
New Mexico	1,689,849	25.6%			SG	SG-MCR	SG-6/6	X	
New York	18,190,562	15.2%	SG, I	year round	SG,	Both-CR	Both-12/6		
North Carolina	7,202,335	14.3%	SG		SG, I	SG-MCR, RB	SG-12/12		Rx only
North Dakota	641,506	8.3%	SG		SG, I	SG-RB I-MCR	Both-12/6	X	Rx only
Ohio	11,134,032	11.9%	SG, I	enrollment cap	SG, I	SG-RB	Both-12/6		
Oklahoma	3,274,870	19.2%	SG		SG	SG-RB	SG-12/6	X	Rx only
Oregon	3,148,855	12.5%	SG		SG	SG-RB	Both-6/6	X	
Pennsylvania	12,060,312	9.9%							
Rhode Island	991,701	12.9%	SG		SG	SG-RB	Both-0/0		
South Carolina	3,667,000	14.6%	SG		SG	Both-RB	SG-12/12;I-portability	X	Rx, allied
South Dakota	729,500	9.4%	SG, I	only w/ prior coverage	SG, I	Both-RB	SG-12/6;I-12/12		Rx only
Tennessee	5,246,723	14.8%	SG		SG	SG-RB	SG-12/12	X	limited
Texas	18,801,380	24.5%	SG		SG	SG-RB	SG-12/6		limited
Utah	1,958,313	11.7%	SG, I	enrollment cap	SG, I	Both-RB	Both-12/6	X	broad
Vermont	584,776	13.2%	SG, I	year round	SG, I	Both-MCR	Both-12/12		
Virginia	6,615,234	13.5%	SG		SG	SG-RB	Both-12/12		Rx, allied
Washington	5,447,720	12.4%	SG, I	year round	SG, I	Both-MCR	Both-3/3	X	broad
West Virginia	1,825,256	15.3%				Both-RB	SG-12/12		
Wisconsin	5,122,100	7.3%	SG		SG	SG-RB	SG-12/6	X	Rx only
Wyoming	479,192	15.9%	SG		SG	SG-RB	Both-12/6	X	broad

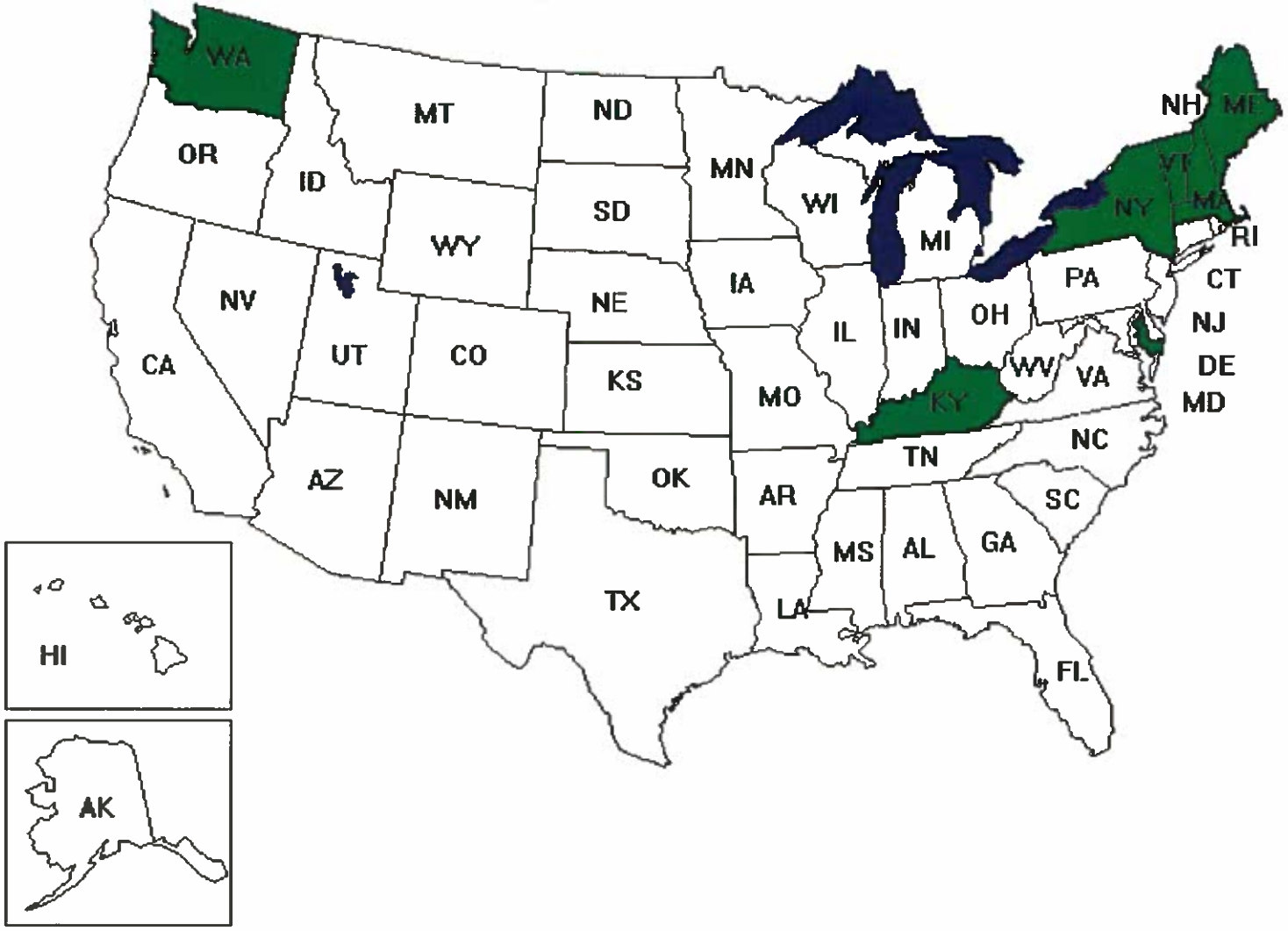
Kentucky Department of Insurance
Sources: 1) U.S. Census Bureau 2) Health Policy Tracking Service 3) Blue Cross/Blue Shield Assn. 4) National Assn. of Insurance Commissioners 5) Communicating for Agriculture

Health Reform: Profiles of 50 States
Definitions and explanations

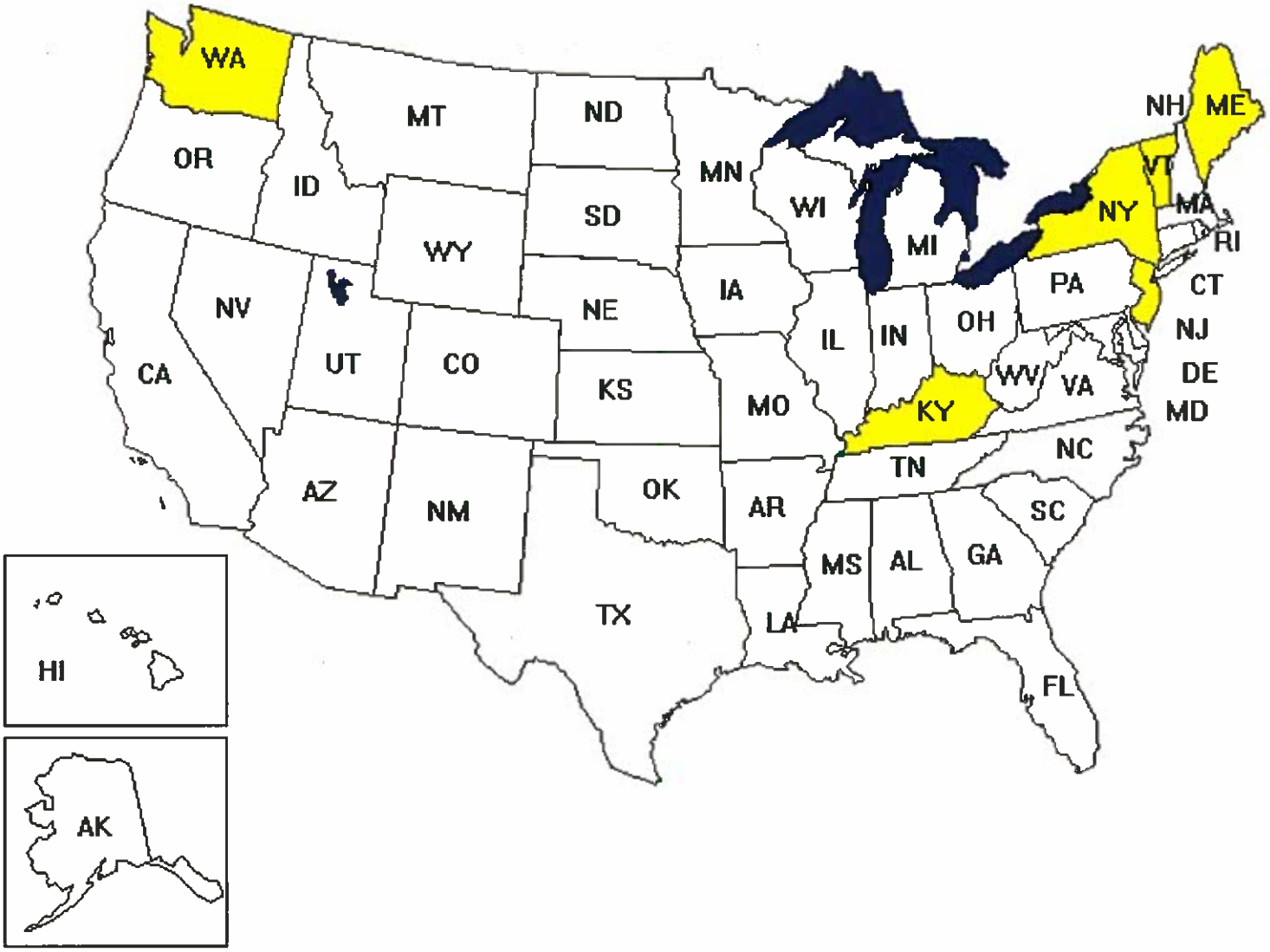
SG--small group
I--individual
MCR--modified community rating
CR--community rating
RB--rating bands
Pre-existing conditions limitations--6/12 means anything in previous six months or next 12 months would not be covered.

State	Population[1]	Percent[1] uninsured	% of Error[4]	Guaranteed Issue[2]	Limits & rules of guaranteed issue[3]	Guaranteed renewal[2]	Rating Restrictions[2]	Pre-existing conditions limit[2]	High risk pool[4]	Any willing provider[2]
Kentucky	3,686,677	14.60%	SG, I	year round	SG	Both MCR	Both 6/12	[illegible]	broad	[illegible]

Guaranteed Issue and Modified Community Rating/Community Rating for Individuals



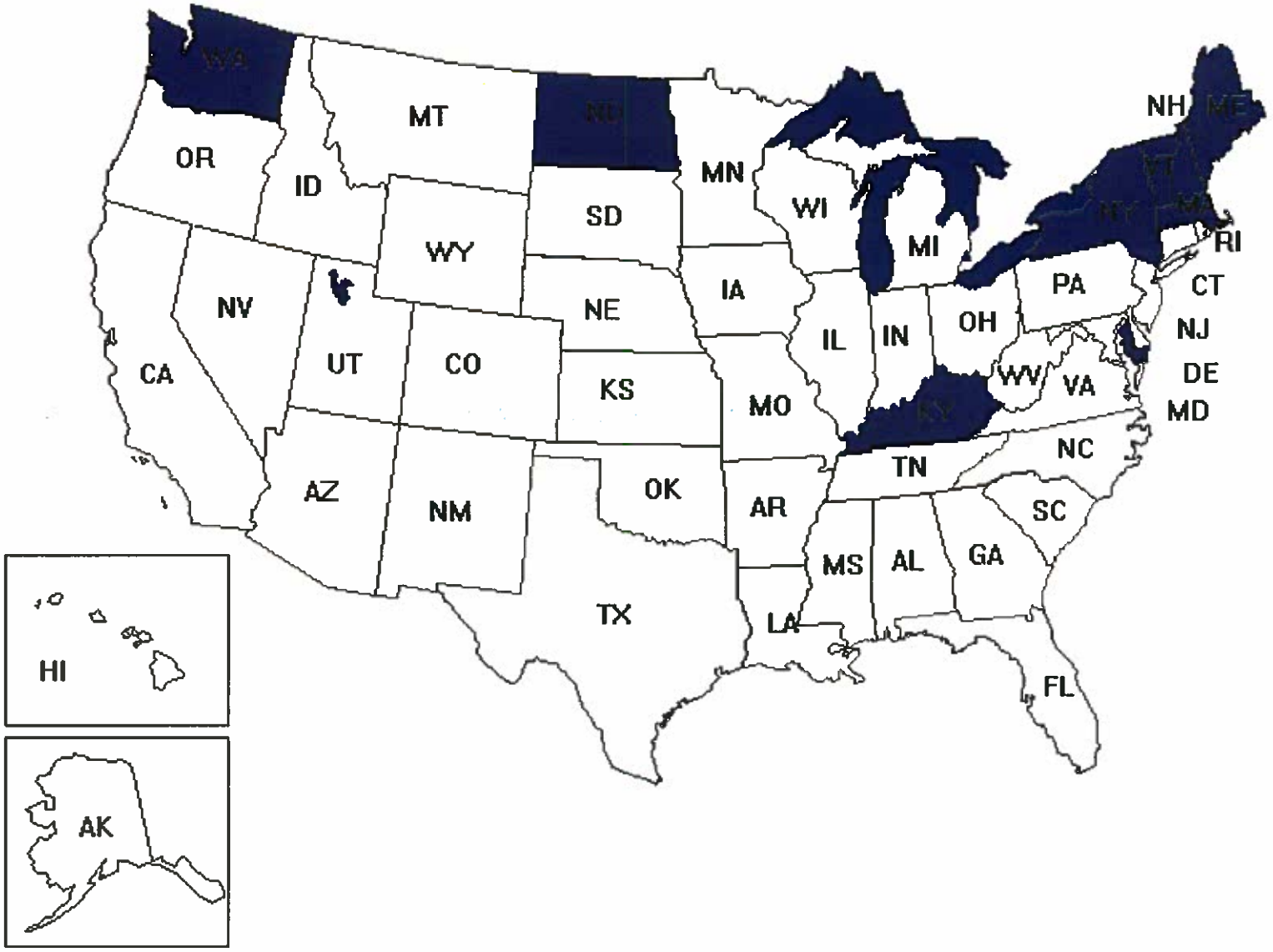
Guaranteed Issue for Individuals



* Idaho, Massachusetts and New Hampshire offer guaranteed issue once a year through open enrollment. Ohio, South Dakota and Utah have an enrollment cap. South Dakota's guaranteed issue law was passed in 1996. Iowa has guaranteed issue only to individuals who had qualifying prior coverage.

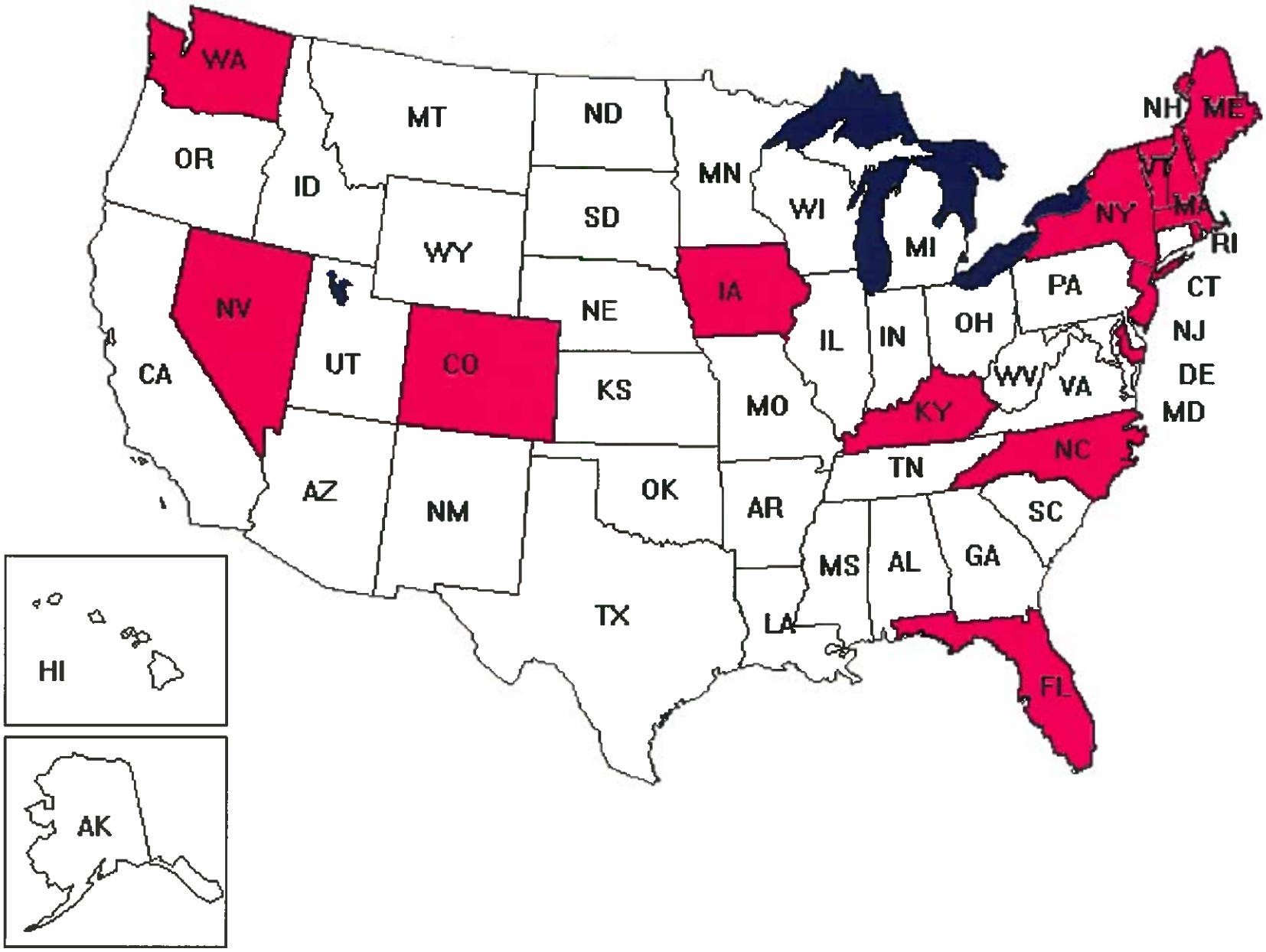
Kentucky Department of Insurance, April 1997

Modified Community Rating/Community Rating for Individuals

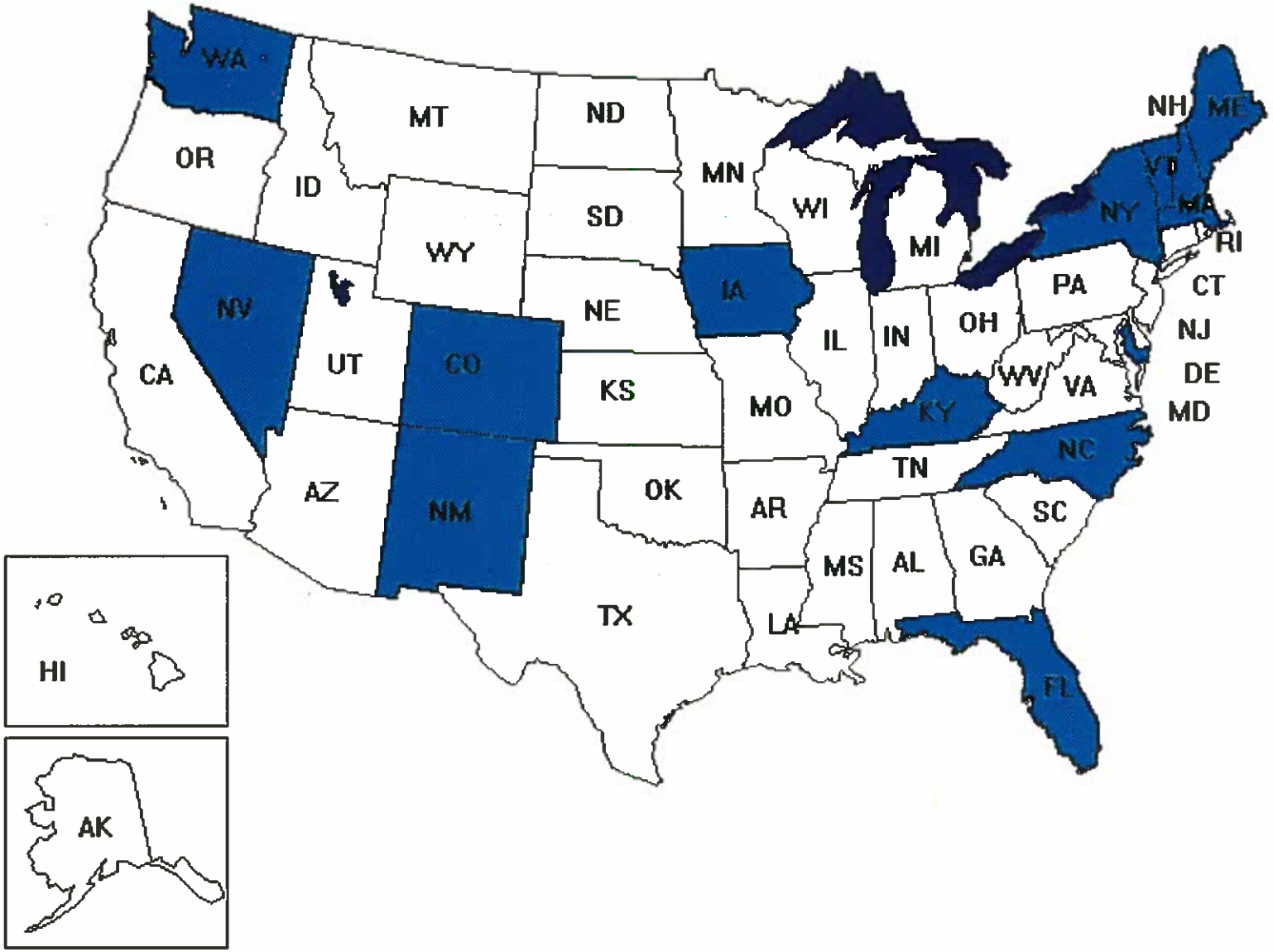


Kentucky Department of Insurance, April 1997

Modified Community Rating/Community Rating and Guaranteed Issue for Small Groups



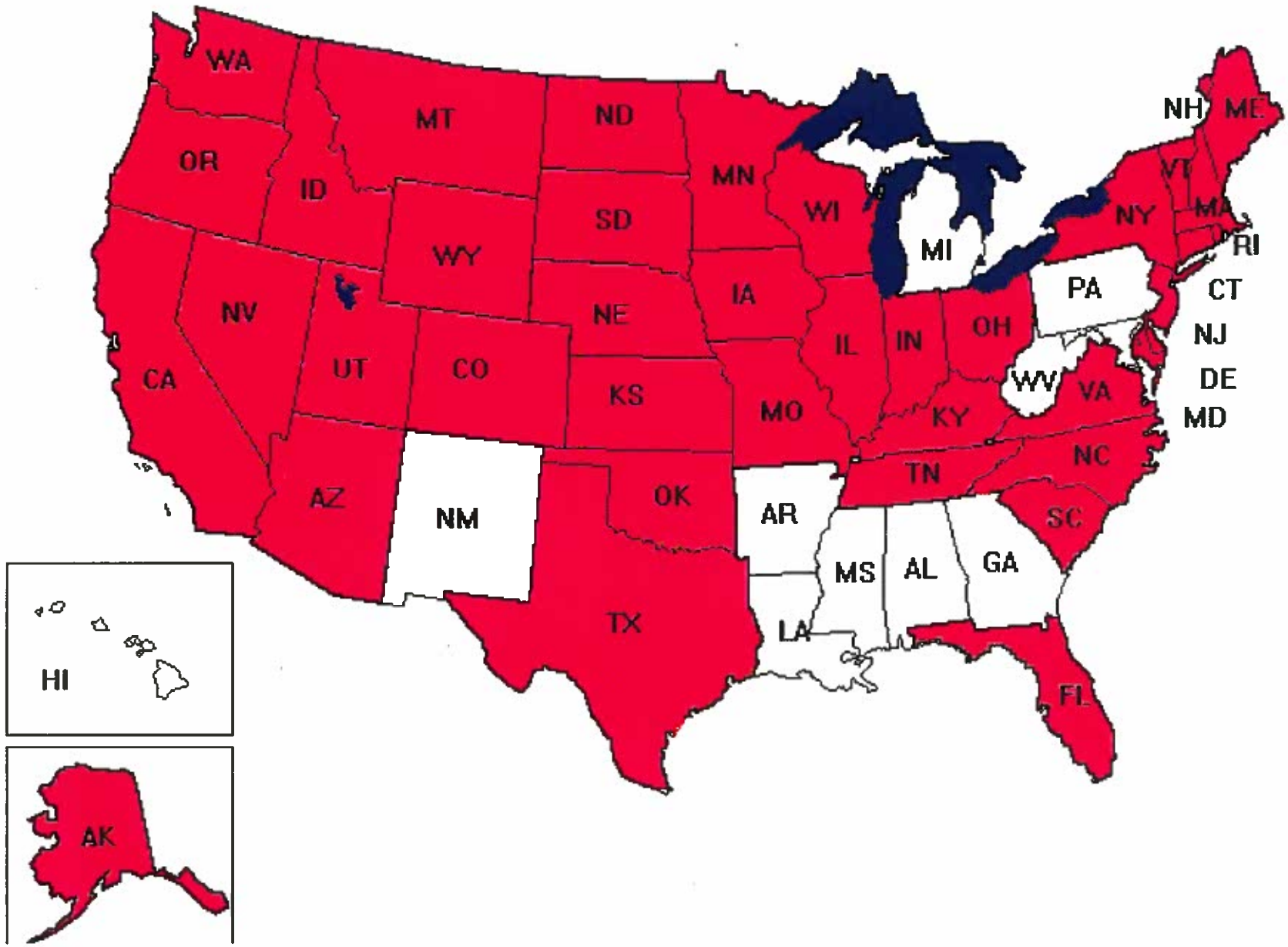
Modified Community Rating/Community Rating for Small Groups



* Massachusetts and Maryland passed modified community rating laws in 1996.

Kentucky Department of Insurance, April 1997

Guaranteed Issue for Small Groups



Kentucky Department of Insurance

National Market Trends

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premium trends

loss ratios

managed care savings

financial impact on consumers

health care expenditures

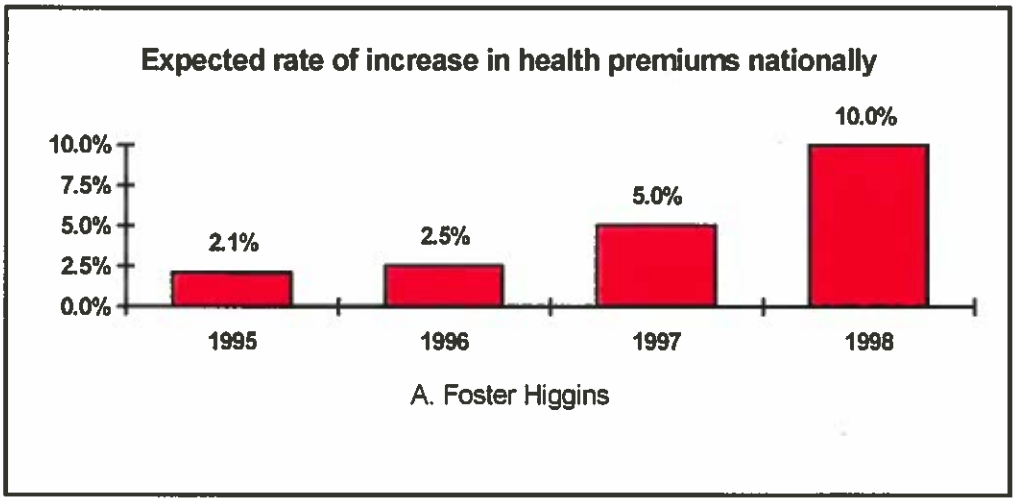
MARKET TRENDS IN HEALTH INSURANCE

EMPLOYERS' HEALTH INSURANCE PREMIUMS EXPECTED TO RISE

Across the nation, employers' health care costs are expected to increase in 1997 and 1998 at a markedly sharper rate than in the past two years, industry analysts have predicted. If this national trend is borne out in Kentucky, small employers and individuals may miss out altogether on the savings from the national slow-down in health premium increases in the early to mid 1990s. Instead, Kentuckians -- especially small employers whose premiums have risen faster than the national rate in the past two years -- may have unmitigated increases in health premiums for the 1990s.

Across the nation, employers' health care costs will increase about 5 percent in 1997, analysts with the benefits consulting firm A. Foster Higgins have said. Small employer groups are expected to see steeper increases, some as high as 12 percent. An overall increase of 5 percent would double the national 1996 inflation rate for employers' health costs, which was 2.5 percent, and more than double the 1995 rate of 2.1 percent.

While there is agreement about the 1997 increase, how steep the increase will be in 1998 is the subject of debate. Foster Higgins analysts predict that employers' costs nationally will increase 10 percent in 1998. The Lewin Group expects health insurance premiums to rise more in 1998, but predicts the rate of inflation will stay in single digits.



Employers with small group plans (50 employees or less) will see a greater rate of increase than large groups in 1997. However, rates for large group plans will begin to catch up in 1998, according to industry analysts.

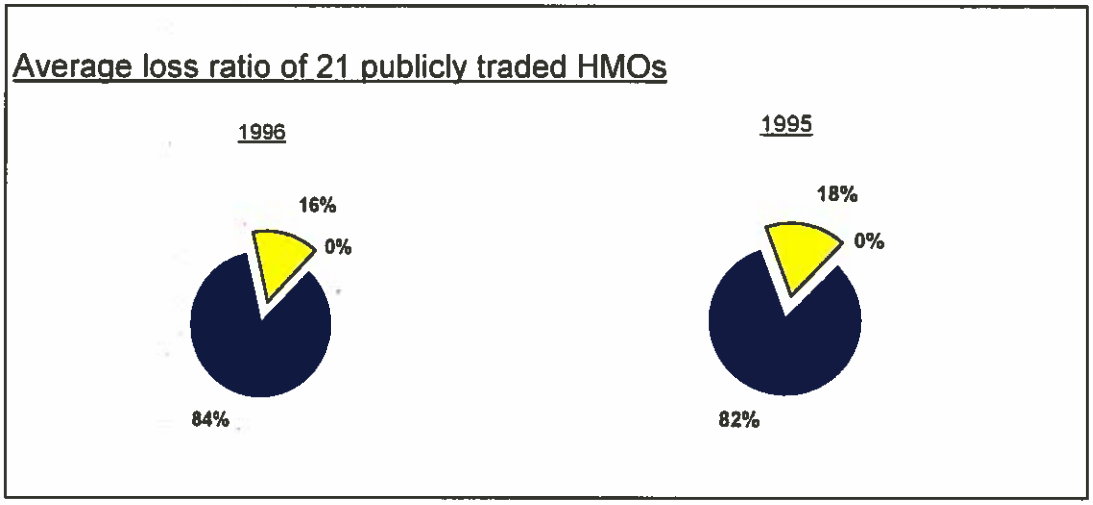
Health plans which experienced losses in a competitive market nationally and relied on investment income to balance the books in 1996 seek to boost their income from premiums in

1997 and 1998. The national trend in the early 1990s of slim annual increases in premiums was in part an industry response to President Clinton's health care plan and to public outcry about health costs, according to analysts with Conning & Co., Hartford, Conn. That trend is reversing.

Total health care costs paid jointly by employers and employees averaged $3,915 a year for each active and retired employee covered, the Foster Higgins survey of 3,290 employees showed. HMOs offered the lowest price; indemnity products cost the most. For their part, employers paid an average of $3,185 for each HMO member and $3,739 for each indemnity member.

LOSS RATIOS HIGH IN 1996 FOR HMO PLANS

Sherlock Co. of Gwynedd, Pa., which tracks 21 publicly traded managed care companies, reported increases in the average medical loss ratio for HMOs in 1996. The average loss ratio for the year was 84.3 percent, up from 81.9 percent in 1995. The companies tracked included United Health Care, Humana Inc., Aetna and Healthsource, which also operate in Kentucky. Some HMOs saw double-digit increases in their loss ratios, Sherlock reported.



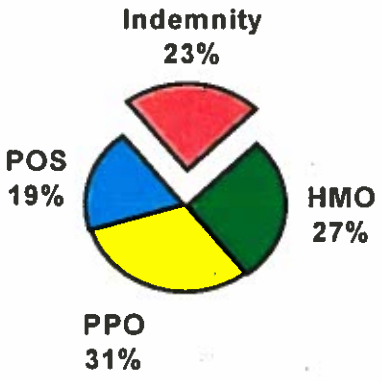
Most of the nation's 64 Blue Cross Blue Shield affiliates lost money on their underwriting in 1995 -- for the first time in seven years -- according to an analysis by Weiss Ratings Inc. The losses were greatest for Blues affiliates Anthem Insurance Companies in Indiana ($106 million total company losses reported, including Kentucky's Anthem), Empire Blue Cross/Blue Shield in New York ($97 million), Blue Cross/Blue Shield of Texas ($45.4 million), Blue Cross/Blue Shield of New Jersey ($39 million), and Pierce County Medical in Washington State ($32 million).

Reasons cited for the increases in loss ratios in 1996 include: fierce competition in the managed care market, HMOs' inexperienced forays into risk programs for Medicaid and Medicare, higher than expected outpatient claims and high pharmaceutical costs.

Sherlock reported that enrollments were up 19.2 percent for the HMOs it tracks, but operating margins declined to 0.2 percent. Investment income is what kept the bottom line in the black for many HMOs across the nation in 1996.

SAVINGS FROM NATIONAL MOVEMENT TO MANAGED CARE MAY END

More than three-fourths of Americans who had health coverage under employers' health plans were enrolled in some form of managed care plans last year. Employers' health plans covered 27 percent of their members through health maintenance organizations (HMOs), 31 percent through preferred provider organizations (PPOs) and 19 percent through point-of-service (POS) plans -- for a total of 77 percent in managed care. The numbers rose 6 percent last year from 71 percent in 1995, according to a study by the benefits consulting firm A. Foster Higgins. The American Association of Health Plans estimates that 150 million Americans are enrolled in managed care, with 59.1 million of those in HMOs.



Managed care dominates employer health plans nationally, an A. Foster Higgins study shows. Employers' ability to save costs by moving more employees to managed care is near the limit.

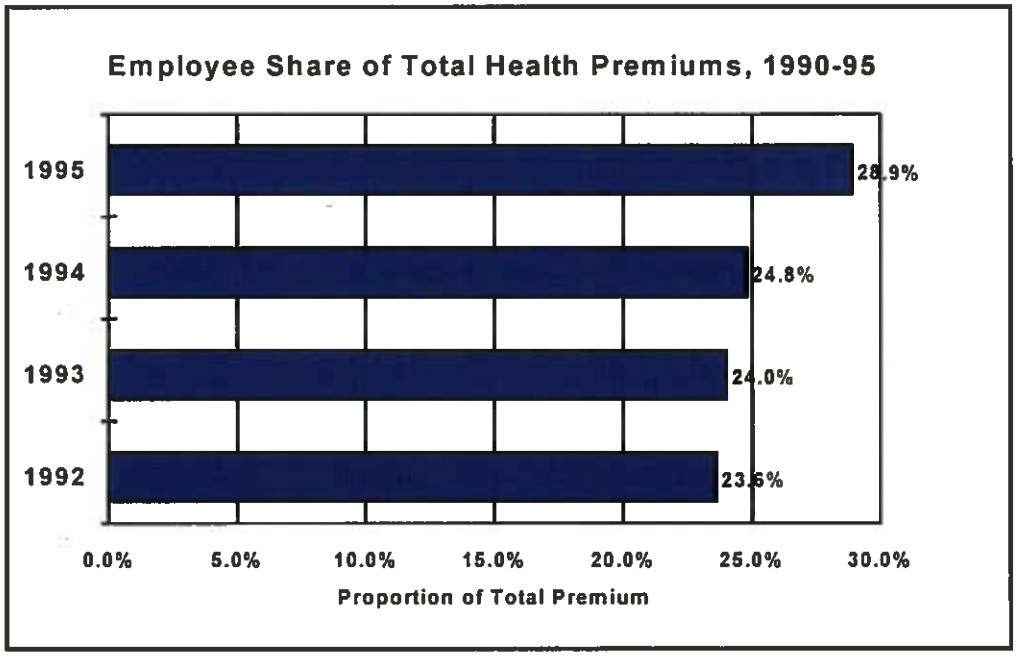
However, it should be noted that managed care has developed unevenly across the country, is still evolving in Kentucky and has not yet penetrated many parts of the state. Future savings from increased penetration of managed care in Kentucky is likely, but the amount may be limited because of Kentucky's rural nature.

CONSUMERS/EMPLOYEES PERCEIVE HIGH INCREASES IN PAST YEARS

Despite various reports showing that the national rate of increase in health insurance premiums slowed dramatically after 1990, consumers continued to perceive that the annual inflation rate was steep for health care.

A Louis A. Harris and Associates survey showed that 64 percent of respondents reported their out-of-pocket costs had increased over the past three years and 26 percent said their family health care costs were out of control.

One reason consumers may be feeling pressed even when inflation was relatively low is that employees are paying an increasingly greater share of premiums. Employees' share of the total health insurance premium rose from 23.6 percent to 28.9 percent between 1992 and 1995, according to a study by KPMG Peat Marwick. (see chart) That increase coupled with a 5.0 percent average annual increase in the total premium dug deeper into employees' pockets.



This trend has an even more significant impact on employees at Kentucky's small businesses, where premium increases have been greater than the national average in the 1990s.

RATE OF GROWTH IN HEALTH CARE EXPENDITURES: PAST AND FUTURE

As a percent of the Gross Domestic Product, health care expenditures have increased over the past decade and are expected to continue to increase. Nationally, health care expenditures *as a percent of the GDP* rose from 10.9 percent of the GDP in 1987 to 12.1 percent in 1990 to 13.9 percent in 1993 and are expected to reach 20 percent of the GDP by 2004, according to the Congressional Budget Office.

However, the annual percent growth in national expenditures for health services and supplies has slowed since the dramatic increases before 1991. The average annual growth in health expenditures between 1980 and 1990 was 10.9 percent. But expenditures increased 8.7 percent in 1991, 8.5 percent in 1992, 7.9 percent in 1993. And a study by Milliman & Robertson of

provider survey data from 1995 showed only a 3.2 percent increase in per capita spending on health care that year.

There are indications that the slowdown in the growth of health care expenditures may have been temporary, and that moderate increases in the rate will be noticed this year.

Certain segments of the health-care industry may see more dramatic increases in costs than others. A survey of the top 500 drugs dispensed in retail pharmacies showed prescription drug prices increased by 4.1 percent last year. Results of the survey, conducted for the National Association of Chain Drug Stores, was reported recently by the *Wall Street Journal.* Medical researchers see a tide of new high-tech treatments hitting the market just as waves of baby boomers' begin to suffer heart disease and other illnesses associated with aging. Because of these and other factors, William B. Schwartz, a professor of medicine at the University of Southern California, predicts annual double-digit growth in health spending well into the next century.

DRAMATIC CHANGES WITNESSED IN STRUCTURE OF THE MARKET

Changes have occurred rapidly in the health insurance market in the past 15 years. New players outside the traditional realm of the insurance industry have gained ground. Some regional HMOs have proved lean and strong. Some national HMOs have quickly grown to achieve a presence in nearly every state. Some medical providers have formed networks and are contracting directly with employers to provide HMO risk products. Mergers, alliances and consolidations among health care providers have given them more clout to negotiate with health plans and made them less-inclined to give discounts to health plans. Even public programs, such as Medicare and Medicaid, are beginning to operate through HMOs. Meanwhile, many traditional nonprofit Blue Cross/Blue Shield Plans around the country are merging with other Blues and converting to commercial carriers.

Kentucky's market has been impacted by these structural changes. Kentucky's former nonprofit Blue Cross/Blue Shield plan has been merged with the Anthem Blue Cross/Blue Shield based in Indianapolis, which in turn has become a national player in the health insurance market. Anthem has pursued acquisitions of other Blues plans, reaching to the Eastern seaboard. Meanwhile, national HMOs have moved into Kentucky. United Health Care has purchased the regional HMO Healthwise. FHP, which recently merged with PacificCare, has been growing rapidly in Northern Kentucky. As these companies forge their plans to compete on the national scene, their strategies can have a profound impact on Kentucky's market. As Kentucky policymakers seek to restructure and regulate health plans, these signficant changes in the national market must be considered.

Through corporate and structural changes, providers of health care coverage have been creating a complex conglomerate of products in which distinctions between types of health plans have blurred. HMOs, which once by definition had very limited networks of providers, now offer PPOs (preferred provider organizations) and provide self-insured products. Traditional

indemnity, or fee-for-service, plans are instituting many of the restrictions and cost-saving measures of HMOs through point-of-service (POS) plans and by requiring second opinions and referrals.

Insurance carriers and health plans are developing new relationships with hospitals and physicians, too. Some collaborate on contracts with major employers. Some have formed strategic alliances; some create new integrated health systems. These changes are significantly blurring the lines between insurer and provider.

States that are not flexible and responsive to the changes in the market may find it difficult to regulate the industry so that it remains viable and to the consumer's best advantage.

MARKET RESPONSE TO REAL AND POTENTIAL LEGISLATIVE ACTIONS

State and national legislative activities involving health insurance continue to be of preeminent importance, and complex and volatile in nature. In response, the health insurance industry's reaction to legislation or potential legislation is often complicated, conflicting and protective. When legislative mandates spread rapidly across many states -- as did mandates for maternity benefits in 1996 -- or when the 50 states enact contradictory laws governing the health insurance industry, the industry responds with actions that have the potential to drive up the cost of health coverage.

The current trend in health care/health insurance bills in state legislatures is targeted initiatives to mandate certain benefits and to give consumers more voice in coverage decisions. In 1996, 477 omnibus patient protection acts were introduced in the 44 state legislatures that were in session, according to the Health Policy Tracking Service. On the national level, President Clinton has appointed an Advisory Commission on Consumer Protection and Quality in the Health Care Industry to develop a "Consumer Bill of Rights" by March 30, 1998. This legislative trend in Washington and across the nation follows the tremendous growth in managed care in the past decade, during which managed care gained solid footing in every state and national HMOs began buying regional operations.

The impact of this legislative trend is a movement by some HMOs and insurance carriers to address these consumer-driven issues before legislation is passed. Some are meeting with insurance commissioners and agreeing on administrative regulations. Responding in part to legitimate consumer demands, in part to extensive media coverage of isolated problems and in part to ward off unwanted legislation, HMOs and insurance carriers nevertheless are making changes that may increase the costs of premiums.

UNEMPLOYMENT, ECONOMY IMPACT HEALTH INSURANCE COSTS

Studies by Foster Higgins have shown that since 1992 employees have paid 20 percent to 25 percent of their premiums for individual coverage. A survey by the Robert Wood Johnson

Foundation found that the average employer contribution to health insurance premiums was 81 percent for individual policies and 68 percent for family policies.

However, the percentage of full-time workers with health insurance declined from 76 percent in 1992 to 73 percent in 1994, reported Princeton University economists Alan B. Krueger and Helen Levy.

Kentucky Department of Insurance

KENTUCKY DEMOGRAPHICS

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employers by SIC and typical size

average wages

LEGISLATIVE RESEARCH COMMISSION
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Director

MEMORANDUM

TO: Don Cetrulo, Director
Legislative Research Commission

FROM: Ginny Wilson, Ph.D.
LRC Chief Economist

SUBJECT: Report of Data on the Number and Characteristics of Individually Insured, Small-Group Insured, and Uninsured

DATE: March 18, 1997

The purpose of this memo is to report staff analysis of newly available data on three segments of the Kentucky population — those who reported that they obtain health insurance policies in the individual segment of the health insurance market, those who reported that they obtain health insurance policies in the small group segment of the health insurance market, and those who reported that they have no health insurance, with particular attention given to those who reported being newly uninsured or having uninsured children in the household. Also included is a summary of an exploratory mail survey of small employers who offered health insurance. The data was obtained from three recent surveys of Kentucky households.

Recent policy debates on health insurance reform were hampered by the fact that little reliable information was available on the numbers and characteristics of Kentuckians in the affected segments of the insurance market. The 1996 debate on revisions to reforms initially adopted in 1994 was also hampered by the fact that little reliable data existed on the characteristics of the individual and small-group health insurance markets before any reforms were adopted, and how those markets were changed when initial reform provisions were implemented.

Since it is likely that the policy debate on health insurance reform will continue in future General Assemblies, the Legislative Research Commission sponsored a telephone survey of Kentucky households to gather data on the three segments of the insurance market most affected by changes in insurance laws, along with an additional group in which there is particularly policy interest. These are:

- Adults covered under health insurance policies purchased directly from insurance companies;
- Adults covered under health insurance policies provided through employers with fewer than 50 employees;
- The uninsured, particularly those newly uninsured within the past 12 months;
- Households with uninsured children.

Responses to the Health Insurance Survey, and other available surveys, were used to estimate characteristics of Kentuckians in the four groups of interest at the particular time data was collected. Significant changes have occurred since the data was collected, particularly in the individual insurance market, as insurers withdrew from Kentucky and as it was determined that chambers of commerce and the Farm Bureau could take into account health status in setting the premium for an individual policy. The only reliable way to assess the on-going changes in these market segments is to repeat the data collection at some reasonable interval. *Thus, survey results presented in this memo represent a* **baseline snapshot** *of the individual and small-group markets* **after** *implementation of most of the provisions of HB 250 and* **before** *implementation of most of the provisions of SB 343. Unfortunately, there is no baseline of pre-HB 250 data for comparison. In order to determine how provisions of SB 343 are affecting these markets it would be necessary to repeat the survey, and see how characteristics of policies and covered adults had changed from the baseline snapshot presented here.*

INDIVIDUALLY INSURED

1. Number

It is estimated that 5.5% of the Kentucky population (or 6.3% of the population under 65) are covered under health insurance policies purchased directly from insurance companies. Based on the 1995 Kentucky population, this is about 210,000 individuals.

2. Characteristics of Adults

- 47% were female, and 53% were male
- Average age was 43
- Median household income was between $25,000 and $35,000
- 55% worked outside the home
- 85% scored in the best two out of the four categories of a standard health status index
- 5% scored in the worst category of a standard health status index
- 27% smoked regularly in the past two years
- 60% reported 2 or fewer doctor visits in the previous year, while 12% reported 7 or more
- Nearly 30% were under age 40 and scored in the best category of the health status index.

