



KENTUCKY'S

April 1997

*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

Consumer/Provider Task Force on Health Insurance

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Commissioner George Nichols III, Co-Chair
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Owensboro, KY

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Kentucky Nurses Association

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Kentucky Pharmacists Association

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Lexington, KY

HELEN BARAKAUSKAS,
Executive Director
Kentucky Health Purchasing Alliance

MICHELE FINN
Fisherville, KY

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Executive Director
Office of Rate Intervention
Attorney General's Office

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Catholic Conference of Kentucky

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Chair, State Legislative Committee
American Association of Retired
Persons

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Lexington, KY

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Kentucky State District Council
of Carpenters AFL-CIO

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M.A., Ph.D.
Cultural Horizons, Inc.

CATHY BEYMER
Lexington, KY

RICHARD SECKEL
Kentuckians for Health Care
Reform

KAREN O'CONNOR,
M.A., RN
Managed Care Quality
Assurance Coordinator
Cabinet for Health Services

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Hopkinsville, KY

SEN. GERALD NEAL
Louisville, KY

SEN. JOHN WESTWOOD
Erlanger, KY

REP. THOMAS BURCH
Louisville, KY

REP. JIM GOOCH, JR.
Providence, KY

REP. BOB DEWEESE
Louisville, KY

Industry Task Force on Health Insurance

Lt. Gov. Stephen L. Henry, M.D., Co-Chair

Commissioner George Nichols III, Co-Chair
Kentucky Department of Insurance

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Relations
Anthem Blue Cross Blue Shield

JERRY PHILPOT,
Director
Kentucky Kare Plans

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Golden Rule Insurance Company

DAVID REDDICK
Time Insurance Company

KAREN SCHMIDT
Trustmark Insurance Company

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Coalition for Responsible Health
Care Reform

KATE DEVINE
Health Insurance Association
of America

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Kentucky Health Purchasing
Alliance

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Benefit Insurance Marketing

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Kentucky Farm Bureau

JAMES JOHNS
Aegis Insurance Co.

JEFF JOHNSON
HMO Association,
Advantage Care

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Hopkinsville, KY

SEN. GERALD NEAL
Louisville, KY

SEN. JOHN WESTWOOD
Erlanger, KY

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Louisville, KY

REP. JIM GOOCH, JR.
Providence, KY

REP. BOB DEWEESE
Louisville, KY

Kentucky Health Insurance Advisory Council

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George & George

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Humana, Inc.

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Chief Executive Officer
Regional Medical Center of Hopkins County

PETER L. KEE
Kee's Farm Service

SHEILA SCHUSTER, Ph.D.,
Co-Chair
Kentuckians for Health Care Reform

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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

study¹ 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.

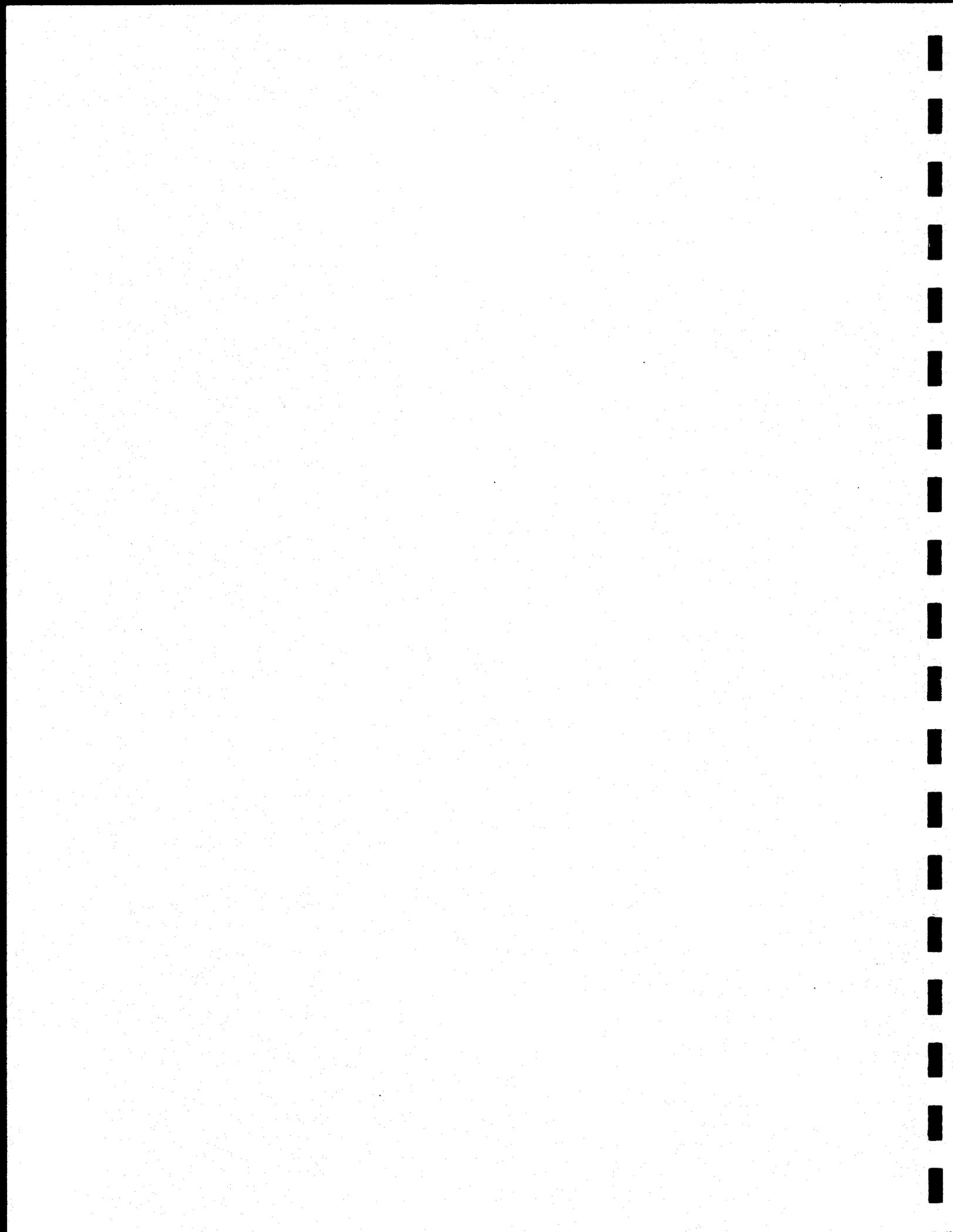
This document is not a complete picture of health insurance in Kentucky. However, combined with studies and reports assembled by the state Legislative Research Commission, it does provide a snapshot of today and benchmark for future comparisons. Collectively these reports will improve our ability to 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.

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%
<i>Subtotal</i>	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%
<i>Percent Total Market</i>	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%
<i>Subtotal</i>	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%
<i>Percent Total Market</i>		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%
<i>Subtotal</i>	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%
<i>Percent Total Market</i>		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%
<i>Subtotal</i>	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%
<i>Percent Total Market</i>	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%
<i>Subtotal</i>	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%
<i>Percent Total Market</i>	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.

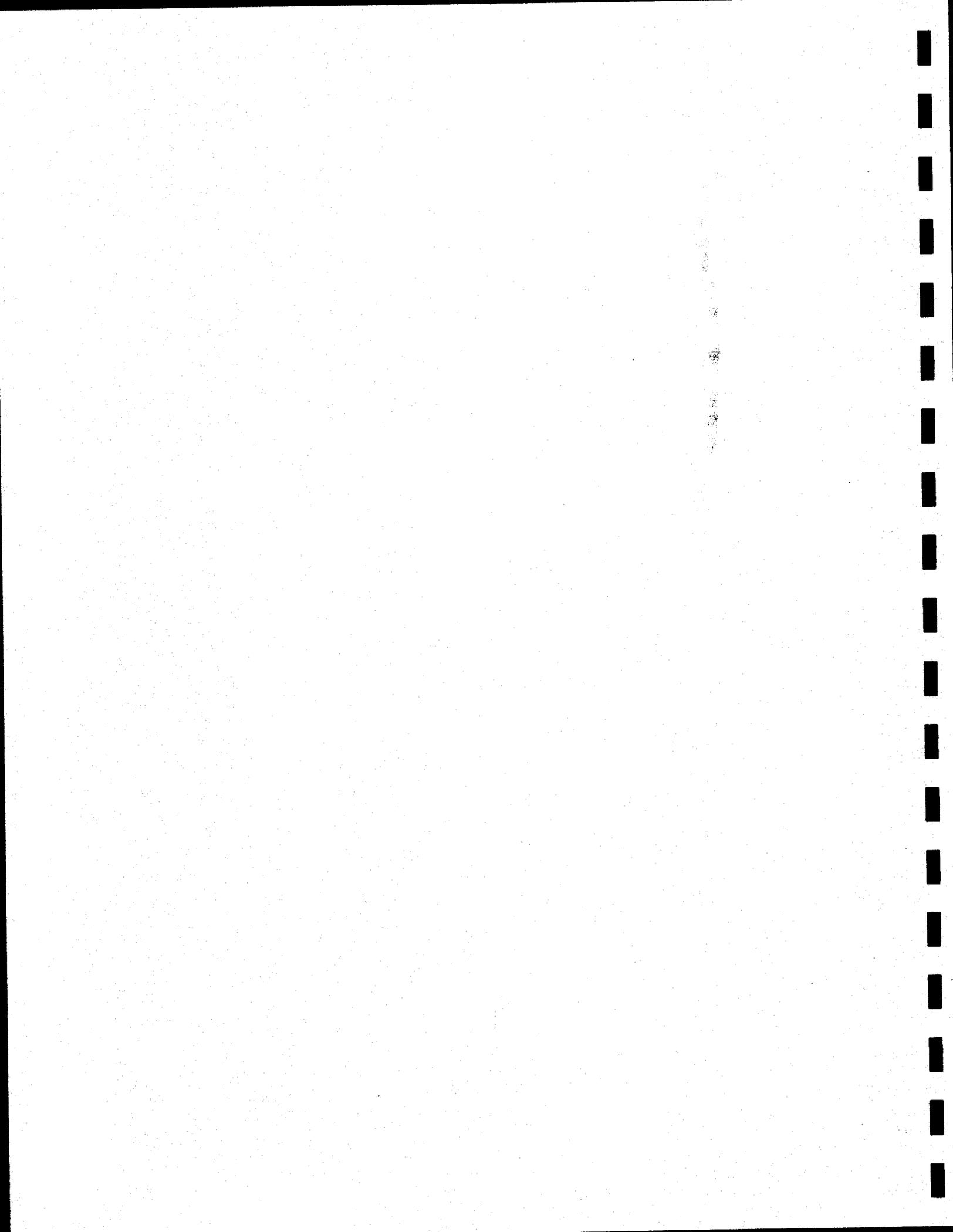


Kentucky Department of Insurance

RATING ISSUES

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.



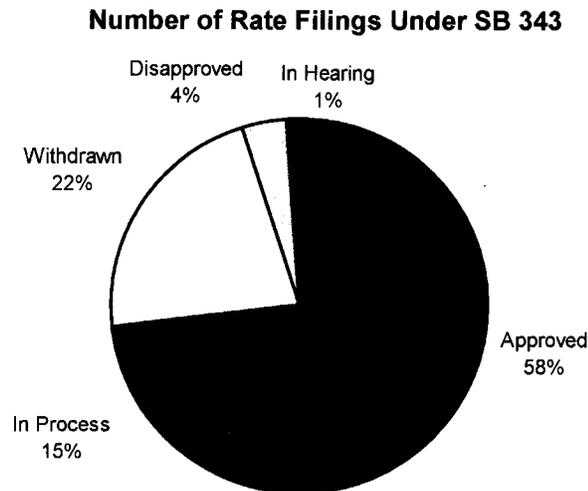
NUMBER OF RATE FILINGS UNDER SB 343

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.



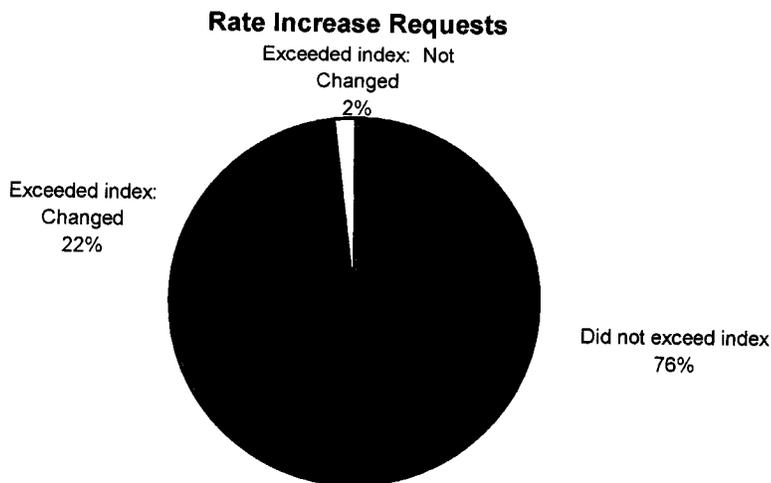


Rate Increase Requests in Relation to Automatic Hearing Trigger

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				MALE			
		Single	Couple	P-Plus	Family	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.