3. Characteristics of Policies

Characteristic	Percent of Individual Policies
Issuing Company	
Blue Cross/Blue Shield	48
Humana	5
American Medical Security	3
Golden Rule	3
Kentucky Kare	3
Other	33
Unknown	6
Total	100
Purchased through KY Health Purchasing Alliance	20
Identified as a standard plan	25
Had managed care features	46
Had deductible greater than $1,000	25

4. Knowledge of Changes in the Law

- 67% had heard of changes in the law
- 37% thought the changes would directly affect them
- 28% said they were familiar with standard plans
- Slightly less than 20% correctly knew that, under standard plans, anyone could buy a policy no matter how sick, and that individuals with similar characteristics would pay the same no matter whether they were healthy or sick

1. Number

It is estimated that 9.3% of the Kentucky population (or 10.7% of the population under 65) are covered under health insurance policies purchased through an employer with fewer than 50 employees. Based on the 1995 Kentucky population, this is about 360,000 individuals.

2. Characteristics of Adults

- Females and males each accounted for about half these respondents
- Average age was 39
- Median household income was between $25,000 and $35,000
- 62% worked outside the home
- 90% scored in the best two out of the four categories of a standard health status index
- 2% scored in the worst category of a standard health status index
- 29% smoked regularly in the past two years
- 67% reported 2 or fewer doctor visits in the previous year, while 9% reported 7 or more
- Nearly 40% were under 40 and scored in the best category of the health status index.

3. Characteristics of Policies

Characteristic	Percent of Small-Group Policies
Issuing Company	
Blue Cross/Blue Shield	49
Alternative Health Delivery Systems	4
Humana	8
Aetna	2
HealthWise	2
Other	28
Unknown	7
Total	100
Purchased through KY Health Purchasing Alliance	17
Identified as a standard plan	18
Had managed care features	58
Had deductible greater than $1,000	9

4. Knowledge of Changes in the Law

- 65% had heard of changes in the law
- 24% thought the changes would directly affect them
- 21% said they were familiar with standard plans
- Approximately 13% correctly knew that, under standard plans, anyone could buy a policy no matter how sick, and that individuals with similar characteristics would pay the same no matter whether they were healthy or sick

UNINSURED

1. Number

- There has recently been some confusion about various estimates of the number of uninsured in Kentucky and whether different estimates can be used to gauge changes in the number of uninsured since new laws governing health insurance were enacted. Generally, differences in the estimates offer no reliable measure of changes in the number of uninsured in the state.
- The most recent point estimates of the percentage of uninsured in Kentucky by the Bureau of the Census from the CPS were 15.2% in 1994 and 14.6% in 1995. This gives a 1995 point estimate of about 560,000 uninsured in Kentucky.
- The standard error on either of the estimates is +/- 1.3 percent. Therefore, the Bureau did not find a statistically significant change in the state's percentage of uninsured from 1994 to 1995.
- This does not mean that it is safe to conclude that there was not a change in the number of uninsured in the state. It means that, if changes occurred, they were not large enough to be identifiable using the Bureau of the Census' current methodology for estimating the number of uninsured by state.

2. Characteristics

- Uninsured adults were significantly more likely to be younger, have less family income (median was $10,000 - $15,000), and not be currently employed than the privately insured.
- Uninsured adults were significantly more likely to have worse scores than insured adults on two items of a standard health index..
- 68% said they did not have health insurance because they could not afford it; 5% said a medical condition prevented them from getting coverage.
- 40% had been uninsured for a year or less, while 42% had been uninsured for 5 years or more. It is likely that effective policy proposals for the temporarily uninsured would be different than those for the chronically uninsured.
- Of those previously insured, 74% said coverage ended with a change in either employment or family status (such as divorce or reaching adulthood).
- 18% of the previously insured said they dropped coverage because the premium became too expensive.

3. Newly Uninsured within the Past 12 Months

- Average age was 37.
- Median household income was $15,000 - $25,000.
- 69% said previous coverage was through an employer; 24% had held an individual policy.
- 58% of the previous policies covered 1-2 adults, and no children.
- 66% said they dropped coverage because of a change in employment or family status.
- 18% of these households said they dropped coverage because they could no longer afford it. This response was given by 50% of those who had previously held an individual policy.
- 29% had heard of changes in the law but only 3% were familiar with standard plans.

UNINSURED CHILDREN

- 13% of Kentucky's children, or 125,000, are uninsured, based on an average of the estimates by the Census Bureau for 1991 - 1995.
- 43% of uninsured children live in families with incomes below 100% of the federal poverty level.
- 86% of uninsured children live in families with incomes below 250% of the federal poverty level.
- 25% of uninsured children are under 5, and 31% are between 13 and 17.
- 20% of uninsured children live with an adult who has insurance, usually through an employer.
- 82% of uninsured children live with 2 or more adults.
- The median amount adults in families with uninsured children said they would be willing to pay for one basic child's policy was $30.
- There are approximately 600,000 children in Kentucky covered by private insurance.
- Although "only" 18% of privately insured children live in families with incomes below the federal poverty level, compared to 62% of uninsured children, there are approximately 108,000 insured children in this income class, compared to about 77,000 uninsured children.
- The cost of subsidizing insurance for currently uninsured children is likely to be significantly underestimated unless the estimate incorporates the large number of insured children in the income classes deemed eligible for a subsidy. Many families with currently insured children who meet income criteria would be expected to drop current coverage to avail themselves of an income-based subsidy.

Kentucky Department of Insurance

CHARACTERISTICS OF CONSUMERS

summary report

DEMOGRAPHICS OF KENTUCKY RESIDENTS

Much has been written about the relative ability or inability of Kentuckians to purchase insurance. National and Kentucky specific demographic characteristics relative to demographic profiles impacting the purchase of health insurance are presented in Appendix H.

Kentucky Department of Insurance

INTENT OF HB 250 & SB 343

INTENTION OF HB 250

In 1992, Governor Brereton C. Jones appointed the Task Force on Health Care Access and Affordability to analyze the challenges in Kentucky's health care market. The Task Force found that health care reform in Kentucky needed to address:

- Access
- Quality
- Affordability
- Workforce
- Malpractice reform
- Medicare & workers compensation reform
- Vulnerable populations

In 1994, legislation to reform Kentucky's health care market (HB 250) was introduced to the Kentucky General Assembly. On April 15, 1994, the Kentucky Health Care Reform Bill (HB 250) was enacted by the Kentucky General Assembly and signed into law.

In enacting HB 250, the General Assembly responded to the following problems in the Kentucky health care system a referenced in "Kentucky Health Care Reform: A Citizen's Handbook":[1]

Lack of insurance and inadequate access to health care:

- Lack of health insurance largest barrier to receiving care;
- 429,000 Kentuckians are uninsured - 63% of this group are employed;
- 70% of uninsured workers are employed by firms with fewer than 25 employees; 27% of businesses with 10 or fewer employees provide health insurance;
- Nationally, three out of five uninsured workers earn less than $10,000 per year;
- Uninsured persons are three times more likely than insured persons to obtain inadequate medical care and experience adverse health outcomes;
- Some persons fail to obtain adequate health care out of inconvenience, ignorance, or inability to pay up front costs, such as deductibles.

Financial barriers to access:

- Uninsured workers are more likely to earn lower wages and be employed by small firms that offer no health benefits;
- 19% of Kentuckians are below the poverty level;
- Over 24% of people below poverty are uninsured

[1] Source: "Kentucky's Health Care Reform: A Citizen's Handbook"; Legislative Research Commission; May 1994.

- About 17% of those between 100% and 200% of poverty are uninsured (100 percent of the federal poverty level is $6,970 for one person; 200 percent is $13,940).

Insurance marketplace practices:

- Competition by health plans on the basis of risk selection and exclusion, rather than on quality, price, and service;
- Lack of available and renewable coverage due to medical underwriting practices that deny coverage based on occupation or health condition;
- Coverage gaps, exclusions, and discontinuities in care (includes job-lock and medical exclusionary riders for specific conditions);
- Risk-based rating. This causes wide variation in premiums in the individual and small group markets.

Administrative costs in private insurance policies:

- 40% of premium in individual market;
- 30% of premium in small group market.

Market fragmentation and purchaser confusion:

- Most insurers control only a small share of the market, making it difficult to exercise effective cost control over the system, and contributing to higher administrative costs.
- Small groups and individuals tend to pay higher premiums than large groups because of higher administrative costs, lack of purchasing power, and the tendency for providers and health plans to offset cost reductions given to large groups by increasing charges to small groups and individuals.

Poor allocation of health care providers in the state:

- 45 counties (37%) have a shortage of primary care physicians (based on a physician-to-population ration of 1:3,000).

In 1996, there was a movement to amend HB 250 as some did not feel that the provisions adequately addressed the challenges in Kentucky's health care system. SB 343 was enacted by the 1996 General Assembly. The most notable changes to HB 250 included the abolishment of the Kentucky Health Policy Board, the enhanced regulatory insurance rate approval process, the exemption for associations from the modified community rating provisions, and changes to the modified comjmunity rating methodology. A timeline reflecting key implementation dates for HB 250 and SB 343 follows.

OTHER INFORMATION

Appendix A

Appendix B

Appendix C

Appendix D

Appendix E

Appendix F

Appendix G

Appendix H

Appendix I

APPENDIX A

ASSOCIATION REPORTING

Association Name	Covered Lives
Kentucky Business Group • Associated Industries of Kentucky • Kentucky Automobile Dealers Association • Kentucky Alternative Wholesalers Association • Kentucky Lumber & Building Material Dealers Association • Kentucky Petroleum Marketers Association	15,409
Community Bankers of Kentucky	827
Alliance for Affordable Health Care	3,112
Independent Insurance Agents of Kentucky, Inc.	797
Wholesale Trade Industry • Kentucky Beer Wholesalers Association	5,375
National Association of Independent Truckers	2,117
National Federation of Independent Business	-0-
Kentucky County Judge/Executive Association	-0-
Kentucky Credit Union League	-0-
Kentucky Environmental Marketing Association	-0-
Kentucky Coal Association	-0-
Homebuilders Association of Kentucky	6,789
The Physicians Network	-0-
Louisville Board of Realtors	-0-
Kentucky Auto & Truck Recyclers Association	-0-
Kentucky Communications Industry • Kentucky Broadcasters Association • Kentucky Cable TV Association • Kentucky Press Association	2,494
Kentucky Medical Association	1,463
Community Action	4,546
Funeral Directors Association of Kentucky	912
International Legal Fraternity Phi Delta Phi	27

Towing & Recovering Association of Kentucky	-0-
American Veterinary Medical Association	1,077
Kentucky Gasoline Dealers Association	-0-
National Association of Rural Co-operative Members	-0-
Kentucky Dental Association	1,872
Municipal Electric Power Association of Kentucky	-0-
Kentucky Construction Industry Trust • Builders Exchange of Louisville • Associated General Contractors of Kentucky • Consulting Engineers Council of Kentucky • Kentucky Association of Highway Contractors • Kentucky Association of Plumbing-Heating-Cooling Contractors • Kentucky Crushed Stone Association • Kentucky Ready Mix Concrete Association • Kentucky Society of Architects • Western Kentucky Construction Association	32,575
Jeffersontown Chamber of Commerce	189
Northern Kentucky Chamber of Commerce	3,544
National Association for the Self-Employed	4,158
Louisville Area Chamber of Commerce	116
Kentucky Association of Counties	4,803
Kentucky Growers Association, Inc.	367
Kentucky Motor Transport Association, Inc.	-0-
Kentucky Speech-Language-Hearing Association	-0-
Council of Metro United Way Agency Executives	-0-
National Ground Water Association	401
Kentucky Association of Life Underwriters	-0-
Kentucky Florists Association	-0-
Greater Lexington Club of Printing House Craftsmen, Inc.	3,310

Kentucky Farm Bureau Federation	24,833
American Soybean Association	-0-
Better Business Bureau	-0-
Communicating for Agriculture	198
Danville-Boyle County Chamber of Commerce	-0-
Frankfort Area Chamber of Commerce	550
Greater Lexington Chamber of Commerce	-0-
American Society of Association Executives	1,088
Kentucky Fertilizer & Agricultural Chemical Association	735
Kentucky Optometric Association	661
Kentucky Retail Federation	5,786
Kentucky Thoroughbred Owners & Breeders	4,053
Mining Industry	6,159
Kentucky Feed & Grain Association	265
American College of Physicians	34
American Optometric Association	22
Kentucky Pharmacists Association	267
Kentucky Small Grain Growers Association	-0-
Kentucky Society of CPA's	2,804
Kentucky League of Cities	5,171
Kentucky Oil & Gas Association, Inc.	-0-
Kentucky Regional Business Association	-0-
Kentucky Sheet Metal Contractors Association	-0-
Louisville Chapter of the National Tooling & Machining Association	-0-
Elizabethtown-Hardin County Chamber of Commerce Association	-0-
Consumer Benefits of America	88
Kentucky Restaurant Association	200
Louisville Bar Association	-0-
Metro Seniors Association	-0-
Murray-Calloway County Chamber of Commerce	-0-
National Association of Wheat Growers	-0-
National Contract Poultry Growers Association	-0-
National Electrical Contractors Association	576

National Tire Dealers & Retreaders Association	1,562
Kentucky Corn Growers Association	-0-
Owensboro-Daviess County Chamber of Commerce	-0-
Printing Industry Association of the South	-0-
Professional Insurance Agents	58
Southeastern Lumbermen's Association, Inc.	297
Kentucky Bankers Association	*
Wine & Spirits Wholesalers of Kentucky	-0-
Associated Builders & Contractors, Inc.	-0-
Kentucky Lumber & Building Material Dealers Association	-0-

*Did not report covered lives. Specified only groups (352).

COMPANIES IDENTIFIED AS UNDERWRITING ASSOCIATION PLANS

1. Anthem Blue Cross Blue Shield
2. Humana, Inc.
3. Mega Life and Health Insurance Company/Midwest National Life Insurance Company
4. Continental General Insurance Company
5. New York Life Insurance Company
6. John Deere Insurance Company
7. John Hancock Mutual Life Insurance Company
8. ChoiceCare Health Plans, Inc.

COMPANIES IDENTIFIED AS UNDERWRITERS OF NATIONAL TRUST ASSOCIATION BUSINESS

1. American Pioneer Life Insurance Company
2. First National Life Insurance Company
3. Provident American Life & Health Insurance Company
4. Congress Life Insurance Company

Kentucky Department of Insurance

APPENDIX B

1997 HEALTH RATE FILINGS
LIFE & HEALTH DIVISION
DEPARTMENT OF INSURANCE

Company Name	Product				1996 Final Composite	1997 Trend
Aetna Life Ins. Co.	Group	POS		Alliance	new	n/a
Aetna Life Ins. Co.	Group	Mang Care		Large Grp	n/a	2.60%
Prudential Health Care	Group	Mang Care		Large Grp	3.20%	3.00%
Prudential Health Care	Group	Mang Care		Large Grp	1.80%	3.00%
Southeastern United Medigroup, Inc.	Group	POS		Alliance	n/a	2.50%
Southeastern United Medigroup, Inc.	Group	Mang Care	PPO	Pre Stand	10.36%	0.00%
Southeastern United Medigroup, Inc.	Group	Indemnity	FFS	Pre Stand	10.36%	0.00%
Southeastern United Medigroup, Inc.	Group	POS		Alliance	new	2.50%
Southeastern United Medigroup, Inc.	Group	PPO		Alliance	-2.84%	2.50%
Southeastern United Medigroup, Inc.	Group	PPO		Alliance	new	2.50%
Southeastern United Medigroup, Inc.	Group	Mang Care	POS	Pre Stand	10.89%	0.00%

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APPENDIX C

Recap Claims for Licensed HMO's
For the Year 1996

Name of HMO	Company-Wide Business	Kentucky-Wide Business	KY-Wide Domestic	KY-Wide All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
American Health Network, Inc.	0	0	Fee-for-service only	
Alternative Health Delivery System	102,941,785	87,746,322		
Anthem Health Plan	145,959,563	145,959,563		
Anthem Blue Cross and Blue Shield	554,627,304	554,627,304		
Subtotal	803,528,652	788,333,189	60.58%	57.72%
Humana Plans:				
HMPK, Inc.	39,915,515	39,616,976		
HPLAN, Inc.	5,063,662	5,057,540		
Humana Health Plan	1,035,741,756	276,699,842		
Subtotal	1,080,720,933	321,374,358	24.69%	23.53%
Other Plans:				
Advantage Care, Inc.	37,664,805	37,664,805		
Bluegrass Family Health	21,792,608	21,792,608		
CHA HMO, Inc.	14,747,883	14,747,883		
Healthsource Kentucky, Inc.	21,453,271	21,453,271		
Healthwise of Kentucky	94,468,084	94,468,084		
Owensboro Community Health Plan	1,554,651	1,554,651		
Subtotal	191,681,302	191,681,302	14.73%	14.03%
Total Domestic HMO's	**2,075,930,887**	**1,301,388,849**	100.00%	95.28%
Foreign Companies:				
AETNA Health Plan	109,535,380	8,820,401		
Choice Care	235,566,758	17,185,294		
FHP of Ohio	69,589,264	29,227,491		
Heritage National Health Plan	233,244,321	280,723		
MetraHealth Care Plan	0	0		
Prucare	2,195,278,626	8,985,727		
United Healthcare of Ohio	615543039	0		
Total Foreign HMO's	**3,458,757,388**	**64,499,636**		4.72%
Grand Total All HMO's	**5,534,688,275**	**1,365,888,485**		100.00%

Recap Premium Income for Licensed HMO's				
For the Year 1996				
	Company-Wide	Kentucky-Wide	KY-Wide	KY-Wide
Name of HMO	Business	Business	Domestic	All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
American Health Network, Inc.	6,591,037	6,591,037	Fee-for-service only	
Alternative Health Delivery System	123,534,663	105,299,440		
Anthem Health Plan	187,069,847	187,069,847		
Anthem Blue Cross and Blue Shield	588,231,689	588,231,689		
Subtotal	905,427,236	887,192,013	59.52%	56.90%
Humana Plans:				
HMPK, Inc.	43,246,058	42,969,916		
HPLAN, Inc.	5,582,614	5,576,749		
Humana Health Plan	1,211,642,037	341,276,739		
Subtotal	1,260,470,709	389,823,404	26.15%	25.00%
Other Plans:				
Advantage Care, Inc.	43,194,039	43,194,039		
Bluegrass Family Health	23,436,878	23,436,878		
CHA HMO, Inc.	12,554,857	12,554,857		
Healthsource Kentucky, Inc.	22,989,447	22,989,447		
Healthwise of Kentucky	109,541,271	109,541,271		
Owensboro Community Health Plan	1,769,489	1,769,489		
Subtotal	213,485,981	213,485,981	14.32%	13.69%
Total Domestic HMO's	**2,379,383,926**	**1,490,501,398**	100.00%	95.59%
Foreign Companies:				
AETNA Health Plan	121,451,500	8,628,063		
Choice Care	276,609,016	18,407,985		
FHP of Ohio	74,280,426	31,188,170		
Heritage National Health Plan	282,683,337	264,519		
MetraHealth Care Plan				
Prucare	2,442,019,625	10,231,785		
United Healthcare of Ohio	703,884,160	-		
Total Foreign HMO's	**3,900,928,064**	**68,720,522**		4.41%
Grand Total All HMO's	**6,280,311,990**	**1,559,221,920**		100.00%

Recap Claims Loss Ratios for Licensed HMO's

For the Year 1996

Name of HMO	Company-Wide Business	Kentucky-Wide Business		
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
American Health Network, Inc.	0.00%	0.00%	Fee-for-service only	
Alternative Health Delivery System	83.33%	83.33%		
Anthem Health Plan	78.02%	78.02%		
Anthem Blue Cross and Blue Shield	94.29%	94.29%		
Subtotal	88.75%	88.86%		
Humana Plans:				
HMPK, Inc.	92.30%	92.20%		
HPLAN, Inc.	90.70%	90.69%		
Humana Health Plan	85.48%	81.08%		
Subtotal	85.74%	82.44%		
Other Plans:				
Advantage Care, Inc.	87.20%	87.20%		
Bluegrass Family Health	92.98%	92.98%		
CHA HMO, Inc.	117.47%	117.47%		
Healthsource Kentucky, Inc.	93.32%	93.32%		
Healthwise of Kentucky	86.24%	86.24%		
Owensboro Community Health Plan	87.86%	87.86%		
Subtotal	89.79%	89.79%		
Total Domestic HMO's	**87.25%**	**87.31%**		
Foreign Companies:				
AETNA Health Plan	90.19%	102.23%		
Choice Care	85.16%	93.36%		
FHP of Ohio	93.68%	93.71%		
Heritage National Health Plan	82.51%	106.13%		
MetraHealth Care Plan				
Prucare	89.90%	87.82%		
United Healthcare of Ohio	87.45%	#DIV/0!		
Total Foreign HMO's	**88.66%**	**93.86%**		
Grand Total All HMO's	**88.13%**	**87.60%**		

Recap Claims Paid for Licensed HMO's				
For the Year 1995				
	Company-Wide	Kentucky-Wide	KY-Wide	KY-Wide
Name of HMO	Business	Business	Domestic	All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
American Health Network, Inc.	160,339	0		
Alternative Health Delivery System	115,838,956	101,185,328		
Blue Cross & Blue Sheild of Kentucky	213,165,859	213,165,859		
Southeastern United Medigroup	306,815,244	306,815,244		
Subtotal	635,980,398	621,166,431	56.23%	54.20%
Humana Plans:				
HMPK, Inc.	46,939,662	46,939,662		
HPLAN, Inc.	31,801,957	31,470,248		
Humana Health Plan	899,811,666	283,154,884		
Subtotal	978,553,285	361,564,794	32.73%	31.55%
Other Plans:				
Advantage Care, Inc.	24,826,708	24,257,005		
Bluegrass Family Health	13,149,231	13,149,231		
CHA HMO, Inc.	87,229	87,229		
Healthsource Kentucky	7,463,398	7,463,398		
Healthwise of Kentucky	77,050,791	77,050,791		
Subtotal	122,577,357	122,007,654	11.04%	10.65%
Total Domestic HMO's	**1,737,111,040**	**1,104,738,879**	100.00%	96.39%
Foreign Companies:				
AETNA Health Plan	63,019,753	852,069		
Choice Care	229,467,921	15,122,939		
FHP of Ohio	46,878,035	20,168,077		
Heritage National Healthplan	163,733,481	-		
Prucare	1,766,445,697	5,203,723		
Total Foreign HMO's	**2,269,544,887**	**41,346,808**		3.61%
Grand Total All HMO's	**4,006,655,927**	**1,146,085,687**		100.00%

Recap Premium Income for Licensed HMO's				
For the Year 1995				
	Company-Wide	Kentucky-Wide	KY-Wide	KY-Wide
Name of HMO	Business	Business	Domestic	All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
American Health Network, Inc.	0	0		
Alternative Health Delivery System	129,295,557	112,939,669		
Blue Cross & Blue Sheild of Kentucky	245,964,991	245,964,991		
Southeastern United Medigroup	362,009,026	362,009,026		
Subtotal	737,269,574	720,913,686	55.58%	53.21%
Humana Plans:				
HMPK, Inc.	52,640,437	52,640,437		
HPLAN, Inc.	32,414,424	32,070,813		
Humana Health Plan	1,075,485,097	342,652,525		
Subtotal	1,160,539,958	427,363,775	32.95%	31.54%
Other Plans:				
Advantage Care, Inc.	29,030,823	28,165,392		
Bluegrass Family Health	15,469,682	15,469,682		
CHA HMO, Inc.	90,300	90,300		
Healthsource Kentucky	8,010,501	8,010,501		
Healthwise of Kentucky	97,053,991	97,053,991		
Subtotal	149,655,297	148,789,866	11.47%	10.98%
Total Domestic HMO's	**2,047,464,829**	**1,297,067,327**	100.00%	95.74%
Foreign Companies:				
AETNA Health Plan	74,025,691	1,022,348		
Choice Care	252,678,386	24,891,834		
FHP of Ohio	53,876,610	23,181,240		
Heritage National Healthplan	155,678,755	-		
Prucare	2,042,808,523	8,665,512		
Total Foreign HMO's	**2,579,067,965**	**57,760,934**		4.26%
Grand Total All HMO's	**4,626,532,794**	**1,354,828,261**		100.00%

Recap Claims Loss Ratios for Licensed HMO's				
For the Year 1995				
	Company-Wide	Kentucky-Wide		
Name of HMO	Business	Business		
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
American Health Network, Inc.				
Alternative Health Delivery System	89.59%	89.59%		
Blue Cross & Blue Sheild of Kentucky	86.67%	86.67%		
Southeastern United Medigroup	84.75%	84.75%		
Subtotal	86.26%	86.16%		
Humana Plans:				
HMPK, Inc.	89.17%	89.17%		
HPLAN, Inc.	98.11%	98.13%		
Humana Health Plan	83.67%	82.64%		
Subtotal	84.32%	84.60%		
Other Plans:				
Advantage Care, Inc.	85.52%	86.12%		
Bluegrass Family Health	85.00%	85.00%		
CHA HMO, Inc.	96.60%	96.60%		
Healthsource Kentucky	93.17%	93.17%		
Healthwise of Kentucky	79.39%	79.39%		
Subtotal	81.91%	82.00%		
Total Domestic HMO's	**84.84%**	**85.17%**		
Foreign Companies:				
AETNA Health Plan	85.13%	83.34%		
Choice Care	90.81%	60.75%		
FHP of Ohio	87.01%	87.00%		
Heritage National Healthplan	105.17%			
Prucare	86.47%	60.05%		
Total Foreign HMO's	**88.00%**	**71.58%**		
Grand Total All HMO's	**86.60%**	**84.59%**		

Recap Claims Paid for Licensed HMO's For the Year 1994				
Name of HMO	Company-Wide Business	Kentucky-Wide Business	KY-Wide Domestic	KY-Wide All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
Alternative Health Delivery System	99,611,208	85,795,133		
Blue Cross & Blue Sheild of Kentucky	209,254,382	209,254,382		
Southeastern United Medigroup	257,274,664	245,243,844		
Subtotal	566,140,254	540,293,359	58.01%	55.69%
Humana Plans:				
HMPK, Inc.	29,948,439	29,948,439		
HPLAN, Inc.	25,777,709	25,375,029		
Humana Health Plan	750,377,075	250,354,065		
Subtotal	806,103,223	305,677,533	32.82%	31.51%
Other Plans:				
Bluegrass Family Health	3,441,368	3,441,368		
Healthwise of Kentucky	70,662,556	70,662,556		
Lexington Health Advantage, Inc.	11,340,895	11,340,895		
Subtotal	85,444,819	85,444,819	9.17%	8.81%
Total Domestic HMO's	**1,457,688,296**	931,415,711	100.00%	96.01%
Foreign Companies:				
AETNA Health Plan	22,142,472	13,252		
Choice Care	203,622,152	14,058,335		
Metlife Healthcare Network	(4,663)	(4,663)		
Prucare	1,504,114,443	5,569,707		
Takecare Health Plan Ohio	44,295,533	19,047,160		
Total Foreign HMO's	**1,774,169,937**	**38,683,791**		3.99%
Grand Total All HMO's	**3,231,858,233**	**970,099,502**		100.00%

Recap Premium Income for Licensed HMO's				
For the Year 1994				
Name of HMO	Company-Wide Business	Kentucky-Wide Business	KY-Wide Domestic	KY-Wide All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
Alternative Health Delivery System	120,274,769	103,592,659		
Blue Cross & Blue Sheild of Kentucky	273,259,286	273,259,286		
Southeastern United Medigroup	339,514,014	339,514,014		
Subtotal	733,048,069	716,365,959	59.28%	56.84%
Humana Plans:				
HMPK, Inc.	38,927,861	38,927,861		
HPLAN, Inc.	26,379,767	26,085,983		
Humana Health Plan	914,167,629	320,868,845		
Subtotal	979,475,257	385,882,689	31.93%	30.62%
Other Plans:				
Bluegrass Family Health	3,894,208	3,894,208		
Healthwise of Kentucky	88,124,558	88,124,558		
Lexington Health Advantage, Inc.	14,219,949	14,219,949		
Subtotal	106,238,715	106,238,715	8.79%	8.43%
Total Domestic HMO's	**1,818,762,041**	**1,208,487,363**	100.00%	95.89%
Foreign Companies:				
AETNA Health Plan	29,194,332	17,201		
Choice Care	235,665,702	21,813,783		
Metlife Healthcare Network	0	0		
Prucare	1,788,792,846	7,178,240		
Takecare Health Plan Ohio	52,940,395	22,764,370		
Total Foreign HMO's	**2,106,593,275**	**51,773,594**		4.11%
Grand Total All HMO's	**3,925,355,316**	**1,260,260,957**		100.00%

Recap Claims Loss Ratios for Licensed HMO's		
For the Year 1994		
Name of HMO	Company-Wide Business	Kentucky-Wide Business
Domestic Companies:		
Blue Cross - Blue Sheild Plans:		
Alternative Health Delivery System	82.82%	82.82%
Blue Cross & Blue Sheild of Kentucky	76.58%	76.58%
Southeastern United Medigroup	75.78%	72.23%
Subtotal	77.23%	75.42%
Humana Plans:		
HMPK, Inc.	76.93%	76.93%
HPLAN, Inc.	97.72%	97.27%
Humana Health Plan	82.08%	78.02%
Subtotal	82.30%	79.22%
Other Plans:		
Bluegrass Family Health	88.37%	88.37%
Healthwise of Kentucky	80.18%	80.18%
Lexington Health Advantage, Inc.	79.75%	79.75%
Subtotal	80.43%	80.43%
Total Domestic HMO's	80.15%	77.07%
Foreign Companies:		
AETNA Health Plan	75.85%	77.04%
Choice Care	86.40%	64.45%
Metlife Healthcare Network		
Prucare	84.09%	77.59%
Takecare Health Plan Ohio	83.67%	83.67%
Total Foreign HMO's	84.22%	74.72%
Grand Total All HMO's	82.33%	76.98%

Recap Claims for Licensed HMO's				
For the Year 1993				
Name of HMO	Company-Wide Business	Kentucky-Wide Business	KY-Wide Domestic	KY-Wide All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
Alternative Health Delivery System	88,977,738	76,197,140		
Blue Cross & Blue Sheild of Kentucky	116,913,027	116,913,027		
Southeastern United Medigroup	264,749,507	255,755,438		
Subtotal	470,640,272	448,865,605	55.48%	53.14%
Humana Plans:				
HMPK, Inc.	27,515,960	27,515,960		
HPLAN, Inc.	25,772,104	25,377,951		
Humana Health Plan	690,239,763	247,371,791		
Subtotal	743,527,827	300,265,702	37.12%	35.55%
Other Plans:				
Advantage Care, Inc. (Lexington Health)	148,382	143,892		
Bluegrass Family Health	-	-		
Healthwise of Kentucky	59,718,641	59,718,641		
Subtotal	59,867,023	59,862,533	7.40%	7.09%
Total Domestic HMO's	**1,274,035,122**	**808,993,840**	100.00%	95.78%
Foreign Companies:				
Choice Care	199,162,162	14,902,164		
FHP of Ohio (Takecare)	41,974,397	17,629,247		
Metlife Healthcare Network	(50,374)	(50,374)		
Prucare	1,218,735,678	3,154,582		
Total Foreign HMO's	**1,459,821,863**	**35,635,619**		4.22%
Grand Total All HMO's	**2,733,856,985**	**844,629,459**		100.00%

Recap Premium Income for Licensed HMO's				
For the Year 1993				
	Company-Wide	Kentucky-Wide	KY-Wide	KY-Wide
Name of HMO	Business	Business	Domestic	All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
Alternative Health Delivery System	99,788,539	85,455,097		
Blue Cross & Blue Sheild of Kentucky	153,345,123	153,345,123		
Southeastern United Medigroup	327,755,626	327,755,626		
Subtotal	580,889,288	566,555,846	56.05%	53.74%
Humana Plans:				
HMPK, Inc.	34,200,897	34,200,897		
HPLAN, Inc.	28,175,928	27,890,642		
Humana Health Plan	825,112,961	304,666,612		
Subtotal	887,489,786	366,758,151	36.28%	34.79%
Other Plans:				
Advantage Care, Inc. (Lexington Health)	238,682	238,682		
Bluegrass Family Health	-	-		
Healthwise of Kentucky	77,248,449	77,248,449		
Subtotal	77,487,131	77,487,131	7.67%	7.35%
Total Domestic HMO's	**1,545,866,205**	**1,010,801,128**	100.00%	95.88%
Foreign Companies:				
Choice Care	237,204,107	18,424,238		
FHP of Ohio (Takecare)	49,720,296	20,882,524		
Metlife Healthcare Network	796	796		
Prucare	1,427,128,230	4,179,762		
Total Foreign HMO's	**1,714,053,429**	**43,487,320**		4.12%
Grand Total All HMO's	**3,259,919,634**	**1,054,288,448**		100.00%

Recap Claims Loss Ratios for Licensed HMO's		
For the Year 1993		
Name of HMO	Company-Wide Business	Kentucky-Wide Business
Domestic Companies:		
Blue Cross - Blue Sheild Plans:		
Alternative Health Delivery System	89.17%	89.17%
Blue Cross & Blue Sheild of Kentucky	76.24%	76.24%
Southeastern United Medigroup	80.78%	78.03%
Subtotal	81.02%	79.23%
Humana Plans:		
HMPK, Inc.	80.45%	80.45%
HPLAN, Inc.	91.47%	90.99%
Humana Health Plan	83.65%	81.19%
Subtotal	83.78%	81.87%
Other Plans:		
Advantage Care, Inc. (Lexington Health)	62.17%	60.29%
Bluegrass Family Health	#DIV/0!	#DIV/0!
Healthwise of Kentucky	77.31%	77.31%
Subtotal	77.26%	77.25%
Total Domestic HMO's	**82.42%**	**80.03%**
Foreign Companies:		
Choice Care	83.96%	80.88%
FHP of Ohio (Takecare)	84.42%	84.42%
Metlife Healthcare Network	-6328.39%	-6328.39%
Prucare	85.40%	75.47%
Total Foreign HMO's	**85.17%**	**81.94%**
Grand Total All HMO's	**83.86%**	**80.11%**

Recap Claims for Licensed HMO's For the Year 1992				
Name of HMO	Company-Wide Business	Kentucky-Wide Business	KY-Wide Domestic	KY-Wide All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
Alternative Health Delivery System	60,109,832	50,492,259		
Southeastern United Medigroup	219,921,134	218,099,256		
Subtotal	280,030,966	268,591,515	45.83%	43.76%
Humana Plans:				
HMPK, Inc.	5,117,350	5,117,350		
HPLAN, Inc.	4,144,918	4,144,918		
Humana Health Plan	667,142,087	259,015,087		
Subtotal	676,404,355	268,277,355	45.77%	43.70%
Other Plans:				
Healthwise of Kentucky	49,240,049	49,240,049		
Subtotal	49,240,049	49,240,049	8.40%	8.02%
Total Domestic HMO's	**1,005,675,370**	**586,108,919**	100.00%	95.48%
Foreign Companies:				
Choice Care	185,630,554	10,653,276		
FHP of Ohio (Takecare)	39,267,603	16,389,711		
Metlife Healthcare Network	70,505	70,505		
Prucare	1,048,648,567	625,849		
Total Foreign HMO's	**1,273,617,229**	**27,739,341**		4.52%
Grand Total All HMO's	**2,279,292,599**	**613,848,260**		100.00%

Recap Premium Income for Licensed HMO's				
For the Year 1992				
	Company-Wide	Kentucky-Wide	KY-Wide	KY-Wide
Name of HMO	Business	Business	Domestic	All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
Alternative Health Delivery System	68,745,830	57,746,497		
Southeastern United Medigroup	271,711,523	271,711,523		
Subtotal	340,457,353	329,458,020	44.60%	42.62%
Humana Plans:				
HMPK, Inc.	5,809,419	5,809,419		
HPLAN, Inc.	4,652,459	4,610,849		
Humana Health Plan	658,723,515	335,350,632		
Subtotal	669,185,393	345,770,900	46.80%	44.73%
Other Plans:				
Healthwise of Kentucky	63,525,467	63,525,467		
Subtotal	63,525,467	63,525,467	8.60%	8.22%
Total Domestic HMO's	**1,073,168,213**	738,754,387	100.00%	95.56%
Foreign Companies:				
Choice Care	219,196,653	14,461,421		
FHP of Ohio (Takecare)	45,490,504	18,651,107		
Metlife Healthcare Network	72,541	72,541		
Prucare	1,192,633,865	1,121,587		
Total Foreign HMO's	**1,457,393,563**	**34,306,656**		4.44%
Grand Total All HMO's	**2,530,561,776**	**773,061,043**		100.00%

Recap Claims Loss Ratios for Licensed HMO's		
For the Year 1992		
	Company-Wide	Kentucky-Wide
Name of HMO	Business	Business
Domestic Companies:		
Blue Cross - Blue Sheild Plans:		
Alternative Health Delivery System	87.44%	87.44%
Southeastern United Medigroup	80.94%	80.27%
Subtotal	82.25%	81.53%
Humana Plans:		
HMPK, Inc.	88.09%	88.09%
HPLAN, Inc.	89.09%	89.89%
Humana Health Plan	101.28%	77.24%
Subtotal	101.08%	77.59%
Other Plans:		
Healthwise of Kentucky	77.51%	77.51%
Subtotal	77.51%	77.51%
Total Domestic HMO's	93.71%	79.34%
Foreign Companies:		
Choice Care	84.69%	73.67%
FHP of Ohio (Takecare)	86.32%	87.88%
Metlife Healthcare Network	97.19%	97.19%
Prucare	87.93%	55.80%
Total Foreign HMO's	87.39%	80.86%
Grand Total All HMO's	90.07%	79.40%

Recap Claims for Licensed HMO's				
For the Year 1991				
Name of HMO	Company-Wide Business	Kentucky-Wide Business	KY-Wide Domestic	KY-Wide All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
Alternative Health Delivery System	47,910,054	40,778,854		
Southeastern United Medigroup	220,878,265	220,775,453		
Subtotal	268,788,319	261,554,307	46.22%	44.49%
Humana Plans:				
Humana Medical Plan	15,636,259	15,636,259		
Humana Care Plan	89,945,029	85,769,523		
Humana Health Plan	456,789,270	153,195,233		
Subtotal	562,370,558	254,601,015	44.99%	43.31%
Other Plans:				
Healthwise of Kentucky	37,611,277	37,611,313		
HMO Kentucky	18,343,018	12,170,959		
Subtotal	55,954,295	49,782,272	8.80%	8.47%
Total Domestic HMO's	**887,113,172**	**565,937,594**	100.00%	96.27%
Foreign Companies:				
Choice Care	8,398,506	8,398,506		
Lincoln Nat. Health Plan Ohio	34,682,393	13,674,965		
Metlife Healthcare Network	(132,858)	(132,858)		
Prucare	837,330,667	-		
Total Foreign HMO's	**880,278,708**	**21,940,613**		3.73%
Grand Total All HMO's	**1,767,391,880**	**587,878,207**		100.00%

Recap Premium Income for Licensed HMO's				
For the Year 1991				
	Company-Wide	Kentucky-Wide	KY-Wide	KY-Wide
Name of HMO	Business	Business	Domestic	All Co's
Domestic Companies:				
Blue Cross - Blue Sheild Plans:				
Alternative Health Delivery System	56,703,056	47,810,049		
Southeastern United Medigroup	264,479,976	264,479,976		
Subtotal	321,183,032	312,290,025	44.86%	43.41%
Humana Plans:				
Humana Medical Plan	17,381,620	17,381,620		
Humana Care Plan	110,942,040	104,561,635		
Humana Health Plan	433,827,589	191,628,779		
Subtotal	562,151,249	313,572,034	45.05%	43.59%
Other Plans:				
Healthwise of Kentucky	50,254,226	50,254,225		
HMO Kentucky	20,099,123	19,960,439		
Subtotal	70,353,349	70,214,664	10.09%	9.76%
Total Domestic HMO's	**953,687,630**	**696,076,723**	100.00%	96.76%
Foreign Companies:				
Choice Care	10,609,056	10,609,056		
Lincoln Nat. Health Plan Ohio	40,866,930	12,662,500		
Metlife Healthcare Network	50,859	50,859		
Prucare	936,236,692	-		
Total Foreign HMO's	**987,763,537**	23,322,415		3.24%
Grand Total All HMO's	**1,941,451,167**	**719,399,138**		100.00%

Recap Claims Loss Ratios for Licensed HMO's		
For the Year 1991		
	Company-Wide	Kentucky-Wide
Name of HMO	Business	Business
Domestic Companies:		
Blue Cross - Blue Sheild Plans:		
Alternative Health Delivery System	84.49%	85.29%
Southeastern United Medigroup	83.51%	83.48%
Subtotal	83.69%	83.75%
Humana Plans:		
Humana Medical Plan	89.96%	89.96%
Humana Care Plan	81.07%	82.03%
Humana Health Plan	105.29%	79.94%
Subtotal	100.04%	81.19%
Other Plans:		
Healthwise of Kentucky	74.84%	74.84%
HMO Kentucky	91.26%	60.98%
Subtotal	79.53%	70.90%
Total Domestic HMO's	**93.02%**	**81.30%**
Foreign Companies:		
Choice Care	79.16%	79.16%
Lincoln Nat. Health Plan Ohio	84.87%	108.00%
Metlife Healthcare Network	-261.23%	-261.23%
Prucare	89.44%	#DIV/0!
Total Foreign HMO's	**89.12%**	**94.08%**
Grand Total All HMO's	**91.03%**	**81.72%**

APPENDIX D

Companies Selling Individual Health Coverage Prior to HB 250						
Premiums 1991 to 1996						
Company	1996	1995	1994	1993	1992	1991
Advantage Care	43,194,039	28,165,392	-	-	-	-
Aetna Life Insurance Co	17,094,140	18,310,095	18,979,957	13,286,117	8,502,060	19,640,346
Aid Association for Lutherans	220,964	234,569	247,446	208,435	201,459	175,092
American Chambers Life Ins Co	102,170	146,290	199,496	200,860	254,609	278,870
American Fidelity Assurance Co	4,435,129	4,255,587	3,943,766	3,358,684	3,174,322	2,764,642
American National Ins Co	940,814	2,100,518	2,104,274	2,310,564	1,370,132	1,501,360
American National Insurance Co of TX	22,836	321,254	550,890	697,811	874,939	516,332
American Pioneer Life Insurance Co	498,143	716,095	810,475	699,254	547,460	663,083
Southeastern United Medigroup, Inc Southeastern Group, Inc Blue Cross and Blue Shield of Kentucky	887,192,013	720,913,686	716,365,959	566,555,846	329,458,020	312,290,025
Celtic Life Ins Co (The)	895,366	1,165,872	1,158,449	1,187,454	1,256,936	1,425,763
Central Benefits National Life Ins Co	2,052,014	3,921,667	5,296,030	5,151,667	5,808,475	5,407,443
Central Reserve Life Ins Co (The)	201,472	1,738,686	2,373,610	2,449,223	1,966,179	1,306,937
Equitable Life Assurance Society of the U.S.	508,539	530,517	584,608	2,612,832	3,998,240	4,212,613
Fortis Benefits Ins Co	10,385,598	11,684,516	9,273,340	8,328,538	9,692,365	3,433,314
Golden Rule Ins Co (The)	6,659,326	13,037,337	13,866,475	15,275,993	13,950,095	11,363,650
Hartford Life and Accident Ins Co	4,882,047	3,005,898	3,816,570	5,456,926	2,769,338	2,490,980
Humana Plans	389,823,404	427,363,775	385,882,689	366,758,151	345,770,900	313,572,034
John Alden Life Ins Co	9,045,442	22,576,096	23,583,026	18,808,839	12,109,230	9,444,101
John Hancock Mutual Life Ins Co	3,327,035	3,741,648	2,876,580	3,525,556	2,983,266	1,708,911
Life Insurance Co of Georgia	2,263,029	2,532,976	2,786,313	837,634	995,000	1,062,007
Life Insurance Co of North America	3,915,945	4,649,940	5,440,547	3,146,981	1,680,677	1,337,302
Mega Life and Health Ins Co	3,487,128	2,914,958	1,998,442	1,651,145	1,776,137	1,428,830
Metropolitan Life Ins Co	14,464,340	13,282,143	13,837,223	11,454,087	14,956,583	11,721,032
Mid-West National Life Ins Co of TN	609,375	609,375	107,580	180,609	147,844	201,224
Mutual of Omaha Ins Co	12,088,080	12,190,972	13,112,533	14,351,414	9,218,347	8,913,427
New York Life Ins Co	6,756,812	8,950,018	8,466,251	7,278,038	6,005,306	5,564,796
Nippon Life Ins Co of America	416,221	2,119,203	2,396,816	1,711,345	617,248	-

The above figures represent all health products: disability income, workers' comp, etc. as well as individual and group medical expense plans. The reporting formats do not provide for companies to report in detail by product lines.

Companies Selling Individual Health Coverage Prior to HB 250						
Premiums 1991 to 1996						
Company	1996	1995	1994	1993	1992	1991
Philadeophia American Life Ins Co	107,397	233,765	547,225	694,393	821,837	473,957
Pioneer Life Ins Co of IL	13,555,828	15,646,334	14,903,377	15,051,208	14,411,598	14,334,959
Principal Mutual Life Ins Co	9,765,109	19,036,914	20,920,964	18,986,237	15,886,555	12,638,882
Protective Life Ins Co	3,517,869	2,706,083	2,380,801	2,537,599	1,823,633	1,226,605
Prudential Ins Co of America	56,665,600	49,366,222	47,248,372	51,168,844	49,918,627	46,010,438
Pyramid Life Ins Co	1,041,075	1,349,267	1,641,310	1,566,789	1,549,688	1,234,262
Shelter Life Ins Co	575,574	1,371,426	2,288,429	2,612,381	2,849,574	3,224,512
State Farm	6,178,408	7,802,147	13,988,704	16,943,679	16,872,937	16,129,868
Time Ins Co	3,817,269	15,813,646	17,058,117	17,654,528	18,453,424	17,052,781
Travelers Ins Co	2,245,777	17,729,058	25,166,511	18,263,864	16,244,837	16,705,521
Trustmark Ins Co (Mutual)	1,533,795	2,075,244	2,329,913	5,277,212	4,296,679	3,838,543
Union Bankers Ins Co	4,997,711	5,151,169	5,747,814	5,838,684	5,553,343	5,116,409
United Wisconsin Life Ins Co	16,044,921	6,590,645	2,555,266	709,733	-	-
United World Life Insurance Company	243,297	315,157	146,955	18,036	11,111	-
Washington National Ins Co	4,477,217	5,614,321	5,789,518	5,708,275	4,592,712	3,409,547
Total Premiums	1,507,054,229	1,433,815,089	1,402,772,621	1,220,515,465	933,371,722	863,820,398

The above figures represent all health products: disability income, workers' comp, etc. as well as individual and group medical expense plans. The reporting formats do not provide for companies to report in detail by product lines.