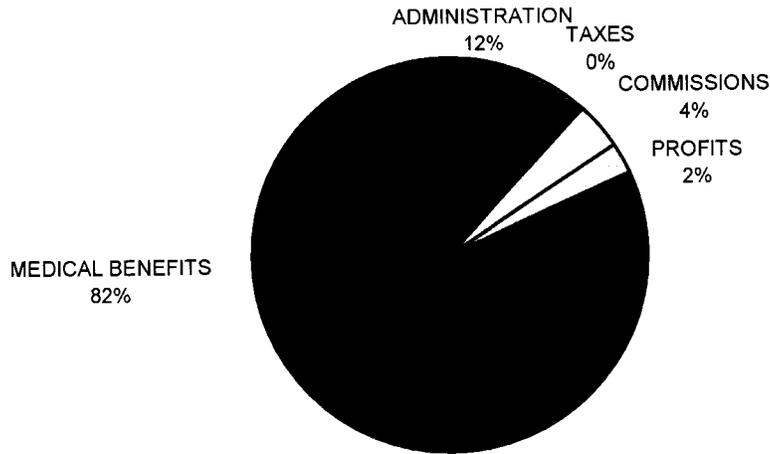
The following chart summarizes the average percentage found in the rate filings for administration, taxes, commissions, and profit margin. The total administration and profit column is the sum of the first four columns. This total percentage is subtracted from 100% to obtain the medical loss ratio anticipated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

Average Percentage Load by Product Type by Market Segment

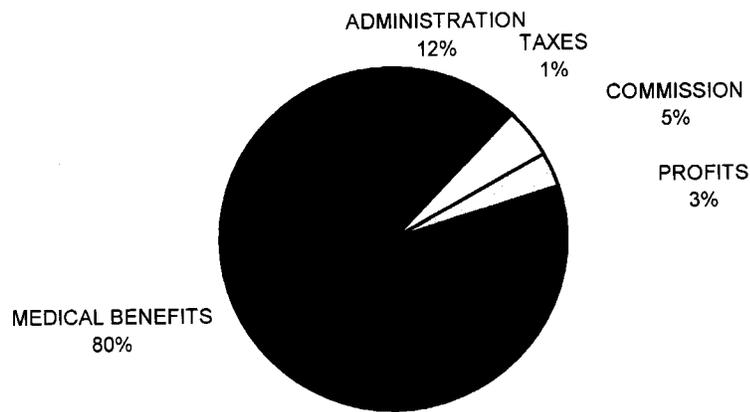
Product Type	Admini- stration	Taxes	Commissions	Profits	Total Admin .& Profit	Medical Loss Ratio
Alliance- Group- Mgd. Care (HMO & POS)	11.7%	.35%	3.82%	2.45%	18.32%	81.68%
Non-Alliance- Group-Mgd. Care (HMO & POS)	11.56%	.56%	4.89%	3.19%	20.2%	79.8%
Alliance-Group- Indemnity (FFS & PPO)	8.81%	.47%	2.5%	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

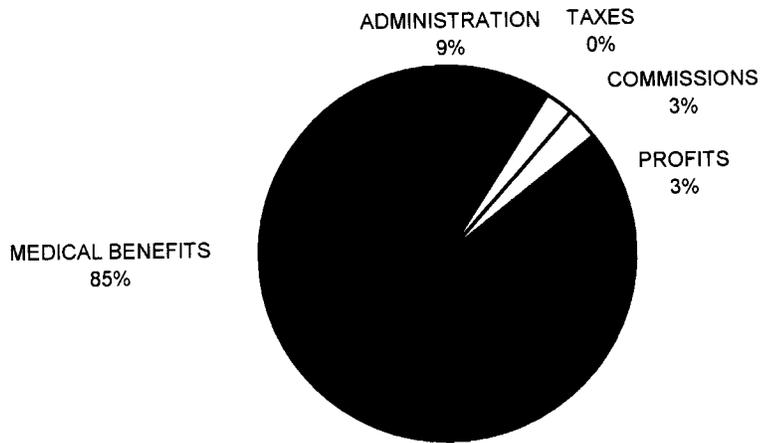


1997 NON-ALLIANCE MANAGED CARE (HMO&POS) PREMIUM

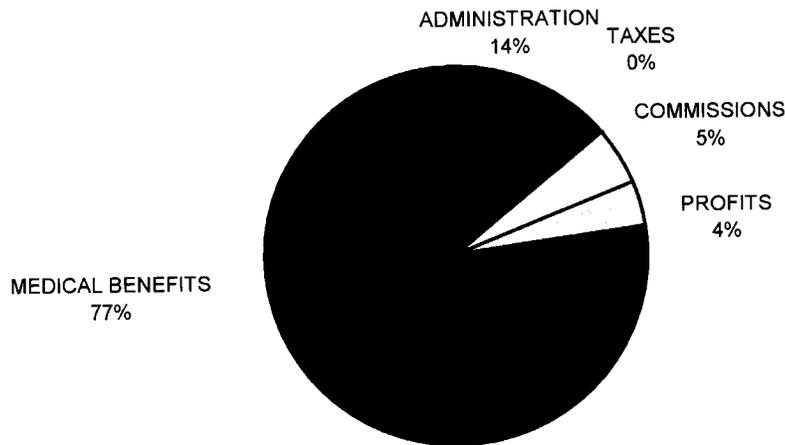




1997 ALLIANCE GROUP INDEMNITY (FFS & PPO) PREMIUM

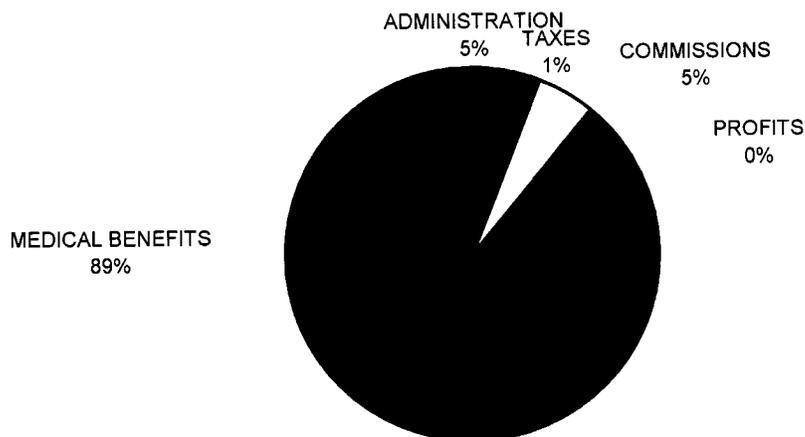


1997 NON-ALLIANCE SMALL-GROUP INDEMNITY (FFS&PPO)





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. Code	Final Comp. Change 1996 to 1997	1997 Net Composite Change	Cert Inhd 7/95	Cert Inhd 7/96	Weight 7/96 %	Cert Inhd 1/97	Weight 1/97 %	Effect Date	LIST			BILL			MONTHLY			RATES			FEMALE			MALE															
									ATTAINED AGE < 30			ATTAINED AGE 30-39			ATTAINED AGE 40-64			FEMALE			MALE			FEMALE			MALE												
									Single	Couple	Parent	Family	Single	Couple	Parent	Family	Single	Couple	Parent	Family	Single	Couple	Parent	Family	Single	Couple	Parent	Family	Single	Couple	Parent	Family							
A	-4.51%	1.40%	148	9.24%	19.75%	13,776	19.75%	Private	795	\$113	\$227	\$189	\$300	\$109	\$109	\$223	\$189	\$300	\$229	\$303	\$268	\$223	\$205	\$533	\$445	\$723	\$205	\$533	\$445	\$723									
									796	\$120	\$197	\$218	\$293	\$80	\$233	\$145	\$333	\$137	\$221	\$243	\$342	\$238	\$171	\$370	\$247	\$510	\$319	\$601	\$209	\$515	\$348	\$603							
										0.19%	-13.22%	15.34%	-4.87%	29.20%	2.64%	23.28%	8.12%	3.01%	17.54%	8.97%	-5.79%	-11.19%	-23.32%	1.93%	-6.79%	-4.32%	-28.31%	-16.87%	1.51%	-3.98%	-21.90%	-16.60%							
B	-1.90%	-8.50%	315	19.60%	19.75%	22,005	19.75%	Private	795	\$120	\$203	\$220	\$345	\$120	\$203	\$220	\$345	\$148	\$251	\$239	\$375	\$148	\$251	\$239	\$375	\$325	\$552	\$511	\$802	\$325	\$552	\$511	\$802						
									796	\$125	\$316	\$254	\$405	\$90	\$270	\$109	\$377	\$153	\$304	\$291	\$375	\$114	\$272	\$194	\$369	\$318	\$741	\$510	\$791	\$337	\$570	\$410	\$684						
										4.17%	55.67%	15.45%	17.39%	20.00%	37.44%	23.10%	9.20%	3.38%	21.12%	21.76%	0.00%	-27.97%	8.97%	-18.83%	-2.40%	-2.15%	-34.24%	-0.20%	-1.37%	3.69%	4.89%	-10.77%	-14.71%						
C	-3.40%	2.69%	40	2.50%	5.30%	3,685	5.30%	Public	795	\$101	\$220	\$165	\$303	\$101	\$220	\$165	\$303	\$114	\$250	\$187	\$344	\$114	\$250	\$187	\$344	\$258	\$563	\$421	\$774	\$258	\$563	\$421	\$774						
									796	\$112	\$189	\$191	\$267	\$76	\$189	\$155	\$287	\$127	\$214	\$231	\$318	\$107	\$214	\$191	\$318	\$278	\$567	\$345	\$634	\$288	\$597	\$356	\$634						
										11.09%	-14.09%	15.76%	-11.08%	24.75%	-14.09%	-6.05%	-11.08%	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%						

ALLIANCE HMO GROUP

ALLIANCE HMO GROUP

Final Com- posi- ble	1997 Net Composite Change Trend 1996 to 1997	Cert hld's 796	Weight 796 %	Cert hld's 197	Weight 197 %	Effect	ATTAINED AGE < 39			MONTHLY			RATES			ATTAINED AGE 60-64										
							FEMALE			FEMALE			FEMALE			FEMALE			FEMALE							
							Single	Parent	Family	Single	Parent	Family	Single	Parent	Family	Single	Parent	Family	Single	Parent	Family					
D	3.04%	796	796 %	197	197 %	Private	992	\$185	\$240	\$110	\$220	\$285	\$110	\$220	\$285	\$252	\$505	\$530	\$252	\$505	\$530					
							10.87%	1.82%	2.06%	2.73%	2.27%	1.74%	15.09%	21.82%	2.27%	-13.48%	15.09%	-10.32%	-1.10%	-45.28%	-14.18%	-4.37%	-7.92%	-42.45%		
							3.78%	15.98%	18.33%																	
							20.91%	3.78%	15.98%																	
							20.91%	3.78%	15.98%																	
							20.91%	3.78%	15.98%																	
							20.91%	3.78%	15.98%																	
							20.91%	3.78%	15.98%																	
							20.91%	3.78%	15.98%																	
							20.91%	3.78%	15.98%																	
E	2.26%	796	796 %	197	197 %	Private	87	\$206	\$359	\$145	\$276	\$290	\$145	\$276	\$290	\$356	\$818	\$940	\$356	\$818	\$940					
							3.57%	-26.71%	-1.59%	0.00%	17.12%	11.11%	3.95%	23.45%	-17.12%	-1.92%	3.95%	-21.91%	-25.06%	-30.42%	-16.57%	-30.20%	-41.41%			
							25.47%	-1.60%	7.69%																	
							24.47%	-1.60%	7.69%																	
							24.47%	-1.60%	7.69%																	
							24.47%	-1.60%	7.69%																	
							24.47%	-1.60%	7.69%																	
							24.47%	-1.60%	7.69%																	
							24.47%	-1.60%	7.69%																	
							24.47%	-1.60%	7.69%																	
K	2.94%	796	796 %	197	197 %	Private	109	\$260	\$414	\$114	\$252	\$406	\$114	\$252	\$406	\$232	\$404	\$618	\$232	\$404	\$618					
							11.10%	-5.77%	13.47%	28.95%	11.09%	13.20%	3.94%	-14.04%	1.19%	-10.80%	3.94%	2.16%	7.11%	-1.90%	7.77%	9.91%	7.11%			
							5.77%	16.33%	2.66%																	
							19.27%	5.77%	16.33%																	
							19.27%	5.77%	16.33%																	
							19.27%	5.77%	16.33%																	
							19.27%	5.77%	16.33%																	
							19.27%	5.77%	16.33%																	
							19.27%	5.77%	16.33%																	
							19.27%	5.77%	16.33%																	

ALLIANCE HMO GROUP

ALLIANCE PPO GROUP

Final Com- CO. Mobile	1997 Net Composite Change 198 to 197	Cert. Ind. 786	Weight 796 %	Cert. Ind. 197	Weight 197 %	Effect	ATTAINED AGE < 30			MONTHLY ATTAINED AGE 30-39			RATES			ATTAINED AGE 60-64															
							FEMALE			FEMALE			FEMALE			FEMALE			FEMALE												
							Single	Couple	Percent	Single	Couple	Percent	Single	Couple	Percent	Single	Couple	Percent	Single	Couple	Percent										
3.32%	2.50%	46	30.36%	796	796 %	Private	\$306	\$164	177%	\$278	\$95	\$164	\$177	\$278	\$119	\$203	\$192	\$302	\$119	\$203	\$192	\$302	\$202	\$445	\$412	\$647	\$202	\$445	\$412	\$647	
						Public	\$105	\$266	\$214	\$342	\$81	\$235	\$143	\$318	\$129	\$257	\$246	\$317	\$196	\$230	\$104	\$300	\$208	\$625	\$431	\$687	\$284	\$408	\$346	\$577	
							3.38%	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%	4.61%	3.09%	8.40%	9.68%	-16.02%	-10.82%	
							\$94	\$218	\$197	\$319	\$94	\$218	\$197	\$319	\$109	\$208	\$240	\$340					\$208	\$509	\$422	\$704	\$238	\$509	\$422	\$704	
							\$108	\$255	\$226	\$398	\$100	\$255	\$226	\$398	\$108	\$233	\$235	\$376	\$109	\$208	\$210	\$340	\$275	\$641	\$442	\$684	\$291	\$500	\$355	\$591	
							14.45%	25.07%	11.35%	9.89%	-11.68%	10.49%	-25.00%	2.18%	21.31%	10.68%	20.07%	-4.43%	-9.72%	-0.95%	-19.95%	-6.85%	15.42%	25.88%	4.69%	-2.89%	22.31%	-1.73%	-15.98%	-15.99%	
2.50%	1.14%	107	69.64%	796	796 %	Private	\$112	\$197	\$231	\$332	\$75	\$197	\$108	\$332	\$124	\$188	\$237	\$378	\$83	\$108	\$183	\$375	\$219	\$431	\$314	\$630	\$244	\$431	\$338	\$590	
						Public	\$100	\$255	\$226	\$398	\$100	\$255	\$226	\$398	\$108	\$233	\$235	\$376	\$109	\$208	\$210	\$340	\$275	\$641	\$442	\$684	\$291	\$500	\$355	\$591	
							12.00%	-22.75%	2.21%	-16.56%	-25.00%	-22.75%	-25.66%	-16.56%	14.81%	-19.31%	0.05%	0.53%	-21.15%	-19.31%	-22.13%	-0.27%	-9.13%	-15.66%	-14.67%	-3.07%	1.24%	-15.06%	-8.15%	-6.79%	
							\$108	\$233	\$206	\$355	\$100	\$233	\$206	\$355	\$118	\$213	\$214	\$335	\$118	\$213	\$214	\$335	\$202	\$466	\$305	\$589	\$202	\$466	\$305	\$589	
							5.09%	-14.32%	13.64%	-5.23%	-29.62%	-14.32%	-17.35%	-5.23%	6.49%	-10.55%	12.23%	14.35%	-28.72%	-10.55%	-19.34%	13.44%	-15.25%	-6.27%	-5.01%	9.51%	-5.62%	-6.27%	2.25%	2.56%	
							\$110	\$218	\$226	\$335	\$77	\$209	\$160	\$328	\$126	\$200	\$240	\$359	\$97	\$201	\$177	\$355	\$234	\$490	\$350	\$641	\$256	\$440	\$340	\$586	
							\$111	\$220	\$228	\$342	\$79	\$215	\$161	\$302	\$128	\$218	\$245	\$361	\$90	\$208	\$170	\$356	\$242	\$515	\$305	\$656	\$204	\$461	\$347	\$505	
							Weighted Average Total																								