Companies Selling Individual Health Coverage Prior to HB 250						
Claims 1991 to 1996						
Company	1996	1995	1994	1993	1992	1991
Advantage Care	37,664,805	24,257,005	-	-	-	-
Aetna Life Insurance Co	19,088,291	16,996,409	15,537,546	9,061,183	8,199,397	25,873,703
Aid Association for Lutherans	71,875	91,405	69,074	71,342	76,293	41,158
American Chambers Life Ins Co	95,997	98,638	81,604	207,838	786,765	231,098
American Fidelity Assurance Co	2,202,365	1,758,000	2,132,446	1,420,203	1,442,188	1,118,414
American National Ins Co	1,243,004	2,161,873	1,923,914	1,615,893	1,826,121	1,122,170
American National Insurance Co of TX	119,019	181,447	357,714	346,691	211,199	65,434
American Pioneer Life Insurance Co	344,976	496,485	336,989	159,049	376,237	321,842
Southeastern United Medigroup, Inc						
Southeastern Group, Inc						
Blue Cross and Blue Shield of Kentucky	788,333,189	621,166,431	540,293,359	448,865,605	268,591,515	261,554,307
Celtic Life Ins Co (The)	1,195,867	632,691	498,623	529,566	582,110	703,513
Central Benefits National Life Ins Co	2,420,171	4,057,566	4,128,434	4,461,985	5,027,496	3,659,199
Central Reserve Life Ins Co (The)	550,662	1,556,525	1,512,880	1,353,009	993,343	974,193
Equitable Life Assurance Society of the U.S.	352,405	530,250	474,083	2,367,735	3,227,442	3,983,147
Fortis Benefits Ins Co	10,884,493	9,617,296	7,162,826	6,478,007	6,817,420	1,797,550
Golden Rule Ins Co (The)	6,621,283	10,110,809	10,414,775	9,398,272	7,947,712	6,740,342
Hartford Life and Accident Ins Co	2,260,375	1,199,996	3,903,836	2,911,399	1,997,633	1,081,769
Humana Plans	321,374,358	361,564,794	305,677,533	300,265,702	268,277,355	264,601,015
John Alden Life Ins Co	10,272,163	17,325,432	16,941,651	11,077,927	7,673,721	6,970,668
John Hancock Mutual Life Ins Co	2,146,745	2,676,417	2,041,781	1,642,653	1,874,075	1,320,152
Life Insurance Co of Georgia	1,635,096	1,270,886	1,477,567	240,866	286,254	406,343
Life Insurance Co of North America	5,205,884	5,950,662	3,967,321	3,036,184	2,986,993	2,917,123
Mega Life and Health Ins Co	1,589,098	1,169,382	904,120	825,986	940,917	435,082
Metropolitan Life Ins Co	9,070,746	12,509,929	11,704,933	10,708,934	11,352,278	9,996,149
Mid-West National Life Ins Co of TN	54,179	54,179	100,480	32,652	182,116	301,716
Mutual of Omaha Ins Co	9,735,340	8,001,606	8,523,289	9,370,487	5,471,018	5,493,872
New York Life Ins Co	5,222,674	7,708,040	6,782,206	5,953,612	5,138,587	3,400,176
Nippon Life Ins Co of America	1,216,803	1,737,574	1,773,505	1,239,366	243,399	-

The above figures represent all health products: disability income, workers' comp, etc. as well as individual and group medical expense plans. The reporting formats do not provide for companies to report in detail by product lines.

Companies Selling Individual Health Coverage Prior to HB 250						
Claims 1991 to 1996						
Company	1996	1995	1994	1993	1992	1991
Philadeophia American Life Ins Co	83,105	154,868	384,910	757,406	345,307	250,139
Pioneer Life Ins Co of IL	10,164,733	10,441,871	8,941,234	7,975,238	8,293,545	7,667,127
Principal Mutual Life Ins Co	9,608,483	17,132,782	16,196,666	14,326,226	12,530,106	9,017,634
Protective Life Ins Co	1,876,986	1,176,701	1,144,193	1,152,985	721,226	576,531
Prudential Ins Co of America	49,117,045	48,199,580	43,013,576	41,181,904	41,725,607	38,370,623
Pyramid Life Ins Co	776,266	1,225,876	1,036,220	1,097,678	688,186	648,362
Shelter Life Ins Co	461,725	1,884,393	2,413,722	2,798,159	4,444,448	2,641,226
State Farm	4,593,194	7,317,977	10,090,646	10,941,795	12,844,336	12,827,424
Time Ins Co	4,993,593	12,268,608	11,342,980	11,200,393	11,847,336	9,886,943
Travelers Ins Co	5,513,890	17,523,365	23,897,339	16,662,794	14,942,323	15,378,176
Trustmark Ins Co (Mutual)	933,617	1,642,064	1,859,479	2,170,119	2,684,154	2,383,301
Union Bankers Ins Co	4,135,221	3,494,321	3,497,495	3,600,052	2,999,851	3,008,208
United Wisconsin Life Ins Co	17,968,486	4,215,075	1,652,390	-	-	-
United World Life Insurance Company	429,606	156,075	38,775	1,946	467	-
Washington National Ins Co	2,594,170	3,187,291	2,698,862	2,361,599	1,759,198	1,198,933
Total Claims	1,316,557,178	1,220,645,569	1,076,930,976	949,870,440	728,355,674	708,964,762

The above figures represent all health products: disability income, workers' comp, etc. as well as individual and group medical expense plans. The reporting formats do not provide for companies to report in detail by product lines.

Companies Selling Individual Health Coverage Prior to HB 250 Claims Loss Ratios 1991 to 1996						
Company	1996	1995	1994	1993	1992	1991
Advantage Care	87.20%	86.12%	0.00%	0.00%	0.00%	0.00%
Aetna Life Insurance Co	111.67%	92.83%	81.86%	68.20%	96.44%	131.74%
Aid Association for Lutherans	32.53%	38.97%	27.91%	34.23%	37.87%	23.51%
American Chambers Life Ins Co	93.96%	67.43%	40.91%	103.47%	309.01%	82.87%
American Fidelity Assurance Co	49.66%	41.31%	54.07%	42.28%	45.43%	40.45%
American National Ins Co	132.12%	102.92%	91.43%	69.94%	133.28%	74.74%
American National Insurance Co of TX	521.19%	56.48%	64.93%	49.68%	24.14%	12.67%
American Pioneer Life Insurance Co	69.25%	69.33%	41.58%	22.75%	68.72%	48.54%
Southeastern United Medigroup, Inc Southeastern Group, Inc Blue Cross and Blue Shield of Kentucky	88.86%	86.16%	75.42%	79.23%	81.53%	83.75%
Celtic Life Ins Co (The)	133.56%	54.27%	43.04%	44.60%	46.31%	49.34%
Central Benefits National Life Ins Co	117.94%	103.47%	77.95%	86.61%	86.55%	67.67%
Central Reserve Life Ins Co (The)	273.32%	89.52%	63.74%	55.24%	50.52%	74.54%
Equitable Life Assurance Society of the U.S.	69.30%	99.95%	81.09%	90.62%	80.72%	94.55%
Fortis Benefits Ins Co	104.80%	82.31%	77.24%	77.78%	70.34%	52.36%
Golden Rule Ins Co (The)	99.43%	77.55%	75.11%	61.52%	56.97%	59.31%
Hartford Life and Accident Ins Co	46.30%	39.92%	102.29%	53.35%	72.13%	43.43%
Humana Plans	82.44%	84.60%	79.22%	81.87%	77.59%	84.38%
John Alden Life Ins Co	113.56%	76.74%	71.84%	58.90%	63.37%	73.81%
John Hancock Mutual Life Ins Co	64.52%	71.53%	70.98%	46.59%	62.82%	77.25%
Life Insurance Co of Georgia	72.25%	50.17%	53.03%	28.76%	28.77%	38.26%
Life Insurance Co of North America	132.94%	127.97%	72.92%	96.48%	177.73%	218.13%
Mega Life and Health Ins Co	45.57%	40.12%	45.24%	50.03%	52.98%	30.45%

The above figures represent all health products: disability income, workers' comp, etc. as well as individual and group medical expense plans. The reporting formats do not provide for companies to report in detail by product lines.

Companies Selling Individual Health Coverage Prior to HB 250						
Claims Loss Ratios 1991 to 1996						
Company	1996	1995	1994	1993	1992	1991
Metropolitan Life Ins Co	62.71%	94.19%	84.59%	93.49%	75.90%	85.28%
Mid-West National Life Ins Co of TN	8.89%	8.89%	93.40%	18.08%	123.18%	149.94%
Mutual of Omaha Ins Co	80.54%	65.64%	65.00%	65.29%	59.35%	61.64%
New York Life Ins Co	77.29%	86.12%	80.11%	81.80%	85.57%	61.10%
Nippon Life Ins Co of America	292.35%	81.99%	73.99%	72.42%	39.43%	0.00%
Philadeophia American Life Ins Co	77.38%	66.25%	70.34%	109.07%	42.02%	52.78%
Pioneer Life Ins Co of IL	74.98%	66.74%	59.99%	52.99%	57.55%	53.49%
Principal Mutual Life Ins Co	98.40%	90.00%	77.42%	75.46%	78.87%	71.35%
Protective Life Ins Co	53.36%	43.48%	48.06%	45.44%	39.55%	47.00%
Prudential Ins Co of America	86.68%	97.64%	91.04%	80.48%	83.59%	83.40%
Pyramid Life Ins Co	74.56%	90.85%	63.13%	70.06%	44.41%	52.53%
Shelter Life Ins Co	80.22%	137.40%	105.48%	107.11%	155.97%	81.91%
State Farm	74.34%	93.79%	72.13%	64.58%	76.12%	79.53%
Time Ins Co	130.82%	77.58%	66.50%	63.44%	64.20%	57.98%
Travelers Ins Co	245.52%	98.84%	94.96%	91.23%	91.98%	92.05%
Trustmark Ins Co (Mutual)	60.87%	79.13%	79.81%	41.12%	62.47%	62.09%
Union Bankers Ins Co	82.74%	67.84%	60.85%	61.66%	54.02%	58.80%
United Wisconsin Life Ins Co	111.99%	63.96%	64.67%	0.00%	0.00%	0.00%
United World Life Insurance Company	176.58%	49.52%	26.39%	10.79%	4.20%	0.00%
Washington National Ins Co	57.94%	56.77%	46.62%	41.37%	38.30%	35.16%
Total Claims Loss Ratios	87.36%	85.13%	73.72%	77.83%	78.03%	82.07%

The above figures represent all health products: disability income, workers' comp, etc. as well as individual and group medical expense plans. The reporting formats do not provide for companies to report in detail by product lines.

APPENDIX E

INDEMNITY PLANS

Effective January 1, 1997

BENEFIT / PLAN COST SHARING	BUDGET LOW	BUDGET HIGH	ECONOMY LOW	ECONOMY HIGH	STANDARD LOW (BASIC PLAN)	STANDARD HIGH	ENHANCED LOW	ENHANCED HIGH
REGULAR PLANS								
Deductible	Single $3,000 Family $6,000	Single $2,500 Family $5,000	Single $1,000 Family $2,000	Single $750 Family $1,500	Single $750 Family $1,500	Single $400 Family $800	Single $200 Family $400	Single $150 Family $300
Maximum Out-of-Pocket for Covered Expenses (Infertility Services Do Not Apply)	Single $6,000 Family $12,000 (After Deductible)	Single $5,000 Family $10,000 (After Deductible)	Single $4,000 Family $8,000 (After Deductible)	Single $2,500 Family $5,000 (After Deductible)	Single $2,500 Family $5,000 (After Deductible)	Single $1,500 Family $3,000 (After Deductible)	Single $1,250 Family $2,500 (After Deductible)	Single $1,000 Family $2,000 (After Deductible)
Coinsurance	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service
PPO PLANS								
IN-NETWORK								
Deductible	Not Available	Single $2,500 Family $5,000	Single $1,000 Family $2,000	Single $750 Family $1,500	Single $750 Family $1,500	Single $400 *** Family $800	Single $200 Family $400	Single $150 Family $300
Maximum Out-of-Pocket for Covered Expenses (Infertility Services Do Not Apply)		Single $5,000 Family $10,000 (After Deductible)	Single $4,000 Family $8,000 (After Deductible)	Single $2,500 Family $5,000 (After Deductible)	Single $2,500 Family $5,000 (After Deductible)	Single $1,500 Family $3,000 (After Deductible)	Single $1,250 Family $2,500 (After Deductible)	Single $1,000 Family $2,000 (After Deductible)
Provider Office Visit Copayments (includes well child, well adult, immunizations, office diagnostic testing, allergy testing and other office visits) *		$25 Copay Per Visit No Deductible	$20 Copay Per Visit No Deductible	$15 Copay Per Visit No Deductible	$15 Copay Per Visit No Deductible	$10 Copay Per Visit No Deductible	$10 Copay Per Visit No Deductible	$5 Copay Per Visit No Deductible
Coinsurance (Other Than Provider Office Visits)		As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service
OUT-OF-NETWORK **								
Deductible		Single $3,000 Family $6,000	Single $1,500 Family $3,000	Single $1,200 Family $2,400	Single $1,200 Family $2,400	Single $700 Family $1,400	Single $400 Family $800	Single $300 Family $600
Maximum Out of Pocket for Covered Expenses		Single $6,000 Family $12,000 After Deductible	Single $5,000 Family $10,000 After Deductible	Single $3,500 Family $7,000 After Deductible	Single $3,500 Family $7,000 After Deductible	Single $2,500 Family $5,000 After Deductible	Single $2,250 Family $4,500 After Deductible	Single $2,000 Family $4,000 After Deductible
Coinsurance		As Indicated for Each Service plus 20%	As Indicated for Each Service Plus 20%	As Indicated for Each Service Plus 20%	As Indicated for Each Service Plus 20%	As Indicated for Each Service Plus 20%	As Indicated for Each Service Plus 20%	As Indicated for Each Service Plus 20%

* THE BUDGET LOW AND HIGH PLANS DO NOT PROVIDE COVERAGE FOR ALLERGY TESTING.

** PPO PLANS OUT-OF-NETWORK COVERAGE IS LIMITED TO USUAL, CUSTOMARY AND REASONABLE CHARGES.
PPO PLANS OUT-OF-NETWORK COVERAGE IS NOT AVAILABLE FOR INFERTILITY SERVICES AND PREVENTIVE CARE.
PPO PLANS OUT-OF-NETWORK COVERAGE FOR TRANSPLANTS, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES IS SUBJECT TO CERTIFICATION.

*** PPO IN-NETWORK DEDUCTIBLE DOES NOT APPLY TO COVERED EXPENSES FOR IN-HOSPITAL CARE

INDEMNITY PLANS

BENEFIT	BUDGET LOW	BUDGET HIGH	ECONOMY LOW	ECONOMY HIGH	STANDARD LOW	STANDARD HIGH	ENHANCED LOW	ENHANCED HIGH
IN-HOSPITAL CARE								
Provider Services, Authorized Inpatient Care, Semi-Private Room and Misc. Hospital Services, Intensive/Cardiac/Neonatal Care, Ancillary Services, Pre-Admission Testing	50% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	40% Coinsurance Deductible Applies	30% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	15% Coinsurance Deductible Applies (No Deductible Applies to PPO Plans In-Network)	15% Coinsurance Deductible Applies	10% Coinsurance Deductible Applies
Transplant Coverage (Limited to Kidney, Cornea, Bone Marrow, Heart, Liver, Lung, Heart/Lung and Pancreas) *	50% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	40% Coinsurance Deductible Applies	30% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	15% Coinsurance Deductible Applies (No Deductible Applies to PPO Plans In-Network)	15% Coinsurance Deductible Applies	10% Coinsurance Deductible Applies
OUTPATIENT SERVICES								
Provider Office Visit, Diagnostic Testing, Allergy Testing **	50% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	40% Coinsurance Deductible Applies	30% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	15% Coinsurance Deductible Applies	10% Coinsurance Deductible Applies
Ambulatory/Hospital Outpatient Surgery	50% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	40% Coinsurance Deductible Applies	30% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	15% Coinsurance Deductible Applies	10% Coinsurance Deductible Applies
Allergy Serum and Injections	Not Covered	Not Covered	40% Coinsurance Deductible Applies	30% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	15% Coinsurance Deductible Applies	10% Coinsurance Deductible Applies
Infertility Services ***	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	50% Coinsurance Deductible Applies (Out-of-Pocket Maximum Not Applicable)	50% Coinsurance Deductible Applies (Out-of-Pocket Maximum Not Applicable)
MATERNITY CARE								
Prenatal, Labor and Delivery, and Postpartum ****	Not Covered	20% Coinsurance Deductible Applies	40% Coinsurance Deductible Applies	30% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	15%Coinsurance***** Deductible Applies	15% Coinsurance Deductible Applies	10% Coinsurance Deductible Applies
Pregnancy of Dependents Other Than Spouse	Not Covered	Not Covered	Covered Same as Spouse Pregnancy	Covered Same as Spouse Pregnancy	Covered Same as Spouse Pregnancy	Covered Same as Spouse Pregnancy	Covered Same as Spouse Pregnancy	Covered Same as Spouse Pregnancy

* PPO PLANS OUT-OF-NETWORK COVERAGE FOR TRANSPLANT SERVICES IS SUBJECT TO CERTIFICATION.
** THE BUDGET LOW AND HIGH PLANS DO NOT PROVIDE COVERAGE FOR ALLERGY TESTING.
*** PPO PLANS OUT-OF-NETWORK COVERAGE FOR INFERTILITY SERVICES IS NOT AVAILABLE.
**** FOR PPO PLANS IN-NETWORK COVERAGE, THE INITIAL OFFICE VISIT IN WHICH PREGNANCY IS DIAGNOSED IS SUBJECT TO THE PROVIDER OFFICE VISIT COPAYMENT. NO ADDITIONAL COPAYMENTS WILL BE APPLIED TO PRENATAL VISITS. ALL OTHER IN-NETWORK MATERNITY EXPENSES ARE SUBJECT TO THE DEDUCTIBLE AND COINSURANCE EXCEPT AS NOTED BELOW.
***** FOR PPO PLANS IN-NETWORK COVERAGE, NO DEDUCTIBLE APPLIES TO THE HOSPITAL ADMISSION (STANDARD HIGH PLAN ONLY).

INDEMNITY PLANS

BENEFIT	BUDGET LOW	BUDGET HIGH	ECONOMY LOW	ECONOMY HIGH	STANDARD LOW	STANDARD HIGH	ENHANCED LOW	ENHANCED HIGH
EMERGENCY SERVICES Hospital Emergency Room (Coinsurance Waived if Admitted) Ambulance (Ground Only)	50% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	40% Coinsurance Deductible Applies	30% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	15% Coinsurance Deductible Applies	10% Coinsurance Deductible Applies
PREVENTIVE SERVICES Immunizations *	Not Covered	20% Coinsurance No Deductible	20% Coinsurance No Deductible	20% Coinsurance No Deductible	10% Coinsurance No Deductible	10% Coinsurance No Deductible	10% Coinsurance No Deductible	10% Coinsurance No Deductible
Well Child Care * Plan Year Limit: Ages 0 through 3 and 4 through 10	Not Covered	Office visits covered up to $200 (Ages 0-3) and $100 (Ages 4-10) Per Plan Year - No Coverage Above Limit No Deductible - No Coinsurance	Office visits covered up to $200 (Ages 0-3) and $100 (Ages 4-10) Per Plan Year - No Coverage Above Limit No Deductible - No Coinsurance	Office visits covered up to $200 (Ages 0-3) and $100 (Ages 4-10) Per Plan Year - No Coverage Above Limit No Deductible - No Coinsurance	Office visits covered up to $200 (Ages 0-3) and $100 (Ages 4-10) Per Plan Year - No Coverage Above Limit No Deductible - No Coinsurance	Office visits covered up to $200 (Ages 0-3) and $100 (Ages 4-10) Per Plan Year - No Coverage Above Limit No Deductible - No Coinsurance	Office visits covered up to $200 (Ages 0-3) and $100 (Ages 4-10) Per Plan Year - No Coverage Above Limit No Deductible - No Coinsurance	Office visits covered up to $200 (Ages 0-3) and $100 (Ages 4-10) Per Plan Year - No Coverage Above Limit No Deductible - No Coinsurance
Well Adult Care * Periodic Routine Physical Examination and Annual Gynecological Examination Early Detection Mammogram, Pap Test, Cardiac Risk, PSA, Sigmoidoscopy, Glucose Serum, EKG	Screening Mammogram Coverage Only - $50 Per Mammogram Limit Age and Periodicity Limits May Apply No Deductible	$300 Per Plan Year Limit For All Well Adult and Early Detection Services Combined - No Coverage Above Limit - No Coinsurance Age and Periodicity Limits May Apply No Deductible	$300 Per Plan Year Limit For All Well Adult and Early Detection Services Combined - No Coverage Above Limit - No Coinsurance Age and Periodicity Limits May Apply No Deductible	$300 Per Plan Year Limit For All Well Adult and Early Detection Services Combined - No Coverage Above Limit - No Coinsurance Age and Periodicity Limits May Apply No Deductible	$300 Per Plan Year Limit For All Well Adult and Early Detection Services Combined - No Coverage Above Limit - No Coinsurance Age and Periodicity Limits May Apply No Deductible	$300 Per Plan Year Limit For All Well Adult and Early Detection Services Combined - No Coverage Above Limit - No Coinsurance Age and Periodicity Limits May Apply No Deductible	$300 Per Plan Year Limit For All Well Adult and Early Detection Services Combined - No Coverage Above Limit - No Coinsurance Age and Periodicity Limits May Apply No Deductible	$300 Per Plan Year Limit For All Well Adult and Early Detection Services Combined - No Coverage Above Limit - No Coinsurance Age and Periodicity Limits May Apply No Deductible

* PPO PLANS OUT-OF-NETWORK PREVENTIVE SERVICES ARE NOT AVAILABLE.

INDEMNITY PLANS

BENEFIT	BUDGET LOW	BUDGET HIGH	ECONOMY LOW	ECONOMY HIGH	STANDARD LOW	STANDARD HIGH	ENHANCED LOW	ENHANCED HIGH
SUBSTANCE ABUSE								
Inpatient *	Not Covered	Not Covered	40% Coinsurance Maximum 10 days per plan year and 1 admission per plan year Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies	30% Coinsurance Maximum 10 days per plan year and 1 admission per plan year Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies	20% Coinsurance Maximum 21 days per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies	20% Coinsurance Maximum 21 days per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies	15% Coinsurance Maximum 30 days per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies	10% Coinsurance Maximum 30 days Per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies
Outpatient *	Not Covered	Not Covered	40% Coinsurance 20 visits per plan Yr. Deductible Applies	30% Coinsurance 20 visits per plan yr. Deductible Applies	20% Coinsurance 20 Visits Per Plan Yr. Deductible Applies	20% Coinsurance 20 Visits Per Plan Yr. Deductible Applies	15% Coinsurance 30Visits Per Plan Yr. Deductible Applies	10% Coinsurance 30 Visits Per Plan Yr. Deductible Applies
MENTAL HEALTH								
Inpatient *	Not Covered	20% Coinsurance Maximum 5 days per plan year and 1 admission per plan year. Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies	40% Coinsurance Maximum 10 days per plan year and 1 admission per plan year. Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies	30% Coinsurance Maximum 10 days per plan year and 1 admission per plan year. Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies	20% Coinsurance Maximum 21 days per plan year and 1 admission per 6 months. Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies	20% Coinsurance Maximum 21 days per plan year and 1 admission per 6 months. Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies	15% Coinsurance Maximum 30 days per plan year and 1 admission per 6 months. Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies	10% Coinsurance Maximum 30 days per plan year and 1 admission per 6 months. Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis Deductible Applies
Outpatient *	Not Covered	20 % Coinsurance 10 visits per plan yr. Deductible Applies	40% Coinsurance 20 visits per plan yr. Deductible Applies	30% Coinsurance 20 visits per plan yr. Deductible Applies	20% Coinsurance 20 visits per plan yr. Deductible Applies	20% Coinsurance 20 visits per plan yr. Deductible Applies	15% Coinsurance 30 visits per plan yr. Deductible Applies	10% Coinsurance 30 visits per plan yr. Deductible Applies

* PPO PLANS OUT-OF-NETWORK COVERAGE FOR SUBSTANCE ABUSE AND MENTAL HEALTH IS SUBJECT TO CERTIFICATION.

INDEMNITY PLANS

BENEFIT	BUDGET LOW	BUDGET HIGH	ECONOMY LOW	ECONOMY HIGH	STANDARD LOW	STANDARD HIGH	ENHANCED LOW	ENHANCED HIGH
OTHER SERVICES								
Prescription Drugs	Not Covered	Not Covered	40% Coinsurance 1 Month Supply Deductible Applies	30% Coinsurance 1 Month Supply Deductible Applies	20% Coinsurance 1 Month Supply Deductible Applies	20% Coinsurance 1 Month Supply Deductible Applies	15% Coinsurance 1 Month Supply Deductible Applies	10% Coinsurance 1 Month Supply Deductible Applies
Contraceptives (PPO Coverage In Network Only)	Not Covered	Not Covered	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs	Covered Same and Prescription Drugs	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs
Dental	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Vision	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	10% Coinsurance for annual exam every year to age 18 and every other year after age 18 Deductible Applies
Physical/Occupational/Cardiac Rehabilitation Therapy	Not Covered	Not Covered	40% Coinsurance 13 Weeks Plan Yr. Limit Deductible Applies	30% Coinsurance 13 Weeks Plan Yr. Limit Deductible Applies	20% Coinsurance 26 Weeks Plan Yr. Limit Deductible Applies	20% Coinsurance 26 Weeks Plan Yr. Limit Deductible Applies	15% Coinsurance 26 Weeks Plan Yr. Limit Deductible Applies	10% Coinsurance 26 Weeks Plan Yr. Limit Deductible Applies
Speech Therapy	Not Covered	Not Covered	40% Coinsurance 13 Weeks Plan Yr. Limit Deductible Applies	30% Coinsurance 13 Weeks Plan Yr. Limit Deductible Applies	20% Coinsurance 26 Weeks Plan Yr. Limit Deductible Applies	20% Coinsurance 26 Weeks Plan Yr. Limit Deductible Applies	15% Coinsurance 26 Weeks Plan Yr. Limit Deductible Applies	10% Coinsurance 26 Weeks Plan Yr. Limit Deductible Applies
Home Health	Not Covered	Covered In Full When Substituted for Hospitalization - 10 Visits Per Plan Yr. Limit Deductible Applies	Covered In Full When Substituted for Hospitalization - 20 Visits Per Plan Yr. Limit Deductible Applies	Covered In Full When Substituted for Hospitalization - 20 Visits Per Plan Yr. Limit Deductible Applies	Covered In Full When Substituted for Hospitalization - 40 Visits Per Plan Yr. Limit Deductible Applies	Covered In Full When Substituted for Hospitalization - 100 Visits Per Plan Yr. Limit Deductible Applies	Covered In Full When Substituted for Hospitalization - 100 Visits Per Plan Yr. Limit Deductible Applies	Covered In Full When Substituted for Hospitalization - 100 Visits Per Plan Yr. Limit Deductible Applies
Skilled Nursing Facilities	Not Covered	Not Covered	40% Coinsurance - 14 Days Per Plan Yr. Limit Deductible Applies	30% Coinsurance - 14 Days Per Plan Yr. Limit Deductible Applies	20% Coinsurance - 14 Days Per Plan Yr. Limit Deductible Applies	20% Coinsurance - 28 Days Per Plan Yr. Limit Deductible Applies	15% Coinsurance - 40 Days Per Plan Yr. Limit Deductible Applies	10% Coinsurance - 60 Days Plan Yr. Limit Deductible Applies
DME and Prosthetic Devices	Not Covered	Not Covered	40% Coinsurance Deductible Applies	30% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	15% Coinsurance Deductible Applies	10% Coinsurance Deductible Applies
Hospice	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies

MANAGED CARE PLANS

BENEFIT	BUDGET LOW	BUDGET HIGH	ECONOMY LOW	ECONOMY HIGH	STANDARD LOW	STANDARD HIGH	ENHANCED LOW	ENHANCED HIGH
PLAN COST SHARING					(BASIC PLAN)			
EXCLUSIVE HMO PLANS								
Deductible	NONE	NONE	NONE	NONE	NONE	NONE	NONE	NONE
Maximum Out-of Pocket for Covered Expenses (Infertility Services Do Not Apply	Single $6,000 Family $12,000	Single $5,000 Family $10,000	Single $4,000 Family $8,000	Single $2,500 Family $5,000	Single $2,500 Family $5,000	Single $1,500 Family $3,000	Single $1,250 Family $2,500	Single $1,000 Family $2,000
Copayment (Copay)	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service
POINT-OF-SERVICE HMO PLANS								
IN-NETWORK								
Deductible	Not Available	Not Available	NONE	NONE	NONE	NONE	NONE	NONE
Maximum Out-of Pocket for Covered Expenses (Infertility Services Do Not Apply)			Single $4,000 Family $8,000 After Deductible	Single $2,500 Family $5,000 After Deductible	Single $2,500 Family $5,000 After Deductible	Single $1,500 Family $3,000 After Deductible	Single $1,250 Family $2,500 After Deductible	Single $1,000 Family $2,000 After Deductible
Copayment (Copay)			As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service	As Indicated for Each Service
OUT-OF-NETWORK*								
Deductible	Not Available	Not Available	Single $1,500 Family $3,000	Single $1,200 Family $2,400	Single $1,200 Family $2,400	Single $700 Family $1,400	Single $400 Family $800	Single $300 Family $600
Maximum Out-of Pocket for Covered Expenses			Single $5,000 Family $10,000	Single $3,500 Family $7,000	Single $3,500 Family $7,000	Single $2,500 Family $5,000	Single $2,250 Family $4,500	Single $2,000 Family $4,000
Coinsurance			40%	40%	30%	30%	30%	20%

* POS PLANS OUT-OF-NETWORK COVERAGE IS LIMITED TO USUAL, CUSTOMARY AND REASONABLE CHARGES.
POS PLANS OUT-OF-NETWORK COVERAGE FOR TRANSPLANTS, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES IS SUBJECT TO CERTIFICATION.
POS PLANS OUT-OF-NETWORK COVERAGE IS NOT AVAILABLE FOR INFERTILITY SERVICES OR PREVENTIVE SERVICES.

MANAGED CARE PLANS

BENEFIT	BUDGET LOW	BUDGET HIGH	ECONOMY LOW	ECONOMY HIGH	STANDARD LOW	STANDARD HIGH	ENHANCED LOW	ENHANCED HIGH
IN-HOSPITAL CARE								
Provider Services, Authorized Inpatient Care, Semi-Private Room and Misc. Hospital Services, Intensive/Cardiac/Neonatal Care, Ancillary Services, Pre-Admission Testing	$1,000 Copay Per Admission	$750 Copay Per Admission	$700 Copay Per Admission	$350 Copay Per Admission	$300 Copay Per Admission	$150 Copay Per Admission	$100 Copay Per Admission	No Copay
Transplant Coverage (Limited to Kidney, Cornea, Bone Marrow, Heart, Liver, Lung, Heart/Lung and Pancreas). *	$1,000 Copay Per Admission	$750 Copay Per Admission	$700 Copay Per Admission	$300 Copay Per Admission	$350 Copay Per Admission	$150 Copay Per Admission	$100 Copay Per Admission	No Copay
OUTPATIENT SERVICES								
Provider Office Visit - includes well child care, well adult care, immunizations, office diagnostic testing, allergy testing and other office visits **	$30 Copay Per Visit	$25 Copay Per Visit	$20 Copay Per Visit	$15 Copay Per Visit	$15 Copay Per Visit	$10 Copay Per Visit	$10 Copay Per Visit	$5 Copay Per Visit
Diagnostic Tests	$30 Copay Per Testing Session	$25 Copay Per Testing Session	$20 Copay Per Testing Session	$15 Copay Per Testing Session	$15 Copay Per Testing Session	$10 Copay Per Testing Session	$10 Copay Per Testing Session	$5 Copay Per Testing Session
Allergy Serum and Injections	Not Covered	Not Covered	$5 Copay Per Visit - office visit may be subject to an additional office visit copay (see above)	$5 Copay Per Visit - office visit may be subject to an additional office visit copay (see above)	$5 Copay Per Visit - office visit may be subject to an additional office visit copay (see above)	$5 Copay Per Visit - office visit may be subject to an additional office visit copay (see above)	$5 Copay Per Visit - office visit may be subject to an additional office visit copay (see above)	$5 Copay Per Visit - office visit may be subject to an additional office visit copay (see above)
Ambulatory/Hospital Outpatient Surgery	$500 Copay Per Visit	$375 Copay Per Visit	$350 Copay Per Visit	$175 Copay Per Visit	$150 Copay Per Visit	$75 Copay Per Visit	$50 Copay Per Visit	No Copay
Infertility Services **	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	50% Coinsurance (Out-of-Pocket Maximum Not Applicable)	50% Coinsurance (Out-of-Pocket Maximum Not Applicable)
MATERNITY CARE								
Prenatal Care, Labor and Delivery and Postpartum ***	Not Covered	$750 Copay Per Admission	$700 Copay Per Admission	$350 Copay Per Admission	$300 Copay Per Admission	$150 Copay Per Admission	$100 Copay Per Admission	No Copay
Pregnancy of Dependents Other than Spouse	Not Covered	Not Covered	Covered Same as Spouse Pregnancy	Covered Same as Spouse Pregnancy	Covered Same as Spouse Pregnancy	Covered Same as Spouse Pregnancy	Covered Same as Spouse Pregnancy	Covered Same as Spouse Pregnancy

* POS PLANS OUT-OF-NETWORK TRANSPLANT COVERAGE IS SUBJECT TO CERTIFICATION.
** POS PLANS PREVENTIVE AND INFERTILITY SERVICES ARE NOT AVAILBLE OUT-OF-NETWORK.
*** FOR HMO AND POS PLANS IN-NETWORK COVERAGE, THE INITIAL OFFICE VISIT IN WHICH PREGNANCY IS DIAGNOSED IS SUBJECT TO THE PROVIDER OFFICE VISIT COPAYMENT. NO ADDITIONAL COPAYMENTS WILL BE APPLIED TO PRENATAL CARE VISITS.

MANAGED CARE PLANS

BENEFIT	BUDGET LOW	BUDGET HIGH	ECONOMY LOW	ECONOMY HIGH	STANDARD LOW	STANDARD HIGH	ENHANCED LOW	ENHANCED HIGH
EMERGENCY SERVICES								
Hospital Emergency Room (Coinsurance Waived if Admitted)	$150 Copay Per Visit	$125 Copay Per Visit	$100 Copay Per Visit	$75 Copay Per Visit	$75 Copay Per Visit	$50 Copay Per Visit	$50 Copay Per Visit	$25 Copay Per Visit
Ambulance (Ground Only)	$75 Copay Per Use	$75 Copay Per Use	$75 Copay Per Use	$75 Copay Per Use	$50 Copay Per Use	$50 Copay Per Use	$25Copay Per Use	$25 Copay Per Use
PREVENTIVE SERVICES								
Immunizations *	Not Covered	See Office Visit Copay	See Office Visit Copay	See Office Visit Copay	See Office Visit Copay	See Office Visit Copay	See Office Visit Copay	See Office Visit Copay
Well Child Care (Ages 0 through 18) *	Not Covered	See Office Visit Copay	See Office Visit Copay	See Office Visit Copay	See Office Visit Copay	See Office Visit Copay	See Office Visit Copay	See Office Visit Copay
Well Adult Care * Periodic Routine Physical Examination and Annual Gynecological Examination Early Detection Mammogram, Pap Test, Cardiac Risk, PSA, Sigmoidoscopy, Glucose Serum, EKG	Screening Mammogram Coverage Only - $50 Per Mammogram Limit (No Copay) Age and Periodicity Limits May Apply	See Office Visit Copay Age and Periodicity Limits May Apply	See Office Visit Copay Age and Periodicity Limits May Apply	See Office Visit Copay Age and Periodicity Limits May Apply	See Office Visit Copay Age and Periodicity Limits May Apply	See Office Visit Copay Age and Periodicity Limits May Apply	See Office Visit Copay Age and Periodicity Limits MayApply	See Office Visit Copay Age and Periodicity Limits May Apply

* POS PLANS PREVENTIVE SERVICES ARE NOT AVAILABLE OUT-OF-NETWORK.

MANAGED CARE PLANS

BENEFIT	BUDGET LOW	BUDGET HIGH	ECONOMY LOW	ECONOMY HIGH	STANDARD LOW	STANDARD HIGH	ENHANCED LOW	ENHANCED HIGH
SUBSTANCE ABUSE								
Inpatient *	Not Covered	Not Covered	$700 Copay Per Admission Maximum 10 days per plan year and 1 admission per plan year Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	$350 Copay Per Admission Maximum 10 days per plan year and 1 admission per plan year Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	$300 Copay Per Admission Maximum 21 days per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	$150 Copay per Admission Maximum 21 days per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	$100 Copay Per Admission Maximum 30 days per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	No Copay Maximum 30 days per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis
Outpatient *	Not Covered	Not Covered	$40 Copay 20 Visits Per Plan Yr.	$30 Copay 20 Visits Per Plan Yr.	$30 Copay 20 Visits Per Plan Yr.	$20 Copay 20 Visits Per Plan Yr.	$20 Copay 30 Visits Per Plan Yr.	$10 Copay 30 Visits Per Plan Yr.
MENTAL HEALTH								
Inpatient *	Not Covered	$750 Copay Per Admission Maximum 5 days per plan year and 1 admission per plan year Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	$700 Copay Per Admission Maximum 10 days per plan year and 1 admission per plan year Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	$350 Copay Per Admission Maximum 10 days per plan year and 1 admission per plan year Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	$300 Copay Per Admission Maximum 21 days per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	$150 Copay Per Admission Maximum 21 days per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	$100 Copay Per Admission Maximum 30 days per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	No Copay Maximum 30 days per plan year and 1 admission per 6 months Day treatment/intensive outpatient can be substituted for inpatient days on a 2 for 1 basis
Outpatient *	Not Covered	$50 Copay 10 Visits Per Plan Yr.	$40 Copay 20 Visits Per Plan Yr.	$30 Copay 20 Visits Per Plan Yr.	$30 Copay 20 Visits Per Plan Yr.	$20 Copay 20 Visits Per Plan Yr.	$20 Copay 30 Visits Per Plan Yr.	$10 Copay 30 Visits Per Plan Yr.

* POS PLANS OUT-OF-NETWORK COVERAGE FOR SUBSTANCE ABUSE AND MENTAL HEALTH IS SUBJECT TO CERTIFICATION.

MANAGED CARE PLANS

BENEFIT	BUDGET LOW	BUDGET HIGH	ECONOMY LOW	ECONOMY HIGH	STANDARD LOW	STANDARD HIGH	ENHANCED LOW	ENHANCED HIGH
OTHER SERVICES								
Prescription Drugs	Not Covered	Not Covered	$15 Copay (1 Month Supply Unless Mail Order is Available)	$12 Copay (1 Month Supply Unless Mail Order is Available)	$10 Copay (1 Month Supply Unless Mail Order is Available)	$10 Copay (1 Month Supply Unless Mail Order is Available)	$7 Copay (1 Month Supply Unless Mail Order is Available)	$5 Copay (1 Month Supply Unless Mail Order is Available)
Contraceptives (POS Coverage In Network Only)	Not Covered	Not Covered	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs
Dental	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Vision	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	$10 Copay Per Visit for Annual Exam Every Year to Age 18 and Every Other Year After Age 18
Physical/Occupational/Cardiac Rehabilitation Therapy	Not Covered	Not Covered	$30 Copay Per Visit 10 Visit Limit Per Plan Year	$30 Copay Per Visit 10 Visit Limit Per Plan Year	$30 Copay Per Visit 20 Visit Limit Per Plan Year	$20 Copay Per Visit 20 Visit Limit Per Plan Year	$10 Copay Per Visit 30 Visit Limit Per Plan Year	$10 Copay Per Visit 30 Visit Limit Per Plan Year
Speech Therapy	Not Covered	Not Covered	$30 Copay Per Visit 10 Visit Limit Per Plan Year	$30 Copay Per Visit 10 Visit Limit Per Plan Year	$30 Copay Per Visit 20 Visit Limit Per Plan Year	$20 Copay Per Visit 20 Visit Limit Per Plan Year	$10 Copay Per Visit 30 Visit Limit Per Plan Year	$10 Copay Per Visit 30 Visit Limit Per Plan Year
Home Health	Not Covered	Covered In Full When Substituted for Hospitalization - Up To 10 Visits Per Plan Year	Covered In Full When Substituted for Hospitalization - Up To 20 Visits Per Plan Year	Covered In Full When Substituted for Hospitalization - Up To 20 Visits Per Plan Year	Covered In Full When Substituted for Hospitalization - Up To 40 Visits Per Plan Year	Covered In Full When Substituted for Hospitalization - Up To 40 Visits Per Plan Year	Covered In Full When Substituted for Hospitalization - Up To 100 Visits Per Plan Year	Covered In Full When Substituted for Hospitalization - Up To 100 Visits Per Plan Year
Skilled Nursing Facility	Not Covered	Not Covered	$700 Copay Per Admission 20 Day Limit Per Plan Year	$350 Copay Per Admission 20 Day Limit Per Plan Year	$300 Copay Per Admission 20 Day Limit Per Plan Year	$150 Copay Per Admission 30 Day Limit Per Plan Year	$100 Copay Per Admission 40 Day Limit Per Plan Year	No Copay 60 Day Limit Per Plan Year
DME and Prosthetic Devices	Not Covered	Not Covered	40% Coinsurance	40% Coinsurance	30% Coinsurance	20% Coinsurance	10% Coinsurance	10% Coinsurance
Hospice	Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit

MEDICAL SAVINGS ACCOUNT (MSA) PLAN

BENEFIT	FEE FOR SERVICE	PPO (IN-NETWORK)	PPO (OUT-OF-NETWORK)
COST SHARING[1]			
Deductible (single)[2]	$1,500	$1,500	$2,250
Deductible (family)[3]	$3,000	$3,000	$4,500
Maximum Out-of-Pocket (single)[4]	$3,000	$3,000	$3,000
Maximum Out-of-Pocket (family)[5]	$5,500	$5,500	$5,500
IN HOSPITAL CARE			
Provider Services, Authorized Inpatient Care, Semi-Private Room and Misc. Hospital Services, Intensive/Cardiac/Neonatal Care, Ancillary Services, Surgical Services, Pre-Admission Testing	20% coinsurance	20% coinsurance	40% coinsurance

[1] All covered services are subject to the deductible. Amounts applied to meet the deductible do not accrue to the maximum out-of-pocket limit. With regard to family plans, one person must meet the single deductible. Thereafter, all eligible family expenses accrue to the deductible.

[2] The allowable range for a federal MSA is $1,500 - $2,250.

[3] The allowable range for a federal MSA is $3,000 - $4,500.

[4] This amount is prescribed by the Kennedy-Kassebaum Bill.

[5] This amount is prescribed by the Kennedy-Kassebaum Bill.

Transplant Coverage (limited to kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas)	20% coinsurance	20% coinsurance	40% coinsurance
OUTPATIENT SERVICES			
Provider Office Visit, Diagnostic Testing	20% coinsurance	20% coinsurance	40% coinsurance
Ambulatory/ Hospital Outpatient Surgery	20% coinsurance	20% coinsurance	40% coinsurance
MATERNITY CARE			
Prenatal, labor and delivery, and postpartum	20% coinsurance	20% coinsurance	40% coinsurance
Pregnancy of dependents other than spouse	not covered	not covered	not covered
EMERGENCY SERVICES			
Hospital Emergency Room (coinsurance waived if admitted)	20% coinsurance	20% coinsurance	40% coinsurance
Ambulance (Ground only)	20% coinsurance	20% coinsurance	40% coinsurance
PREVENTIVE SERVICES			
Early Detection (Mammogram only)	20% coinsurance age and periodicity limits may apply	20% coinsurance age and periodicity limits may apply	40% coinsurance age and periodicity limits may apply

MENTAL HEALTH			
Inpatient	20% coinsurance Maximum 5 days/ plan year 1 admission/ plan year Day treatment or Intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	20% coinsurance Maximum 5 days/ plan year 1 admission/ plan year Day treatment or Intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	40% coinsurance Maximum 5 days/ plan year 1 admission/ plan year Day treatment or Intensive outpatient can be substituted for inpatient days on a 2 for 1 basis
Outpatient	20% coinsurance 10 visits per plan year	20% coinsurance 10 visits per plan year	40% coinsurance 10 visits per plan year
OTHER SERVICES			
Physical/ Occupational/ Cardiac Rehabili-tation Therapy	20% coinsurance 13 weeks plan year limit	20% coinsurance 13 weeks plan year limit	40% coinsurance 13 weeks plan year limit
Speech Therapy	20% coinsurance 13 weeks plan year limit	20% coinsurance 13 weeks plan year limit	40% coinsurance 13 weeks plan year limit
Skilled Nursing Facilities	20% coinsurance 14 days plan year limit	20% coinsurance 14 days plan year limit	40% coinsurance 14 days plan year limit
Home Health	Covered in full when substituted for hospitalization 10 visits plan year limit	Covered in full when substituted for hospitalization 10 visits plan year limit	Covered in full when substituted for hospitalization 10 visits plan year limit
Hospice	Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit

APPENDIX F

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (KASSEBAUM-KENNEDY) AND RELATED FEDERAL LEGISLATION AFFECTING THE INSURANCE MARKET

Table of Contents

KASSEBAUM-KENNEDY	REQUIREMENT
Title I - Health Care Access, Portability, and Renewability Subtitle A - Group Market Rules Part I - Portability, Access and Renewability Section 101, ERISA	ALL REFERENCES APPLICABLE TO ERISA ONLY Amends ERISA by adding a new Part 7, Group Plan Portability, Access and Renewability requirements.
Section 701 - Increased Portability Through Limitation on Preexisting Condition Exclusions	Requires employer group plans to comply with the following provisions as applicable to insurers and discussed in detail in the Group Market Reform Section 2701: • Preexisting conditions; • Recognition and calculation of prior creditable coverage; • Certification of prior creditable coverage; • Special enrollment periods; and • HMO affiliation periods to the extent that employers are enabled to purchase such plans.
Section 702 - Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status	Requires employer group plans to comply with the following provisions as applicable to insurers and discussed in detail in the Group Market Reform Section 2702: • Health factors may not be considered as a basis for eligibility or continued eligibility; and • Higher premiums may not be charged to similarly situated individuals based on health status.
Section 703 - Guaranteed Renewability in Multiemployer Plans and MEWAS	Requires multiemployer plans and MEWAS to guarantee to renew under the same provisions as Group Market Reform Section 2712, (except association membership) and adds: • additional language regarding service areas; and • a nonrenewal provision regarding failure to comply or renew collective bargaining agreements and related agreements.
Section 704 - Preemption, State Flexibility, Construction	Applies the requirements of Group Market Reforms Section 2723, to multiemployers plans and MEWAS.
Section 705 - Special Rules Relating to Group Health Plans	Omits references in Group Market Reforms Section 2721, to governmental and nongovernmental plans and otherwise applies Section 2721 provisions to multiemployer plans and MEWAS.
Section 706 - Definitions	Omits definition of Individual Health Insurance and provides ERISA related definitions not discussed in Group Market Reforms Section 2791.
Section 707 - Regulations	• Provides for the Secretary to promulgate regulations and otherwise enforce provisions specific to ERISA; imposes reporting requirements, imposes penalties, and enables coordination of implementation.

KASSEBAUM-KENNEDY	REQUIREMENT
Title XXVII Assuring Portability, Availability and Renewability of Health Insurance Coverage Part A - Group Market Reforms Subpart 1 - Portability, Access and Renewability Requirements Section 2701 - Increased Portability Through Limitation of Preexisting Condition Requirements (Rules Apply to Small and Large Group)	ALL REFERENCES APPLICABLE TO GROUP MARKET ONLY PREEXISTING CONDITION PROVISIONS • Groups may impose a preexisting exclusion only if such exclusion relates to "a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date." • The preexisting exclusion is not more than 12 months or 18 months for late entrants. • Preexisting is reduced by aggregate period of creditable coverage as later defined, applicable as of the enrollment date. • The term preexisting condition exclusion means, with respect to coverage, "a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date." • Genetic information not be to considered without a diagnosis. • A newborn child, or a child under 18 adopted or placed for adoption may not be imposed a preexisting waiting period if covered under creditable coverage as of the last day of the 30 day period beginning with the date of birth, adoption or placement. • Pregnancy is not a preexisting condition. AFFILIATION PERIODS IN LIEU OF PREEXISTING CONDITIONS (HMOS ONLY) • A HMO that imposes no preexisting condition can impose an affiliation period which is defined as "a period which, under the terms of the health insurance coverage offered by the HMO, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period." • Affiliation period may be imposed only if: (a) the period is applied uniformly without regard to any health status related factors and (b) the period does not exceed 2 months (3 months for late entrants). • The affiliation period begins on the enrollment date and run concurrently with any waiting periods. • Other alternatives can be approved by the Commissioner

KASSEBAUM-KENNEDY	REQUIREMENT
	DEFINITIONS APPLICABLE TO THESE AREAS Enrollment Date: (With respect to an individual) "The date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment." Late Enrollee: "A participant or beneficiary who enrolls under the plan other than during (a) the first period in which the individual is eligible to enroll under the plan, or (b) a special enrollment period...". Waiting Period: "The period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan." Creditable Coverage: "Coverage of the individual under any of the following: (a) a group health plan; (b) health insurance coverage (per definition does not include short-term/HIAA report says should be considered per conferees); (c) Part A or B of title XVII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) Chapter 55 of title 10, USC; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state risk pool; (h) a health plan offered under chapter 89 of title 5, USC; (I) a public health plan (as defined in regulations); and (j) a health benefit plan under section 5(e) of the Peace Corps Act. Creditable coverage does not include "excepted benefits" under one or more (or any combination of): • Benefits not subject to requirements: (a) Accident only or disability income or combination thereof. (b) Supplements to liability insurance. (c) Liability, including general and automobile liability. (d) Workers compensation or similar insurance. (e) Automobile medical payment insurance. (f) Credit-only insurance. (g) Coverage for on-site medical clinics. (h) Other similar insurance, *specified in regulations*, under which benefits for medical care are secondary or incidental. • Benefits not subject to requirements if offered separately: (a) Limited scope dental or vision benefits. (b) Benefits for long term care, nursing home care, home health care, community based care, or any combination thereof (c) Such other similar, limited benefits as are *specified in regulations*. • Benefits not subject to requirements if offered as independent, noncoordinated benefits: (d) Coverage only for a specified disease or illness (e) Hospital indemnity or other fixed indemnity insurance • Benefits not subject if offered as a separate insurance policy: (f) Medicare supplement and similar coverage provided under a group health plan.

KASSEBAUM-KENNEDY	REQUIREMENT
	COUNTING PERIODS OF CREDITABLE COVERAGE • A period of creditable coverage will not be counted if after the period of coverage, and before the enrollment date, there was a 63 day period during which the individual was not covered under any creditable coverage. • Waiting periods or affiliation periods (HMO) are not taken into account in determining continuous coverage. TWO METHODS FOR COUNTING PERIODS OF CREDITABLE COVERAGE Standard Method: Count a period of creditable coverage without regard to specific benefits covered during the period. Alternative Method: Plan or issuer can elect to apply aggregate period of creditable coverage to coverage of benefits *specified in regulations* rather than without regard to specific benefits. • Must be uniform for all participants. • Under such an election, the health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category. • Must disclose to the beneficiary and plan sponsor the election of the alternative method at the time of enrollment and describe the effect of the alternative method. REQUIREMENTS FOR CERTIFICATION OF PERIODS OF CREDITABLE COVERAGE • Periods of creditable coverage through certifications or in other manners as may be *prescribed by regulations.* • The period of coverage and COBRA (if applicable) and the waiting/affiliation periods (if applicable) are to be certified by the plan or issuer: (a) when plan coverage ceases and COBRA is available; (b) when COBRA ceases; and (c) on request made not later than 24 months after the end of these coverages, whichever is later. • Notices can be consistent with the time frames of COBRA notices to the extent practical. • The certifications should include: (a) the period of coverage under the plan and COBRA (if applicable); (b) the waiting period (if any) and the affiliation period (if applicable) imposed on the individual; • An issuer which elects to implement the Alternative Method of crediting coverage (discussed above) can request, from the entity issuing the certification, information on the coverage of classes and categories of health benefits under the prior plan. This information should be disclosed promptly. The requesting plan can be charged reasonable costs for disclosing the information.

KASSEBAUM-KENNEDY	REQUIREMENT
	SPECIAL ENROLLMENT PERIODS • Individuals who lose other coverage (eligible employees or eligible dependents) may enroll in a plan at a later date if: (a) They were covered under a group health plan or had other health insurance coverage at the time the plan was offered; (b) They stated in writing (if written statement required and the consequences of rejection were disclosed) that other coverage was the reason for declining; (c) The other coverage was COBRA which is exhausted or not COBRA and loss of coverage resulted from separation, divorce, death, termination of employment, reduction in hours or termination of employer contribution; and (d) The request is made not later than 30 days after the date of exhaustion of previous coverage. • A special enrollment for dependent beneficiaries exists if the plan provides dependent coverage: (a) An eligible employee and/or spouse may enroll upon acquiring a new dependent through marriage, birth, adoption or placement for adoption. (b) The special period is not less than 30 days from the later of (1) the date coverage is made available or (2) the date of marriage, birth, adoption or placement for adoption. (c) The effective dates are (1) marriage - 1st day of the 1st month after receipt of the request for enrollment and (2) the date of birth, adoption or placement for adoption. • Special enrollees are exempt from the definition of late enrollee.
Section 2702 - Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status **(Rules Apply to Small and Large Group)**	ELIGIBILITY TO ENROLL • A group health plan or insurance issuer may not establish rules for eligibility or continued eligibility of an individual or dependent based on the following health factors: (a) Health status; (b) Medical condition (physical and/or mental); (c) Claims experience; (d) Receipt of health care; (e) Medical history; (f) Genetic information; (g) Evidence of insurability (including domestic violence); (h) Disability. • To the extent consistent with preexisting rules, this does not require the inclusion of special benefits or prevent establishing limits or restrictions on benefits or coverage for similarly situated individuals. PREMIUM CONTRIBUTIONS • A higher premium or contribution may not be charged to similarly situated individuals based on health status. • This is not intended to restrict the amount charged by a health plan or to prohibit discounts or rebates or other modifications, copayments or deductibles in relation to healthy lifestyles.

KASSEBAUM-KENNEDY	REQUIREMENT
PART A - Subpart 2 Section 2711 - Guaranteed Availability of Coverage for Employers in the Group Market (Technical Rules Apply to Small Group Only)	PROVISIONS APPLICABLE ONLY TO HEALTH INSURANCE ISSUERS SMALL GROUP MARKET • Subject to network rules, application of financial capacity limits, failure to meet participation or contribution rules or association exceptions, issuers in the small group market must: (a) accept every small employer (as later defined) in the state that applies; (b) accept every eligible individual who applies during the period in which the individual first becomes eligible without imposing any restrictions inconsistent with Section 2702; except (c) as provided in Section 2711(f), this does not apply to an issuer who offers small group coverage only through one or more bona fide associations. • An eligible individual in relation to a small employer is determined: (a) in accordance with the terms of such plan; (b) as provided by the issuer under its rules which are applied uniformly to small employers in the state; and (c) in accordance with state laws. LARGE GROUP MARKET • The Governor shall submit to the Secretary of HHS by 12/31/2000 and every 3 years thereafter a report on the availability of coverage for large employers. • The Secretary of HHS will report to Congress. • The GAO will study and report to Congress not later than 18 months from the effective date of this Act. NETWORK RULES/FINANCIAL CAPACITY RULES • In the small group market, an issuer may: (a) limit employers to those with individuals who live, work or reside in the service area; (b) deny coverage if the issuer does not have the capacity to deliver services to new groups and this is applied uniformly to all new applicants and is not based on medical experience; (c) which must be demonstrated to the appropriate state authority; and (d) if coverage is denied due to network capacity, the issuer may not offer coverage in the small group market in that service area for 180 days. (e) deny coverage based on financial capacity if applied uniformly and demonstrated, if required, to the state authority; and (f) if coverage is denied due to financial capacity, issuers may not issue coverage in the small group market for 180 days or until financial ability is demonstrated. • Exceptions: (a) issuers are not precluded from establishing employer contribution or group participation rules as allowed by state law and as defined. (b) issuers to associations only do not have to comply with 2711 (a).

KASSEBAUM-KENNEDY	REQUIREMENT
Section 2712 - Guaranteed Renewability of Coverage for Employers in the Group Market **(Rules Apply to Small and Large Group)**	<u>GENERAL RULES FOR DISCONTINUANCE</u> • Coverage in the small or large group market must be renewed or continued in force except for one or more of the following reasons (defined more explicitly in the bill): (a) nonpayment of premiums; (b) fraud; (c) violation of participation or contribution rules; (d) termination of coverage; (e) movement outside the service area; (f) association membership ceases. <u>Discontinuance of a Type of Coverage</u> • When an issuer determines to discontinue the offer of a particular type of coverage in the small or large group market, the type of coverage can be discontinued in accordance with state law if: (a) notice is provided to each plan sponsor, participant and beneficiary at least 90 days prior to the date of discontinuance; (b) the issuer offers to each plan sponsor the option to purchase all (or in the case of a large employer, any) other coverage currently offered by the issuer in the group market; (c) when exercising discontinuance and offering other coverage, the issuer acts uniformly without regard to claims experience of sponsors or health factors of participants or beneficiaries. <u>Discontinuance of All Coverage</u> • When an issuer determines to discontinue offering all health insurance coverage in the small or large, or both markets in a state, coverage must be terminated in accordance with state law and if: (a) notice is provided to the applicable state authority and to each plan sponsor, participant and beneficiary at least 180 days prior to the date of discontinuance; (b) all health insurance issued or delivered for issuance in the state in such market or markets is discontinued and not renewed; and (c) when coverage is discontinued in a market, the issuer may not reenter the market for a period of 5 years beginning on the date of discontinuance of the last coverage not renewed. <u>EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE</u> • At the time of renewal, an issuer may modify the coverage of a product offered to a group health plan: (a) in the large group market; or (b) in the small group market if, for coverage that is available other than only through one or more associations, the modification is consistent with state law and effective uniformly among group health plans with that product.
Section 2713 - Disclosure of Information **(Rules Apply to Small Group)**	<u>INFORMATION TO BE DISCLOSED WITH THE OFFERING OF COVERAGE TO A SMALL EMPLOYER</u> • The following information is to be provided as part of sales and solicitation materials and upon the request of a small employer: (a) provisions concerning the issuer's right to change premiums and the factors that would affect premium changes; (b) renewability provisions;

KASSEBAUM-KENNEDY	REQUIREMENT
	(c) information concerning preexisting conditions; and (d) the benefits and premiums of all coverage for which the employer is qualified. • The information should be made available in a manner determined to be understandable by the average small employer and sufficient to advise the small employers of their rights. • This section does not require the disclosure of information that is proprietary or trade secret under state law.
PART A - Subpart 3 Exclusion of Plans; Enforcement; Preemption Section 2721 - Exclusion of Certain Plans	• The requirements of Subparts 1 and 2 do apply to nonfederal governmental plans (defined as a governmental plan established or maintained for its employees by the U.S. Government, etc.) • The requirements of Subparts 1 and 2 do apply to chuch and governmental plans. • The sponsor of a nonfederal governmental plan may elect, *in a form and manner to be prescribed by regulations*, to be excluded from the Provisions of Subparts 1 and 2: (a) for a single specified plan year which may be extended through subsequent elections; or (b) for the term of a collective bargaining agreement if applicable. • If such election is made, the plan must provide for: (a) notice to enrollees (annually and at enrollment) of the fact and consequences of the elections; and (b) certification and disclosure of creditable coverage as discussed in Section 2701. • Subparts 1 and 2 do not apply to the excepted benefits enumerated in Section 2791 and listed earlier under Section 2701. • Partnerships are to be considered as group health plans.
Section 2722 - Enforcement	<u>STATE ENFORCEMENT</u> • Subject to Section 2723, each state may require that health insurance issuers that issue, sell, renew or offer health insurance coverage in the small and large group markets meet the requirements of this part (Part A). • If the Secretary determines that a state has failed to substantially enforce this Part the Secretary may undertake enforcement. Limitations, liabilities, penalties, administrative and judicial review are discussed in detail in this Section.
Section 2723 - Preemption; State Flexibility; Construction	• Except as noted, no provision of state law is superseced which establishes, implements, or continues any standard or requirement solely relating to health insurance issuers in the group market (unless the state law prevents the application of this Part). • Nothing in this part affects or modifies Section 514 of ERISA with respect to group health plans. • In relation to health insurance coverage offered by an issuer, this part does not supersede state law to the extent that state law: (a) substitutes a preexisting "lookback" period of less than 6 months; (b) substitutes a preexisting waiting period of less than 12 months or18 months for late entrants; (c) substitutes a number of days greater than 63 concerning breaks in coverage; (d) substitutes a period greater than 30 days for adding an adopted child; (e) prohibits the imposition of preexisting exclusions in cases not described in 2701(d) or expands the exceptions of that section;

KASSEBAUM-KENNEDY	REQUIREMENT
	(f) requires additional special enrollment periods; (g) reduces the period of time applicable to HMO affiliation periods. • Nothing in this Part should be construed to require a group health plan or insurance issuer to provide specific benefits.
PART C - Definitions; Miscellaneous provisions **Section 2791** - Definitions	• This section defines numerous terms in addition to those defined throughout the bill.
Section 2792 - Regulations	• The HMO Act is amended to enable affiliation periods. • Except as provided, Part A of Title XXVII shall apply to group health plans for plan years beginning after 6/1/97. • No period before 7/1/96 shall be taken into account in determining creditable coverage, but the Secretary of HHS will establish a process where individuals can be credited for such coverage through documents, etc. • Certification requirements apply to event occuring after 6/30/96. • Certification is not required to be provided before 6/1/97. • For events occuring after 6/30/96 and before 10/1/96 certification is not required unless requested in writing. • Except for certification requirements, collective bargaining agreements are not subject to Part A of Title XXVII until plan years beginning before the later of: (a) the date when the last collective bargaining agreement relating to the plan terminates (without regard to any extension agreed to after the date of this Act; or (b) July 1, 1997. • The Secretary of HHS will issue regulations not later than 4/1/97. • No enforcement actions will be taken regarding violations before 1/1/98 if the plan or issuer has made a good faith effort to comply.
Section 103 - IRS Code	• References to revisions of the IRS Code and cross references.
Section 104 - Assuring Coordination	• Enables Secretaries of HHS, Treasury and Labor to co-administer and coordinate efforts of implementation.
	ALL REFERENCES APPLICABLE TO INDIVIDUAL MARKET ONLY
Subtitle B - Part B - Individual Market Rules **Section 2741** - Guaranteed Availability of Individual Health Insurance Coverage to Certain Individual With Prior Group Coverage	• Issuers that offer individual coverage may not: (a) decline coverage to an eligible individual under the fallback provisions; or (b) impose a preexisting condition exclusion as defined in Section 2701(b)(1)(A) on an eligible individual. • Preexisting exclusion is defined in the area noted above as: "... a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date."

KASSEBAUM-KENNEDY	REQUIREMENT
	• An eligible individual: (a) has 18 months aggregate prior creditable coverage as defined in Section 2701(c), the most recent of which was with a group, government or church plan, or coverage offered in connection with such plan; (b) is not eligible for group coverage, Medicare, Medicaid, and does not have other health insurance coverage. (c) did not lose the most recent coverage for "a factor described in Section 2712(b), paragraphs (1) and (2) relating to fraud and nonpayment of premium. (d) was offered COBRA or state continuation, elected such coverage and such coverage is exhausted. <u>Rules for States With No Acceptable Alternative Mechanism (AAM)</u> • If a state elects not to implement an AAM (later defined and discussed), an individual health insurance issuer may elect to limit the coverage offered to eligible individuals, it may limit the offered coverage so long as it offers at least two different policy forms which: (a) "are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the issuer;" and (b) are either the most popular policy forms or are policy forms which provide representative coverage as defined; and (c) this election is applied uniformly and for a period of not less than 2 years. • If an Acceptable Alternative Mechanism is not adopted and the previous rules are followed, the following apply: (a) Special Rules for Network Plans as described for the Small Group Market; (b) Financial Capacity Limits as described for the Small Group Market; (c) Issuers selling group only and/or through bona fide associations are not required to offer to individuals; (d) Issuers offering conversion policies are not required to offer to individuals; (e) The rules do not restrict the premium charges or the opportunity to offer healthy lifestyle discounts, etc.
Sections 2742 and 2743	• These sections are outlined following Section 2744.
Section 2744 - State Flexibility in Individual Market Reforms	<u>Rules for State Which Adopt An Acceptable Alternative Mechanism (AAM)</u> • Section 2741 requirements are waived for states that implement an AAM which: (a) provides a choice of health insurance to eligible individuals; (b) does not impose a preexisting exclusion on such coverage; and (c) includes at least one form of coverage which is comparable to comprehensive health insurance offered in the group market or that is comparable to a standard group or individual option available under state law; and (d) the state must implement either: • the NAIC Small Employer and Individual Health Insurance Availability Act or the NAIC Individual Health Insurance Portability Model Act, both adopted 6/3/96; • a qualified high risk pool which provides coverage to all eligible individuals that does not impose a preexisting exclusion for eligible individuals and provides for premiums and benefits consistent with the NAIC Model Health Plan for Uninsurable Individuals; or • an alternative mechanism which provides for risk adjustment, risk spreading or a risk spreading mechanism.

KASSEBAUM-KENNEDY	REQUIREMENT
	• The following are discussed as potential AAMs (or a combination thereof): (a) a private or public individual health insurance mechanism; (b) mandatory group conversion plans; (c) guarantee issue of one or more plans; (d) open enrollment. • The time frame to implement an AAM is discussed in this section but is not outlined in this document. <u>GENERAL RULES FOR DISCONTINUANCE</u> • Coverage in the individual market must be renewed or continued in force except for one or more of the following reasons (defined more explicitly in the bill): (a) nonpayment of premiums; (b) fraud; (c) termination of coverage; (d) movement outside the service area; or (e) association membership ceases. <u>Discontinuance of a Type of Coverage</u> • When an issuer determines to discontinue the offer of a particular type of coverage in the individual market, the type of coverage can be discontnued in accordance with state law only if: (a) notice is provided to each covered individual at least 90 days prior to the date of discontinuance; (b) the issuer offers to each individual the option to purchase all other coverage currently offered by the issuer in the group market; and (c) when exercising discontinuance and offering other coverage, the issuer acts uniformly without regard to claims experience of individuals enrolled or who may become enrolled. <u>Discontinuance of All Coverage</u> • When an issuer determines to discontinue offering all health insurance coverage in the individual market in a state, coverage must be terminated in accordance with state law and only if: (a) notice is provided to the applicable state authority and to each individual at least 180 days prior to the date of discontinuance; (b) all health insurance issued or delivered for issuance in the state in such market or markets is discontinued and not renewed; and (c) when coverage is discontinued in a market, the issuer may not reenter the market for a period of 5 years beginning on the date of discontinuance of the last coverage not renewed. <u>EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE</u> • At the time of renewal, an issuer may modify the coverage of a product offered to an individual: (a) if the modification is consistent with state law and applied uniformly; and (b) the reference to "individual" includes a reference to the association of which the individual is a member.

KASSEBAUM-KENNEDY	REQUIREMENT
Section 2743 - Certification of Coverage	• The provisions of Small Group Market Section 2701(e) are applicable to the individual market.
Section 2745 - Enforcement	• Except as provided in Section 2746, each state may require that health insurance issuers meet the requirements of Part B - Individual Market Rules. If the Secretary determines that a state has failed to enforce the requirements, the Secretary can enforce the requirements.
Section 2746 - Preemption	• Nothing in this part affects or modifies Section 514 of ERISA with respect to group health plans.
Section 2747 - General Exceptions	• The Individual Market Rules do not apply to the excepted benefits for Small Group Market outlined in Section 2791. • Except as provided in Title XXVII, Part B(a), this Part is effective for coverage issued, sold, offered or renewed after 6/30/97, regardless of when a period of creditable coverage occurs. (Note (a) discusses the application of an AAM). • Section 102(d)(2) of this Act applies to Section 2743 in the same manner as it applies to Section 2701(e).
Title III - Tax Related Health Provisions Sections 300, 301 and 220(a) through (c)(1) - Revisions to IRS Code Unless Otherwise Provided, Subtitles A&B,	Most of Title III, Subtitles A&B, discusses the manner in which the IRS will evaluate tax deductions for MSA plans (exempt payments, qualified employers/beneficiaries, transfer of account due to death, divorce, etc., what may or may not be reimbursed by the spending account, reporting requirements, penalties, limitations on spending accounts, etc. • Defines High Deductible Health Plan (HDHP): Single Deductible - $1500 - $2250 Family Deductible - $300 - $4500 Single OOP - $3000 Family OOP - $5500 • The definition of HDHP does not include coverage for: (a) any benefit provided by permitted insurance; or (b) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long term care. • Permitted insurance means: (a) medicare supplemental insurance; (b) insurance coverage if substantially all of the coverage relates to liabilities incurred under workers comp, tort, ownership or use of property, or similar liability as the Secretary may *prescribe by regulation*, insurance for a specified disease or illness or insurance paying an indemnity for hositalization. • HDHP does not fail to qualify as a MSA if it does not have a deductible for preventive care as required by state law. • Small employer means, in general, any employer who employed an average of 50 or fewer employees during either of the preceding 2 calendar years. Exceptions are made for employers not in business during the preceding year and employers who later exceed 50 employees.
Section 301	• Study effects of MSAs on small group market • Monitoring of participation in MSAs
KASSEBAUM-KENNEDY	REQUIREMENT

KASSEBAUM-KENNEDY	REQUIREMENT
Title IV - Application & Enforcement of Group Health Plan Requirements Subtitle A, Sec. 401(a)	Adds a new Chapter 100 to Subtitle K of the IRS Code. This chapter reiterates the provisions of Title XXVII except as noted.
Chapter 100 - Group Health Portability, Access and Renewability Requirements	
Section 9801 - Increased Portability Through Limitation of Preexisting Condition Exclusions	• Basically restates the provisions of Title XXVII, Section 2701, with wording changes specific to the IRS Code. • Omits the requirement of issuer notice of Alternative Method of crediting prior coverage. • Omits references to HMO affiliation periods.
Section 9802 - Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status	• Basically restates the provisions of Title XXVII, Section 2702, with working changes specific to the IRS Code.
Section 9803 - Guaranteed Renewability in Multiemployer and Certain MEWAS	• Requires multiemployer plans and MEWAS to guarantee renewal under the same provisions as Title XXVII, Section 2712, (except association membership) and adds: (a) additional language regarding service areas; and (b) a nonrenewal provision regarding failure to comply or renew collective bargaining agreements and related agreements.
Section 9804 - General Exceptions	• Basically restates the provisions of Title XXVII, Section 2712, with working changes particular to the IRS Code. • Omits references to church and nongovernmental plans. • Omits references to treatment of partnerships.
Section 9805 - Definitions	Omits definition of group health insurance, individual health insurance, appropriate state authority, beneficiary, bona fide association, employee, employer, church plan, federal government plan, nonfederal government plan, health status related factor, participants, plan sponsor, state and other market related terms.
Section 9806 - Regulations	• Provides for the Secretary to promulgate regulations and otherwise enforce the provisions required to implement this Title.
Section 402 - Penalty On Failure to Meet Certain Group Health Plan Requirements	• Specifies tax penalties. • Provides exception for church plans. • Allows for correctional periods. • Addresses unintentional failures to comply. • Not applicable to certain small employer plans.
Subtitle B - Clarification of Certain Continuation Coverage Requirements **Sec. 421** - Cobra Clarifications	Makes clarifications to COBRA and ERISA by inserting revisions to referenced federal statutes. The full impact is not stated in the bill. HIAA Report "Implementing Kassebaum-Kennedy," September 11, 1996, discusses COBRA changes effective 1/1/97: • The extended maximum coverage period (29 months) due to disability applies to disabled qualified beneficiaries. • Extended disability coverage applies if disability exists at any time during the first 60 days of COBRA (previously at time of qualifying event) - determination still must be made and notice given during the period of COBRA coverage.

	• COBRA can be terminated if beneficiary becomes covered under another group plan with a pre-existing clause if the new plan exclusion does not apply by reason of prior creditable coverage. • Qualified beneficiary includes adopted children, enabling plan changes upon adoption of a child.
Newborns and Mothers Health Protect Act Effectiive 1/1/98	• Group health plans/insurers may not: (a) restrict benefits for any hospital stay in connection with childbirth for the mother or the newborn to less than 48 hours for a normal vaginal delivery or 96 hours for a cesarean section although the provider and mother in consultation may agree to an earlier discharge; (b) require that a provider obtain preauthorization to assure these lengths of stay; (c) deny eligibility to avoid this Act; (d) provide payments or rebates to mothers to accept less limits; (e) penalize or reduce reimbursement to providers due to compliance; (f) provide incentives to provides to encourage noncompliance; or (g) restrict benefits. • The Act does not: (a) require the mother to give birth in a hospital or to stay in the hospital for the specified times; (b) prevent the application of deductibles, coinsurance, copays, etc., although the deductibles, coinsurance, etc., related to the extended stay may not be greater than the basic charges; or (c) prohibit negotiation of provider charges.
Mental Health Parity Act **(Amends HIPAA)** **Effective for plan years beginning 1/1/98 and Sunsets 9/30/2001.**	• Group health plans which provide medical, surgical and mental health benefits may not impose an aggregate dollar lifetime limit on mental health benefits if it does not impose such a limit on medical and surgical benefits. • If there is an aggregate dollar lifetime limit on substantially all medical and surgical benefits, the plan must either: (a) apply one limit equally to all benefits; or (b) use equal limits for medical-surgical/mental health benefits. • Group health plans which do not impose an annual dollar limit on medical and surgical benefits may not impose an annual limit on mental health benefits. • Group health plans which do impose an annual dollar limit on substantially all medical and surgical benefits must either: (a) apply one limit equally to all benefits; or (b) use equal limits for medical-surgical/mental health benefits. • If none of the above apply, the Secretary will establish rules for compliance. • The Act does not require that mental health benefits be provided. • The Act does not affect the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage and medical necessity) except as expressed above regarding parity in aggregate/annual benefit limits. • The Act does not apply to small employers (2-50) and rules are provided for computing employer status. • The Act does not apply to a group health plan if application would result in a cost increase of at least 1% .

Kentucky Department of Insurance

APPENDIX G

LEGISLATIVE RESEARCH COMMISSION

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MEMORANDUM

To: Members of the General Assembly

From: Ginny Wilson, Ph.D.
LRC Chief Economist

Subject: Health Insurance Data

Date: August 12, 1997

The purpose of this memo is to present data that members of the General Assembly may find useful in considering further changes to laws governing health insurance in the individual and small-group markets. Data on three topics is presented. First is an estimate of the current insurance status of Kentuckians, and how that might have changed in the last two years. Next is a summary of available data on those who purchased insurance through the buy-in program, which predated implementation of the provisions of HB 250. Last is a summary and analysis of data for state high-risk pools in operation for at least three years. These topics were not chosen for any particular policy reason, but because they represent areas where staff has obtained data not yet reviewed by most legislators. Data on other topics will be presented, as it becomes available.

Current Insurance Status

The Legislative Research Commission, in conjunction with the Survey Research Center at the University of Louisville, is now completing an enhanced replication of the Health Insurance Survey that was first conducted in the summer of 1996.[1] Collection of data for the 1997 Health Insurance Survey began in May, and is proceeding in two stages. In the first stage, data on health status, health insurance, and demographics was obtained from a random telephone sample of approximately 1200 Kentucky households. That stage of the data collection was just completed and is the data used to make the preliminary estimates presented below.

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[1] Legislative Research Commission, *Number and Characteristics of the Individually Insured, Small-Group Insured, and Uninsured in Kentucy,* Research Memorandum No. 474, March 1997.

The individually insured, small-group insured, uninsured, and newly uninsured are groups about which there is intense policy interest, yet they represent relatively small proportions of the total population. This means that, unless it is extremely large, a random sample of the population will not yield enough cases to allow reliable estimation of the characteristics of these groups. Therefore, the second stage of the data collection is designed to obtain additional sample responses only from members of these groups. The "oversampled" responses will not be used to make estimates of population proportions, but only to describe group characteristics. That stage of the data collection is still in progress; therefore, it should be understood that the estimates presented below are preliminary, subject to further analysis of the final sample. A complete and formal report of the 1997 Health Insurance Survey will be published as soon as possible after data collection and analysis is finished.

Table 1 presents the preliminary estimate of the insurance status of Kentuckians. Note that the estimate of the percentage of uninsured is from the Census Bureau, rather than the 1997 Health Insurance Survey. It has been shown that the characteristics of those without a telephone are, in many respects, similar to those who do not have health insurance.[2] Thus, there was some concern that estimates from the telephone survey would understate the number of uninsured in the total population. For this reason, the estimate of the number of uninsured is taken from the 1996 Current Population Survey (CPS), which was an in-person survey conducted by the Census Bureau.

Uninsured

Based on the CPS conducted in March of 1996, the Census Bureau estimated that 14.6% of Kentuckians were uninsured in 1995.[3] When applied to the official 1996 estimate of the Kentucky population, this represents about 570,000 individuals. This estimate is not significantly[4] different from the estimate derived from the 1995 CPS. Note that the 1996 CPS collected data on insurance status in 1995, prior to enactment of HB 250. While telephone surveys may not accurately reflect the absolute number of uninsured, the telephone bias may not be as serious a problem for estimating changes over time. Estimates of the percentage of non-elderly Kentuckians, with telephones, who were uninsured were taken from the 1994 - 1996 Health Polls conducted by the University of Kentucky Survey Research Center, and from the 1997 Health Insurance Survey. All of these estimates ranged from 16% to 17%, a variation not statistically significant. Thus, the available data does not show evidence of a large change in the percentage of the non-elderly population without insurance. Results from a full population sample would be expected to be different only if the uninsured who do not have telephones act in a manner very different from the uninsured with telephones.

Table 2 shows the weighted average age and health status distributions of the uninsured found in the annual 1991 – 1995 Health Polls, compared to the distributions found in the 1997 Health Insurance Survey. There was not a significant difference in the age distribution of the uninsured between the two time periods. However, those uninsured in 1997 were significantly more likely to report that their health status was excellent, and less likely to report that it was fair, than in previous years. This is

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[2] U.S. Bureau of the Census, *Phoneless in America*, July 1994 and *Who Goes without Health Insurance?*, September, 1996.

[3] Estimates from the March 1997 CPS, with data for 1996 will be released this fall.

[4] Throughout this memo the term "significant" is reserved for those cases where a difference has been found to be statistically significant at the 0.05 level.

consistent with the expectation that changes in health insurance laws may have made health insurance less attractive for healthy individuals, and more attractive for those who consider their health only fair.

Privately Insured

Data from the 1996 and 1997 Health Insurance Surveys indicate that the percentage of the population with individual health insurance policies has declined from 5.5% to 4.3%. This decline is significant. Conversely, the percentage with small-group insurance significantly increased, from approximately 9% to 12%.[5]

One explanation for the decline in the percentage of individually insured might be the general disruption in that market, and the withdrawal of all but two insurance carriers, Anthem and Kentucky Kare. An explanation for the increase in the small-group percentage could be the relative stability of that market and the possibility that the insurance reforms made insurance more affordable for those firms. However, caution should be used in attempting to explain the changes only in terms of the insurance legislation. Other factors, particularly the strong growth of the Kentucky economy, could account for some of the change. For example, it is estimated that total state employment in Kentucky will be 4% higher in 1997 than in 1995, a gain of about 66,000 employed persons.[6]

Approximately 46% of the state's population is insured through employers with 50 or more employees, based on the 1997 Health Insurance Survey results (this group was not surveyed in 1996.) Using the assumption that most self-insured firms have 50 or more employees, it is estimated that nearly half of the large-group insured, or a third of all privately insured, are covered under self-insured plans.

Buy-In Group

HB 250 established the "CommonHealth of Kentucky" program (more commonly known as the "buy-in" program), which allowed any Kentucky resident to purchase health insurance as part of the state employee group. Applications were to be accepted only between the time the law became effective in July 1994, and the time that the Kentucky Health Purchasing Alliance was to become operational in July 1995. At that time, those in the buy-in group were to be transferred to the individual segment of the Alliance group.

Applicants to the program could not be refused a policy, but those with medical conditions considered high-risk were to be charged a premium not to exceed 200% of the premium charged for state employees. It is staff's understanding that members of the buy-in group who were classified as high-risk were charged 150% of a state-employee premium until they were moved into the Alliance. At that time, the excess premium was dropped in accordance with the requirement of HB 250 that health status not be used to price health insurance. The buy-in group was never transferred to the individual segment of the Alliance, and remains as part of the state group for insurance purposes.

According to data provided by both the Department of Personnel and the Alliance, just under 5,000 policies, covering about 6,400 individuals, were ever issued through the program. Slightly over 43% of those policies were designated as high-risk.

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[5] SB 343 defined small employers as those with fewer than 50 employees.

[6] Manoj Shanker, *Kentucky Economic Outlook*, presented at a seminar held by the Office of Financial Management and Economic Analysis, August 5, 1997.

As of March 1997, approximately 2,200 of the buy-in policies were still active. These policies provide coverage for nearly 3,300 individuals. The policyholders, themselves, account for about two-thirds of the covered individuals, while spouses and covered children make up about 14% and 17%, respectively.

If dependents of an original policyholder chose to stay in the program after the policyholder did not, then the high-risk status of that contract was not noted in the data.[7] Just over two hundred contracts fall into this category. For those contracts where the designation is known, 42% of the currently active policies were originally classified as high-risk. Thus, it does not appear that policyholders classified as high-risk were less likely to drop out of the program than those not so classified.

The average age of current buy-in policyholders is 55, compared to 45 for insured state employees; and 59% are female, compared to 49% of insured state employees. A comparison of the purchasing behavior between those in the buy-in group who were classified as high-risk and those not so classified indicates that the high-risk group was significantly more likely to purchase an enhanced plan, and significantly less likely to purchase a standard, economy, or budget plan. The high-risk group was also more likely to purchase an indemnity plan and less likely to purchase an HMO or PPO plan. Finally, 34% of the high-risk group chose a Kentucky Kare plan, compared to 22% of the non-high-risk group – a significant difference and likely related to their preference for indemnity plans. The situation was reversed for Alternative Health Delivery Systems, where the percentages were 3% and 8%, respectively. No other carrier had a difference that was significant. For example, Anthem was chosen by 29% of the high-risk group, and 32% of the non-high-risk group.

A final point to note about the Buy-in policyholders still included in the state employee group is that they come under the same *pure* community rating system used for all state employees. The General Assembly appropriates the same dollar amount for the health insurance purchases of all state employees, without regard to the age, gender, or health status of particular individuals. The premiums for dependent coverage are also set without regard to individual characteristics. Thus, the premiums *observed* by those in the state group vary only by the richness of the plan, and the type of coverage (such as single or family) that is chosen.

However, the premium *paid* to the insurance company by the Alliance *for* an individual employee *is* adjusted for age and gender, as was allowed by SB 343. Because of the fact that the buy-in group was maintained in the state employee group, the premiums paid by these policyholders were also not adjusted for age and gender, as they would have been had they transferred to the individual segment of the Alliance. Analysis of the data indicates that the state pays approximately $1.6 million per year more *for* this group of policyholders than it receives *from* them in premiums. Note that this amount is solely due to the fact that they are not rated for age and gender. In order to estimate the full amount of their cost to the state, it would be necessary to add to the $1.6 million any additional amount by which their claims exceed their age-and-gender-adjusted premiums. This information would only be available from insurance carriers. To the extent that total claims exceed total age-and-gender-adjusted premiums, then the buy-in group increases the average premium charged for the community-rated state employee group.

[7] Examples of when this situation could occur would be if the original policyholder became eligible for another form of insurance, such as Medicare, or was no longer a member of the family, such as through divorce or death.

High-Risk Pools

Establishment of a state high-risk pool is an option mentioned frequently in the policy debate over alternatives for changing the current insurance laws. Communicating for Agriculture publishes an annual edition of *Comprehensive Health Insurance for High-risk Individuals*, which contains a wealth of current and historical data on the operation of all state high-risk pools. The most recent edition contains data for 1995 and previous years. A summary and analysis of this data was performed to address questions legislators may have about how such pools are functioning in other states.

1995 Operations

Twenty-three state high-risk pools had sufficient data to be included in the analysis (Table 3). These pools had 91,000 participants in 1995. Fifteen of the pools had maximum lifetime benefits of $500,000 or less, and only one had unlimited lifetime benefits. Twenty had waiting periods of six months or less, and all but one had a condition exclusion period 6 months or less. About half set maximum premium caps at 150% of the standard premium or below. Just over half devoted some state funds to the pool, either through a direct appropriation or through a state tax credit against premium assessments.

For all of the pools, the per capita premium received was $2,458, which left a per capita deficit of $1,984 after payment of all claims and administration costs. On average, premiums equaled 55% of the total costs of operation (Table 4). In every state, the number of pool participants was less than 1% of the state population. This is not surprising since the text quotes the estimate that, nationally, only 1% of the non-elderly population is uninsured *and* has a medical condition that makes them uninsurable in an experience rated market. Given that estimate, pool participation equals about 8% of that group.

Premiums in high-risk pools are usually set at some percentage above the comparable "standard" premium for a similar person without a high-risk condition. Table 6 summarizes the pricing factors used by several pools. Examples of the actual premiums charged are shown in Table 7. For comparison sake, only premiums for states offering plans with a $1,000 deductible are displayed. It is clear that the variation in high-risk premiums is a function of three primary factors -- variations in the level of the "standard" premium, variations in the non-health factors of age and gender, and variations in the additional percentage charged for the "high-risk" designation. The interaction of where these three factors are set determines, in large measure, how many participants will join the pool, and how much of their costs will have to be subsidized by non-premium receipts. The lower the high-risk premium, the greater the number of individuals who will be able to join the pool, but also the more of their costs that will have to be covered through some other means.

Changes in Operations

Historical data was analyzed to show changes in the operation of state high-risk pools between 1990 and 1995. In general, both the number of pools and the number of participants in those pools increased between 1990 and 1993. Florida, which closed its pool, Iowa, and North Dakota were the only states to show consistent declines in the number of participants over most of the period. Conversely, about two-thirds of the states experienced reductions in 1994 or 1995, or both (Table 8).

The national trend in increases in per capita premiums was in the neighborhood of 10% per year through 1994, when the rate fell back to 3% (Table 9). About half of the states had actual decreases in per capita premiums in 1995. Premiums as a percent of total costs increased from 51% in 1990 to 60%

in 1993, then dropped to 55% in 1995 (Table 10). Per capita deficits moved in the opposite direction - increasing in every year except 1993. Most of the decline in that year was from a 55% reduction in claims paid by the closed Florida pool (Table 11). For those states which impose an assessment on premiums to fund their deficits, there was no clear pattern of increases or decreases apparent in Table 12. Collections in many states appeared to be erratic from one year to the next. Minnesota was the only state that showed a consistent increase in assessments over the period.

I hope you find this data useful as you continue your deliberations. Please let me know if you have questions about the information presented here, or if there is other data you would like me to seek. As additional data is acquired, it will be made available to you as soon as possible.

Table 1

Insurance Status of Kentuckians		
	Number	Percent
Population: 7/1/96[a]	**3,880,000**	**100.0%**
Less: Uninsured[b]	570,000	14.6%
Total Insured	**3,310,000**	**85.3%**
Less: Government Insured[c]	880,000	22.7%
Privately Insured	**2,430,000**	**62.6%**
Insurance Companies[d]		
Individually Insured	165,000	4.3%
Small-Group Insured	465,000	12.0%
Large-Group Insured	1,000,000	25.8%
Self-Insured[e] (assumed to be mostly large groups)	800,000	20.6%
Total Large-Group Insured	1,800,000	46.4%
Source: LRC staff estimates based on notes below.		
Notes:		
a. U.S. Census Bureau.		
b. Estimate from the 1996 Current Population Survey (CPS), published by the Census Bureau.		
c. Rounded estimates of Medicare, Medicaid net of Medicare, and other government coverage (such as CHAMPUS & VA) net of all other coverage, from 1997 Health Insurance Survey.		
d. Rounded estimates from the 1997 Health Insurance Survey except for the estimate of associations which was taken from the Department of Insurance, *Market Report on Health Insurance*.		
e. Estimated by applying national percentages, published by the Bureau of Labor statistics, to the distribution of KY firms by size, and updated from the 1993 base.		

Table 2

Age and Health Characteristics of the Uninsured			
Age Category	Average 1991 - 1995	1997	Difference Statistically Significant
under 30	31.3%	30.1%	No
30-39	25.5%	26.7%	No
40-49	19.4%	23.3%	No
50-59	16.2%	15.3%	No
60-64	7.7%	4.6%	No
	100.0%	100.0%	
(Sample Size)	(326)	(327)	
Self-Reported Health Status			
Excellent	17.6%	24.5%	Yes
Very Good	24.8%	29.8%	No
Good	27.6%	25.8%	No
Fair	20.0%	11.0%	Yes
Poor	10.0%	8.9%	No
	100.0%	100.0%	
(Sample Size)	(290)	(327)	
Notes:			
1. The 1991 - 1995 data is from the annual health polls conducted by the University of Kentucky Survey Research Center.			
2. The general health status question was not asked on the 1994 Health Poll.			
3. There were no significant differences between the data for any years of the Health Poll, so using the average of all years to increase sample size should not give spurious results.			
4. The 1997 data is from the Health Insurance Survey conducted by the University of Louisville Survey Research Center.			

Table 3

Summary of State High-Risk Pool Characteristics
1995

State	1995 Participants	Year Operational	Max Lifetime Benefits	Waiting Period (Months)	Condition Period (Months)	Funding of Deficit	Premium Cap (% of Standard)	Agent Fee	Enrollment Cap
Alaska	179	1993	$ 1,000,000	6	3	assessment in proportion to % total premiums	200	$ 25	None
California	19,200	1991	500,000	3	6	$30 million per year from state cigarette and tobacco surtax rev	125	50	Budget
Colorado	1,572	1991	500,000	6	6	unclaimed business association property	150 - 175	25	None
Connecticut	1,419	1976	1,000,000	12	6	premium assessments	125 - 150	50	None
Florida	1,689	1983	500,000	12	6	premium assessments	200 - 250	50	Closed
Illinois	4,805	1989	500,000	6	6	General Fund appropriation	135	50	5000
Indiana	4,483	1982	---	6	6	premium assessments with tax offset	150	25	None
Iowa	1,099	1987	250,000	6	6	premium assessments with 20% tax offset	150	0	None
Kansas	952	1993	500,000	3	6	premium assessments with 80% tax offset	strict	50	None
Louisiana	532	1992	500,000	6	6	$2 per day hospital fee; $1 per day outpatient surgery	150 - 200	None	None
Minnesota	30,470	1976	1,500,000	6	3	premium assessments	125	50	None
Mississippi	835	1992	250,000	6	6	$1 per policy per month (ind); $1 per emp. per mo (gp)	150 - 175	100	None
Missouri	1,107	1992	1,000,000	12	6	premium assessment not exceeding 1%	150 - 200	None	None
Montana	321	1987	250,000	12	60	premium assessment with tax offset	150 - 200	100	None
Nebraska	3,366	1986	500,000	6	6	premium assessment with tax offset	135	25	None
New Mexico	858	1988	750,000	6	6	premium assessment with 30% tax offset for payments over $75,000	150	None	None
North Dakota	1,334	1982	1,000,000	6	3	premium assessment with tax offset	135	25	None
Oregon	4,422	1990	1,000,000	6	6	insurance and reinsurance premium assessment	100 - 125	25	None
South Carolina	1,078	1990	250,000	6	6	premium assessment with $5 million max tax offset	200 - 300	NA	None
Utah	680	1991	500,000	6	6	state appropriations	150	None	None
Washington	862	1988	500,000	6	6	premium assessment with tax offset	150	25	None
Wisconsin	9,512	1981	500,000	6	6	premium assessment with no tax offset, but with a direct appropriation	60% of costs	35	None
Wyoming	279	1991	300,000	12	6	max premium assessment of $2.5M with graduated tax offset	125 - 200	30	None
Total	91,054								

Source; Communicating for Agriculture, *Comprehensive Health Insurance for High-risk Individuals, 1996*.