ALLIANCE PPO GROUP

NON-ALLIANCE PPO GROUP

Final Comp Co. points	1997 Trend	Not Composite Change 1996 to 1997	Curt holder	Weight 796%	Direct Rate	FEMALE			MALE			FEMALE			MALE			FEMALE			MALE								
						Single	Couple	Parent	Family	Single	Couple	Parent	Family	Single	Couple	Parent	Family	Single	Couple	Parent	Family	Single	Couple	Parent	Family				
						\$102	\$130	\$178	\$275	\$82	\$138	\$178	\$275	\$112	\$107	\$195	\$300	\$112	\$107	\$195	\$300	\$295	\$493	\$433	\$667	\$493	\$433	\$667	
-1.00%	2.50%	1.47%	482	100.00%	196	\$95	\$102	\$175	\$275	\$95	\$161	\$175	\$275	\$118	\$200	\$190	\$298	\$118	\$200	\$190	\$298	\$259	\$140	\$407	\$440	\$407	\$639	\$580	
					197	\$107	\$273	\$219	\$350	\$80	\$210	\$146	\$325	\$132	\$263	\$251	\$324	\$132	\$263	\$251	\$324	\$274	\$399	\$440	\$499	\$353	\$580		
					197	\$110	\$280	\$224	\$359	\$85	\$246	\$150	\$333	\$135	\$270	\$257	\$332	\$135	\$270	\$257	\$332	\$281	\$655	\$451	\$700	\$511	\$382	\$605	
						15.85%	17.39%	-1.69%	0.00%	15.85%	16.67%	-1.69%	0.00%	5.96%	6.95%	-2.56%	0.67%	5.96%	6.95%	-2.56%	0.67%	-12.20%	-10.75%	-6.00%	-4.20%	-12.20%	-10.75%	-6.00%	-4.20%
						12.03%	68.52%	25.14%	27.27%	-12.63%	49.07%	-10.57%	18.18%	11.86%	31.50%	32.11%	8.72%	11.86%	31.50%	32.11%	8.72%	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%
						\$107	\$273	\$219	\$350	\$89	\$240	\$146	\$325	\$132	\$263	\$251	\$324	\$132	\$263	\$251	\$324	\$274	\$639	\$440	\$1003	\$290	\$499	\$353	\$580
						\$110	\$280	\$224	\$359	\$85	\$246	\$150	\$333	\$135	\$270	\$257	\$332	\$135	\$270	\$257	\$332	\$281	\$655	\$451	\$700	\$511	\$382	\$605	

NON-ALLIANCE PPO GROUP

LEGEND

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 ADVANTAGE |
| 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 |

LEGEND

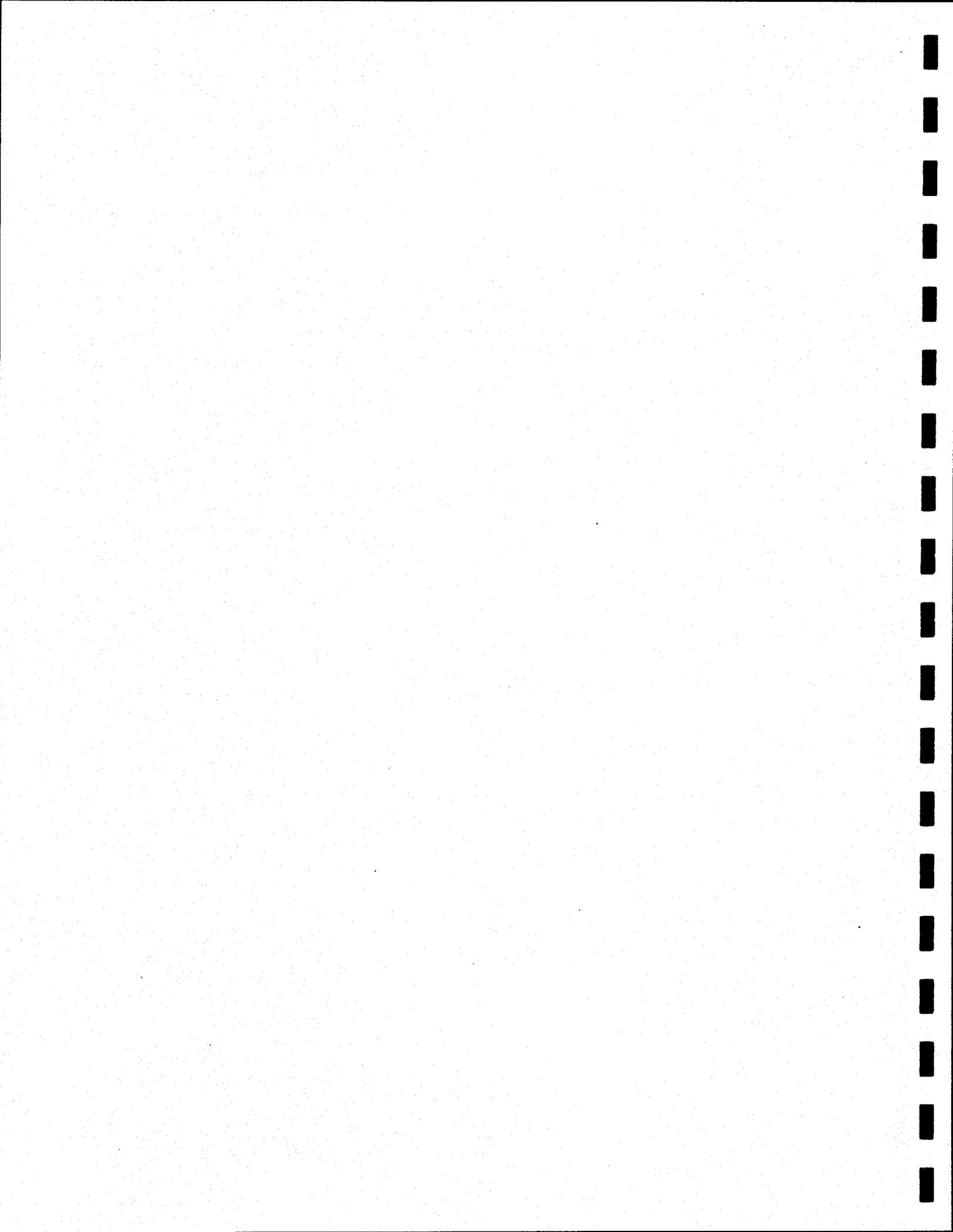
Footnotes

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.

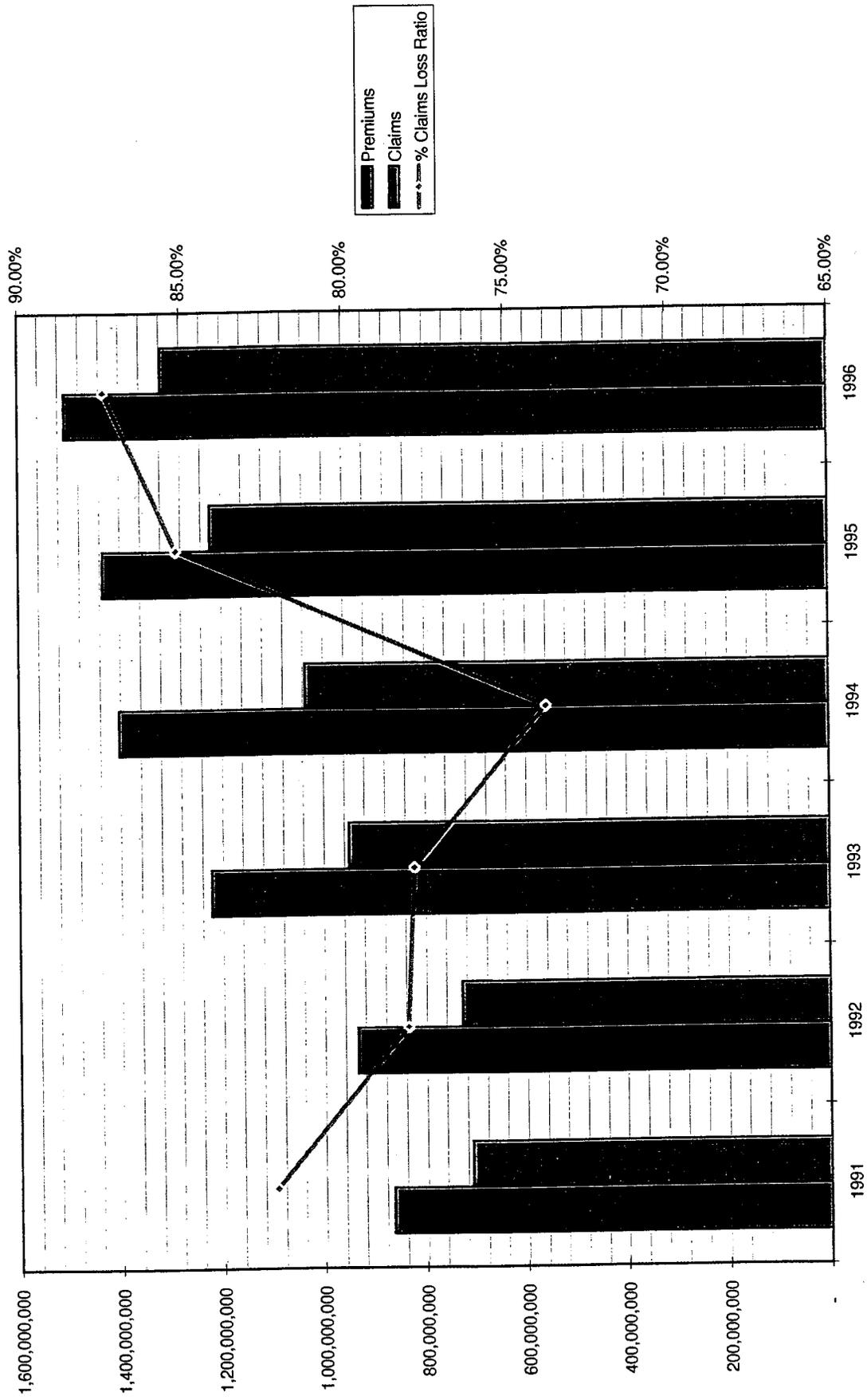
Prior to 1994, the year of reform, Kentucky health premium income was increasing. For most of the companies selling individual coverage, there is a downward trend in total health premium income beginning in 1994. With the exception of United Wisconsin Life Insurance Company, which only entered the Kentucky 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

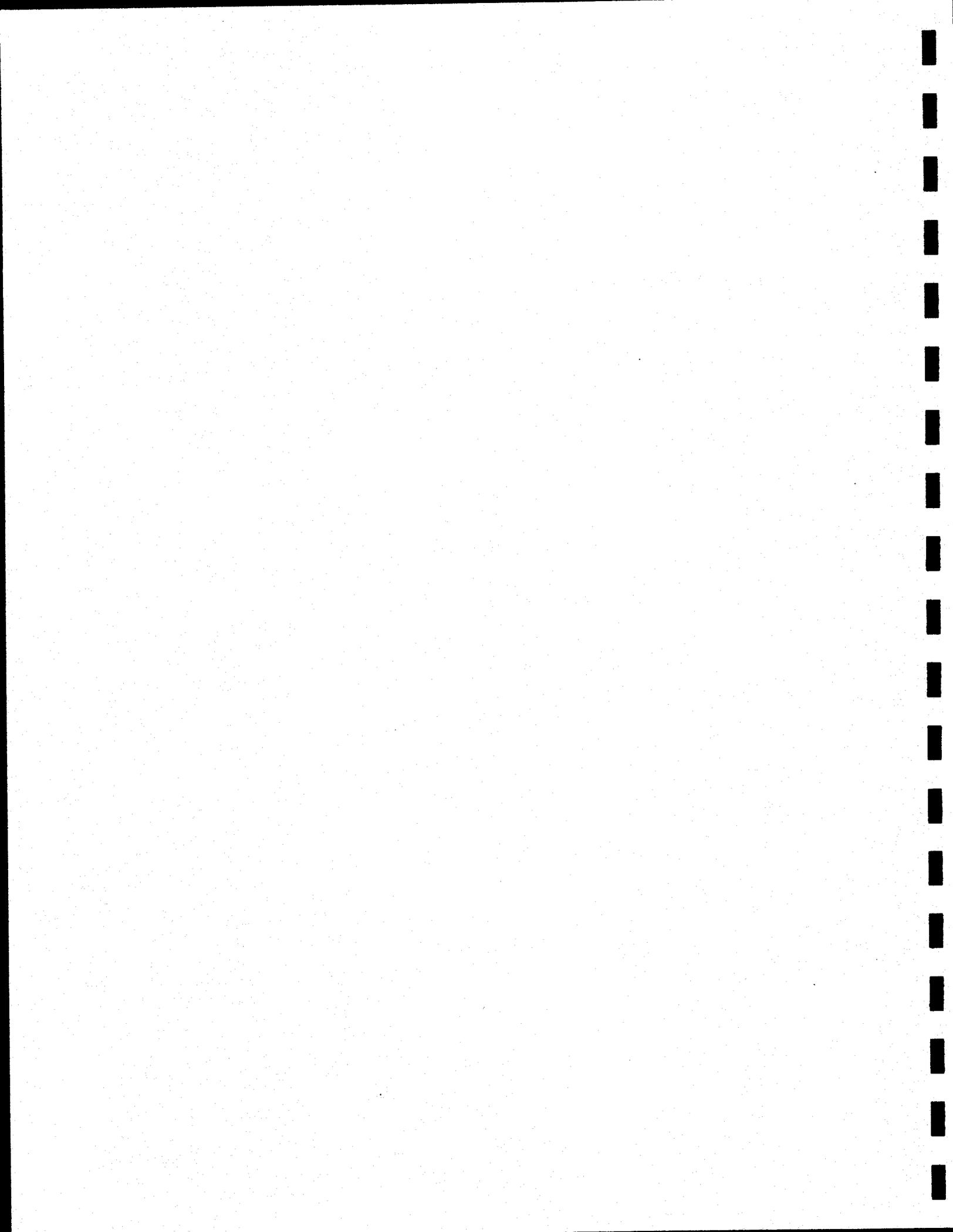
REGULATORY ENVIRONMENT

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, Centennial 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 policies, 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

PRIOR TO HB 250			
CURRENTLY	HMOs	Indemnity Individual	Indemnity Group
<p>HMOs, Indemnity Individual, and Indemnity Group</p> <p>RATES</p> <p>Rate Filing [KRS 304.17A-095]</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> *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 	<p>Rate Filing [KRS 304.38-050]</p> <ul style="list-style-type: none"> • File and approve prior to use • Deemed approved after 60 days • *30 day extension option • Standards for approval <ul style="list-style-type: none"> *not excessive *not inadequate *not unfairly discriminatory (these standards are defined in 806 KAR 38:070 Section 2) 	<p>Rate Filing [KRS 304.17-380 and 304.17-383]</p> <ul style="list-style-type: none"> • 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 	<p>(No Filings Required)</p>