Table 4

Operations of State High-Risk Pools
1995

State	1995 Participants	Premiums Collected	Per Capita Premiums	Claims Paid	Per Capita Claims	Assessments to Members	Per Capita Assessment	Administration Costs	Per Capita Admin	Per Capita Deficit	Premium as % Total Costs
Alaska	179	$ 479,001	$ 2,676	$ 1,903,747	$10,635	$ 1,775,615	$ 9,920	$ 178,909	$ 999	$ 8,959	23%
California	19,200	46,687,879	2,432	70,092,413	3,651			4,400,000	229	1,448	63%
Colorado	1,572	4,474,798	2,847	6,897,480	4,388			717,432	456	1,998	59%
Connecticut	1,419	6,160,495	4,341	10,649,749	7,505	7,481,031	5,272	505,818	356	3,520	55%
Florida	1,689	6,769,508	4,008	13,450,724	7,964			571,665	338	4,294	48%
Illinois	4,805	19,242,682	4,005	30,007,144	6,245			2,526,158	526	2,766	59%
Indiana	4,483	15,787,366	3,522	30,327,965	6,765	17,479,402	3,899	1,595,978	356	3,600	49%
Iowa	1,099	4,725,141	4,299	5,325,226	4,846	3,000,000	2,730	256,489	233	779	85%
Kansas	952	1,569,407	1,649	2,263,636	2,378			209,200	220	949	63%
Louisiana	532	1,265,709	2,379	2,100,773	3,949			443,901	834	2,404	50%
Minnesota	30,470	52,352,000	1,718	94,608,000	3,105	48,000,000	1,575	6,563,213	215	1,602	52%
Mississippi	835	1,919,933	2,299	2,356,366	2,822	1,001,535	1,199	200,640	240	763	75%
Missouri	1,107	4,382,362	3,959	6,229,528	5,627	1,472,583	1,330	219,190	198	1,867	68%
Montana	321	916,000	2,854	955,449	2,976			73,964	230	353	89%
Nebraska	3,366	7,976,611	2,370	12,881,649	3,827	8,200,000	2,436	627,948	187	1,644	59%
New Mexico	858	3,630,614	4,231	5,556,788	6,476	1,200,000	1,399	322,636	376	2,621	62%
North Dakota	1,334	3,077,624	2,307	4,247,364	3,184	1,250,000	937	201,809	151	1,028	69%
Oregon	4,422	9,326,627	2,109	15,054,852	3,405	7,323,089	1,656	806,328	182	1,478	59%
South Carolina	1,078	4,849,351	4,498	6,058,870	5,620	1,490,700	1,383	546,618	507	1,629	73%
Utah	680	2,093,506	3,079	2,952,634	4,342			311,122	458	1,721	64%
Washington	862	1,857,293	2,155	8,422,077	9,770	6,308,228	7,318	311,910	362	7,978	21%
Wisconsin	9,512	23,720,229	2,494	47,623,069	5,007	29,932,000	3,147	1,847,775	194	2,707	48%
Wyoming	279	545,205	1,954	1,071,636	3,841	997,000	3,573	21,406	77	1,964	50%
Total	91,054	$ 223,809,341	$ 2,458	$ 381,037,139	$ 4,185	$ 136,911,183	$ 1,504	$ 23,460,109	$ 258	$ 1,984	55%

Source: LRC staff analysis of data from Communicating for Agriculture, *Comprehensive Health Insurance for High-risk Individuals, 1996.*

Table 5

Population Coverage of State High-Risk Pools 1995

State	Participants	Year Operational	1995 State Population (Millions)	# of Nonelderly Uninsured	Nonelderly Uninsured as Percent of Population	Pool Participants as % of Population	Pool Participants as % Estimated Uninsured & Uninsurable
Alaska	179	1993	0.6	100,000	17%	0.03%	3.0%
California	19,200	1991	31.6	6,600,000	21%	0.07%	6.1%
Colorado	1,572	1991	3.8	500,000	13%	0.04%	4.1%
Connecticut	1,419	1976	3.3	300,000	9%	0.06%	4.3%
Florida	1,689	1983	14.2	2,400,000	17%	0.01%	1.2%
Illinois	4,805	1989	11.8	1,300,000	11%	0.05%	4.1%
Indiana	4,483	1982	5.8	600,000	10%	0.09%	7.7%
Iowa	1,099	1987	2.8	300,000	11%	0.04%	3.9%
Kansas	952	1993	2.6	300,000	12%	0.05%	3.7%
Louisiana	532	1992	4.3	800,000	19%	0.01%	1.2%
Minnesota	30,470	1976	4.6	400,000	9%	0.81%	66.2%
Mississippi	835	1992	2.7	500,000	19%	0.03%	3.1%
Missouri	1,107	1992	5.3	600,000	11%	0.03%	2.1%
Montana	321	1987	0.9	100,000	11%	0.05%	3.6%
Nebraska	3,366	1986	1.6	200,000	13%	0.21%	21.0%
New Mexico	858	1988	1.7	400,000	24%	0.06%	5.0%
North Dakota	1,334	1982	0.6	100,000	17%	0.13%	22.2%
Oregon	4,422	1990	3.1	400,000	13%	0.16%	14.3%
South Carolina	1,078	1990	3.7	500,000	14%	0.03%	2.9%
Utah	680	1991	1.9	200,000	11%	0.04%	3.6%
Washington	862	1988	5.4	700,000	13%	0.02%	1.6%
Wisconsin	9,512	1981	5.1	400,000	8%	0.23%	18.7%
Wyoming	279	1991	0.5	100,000	20%	0.05%	5.6%
Total	**91,054**		**117.9**	**17,800,000**	**15%**	**0.08%**	**7.7%**

Source: All data from Communicating for Agriculture, *Comprehensive Health Insurance for High-risk Individuals, 1996*, except 1995 state population, which is from the U.S. Census Bureau.

Table 6

State High-Risk Pool Pricing Factors
1995

State	Deductibles Offered	Family Rate Structure	Regions Defined	Case Characteristics Allowed
ARKANSAS	$1,000; $5,000; $10,000	Single Family	None	Age
CALIFORNIA	(500 for BS PPO option) (0 for HMO option) Not figured in premium	Subscriber Subscriber & 1 dependent Subscriber & 2 dependents	6	Age
COLORADO	$300; $750; $2,000	Single	None	Age Gender Smoker, Nonsmoker
ILLINOIS	$500; $1,000; $2,500	Single Family*=90% of single rate	4	Age Gender
LOUISIANA	$1,000; $2,000	Single	2 urban plus rest of state	Age Gender Smoker, Nonsmoker
MINNESOTA	$1,000; $2,000	Single* Dependent children - 1, 2+	None	Age
MISSISSIPPI	$500; $1,500	Single	None	Age Gender
MONTANA	$1,000	Single	None	Age
NEW MEXICO	$500; $1,000; $2,000; $5,000	Single	None	Age Gender
NORTH DAKOTA	$500; $1,000	Single	None	Age
OKLAHOMA	$500; $1,000; $1,500; $2,000; $5,000; $7,000	Single 1 child 2 children 2+ children	None	Age Gender
WYOMING	$500/$2,000*	Single 2 adults Per child*	None	Age Gender

Source: Communicating for Agriculture, *Comprehensive Health Insurance for High-risk Individuals, 1996.*

*Illinois - Spouses or dependents of risk pool eligible persons who do not otherwise qualify for progrogram may enroll at 90% of rates rounded up to nearest whole dollar.
*Minnesota - Premiums established for insured person and insured person's spouse based on age of insured person and age of insured person's spouse.
*Wyoming - 1) Only 1 deductible plan offered; deductible varies according to services and benefits provided.
2) Per child rate for children being added to contract with at least 1 adult. If child to be covered as insured, single male or female under 30 rate applies. Family may insure as many children as are eligible, but risk pool will only charge for maximum of 4 children or contract with 1 or 2 adults.

Table 7

Standard and High-Risk Monthly Premiums
State High-Risk Pools
1995

Males
$1,000 Deductible Policy

State	Under Age 30 Standard	Under Age 30 High-Risk	Age 60 - 64 Standard	Age 60 - 64 High-Risk	High Risk Premium as % of Standard
Minnesota*	$ 54	$ 67	$ 151	$ 189	125
Oklahoma	76	96	344	430	125
Illinois	150	203	608	821	135
North Dakota**	80	108	249	336	135
Montana**	110	165	348	522	150
New Mexico*	89	133	381	571	150
Louisiana**	78	156	303	605	200

Females
$1,000 Deductible Policy

State	Under Age 30 Standard	Under Age 30 High-Risk	Age 60 - 64 Standard	Age 60 - 64 High-Risk	High Risk Premium as % of Standard
Minnesota*	$ 54	$ 67	$ 151	$ 189	125
Oklahoma	115	143	315	394	125
Illinois	188	254	496	670	135
North Dakota**	80	108	249	336	135
Montana**	110	165	348	522	150
New Mexico*	114	171	323	484	150
Louisiana**	108	216	268	536	200

Source: LRC staff analysis of data in Communicating for Agriculture, *Comprehensive Health Insurance for High-risk Individuals, 1996.*

Notes:

1. LA, MN, MT, NM, ND & OK - All age categories under 30 averaged to obtain the under 30 premium.
2. Smoker premium rates used for LA.
3. Premiums by region: IL - rates for Chicago used; LA - rates for New Orleans used.
4. New Mexico - rates with optional maternity benefits used.
5. North Dakota - rates without optional chiropractic benefits used.

Table 8

Participants
State High Risk Pools
1990 - 1995

	Number of Participants						Percent Change in Number of Participants				
	1990	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995
Alaska				57	128	179				125%	40%
California		10,912	13,589	16,785	19,353	19,200		25%	24%	15%	-1%
Colorado		1,033	1,767	2,046	1,921	1,572		71%	16%	-6%	-18%
Connecticut	1,434	1,246	1,534	1,610	1,364	1,149	-13%	23%	5%	-15%	-16%
Florida	7,500	5,200	4,326	3,476	2,387	1,689	-31%	-17%	-20%	-31%	-29%
Illinois	4,370	4,408	4,405	4,693	4,755	4,805	1%	0%	7%	1%	1%
Indiana	3,080	3,984	4,791	4,924	4,638	4,483	29%	20%	3%	-6%	-3%
Iowa	1,971	2,141	2,068	1,753	1,341	1,099	9%	-3%	-15%	-24%	-18%
Kansas				224	578	952				158%	65%
Louisiana			32	228	386	532			613%	69%	38%
Minnesota	25,272	29,902	33,805	35,296	33,477	30,470	18%	13%	4%	-5%	-9%
Mississippi			200	365	610	835			83%	67%	37%
Missouri			847	987	931	1,107			17%	-6%	19%
Montana	304	307	341	289	268	321	1%	11%	-15%	-7%	20%
Nebraska	2,904	3,111	3,247	3,282	3,331	3,366	7%	4%	1%	1%	1%
New Mexico	1,303	1,414	1,289	1,294	1,124	858	9%	-9%	0%	-13%	-24%
North Dakota	1,656	1,690	1,590	1,538	1,422	1,334	2%	-6%	-3%	-8%	-6%
Oregon	1,211	2,606	3,111	3,972	4,235	4,422	115%	19%	28%	7%	4%
South Carolina	1,072	1,390	1,418	1,437	1,264	1,078	30%	2%	1%	-12%	-15%
Utah			486	681	710	680			40%	4%	-4%
Washington	2,793	3,343	3,930	4,387	1,307	862	20%	18%	12%	-70%	-34%
Wisconsin	9,287	12,009	12,707	12,045	10,864	9,512	29%	6%	-5%	-10%	-12%
Wyoming		189	215	206	200	279		14%	-4%	-3%	40%
Total	64,157	84,885	95,698	101,575	96,594	90,219	32%	13%	6%	-5%	-7%

Source: LRC staff analysis of data from Communicating for Agriculture, *Comprehensive Health Insurance for for High-risk Individuals, 1996.*

Table 9

Per Capita Premiums
State High-Risk Pools
1990 - 1995

	Per Capita Premiums						Percent Change in Per Capita Premiums				
	1990	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995
Alaska	$	$	$	$ 1,550	$ 2,725	$ 2,676				76%	-2%
California		1,307	1,959	1,589	2,055	2,432		50%	-19%	29%	18%
Colorado		971	2,075	2,612	2,951	2,847		114%	26%	13%	-4%
Connecticut	3,585	4,608	4,136	4,228	4,565	5,362	29%	-10%	2%	8%	17%
Florida	2,122	4,386	3,640	3,862	4,167	4,008	107%	-17%	6%	8%	-4%
Illinois	2,735	3,086	3,464	3,856	3,971	4,005	13%	12%	11%	3%	1%
Indiana	2,720	2,216	2,426	3,012	3,409	3,522	-19%	9%	24%	13%	3%
Iowa	2,321	2,692	3,237	3,659	4,509	4,299	16%	20%	13%	23%	-5%
Kansas				570	1,373	1,649				141%	20%
Louisiana			212	1,254	2,053	2,379			491%	64%	16%
Minnesota	1,018	1,187	1,289	1,460	1,619	1,718	17%	9%	13%	11%	6%
Mississippi			980	1,997	2,032	2,299			104%	2%	13%
Missouri			1,653	3,384	4,239	3,959			105%	25%	-7%
Montana	2,071	2,542	2,803	3,604	5,939	2,854	23%	10%	29%	65%	-52%
Nebraska	1,523	2,039	2,345	2,507	2,481	2,370	34%	15%	7%	-1%	-4%
New Mexico	2,191	2,588	3,404	3,391	3,916	4,231	18%	32%	0%	16%	8%
North Dakota	1,553	1,688	2,046	2,199	2,328	2,307	9%	21%	7%	6%	-1%
Oregon	1,123	1,398	1,961	1,769	1,944	2,109	24%	40%	-10%	10%	8%
South Carolina	1,526	3,159	3,885	4,309	4,730	4,498	107%	23%	11%	10%	-5%
Utah			2,083	2,062	2,710	3,079			-1%	31%	14%
Washington	1,689	2,033	2,297	2,606	5,131	2,155	20%	13%	13%	97%	-58%
Wisconsin	938	1,134	1,559	2,207	2,362	2,494	21%	37%	42%	7%	6%
Wyoming		1,634	2,789	3,669	3,628	1,954		71%	32%	-1%	-46%
Total	1,537	1,766	1,979	2,147	2,386	2,459	15%	12%	9%	11%	3%

Source: LRC staff analysis of data from Communicating for Agriculture, *Comprehensive Health Insurance for High-risk Individuals, 1996*.

Table 10

Premiums as a Percent of Total Costs
State High-Risk Pools
1990 - 1995

State	Premiums as a Percent of Total Costs					
	1990	1991	1992	1993	1994	1995
Alaska				38%	59%	23%
California		44%	56%	56%	67%	63%
Colorado		257%	123%	98%	82%	59%
Connecticut	46%	45%	49%	51%	47%	55%
Florida	41%	43%	36%	65%	50%	48%
Illinois	46%	50%	56%	64%	64%	59%
Indiana	47%	50%	40%	51%	63%	49%
Iowa	84%	74%	76%	71%	80%	85%
Kansas				72%	63%	64%
Louisiana			2%	44%	44%	50%
Minnesota	49%	55%	53%	56%	55%	52%
Mississippi			70%	167%	85%	75%
Missouri			108%	81%	68%	68%
Montana	101%	88%	81%	92%	111%	89%
Nebraska	63%	64%	80%	62%	61%	59%
New Mexico	65%	63%	65%	61%	57%	62%
North Dakota	57%	52%	66%	70%	67%	47%
Oregon	88%	72%	73%	60%	63%	59%
South Carolina	77%	61%	73%	84%	71%	73%
Utah			81%	77%	61%	64%
Washington	61%	69%	54%	57%	33%	21%
Wisconsin	62%	54%	50%	64%	56%	48%
Wyoming		132%	127%	73%	66%	50%
Total	51%	52%	54%	60%	59%	55%

Source: LRC staff analysis of data from Communicating for Agriculture, *Comprehensive Health Insurance for High-risk Individuals, 1996*.

Table 11

Per Capita Deficits
State High-Risk Pools
1990 - 1995

State	Per Capita Deficits 1990	1991	1992	1993	1994	1995	Percent Change in Per Capita Deficits 1991	1992	1993	1994	1995
Alaska	$	$	$	$ 2,561	$ 1,869	$ 8,959				-27%	379%
California		1,693	1,544	1,234	991	1,448		-9%	-20%	-20%	46%
Colorado		-594	-392	55	635	1,998		-34%	-114%	1055%	215%
Connecticut	4,209	5,662	4,258	4,143	5,216	4,347	35%	-25%	-3%	26%	-17%
Florida	3,033	5,862	6,436	2,074	4,245	4,294	93%	10%	-68%	105%	1%
Illinois	3,185	3,048	2,715	2,136	2,243	2,766	-4%	-11%	-21%	5%	23%
Indiana	3,025	2,179	3,571	2,939	2,021	3,600	-28%	64%	-18%	-31%	78%
Iowa	434	931	1,043	1,462	1,095	779	115%	12%	40%	-25%	-29%
Kansas				217	814	935				275%	15%
Louisiana			9,355	1,610	2,626	2,404			-83%	63%	-8%
Minnesota	1,060	972	1,132	1,170	1,335	1,602	-8%	16%	3%	14%	20%
Mississippi			425	-799	363	763			-288%	-145%	110%
Missouri			-118	792	2,015	1,867			-771%	154%	-7%
Montana	-20	350	637	297	-573	353	-1836%	82%	-53%	-293%	-162%
Nebraska	909	1,162	569	1,552	1,603	1,644	28%	-51%	173%	3%	3%
New Mexico	1,205	1,547	1,804	2,140	3,001	2,621	28%	17%	19%	40%	-13%
North Dakota	1,174	1,533	1,059	928	1,152	1,778	31%	-31%	-12%	24%	54%
Oregon	155	547	716	1,194	1,146	1,478	253%	31%	67%	-4%	29%
South Carolina	461	2,056	1,467	820	1,909	1,629	346%	-29%	-44%	133%	-15%
Utah			489	618	1,709	1,721			26%	177%	1%
Washington	1,086	958	1,984	1,979	10,504	7,978	-12%	107%	0%	431%	-24%
Wisconsin	566	982	1,560	1,216	1,873	2,707	73%	59%	-22%	54%	45%
Wyoming		-394	-596	1,351	1,885	1,964		52%	-327%	40%	4%
Total	1,477	1,605	1,698	1,412	1,665	1,988	9%	6%	-17%	18%	19%

Source: LRC staff analysis of data from Communicating for Agriculture, *Comprehensive Health Insurance for High-risk Individuals, 1996.*

Table 12

Total Assessments
State High-Risk Pools
1990 - 1995

State	Total Assessments						Percent Change in Total Assessments				
	1990	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995
Alaska	$	$	$	$ 338,874	$ 1	$ 1,775,615				-100%	177561400%
California											
Colorado											
Connecticut	6,337,562	6,076,638	6,258,544	9,197,942	8,365,979	7,481,631	-4%	3%	47%	-9%	-11%
Florida	33,354,379	5,583,791	7,138,078	5,796,035	11,814,627	1	-83%	28%	-19%	104%	-100%
Illinois											
Indiana	7,316,933	13,256,885	15,912,425	14,326,415	10,717,539	17,479,402	81%	20%	-10%	-25%	63%
Iowa	2,088,517	2,000,000	1	2,707,377	3,000,000	3,000,000	-4%	-100%	0%	11%	0%
Kansas											
Louisiana											
Minnesota	22,167,000	24,239,000	32,074,000	40,626,525	44,424,903	48,000,000	9%	32%	27%	9%	8%
Mississippi			4,694,876	3,412,263	2,020,855	1,001,535			-26%	-41%	-50%
Missouri			2,300,000	1,123,416	1,934,854	1,472,583			-51%	72%	-24%
Montana		300,000	500,000	200,000	1	1		67%	-60%	-100%	0%
Nebraska	4,000,000	4,723,292	2,500,000	6,300,000	6,200,000	8,200,000	18%	-47%	152%	-2%	32%
New Mexico	2,513,710	2,145,509	2,772,086	2,790,871	3,426,625	1,200,000	-15%	29%	1%	23%	-65%
North Dakota	1,699,880	2,075,220	2,792,720	1,987,960	1,500,000	1,250,000	22%	35%	-29%	-25%	-17%
Oregon	1,112,762	1,361,877	3,345,705	4,121,024	3,997,238	7,323,089	22%	146%	23%	-3%	83%
South Carolina	90,400	2,205,171	4,083,000	1,627,301	1	1,490,700	2339%	85%	-60%	-100%	149069900%
Utah											
Washington	2,999,470	2,499,451	10,199,088	10,198,943	11,499,657	6,308,228	-17%	308%	0%	13%	-45%
Wisconsin	7,330,245	10,386,725	22,887,094	17,545,905	17,107,689	29,932,000	42%	120%	-23%	-2%	75%
Wyoming					517,350	997,000					93%
Total	$91,010,858	$76,853,559	$117,357,617	$122,300,851	$126,527,319	$136,911,784	-16%	53%	4%	3%	8%

Source: LRC staff analysis of data from Communicating for Agriculture, *Comprehensive Health Insurance for High-risk Individuals, 1996.*

Note: For states which had assessments in one year, but not the next, that year's assessment was set equal to $1, rather than zero, so the percent change formula would accurately reflect the change. However, an effect of that was to yield the fantastically large one-year percentage increases observed in both Alaska and South Carolina in 1995.

NUMBER AND CHARACTERISTICS OF THE INDIVIDUALLY INSURED, SMALL-GROUP INSURED, AND UNINSURED IN KENTUCKY

RESEARCH MEMORANDUM NO. 474

LEGISLATIVE RESEARCH COMMISSION

MARCH, 1997

NUMBER AND CHARACTERISTICS OF THE INDIVIDUALLY INSURED, SMALL-GROUP INSURED, AND UNINSURED IN KENTUCKY

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Research Memorandum No. 474

Legislative Research Commission

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MEMORANDUM

TO: Don Cetrulo, Director
Legislative Research Commission

FROM: Ginny Wilson, Ph.D.
LRC Chief Economist

SUBJECT: Report of Data on the Number and Characteristics of Individually Insured, Small-Group Insured, and Uninsured

DATE: March 18, 1997

The purpose of this memo is to report staff analysis of newly available data on three segments of the Kentucky population — those who reported that they obtain health insurance policies in the individual segment of the health insurance market, those who reported that they obtain health insurance policies in the small group segment of the health insurance market, and those who reported that they have no health insurance, with particular attention given to those who reported being newly uninsured or having uninsured children in the household. Also included is a summary of an exploratory mail survey of small employers who offered health insurance. The data was obtained from three recent surveys of Kentucky households.

EXECUTIVE SUMMARY

Recent policy debates on health insurance reform were hampered by the fact that little reliable information was available on the numbers and characteristics of Kentuckians in the affected segments of the insurance market. The 1996 debate on revisions to reforms initially adopted in 1994 was also hampered by the fact that little reliable data existed on the characteristics of the individual and small-group health insurance markets before any reforms were adopted, and how those markets were changed when initial reform provisions were implemented.

Since it is likely that the policy debate on health insurance reform will continue in future General Assemblies, the Legislative Research Commission sponsored a telephone survey of Kentucky households to gather data on the three segments of the insurance market most affected by changes in insurance laws, along with an additional group in which there is particularly policy interest. These are:

- Adults covered under health insurance policies purchased directly from insurance companies;
- Adults covered under health insurance policies provided through employers with fewer than 50 employees;
- The uninsured, particularly those newly uninsured within the past 12 months;
- Households with uninsured children.

Responses to the Health Insurance Survey, and other available surveys, were used to estimate characteristics of Kentuckians in the four groups of interest at the particular time data was collected. Significant changes have occurred since the data was collected, particularly in the individual insurance market, as insurers withdrew from Kentucky and as it was determined that chambers of commerce and the Farm Bureau could take into account health status in setting the premium for an individual policy. The only reliable way to assess the on-going changes in these market segments is to repeat the data collection at some reasonable interval. *Thus, survey results presented in this memo represent a* **baseline snapshot** *of the individual and small-group markets* **after** *implementation of most of the provisions of HB 250 and* **before** *implementation of most of the provisions of SB 343. Unfortunately, there is no baseline of pre-HB 250 data for comparison. In order to determine how provisions of SB 343 are affecting these markets it would be necessary to repeat the survey, and see how characteristics of policies and covered adults had changed from the baseline snapshot presented here.*

INDIVIDUALLY INSURED

1. Number

It is estimated that 5.5% of the Kentucky population (or 6.3% of the population under 65) are covered under health insurance policies purchased directly from insurance companies. Based on the 1995 Kentucky population, this is about 210,000 individuals.

2. Characteristics of Adults

- 47% were female, and 53% were male
- Average age was 43
- Median household income was between $25,000 and $35,000
- 55% worked outside the home
- 85% scored in the best two out of the four categories of a standard health status index
- 5% scored in the worst category of a standard health status index
- 27% smoked regularly in the past two years
- 60% reported 2 or fewer doctor visits in the previous year, while 12% reported 7 or more
- Nearly 30% were under age 40 and scored in the best category of the health status index.

3. Characteristics of Policies

Characteristic	Percent of Individual Policies
Issuing Company	
Blue Cross/Blue Shield	48
Humana	5
American Medical Security	3
Golden Rule	3
Kentucky Kare	3
Other	33
Unknown	6
Total	**100**
Purchased through KY Health Purchasing Alliance	20
Identified as a standard plan	25
Had managed care features	46
Had deductible greater than $1,000	25

4. Knowledge of Changes in the Law

- 67% had heard of changes in the law
- 37% thought the changes would directly affect them
- 28% said they were familiar with standard plans
- Slightly less than 20% correctly knew that, under standard plans, anyone could buy a policy no matter how sick, and that individuals with similar characteristics would pay the same no matter whether they were healthy or sick

SMALL-GROUP INSURED

1. Number

It is estimated that 9.3% of the Kentucky population (or 10.7% of the population under 65) are covered under health insurance policies purchased through an employer with fewer than 50 employees. Based on the 1995 Kentucky population, this is about 360,000 individuals.

2. Characteristics of Adults

- Females and males each accounted for about half these respondents
- Average age was 39
- Median household income was between $25,000 and $35,000
- 62% worked outside the home
- 90% scored in the best two out of the four categories of a standard health status index
- 2% scored in the worst category of a standard health status index
- 29% smoked regularly in the past two years
- 67% reported 2 or fewer doctor visits in the previous year, while 9% reported 7 or more
- Nearly 40% were under 40 and scored in the best category of the health status index.

3. Characteristics of Policies

Characteristic	Percent of Small-Group Policies
Issuing Company	
Blue Cross/Blue Shield	49
Alternative Health Delivery Systems	4
Humana	8
Aetna	2
HealthWise	2
Other	28
Unknown	7
Total	**100**
Purchased through KY Health Purchasing Alliance	17
Identified as a standard plan	18
Had managed care features	58
Had deductible greater than $1,000	9

4. Knowledge of Changes in the Law

- 65% had heard of changes in the law
- 24% thought the changes would directly affect them
- 21% said they were familiar with standard plans
- Approximately 13% correctly knew that, under standard plans, anyone could buy a policy no matter how sick, and that individuals with similar characteristics would pay the same no matter whether they were healthy or sick

UNINSURED

1. Number

- There has recently been some confusion about various estimates of the number of uninsured in Kentucky and whether different estimates can be used to gauge changes in the number of uninsured since new laws governing health insurance were enacted. Generally, differences in the estimates offer no reliable measure of changes in the number of uninsured in the state.
- The most recent point estimates of the percentage of uninsured in Kentucky by the Bureau of the Census from the CPS were 15.2% in 1994 and 14.6% in 1995. This gives a 1995 point estimate of about 560,000 uninsured in Kentucky.
- The standard error on either of the estimates is +/- 1.3 percent. Therefore, the Bureau did not find a statistically significant change in the state's percentage of uninsured from 1994 to 1995.
- This does not mean that it is safe to conclude that there was not a change in the number of uninsured in the state. It means that, if changes occurred, they were not large enough to be identifiable using the Bureau of the Census' current methodology for estimating the number of uninsured by state.

2. Characteristics

- Uninsured adults were significantly more likely to be younger, have less family income (median was $10,000 - $15,000), and not be currently employed than the privately insured.
- Uninsured adults were significantly more likely to have worse scores than insured adults on two items of a standard health index..
- 68% said they did not have health insurance because they could not afford it; 5% said a medical condition prevented them from getting coverage.
- 40% had been uninsured for a year or less, while 42% had been uninsured for 5 years or more. It is likely that effective policy proposals for the temporarily uninsured would be different than those for the chronically uninsured.
- Of those previously insured, 74% said coverage ended with a change in either employment or family status (such as divorce or reaching adulthood).
- 18% of the previously insured said they dropped coverage because the premium became too expensive.

3. Newly Uninsured within the Past 12 Months

- Average age was 37.
- Median household income was $15,000 - $25,000.
- 69% said previous coverage was through an employer; 24% had held an individual policy.
- 58% of the previous policies covered 1-2 adults, and no children.
- 66% said they dropped coverage because of a change in employment or family status.
- 18% of these households said they dropped coverage because they could no longer afford it. This response was given by 50% of those who had previously held an individual policy.
- 29% had heard of changes in the law but only 3% were familiar with standard plans.

UNINSURED CHILDREN

- 13% of Kentucky's children, or 125,000, are uninsured, based on an average of the estimates by the Census Bureau for 1991 - 1995.
- 43% of uninsured children live in families with incomes below 100% of the federal poverty level.
- 86% of uninsured children live in families with incomes below 250% of the federal poverty level.
- 25% of uninsured children are under 5, and 31% are between 13 and 17.
- 20% of uninsured children live with an adult who has insurance, usually through an employer.
- 82% of uninsured children live with 2 or more adults.
- The median amount adults in families with uninsured children said they would be willing to pay for one basic child's policy was $30.
- There are approximately 600,000 children in Kentucky covered by private insurance.
- Although "only" 18% of privately insured children live in families with incomes below the federal poverty level, compared to 62% of uninsured children, there are approximately 108,000 insured children in this income class, compared to about 77,000 uninsured children.
- The cost of subsidizing insurance for currently uninsured children is likely to be significantly underestimated unless the estimate incorporates the large number of insured children in the income classes deemed eligible for a subsidy. Many families with currently insured children who meet income criteria would be expected to drop current coverage to avail themselves of an income-based subsidy.

INTRODUCTION

HB 250, enacted by the 1994 General Assembly, mandated that health insurance policies sold by insurers directly to individual policyholders (meaning they were not purchased through membership in any group), and group policies sold to employers with fewer than 100 employees be priced according to a modified community rating system.[1] The modified community rating structure enacted in HB 250 no longer allowed health status or gender to be considered in setting the price charged for health insurance policies sold in these segments of the market. The price considerations for age were limited by a provision that the oldest policy holder could be charged no more than 3 times the premium charged the youngest adult. The only other factors which could be considered were geographic location and, for small employers, type of industry. However, the effect of these last two factors on premiums was limited to 15% when comparing the highest to the lowest.

The 1996 General Assembly enacted SB 343, which made significant modifications to the insurance provisions of HB 250. First, policies sold to employers with 50 to 99 employees were no longer subject to the rating restrictions. Second, the bands allowed on premium rates were widened so that females of a specific age could be charged a premium 1.5 times as much as males of the same age, and the oldest policyholders could be charged a premium greater than that of the youngest adults, but the highest premium for a particular policy could be no more than 5 times the lowest premium, considering all demographic factors. Finally, insurance plans sold by associations of small employers and individuals were exempt from the restrictions set in the modified community rating structure.

The policy debate on both of these bills was hampered by the fact that little reliable information was available on the numbers and characteristics of Kentuckians in the affected segments of the insurance market. The debate on SB 343 was also hampered by the fact that little reliable data existed on the characteristics of the individual and small-group health insurance markets before the passage of HB 250, and how those markets were changed when its provisions were implemented.

Since it is likely that the policy debate on health insurance reform will continue in future General Assemblies, the Legislative Research Commission sponsored a telephone survey of Kentucky households to gather data on the three segments of the insurance market most affected by the changes in the insurance laws - policyholders in the individual market, policyholders in the small-group market, and the uninsured. Because legislators had expressed particular interest in the characteristics of uninsured children, information on this group was sought as well.

Responses to survey questions are used to estimate the characteristics of Kentuckians in the four groups of interest at the particular time the data was collected. Significant changes have occurred since the data was collected, particularly in the individual insurance market, as insurers withdrew from Kentucky, and as it was determined that chambers of commerce and the Farm Bureau could

[1] Provisions of the 1994 and 1996 legislation discussed here also applied to policies sold to various public employee groups. However, because relatively more data either was available at the time, or could be obtained in a fairly direct manner likely to be more reliable than these surveys, public employees are not discussed in this memo.

take into account health status in setting the premium for an individual policy. The only reliable way to assess on-going changes in these market segments is to repeat data collection at some reasonable interval. *Thus, the survey results presented in this memo represent a* ***baseline snapshot*** *of the individual and small-group markets* ***after*** *implementation of most of the provisions of HB 250 and* ***before*** *implementation of most of the provisions of SB 343. Unfortunately, there is no baseline of pre-HB 250 data for comparison. In order to determine how provisions of SB 343 are affecting these markets it would be necessary to repeat the survey, and see how characteristics of policies and covered adults had changed from the baseline snapshot presented here.*

The memo is organized in the following manner. First is a description of each of the surveys from which the data is drawn. Then analysis results are presented for policyholders in the individual market, policy holders in the small-group market and, finally, for the uninsured.

DATA SOURCES

Data on insurance status and demographic characteristics was collected in three separate random surveys of Kentucky households. These surveys were conducted at different times, asked different questions and have different strengths and limitations for the analysis. Therefore, the decision was made to draw on each data source as it was judged to provide a more reliable estimate of the characteristics of the population of interest. Results from the three sources are not always strictly comparable, and may even provide substantially different estimates because of their differences in timing, methodology, and content. The three surveys are denoted as

1. 1996 Health Insurance Survey,
2. Spring 1996 Kentucky Survey,
3. Current Population Survey for various years (CPS).

1996 HEALTH INSURANCE SURVEY

The 1996 Health Insurance Survey was targeted to Kentucky households with members who obtained health insurance in the individual market, or in the small-group market, or who became uninsured within the past 12 months, or who were uninsured children. The survey was conducted by the University of Kentucky Survey Research Center. Dr. Glenn Blomquist, Professor of Economics and Public Policy at the University of Kentucky, supervised the design and implementation of the survey. Between June 20, 1996 and August 22, 1996, the Survey Research Center (SRC) made 13,354 calls to Kentucky telephone numbers generated from a random digit dialing routine. Of these calls, 8,173 households were determined to be ineligible to participate in the survey because they had no members who fell into one of the groups of interest, or for other reasons, such as language problems or that no one was available who could answer questions about household insurance policies. Another 3,543 respondents refused to participate in the survey. Completed interviews were obtained from 1,638 respondents, for a response rate of 31.6%. The overall margin of error on the estimates from this survey is plus or minus 2.5%.

Content

The survey questions addressed to each respondent depended on whether members of that household fell into one or more of the targeted groups. Those who reported having uninsured children were asked questions about the number and ages of those children, and the amount the respondent might be willing to pay to purchase a basic health insurance policy for each child. Uninsured adults were asked whether they had been covered within the past 12 months and, if they had, the characteristics of that coverage and why it had lapsed.

Respondents with household members insured under a policy obtained directly from an insurer or through an employer with fewer than 50 employees were asked a more detailed set of questions. First, respondents were questioned about the characteristics of each individually purchased or small-group health insurance policy held by members of the household. Information requested included the name of the insurer, the benefits covered by the policy, the cost-sharing provisions of the policy, and the amount of the premium paid for the policy. Those holding small-group policies were asked the amount, if any, the employer contributed to the premium. Respondents were also asked whether the policy was one of the standard plans mandated under the insurance reforms and whether the policy was obtained through the Kentucky Health Purchasing Alliance.

Next, respondents were questioned about characteristics of each adult in the household covered under each policy. The characteristics of interest were age, gender, occupation, number of physician visits in the last 12 months, and measures of health status. The respondent was also asked whether any individual (adult or child) covered under the policy had been previously refused health insurance, suffered from one of a list of serious medical conditions generally considered uninsurable (such as heart disease, diabetes, and cancer), or had been newly insured in the past 12 months.

Finally, respondents were questioned about their knowledge of the enacted changes in health insurance laws and how they thought their families would be affected by those changes. Information about total household income was also requested.

Limitations

In any research on the characteristics of a particular subset of the population, it is preferable to have information about how that subset compares to the larger group. In this instance it would have been preferable to collect comparable survey data on individuals insured through large employers, who comprise the majority of insureds. However, because the primary policy focus was on the individual and small-group segments of the market, and because these segments represent such a small percentage of the insured market, the decision was made to expend all available resources on increasing the sample size of the target groups rather than collecting data on other insured. Generally, the number of respondents insured by large employers is sufficient in other surveys, such as those discussed below, to allow adequate estimation of the characteristics of that group.

Just as resource limitations force priority-setting for sample selection, time constraints force restrictions on content. Survey participation was entirely voluntary on the part of respondents. To hold down the number of respondents who might refuse to participate, or who might drop out before the interview was completed, the time questions took to complete was restricted to about 20 minutes. Because the pricing of insurance policies is usually based on the characteristics of adults, but only on the presence and number of children (unless they have a high risk condition, which was captured in the survey), information about the characteristics of children insured in the individual and small-group markets was not sought in the survey.

In this survey, the RAND 5-Item Health Index was used as a measure of the health status of adults insured in the individual and small-group markets. The total score on the index was determined by asking respondents if they agree or disagree with several questions about their health, such as, "I seem to get sick a little easier than other people." Answers for each question were ranked from healthy to unhealthy and then all responses were summed to get the final index score.[2] Respondents with low scores had relatively good health, while those with high scores had relatively poor health. This is a widely used and well-validated index of self-reported health status that has been shown to be highly correlated with actual utilization of health services and with independent assessments of health status by health care professionals.[3] The American Academy of Actuaries has even suggested the index as a possible method for calculating risk-adjustment factors for insurance carriers.[4]

However, it should be understood that, in this survey, the respondent who answered the survey questions was asked to answer the RAND Index questions not only about themselves, but also about any other adults in the house who were covered under the target policies. The methodology of having one respondent answer health status questions about other members of the household was used by the federal Agency for Health Care Policy Research in the National Medical Expenditure Panel Survey, and by the Bureau of the Census in the supplement to the March 1995 CPS.[5] The health index scores based on reports by the respondent for other members of the household are thought to be generally reliable, as it is expected that respondents would be fairly well-informed about the health characteristics of other household members. The fact that the distribution of responses on the health status questions using the respondents' assessment of other household members does not differ significantly from the distribution that other recent SRC polls have obtained using only self-reported responses is an indication that the use of this approach is not a serious source of error.

Finally, due to an error in the structure of the data collection program, the total number of people in the household was not obtained for those with individual or small-group policies, and total household income was not obtained for those with uninsured children. Because federal poverty

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[2] Aday, Lu Ann, *Designing and Conducting Health Surveys, Second Edition.* San Francisco: Jossey-Bass Publishers, 1996.

[3] Hornbrook, M.C., and Goodman, M.J. Assessing Relative Health Plan Risk with the RAND-36 Health Survey. *Inquiry* 32:56-74, Spring, 1995.

[4] American Academy of Actuaries, Health Risk Assessment and Health Risk Adjustment: Crucial Elements in Health Care Reform. Monograph Number One, May 1993.

[5] Medical Expenditure Panel Survey, Family Medical Expenditure Survey, Programming Specifications, Rounds 1-3 Consolidated Instrument, Round 1 Main Study, Agency for Health Care Policy Research, March 22, 1996.

levels are determined by both household income and household size, it was not possible to use this data to determine the poverty characteristics of these groups. However, as noted below, data from other sources were used to make these estimates.

SPRING 1996 KENTUCKY SURVEY

The Survey Research Center at the University of Kentucky conducted a random telephone survey of Kentucky households from May 21 to June 11, 1996. Of the 1278 eligible respondents, 658 (52%) completed interviews. The margin of error on the survey results is +/- 4 percentage points. The number of respondents in this sample who fell into a target group of interest is generally small, which increases the error of the estimates regarding the characteristics of these population segments. Therefore, estimates from this data are used only if comparable data were not available in the 1996 Health Insurance Survey. This data is primarily used to develop comparisons of the target groups with other groups of Kentuckians, and to address limitations noted in that survey.

MARCH SUPPLEMENT TO THE CURRENT POPULATION SURVEY

In March of every year, the Census Bureau supplements the monthly current population survey (CPS) with an extensive set of questions regarding household income and benefits for the prior year. In some years, the Census will add or modify certain questions to better collect information on a particular policy issue of interest. The March 1995 Supplement to the CPS included questions designed to obtain more complete information on the source of health insurance coverage.

The March 1995 CPS sample was about 57,000 households nationwide. Since information was collected for each member of the household, the sample includes over 150,000 individuals. The sample was designed to be nationally representative of the civilian noninstitutional population of the United States. The March 1995 CPS sample includes 632 Kentucky households with 1,650 individuals. Results from other years of CPS data are reported as noted.

There are two reasons selected results from CPS data are reported here. First, the U.S. Governmental Accounting Office used this data source in a recently published report on those insured in the individual health insurance market. Since that is one of the targeted groups, the decision was made to address the results of that report. Second, where possible, data from this source was used to address a limitation of the 1996 Health Insurance Survey.

It was not possible to use the CPS data to describe the characteristics of those insured in the small-group market. The CPS categories for employer size include only one category for employers with 25 - 99 employees. Since SB 343 redefined the affected small employers as those with fewer than 50 employees, it was determined that the CPS data could not be used for estimating the characteristics of that group.

DESCRIPTION OF INSURANCE MARKET SEGMENTS

The market for health insurance in Kentucky can be separated into several distinct segments for the purposes of analysis. The first segment is comprised of those who obtain coverage for medical services through a government program, such as Medicare or Medicaid. Because that group was not affected by changes in the Kentucky law, it is not considered here. Also, since there is nearly universal coverage of those 65 and older under Medicare, estimates for relevant categories of the privately insured and uninsured are presented both as a percent of the total population and as a percent of the non-elderly population.

The individual segment of the market is composed of policyholders who do not obtain health insurance as a member of an employee group, but who purchase it directly from an insurance carrier. Information on that market segment is presented in the memo. Next is the segment of the market comprised of those who obtain health insurance as part of an employee group. In this segment of the market, the employer negotiates with an insurer for plans to offer eligible employees. Employers may or may not contribute to the employees' premiums, but the pricing of the policy is such that the premiums for the policies usually reflect the average health characteristics of the group, rather than the individual. SB 343 restricted the limits on the factors which can be used to price health insurance policies to employers with fewer than 50 employees, so only the small-employer segment of the market is discussed in this report. The final segment is the uninsured, also discussed here.

INDIVIDUAL MARKET

The individual health insurance market is comprised of those who purchase health insurance directly from an insurer, rather than purchasing it as a member of an insured group.

Number Covered Under Individual Policies

It is estimated that, in the summer of 1996, approximately 6.3% of the Kentucky non-elderly population (or 5.5% of the total population) was insured under a policy purchased directly from an insurer.[6] The standard error on the estimate is +/- 0.4%, so there is a 95% probability that the actual percentage is between 5.9% and 6.7%. When these percentages are applied to the Bureau of the Census estimate of the 1995 non-elderly population for Kentucky, the estimate of the number of individuals is between 200,000 and 225,000, with the point estimate at 210,000. Estimates from the Spring 1996 Kentucky Survey were not significantly different from this.

In its report on those who purchase individual policies, the GAO estimated that, in 1994, 2.3% of the non-elderly population of Kentucky was exclusively covered under such policies during the year.[7] This means that the policyholders only held an individually-purchased health insurance policy during 1994. However, the report also noted that the individual market is fluid. Individual

[6] The U.S. GAO reports the number of individually insured as a percent of the non-elderly population to control for the effects of the provision of Medicare to most individuals 65 and older. This convention is followed in the discussion of the individually and small-group insured in this report as well.

[7] U.S. General Accounting Office, *Private Health Insurance*, Washington, D.C., November, 1996.

coverage is often purchased for temporary periods when policyholders lose employment-based policies through layoffs or job changes. Early retirees may purchase policies until they are eligible for Medicare, while young adults may purchase individual policies as they exceed the age at which they can be covered under a parent's policy but have not obtained their own coverage. Also, insurance policies are not always sold on a calendar-year basis. A policyholder may have had an individually-purchased policy for the 12 months from August of 1993 to August of 1994, then switched to some other source of coverage (or dropped coverage) for the remainder of 1994. The CPS estimate would not have counted such a policyholder as being "exclusively" covered under such policies for the year. Thus, during any calendar year, many more individuals may be covered under an individual health insurance policy than are covered exclusively during the year. The 2.3% estimate by GAO reflects only those who reported having been covered exclusively by an individual policy during 1994.

Additional analysis of the March 1995 CPS data yields the estimate that approximately 7.2% of the 1994 non-elderly population was covered under an individual health insurance policy at some point during the year.[8] This 7.2% figure is comparable to the 6.3% estimate derived from the Health Insurance Survey. Because the difference between the 1996 estimates and the 1994 estimate is within the margin of error for the CPS estimates, it is not possible to determine whether there was any change in the percentage of the non-elderly population covered by individually purchased policies from 1994 to 1996. It is believed that either the estimate of 6.3% from the targeted sample, or the estimate of 7.2% from the CPS is more relevant to state policy makers than GAO's published estimate of 2.3%, because the larger figures give a more complete estimate of the number of people who might be affected during any year by changes in the laws governing the individual health insurance market.

In a November, 1996 report, The Employee Benefit Research Institute, using the March 1996 CPS, estimated that roughly 200,000 individuals in Kentucky, or 5.9% of the non-elderly population, were covered under individual policies during 1995.[9] After adjusting for differences in degree of rounding, these estimates were very similar to those obtained from the Health Insurance Survey.

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[8] In its analysis of the CPS data, LRC staff obtained the result that 2.8% of the Kentucky sample was covered exclusively by an individual policy during 1994. In consultation with John Dicken of the GAO, LRC staff determined that the analysis procedure was similar to that used by GAO to generate its estimate. Mr. Dicken believes that the small difference in the estimates is due to the fact that GAO used a preliminary version of the data, while LRC analyzed the final dataset that was made available to the public. The 7.2% figure is the sum of the LRC result that 2.8% of the non-elderly Kentucky sample in the Supplement to the March 1995 CPS exclusively had individual policies in 1994, and the finding that 4.4% had individual policies along with some other form of coverage during the year. Because of the small sample size for the Kentucky estimates, the difference between the LRC and GAO estimates is well within the fairly large margin of error for the GAO estimate.

[9] Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured*, EBRI Issue Brief Number 179, November 1996.

Characteristics of Adults Covered Under Individual Policies

The GAO report also included a description of the characteristics of those who were covered under individual insurance policies. GAO reported that, nationally:

> Most adults who purchase individual insurance are employed and often work in particular industries. For example, about 17 percent of farm workers and 7 percent of construction workers rely on this market for coverage. In contrast, less than 2 percent of workers in the durable goods manufacturing and public administration sectors purchase individual plans....Those with individual health insurance tend to be older than those with employment-based coverage but are similar in their self-reported health status. People between 60 and 64 years of age are nearly three times as likely to have individual insurance as those 20 to 29 years old. Also, a disproportionate share of early retirees and people who have been widowed participate in the individual market....Because of the often transient nature of this market, some of these people may have held individual insurance temporarily and then had another source of coverage during the remainder of the year...[10]

Characteristics of adults covered under individual health insurance policies in Kentucky are shown in Table 1. Approximately 47% of this group was female. Respondents were fairly evenly distributed among the relevant age categories. The average age of individually insured adults was 43. The median household income category for the group is $25,000 - $35,000 per year. Approximately two thirds of the CPS sample had family incomes less than 250% of the federal poverty level. In the Spring 1996 Kentucky Survey, just over half reported working outside the home and, of those, about a fourth worked part-time.

Scores on the 5 items of the RAND Health Index were summed, then the total scores were divided into four categories, with category I indicating the best overall health score and category IV indicating the worst overall health score (Table 2). Approximately 5% of the individually insured adults in this sample had overall health scores in the worst category, while 85% had scores in the two best categories. Twenty-seven percent of the sample smoked regularly in the last 2 years. Sixty percent of the adults in the sample went to the doctor no more than twice in the last year, while 12% went 7 or more times.

One of the major unanswered questions during the policy debate on SB 343 was the distribution of individual policyholders by age, gender, and health status. While there was data on the age and gender distribution of the Kentucky population, there was no data which coupled age and gender information with that on source of insurance and a measure of health status. One of the major goals of the Health Insurance Survey was to capture such data. Table 3 shows the percentage of the total sample of individually insured adults which fell into the various age, gender and health status categories. While the percentage for any particular cell may have substantial error, the

[10]U.S. General Accounting Office, *Private Health Insurance*, Page 3.