<ul style="list-style-type: none"> *other factors deemed relevant by commissioner Filing frequency <ul style="list-style-type: none"> *decrease: file anytime *increase: no more often than every 12 months May withdraw approval if benefits no longer reasonable in relation to premium <ul style="list-style-type: none"> *after hearing *may require appropriate refund of premium Required information and supporting documentation [806 KAR 17:140] <ul style="list-style-type: none"> *product information *income and expense *actuarial memorandum *premium parameters worksheet *modified community rate diskettes *standard industry codes *discounts *load factors *provider fee information 	<ul style="list-style-type: none"> May withdraw approval Required information and supporting documentation [806 KAR 38:070] <ul style="list-style-type: none"> *letter of explanation *certification by actuary *capitation rates and formula *HMO's budget *recent financial data *other supporting info 	<ul style="list-style-type: none"> Filing frequency <ul style="list-style-type: none"> *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] <ul style="list-style-type: none"> *all forms *rate sheet *actuarial memorandum *comparison with same filing in other states 	
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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

<ul style="list-style-type: none"> Required Family Compositions <ul style="list-style-type: none"> *single individual *couple *single parent family *two parent family with children Optional Phase In of MCR <ul style="list-style-type: none"> *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 <p>FORMS</p> <ul style="list-style-type: none"> Standard Plans [KRS 304.17A-160] Issue only Standard Plans Renew only Standard Plans after 7/15/97 Must offer Basic Health Benefit Plan 	<ul style="list-style-type: none"> Form Filings [KRS 304.38-050] 	<ul style="list-style-type: none"> Form Filings [KRS 304.14-120] 	<ul style="list-style-type: none"> Form Filings [KRS 304.14-120]
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<ul style="list-style-type: none"> • File and approve before use • Coordination of benefits required • Providers listed in network must be under contract 	<ul style="list-style-type: none"> • File and approve before use • Deemed approved after 60 days • *30 day extension option May withdraw approval • Must contain complete and clear statement of <ul style="list-style-type: none"> *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] 	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> *if in violation of code *if inconsistent, ambiguous, or misleading *if substantially illegible *if excludes HIV coverage *if benefits unreasonable in relation to premium 	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> *if in violation of code *if inconsistent, ambiguous, or misleading *if substantially illegible *if excludes HIV coverage *if benefits unreasonable in relation to premium
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<p>MISCELLANEOUS</p> <ul style="list-style-type: none"> • 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 		<ul style="list-style-type: none"> • Renewable by terms of policy [KRS 304.14-240] *if no term, at option of insurer
	<ul style="list-style-type: none"> • Renewable by terms of policy [KRS 304.14.240] *if no term, at option of insurer 	<ul style="list-style-type: none"> • Renewable by terms of policy [KRS 304.14-240] *if no term, at option of insurer

<p>*insurer no longer doing business in Kentucky 12 months prior notice to policyholder and Department 5 year ban from State</p> <p>*individual becomes eligible for employer group plan</p>	<ul style="list-style-type: none">• Cancellation of enrollee's coverage [806 KAR 38:060]<ul style="list-style-type: none">*non payment of premium*misrepresentation in application*dependent child canceled when marriesattains limiting agetermination of legal residenceno longer totally disabledenrollee's coverage terminatestermination 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		
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<ul style="list-style-type: none">• 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)]			
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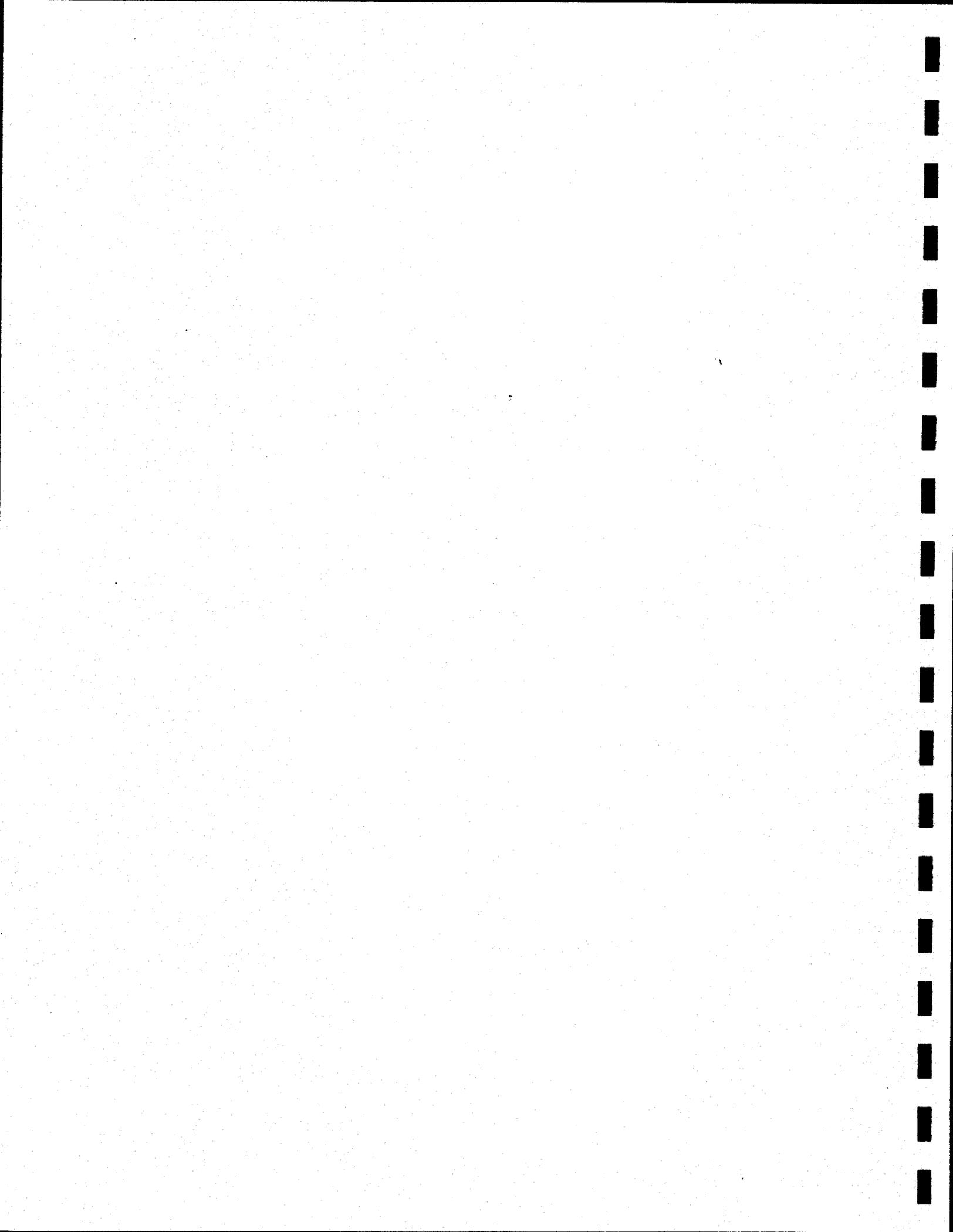
Kentucky Department of Insurance

SELECTED PROVISIONS OF HB 250 AND SB 343

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.

SECTION 5
Selected Provisions

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.

SECTION 5
Selected Provisions

Carrier	1995 HCCF Payouts		1996 HCCF Payouts	
	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				

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Selected Provisions

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

SECTION 5
Selected Provisions

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

SECTION 5
Selected Provisions

John Hancock			
Kentucky Kare			
MEGA Life (United Ins. Co.)	\$1,953.02	(\$258,610.78)	\$659,211.07
Mid-West National Life		\$8,017.07	(\$15,526.24)
Nippon			
PFL	\$3,916.65	\$17,825.04	
Pioneer Financial (PFS)			(\$45,278.54)
Principal Financial			(\$8,158.08)
Prudential HealthCare			
Prudential Ins. Co. of Amer.		(\$1,393.66)	\$6,641.83
Southwestern		(\$19,121.42)	\$38,275.27
State Mutual			
Trustmark	\$2,183.46	\$7,972.97	
UNICARE (fka Mass Mutual)		\$1,080.88	(\$7,891.89)
Union Bankers			(\$2,889.67)
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 plans¹. 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

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.

*SECTION 5
Selected Provisions*

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 plan. Thus, by July 15, 1998, all health benefit plans will conform to the standard health benefit plans.

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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

*SECTION 5
Selected Provisions*

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.

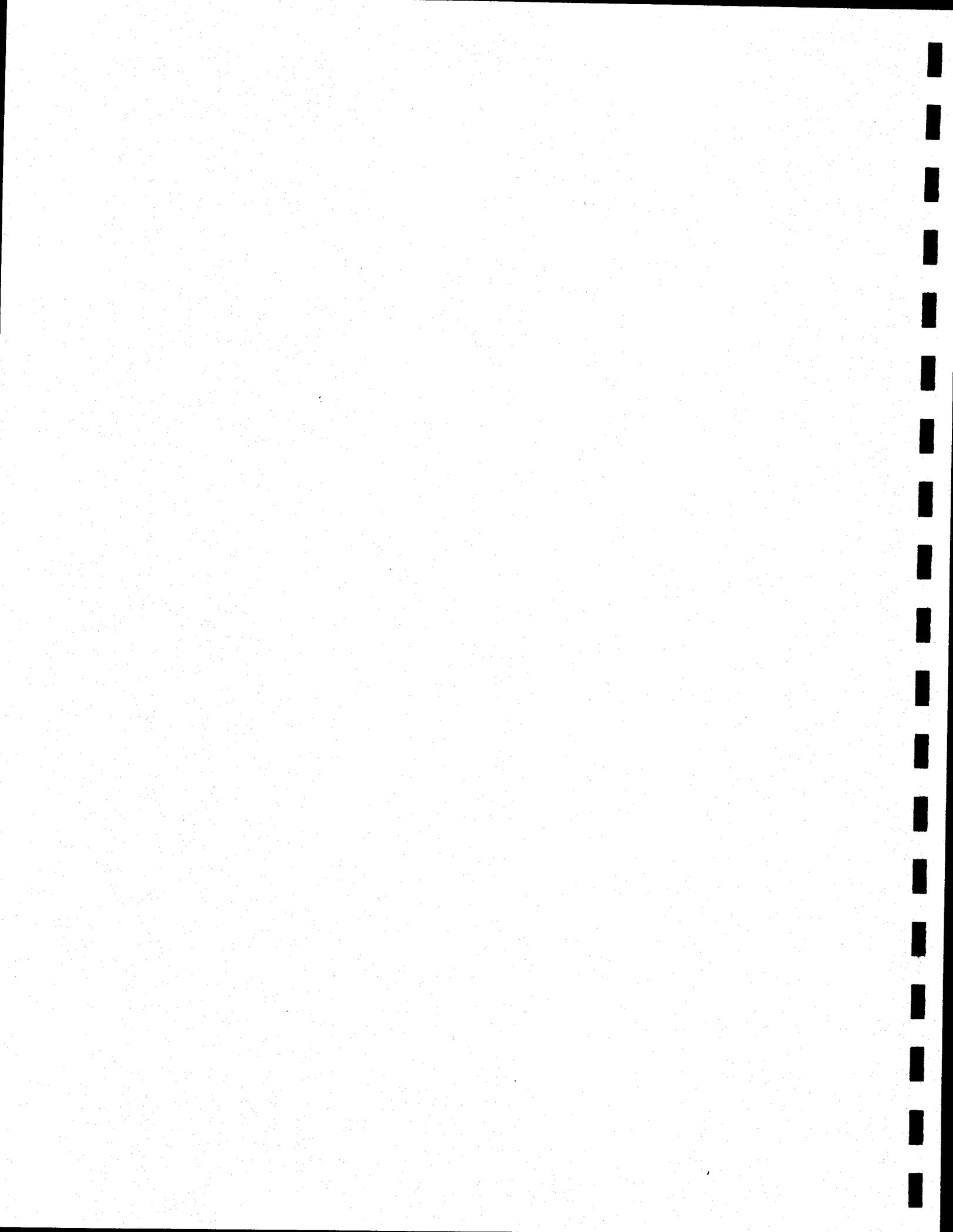
In regard to premium, due to inconsistencies in premium and claims reported by the insurers, the Department is unable to provide accurate data. The Department is continuing to collect and analyze necessary data with assistance from Coopers & Lybrand.

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 forth 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