Table 1

Demographic Characteristics of Individually Insured Adults

Characteristic	Percent
1. Gender	
Female	47%
Male	53%
2. Age	
Less than 30	23%
30 to 39	20%
40 to 49	23%
50 to 59	22%
60 to 64	11%
3. Annual Household Income	
Less than $10,000	8%
$10,000-$15,000	6%
$15,000-$25,000	19%
$25,000-$35,000	24%
$35,000-$45,000	13%
$45,000-$55,000	9%
More than $55,000	21%
4. Family Income as a Percent of the Federal Poverty Level (FPL)	
Less than 100% of FPL	10%
100% to 149% of FPL	10%
150% to 249% of FPL	44%
250% or more of FPL	36%
5. Work Status	
Work outside home	55%
If yes, work part-time	23%

Characteristic	Percent
6. Occupation	
Managers & professionals	30%
Technical, sales, & administrative support	5%
Service	6%
Agricultural	7%
Precision production, craft & repair	5%
Operators, fabricators & laborers	5%
Unemployed	4%
Other	38%
7. Health in General	
Excellent	33%
Very Good	30%
Good	21%
Fair	10%
Poor	6%
8. Smoked regularly in last 2 years.	27%
9. Number Dr. visits within last year	
0	20%
1 to 2	40%
3 to 4	21%
5 to 6	7%
More than 6	12%

Source: 1996 Health Insurance Survey, with 609 individually insured adults, except for work status, which was taken from the Spring 1996 Kentucky Survey, with 56 individually insured respondents.

Table 2

Health Status of Individually Insured Adults

Response	Gets Sick Easier	Healthy as Anyone	Health Expected to Worsen	In Excellent Health
Definitely True	4%	56%	5%	47%
Mostly True	8%	26%	17%	35%
Mostly False	20%	11%	25%	11%
Definitely False	68%	7%	53%	7%

Overall Health Index Score	Percent
I (best health)	57%
II	28%
III	10%
IV (worst health)	5%

Source: 1996 Health Insurance Survey, with 609 individually insured adults.

Table 3

Distribution of Individually Insured Adults by Age, Gender, and Health Status

Percent of Total
(* denotes less than 1/2 of one percent)

MALES	Health Status Category				
Age	I (best health)	II	III	IV (worst health)	Total
Under 30	8%	3%	1%	1%	12%
30 - 39	7%	3%	1%	*	11%
40 - 49	7%	3%	2%	*	13%
50 - 59	4%	4%	1%	1%	11%
60 - 64	2%	3%	1%	*	6%
Male Totals	**28%**	**16%**	**6%**	**3%**	**53%**
FEMALES					
Age					
Under 30	7%	2%	*	*	10%
30 - 39	7%	2%	1%	*	10%
40 - 49	8%	2%	1%	*	11%
50 - 59	5%	4%	1%	1%	11%
60 - 64	2%	1%	1%	1%	5%
Female Totals	**29%**	**11%**	**4%**	**3%**	**47%**
Overall Totals	**57%**	**27%**	**10%**	**6%**	**100%**

Note: Column and row totals may not exactly equal summary figures shown in other tables due to rounding.
Source: 1996 Health Insurance Survey, with 609 individually insured adults.

overall distribution of percentages should be a fairly accurate depiction of the distribution of adults covered under individual policies by age, gender, and health status.

Characteristics of Individual Policies

Blue Cross/Blue Shield accounted for 48% of the individual policies held in these households, while Humana accounted for about 5%. American Medical Security, Golden Rule, and Kentucky Kare each issued about 3% of the policies (Table 4). In 6% of the cases, survey respondents could not name the issuing company. The remaining 33% of the policies held were distributed among about 75 other issuing companies.

Respondents reported that 20% of the individual policies discussed had been obtained through the Kentucky Health Purchasing Alliance. They were also asked whether a policy was one of the standard plans. However, because there was substantial concern that respondents not familiar with changes in the law might not understand what a "standard" plan was, a follow-up question asked which standard plan (such as economy or enhanced-high) they had. Of the plans discussed, respondents identified 25% as being one of the specific standard plan types.

About one-fourth of the households with individual policies reported that an insured member had suffered from a serious illness (such as heart disease, diabetes, or cancer) in the past 10 years and 8% reported that an insured member of the household had previously been refused health insurance coverage. Approximately one third reported that a member was newly insured in the last 12 months. The distribution of policies by company among households who answered yes to one of these three questions is largely similar to the distribution of policies by company among all households with individual coverage. The only differences large enough to be statistically significant (given the number of respondents for each question) is that Blue Cross/Blue Shield was given as the issuing company for significantly more of the policies sold to households with a newly insured member than it was for all policies, while companies in the "other" category were given as the issuing company significantly less often. Similarly, significantly more of the households with newly insured members reported obtaining a policy through the Kentucky Health Purchasing Alliance than did all individually insured households.

Of the individual policies sold to these households, 54% allowed the same payment for any physician selected by the policyholder (Table 5). This is taken as an indication that non-managed care plans comprise a slight majority of the individual health insurance market. One-fourth of the policies permitted a reduced payment to physicians not on the plan's approved list, and about one fifth would only pay for physicians on the approved list. Of the approximately 80% of the individual policies with a deductible, somewhat less than half had an annual deductible of $400 or less, while one fourth had an annual deductible greater than $1,000. This indicates that high-deductible, or "catastrophic" plans accounted for a non-trivial share of the individual market at the time the survey was conducted.

Nearly all of the plans paid at least 80% of the allowable cost for approved medical services, once any applicable deductible had been met. Forty-four percent of the plans imposed a fixed copayment for doctor visits. Of these plans, 70% had copayments of $10 or less. In-patient hospital services were covered by virtually all individual policies, while out-patient doctor visits were covered by most. Prescription drugs and at least some mental health services were covered by approximately two-thirds of the policies. Vision and dental services were included in 20% and 14% of the policies, respectively.

The average monthly premium for all of the individual policies in the sample was $173. The median monthly premium was $142.[11] While an overall measure of premium amount for these policies offers some information about rates in the individual market, it should be understood that

[11] The median premium amount is that amount at which half of the premiums in the sample are above that amount, and half are below. The median is a useful measure because it is not affected by a few very high or very low amounts, as is the average premium.

the significance of that information is severely limited by the complexity of factors which determine the premium for any single policy. Even for a single insurer in a stable insurance market, the premium charged for any particular policy is affected by the age, gender, location, occupation, and (when allowed) health status of the individuals covered under the policy. The premium also reflects the scope of the medical services covered, the amount of co-insurance paid by the insured, and the size of the deductible. In the individual insurance market in Kentucky in 1996, premiums were also likely affected by whether the policy was a standard or non-standard plan, whether it was purchased inside or outside the Kentucky Health Purchasing Alliance, and whether it was a new policy or a renewal. Increase this complexity by the business strategy particular to each insurer, and the fact that the overall market was undergoing considerable change, and the limited usefulness of a measure of the "average" premium should become apparent.

Table 4

Market Share of Companies Offering Individual Policies

Company	Percent of All Policies	Percent of Policies Sold to Respondents Reporting that an Insured Member...*		
		Had A Serious Health Problem	Had Previously Been Refused Health Insurance	Was Newly Insured within Past 12 Months
Blue Cross-Blue Shield	48%	41%	50%	63%
Humana	5%	8%	3%	5%
American Medical Security	3%	5%	8%	4%
Golden Rule	3%	1%	3%	1%
Kentucky Kare	3%	4%	3%	1%
Other	33%	35%	31%	18%
Unknown	6%	7%	3%	6%
KY Health Purchasing Alliance	20%	22%	32%	29%

*The only percentages in these three categories that were statistically significantly different from the distribution of companies for all policies at the .01 level were the 63% for BCBS and 18% for other companies among the newly insured, and the 29% for the Kentucky Health Purchasing Alliance in the same category.

Source: 1996 Health Insurance Survey, with 439 individual policies.

Even with the relatively large sample size obtained in the 1996 Health Insurance Survey, it was not possible to control for all of the factors which affect the amount of premium charged for a particular policy. For example, this sample did not contain enough higher-deductible, basic-coverage, non-standard policies covering single males under age 30 who scored in the best half of the health index, to reliably estimate what the average premium for that group might actually be in the overall individual market. Because the sample would have to be divided into so many small pieces to estimate the average premium for any particular group of policies, none of the groups was large enough to allow reliable estimation of the average premium. The implication is that

collection of survey data, while valuable for describing and tracking many aspects of the health insurance market, is unlikely to be a reliable method for gauging and monitoring market premiums unless the sample size is significantly increased, the same households are surveyed repeatedly, or the number of factors used to set premiums on individual policies is reduced.

Table 5

Characteristics of Individual Policies

Characteristic	Percent
1. Physician Choice	
Same amount paid all physicians	54%
Smaller amount paid physicians not on plan list	25%
Only paid physicians on plan list	21%
2. Annual Deductible Included in Plan	
Yes	79%
If Deductible Assessed:	
Amount of Deductible	
Less than $200	21%
$201-$400	23%
$401-$800	22%
$801-$1,000	8%
$1,001-$2,500	19%
More than $2,500	6%
3. Percent of Medical Costs Paid by Plan	
Less than 80%	4%
80%	79%
More than 80%	17%

Characteristic	Percent
4. Copayment for Doctor Visits	
Yes	44%
If Copayment Assessed:	
Amount of Copayment	
$5 to $9	18%
$10	52%
$15	15%
More than $15	15%
5. Services Covered by Plan	
Hospital stay	98%
Outpatient doctor visits	89%
Prescriptions	70%
Mental health	66%
Vision	20%
Dental	14%

Source: 1996 Health Insurance Survey, with 439 individual policies.

Ignoring the myriad factors which determine individual premiums, one question which can be addressed is what percentage of household income the premium paid represents. It is estimated that premiums for individual policies range from a high of 26% of the midpoint of the household's income range, for households reporting an income under $10,000, to a low of 3% or less, for households reporting an income over $55,000.[12] The weighted average percentage for all households with individual policies was approximately 8%. Two points should be made about this estimate. First, 8% is not an estimate of what percentage of income households spend for all insurance coverage, but only for coverage obtained under individual policies. Many households

[12] To increase willingness to respond to the question, the Survey Research Center does not usually ask respondents for their exact household income, but whether the household income falls within some range, such as $25,000 to $35,000. In order to estimate premium as a percent of household income, the midpoint of the household's income range was used. For households reporting incomes above $55,000, the figure $75,000 was arbitrarily selected to represent the midpoint.

with some members covered under individual policies also had other members covered under an employment-based policy from either a large or small employer. While the 1996 Health Insurance Survey obtained information on coverage in the household obtained through small employers, no information was obtained for coverage obtained through large employers. Also, it may seem inconceivable that households with less than $10,000 in gross income dedicate approximately 26 percent of that amount to health insurance premiums. It should be remembered that measures of income do not capture the amount of wealth available to the household. Many of the individually insured are likely to be early retirees who have lower-than-average incomes but who are drawing on accumulated wealth to pay for on-going living expenses. This is not to say that there are no poor households who are dedicating a significant share of their incomes to insurance premiums, but that not all households with low incomes are without financial resources.

Knowledge of Changes in the Law

In the Spring 1996 Kentucky Survey, respondents were asked to list the three most important problems facing Kentucky. Ten percent of all respondents mentioned health care or its cost as an important problem, compared to 20% of the individually insured. When asked if they had heard about the changes in the health insurance laws in Kentucky, 67% of individually insured respondents in the 1996 Health Insurance Survey indicated that they had (Table 6). Of those, 74% heard about the changes through the media, while 45% said they received a letter from their insurance carrier.

Among respondents who had heard about the changes in the law, only 62% (or 37% of the total) believed those changes would directly affect their family. In actuality, when fully implemented, the changes in the law would have some type of effect on every holder of an individually purchased insurance policy. It is clear that about half of these households either did not know about the changes, or did not understand that they would be affected in some way. Of those who did think that they would be affected, the most frequent expectation was that premiums would increase. It should be understood that the fact that people had the expectation that their premiums would increase is not a reliable indication that their premiums actually did (or will) increase. Their expectations may have been formed by factors such as biased media ads, incomplete information, or the typical cynicism of many citizens that any government or industry change is likely to cost them more money. It is also important to note that, while they were a large share of those who believed their family would be affected by the changes in the law, the number who said they expected a premium increase comprised only one-fourth of the total households with an individual health insurance policy.

That the affected population was not fully informed about the changes in the law affecting their insurance coverage in the summer of 1996 is evidenced by the fact that, although 67% had heard of changes in the law, fewer than one-fifth knew that the reforms meant that a person in good health would pay the same premium for insurance as someone with a serious health condition or that a person who could afford the premium could buy a health insurance policy, no matter how sick they were.

Table 6

Knowledge of Changes in Kentucky Insurance Laws
Individual Policyholders

	Percent		Percent
1. Heard about changes in the law	67%	**2. Familiar with standard plans**	28%
Of those who said yes:			
Source of Information			
Letter from insurance company	45%	**3. Correctly knew features of standard plan:**	
Newspaper or television ads	69%	Healthy and sick people pay the same	17%
News reports	74%	Can buy a policy no matter how sick	18%
Friends/family	29%	Family could purchase standard plan	25%
2. Believe changes directly affect family	37%		

Source: 1996 Health Insurance Survey, with 513 households with individual policies.

SMALL-GROUP MARKET

The small-group market consists of those who obtain a health insurance policy through an employer with fewer than 50 employees. In this segment of the market, the employer negotiates with an insurer for plans to offer eligible employees. Employers may or may not contribute to the employees' premiums, but the pricing of the policy is such that the premium for the policies generally reflects the average health characteristics of the group, rather than the individual.

Number Covered Under Small-Group Policies

Based on the Health Insurance Survey, it is estimated that 10.7% of the non-elderly population in Kentucky (or 9.3% of the total population) were covered under a health insurance policy obtained through a small employer, in the summer of 1996. The standard error of the estimate is +/- 0.5%, meaning that there is a 95% probability that the actual percentage is between 10.2% and 11.2%. If these percentages are applied to the Bureau of the Census estimate of the 1995 non-elderly population in Kentucky, the estimate is that between 340,000 and 380,000 non-elderly residents were covered in the small-group market at the time the survey was conducted. The point estimate is 360,000. Estimates from the Spring 1996 Kentucky Survey were not significantly different from these. Because the CPS aggregates employers with 25-99 employees into one category, it was not possible to use that data to estimate the number of Kentuckians with policies obtained through employers with fewer than 50 employees.

Characteristics of Adults Covered Under Small-Group Policies

Adults insured in the small-group market tended to be concentrated in the below-50 age categories (Table 7). The average age of this group of adults was 39. Males and females were distributed about equally. Approximately half of the households with small-group insureds had incomes below $35,000 and half had incomes above.[13] Sixty-two percent of small-group insureds in the Spring 1996 Kentucky Survey reported being employed, 15% of those part-time.

Ninety percent of this group scored in the two best categories of the health index, while 2% scored in the worst health category. Two thirds of the group visited a doctor no more than twice in the previous year, and 9% had 7 or more doctor visits. Twenty nine percent smoked regularly in the last two years. Table 9 shows the distribution of adults insured under small-group policies by age, gender, and health status category.

Characteristics of Small-Group Policies

The small employers offering these policies were predominantly private firms, with public and non-profit organizations accounting for 20% of the total. Blue Cross/Blue Shield issued 49% of these policies, while Alternative Health Delivery Systems, an independent licensee of Blue Cross, issued 4% (Table 10). Eight percent of the policies were issued by Humana and 2% each by Aetna and Healthwise. Issuers of 7% of the policies could not be identified. The remaining 28% of the policies were distributed among more than 100 other insurers. Respondents indicated that 17% of the small-group policies discussed had been obtained through the Kentucky Health Purchasing Alliance, and could identify 18% as one of the standard plans.

Twenty-three percent of the households with a small-group policy contained an insured member who had had a serious health problem in the last 10 years, and 3% an insured member who had previously been refused health insurance. A third of the households had members who were newly insured within the last 12 months. There were no statistically significant differences in the distributions of insurers for these three categories of households and the distribution for all households with small-group policies.

The majority of small-group policies contained some form of restriction on the payment of physicians not on an approved list (Table 11). Of the policies in which a deductible was imposed, 9% had a deductible greater than $1,000. Virtually all of the small-group policies covered at least 80% of allowable medical services. Slightly more than one-half imposed a fixed copayment for each doctor visit and, of those, nearly 80% were $10 or less. Nearly all small-group policies covered a hospital stay and out-patient doctor visits, over 80% covered prescription drugs and some mental health services, and approximately 30% covered vision and dental services.

[13] Estimates of family income as a percent of the federal poverty level for the individually insured were derived from the CPS data. However, because the CPS data on employer size aggregates employers with 25 to 99 employees, it was not possible to use that data to make similar estimates for those insured through an employer with fewer than 50 employees.

Table 7

Demographic Characteristics of Adults Insured Under Small-Group Policies

Characteristic	Percent
1. Gender	
Female	50%
Male	50%
2. Age	
Less than 30	23%
30 to 39	32%
40 to 49	26%
50 to 59	14%
60 to 64	4%
3. Annual Income	
Less than $10,000	2%
$10,000-$15,000	6%
$15,000-$25,000	15%
$25,000-$35,000	22%
$35,000-$45,000	18%
$45,000-$55,000	12%
More than $55,000	26%
4. Work Status	
Work outside home	62%
If work, part-time	15%

Characteristic	Percent
5. Occupation	
Managers & professionals	45%
Technical, sales, administrative support	8%
Service	4%
Agricultural	2%
Precision production, craft & repair	9%
Operators, fabricators & laborers	9%
Unemployed	1%
Other	23%
6. Health in General	
Excellent	39%
Very Good	32%
Good	21%
Fair	6%
Poor	2%
7. Smoked Regularly within Last 2 Yrs.	
Yes	29%
8. Number of Visits to Doctor within Last 12 Mos.	
0	21%
1 to 2	46%
3 to 4	17%
5 to 6	8%
More than 6	9%

Source: 1996 Health Insurance Survey, with 1,231 adults covered under small-group policies, except work status which was from the Spring 1996 Kentucky Survey.

Table 8

Health Status of Adults Insured Under Small-Group Policies

Response	Gets Sick Easier	Healthy as Anyone	Health Expected to Worsen	Excellent Health
Definitely True	3%	59%	5%	55%
Mostly True	6%	30%	14%	33%
Mostly False	23%	7%	22%	9%
Definitely False	69%	4%	59%	4%

Overall Health Index Score	Percent
I (best health)	64%
II	26%
III	8%
IV (worst health)	2%

Source: 1996 Health Insurance Survey, with 1,231 adults covered under small-group policies.

Table 9

Distribution of Small-Group Insured Adults by Age, Gender, and Health Status

Percent of Total
(* denotes less than 1/2 of one percent)

	Health Status Category				
MALES					
Age	I (best health)	II	III	IV (worst health)	Total
Under 30	8%	2%	1%	*	11%
30 - 39	11%	4%	1%	1%	17%
40 - 49	7%	4%	2%	*	13%
50 - 59	4%	2%	1%	*	7%
60 - 64	1%	1%	*	*	2%
Male Totals	31%	13%	5%	1%	50%
FEMALES					
Age					
Under 30	10%	2%	*	*	12%
30 - 39	11%	4%	*	*	15%
40 - 49	8%	5%	1%	*	14%
50 - 59	4%	2%	1%	*	7%
60 - 64	1%	*	*	*	2%
Female Totals	34%	13%	2%	1%	50%
Overall Totals	65%	26%	7%	2%	100%

Note: Column and row totals may not exactly equal summary figures shown in other tables, due to rounding.
Source: 1996 Health Insurance Survey, with 1,307 adults covered under small-group policies.

The average monthly premium for the small-group policies, not including any employer contribution, was $77 per month, and the median premium was $24 per month. The premium paid as a percent of the mid-point of the household's income category ranged from 0% for those with incomes above $55,000 to 5% for those with incomes below $10,000. While households with incomes below $10,000 allocated a larger share of their income to health insurance than other households, they actually contributed less than most other income categories, in terms of actual dollars. The median contribution for households with incomes below $10,000 was $240 annually, while the median contribution for households with incomes between $45,000 and $55,000 was $312. The weighted average premium as a percent of the mid-point of the household's income category was 1% for all the households with small-group policies.

Table 10

Market Share of Companies Offering Small-Group Policies

Company	Percent of All Policies	Percent of Policies Sold to Respondents Reporting that an Insured Member.... Had A Serious Health Problem	Had Previously Been Refused Health Insurance	Was Newly Insured within Past 12 Months
Blue Cross-Blue Shield	49%	51%	60%	46%
Humana	8%	7%	5%	9%
Alternative Health	4%	5%	10%	3%
Aetna	2%	2%	0%	2%
HealthWise	2%	2%	5%	1%
Other	28%	26%	20%	30%
Unknown	7%	6%	0%	9%
KY Health Purchasing Alliance	17%	18%	27%	23%

Source: 1996 Health Insurance Survey, with 786 small-group policies.

Knowledge of Changes in the Law

In the Spring 1996 Kentucky Survey, 15% of the respondents insured through a small employer mentioned health care or its cost as an important problem facing Kentucky. In the 1996 Health Insurance Survey, 65% of respondents with small-group policies said they had heard of changes in the health insurance laws in Kentucky. Most of these learned of the changes through the media, while 29% said they had received a letter from their insurance carrier. Twenty-four percent thought the changes would directly affect their family. Half of those who expected their family to be affected (13% of all respondents with a small-group policy) thought the effect would be an increase in premiums. Only one-fifth of these respondents said they were familiar with standard plans and 13% correctly answered that a person's health status would not affect whether an individual would be allowed to purchase a policy or how much that policy would cost. As with the previous group, this group of insureds was not generally knowledgeable about recent changes in the laws governing their health insurance policies.

Employer Mail Survey

Respondents who said they had health insurance coverage through an employer with fewer than 50 employees were also asked if they would provide the name and address of that employer, on the condition that their participation in the survey would remain confidential. Employer names were provided by 393 of the respondents. Of these 393 identified employers, 106 were found to employ more than 49 persons, 33 were out-of-state, 5 did not provide insurance, 16 were

duplicate listings, and 53 could not be reached by phone to determine the name and address of an individual who would best be able to answer questions about insurance coverage. A mail survey was sent to the remaining 180 employers, who were contacted by phone and determined to be eligible to participate in the survey. Responses were received from 70 of them, for a response rate of 39%. [14]

Table 11

Characteristics of Small-Group Policies

Characteristic	Percent	Characteristic	Percent
1. Physician Choice		**4. Copayment for Doctor Visits**	
Same amount paid all physicians	42%	Yes	56%
Smaller amount paid physicians not on plan list	31%	**If Copayment Assessed:**	
Only paid physicians on plan list	27%	**Amount of Copayment**	
		$5 to $9	24%
2. Annual Deductible Included in Plan		$10	54%
Yes	81%	$15	13%
If Deductible Assessed:		More than $15	9%
Amount of Deductible			
Less than $200	26%	**5. Services Covered by Plan**	
$201-$400	33%	Hospital stay	100%
$401-$800	27%	Outpatient doctor visits	96%
$801-$1,000	5%	Prescriptions	88%
$1,001-$2,500	8%	Mental health	84%
More than $2,500	1%	Vision	31%
		Dental	28%
3. Percent of Medical Costs Paid by Plan			
Less than 80%	2%	**6. Type of Employer**	
80%	80%	Private	79%
More than 80%	19%	Non-profit	8%
		Public	12%
		Other/unknown	2%

Source: 1996 Health Insurance Survey, with 835 small-group policies.

Because of the small size of the employer sample, and the fact that the sample was generated from the telephone survey of insureds rather than a direct random sample of small employers, it is not appropriate to conclude that responses from these firms are representative of all Kentucky small firms which offer insurance.[15] Basic descriptive results from the sample are presented as an initial

[14] If it was determined that the employer had more than 49 employees, no further information was obtained from that employer and the individual respondent who had provided that employer's name was removed from the analysis of the small-group insured.

[15] The federal Agency for Health Care Policy Research uses a similar methodology to identify employers for the National Health Insurance Study; the major difference is that their household survey is conducted in person, and they obtain a written release from the respondent allowing them to get detailed information from both the respondent's employer and insurance company. The attempt here was to see whether a similar methodology could

exploratory investigation of this population. For results that are generalizable to all small firms, it is recommended that a much larger direct random sample of small employers be used.

Table 12

Knowledge of Changes in Kentucky Insurance Laws
Small-Group Policyholders

	Percent		Percent
1. Heard about changes in the law	65%	**3. Familiar with standard plans**	21%
If answered yes:			
Source of Information			
Letter from insurance company	29%	**4. Correctly knew features of standard plan:**	
Newspaper or television ads	62%	Healthy and sick people pay the same	13%
News reports	75%	Can buy a policy no matter how sick	12%
Friends/family	25%	Family could purchase standard plan	19%
2. Believe changes directly affect family	24%		

Source: 1996 Health Insurance Survey, with 841 households with small-group policies.

The majority of the firms responding to the mail survey had 15 or fewer full-time employees, with the average number at 15 (Table 13). More than half the firms were classified as either services and trade, while manufacturing and construction together accounted for about one-fourth. On average, it was reported that 82% of eligible employees actually enrolled in the offered plans. All but two of the respondents reported that they contributed some amount to the employee premium.

Conventional indemnity plans and preferred-provider plans (PPO) were the types offered most often by these firms. Only three respondents indicated that they offered employees a choice of more than one plan. Nearly one-third of the firms said they obtained health insurance coverage through a trade association, while only two said they were self-insured. One-fourth reported that the plan they offered was one of the standard plans, while 5 respondents said they had a policy which allowed the insurer to refuse to cover an employee on the basis of the individual's health status. Blue Cross/Blue Shield was the insurer for 52 of the firms.

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be used in a telephone survey, without the benefit of having the respondent's social security number or a signed form authorizing release of more detailed information. The approach is judged to have been inadequate in this attempt.

UNINSURED

Three groups of uninsured were investigated. These groups included all of the uninsured, those who were newly uninsured in the last 12 months, and households with uninsured children.

Number of Uninsured

There has recently been some confusion about various estimates of the number of uninsured in Kentucky and whether they can be used to gauge changes in the number of uninsured since revisions were made in the laws governing health insurance. A brief summary of the source and timing of the various estimates may serve to clarify the differences in the numbers commonly quoted, and the implications of those differences for evaluating the effect of changes in the law on the number of uninsured.

On June 17, 1993, Professors Berger, Black, and Scott appeared before the Task Force on Health Care Reform and presented an estimate that 429,000 Kentuckians were uninsured. They based the estimate on the 1991 and 1992 Health Surveys and the 1992 Spring Poll conducted by the UK Survey Research Center. Their point estimate was that 11.6% of the state's population was uninsured and they applied that to the 1991 population estimate for the state.[16] However, they noted that the margin of error on the estimate meant that the range on the estimate was from a low of 382,000 to a high of 537,000.

A March 1996 memo by LRC staff gave a point estimate of the number of uninsured as 530,000. This estimate was generated using a rounded average of the 1992-1993 estimates of the uninsured in the state from the Census Bureau (13.6%) and the most recent estimate from the Employee Benefits Research Institute (14.7%). This average estimate of 14% of the population uninsured was applied to the Bureau of the Census estimate of the 1993 Kentucky population to derive the point estimate of 530,000.

The most recent point estimates of the percentage of uninsured in Kentucky by the Bureau of the Census from the CPS were 15.2% in 1994 and 14.6% in 1995.[17] Taken at face value this would indicate that the percentage of Kentuckians who are uninsured declined from 1994 to 1995. However, because the percentages represent estimates of the characteristics of the state's population based on a sample of about 650 respondents, the standard error on either of the estimates is 1.3 percent. This means there is a 90 percent chance that the 1995 rate of uninsured could range from 13.3% to 15.9%. Based on the estimated 1995 Kentucky population, this means that there is a 90% probability that the actual number of uninsured in the state is between 510,000 and 610,000 people, with the 1995 point estimate at 560,000. (This represents 16.7% of the non-elderly population.)

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[16] Because the SRC surveys were conducted by phone, households without phones were not included. Approximately 10% of Kentucky's households do not have phones. Because these are likely to be low income households, estimates of the number of uninsured based on such surveys may be lower than those based on in-person interviews, such as those used by the Bureau of the Census in the CPS.

[17] The 1994 estimate is from the 1995 CPS, and the 1995 estimate is from the 1996 CPS.

Table 13

Characteristics of a Non-Random Sample of 70 Small Employers Who Offer Health Insurance

	Percent
1. Type of Business	
For profit	86%
Not for profit or government	14%
2. Industrial Classification	
Service	30%
Trade	24%
Manufacturing	11%
Construction	11%
Public administration	6%
Transport, communications, & utilities	1%
Agriculture	1%
Unknown	14%
3. Number of Full-Time Employees	
1 to 9	40%
10 to 15	23%
16 to 25	17%
26 to 49	14%
Unknown	6%
Average	15
4. Self-insured	
Yes	3%
5. Insured Through a Trade Association	31%
6. Number of Plans Offered to Employees	Percent
One	96%
More than One	4%
7. Plan(s) Offered Is a Standard Plan	
Yes	27%
8. Insurance Company	
Blue Cross/Blue Shield*	74%
Other or Unknown	26%
9. Plan Can Refuse an Individual Employee Based on Health Status	
Yes	7%
10. Type of Plan	
HMO	16%
PPO	43%
POS	10%
Indemnity	30%
Unknown	1%
11. Employer Contributes Some Amount to Employee Premium	
Yes	97%
No	3%
12. Average Percentage of Eligible Employees Enrolled in the Plan	82%

* Includes Alternative Health Delivery Systems policies.

Source: Results from a mail survey of 70 small employers who offer insurance. Because of the small sample size and the fact that the sample was not a directly selected random sample, results may not be generalizable to the whole population of small employers who offer health insurance.

Thus, there are three factors which can cause point estimates of the number of uninsured to be different when the estimates are made at different times and are based on different sources of data. First, the size of the population changes over time, so number estimates like 429,000, from 1991, aren't valid for 1997, even if the estimate of the percent of the population which is uninsured does not change. Second, the margins of error on the estimates are relatively large, so that it is not

possible to tell whether small variations from year-to-year are the result of real changes or the result of random sample variations. Third, it was estimated above that 5.5% of the population in the state was covered under an individual policy, while 9.3% was covered in the small-group market. This means that less than 15% of the population had insurance in the segments of the health insurance market most affected by changes in the insurance laws. Nearly 10% of the individuals covered in those two segments of the insurance market would have to drop coverage before the change in the number of uninsured would be large enough for the methods used by the Bureau of the Census to show a statistically significant change. The Bureau did not find a statistically significant change in the state's percentage of uninsured from 1994 to 1995.

This does not mean that it is safe to conclude that changes in the law had no effect on the number of uninsured in the state. It means that the changes would have to be very large before they would be identifiable using the current standard methodology for estimating the number of uninsured. If there is great policy interest in tracking the number of uninsured more closely, there would need to be additional resources devoted to increasing the size of the Kentucky sample on which such estimates are based. A major problem, even with that approach, is that, to our knowledge, there is no large pre-1994 sample of Kentuckians which captures insurance status. Without baseline data from a period prior to initial changes in the law, it would be difficult to estimate how changes in the law might have affected insurance status. About the only method available would be to ask individuals now about their insurance status in 1993 and every year since, and to ask why changes in their status had occurred. Such information would be expected to be significantly less accurate than if it had been collected at each point in time.

Characteristics of the Uninsured

Three topics are addressed in regard to characteristics of the uninsured - how they compared to the privately insured, questions of how long and why they lacked insurance; and the particular characteristics of uninsured children. Based on data from the Spring 1996 Kentucky Survey (Table 14), non-elderly uninsured adults were significantly more likely to be younger, have less family income, and not be currently employed than were the privately insured. They were also significantly more likely to have worse scores on the two items included in the poll from the RAND 5-Item Health Index.

Most uninsured respondents said they did not have coverage because they could not afford it, while 5% said a medical condition prevented them from getting a policy. Two-thirds of the uninsured reported that they had previously been covered under a private health insurance policy. Of those, nearly three-fourths had either been uninsured for less than a year, or for 5 years or more. This means that the uninsured is largely comprised of two groups, the chronically uninsured and those who temporarily lack coverage. It is likely that differences in the characteristics of these two groups of uninsured would affect the success of any single policy developed to address the plight of all uninsured.

Of respondents who had previously been privately insured, 74% reported that their previous coverage ended with a change in either employment situation or family status, (such as divorce or no longer a covered child). Eighteen percent reported having dropped coverage because the

premium became too expensive, while 7% said increases in other expenses caused them to drop coverage. Two percent of the respondents said they lost coverage because of a health condition. When asked the maximum premium per month they would be willing to pay for health insurance, 10% said zero, 35% said less than $100, and 33% said they didn't know.

Characteristics of the Newly Uninsured

One of the groups captured in the 1996 Health Insurance Survey was the uninsured who had dropped their health insurance coverage within the past 12 months. The attempt was to examine the characteristics of the newly uninsured, the type of coverage they had had, and why that coverage was dropped.

The newly uninsured generally reported higher family incomes than did the uninsured in general. While 44% of all uninsured reported family incomes below $10,000, only 13% of the newly uninsured fell into that income category. The majority of the newly uninsured reported incomes of $15,000 to $35,000. The newly uninsured were more likely to be under 40 and less likely to be over 50 than all uninsured. The average age of the newly uninsured was 37. The distribution of genders was not significantly different for the two groups.

Sixty-nine percent of the newly uninsured indicated that their last health insurance coverage had been obtained through an employer, while 24% said the policy had been purchased directly from an insurance carrier. Forty-four percent of the previously held policies were for single adult coverage, 14% for couple, 7% for one adult plus child(ren), and 35% for family coverage. Blue Cross/Blue Shield had issued 30% of the lapsed policies, with Humana, Aetna, and Time accounting for 8%, 5% and 3% respectively. Nearly half of the policies were distributed in very small percentages among a large number of insurers.

When asked why they no longer had that insurance policy, 54% of newly uninsured respondents said it was because they no longer worked for the employer through which the coverage had been obtained. Four percent said they still worked for the same employer, but that the employer had stopped providing coverage. A change in life situation, such as divorce, widowhood, or becoming ineligible for coverage under a parent's policy, was the reason given by 12%. Dissatisfaction with the coverage delivered for the premium was mentioned by 6%, while 4% said they lost coverage when their insurer stopped doing business in the Commonwealth. Slightly less than one fifth of the newly uninsured said they dropped coverage because they could no longer afford the premium.

There was a significant difference in the reason given for no longer having a policy depending on whether the previous policy was obtained through an employer or directly from an insurance company. Nearly three-fourths of the households with previous coverage through an employer said coverage was dropped because of a change in employment, while 6% said it was because they could no longer afford the premium and 20% gave other reasons. In contrast, half of households with individual policies said they dropped coverage because they could no longer afford the premium, while only 5% reported dropping because of a change in employment situation, and 45% gave other reasons.

Table 14

Comparison of Characteristics of Uninsured and Privately Insured Adults*

Characteristic	Percent of Uninsured	Percent of Privately Insured	Characteristic	Percent of Uninsured	Percent of Privately Insured
1. Gender			**6. Number of Employees**		
Female	51%	48%	Less than 50	56%	19%
Male	49%	52%	50 to 99	11%	12%
			More than 100	33%	69%
2. Age					
Less than 30	34%	20%	**7. If not working, currently looking for a job**		
30 to 39	22%	27%	No	68%	87%
40 to 49	24%	26%			
50 to 64	21%	26%	**If not, why not:**		
			Student	4%	4%
3. Marital Status			Homemaker	33%	36%
Married	34%	68%	Disabled	46%	14%
Single	66%	32%	Retired	4%	30%
			Home business	8%	12%
4. Household Income			Other	6%	4%
Less than $10,000	44%	5%			
$10,000 to $15,000	14%	7%	**8. General Health Status**		
$15,000 to $25,000	19%	17%	Excellent	19%	27%
$25,000 to $40,000	15%	30%	Very good	22%	33%
$40,000 to $50,000	4%	10%	Good	22%	28%
More than $50,000	4%	31%	Fair	20%	7%
			Poor	16%	5%
5. Employment Status					
Employed	47%	77%	**9. Am As Healthy as Anyone**		
Unemployed	53%	23%	Definitely true	28%	35%
If working:			Mostly true	38%	48%
full-time	77%	90%	Mostly False	11%	6%
part-time	23%	10%	Definitely False	18%	6%
			Not sure	6%	5%

* Except for gender, the distributions on all these characteristics were different by a statistically significant amount at the .01 level.

Source: LRC staff analysis of the Spring 1996 Kentucky Survey, with 149 uninsured respondents and 390 privately insured respondents.

The newly uninsured were generally unfamiliar with changes in laws governing health insurance. Only 29% were aware that any changes had taken place. Seventeen percent of newly uninsured respondents thought their family might be directly affected by the changes, while only 3% were familiar with the features of standard plans.

Table 15

Duration and Reasons for Periods of Uninsured Status

1. Reason Not Insured	Percent	3. Length of Time without Insurance	Percent
Medical condition	5%	Less than 1 year	30%
Could not afford premium	68%	1 year	10%
Other	27%	2 years	7%
		3 years	7%
2. Previously Had Private Insurance	66%	4 years	4%
If answered yes:		5 years or more	42%
Reason Coverage Dropped			
Change in employment status	41%	4. Maximum Monthly Premium	
Change in family status	33%	Willing to Pay for Coverage	
Could not afford premium	18%	$0	10%
Other expenses too costly	7%	$1 to $50	20%
Health condition	2%	$51 to $100	15%
		$101 to $150	11%
		More than $150	11%
		Don't know	33%

Source: LRC staff analysis of the Spring 1996 Kentucky Survey, with 149 uninsured respondents.

Uninsured Children

Except where otherwise noted, data for this section comes from the 1996 Health Insurance Survey. Of the 7,400 Kentucky households who were asked the question, 7.4 % reported having uninsured children. Based on an average of figures reported in the 1991 - 1996 CPS, it is estimated that roughly 13 percent, or 125,000, of Kentucky's children are uninsured. The Governmental Accounting Office estimated that, in the U.S. as a whole, 30 percent of uninsured children are actually Medicaid eligible.[18] If the Kentucky percentage is similar to that of the U.S., then about 38,000 uninsured children could potentially be covered by Medicaid, leaving about 87,000 children uninsured.

The estimate is that roughly 43% of uninsured children in Kentucky live in families with incomes below 100% of the federal poverty level, and 73% live in families with incomes below 200% of the federal poverty level (Table 17). Most families (86%) with uninsured children have incomes below 250% of the federal poverty level.

About 75% of survey respondents with uninsured children who answered the question said they would be willing to pay some amount for a basic insurance policy for one uninsured child. The mean amount they said they would be willing to pay was $48; however this amount is skewed by large amounts given by very few respondents. The median was $30, meaning that half said they would be willing to pay less than $30 and half said they would be willing to pay more. Seventy-

[18] "Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion," Governmental Accounting Office, July 19, 1995. (GAO/HEHS-95-175, July 19, 1995).

five percent of the respondents indicated an amount $50 or less, and 23% said they would (or could) pay nothing for such a policy.

Table 18 shows a comparison of estimates of the family incomes, represented as a percent of the federal poverty level (FPL) for children in Kentucky who are either uninsured or are covered under a private insurance policy, whether employer-provided or purchased directly from an insurer. Children covered by any government-provided medical coverage, such as Medicaid, are excluded from the table. This table shows the different information which can be obtained by examination of rates, or percentages, compared to actual numbers of children. For example, nearly two-thirds of uninsured children were estimated to live in families with incomes below 150% of the FPL, compared with "only" 18% of insured children. However, because there are about 5 times as many insured children as uninsured children in Kentucky, taking the smaller percentage of a much larger number means that there are actually more insured children in the lowest family income categories than there are uninsured children.

Table 16

Characteristics of Newly Uninsured Adults

Characteristic	Percent	Characteristic	Percent
1. Gender		**6. Previous Insurance Company**	
Female	52%	Blue Cross-Blue Shield	30%
Male	48%	Humana	8%
2. Age		Aetna	5%
Less than 30	30%	Time	3%
30 to 39	33%	Other	48%
40 to 49	22%	Don't know	16%
50 to 59	11%		
60 to 64	5%	**7. Reason No Longer Insured**	
3. Annual Income		Change in employment status	54%
Less than $10,000	13%	Change in life situation	12%
$10,000-$15,000	17%	Employer dropped coverage	4%
$15,000-$25,000	29%	Could not afford premium	18%
$25,000-$35,000	24%	Dissatisfied with coverage	6%
$35,000-$45,000	6%	Company left state	4%
More than $45,000	10%	Other/unknown	2%
4. Source of Last Insurance		**8. Knowledge of Changes in Law**	
Provided by employer	69%	Yes	29%
Purchased from insurance company	24%	**Of those reporting yes:**	
Other	7%	**Source of information:**	
5. Type of Previous Coverage		Letter from insurance company	20%
Single	44%	Newspaper or television ads	51%
Couple	14%	News reports	70%
Parent Plus	7%	Friends/family	18%
Family	35%		
		9. Believe changes affect family	17%
		10. Familiar with standard plans	3%

Source: 1996 Health Insurance Survey, with 265 uninsured adults.

Table 17

DEMOGRAPHIC CHARACTERISTICS OF UNINSURED CHILDREN

Characteristic	Estimate		Source
1. Number of uninsured children in Kentucky	125,000		A
2. Percent of children uninsured in Kentucky	13%		A
3. Percent of KY households with uninsured children	7.4%		B
4. Number of uninsured children in household:			B
1	51%		
2	31%		
3	14%		
4+	4%		
5. Number of adults in households with uninsured children:			B
1	18%		
2	64%		
3	11%		
4+	7%		
6. Ages of uninsured children:			B
0 to 4	25%		
5 to 8	23%		
9 to 12	21%		
13 to 17	31%		
7. Insurance status of adults with uninsured children:			B
No adult family members insured	80%		
One or more adult family members insured	20% (mostly employer-provided)		
8. Family income as a percent of poverty level:			A
Families with uninsured children	**Category Percent**	**Cumulative Percent**	
0 to 99%	43%	43%	
100 to 149%	19%	62%	
150 to 199%	11%	73%	
200 to 249%	13%	86%	
250 to 299%	6%	92%	
300% or more	8%	100%	
9. Amount adult respondents with uninsured children would be willing to pay per month for a basic health insurance policy for one child:			B
Number of respondents answering question	340 respondents		
Mean amount (affected by a few very large responses)	$48		
Median amount (half would pay more and half would pay less)	$30		
Amount greater than 75% of responses	$50		
Percent of respondents who would (or could) not pay any amount	23%		

Sources: **A** A rounded average of the Bureau of the Census estimates made from the 1991 - 1996 March Current Population Surveys. Family income as a percent of FPL from 1993-1995 CPS.

B 1996 Health Insurance Survey, with 548 households with uninsured children.

The implication is that estimates of the cost of policy proposals to subsidize the purchase of health insurance policies by low-income families with uninsured children are likely to significantly err on the low side unless they take account of the large number of insured children in the same income class whose families might drop current coverage to avail themselves of an income-based subsidy. According to estimates from the CPS, there are nearly 2.5 times as many children privately insured and living in families with incomes below 250% of the FPL as there are uninsured children. Although data on the topic is sparse, figures from the Census Bureau indicate that the majority of privately insured children are covered under policies obtained through a family member's employer.[19] No data could be identified which would allow an estimate of what percentage of the costs of child insurance are currently subsidized by employers.

Table 18

Family Incomes as a Percent of the Federal Poverty Level Uninsured and Insured Children

	Uninsured Children				Privately Insured Children			
Percent of the FPL	Percent	Cumulative Percent	Number	Cumulative Number	Percent	Cumulative Percent	Number	Cumulative Number
less than 100	43%	43%	53,750	53,750	7%	7%	42,000	42,000
100 - 149	19%	62%	23,750	77,500	11%	18%	66,000	108,000
150 - 199	11%	73%	13,750	91,250	13%	31%	78,000	186,000
200 - 249	13%	86%	16,250	107,500	13%	44%	78,000	264,000
250 - 299	6%	92%	7,500	115,000	8%	52%	48,000	312,000
300+	8%	100%	10,000	125,000	48%	100%	288,000	600,000
Totals	100%		125,000		100%		600,000	

Source: LRC staff estimates from the March 1991 - 1995 Current Population Surveys of Kentucky households conducted by the U.S. Bureau of the Census. Each annual survey includes approximately 630 Kentucky households.

[19] Census Bureau, "Health Insurance Coverage Status by State: Number and Percent of Persons Under 18 Years Old by Type of Coverage: 1987 to 1995."

LEGISLATIVE RESEARCH COMMISSION

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MEMORANDUM

To: Representative Jim Gooch

From: Ginny Wilson, Ph.D.
LRC Chief Economist

Subject: Information Regarding Effects of HB 250 and SB 343 on the Individual Insurance Market

Date: April 3, 1997

Per your request this memo presents information staff was able to develop regarding the effects of HB 250 and SB 343 on the individual insurance market in Kentucky. Specific attention was given to the issues you raised, as well as several others. As you know, this effort is greatly hampered by the fact that staff does not have access to complete baseline data on the characteristics of this market prior to implementation of HB 250. Thus, the estimates presented below should be considered as suggestive only.

Three major areas have dominated the discussion of possible negative effects associated with implementation of HB 250 and SB 343. These include significant rate increases for individual policyholders, an increase in the number of uninsured because of rate increases, and a deterioration of the business climate for insurance companies who marketed health insurance to non-group policyholders. This memo presents the data staff was able to obtain relating to each possible effect. Where no data was available, staff presents a brief discussion of the economic incentives which would lead to an expectation about the nature of a particular effect.

Background

During World War II a wage freeze was imposed on U.S. employers. Employers who wanted to attract good employees attempted to circumvent the freeze by offering health insurance coverage as a benefit. This allowed employers to increase total compensation without violating the freeze. It also allowed employees to shift part of the cost of health insurance to the government. Employees benefited from the arrangement by being able to purchase health insurance at group

rates, which are usually lower than individual rates, and because payments for health insurance were not taxed as employee income. Larger employers benefit because they may improve the health, and therefore, the performance of employees. Employers are able to deduct premium payments from gross income for tax purposes. However, it is also true that any contribution to total compensation for employees would be similarly deductible, whether in the form of direct cash payments or health insurance premiums.[1] This arrangement has proven so attractive to employees that, in 1995, employment-based health insurance was the norm in the U.S. and Kentucky. It was estimated that 63.8% of all non-elderly residents in the U.S., and 62.4% in Kentucky, were covered under health insurance policies obtained through an employer. Over 90% of the privately insured non-elderly in Kentucky and the U.S. obtain their coverage through an employer.[2]

Employers who predominantly hire low-wage workers do not have the same incentive to offer health insurance because its cost represents a much larger share of total compensation, and may be more than they are willing to pay. Small employers, in particular, often do not have the resources to fund employee health insurance, particularly since their average premiums are higher than large employers because there are fewer policies over which to spread health risks.

Individuals not able to obtain health insurance through an employer must bear the full cost of the premium in after-tax dollars. Their premiums are often higher than for the same coverage obtained under a group policy because individual policies are more costly to administer, individual purchasers have less bargaining power, and their health risks are not spread over a larger group. The higher prices faced by individual purchasers, the fact that they have to research and evaluate their own coverage options, and that premiums are paid with after-tax dollars, combine to make them generally more responsive to price changes than those with employer-based coverage.

Because of perceived problems of accessibility and affordability in the small-group and individual markets for health insurance in Kentucky, the 1994 General Assembly adopted HB 250, which established rules of issue and pricing in these markets, and for a mandated group of public employees. The law required that health insurance products sold into these markets be issued to all comers, be guaranteed renewable, limit pre-existing condition exclusions to the first six months of the policy, require credit against any new-policy pre-existing condition period for time covered under a previous policy if there was no more than a 60-day lapse between coverages, and mandated that policies conform to one of a set of pre-defined standard benefit plans. HB 250 also required that the pricing of policies sold in these markets not reflect the particular health status or gender of the individuals covered under the policy, and reflect a maximum 300% variation regarding age. A small variation was allowed for geographic region and industry.