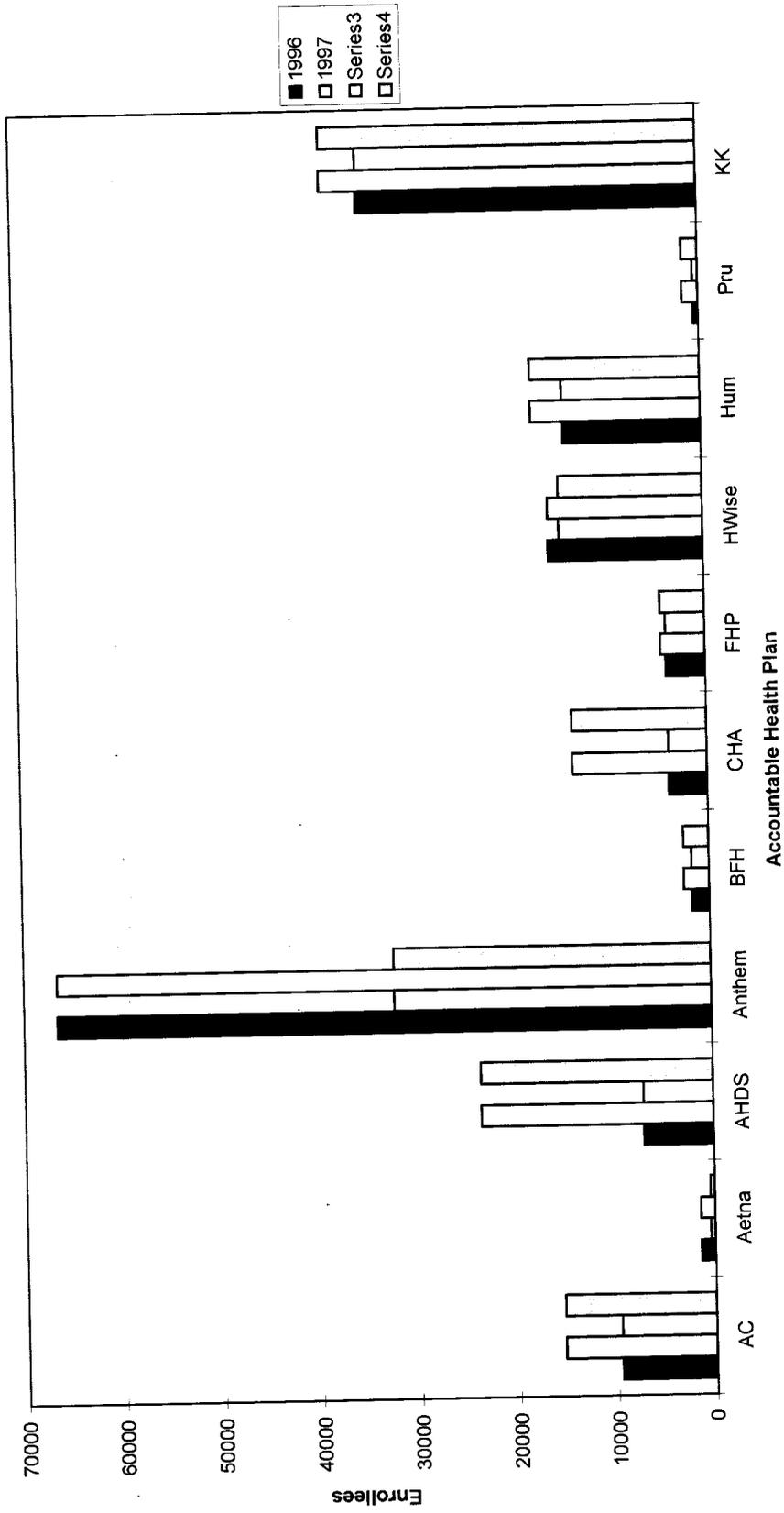




EXHIBIT B

ALLIANCE ENROLLEES BY EMPLOYER

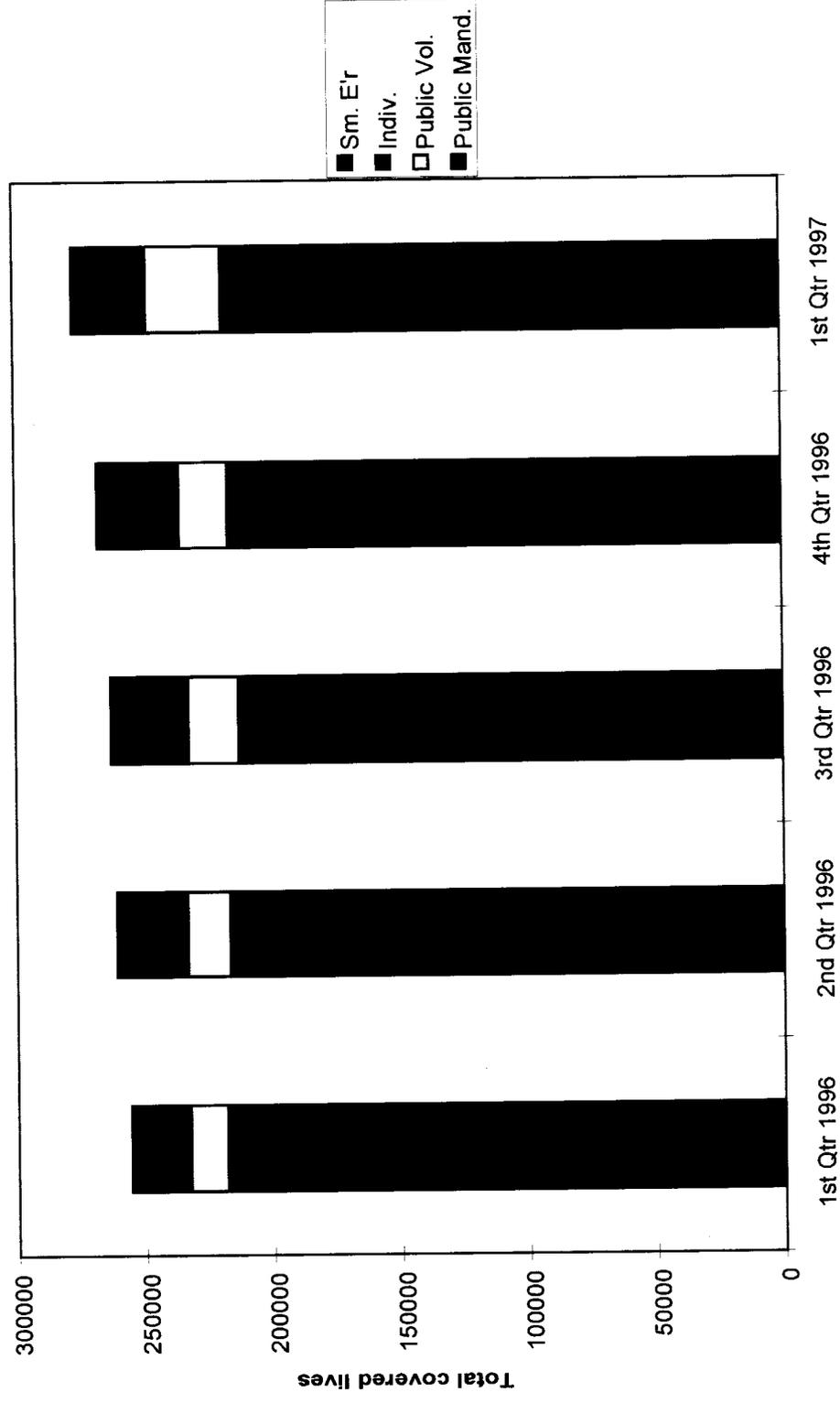
State	38,333
School systems	75,427
Kentucky Retirement Systems	10,023
Teacher Retirement System	8,726
Health Departments	2,752
Buy-in Enrollees	2,147
Universities	6,277
Cities, Counties, Special Districts	4,231
Small employers	9,370
Individuals	7,283
TOTAL	168,800

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

<u>Group</u>	<u>Enrollees</u>	<u>Date of entry</u>	<u>Date of renewal</u>
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





Kentucky Department of Insurance

STATE & FEDERAL REFORM INITIATIVES

reform provisions

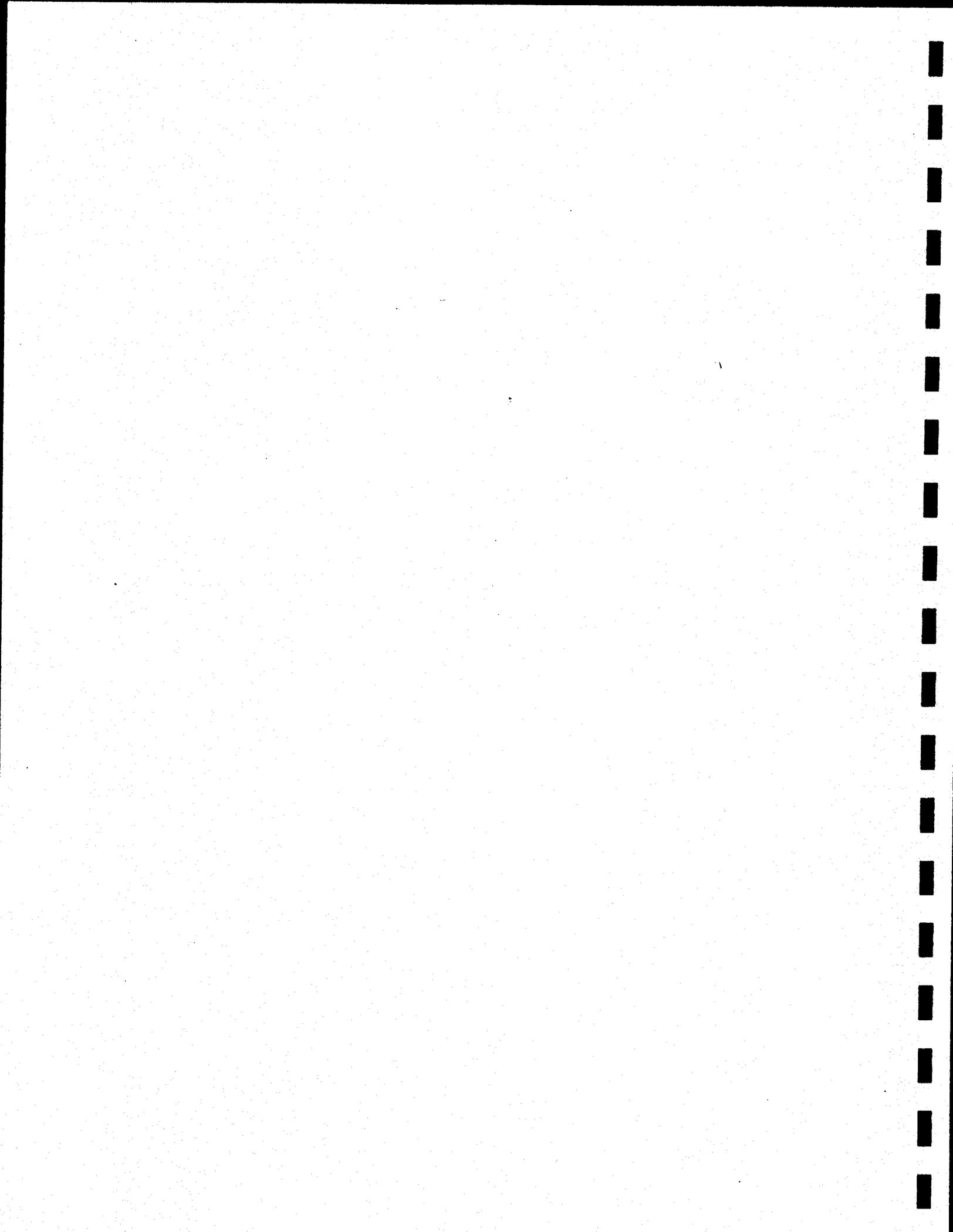
rate bands

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.

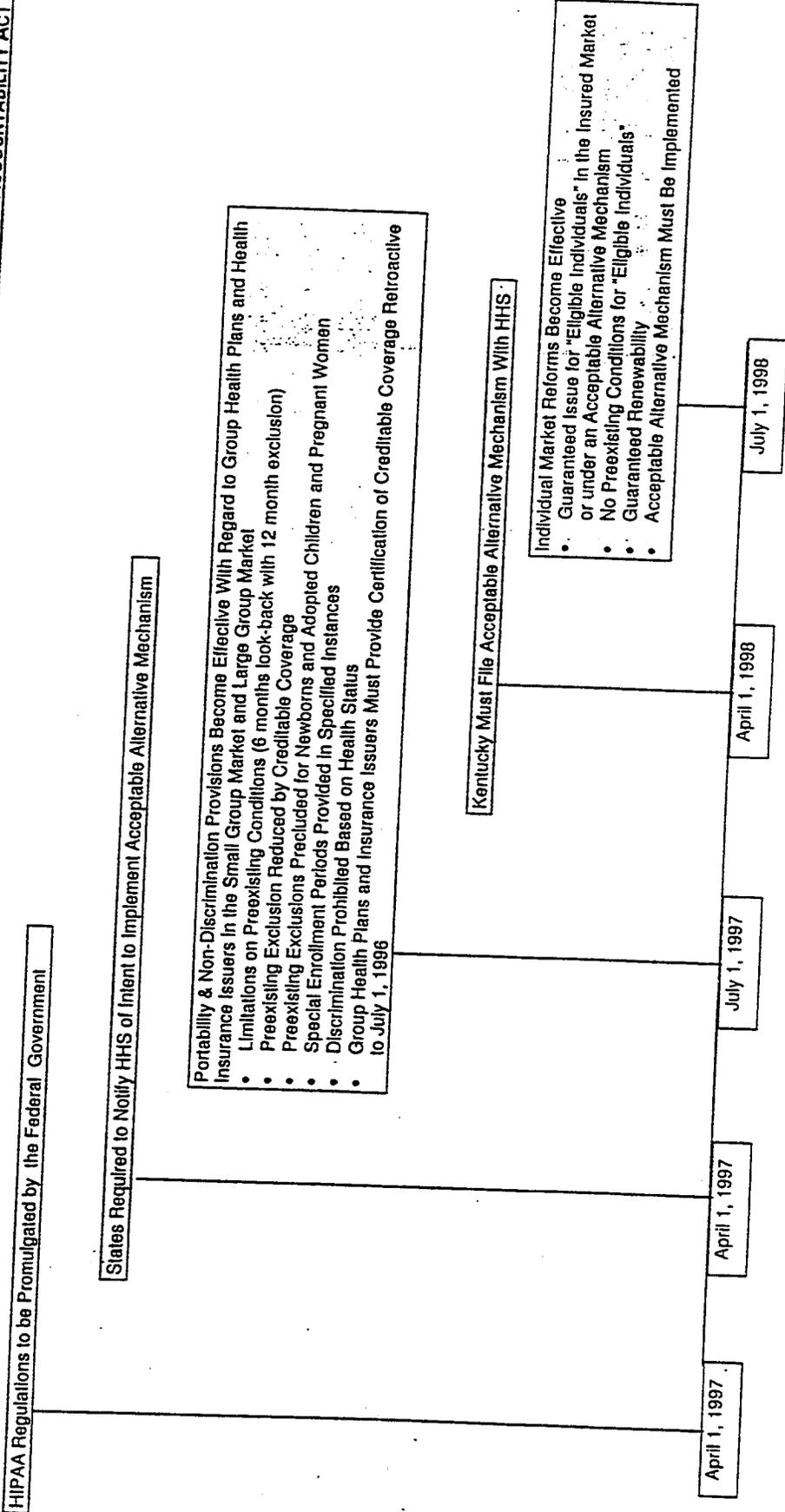
CHILDREN'S HEALTH CARE

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 multifaceted 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 employer 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 uninsured	Guaranteed issue ²	Limits & rules of guaranteed issue ³	Guaranteed renewal ⁴	Rating Restrictions ⁵	Pre-existing conditions limit ⁶	High risk pool ⁷	Any willing provider ⁸
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;1-12/12	X	
Colorado	3,747,560	14.8%	SG		SG, I	SG-MCR	SG-6/6;1-12/12	X	
Connecticut	3,270,740	8.8%	SG		SG	SG-RB	SG-12/6;1-12/12	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;1-24/24	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;1-18/12	X	broad
Iowa	2,843,074	11.3%	SG, I	year round	SG, I	SG-MCR I-RB	SG-12/6;1-12/12	X	
Kansas	2,563,618	12.4%	SG		SG	SG-RB	SG-3/6	X	Rx only
Kentucky	3,888,877	14.6%	SG	year round	SG	Both-MCR	Both-9/9		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;1-0/0		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
Page 7-9