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[1]U.S. General Accounting Office, *Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases*, February 1997, GAO/HEHS-97-35.

[2]Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured, EBRI Issue Brief Number 179*, November 1996.

The 1996 General Assembly amended the law to allow pricing of policies in these markets to reflect a maximum 150% variation for gender, and a variation for age such that the total variation from the lowest to highest premium could be no more than 500%. It reduced the size of groups subject to community rating from 100 to 50 persons, exempted associations from community rating, and allowed a phase-in of community rating until July 1, 2000. It also extended the allowable pre-existing condition period from six months to one year. The Commissioner of Insurance was also authorized to approve the issuance of additional standard benefit plans.

Based on a survey of residents, it is estimated that approximately 5.5% of the total Kentucky population, or about 210,000 individuals, were covered under a non-group private insurance policy in the summer of 1996. The group was found to be 53% male, with an average age of 43 and a median household income between $25,000 and $35,000. Eighty-five percent scored in the best two out of the four categories of a standard health status index, while 5% scored in the worst category. One-fourth of the individual policies reported by respondents were identified as a standard plan, meaning that three-fourths of the policies did not conform to the provisions of HB 250.[3]

That most individual policies did not reflect the provisions of the new law in the summer of 1996 was not surprising because both Executive Orders and SB 343 granted consumers the right to renew existing non-standard policies through July 15, 1996. Staff currently has no information about the percentage of policies which are standard plans at the current time, (a guess of 40-50 percent is believed reasonable, but is supported by no data.) However, unless the Governor or General Assembly takes additional action, all individual policies sold or renewed outside of an exempt association after July 15, 1997 are subject to the rating and benefit provisions of SB 343.

The rest of the memo presents information staff was able to obtain about possible effects these provisions may have had on the market for individual insurance in Kentucky. In analyzing the effects of changes in the law, it is critical to remember that the relevant comparison is not between the status of the market at the current time and what it was prior to the implementation of the changes. The relevant comparison is between the status of the market at the current time and *what it would have been at the current time if no legislative changes had been made.* It is important to remember that many other forces are affecting insurance markets besides legislative actions. To isolate the effect of legislative actions it is necessary to consider those actions *holding all other factors constant.* That this is extremely difficult to do, even with complete historical and current data, does not negate the fact that it is the only correct method to accurately estimate such effects. In the absence of complete historical and current data on the features of the individual health insurance market in Kentucky, staff has drawn on the available data to make its best estimates regarding the issues of interest to you.

Rate Effects

By far, the most frequent complaint policymakers heard regarding legislative changes in the laws governing individual health insurance was that the changes resulted in large increases in

[3] Legislative Research Commission, *Number and Characteristics of the Individually Insured, Small-Group Insured, and Uninsured in Kentucky*, Research Memorandum No. 474, March 1997.

premiums. The two critical questions are whether similar increases would have occurred in the absence of legislative action, and, if not, how much of the increase can be attributed to changes in the law and what percentage of the market was affected. The two major problems with making a reliable assessment of premium increases is that there is little uniform data on premiums prior to July 1995, when HB 250 took effect, and staff has access to little uniform data on current premiums (although several attempts are under way to gather such data). The approach used was to isolate possible reasons premiums may have increased over what they would have been and to evaluate each reason separately.

Change in Rating Provisions

Based on the data reviewed, there is general consensus among researchers and actuaries that utilization of medical services is greater for women in the childbearing years than for men of the same age, greater for older adults than for younger adults, and greater for those with poor health status than for those with good health status. In an insurance market where premiums are set to reflect the claims experience of the insured, such as in the individual market in Kentucky prior to legislative action, women, older adults, and individuals with poorer health status generally faced higher premiums reflecting the expectation that they would have higher claims costs. Men, younger adults, and individuals with better health status were generally able to obtain insurance with lower premiums because of the expectation of lower claims costs. *Holding all other factors constant*, a change in the pricing of health insurance premiums to disallow gender and health status, and limit age variations, would be expected to decrease premiums for younger women, older adults, and those with poorer health status. Since, for any insurance market to be financially viable, total claims costs cannot exceed total premiums in the long run, reductions in premiums for the groups mentioned above would have to be offset with increases for young men, younger adults, and those with better health status.

Table 1 shows some information related to that effect. The table compares premium rates for individual health insurance policies which were approved by the Kentucky Department of Insurance prior to July 15, 1995, with those actually paid by policy holders who purchased individual policies through the Kentucky Health Purchasing Alliance in 1995. The selected premiums are shown for the gender, age, and family combinations previously recommended by the Consumer - Provider Task Force on Individual Coverage.

Three filings were selected for comparison to the premiums paid by Alliance members. They were chosen because the companies were thought to have a significant share of the 1994 Kentucky individual market. The premiums quoted for companies A and B were for policy forms still being sold to new entrants just prior to implementation of HB 250.

The premiums quoted for company C are for a policy form that was closed to new entrants in 1988. It is a common practice among insurance companies pricing policies in an experience-rated market to sell a particular policy form as a guaranteed-renewable product. However, they generally only allow new entrants into the covered group for a limited period of time. It is a normal pattern that, for any static group of policyholders, the amount of claims will tend to increase over time because the probability that any particular individual will experience an illness or injury is greater over a period of several years than it is for any single year.

As the natural claims experience of the static group worsens over time, premiums of the whole group must increase to cover costs. As premiums increase, those with few claims find that they can purchase health insurance in a newer policy form at a lower rate. When they leave to take advantage of the lower rate, those left in the static group experience an additional increase in premiums. This process continues until the only ones left in the old policy form are those who have health conditions that make it impossible to purchase insurance in any new policy form. As premiums continue to increase, even most of those individuals are forced to drop their policies because they do not have sufficient income to cover their own high-cost medical claims. (This is the classic death spiral in rates that was given as a reason for the initial legislative actions.) It was believed that premiums in the closed policy form of Company C would be an acceptable proxy measure of the rates faced by those in poor health prior to 1995. (There were 453 Kentuckians in the policy form at the time of the rate filing.)

Since the rates from Companies A, B, and C are from the most recent filing prior to implementation of HB 250, they should be a reasonable example of the premiums which existed at the time of the change. It is clear from the table that the extent to which any particular policyholder might have experienced a significant rate increase or decrease because of the rating provisions of HB 250 is almost entirely dependent on where the policyholder falls in the age, gender, and health status matrix. Also of note is the difference between percentage changes and dollar changes. For example, the table shows that a 25 year-old non-smoking male would have experienced a 98% increase in premium in moving from Company B to an Alliance policy, while one moving from Company C's closed form would have seen a 70% decrease. Based on the percents, the former had a larger price change than the latter. However, the 98% increase represents an additional cost of $30, while the 70% decrease represents a savings of $141, reflecting the much higher initial price.

Table 1 provides no information about the distribution of policyholders in the individual market on these characteristics so it cannot be used to estimate how many policyholders might have experienced a particular change. To make such an estimate staff used data collected in the survey of Kentuckians with individual policies.[4]

Model Estimates

During the 1996 regular session a premium pricing model was developed, and provided to LRC staff, by an actuary working for the governor's office. The purpose of the model was to provide a rough indication of the feasibility of various rate band requirements. The bands that could be 'tweaked' in the model were those being considered in the reform effort--age, gender, and health status. Key assumptions underlying the model were 1) the distribution of the insurable market in terms of age and health status; 2) the pre-reform relationship between health status and premium for those who were insurable; 3) pre-reform ratios of premium rates for men compared to women, and the elderly compared to the young; and 4) the pre-reform premium for a young healthy male.

[4]Legislative Research Commission, Research Memorandum No. 474.

In its first use during the 1996 regular session, the model's underlying assumptions were provided by the actuary based on experience or published estimates for the nation. Kentucky-specific figures did not exist in most cases. This lack of supporting figures for some of the underlying assumptions limited the extent to which the model could be used with confidence. However, in

Table 1
Monthly Premiums for Non-Group Health Insurance Policies
from the 1994 Rate Filings of Three Companies
and Actual 1995 Rates Paid by Individual Members
of the Kentucky Health Purchasing Alliance

	Monthly Premium and Percent Difference from Alliance Premium								
				(Non-Smoker)		(Smoker)			
Policyholder	Alliance	Company A		Company B				Company C	
Single Female	$	$	%	$	%	$	%	$	%
Age 25	$61	$55	10%	$35	74%	$50	22%	$249	-76%
Age 40	90	103	-13	63	43	90	0	382	-76
Age 55	133	146	-9	113	17	162	-18	645	-79
Single Male									
Age 25	$61	38	59	31	98	44	38	202	-70
Age 40	90	64	41	47	90	68	33	341	-74
Age 55	133	141	-6	113	18	161	-18	705	-81
Single Parent									
Age 25	99	148	-33	60	64	86	15	420	-77
Age 40	144	196	-27	88	63	126	14	558	-74
Age 55	212	239	-11	138	53	198	7	823	-74
Couple									
Age 25	129	93	39	65	98	94	38	392	-67
Age 40	189	167	13	110	71	158	20	676	-72
Age 55	279	287	-3	226	23	323	-14	1307	-79
Family									
Age 25	148	197	-25	91	63	130	14	593	-75
Age 40	216	214	1	136	59	194	11	876	-75
Age 55	319	303	5	251	27	360	-11	1302	-76

Notes: Rates for Companies A, B, and C are for indemnity policies with 80/20 co-payments and $2,500 deductibles. Rates for the Alliance are actual rates paid by representative policyholders for a budget high indemnity plan (which had a $5,000 deductible for families). Policy forms of A and B were still sold to new entrants, while that of C was closed in 1988. Although deductibles are comparable, other features of covered benefits are not completely uniform.
Source: LRC staff analysis of premium data supplied by the Kentucky Health Purchasing Alliance, and pre-7/95 rate filings supplied by the Department of Insurance.

the interim, additional Kentucky-specific information has become available from both the Department of Insurance and the Health Insurance Survey. This additional information has been used to somewhat improve confidence in the model. However, it must be noted that the key assumptions in the previous paragraph will never be "nailed down" because of the lack of base-line data and the complexities of the insurance market. Given this, the model is best used for illustrating general effects and relative magnitudes of increases and decreases in premiums as opposed to providing specific dollar estimates.

Figure A, derived from the premium model, provides an illustration of the pure effect on premiums of changes in the rating structure. The chart provides an estimate of the share of the individual insurance market that would have experienced a given percentage change in premium when moving from *pre-reform* to HB 250 (dark bars) or when moving from *pre-reform* to SB 343 (white bars). Movement from pre-reform to either of the reforms is assumed to take one year (an underlying inflation rate of 5% is included in the figures). Reading down the chart in 20 percent increments one moves from high price increases to lower price increases, through the gray area of little change, to low price reductions and large price reductions at the bottom of the chart. So, the bars *above* the grayed area indicate the share of the market experiencing premium *increases* and the bars *below* the grayed area indicate the share of the market experiencing premium *decreases*.

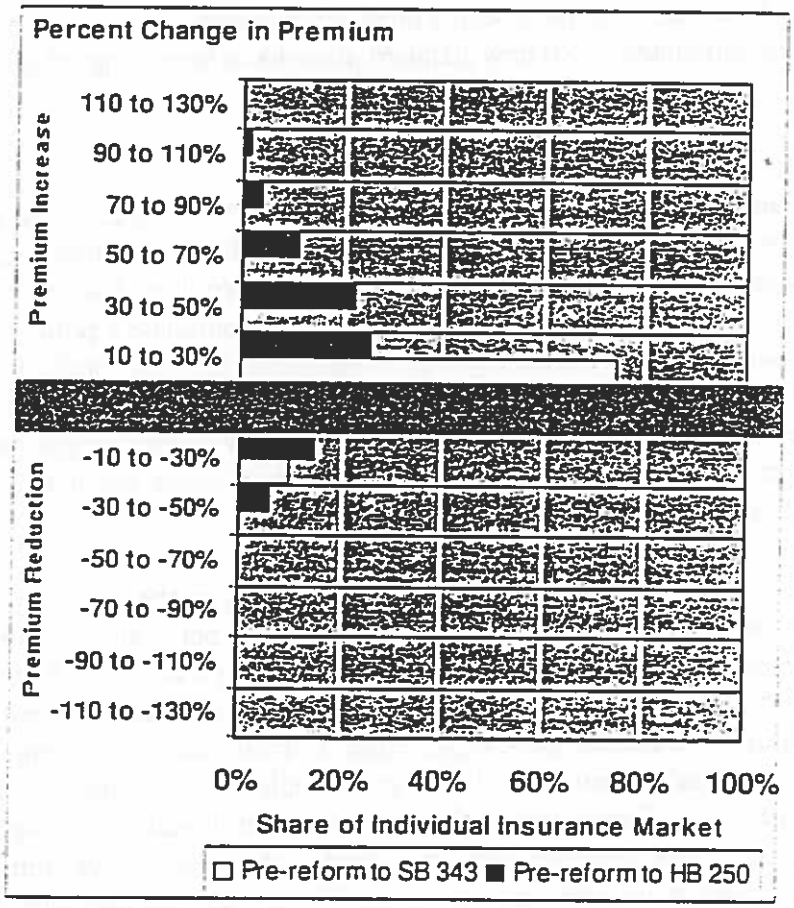
Most noteworthy in the chart is the large share of the market that experienced premium increases. If it was assumed that all 210,000 individually insured had come under the provisions of the two laws, then the bars above the gray line would represent about 130,000 individually insured who would have experienced increases from moving to the HB 250 rating structure, and 155,000 from moving to that of SB 343. In contrast, the bars in the section below the gray line represent about 40,000 individually insured who would have experienced premium decreases under HB 250 and 20,000 who would have experienced decreases from SB 343. The effect of widening the rate bands in SB 343 (white bars) is very apparent in the chart relative to HB 250 (dark bars). The distribution of the bars is important here; while the rating structure of SB 343 would have caused more people to experience rate increases, the increases would have been smaller.

Finally, it must be noted that this chart does not indicate what *actually* happened in Kentucky's health insurance market, because 1) it assumes events that never happened--complete coverage of the market by either of the two reform efforts, and 2) it does not recognize the effects of other aspects of the reform, such as standard plans and guaranteed issue, which are covered in other sections of this memo.

From the Health Insurance Survey, it was estimated that about 35,000 individually insured had policies meeting the provisions of HB 250 in the summer of 1996. If the model results are applied to this group then it is estimated that about 22,000 would have had higher premiums because of the change in rating structure, and about 7,000 would have had lower premiums, all else held equal. Based on the unsupported guess that another 30-35,000 may have come under the provisions of SB 343, then about 22,000 of that group would have experienced moderate-to-large increases, compared to about 3,000 who would have experienced decreases, all else held equal. (Staff is currently working on an estimate of the effect of moving from HB 250 to SB 343.)

While the estimates are thought to be a reasonable representation of the pure effects due solely to changes in rating structure, it is important to remember that the "all else held equal" assumption means that they are not an accurate reflection of what actually happened to premiums. In particular, the existence of the association exemption makes it much less likely that those with lower premiums under experience rating would voluntarily accept their portion of the subsidy required by a change to modified community rating.

Figure A
Pricing Model Estimates
of Share of Individual Insurance Market Experiencing Given Percent Changes in Premium
Due Solely to Changes in Rating Structure
Imposed Under HB 250 and SB 343



Note: The following rate band assumptions were used:

Characteristic	Pre-reform	HB 250	SB 343
Maximum Age Band	4.5	3.0	4.0
Maximum Gender Difference	1.5	1.0	1.5
Health Status Band	2.5	1.0	1.5

Change in Benefits

In addition to restrictions on the rating factors which could be used to price individual insurance policies, HB 250 also limited policies which could be sold, to one of the pre-defined standard benefit plans. There has been criticism that the standard plan with the lowest level of benefits was still much richer than some policyholders had purchased in the individual market in 1994. There have also been complaints that restrictions imposed by standard plans did not allow policyholders to tailor their benefits to their own particular preferences.

To get a rough approximation of the effect of a mandated change in benefits, irrespective of other changes, a comparison was done of the rates listed in the filings of Companies A, B, and C for the same policy forms but with different covered benefits. For the company whose filing was for a policy form still accepting new applicants and who offered a policy with a $5,000 deductible, the increase in premiums for an upgrade to a policy with a $2,500 deductible ranged from 15% to 30%. Thus, those who had previously purchased "catastrophic" coverage and who were forced to upgrade to a standard plan, may have seen a premium increase in the neighborhood of 25%, just because of that benefit change. No new standard plans have been adopted since implementation of HB 250, so this effect is still being felt under SB 343.

Guaranteed Issue

The effects of changes in the rating provisions discussed above only take into account the effects on policyholders who had previously been insured in the individual market. Under the provisions of guaranteed issue, those who had previously been denied access to health insurance because they had high-cost medical conditions were able to purchase a policy at modified community rates which did not reflect the cost of treatments for their medical conditions. In hearings before the various legislative committees at the time the two bills were under consideration, actuaries estimated that guaranteed issue requirements, in the absence of being able to set premiums based on health status, would add, on average, 8% to the price of insurance in the individual market.

Staff analysis of the operations of all high risk pools operating in the country in 1995 indicated that the weighted average per-person costs were about $4,500 per year. Weighted average premiums paid per person were approximately $2,500, leaving a deficit of $2,000 per year per person.[5] Since high risk pools generally impose a 25% to 50% increase in the standard premium for poor health status, the expected per-person deficit of individuals with a high-cost condition under Kentucky's modified community rating system would likely be higher and is estimated to be around $2,500 per year. Depending on the number of individuals with a high-cost condition which are assumed to have entered the individual market after HB 250 was implemented, staff estimates that guaranteed issue added an average of 5% to 9% to the premiums of those who had individual coverage in 1994, compared to what they would have paid without the guaranteed issue provision.

Some have expressed the concern that guaranteed issue plus modified community rating may have provided sufficient incentive for non-state residents with high-cost medical conditions to move to Kentucky. Over 2.5 million residents of contiguous states live in a county bordering Kentucky, so this concern is not trivial. Three of these states have high risk pools, one requires guaranteed issue in the individual market, and none impose rating restrictions.[6] There is no available data regarding how many people might have moved for this reason, or the total costs they might represent. The six months pre-existing condition exclusions specified in HB 250 may have reduced the incentive for adverse selection by those with conditions requiring more

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[5] LRC staff analysis of data contained *in Comprehensive Health Insurance for High-risk Individuals: A State-by-State Analysis, Tenth Edition*, Communicating for Agriculture, 1996.

[6] Health Policy Tracking Service, *Major State Health Carre Policies: Fifty State Profiles, 1996*, January, 1997.

immediate treatment. SB 343 added a residency requirement of 12 months and also extended the pre-existing condition exclusions to 12 months, further reducing the incentive for relocation. However, those with chronic high-cost conditions, such as quadriplegia or multiple sclerosis (MS), may have made such a decision if they were willing to go without insurance coverage of their condition for six months to two years in hopes of obtaining affordable coverage thereafter.

Change in Pricing for Families

Review of the pre-HB 250 rate filings of the three companies noted above indicated that there were variations in the number of pricing options (also called tiers) for various categories of families. Company A listed rates for single males, single females, and families. However, the rate for a single male plus that for a single female was less than the family rate, so it is likely that a couple would have chosen the two single rates. Similarly, the rate for a female plus two children under age 20 would have been lower than the family rate. So it was possible for policyholders to tailor a premium to their situation. Companies B and C had similar structures.

HB 250 required a four-tier structure with pricing for singles, couples, parent plus child(ren), and families (two adults plus one or more children). Rates were not generally affected by how many children were included. This means that single parents, and families, with fewer children would have paid higher premiums, and those with more children would have paid lower premiums, all else held equal. No data is available regarding what the magnitude of this effect might have been.

Market Uncertainty

While it is not possible to estimate the magnitude of this effect, it is important to remember that insurance providers have had to price individual policies in the presence of two major revisions in the rules under which they operate in Kentucky. This dramatically increased companies' uncertainty regarding the demographic mix and claims experience of the group who would choose to purchase their policies, the strategies of competitors, the operation and efficacy of risk adjustment mechanisms, and the duration of particular features of the laws which were implemented.[7]

Some have accused companies of intentionally inflicting premium increases and policy changes on policyholders in an attempt to gain their support in efforts to repeal changes in the law. Staff can make no assessment of the reasons for which company managers have made particular business decisions. However, traditional economic theory is completely compatible with the expectation that efficient managers might set prices higher (or lower) in a short-run period of disruption than they would when the market moves to a long-run equilibrium. The individual insurance market in Kentucky did not have time to make long-run adjustments to HB 250 before SB 343 was enacted. Some company managers appear to believe that SB 343 will be amended before long-run adjustments to its provisions can be achieved. Thus, it is considered highly unlikely that average premiums which existed in the market subsequent to the adoption of HB

[7]While it could be argued that the total cost of delivered medical care was already in the system, in the form of cost shifting and uncompensated care, to remain financially viable, individual companies must price for the share of the market for which they are responsible.

250 and SB 343 are as low as they would have been if company managers had been operating with much greater certainty about how the changes would play out over the long-run.

Exemption of Associations from Rating Provisions

SB 343 specifically exempted associations from the rating provisions imposed on the rest of the individual market. While this provision would not have affected premiums in force under HB 250, and should have only begun to affect those under SB 343, it is expected that the effect will grow in significance as long as modified community rating is imposed on the rest of the individual market.

This effect derives from the existence of adverse selection in the market for health insurance. This means that those most willing to purchase health insurance at a higher price are those who believe they are likely to use more health services than the cost of the insurance. Purchasers who believe they are unlikely to consume a significant dollar amount of health services are only willing to pay a lower price, or none at all. Given free choice between rating provisions, purchasers with an expectation of low utilization will generally select an experience-rated premium, while those with an expectation of higher utilization would prefer a community-rated premium. This results in a situation exactly analogous to the death spiral described above. Over time, premiums in the community-rated section of the market will increase in such a fashion that the entire market will revert back to a pure experience-rated market. It is not possible to estimate exactly what magnitude of effect the exemption had on current community-rated premiums, but it is likely that companies who chose to remain in that market set premiums which reflected expected instability due to the exemption.

Other Factors

Factors unrelated to the provisions of either bill also affected changes in premiums over the period. These changes may have augmented, or offset, the effects on premiums discussed above. Overall increases in the cost of medical services, measured by the medical CPI were 4.5% in 1995 and 3.5% in 1996. The reviewed rate filings approved prior to implementation of HB 250 reflected increases in average premiums of 12.4% (Company A), 11.8% (Company B), and 42.9% (Company C).

General movement to a managed care environment would have reduced average premiums in 1995-97, compared to 1994, although the "any willing provider" provision in Kentucky law may have reduced savings achievable from managed care. The general aging of the population and the demand for more sophisticated medical and pharmaceutical treatments would have increased premiums. State and federal mandates for coverage of specific benefits, such as 48-hour maternity stays, would also have increased premiums, all else held equal.

The point is that, even in the absence of HB 250 and SB 343, average premiums in the individual market would have shown significant increases over the period since 1994. It is incorrect to assume that all increases are attributable to legislative changes.

Increases in the Number of Uninsured

The Census Bureau did not find a statistically significant change in the number of uninsured in Kentucky between 1994 and 1995, based on its analysis of the Current Population Survey (CPS). When applied to the 1990 census count of the Kentucky population, the percentage estimates of the uninsured in 1991-1995 are either within, or very close to, the margin of error on the 1990 estimate. This means that most of the variation in estimates from year-to-year are attributable to normal sample variations and changes in estimates of total population. Because the size of the Kentucky sample in the CPS is relatively small, nearly 10% of policyholders in the small-group and individual markets would have to drop coverage before the method used by the Census Bureau would be able to identify that any change had occurred.[8]

According to the U.S. General Accounting Office (GAO), from 1989 to 1995 there was a national decline in the percentage of the non-elderly population covered under private insurance. They estimated that 70%-90% of this decline was due to reduced coverage of dependents through employer-based policies.

> In the late 1980's, the cost of employment-based health insurance premiums significantly outpaced inflation. Between 1988 and 1989, employer costs for health insurance rose 18 percent in one year. By contrast, general inflation was under 5 percent. Health insurance premium costs began to stabilize recently. However, health insurance continues to be a major portion of employers' total compensation to employees -- 7.3 percent of payroll costs in 1993, compared with 4.4 percent in 1980....Between 1989 and 1996, cost increases for family premiums were 13 to 23 percent higher than cost increases for employee-only premiums, depending on the type of health plan....With the surge in health insurance premium costs, some companies began to reevaluate their obligation to provide coverage to employees and especially their dependents. A recent survey...found that...employers viewed their role in providing coverage to employees and their dependents as diminishing.[9] (Pages 3-7)

This should not be taken to mean that no individual policyholders have chosen to drop coverage in the face of premium increases (whatever the reason). A basic tenet of economic theory is that, as the price of a product increases, demand for that product decreases. Since the analysis above indicates that more policyholders in the individual market were likely to have experienced rate increases than decreases from the change to modified community rating, it is also likely that more people dropped than added coverage. In the Health Insurance Survey, half of the newly uninsured whose previous coverage had been in the individual market reported that they dropped coverage because they could no longer afford the premium. However, because the individually insured comprise only about 5.5% of the total population, changes in their insurance status are not easily captured in overall estimates of the uninsured.

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[8] See Legislative Research Commission Research Memorandum No. 474 for a more complete discussion of this issue.

[9] U.S. General Accounting Office, *Employment-Based Health Insurance: Costs Increase and Family coverage Decreases*, February 1997, GAO/HEHS-97-35.

In general, most people are uninsured because they lack sufficient incomes to purchase health insurance in addition to the other goods and services they feel they need. The uninsured have lower incomes compared to the privately insured, which explains much of their inability to purchase insurance (Table 2). For most uninsured the basic reason for lack of health insurance is affordability - whether affordability is constrained by low income or by high premiums due to a health condition. In surveys which ask the question, very few respondents say they don't have health insurance because they don't think they need it. Less than 8% of the uninsured live in households with incomes above $40,000, compared to 41% of the privately insured.

An attempt to reduce the number of uninsured through changes in rating structure really only benefits the small number of uninsured with high-cost medical conditions and sufficient income to pay an average premium; may cause those without such conditions, and without sufficient income to absorb their share of the subsidy, to drop insurance; and has no affect on the low-income uninsured. Discussions about community rating versus experience rating are really about the basic policy issue of who should pay for medical services for those with high-cost conditions.

Table 2

Household Incomes of the Uninsured and Privately Insured

Household Income	Percent of Uninsured	Percent of Privately Insured
Less than $10,000	44%	5%
$10,000 to $15,000	14	7
$15,000 to $25,000	19	17
$25,000 to $40,000	15	30
$40,000 to $50,000	4	10
More than $50,000	4	31

Source: LRC staff analysis the Spring 1996 Kentucky Survey.

Under an experience-rated pricing system for health insurance, the health risks associated with particular policyholders are segmented. What this means is that those with similar risk characteristics are placed in one category and charged a low price reflecting their similar level of risk, while those with higher risks are placed in another category and charged a higher price reflecting their similar level of risk. Thus, those with different risks are segmented into defined categories, with differing prices attached to each category according to the average level of risk the category represents. It is also important to understand that the categorization of risks for any policyholder only covers the time period covered by a specific contract -- usually a contract year. At the time the contract is renewed, the risks of each policyholder are re-evaluated, and policyholders may be assigned to a new category if their risk status has changed.

Economists might term this arrangement "efficient" and actuaries might term it "equitable" and they would both mean the same thing -- that those who are asking insurance companies to assume a greater magnitude of financial risk should pay more than those who are asking insurance companies to assume a smaller magnitude of financial risk. Two points should be made here. First is that, under this form of "efficient" or "equitable" risk segmentation, the market tends toward an arrangement where insurers prefer to offer health insurance only to low-risk policyholders and where income limitations prevent many higher-risk policyholders from paying premiums in line with the risks they represent. Second is that the technical terms of "efficient" and "equitable" should not be taken to imply anything about "fairness" or "equity" in a public policy sense. Judgments about "fairness" and "equity" represent value judgments and are outside the normal realm of positive economics and actuarial science, but are strictly within the realm of public policy decisions.

There are many who would characterize experience rating as "unfair" and characterize the insurance company as unscrupulous for pricing insurance in this manner. They raise the problem that few families have sufficient resources to pay for very expensive medical procedures. However, the point is made that this situation is simply the end result of the process of using risk segmentation to price health insurance. Those who believe the insurance company has somehow violated the rules misperceive the product of health insurance in a market based on risk segmentation which is re-evaluated at the beginning of each contract period. Under these conditions risk is not pooled across different categories of individuals, and the premiums paid in one period offer no protection for health conditions encountered in a subsequent period. For example, some people think it is not "fair" if, after paying insurance premiums for 10 years without filing a significant claim and then, in the 11th year, having a significant claim for a chronic condition, they face a large increase in the 12th year reflecting their changed risk status. Under a pricing strategy based on risk segmentation this occurrence is logically consistent and does not reflect unscrupulous business practice because the premiums paid in the previous 10 years were set low so as to only cover the expected risk at that time. If, in the 11th year, the risks have increased, it stands to reason that the price must also increase.

If the situation just described is judged "unfair", then it implies a policy judgment that pricing based on risk segmentation is "unfair". The alternative pricing structure is risk pooling. Under this structure, everyone pays a premium closer to the average for the whole group and those who move into a different risk category do not see a directly parallel increase in premiums. This, of course, is also known as community rating. In pure community rating, risks are pooled across all insured individuals in the market segment subject to the rating restrictions. However, there are those who argue that such a system is also "unfair" because those with lower risks, who tend to be younger and often have less income, generally subsidize those with higher risks, who tend to be older and may have more income. This pricing structure yields a price that is more stable across subsequent periods for all policyholders, but which is higher in some periods for those who would benefit from risk segmentation. Modifications to pure community rating, such as allowing adjustments for age, gender, or other factors simply restrict the risk pooling to categories of individuals who share some demographic characteristic.

Others would argue that insurance subsidies, no matter whether for those with expensive medical conditions or those with limited incomes, are more properly funded by all citizens, rather than just those insured in a particular market, since the judgment that they should be subsidized reflects a social policy decision. In particular, it can be questioned whether individuals with lower incomes, but who still manage to purchase health insurance, can equitably be asked to subsidize those with higher incomes, but with expensive medical conditions, when those without sufficient income to pay a premium (whether a high-cost or low-cost premium) are not subsidized at all.

Change in Business Conditions

According to the Department of Insurance, 42 carriers have withdrawn from the Kentucky individual insurance market since 1994. Staff has no data regarding whether these companies withdrew because of changes in the law, or for other reasons. It is likely that a combination of factors was considered in the decision.

> Principal Mutual Life Insurance Co. one of the nation's largest individual health insurers, is leaving that market altogether. The company cited low profitability, problems with state health reform laws and its ongoing consolidation around other lines of insurance... The individual market made up only 3% of Principal Mutual's health insurance business and was not as profitable as other lines of business, according to company officials. The firm says it will focus on group policies and managed care.[10]

Companies unable to secure an adequate share of the exempted association-market for individual coverage would have seen their healthier customers flee seeking lower premiums and may have concluded that staying in the Kentucky market was a losing proposition in the long-run.

No matter why companies left the market, there have been questions regarding how many policyholders were affected. Staff is aware of no complete enumeration of market share for all companies in the individual market in 1994. However, information was obtained from policyholders in the Alliance regarding their previous type of coverage (individual, group, or other) and their previous company.

Staff analysis of the Health Insurance Survey indicated no significant difference in the age and gender of individually insured inside and outside the Alliance. However, those in the Alliance were found to have significantly worse scores on a standard measure of health status than those outside. Thus, the distribution of Alliance members among insurers in 1994, may not be completely representative of all individually insured. Still, because it is the only relevant data staff could obtain at the present time, the results are presented here.

Of the policyholders with individual coverage through the Alliance in 1995 or early 1996 who reported having an individual policy as their previous coverage, 36% said their previous company was one of the companies listed by the Department of Insurance as having withdrawn

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[10] Page, Leigh, "Major insurer exits individual market, citing low profit," American Medical News, March 3, 1997, pp 6.

from the Kentucky market. Eighty percent of those were insured by one of six companies (Time, Golden Rule, Continental, Mutual of Omaha, John Alden, and Shelter.)

Other carriers may not have left Kentucky entirely, but may have stopped selling policies in the individual market. At the current time only Anthem and Kentucky Kare are selling policies in the individual market (excluding HMOs who were recently required to implement 30-day open enrollment periods.) Kentucky Kare was not allowed to sell insurance to non-public employees prior to passage of HB 250. So another way to examine the question is to see what percentage of Alliance individual policyholders reported having previous individual coverage under Anthem. One-fourth of the group reported that their previous individual coverage was an Anthem product. This means that three-fourths of the group no longer has access to their former carrier.

Kentucky Kare is all that prevents a monopoly situation in the community-rated individual market. Given that its reserves have declined by $50 million since it began selling private individual coverage, it is questionable as to whether it can long remain financially viable in its current form. According to traditional theory, companies with an unregulated monopoly set prices higher than they would in the presence of effective competition. That, plus the pricing spiral related to the association exemption, holds out little hope that premiums in the individual community-rated market will stabilize at some efficient level in the absence of further legislative action.

I hope this memo provides the information you need. If I can answer questions or be of further assistance, please let me know.

Kentucky Department of Insurance

APPENDIX H

NATIONAL DATA

Every year in March, the United States Census Bureau completes the Current Population Survey (CPS). This is a monthly survey of approximately 50,000 households conducted for the Bureau of Labor Statistics (BLS). This survey has been produced for over 50 years. It is the primary source of labor force characteristics of the United States population. While statistics are gathered on individuals over 15 years old, published statistics primarily focus on those 16 and older. The major drawback to the use of this survey for summary statistical data arises from the fact that a very small sample (approximately 700 households in the state of Kentucky) is utilized to acquire data. To help alleviate some of the problems arising from a small sample, the Bureau of the Census aggregates annual data into two year averages to help stabilize annual swings. The survey provides estimates for national demographics and is part of the model-based estimates for individual states.

Among estimates gathered by the CPS are employment, unemployment, earnings, hours of work, insurance coverage, and other relevant economic indicators. They are available by some demographic standards as age, sex, race, marital status, and educational achievement. Other demographics measured include categories such as occupation, industry, and class of worker (blue or white collar, technical, professional, etc.). Supplemental questions such as income, school enrollment, work schedules, and employee benefits are sometimes added to the survey.

The following statistics come from the March 1996 Supplement to the survey, which measures 1995 data. These data are released in the year after they are generated. For example, the 1993 survey data are released in 1994. According to this survey data, 223,733,000 people, or 84.6% of the national population, had some form of health insurance coverage during part or all of 1995. Citizens may have more than one kind of insurance at the same time. For example, someone may have purchased private insurance provided by an employer and also be covered by Medicare. They may have Medicare and a supplemental policy purchased on the individual market. Therefore, care must be taken when trying to add the various types of insurance in anticipation of totals adding up to 100% of the insurance market.

There were 40,582,000 people, or 15.4% of the population estimated to be without insurance during 1995. This is approximately 15.4% of the nation's population. Of those individuals with insurance, 70.3% had private insurance, either employer provided or individual policies. Of those with private insurance, 61.1% of these individuals had employer provided insurance, with the rest utilizing the individual insurance market. Government insurance accounted for insurance coverage for 74,908,000 people. Medicare covered 34,655,000 persons, or 13.1%. Medicaid was utilized by 31,877,000 people, or 12.1%. Military insurance such as CHAMPUS, CHAMPVA, veterans, and active military health care covered 9,376,000 people, or 3.5%. There were 40,582,000 people, or 15.4% of the population estimated to be without insurance during 1995.

It was estimated by the Legislative Research Commission that 5.5% of the population, or about 210,000 people, had purchased individual policies in the insurance market in Kentucky during 1995. During that same time period, approximately 9.3% of the population, or 360,000

individuals, were insured by firms with less than 50 employees. They also estimated that 14.65%, or about 560,000 people, were uninsured in 1995. Of those uninsured in Kentucky who responded to the Legislative Research Commission survey, over two-thirds said they were uninsured because of cost, while only 5% said they were uninsured because of a medical condition. It is worth noting here that the survey took place after implementation of the 1994 reforms and before the 1996 reforms were in place.

KENTUCKY DEMOGRAPHICS

The Commonwealth of Kentucky is primarily a state with a workforce consisting of many small employers, a workforce lower than the national average in educational achievement, and containing a population that is substantially less healthy than the national average. Each of these factors will have an adverse effect upon the population to have, or afford, private health insurance. Each factor will be analyzed from the viewpoint of impact of providing affordable insurance and insurance reform for the citizens of Kentucky. National data as well as the Legislative Research Commission survey released in march 1997 will be utilized.

POPULATION

According to the State Data Center at the University of Louisville, both the United States and Kentucky have traditionally had a pyramid shaped population demographic where the younger generation is larger and better educated than the one preceding it. Currently, those Kentuckians in their 30's and 40's are greater in number than the younger generation. The "baby boomers" waited longer to have children, and had fewer per household than older generations. This phenomenon, coupled with the fact that Americans are living longer and healthier, has resulted in a squaring of the population pyramid. Consequently, the younger generations are significantly smaller in number. This decline will impact our social and economic policies in several ways.

A national study was released using data gathered between 1982 and 1994 which shows the percentage of adults over 65 considered disabled has dropped from 24.9% to 21.3%, or an estimated difference of 1.2 million people. This study was produced by the National Long Term Care Survey and Duke University looked at chronic disability among a sample of more than 20,000 persons aged 65 and older. This study, if corroborated, may have important implications for Social Security and expenditures for Medicare and private insurance coverage. According to this study, published in the Proceedings of the National Academy of Sciences in March, 1997, if the percentage of elderly persons in institutions in 1982 remained the same, the 1994 population would total 2.1 million individuals in nursing homes or other facilities. Instead, there are 1.7 million individuals in these institutions. If it is assumed that the nursing home cost per person is approximately $43,300 per year in 1994 as stated in the report, the 400,000 fewer persons in these facilities results in a savings to the nation of $17.3 billion in nursing home costs.

Technology and the employment market are rapidly changing, and our work force will change with it. Today, the employed worker is the worker who continues their education, either in school or on the job. Older workers, combined with fewer children, will dramatically affect the educational, medical care, and insurance delivery systems of the state in the future.

Along with the changing workplace, people are living longer. They are also faced with older retirement ages. As people work longer, they have more insurance options. Medicare eligibility continues to become effective at age 65, while many employees are working well into their seventies and beyond. These workers will have, as long as Congress does not change the eligibility criteria, more insurance coverage options from which to choose.

EDUCATION

The people of Kentucky have traditionally viewed the educational process as a tool to provide needed skills for the workplace. With the economy centered primarily around manufacturing and mining, these jobs have provided high wages for individuals with a high school diploma or less. This economic mix has not provided an economic incentive for continuing educational achievement.

According to the 1996 Current Population Survey from the U.S. Census Bureau utilizing 1995 data, the Commonwealth placed in the lower end nationally for high school graduation rates. The high school graduation rates for individuals 25 years of age and older ranged from a low of 72.7% (with a standard deviation of plus or minus 1.8%) for West Virginia to a high of 92.1% (with a standard deviation of plus or minus 1.3%) for Alaska. Kentucky had a high school graduation rate of 76.7% (with a standard deviation of plus or minus 2.3%). At the 90% confidence level, this means the percentage of Kentuckians completing high school ranged from 74.4% to 79.0%. The 90% confidence level is a statistical tool used to determine the probability that the findings would reflect the survey results if the entire population of Kentucky were questioned. With the relatively small sample size, in 18 out of 20 cases, it can be assumed the findings of the poll would have shown high school graduation rates would be between 74.4% and 79.0%.

According to the same Census Bureau survey, those individuals with a bachelor's degree or greater ranged from a low of 12.7% (with a standard deviation of plus or minus 1.8%) for West Virginia to a high of 38.2% (with a standard deviation of plus or minus 3.0%) for the District of Columbia. Kentucky had a bachelor's degree or greater completion rate of 19.3% (with a standard deviation of plus or minus 2.2%). At the 90% confidence level, this means the percentage of Kentuckians completing a bachelors degree or greater ranged from 17.1% to 21.5%.

For comparative purposes, the following table shows the relative high school and bachelor's degree completion rates for the states contiguous to Kentucky:

STATE	HIGH SCHOOL COMPLETION RATE	BACHELORS DEGREE COMPLETION RATE
IN	81.6	16.9
IL	82.3	24.6
OH	83.4	19.7
VA	82.7	26.0
NC	76.3	20.6
TN	77.4	17.8
MO	82.2	21.9

High school and college graduation rates, while showing the emphasis placed on education, only start to explain the relationship between and education and ability to purchase insurance. The relationship between educational achievement and earnings potential is well documented. It has been well documented that the ability to purchase insurance is relative to earnings. According to the Bureau of Economic Analysis, in 1980, high school dropouts earned 17.3% less than high school graduates and they earned 32.2% less than college graduates. In 1990, high school dropouts earned 15.9% less than high school graduates and they earned 59.5% less than college graduates. So while the 1980's provided little incentive to complete high school, it provided a great incentive to attend college. This survey was based on 1800 interviews during the decade and was controlled for race, marital status, and time of interview.

EMPLOYMENT

As important as the educational achievement of Kentuckians is, the types of jobs available to Kentucky's residents are equally important. The Bureau of Economic Analysis has made estimates of the job structure in Kentucky by industrial classification from 1989 to 2005. Among those industries expecting to show gains are all government (a gain from 298,000 to 345,000), services (410,000 to 625,000), financial, insurance, and real estate (95,000 to 111,000), wholesale and retail (397,000 to 491,000), and the construction industry (99,000 to 125,000).

Those industries expecting to show declines are manufacturing (a decline from 291,000 to 217,000), coal mining (31,000 to 17,000), and farming (127,000 to 115,000).

As evidenced above, the manufacturing and coal mining industries, traditionally utilizing low skill and low educational achievement workers making high wages are expected to experience a significant decline. Experience since 1989 has tended to prove these predictions accurate. The service, wholesale and retail, and service industries tend to use higher educated workers but traditionally do not pay as well as mining or manufacturing. With under-education and a changing education-earnings ratio, Kentucky could conceivably lose ground in its attempt to improve its economic condition in relation to other states. Less income can translate into less ability to afford insurance.

According to the 1994 County Business Patterns, Kentucky has a workforce that works predominately for small employers. This survey, taken each year during the week of March 12th, attempts to measure employment by size of employer and industry division on both the statewide and county levels. Kentucky has 26.32% of its workers employed by firms with 19 or fewer employees. This segment of the workforce earns only 22.74% of the estimated $28,324,513,000 paid in 1994. Employers with 49 or fewer employees make up 43.04% and they earn only 37.39% of the payroll. Those who work for employers of 500 or greater make up only 17.86% of employees and earn 24.36% of the payroll of Kentucky. This study does not include most government employees, railroad employees, and the self employed. The employment size class that measures 1 to 4 employees includes establishments who have payroll but no employees during this mid-March pay period.

HEALTH OF KENTUCKIANS

1996 ReliaStar State Health Rankings

The ReliaStar State Health Rankings are an annual study that uses 17 components to measure the overall health rankings of each state according to such factors as prevalence of deadly diseases, lifestyle factors, access to health care, occupational safety and disability, and mortality. Prior to 1995, this study was known as "The NWNL State Health Rankings". Kentucky's ranking has remained relatively unchanged since 1990. In 1990, Kentucky was rated the 39th healthiest state in the nation. In 1995, Kentucky was tied for 38th, along with Florida, New York, and Tennessee. Tennessee and West Virginia were the only contiguous states to Kentucky to rank lower in overall health. In the 1996 study, Kentucky was rated the 40th healthiest state. For comparative purposes, Virginia was rated 10th, Ohio was tied for 14th, Indiana was tied for 17th, Illinois was tied for 24th, North Carolina was rated 28th, and Missouri was rated 34th in the nation. The following states were rated lower than Kentucky: Tennessee was rated 42nd and West Virginia was rated 47th healthiest state in the nation.

Kentucky was rated in the bottom 10 in the nation for the following measures:

- Prevalence of smoking - 25.5 % of Kentucky's citizens are smokers. This is measured by the percentage of the population over 18 that smokes tobacco products regularly.

- Risk for heart disease - This is a measure of three criteria: obesity, hypertension, and sedentary lifestyle. All three factors are known to contribute to heart disease.

- Support for public health care - we rank 45th in the country. This measure is derived by calculating the percentage of the state budget spent on welfare, health care, and related services divided by the percentage of the population with an annual income of less than $15,000.

- Worker Disability Status - Kentucky ranks 48th in the country with 7.3% of the population with disabilities severe enough to prevent employment.

- Heart Disease - Kentucky is ranked 46th in the United States with 171 deaths per 100,000 population. This measurement is derived by using a three year average, adjusted for age and race, death rate due to heart disease.

- Cancer Cases - This factor utilizes copyright information from the American Cancer Society. It reports the number of projected cases for the current year divided by the estimated total population of the state to get a rate of cancer cases per 100,000 population. Kentucky is ranked 44th in the United States with 601 deaths per 100,000 population.

Kentucky Department of Insurance

APPENDIX I

INSURANCE COMPANIES REPORTED KENTUCKY BUSINESS
AS OF THE DATE OF WITHDRAWAL FROM THE MARKET
(in response to Bulletin 95-10 and
(subsequent requests from the Department of Insurance)

COMPANY NAME	DATE OF DECISION TO WITHDRAW FROM MARKET	NUMBER OF AFFECTED POLICIES	NUMBER OF AFFECTED COVERED LIVES (estimated)	COMMENTS
Aid Association for Lutherans		27	54	
American National Insurance Co.	6/26/95	402	804	participated in the individual market only
American National Insurance Co. of Texas	6/26/95	66	132	participated in the individual market only
American Pioneer Life Insurance Co.	7/6/95	108	216	(the date refers to a letter in which they stated they would non-renew if they were not permitted to continue their existing business)
American Republic Insurance Co.	6/21/95	180	360	participated in the individual market
Bankers Life & Casualty Co.	7/13/95	4	8	participated in the individual market only
Life Insurance Co. of North America (CIGNA)	9/26/95	0	0	
Insurance Co. of North America (CIGNA)	9/26/95	4	8	these policies were group policies
Central Reserve Life Insurance Co.	8/11/95	369	738	
Continental Life Insurance Co.	6/27/95	29	58	participated in the individual market

Revised 9/9/97

Kentucky Department of Insurance

Celtic Life Insurance Company	9/3/96	561	1122	no new business issued since 7/15/95; participated in both group and individual markets
Centennial Life Insurance Company	12/31/96	2,233	4466	
Central Reserve Life Insurance Co.	8/11/95	369	738	
Community National Assurance Co.	5/95	3119	6239	
Cuna Mutual Insurance Society	2/25/97	19	36	participated in the group market only
Fortis Benefits Insurance Company (Time)	5/25/96	6458	12916	
General American Life Insurance Company	8/28/96			participated in the group market
Golden Rule Insurance Co.	6/11/96	5869	11738	
The Guardian Life Insurance Co.	8/14/96	95	190	participated in the group market only
Heritage National Healthplan, Inc.		17	34	
Life of Georgia	9/13/95	8	16	
Hartford Life & Accident Co.	7/12/94	10	20	these are individual policies
John Alden Life Insurance Co.	12/28/95	3383	6766	
John Hancock	3/97	0	0	business sold to Unicare
Metropolitan Life Insurance Co.	11/30/95	338	676	
MidAmerica Mutual Life Insurance Company	3/19/96	57	114	
Mutual of Omaha	7/7/95	917	1834	participated in the individual market only

Revised 9/9/97

The Mutual Life Insurance Co. of New York	7/5/95	0	0	
New York Life Insurance Co.	1995	69	138	these are group policies (sm, lg, and assn. They did not participate in the individual market)
National Financial Insurance Co.	8/16/95	20	40	
National Casualty Co.	8/22/95	711	1422	
Nationwide Life Insurance Co.	7/10/95	300	600	participated in both group and individual markets
Nippon Life Insurance Co.	6/10/96	10	20	participated in the group market only
Pan American Life Insurance Co.	7/3/95	52	104	participated in the group market only
Philadelphia American Life Insurance Co.	7/14/95	28	56	
Physicians Mutual Insurance Co.	7/6/95	227	454	
Phoenix Home Life Mutual Insurance Co.	6/30/95	4	8	
PM Group Life Insurance Co.	7/14/95	27	54	participated in the group market only
Preferred Risk Life Insurance Co.	7/26/95	15	30	participated in individual market only
Principal Mutual Life Insurance Co.	7/14/96	1677	3354	participated in the individual and group markets
Pyramid Life Insurance Co.	6/29/95	387	774	
Provident Indemnity Life Insurance Co.	7/14/95	133	266	

Security Life Insurance Co. of America	8/24/95	9	18	participated in the group market only
Sentry Life Insurance Co.	7/12/95	90	180	
Shelter Life Insurance Co.	2/17/95	500	1000	
State Farm Mutual Insurance Co.	4/94	8923	17846	
The Travelers Insurance Co.	7/17/94	518	9672	participated in group market only; sold business to MetraHealth (now United HealthCare)
Trustmark Insurance Co.	4/19/96	248	496	participated in the group market only
Union Bankers Insurance Co.	6/29/95	104	208	participated only in the individual market
United World Life Insurance Company	7/12/95	172	344	
Washington National Life Insurance Co.	early 1995	2,380	4.760	
TOTAL		40,906	91,129	

Revised 9/9/97

AID ASSOCIATION FOR LUTHERANS
4321 North Ballard Road, Appleton, WI 54919-0001
(414) 734-5721

George Nichols III, Commissioner
Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Dear Mr. Nichols:

Thank you for the opportunity to provide feedback regarding the Individual Health Insurance market in the commonwealth of Kentucky. As you know, AAL no longer offers medical insurance to individuals under age 65 in Kentucky. We do, however, market other forms of individual health insurance including long term care insurance and disability insurance. You may wish to keep in mind that health insurance is more than just major medical insurance.

AAL decided in 1993 to discontinue sales of major medical insurance in all states. Our decision was not directly related to the reform measures being contemplated in Kentucky. However, the various state reform measures did contribute to our decision since it was becoming more and more difficult to be a nationwide provider of individual major medical insurance. It is unlikely that any changes to your current law would lead us to consider reentering this market.

I regret that we will be unable to be present at your meeting. We wish you the best of luck as you deliberate the future of medical insurance in your state.

Sincerely,

B. Leonhardt

Brian Leonhardt
Director and Assistant Actuary
Health Solutions

April 14, 1997

AMERICAN
MEDICAL SECURITY
R for Good Health

March 25, 1997

Commissioner George Nichols III
Commonwealth of Kentucky
Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517

Re: United Wisconsin Life Insurance Company / American Medical Security

Dear Commissioner Nichols:

Thank you for your letter dated March 21, 1997. We enjoyed having an opportunity to speak with you at the recent NAIC meeting in Orlando.

As you are aware, American Medical Security (AMS) designs, markets, and administers group health insurance plans that are underwritten by United Wisconsin Life Insurance Company (UWLIC). Please note UWLIC has not withdrawn from the individual health insurance market in Kentucky. As conveyed in our meeting on February 14, 1997, we are supportive of your efforts towards legislative reform in the health insurance market, and hope to remain in the market until we have an opportunity to evaluate these efforts and their impact on us.

Even though UWLIC has not withdrawn from the individual market, it is probable we share many of the same concerns of the departed carriers. Obviously, the primary concern of all carriers is an apparent lack of ability to obtain a reasonable rate of return. Most carriers, including UWLIC, attribute this to the present mechanism for granting premium rate changes. The requirement that public hearings be conducted for every rate filing exceeding the medical CPI plus 3 percent has created a two-fold dilemma. It has been effective in reducing carriers average renewal premium rate adjustments. On the other hand, it is the primary reason nearly 40 companies have left the health insurance market. As we have previously discussed, the lack of competition in the individual market is already having a detrimental impact on the insurance consumer in Kentucky.

At our meeting on February 14, 1997, you presented an interesting "rebuttal" to many carrier's demands for legislative relief on rating restrictions. We concur with your statements that some of the carriers are blaming their dismal rate of returns on the legislative restrictions, rather than their own pricing inadequacies. Obviously, UWLIC wishes it would have been able to establish a higher "floor", so it could better operate under the current rating mechanism. However, the ability to compensate for unexpected losses is a basic principle which needs to be employed so any carrier can remain in any given market. We strongly urge

AMERICAN
MEDICAL SECURITY
R for Good Health

you, your task force, and the legislators to amend the rating criteria so carriers, including UWLIC, may re-establish itself in the marketplace.

We realize rating restrictions are necessary in a market where insurance coverage is guarantee issued. If certain restrictions are not implemented, the cost of coverage may increase to the point health insurance becomes inaccessible to the insurance consumer (especially in a market that lacks competition). However, if the guaranteed coverage mechanism is changed from guarantee issuance in the individual market to a high risk pool, the need for such stringent rating restrictions is alleviated. Therefore, we are supportive of a high risk pool. Based on our previous meetings, you seem to be heading in this direction.

Obviously, we would prefer the high risk pool be supported by general revenue dollars. This would mean all citizens of the state would be supporting the high risk pool. Assessments on carriers would mean only a small portion of the state's population would be supporting the pool. The uninsured and those plans governed by ERISA would provide no support.

If carrier assessments are used, the assessments should be proportionate to their participation in the market. There should be some protection against excess assessments against carriers in the event of unusually large claims.

We are sure our concerns due not differ greatly from many other carriers. However, the one thing that sets us apart is our intentions to "stay and wait". We currently have nearly 3,800 total individual insured lives in the state of Kentucky. Hopefully, the market will change to such an extent that we can expand on this block of business, and re-establish a strong marketing force in your state.

Again, we are supportive of your efforts, and are willing to assist you in any way we can. If you should have any questions or comments, please feel free to contact me at 1-800-232-5432, extension 13327.

Sincerely,

Joseph W. Keen
Director, Regulatory Affairs

cc: Timothy J. Moore, Senior Vice President & General Counsel
Edward R. Skoldberg, Executive Vice President & Chief Operating Officer

AMERICAN NATIONAL
AMERICAN NATIONAL INSURANCE COMPANY

CHARLES J. JONES, RHU, HIA, ALHC, VICE PRESIDENT, HEALTH UNDERWRITING AND NEW BUSINESS ISSUE
ONE MOODY PLAZA GALVESTON, TEXAS 77550-7999 BUS: (409) 766-6657 FAX: (409) 766-6646

March 25, 1997

Mr. George Nichols, III
Commissioner
Department of Insurance
P. O. Box 517
Frankfort, KY 40602-0517

Dear Commissioner Nichols:

This information is being provided in response to your request for an outline of the reasons that the Company withdrew from the individual health insurance market in Kentucky.

1. Modified community rating.
2. Renewing plans to one of the prescribed health plans on a guaranteed renewable basis.
3. Guaranteed issue of prescribed health plans.
4. Change in the pre-existing condition period.
5. Portability and its impact on the pre-existing provision of the policy.

If you require any further clarification, please contact me.

Sincerely,

Charles J. Jones, RHU
Vice President
Health Administration

CJJ

cc: G. Noelle
G. Tolman

American Republic Insurance Company

NATIONAL HEADQUARTERS: DES MOINES, IOWA 50334
WATSON POWELL, JR., CHAIRMAN OF THE BOARD
AND CHIEF EXECUTIVE OFFICER

RODERICK E. TURNER, F.S.A., M.A.A.A.
VICE PRESIDENT
A&H PRODUCT MANAGER

April 15, 1997

Mr. George Nichols, III, Commissioner
Co-Chair, Task Forces on Individual
Health Insurance
State of Kentucky
Department of Insurance
Post Office Box 517
Frankfort, KY 40602-0517

Dear Mr. Nichols:

Since a representative from American Republic Insurance Company will be unable to attend the Joint Task Force meeting on April 18, 1997, the following reasons outline why we left the health insurance market in Kentucky.

1. Renewability - Need the ability to change the policy to implement changes in the ever changing healthcare environment; i.e., changes in network or required benefits provided by a managed care network. HIPAA addresses this issue by allowing a company to offer a replacement policy or modify a policy at renewal.

2. Limiting rating to 300% for age forces younger people in their early earning years to subsidize people who in most cases have been in the workplace for years and have established careers.

3. Not allowing substandard rating or waivers.

4. Limitation on rate variation to 30% above or below the index community rate, reducing to no deviation after July 1, 2000.

5. Excessive municipality taxes.

   Comment: All of the above restrict the ability of a company to make the product affordable. If an individual health product is not affordable, people in the individual market simply choose not to buy the product. They don't see the "value."

6. Standardized plans restrict innovation and the ability of a company to meet the needs of an individual. Individual purchasers make decisions to buy based on many factors. They cannot be pigeonholed into plans that may not fit their needs, or that are too expensive for them.

7. Guaranteed issue further reduces the incentive to purchase insurance while healthy.

The experience in other states has shown a company cannot offer a health insurance product profitably in the individual marketplace under these conditions listed above.

I apologize for the brevity of this letter, but I wanted to get it to the committee before your meeting.

Sincerely,

Rod E. Turner, F.S.A., M.A.A.A.
Vice President
Product Manager

RET/meh

BANKERS *LIFE AND CASUALTY COMPANY*
P.O. Box 1915 • Carmel, IN 46032-4915
(317) 817-6500

April 18, 1997

Honorable George Nichols III
Commissioner of Insurance
Kentucky Department of Insurance
215 West Main
P.O. Box 517
Frankfort, Kentucky 40602

Dear Commissioner Nichols:

We appreciate the opportunity to explain why our company has had to withdraw from the major medical health market in Kentucky. The continued de-emphasis of this product within our company and the changes to the product and rating requirements as a result of the Kentucky legislation led to our decision to withdraw.

Bankers Life and Casualty Company's primary market has been Medicare Supplement, Long Term Care and other senior marketing products. However, we have had a market for INDIVIDUAL comprehensive health products for many years. (We are not in the small group business in Kentucky.) But in recent years, we have reduced our presence in the major medical market. In 1994 we issued 174 comprehensive or hospital-surgical policies in Kentucky. These policies were first developed and sold on a nationwide basis in 1989. By so doing, we could spread development costs based on nationwide production levels.

HB 250 required changes to our product, limited our ability to underwrite the risks we were to assume, and provided further restrictions of premium rate structures.

Based on projected sales volume alone, it was difficult for us to justify the cost of developing and maintaining a product with specified benefits, different from our nationwide product.

In addition, HB 250 has mandated a guaranteed issue situation. When we can underwrite our policies, we have some control over the risk we assume. We understand that the Kentucky Health Policy Board has set up a risk adjustment mechanism so that no carrier will have a disproportionate share of the unhealthy risks. However, because the Board sets the risk sharing rules and standards, the Board basically exercises control over our profits in Kentucky.

The Rate Filing Procedures under 806.KAR 17:14OE which implements SB 343 Section 16, require very detailed information. The data would be extremely difficult to provide and would lead to considerable administrative expense. The profit information requested is proprietary. Providing such numbers is not public domain, nor should they be. In addition, the providing of loss ratios, expense levels, and profit margins would allow the state to control a carrier's profit levels.

SB 343 subsection 16(2)(c) requires a hearing for any rate increase which exceeds Medical CPI plus 3%, which would essentially require rate hearings for every rate request. Even without the special requirements of guaranteed issue and modified community rating, we would expect trends to generally exceed this guideline. It does not consider increases that occur due to the additional risk that a carrier assumes when writing new business under reform. The claim costs and loss ratio experience under the inforce medical plans is not indicative of what experience will be under the standard plans. Initial pricing of the standard plans is very difficult. This makes the limits on rate increases especially onerous as rate problems cannot be easily corrected.

Therefore, in summary, the provisions of HB 250 required significant enough changes in product and our ability to manage the risk to cause us to withdraw. The additional restrictions imposed by SB 343 only reinforced that decision. We would have strongly preferred to stay in the market in Kentucky. But, we believe it is extremely difficult, if not impossible, for any insurance carrier to successfully manage their products under such severe rating restrictions.

Sincerely,

Donald F. Gongaware
President

DFG/cjn

Grant

CELTIC

Celtic Group, Inc.
Sears Tower
233 South Wacker Drive, Suite 700
Chicago, Illinois 60606-6393
312-332-5403

March 25, 1997

George Nichols III
Commissioner of Insurance
Department of Insurance
Post Office Box 517
215 West Main Street
Frankfort, Kentucky 40602

Re: Kentucky Health Care Reform

Dear Commissioner Nichols:

This is in response to your letter, dated March 21,1997. I am attaching a copy of a letter that I sent to you on January 10,1997. That letter briefly offers a critique of Kentucky insurance reform. Given this opportunity, I will reiterate some of the thoughts and arguments contained in that letter. We, in the insurance industry, face tremendous pressure from consumers, health care providers and politicians to provide universal, affordable health insurance coverage. In attempting to implement this goal, we need to acknowledge the lessons afforded by the implementation of other government programs such as public education. If politicians create a public health insurance entitlement while prohibiting the private health insurance market, standards of care will suffer, consumer choice will be curtailed and costs will go unchecked. At the root of any public entitlement program is the problem of efficiency. Simply put, the free market acts more efficiently than does a controlled market.

Rate guarantees, rate restrictions and a restricted rate approval process are the features of the Kentucky health insurance reform that we weighed most heavily in our decision to stop the solicitation of health insurance in Kentucky. Guaranteed issuance of mandated plans, guaranteed renewablity and guaranteed portability were factors that we very seriously considered in our analysis.

Celtic Life Insurance Company stopped issuing major medical health insurance coverage in Kentucky because the market reforms that the Kentucky legislature enacted, eliminated free market efficiency. Health insurance carriers could no longer underwrite risk, price for risk or even choose which benefits to offer in Kentucky. Such a health insurance market cannot hope to attract profit making enterprises. As we stated in our prior correspondence, the particular reforms enacted in Kentucky, taken individually, serve to impair the efficiency of the health care market. Taken together, the reform package creates a virtual public health insurance entitlement program that lacks the room for insurance companies.

We cannot too greatly emphasize our support for the goal of universal, affordable health insurance coverage. We recommend the utilization of a health insurance safety net,

CELTIC

funded by general revenues to accomplish this goal. We commend the approach taken by a number of states, who have implemented comprehensive health insurance pools. Such markets offer the best of both worlds. On the one hand, such markets efficiently handle health insurance by encouraging competition in the health insurance market, while on the other hand, those who truly need but cannot afford or qualify for health care are able to obtain it via the comprehensive health insurance pool. We hope that the Kentucky legislature opens the Kentucky health insurance market to competition and concurrently provides for those in need by creating a comprehensive health insurance pool funded by general revenues.

We appreciate the opportunity you have provided us to express our views on Kentucky health insurance reform. Thank you.

Very truly yours,

Ronald D. Sojka

Ronald D. Sojka
Assistant Vice President, Counsel
Legal and Regulatory Matters

RDS/rs

CELTIC

Celtic Life Insurance Company
Sears Tower
233 South Wacker Drive, Suite 709
Chicago, Illinois 60606-6393
312-332-5401

January 10, 1997

George Nichols III
Commissioner of Insurance
Department of Insurance
Post Office Box 517
215 West Main Street
Frankfort, Kentucky 40602

Re: Kentucky Health Care Reform

Dear Commissioner Nichols:

At the Winter NAIC meeting, you met with members of the insurance industry to discuss Kentucky health care reform. This letter is to follow up that discussion. As we noted at the meeting, it is the general consensus of the insurance industry that Kentucky politicians have faced the politician's health care dilemma and opted to force the insurance industry to subsidize health care. The problem with health care is that everyone agrees that everyone should have it, but nobody wants to pay for it. The political dilemma then, is to choose between raising taxes to fund an entitlement program for those who cannot obtain or afford health care coverage in an open market or pushing insurance "reform" that ultimately raises the cost of coverage for the average consumer. Since the points we wish to make are not new and have been made better by others, our discussion of the specific deficiencies of the Kentucky reform package are very briefly outlined below, along with our recommendation.

Mandated Plans

Kentucky requires insurers to offer only its mandated plans. Legislators substituted their choice over consumer choice. This attitude, that big brother knows what is best for the consumer, pervades many entitlement programs and once pervaded some quite large economic systems. Consumers who may be happy with their health insurance coverage are forced to obtain coverage that does not meet their needs. Insurers are thus forced to sell policies that do not satisfy consumer demand.

Guaranteed Issuance of Mandated Plans

Kentucky requires insurers to guarantee issue its mandated plans. The analogy oft used to illustrate the problem with guarantee issue, relates it to home owners coverage for fire. That is, guaranteed issue of health insurance is like allowing a homeowner to buy fire insurance while the homeowner's house is on fire. People will not buy health insurance in a guaranteed issue market until they need it. This will undoubtedly raise the claims experience, in turn raising loss ratios and the cost of the insurance. Guaranteed issue eliminates good underwriting, the proper assessment of risk, and the heart of the insurance industry.

CELTIC

Modified Community Rating and Rate Guarantees

Community rating, however it is modified, simply shifts the cost of coverage to the people least able to pay it. That is, community rating forces the young, healthy population to subsidize the older, less healthy population. This public policy choice too often is driven by the group who stands to gain by being subsidized. The closer a rating system gets to true community rating, the closer it gets to becoming an entitlement program. In a free market system, people pay for what they get. Most people consider it only fair to get what is paid for.

Rate guarantees penalize an insurer for making bad predictions about the cost of future medical services or future claims. The longer the rate guarantee the greater the penalty. Reality dictates that rates that hope to take into account future projected increases in the cost of medical services or increases in claims experience cannot hope to pass insurance department scrutiny. Balancing an acceptable loss ratio against the risk of unknowable expenses has in our New Jersey experience taught us a very expensive lesson. We have lost money attempting to administer products with 12 month rate guarantees. We do not believe it can be done. We are not in business to lose money. At this time, we will not attempt to do business in a jurisdiction that does not allow rate flexibility.

Guaranteed Renewability

In a guaranteed issue market there is no need for guaranteed renewability. If someone is not renewed they can obtain insurance coverage from another insurer.

Pre-existing Conditions

The shorter the time period allowed for exclusion of pre-existing conditions, the more likely it is that a sick individual will wait until they begin incurring claims to obtain insurance coverage. Couple this with an insured's ability to switch plans at will and one can see that the cheapest plans will allow access to the market for those at high risk, who will switch to the richest plan as soon as they begin to incur claims. As rates increase, healthy individuals become less inclined to subsidize the sick and eventually the entire market may enter a death spiral.

Portability

Credit for time already spent under a prior insurance policy forces an insurer to live with someone else's underwriting. In a guaranteed issue market, portability of coverage like renewability of coverage is of very little practical importance.

CELTIC

Outlook

Although we do not believe that most of the Kentucky reforms benefit consumers, we also do not consider most of them, on an individual basis, to prevent the functioning of the health insurance market. Rating inflexibility and rating restrictions, for us, are key features that do weigh heavily in our analysis of market profitability. Taken in the aggregate, however, we believe that the entire Kentucky reform package is unworkable.

From the prior discussion, our pre-disposition to a free market insurance market should be clear. No matter how hard the Kentucky legislature tries, it cannot reform the laws of economics. One need only recall college economics to be reminded that a free market, as if by an "invisible hand," rations scarce economic resources. The entitlement program implemented by the Kentucky legislature has already shown the kind of rationing of resources that it will engender. Turning the entire health insurance market into an entitlement program will inevitably lead to shortages of needed medical services and the highest possible costs.

Recommendation

We support the public policy goal of providing a safety net for those people who cannot obtain health insurance coverage. We believe that such a safety net, should be funded by general revenues, since a safety net by its very nature needs to be some form of entitlement program. The program that we believe best suits the needs of the public is some form of comprehensive health insurance pool. Such a pool should be open only to those people who meet strict qualifications for health status, residency and income. Otherwise, the pool will fail to serve its intended purpose.

We believe that Kentucky consumers demand a free market and we believe that a free market best serves consumers. We hope that you are able to persuade the Kentucky legislature to open up the Kentucky health insurance market to competition. We look forward to re-establishing a profitable presence in the Kentucky health insurance market. Thank you for affording us the opportunity to express our views on Kentucky health care reform.

Very truly yours,

Ronald D. Sojka

Ronald D. Sojka
Assistant Vice President, Counsel
Legal and Regulatory Matters

Joan A. Markoe, Esq.
Senior Counsel
CIGNA Group Insurance

CIGNA

April 17, 1997

21TLP
Two Liberty Place
1601 Chestnut Street
P.O. Box P.O. Box 7716
Philadelphia, PA 19192-2211
Telephone 215.761.1980
Facsimile 215.761.5563

George Nichols III, Commissioner
Co-Chair, Task Forces on Individual Health Insurance
Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Dear Commissioner Nichols:

I am responding to your letters of April 3, 1997 to John Leonard, President, Life Insurance Company of North America (LINA) and Richard Franklin, President, Insurance Company of North America (INA), in which you inquired why these companies left the health insurance market in Kentucky and what changes would need to be made to the current law for the companies to re-enter.

In recent years, health insurance has not been a core product line for LINA and INA. The companies wrote health insurance in a few niche group markets; they did not write at all in the individual market. The proliferation of new health insurance requirements in a number of states, including Kentucky, prompted the companies to evaluate whether they could afford the significant compliance and actuarial resources necessary to support the health insurance business, given the relatively small amount of business which they wrote. This evaluation resulted in a decision to withdraw from the health insurance market in certain states.

Since LINA and INA were never in the individual market, their withdrawal would have had no impact on the individual market in Kentucky. And, since LINA and INA were such a small, niche writers in the group market, it is unlikely that their withdrawal had much impact in the group market in Kentucky. The companies have recently revised their business strategy and they are not going to focus on the health insurance market in the future, with the possible exception of student health insurance. In light of this strategic direction, there is no change in the current law which would cause LINA and INA to re-enter the health insurance market.

The companies will not be represented at your meeting, but they do appreciate the opportunity to share these thoughts with you.

Very truly yours,

Joan A. Markoe

cc: John Leonard, Richard Franklin

Metropolitan Life Insurance Company
One Madison Avenue, New York, NY 10010-3690
Tel 212 578-2640 Fax 212 578-8869

R: DJ
GnA

MetLife

Timothy J. Ring
Government Relations Assistant
Government and Industry Relations

Via Overnight Mail

Hon. George Nichols III
Commissioner
Department of Insurance
215 West Main Street
Frankfort, Kentucky 40602-3630

Dear Commissioner Nichols:

I am glad we had an opportunity to meet at the recent NAIC meeting. As I mentioned to you when we spoke, your recent letter to Harry Kamen, the Chairman, President and Chief Executive Officer of MetLife, has been forwarded to me. In your letter, you requested our assistance in providing information about our withdrawal from the health insurance market in Kentucky, in an effort to create a comprehensive market study that may lead to regulatory reforms in the health insurance market.

MetLife did not actually withdraw from the health insurance market in Kentucky. Rather, we entered into a transaction with Travelers whereby the health insurance business of each company was combined into a new company, MetraHealth. That company has subsequently been acquired by United Healthcare.

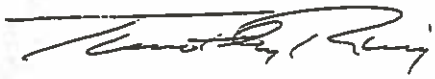
The decision to enter into this transaction was not motivated by the laws and regulations governing health insurance in any single state. It was a strategic corporate decision based on financial considerations and a desire to focus our resources on what we consider our core business - the sale of life insurance and annuity products. Also, in the formation of MetraHealth, most of the individuals at MetLife knowledgeable about health insurance issues left and became employees at the new company. As a result, we simply no longer have the expertise and experience in the health insurance area that we once had.

While we support your efforts, and commend your progressive and forward-looking approach, we are unable to provide you with the type of assistance you are requesting.

You also asked about the number of non-standard health insurance plan contracts and covered lives in effect for our company as of May 1, 1997. At that time, there was only one contract in effect in Kentucky, representing one life.

If there is anything I may be able to do, or if you have any questions, please feel free to contact me directly.

Sincerely,



Timothy Ring

June 13, 1997

Mutual of Omaha Companies

Galen F. Ullstrom
Vice President
State Government Relations
(402) 351-5235
Fax: (402) 351-5710

April 16, 1997

via: Facsimile and Post

The Honorable George Nichols III
Commissioner of Insurance
Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Dear Commissioner Nichols:

This letter is in response to your letters of April 3, 1997, to John Weekly, President of Mutual of Omaha Insurance Company and Thomas Sawicz, President of United World Life Insurance Company.

Unfortunately we will be unable to attend the joint task force meeting on April 18, 1997, but please feel free to share our letter to you of March 25, 1997 (copy attached) with other members of the task force. If you would like us to expand on any of the information provided, we would be happy to do so.

If you have any questions, please contact me.

Very truly yours,

Galen F. Ullstrom

G0411197/sam
Attachment

Galen F. Ullstrom
Vice President
State Government Relations
(402) 351-5235
Fax: (402) 351-5710

March 25, 1997

The Honorable George Nichols III
Commissioner of Insurance
Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Dear Commissioner Nichols:

In response to your letter of March 21, 1997, the following are the primary reasons why our company chose to withdraw from the health insurance market in Kentucky effective July 15, 1995.

The primary reason was the requirement that we guarantee issue up to eight standardized health plans and that no other health plans could be offered. We were concerned that certain of the plans included low deductible options and unlimited lifetime benefits which were plans that our company was not offering in the individual market at that time. We were very concerned about the anti-selection which would occur by requiring guarantee issue of these plans in a voluntary environment (as opposed to a mandatory universal environment) which would allow individuals to stay out of the market until they became sick.

In addition, based upon our experience in other states, we were concerned that the requirement that the insurance commissioner hold a public hearing on every rate filing proposing a rate increase exceeding the percentage change in the Medical Care Consumer Price Index plus 3% would create a political atmosphere that would not allow appropriate or justified rate increases to be granted or at least be an expensive process and could result in considerable delay.

I hope the above provides the information you requested, however, if I can provide any further information, please let me know.

Sincerely,

Galen F. Ullstrom

G0325197/sam

NATIONWIDE INSURANCE
Nationwide is on your side

Nationwide Life Insurance Company
One Nationwide Plaza
Columbus, Ohio 43215

April 16, 1997

The Honorable George Nichols III, Commissioner
Department of Insurance
PO Box 517
Frankfort KY 40602-0517

Dear Mr. Nichols:

Thank you for extending an invitation to our president to speak at your Joint Task Force for Individual Health Insurance. He will be unable to attend but asked me to share our thoughts and concerns. We respect the important responsibilities and goals which you are pursuing. We believe that affordable health care for all is very desirable.

From an insurer's view, it has become very difficult to make even a small profit in health insurance. Volatility is unnerving and losses are frequent. In spite of this, it is common for insurers to be blamed for high costs and it is implied that they are making big profits at the expense of sick people.

It is rudimentary that investors will only support businesses that are expected to be adequately profitable. Rating agencies such as Moody's and Standard & Poors generally give much lower ratings to insurers involved with health. The present regulatory environment makes it most probable that insurers will lose money in the Kentucky market. This is true both for business sold in years past and for prospective sales. Note the following:

1. Recent rate regulation has ignored the cost increases which insurers face. Denied rate increases guarantee losses for insurers who need long term stability and fairness in rate regulation. Insurers will have to be convinced that they will be permitted to charge adequate premiums to sustain profitable operations or they will be forced to invest their capital in products that will, at a minimum, assure some level of profitability.

2. Requirements to issue insurance coverage, regardless of health, both helps people with above average health care needs to obtain insurance and encourages healthy people to delay the purchase of insurance until a claim seems likely. Both of these cause claims costs to increase significantly and decrease the number of persons covered. Premium rates would decline if all healthy people purchased insurance. As a practical matter, however, universal coverage will not happen in a voluntary market.

3. In Kentucky, municipality taxes as high as 14% siphon off policyholder premiums from their intended goal of health care coverage. They also give insurers a very difficult administrative problem which further increases costs. Tax compliance is far more complex in Kentucky than in any other state.

4. While we may all prefer lower costs, individual solicitation, sale, enrollment, billing and administration is more expensive for an individual than for a member of a large group. Adverse selection causes claims costs to be higher for individuals, too. The regulatory environment must accommodate this in some manner or insurers will gravitate to more profitable opportunities.

5. It is important to adequately recognize in premium rates those factors which influence costs. Such factors include age, sex, location and health status.

I hope your task force is successful in the pursuit of its laudable goals.

Sincerely,

Jack Howarth

Jack Howarth, FSA
Vice President - Agency Life and Health Actuary
Nationwide Life Insurance Company

P.S. Please accept these comments on behalf of our sister company, National Casualty Company for which I have related responsibilities for Individual Health.

A MUTUAL COMPANY

Joy S. Jakelis, F.S.A.
Vice President & Actuary
Pan American Life Insurance Co.
601 Poydras Street
New Orleans, LA 70130

Telephone: (504) 566-3304
Fax: (504) 522-5393

PAN AMERICAN LIFE
People you can trust for life®

April 16, 1997

George Nichols, III
Commissioner of Insurance
Department of Insurance
P.O. Box 517
Frankfort KY 40602-0517

Dear Commissioner Nichols,

I am responding to your April 3, 1997, letter to John Roberts inviting a representative from Pan American to speak at an April 18 Joint Task Force meeting. We thank you for your invitation but feel we would not be an ideal choice to speak because we are not in the individual health insurance business.

We did withdraw our small group product from the Kentucky market in 1995. We did so because we believed that the requirements of Kentucky's small group law were so restrictive that the potential existed to lose significant amounts of money by remaining in the market. In particular, we were concerned with the combination of guaranteed issue, severe restrictions on the use of pre-existing conditions exclusions and no latitude in rates to compensate for the resultant anti-selection.

We appreciate your asking for our input and would be more than happy to discuss our concerns with respect to the small group law in more detail.

Sincerely,

Joy S. Jakelis /BP

Joy S. Jakelis, F.S.A.
Vice President & Actuary

JSJ:bjp/41697.doc

cc: John K. Roberts, Jr., FSA, President and Chief Executive Officer
Ronald MacInnis, Executive Vice President, Health Insurance Operations

SHELTER INSURANCE COMPANIES

JAMES A. OFFUTT
EXECUTIVE VICE PRESIDENT
(314) 874-4271

April 10, 1997

George Nichols III, Commissioner
Co-Chair, Task Forces on Individual Health Insurance
Department of Insurance
P. O. Box 517
Frankfort, KY 40602-0517

Dear Commissioner Nichols:

Shelter Life Insurance Company has received your letter of April 3, 1997, addressed to Mr. Robert Maupin, concerning the Industry Task Forces on Individual Health meeting of April18, 1997. We will not be attending the meeting and would like to provide you with the information you requested concerning its withdrawal from the health insurance market in Kentucky.

In 1990, Shelter Life Insurance Company discontinued the sale of its principal individual health insurance policy in all thirteen of the states in which it operates. Shelter Life Insurance Company had not been a significant writer of health insurance in Kentucky or elsewhere. We did continue to renew the existing Comprehensive Health insurance policies, but upon the passage of House Bill 250, this was no longer feasible because it would have required us to re-enter the active insurance market. For this reason, Shelter Life Insurance Company withdrew from the health insurance market in Kentucky.

Sincerely,

James A. Offutt

JAMES A. OFFUTT

Time Insurance Company
501 West Michigan
P.O. Box 624
Milwaukee, WI 53201-0624
Tel: (414) 271-3011

Direct Number:
(414) 299-7722

VIA FACSIMILE (502) 564-6090

March 24, 1997

The Honorable George Nichols III
Commissioner of Insurance
Kentucky Department of Insurance
P. O. Box 517,
Frankfort, Kentucky 40602-0517

Re: Reasons for Withdrawing from the Individual Health Insurance Market in Kentucky

Dear Commissioner Nichols:

In response to your letter of March 21, 1997, the following represents an outline of the reasons why Time Insurance Company (Time) withdrew from the individual health insurance market in Kentucky.

1. **Guarantee Issue Environment**

In analyzing House Bill 250 and Senate Bill 343, Time officials were concerned with the provision in those laws which would restrict the company to selling only standardized guarantee issued products in Kentucky.

As an individual insurer licensed in 47 states, Time has a significant amount of experience in guarantee-issue only states, and the results have not always been very credible. The following chart shows Time's loss ratio experience in two guarantee issue environments, Maine and New Jersey.

Year	Maine	New Jersey
1994	46.9%	98.8%
1995	72.8%	117.3%
Thru 6/96	89.0%	148.3%

In Maine, Time was allowed to market its own products, but they were guarantee issued. In New Jersey, Time could only offer five state designated guarantee issued plans.

As the chart demonstrates, a guarantee issue requirement in the individual medical marketplace causes severe pressures on this market. This is due to the individual market being smaller in size to the small group market and much more vulnerable to fluctuations in premium increases, largely because consumers who purchase individual medical products pay the entire cost of their health insurance premiums as opposed to small employers, who generally pay the largest proportion of small group premiums.

In an guarantee issue environment, individuals, previously denied coverage, suddenly have the ability to purchase individual medical coverage. It is not long before these individuals begin incurring claims, which adds to the block's overall loss ratio. As premiums increase, healthy individuals tend to leave the market because they no longer can afford the premiums. Those who remain generally are those individuals incurring the most claims, thus creating a "death spiral" for the block of business.

Maine provides a very good case study in this regard. On February 26, 1996, the state of Maine approved a rate increase for Time of 44 percent on average to account for the rapidly worsening experience the company was incurring in that state. The effect of the rate increase was a 66 percent decrease in covered insureds in one year's time.

2. Community Rating

Time is of the opinion that community rating does not work in the individual marketplace. If a company is forced to charge the same rate to its insureds, regardless of age, the net result is that younger, healthier individuals end up subsidizing the premiums of older, and generally less healthy individuals. This may not cause a disruption in the marketplace until such time as the claims experience begins to worsen. When that happens, a carrier will generally seek a rate increase, which means that younger insureds will bear a disproportionate share of those increases. With less discretionary income than older individuals, younger insureds tend to simply exit the market because they can no longer afford the premiums.

3. Rate Approval Process

Time is of the opinion that to be successful in a given market, the company must have the ability to adjust its price to the developing experience of its block of business. If the trend rate used in pricing a product is not estimated properly, a company needs the ability to correct its rates for any deficiencies. In analyzing House Bill 250 and Senate Bill 343, Time officials had a concern that the laws did not give the company the opportunity to make rating adjustments in a timely fashion, particularly with the rate approval process being scrutinized by the Attorney General's office.

I hope this letter explains some of the reasons behind Time's decision to withdraw from the individual market in Kentucky. This was not an easy decision on Time's part, but given its experience in other states, the company concluded that it could no longer successfully compete in the individual market in Kentucky. Time is hopeful the recommendations you may make in your white paper and any subsequent legislation to amend current law will cause Time to re-consider its decision to write individual insurance in Kentucky.

If I can be of any further help in this matter, please let me know.

Very truly yours,

David B. Reddick

David B. Reddick
Government Relations Officer

TravelersLife and Annuity
A Member of TravelersGroup

One Tower Square
Hartford, CT 06183
860 277-1716
FAX: 860 277-7631

Katherine McG. Sullivan
Senior Vice President and General Counsel
Law and Regulatory Affairs

April 17, 1997

George Nichols III, Commissioner
Commonwealth of Insurance
State of Kentucky
P. O. Box 517
Frankfort, Kentucky 40602-0517

Dear Commissioner Nichols:

The Travelers Insurance Company appreciates your invitation to be a guest speaker at the April 18, 1997 Joint Task Force meeting regarding Travelers reasons for leaving the health insurance market in Kentucky and provisions of current law that would need changing for Travelers to reenter the market. Travelers is no longer engaged in the health insurance market in Kentucky or anywhere else in the United States. We sold that line of business in 1995. Accordingly, Travelers is unable to accept your offer to be a guest speaker or to attend the task force meeting.

Sincerely,

Katherine McG. Sullivan

KMG:ac

Trustmark

INSURANCE COMPANY

400 Field Drive • Lake Forest, Illinois 60045
Phone (847) 615-1500 • FAX (847) 615-3909

Arnold I. Munson, JD
Assistant General Counsel

April 18, 1997

George Nichols III
Commissioner/Co-Chair
Task Forces on Individual Health Insurance
Kentucky Department of Insurance
P O Box 517
Frankfort, KY 40602-0517

Dear Mr. Nichols:

In response to your letter dated April 3, 1997 to Donald Peterson I have prepared the following comments for consideration by you and the Task Force.

The main reasons for leaving the Kentucky individual health insurance market place start with the requirement that all plans are guaranteed issue. This takes away any control over the risk assumed. The second reason relates to rate controls. Rates are a function of health care provider charges and actual utilization by our insureds. We may exert limited influence on both of those factors through managed care programs, however, we must still be allowed the ability to adjust our rates to meet our costs. In addition, community rating, as it may limit the variation in rates by age, will tend to drive young healthy lives out of the market due to lack of affordability and thus rates for the remaining insureds will be driven higher. If community rating requirements are too severe many insurers will withdraw.

In order for Trustmark to reenter the market I urge the following two suggestions. First, underwriting must be allowed. Mandating guaranteed issue policies is not the only way to accomplish the goal of coverage for everyone. The best approach to the problem can be found in Illinois for example where a high risk pool was established allowing anyone rejected for individual insurance to purchase coverage for a modest surcharge. Even though only a small percentage of applicants are denied coverage by individual insurers the risk represented by this small segment must still be spread in some manner, and there is no way to price for this risk in a guaranteed issue market place. The second suggestion is that rates may be regulated, but not completely controlled or mandated.

I offer this further comment which I trust will be helpful. Creation of a uniform market by allowing only a few specified plans limits consumer options and innovative product development and improvement. Consider requiring all carriers to offer specified plans, but at the same time allow other alternative products as well, which would be priced consistently with the specified plans.

Thank you for giving me this opportunity to comment.

Very truly,

Arnold I. Munson

Arnold I. Munson, JD

AIM/as

cc: E. Fattes
R. Solomon
K. Schmidt

Security Life
Insurance Company of America

SECURITY AMERICAN FINANCIAL ENTERPRISES, INC.

Congress Life
Insurance Company

April 21, 1997

Mr. George Nichols III, Commissioner
Commonwealth of Kentucky
Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Dear Commissioner Nichols:

Thank you for your April 3, 1997 letter. Security Life Insurance Company of America elected to withdraw from Kentucky due to our company's plan to withdraw from the medical insurance business throughout the country. I appreciate your offer as a guest speaker, but I am passing on that offer.

I hope these comments are helpful.

Sincerely,

Robert O. Maxwell, CLU, FLMI
President and CEO

/sle

the Principal® Financial Group

Government Relations

April 16, 1997

The Honorable George Nichols III
Commonwealth of Kentucky
PO Box 517
215 West Main Street
Frankfort, KY 40602

Dear Commissioner Nichols

Thank you for including us in your on-going effort to implement reforms to Kentucky's health laws. We appreciate the opportunity to express our views.

Enclosed please find a copy of a March 24, 1997 letter to you from our company which outlines The Principal's concerns. Our position is unchanged from that stated in the letter and we continue to have the same concerns.

Please contact me at the number listed below if I can be of assistance to you on this or any other matter.

Sincerely

Debra West
Counsel
Government Relations
1-800-325-2532 Ext. 7-0962

DKW:vlc
S:\h022\vlc\dkw\l0415gn
Enc
cc David Drury
Tom Graf
Lucia Riddle
Merle Pederson
State File

the Principal®
Financial Group

Government Relations

March 24, 1997

VIA FACSIMILE and REGULAR MAIL

The Honorable George Nichols III
Commissioner
Kentucky Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517

Re Your March 21, 1997, Correspondence

Dear Commissioner Nichols

Thank you for your letter dated March 21, 1997, addressed to Ms. Deb West in our department. Since Ms. West is out of the office and because your correspondence required immediate response, I have taken the liberty to respond to your request to outline Principal Mutual's reasons for withdrawing from the individual health insurance market in Kentucky.

As you will recall, representatives from Principal Mutual discussed these reasons in detail with you at the December 17, 1996, meeting in Atlanta. There are two primary reasons for Principal Mutual's decision to withdraw from the Kentucky individual health insurance market. First, the Kentucky reform law required that companies guarantee issue their individual health insurance plans in the state. And more specifically, the guarantee issue period was not limited but rather a continuous year around open enrollment with no risk adjustment mechanism. This, in essence, means that carriers with richer benefit plans, excellent customer service, and superior claims paying capabilities are very much adversely selected against and have no mechanism to share their disproportionate share of high claims. Second, Principal Mutual was concerned about the new rate approval process in the Kentucky law which permits rate increases not to exceed CPI + 3%. Anything above that would have required expensive rate hearings with what appeared to be an adversarial involvement on the part of the Attorney General's Office. This perceived rate cap in combination with continuous guarantee issue and no risk adjustment mechanism made the Kentucky health insurance market a tenuous place to continue doing business. Despite that, our decision to withdraw from the Kentucky market was not an easy one.

Finally, Principal Mutual has just recently made a strategic business decision to withdraw from the individual health insurance market on a nationwide basis. This, obviously, had nothing to do with Kentucky's new insurance reforms, but rather was based on The Principal's decision to focus its health insurance business on employer group sponsored managed care products.

I hope this information is helpful to you in creating your white paper. Please contact me at 1-800-325-2532 ext. 82186 if you have any questions.

Sincerely,

Merle T. Pederson
Counsel

MTP:cld

cc Lucia Riddle
Deb West ✓
Kentucky State File

S:\h022\cld\mtp\l0324gn

RECEIVED
DEPT OF INSURANCE
APR 22 11 16 AM '97

PREFERRED RISK LIFE INSURANCE COMPANY

515-267-5000
1111 Ashworth Road
West Des Moines, IA 50265-3537

April 8,1997

George Nichols III, Commissioner
Commonwealth of Kentucky
Department of Insurance
PO Box 517
Frankfort, KY 40602

RE: Kentucky Health Insurance Market

Dear Commissioner Nichols:

Thank you for your kind request to speak at the Joint Task Force Meeting on 4/18/97. We respectfully decline, but would be happy to explain the reasons for Preferred Risk Life Insurance Company's withdrawal from Kentucky. In reviewing our Kentucky Insurance Department file, it appears that we withdrew our Major Medical and Medicare Supplement products both when legislation was enacted in 1986 requiring long term care coverage to be provided in conjunction with any expense incurred health insurance product. Since that time, we have not filed or sold any health insurance product in Kentucky. We are not currently marketing any expense incurred health insurance products in any state, and have no plans to do so in the future. If further information is needed, please feel free to contact me at 800-688-3640.

Sincerely,

Carla Meiners
Staff Attorney

Physicians Mutual Insurance Company
Physicians Life Insurance Company
2600 Dodge • Omaha, Nebraska 68131-2671

April 10, 1997

Honorable George Nichols III
Commissioner
Commonwealth of Kentucky
Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517

Re: Your Letter of April 3, 1997 to Robert Reed, President

Dear Commissioner Nichols,

Mr. Reed has asked that I respond to your recent letter.

At the time legislation was enacted to reform the individual health care market in Kentucky, the types of policies that we sold that were affected by the law had to be nonrenewed and, by law, we could not sell them. They did not comply with the mandates for standardized products.

We chose not to stay in this market because we would have been prevented from underwriting and because we would not have been allowed to sell our own products.

We know from other states passing health care reform legislation that we probably would have remained in this Kentucky market if we could have continued to sell our own product, rather than a standardized product, and if we would have been allowed to underwrite. We have been able to remain in business with the products affected and still comply with limits on preex, portability for preex, modified community rating and limits on renewals.

I hope this provides you with the information you need. If not, please do not hesitate to contact me for anything additional you feel would help.

Sincerely,

Phil Powell CLU
Vice President, Compliance
(402) 633-1096

PM GROUP
A Pacific Mutual Company

WILLIAM L. FERRIS, FSA
President & CEO

April 10, 1997

George Nichols III, Commissioner
Co-Chair, Task Force on Individual Health Insurance
Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517

Dear Mr. Nichols:

Thank you for your letter of April 3, 1997 regarding the Industry Task Force on Individual Health Insurance. PM Group Life Insurance Company does not plan to attend the April 18, 1997 Joint Task Force Meeting. PM Group Life Insurance Company does not write individual health insurance. Historically, PM Group Life Insurance Company has had very limited market presence in Kentucky. As a matter of our limited resources and market priorities, we decided to leave the Kentucky health care market.

Primarily our concerns are centered on the limitations in the current reform law to offering only the statutory plans and the modified community rating provisions. We find that in the small group guarantee issue environment, we must have plan design flexibility and more rating flexibility to offer competitively priced products without unduly endangering underwriting results.

Thank you for offering us the opportunity to come and for your consideration of our response.

Sincerely,

W. L. Ferris

WLF:ro

wlfkentucky

PHILADELPHIA
AMERICAN
LIFE INSURANCE COMPANY℠

P.O. Box 2465 • Houston, Texas 77252 • (713) 871-460

April 16, 1997

Honorable George Nichols III, Commissioner
Co-Chair, Task Forces on Individual Health Insurance
Kentucky Department of Insurance
P. O. Box 517
Frankfort, Kentucky 40602-0517

RE: Your letter dated April 3, 1997

Dear Mr. Nichols:

Thank you for the invitation to voice our concerns and reasons for leaving the health insurance market in Kentucky.

Our decision to leave was in large part due to 1994 House Bill 250. It was our desire to continue marketing health insurance in your state; however, we did not feel we could effectively market and administer products at a reasonable cost to comply with these regulations.

The main concern affecting our decision deals with your requirement to offer mandated health benefit plans on a guaranteed issue basis with restrictive rating methodologies.

Please do not hesitate to let me know if there are any questions or if you need additional information by contacting me at 800-713-4680.

Respectfully,

Bill S. Chen

Bill S. Chen, Ph.D., FSA
President/ Chief Executive Officer
Philadelphia American Life Insurance Company

HB250LT.DOC

Commonwealth of Kentucky

PAUL E. PATTON, GOVERNOR

Public Protection and Regulation Cabinet

LAURA M. DOUGLAS, SECRETARY

Kentucky Department of Insurance, P.O. Box 517, Frankfort, KY 40602-0517,
(800) 595-6053, TTY: (800) 462-2081, (502) 564-3630

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