HEALTH REFORM: PROFILES OF 50 STATES

State	Population ¹	Percent uninsured ¹	Guaranteed issue ²	Limits & rules of guaranteed issue ³	Guaranteed renewal ⁴	Rating Restrictions ⁵	Pre-existing conditions limit ⁶	High risk pool ⁷
Montana	870,351	12.7%	SG		SG	SG-RB	SG-12/06	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 1-12/6	Rx only
New Mexico	1,689,849	25.6%	SG		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	Rx only
Ohio	11,134,032	11.9%	SG, I	enrollment cap	SG, I	SG-RB	Both-12/6	Rx only
Oklahoma	3,274,870	19.2%	SG		SG	SG-RB	SG-12/6	X
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; portability	Rx, allied
South Dakota	729,500	9.4%	SG, I	only w/ prior coverage	SG, I	Both-RB	SG-12/6; 1-12/12	Rx only
Tennessee	5,246,723	14.8%	SG		SG	SG-RB	SG-12/12	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	broad
Vermont	584,776	13.2%	SG, I	year round	SG, I	Both-MCR	Both-12/12	Rx, allied
Virginia	6,615,234	13.5%	SG		SG	SG-RB	Both-12/12	broad
Washington	5,447,720	12.4%	SG, I	year round	SG, I	Both-MCR	Both-3/3	Rx, allied
West Virginia	1,825,256	15.3%	SG		SG	Both-RB	SG-12/12	
Wisconsin	5,122,100	7.3%	SG		SG	SG-RB	SG-12/6	Rx only
Wyoming	479,192	15.9%	SG		SG	SG-RB	Both-12/6	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

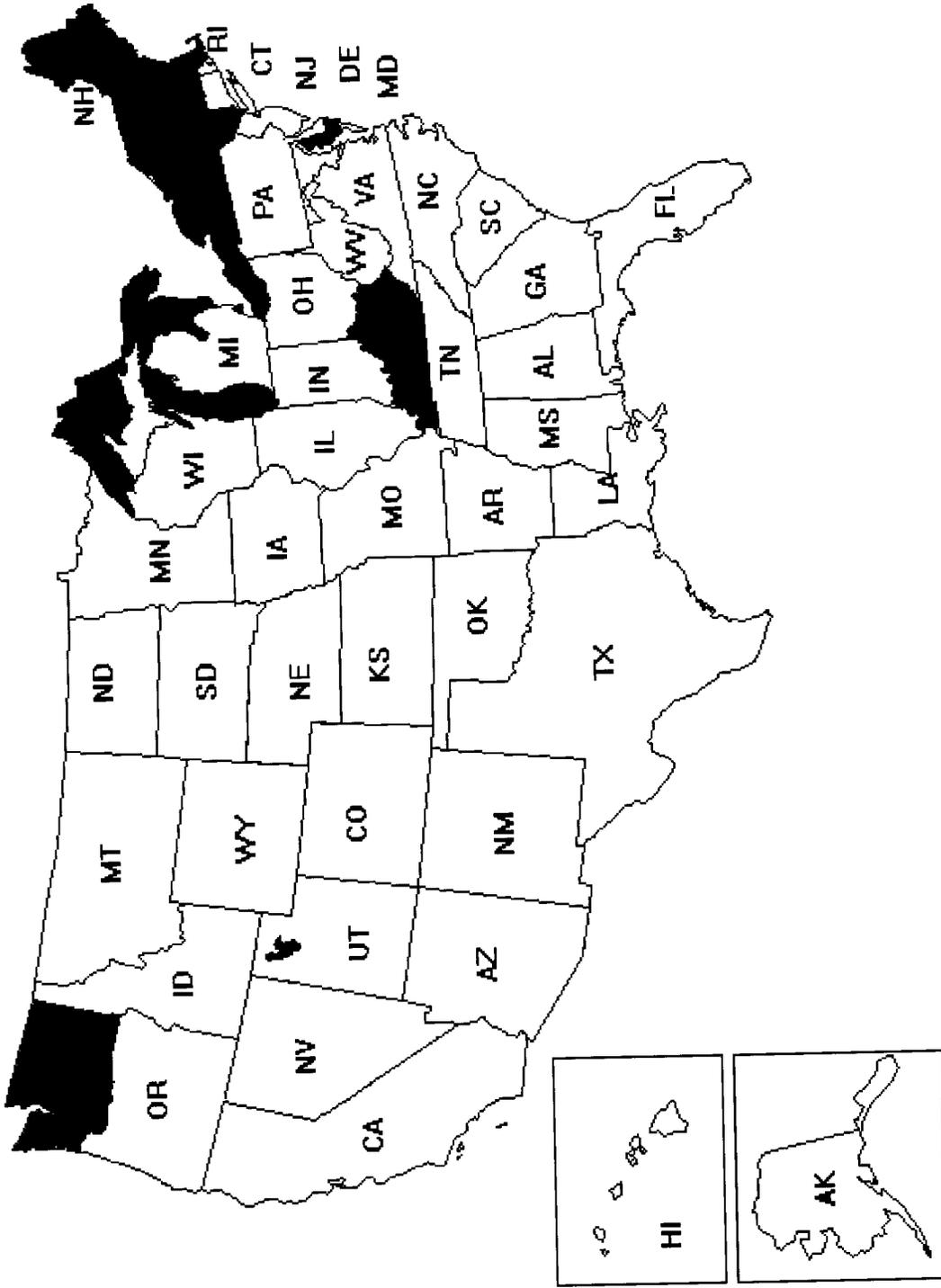
RB--rating bands

Pre-existing conditions limitations--6/12 means anything in previous six months or next 12 months would not be covered.

State	Population ¹	Percent uninsured	% of Error ²	Guaranteed Issue ³	Limits & rules of guaranteed issue ³	Guaranteed renewal ⁴	Rating Restrictions ⁵	Pre-existing conditions limit ⁶	High risk pool ⁷	Any willing provider ⁸
Kentucky	3,968,777	14.80%	SG	Year route	Both MCR	Both MCR	6/12	Pool		



Guaranteed Issue and Modified Community Rating/Community Rating for Individuals

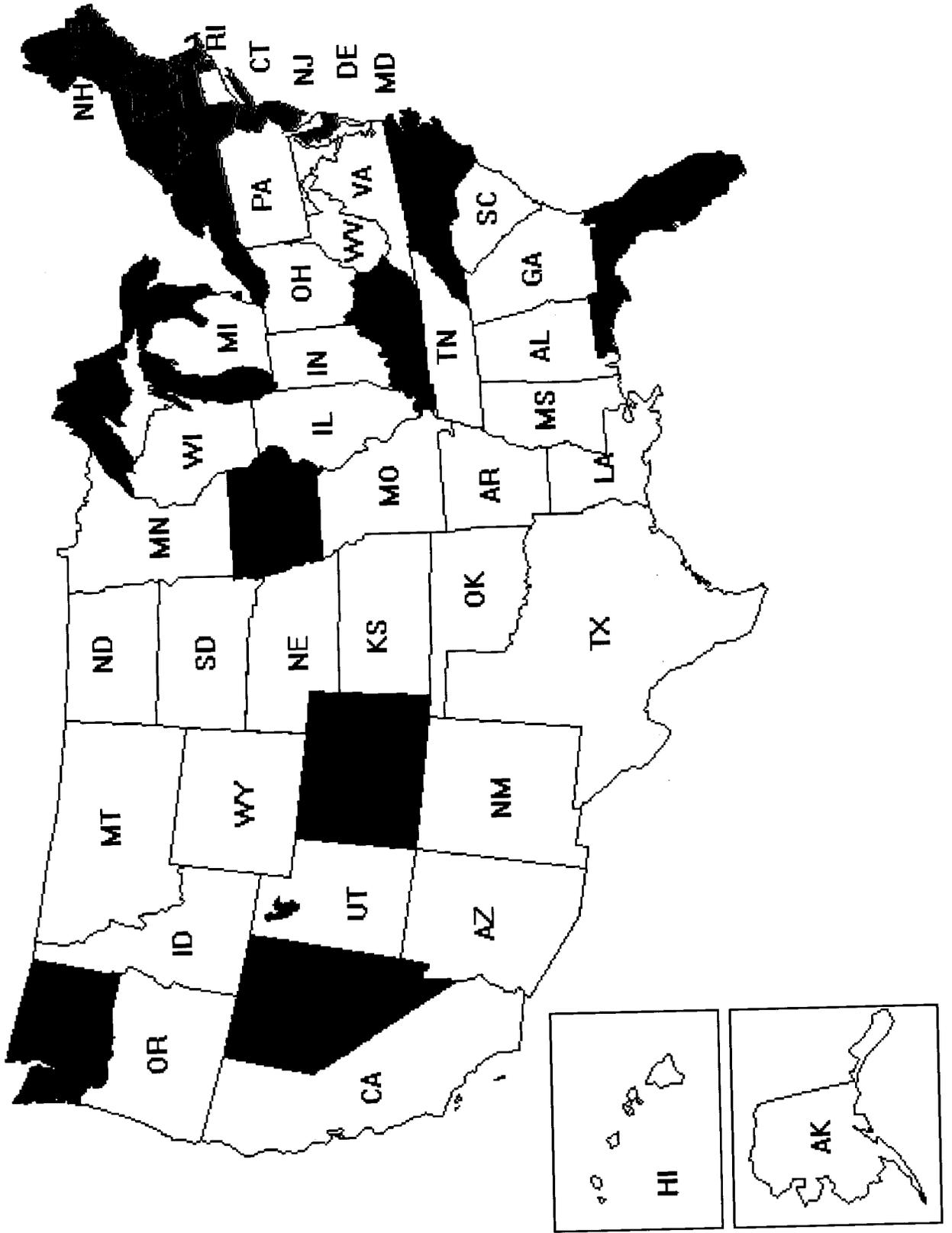








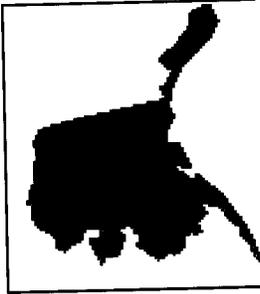
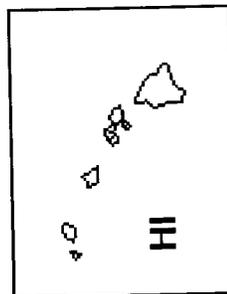
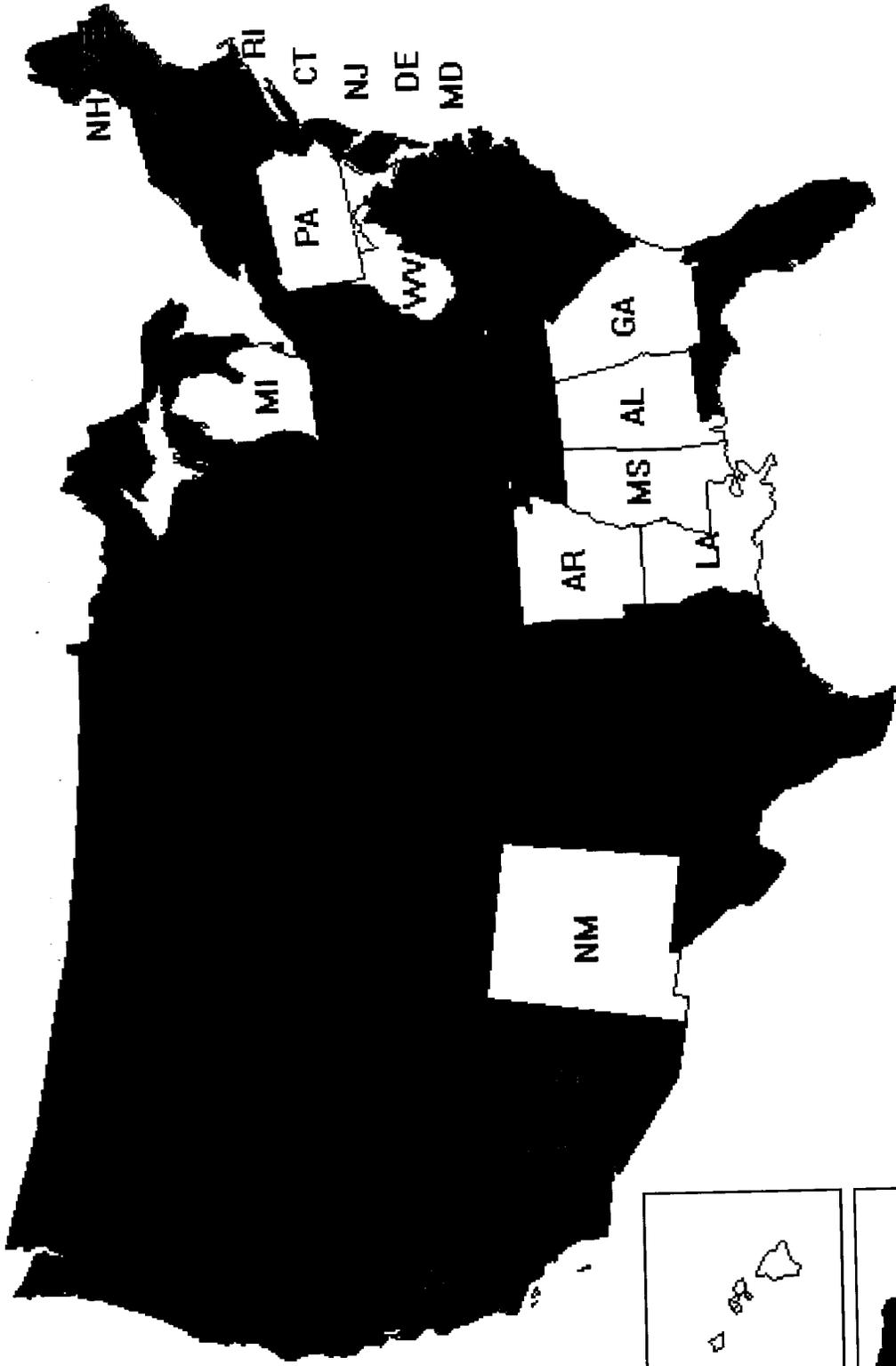
Modified Community Rating/Community Rating and Guaranteed Issue for Small Groups







Guaranteed Issue for Small Groups





Kentucky Department of Insurance

NATIONAL MARKET TRENDS

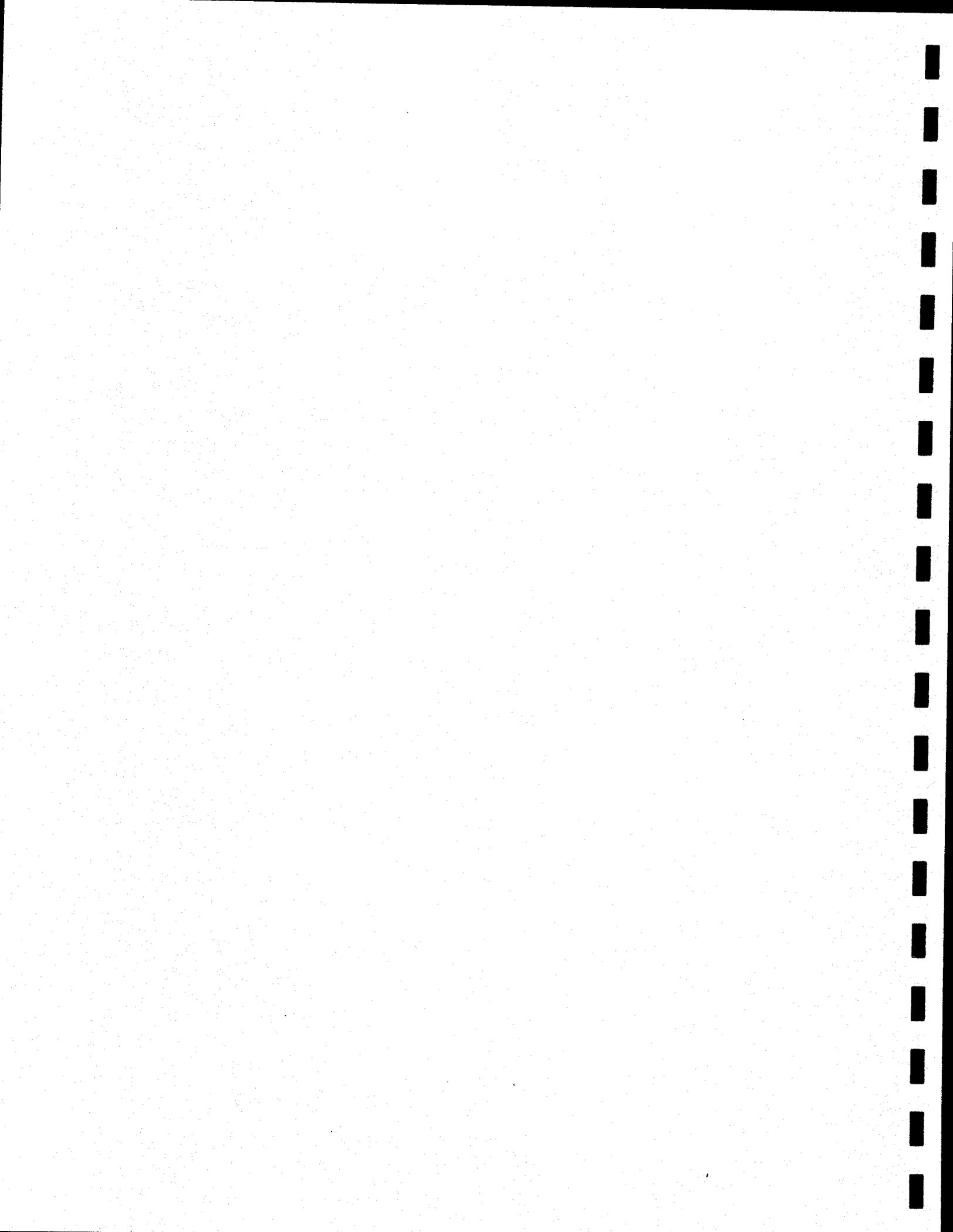
premium trends

loss ratios

managed care savings

financial impact
on consumers

health care expenditures



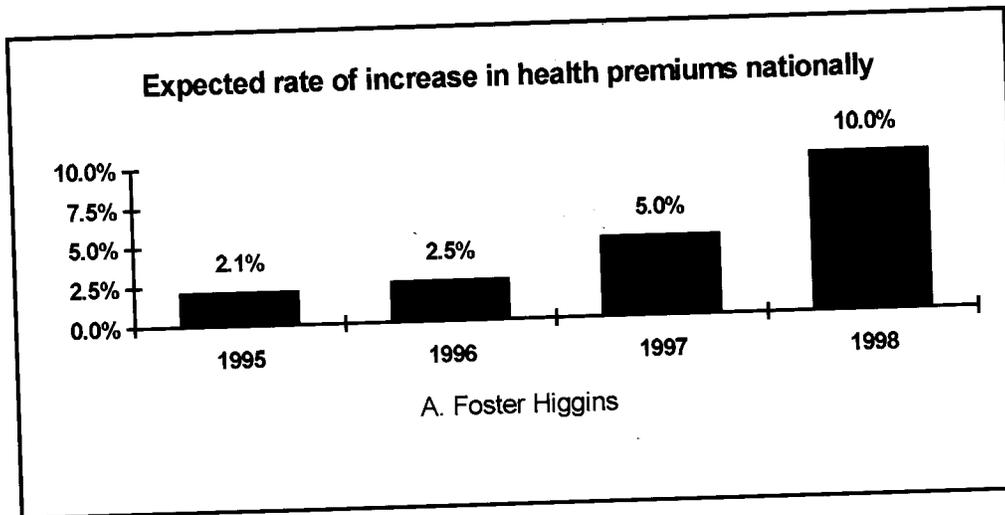
MARKET TRENDS IN HEALTH INSURANCE

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.

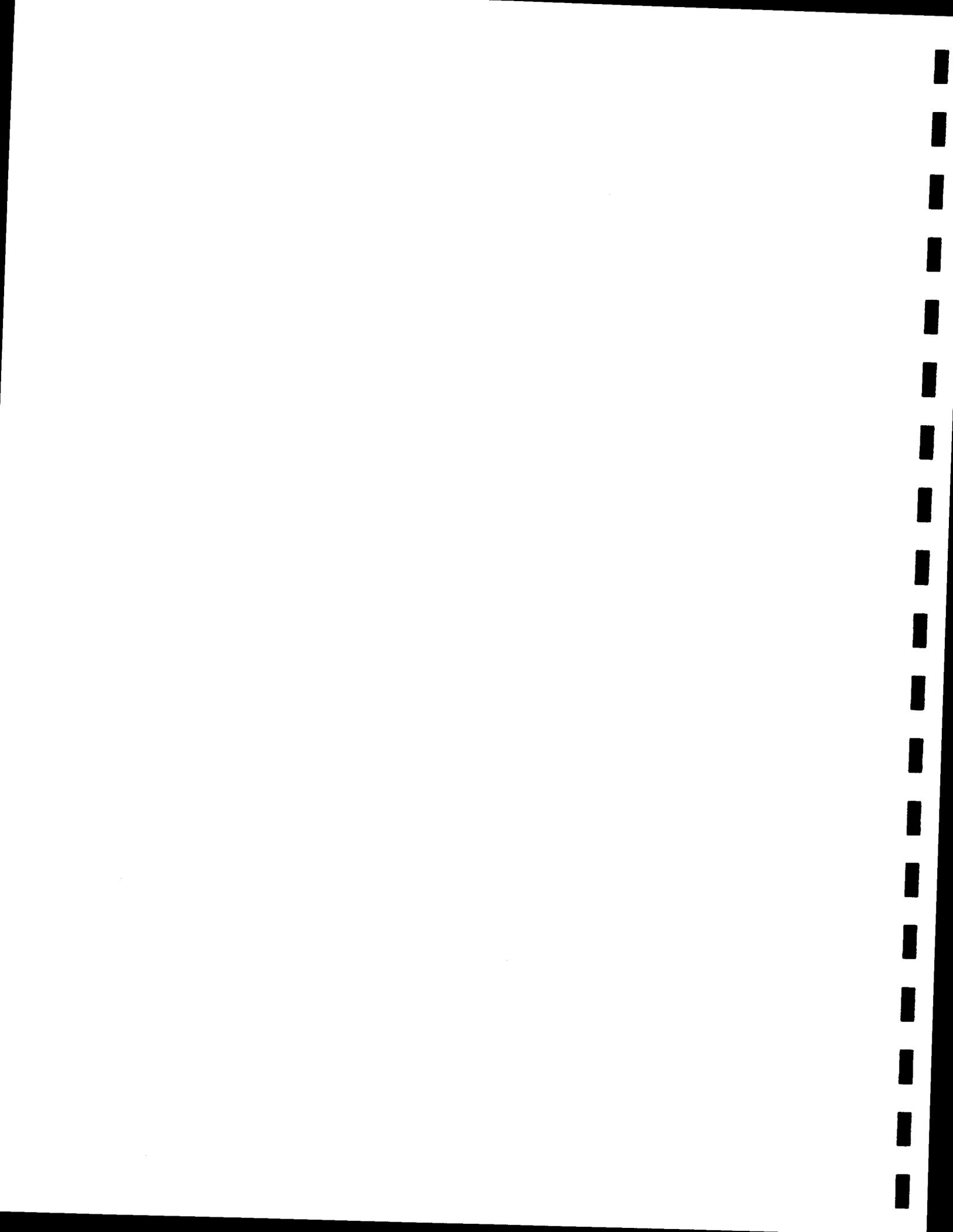
Across the nation, employers' health care costs will increase about 5 percent in 1997, analysts with the benefits consulting firm A. Foster Higgins have said. Small employer groups are expected to see steeper increases, some as high as 12 percent. An overall increase of 5 percent would double the national 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

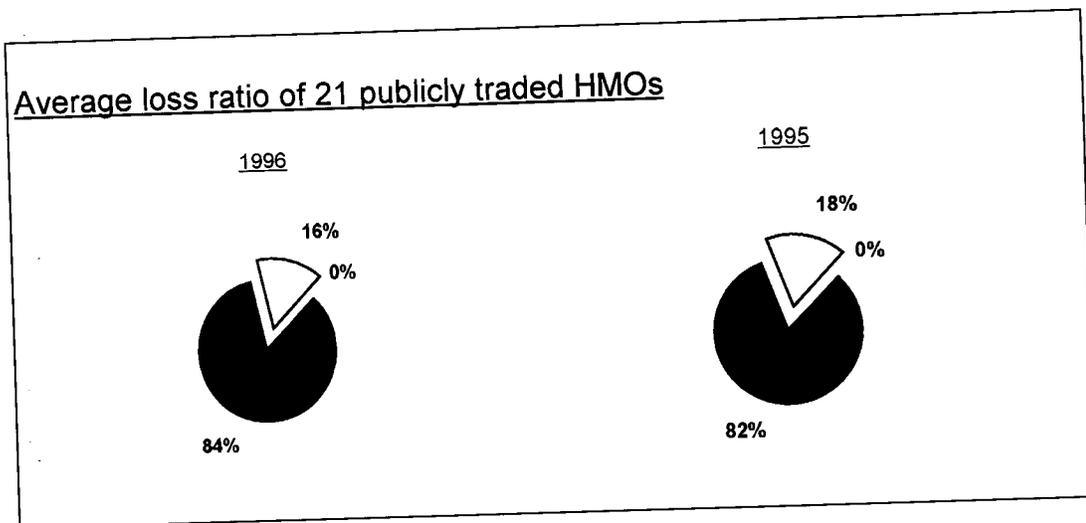


1997 and 1998. The national trend in the early 1990s of slim annual increases in premiums was in part an industry response to President Clinton's health care plan and to public outcry about health costs, according to analysts with Conning & Co., Hartford, Conn. That trend is reversing.

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).

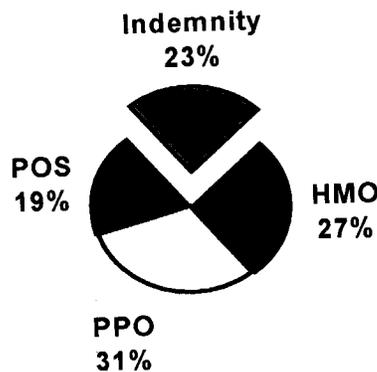


Reasons cited for the increases in loss ratios in 1996 include: fierce competition in the managed care market, HMOs' inexperienced forays into risk programs for Medicaid and Medicare, higher than expected outpatient claims and high pharmaceutical costs.

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.

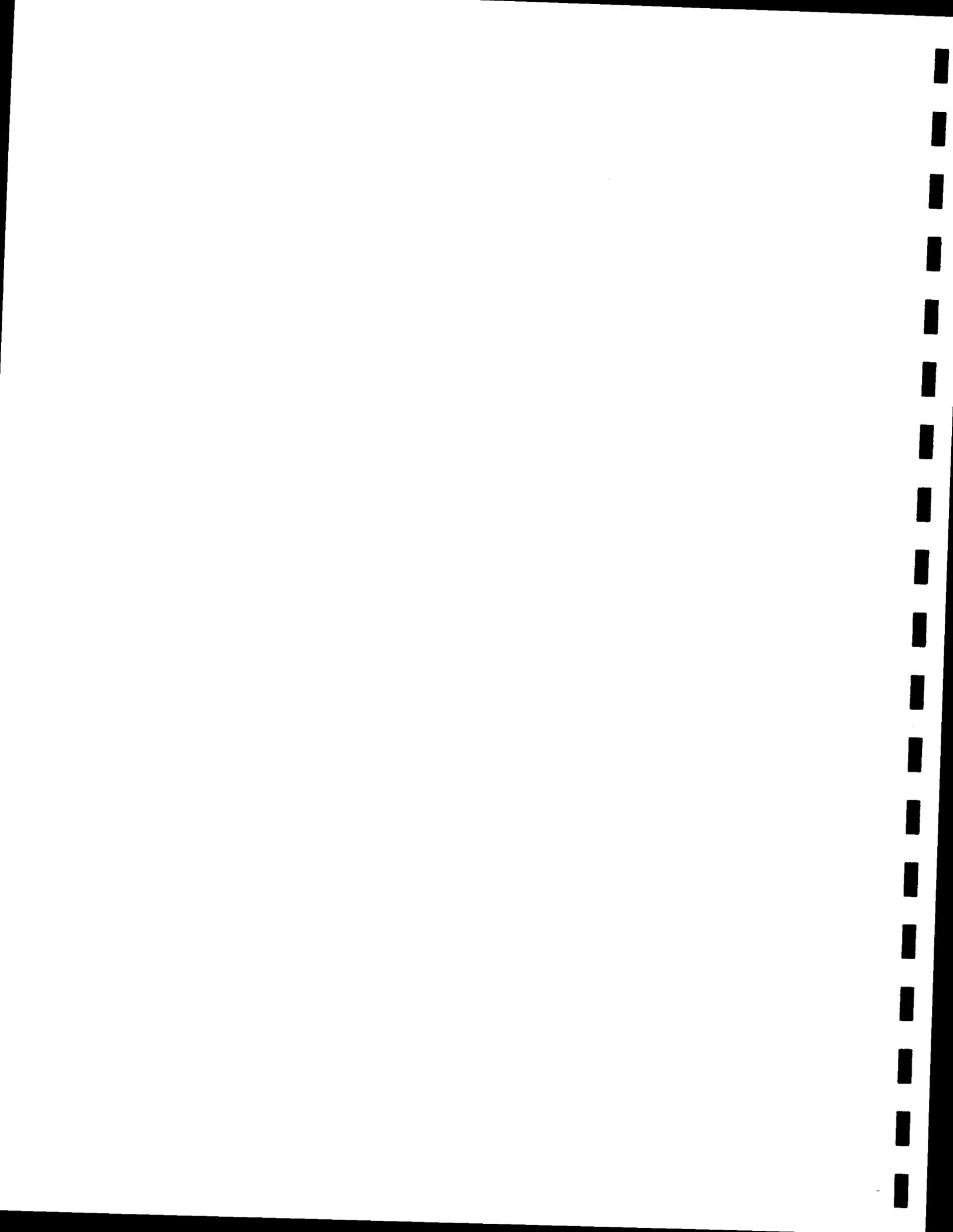


Managed care dominates employer health plans nationally, an A. Foster Higgins study shows. Employers' ability to save costs by moving more employees to managed care is near the limit.

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.

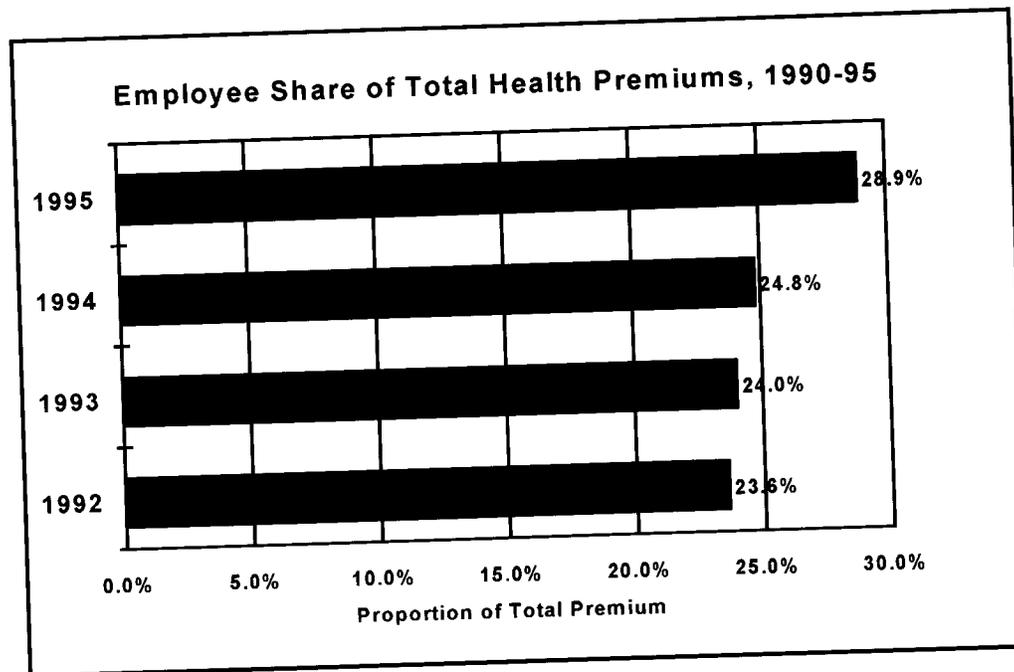
CONSUMERS/EMPLOYEES PERCEIVE HIGH INCREASES IN PAST YEARS

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.

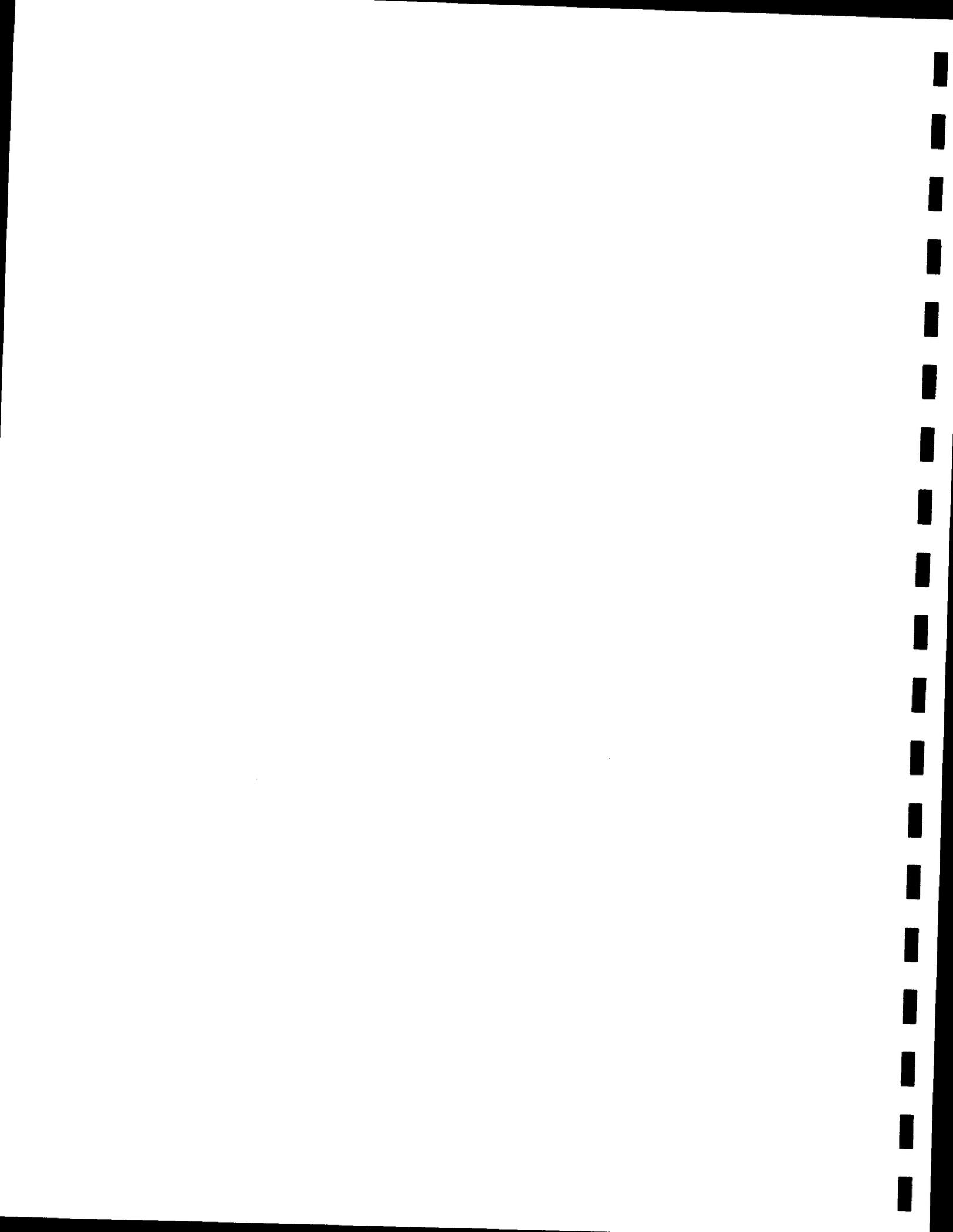


This trend has an even more significant impact on employees at Kentucky's small businesses, where premium increases have been greater than the national average in the 1990s.

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 significant 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.

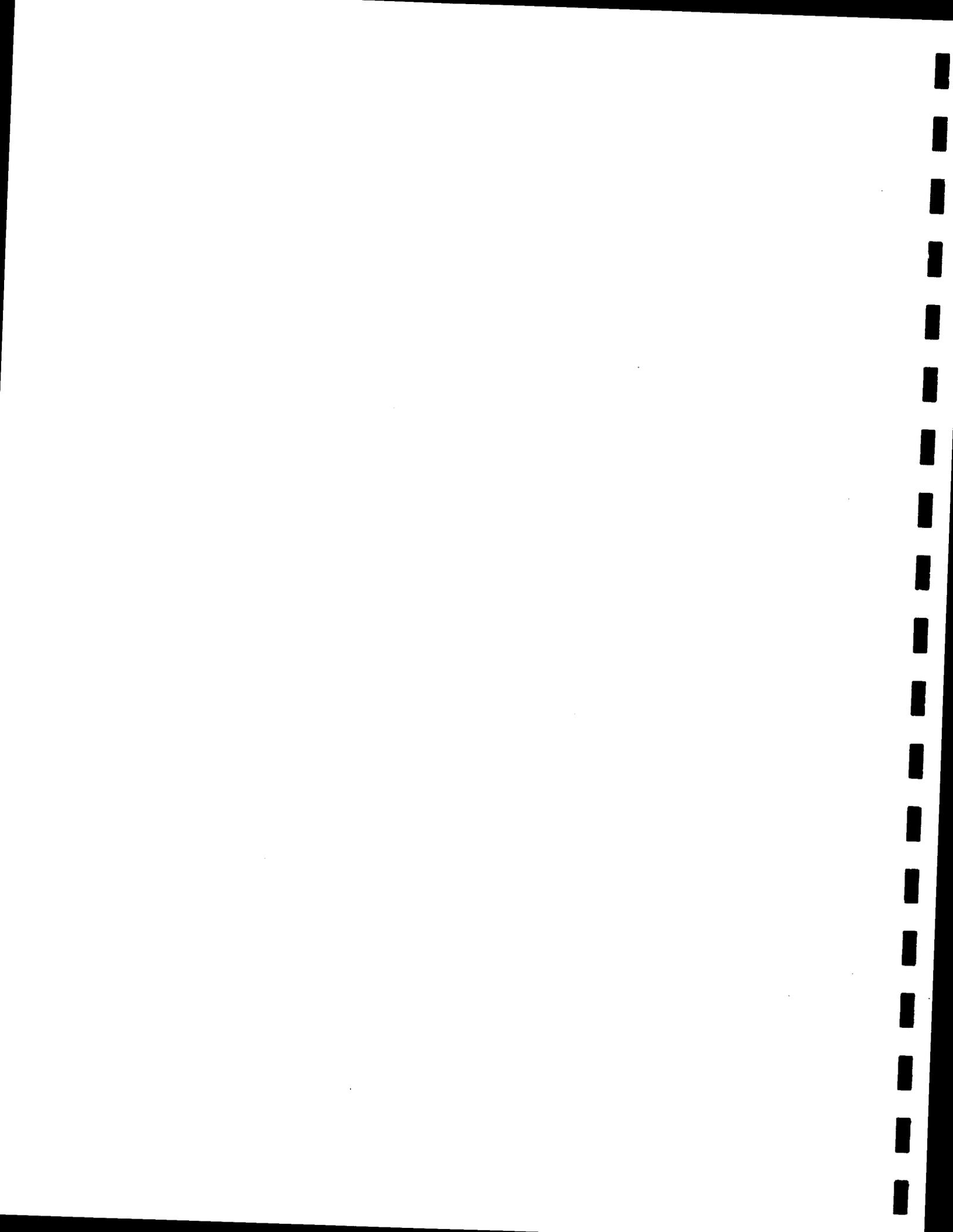
The impact of this legislative trend is a movement by some HMOs and insurance carriers to address these consumer-driven issues before legislation is passed. Some are meeting with insurance commissioners and agreeing on administrative regulations. Responding in part to legitimate consumer demands, in 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.

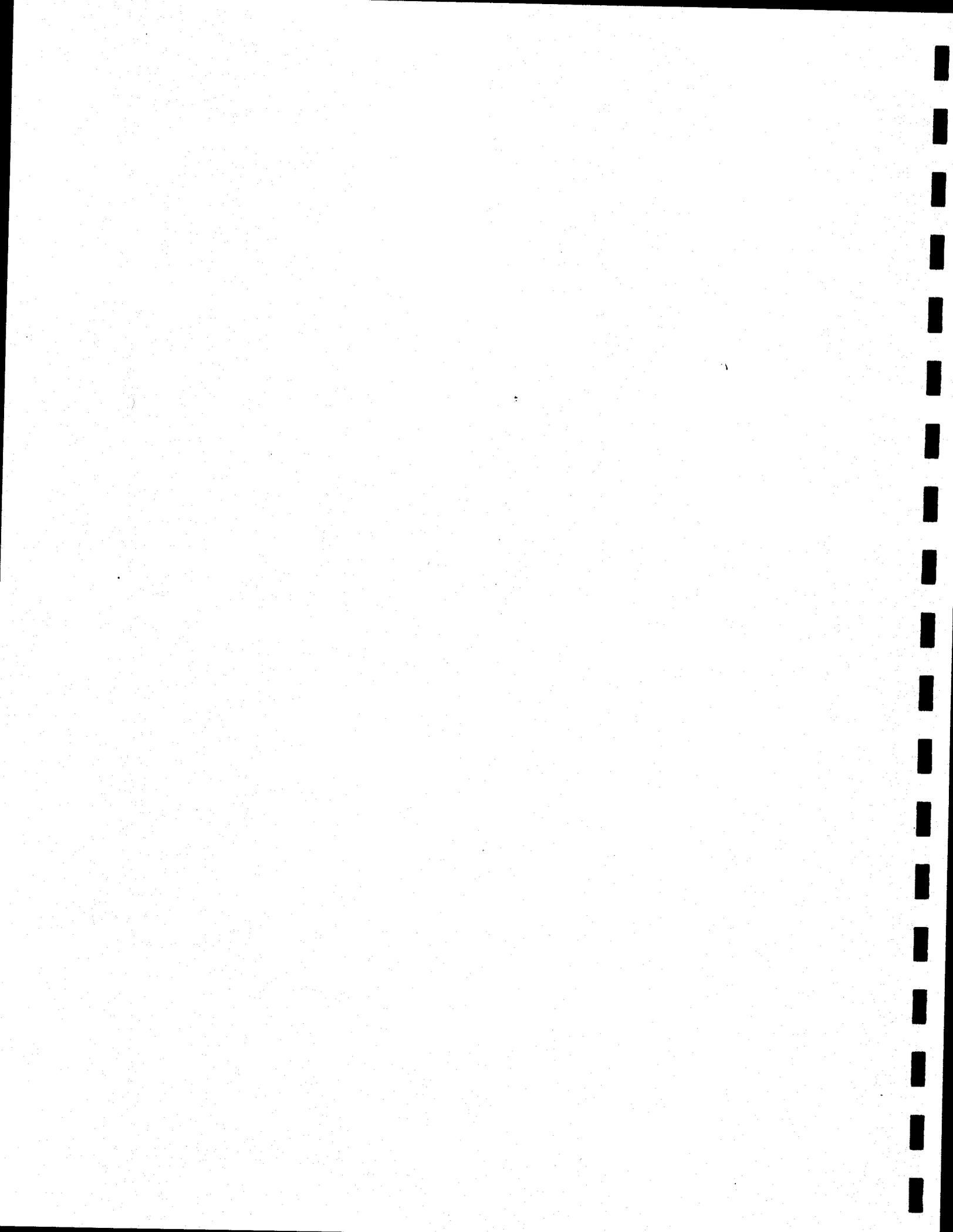


Kentucky Department of Insurance

KENTUCKY DEMOGRAPHICS

employers by SIC
and typical size

average wages





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LEGISLATIVE RESEARCH COMMISSION
State Capitol 700 Capital Avenue 502-564-8100
Frankfort, Kentucky
Capitol FAX 1-502-223-5094
Annex FAX 1-502-564-6543

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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

SECTION 9
Characteristics of Consumers

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.

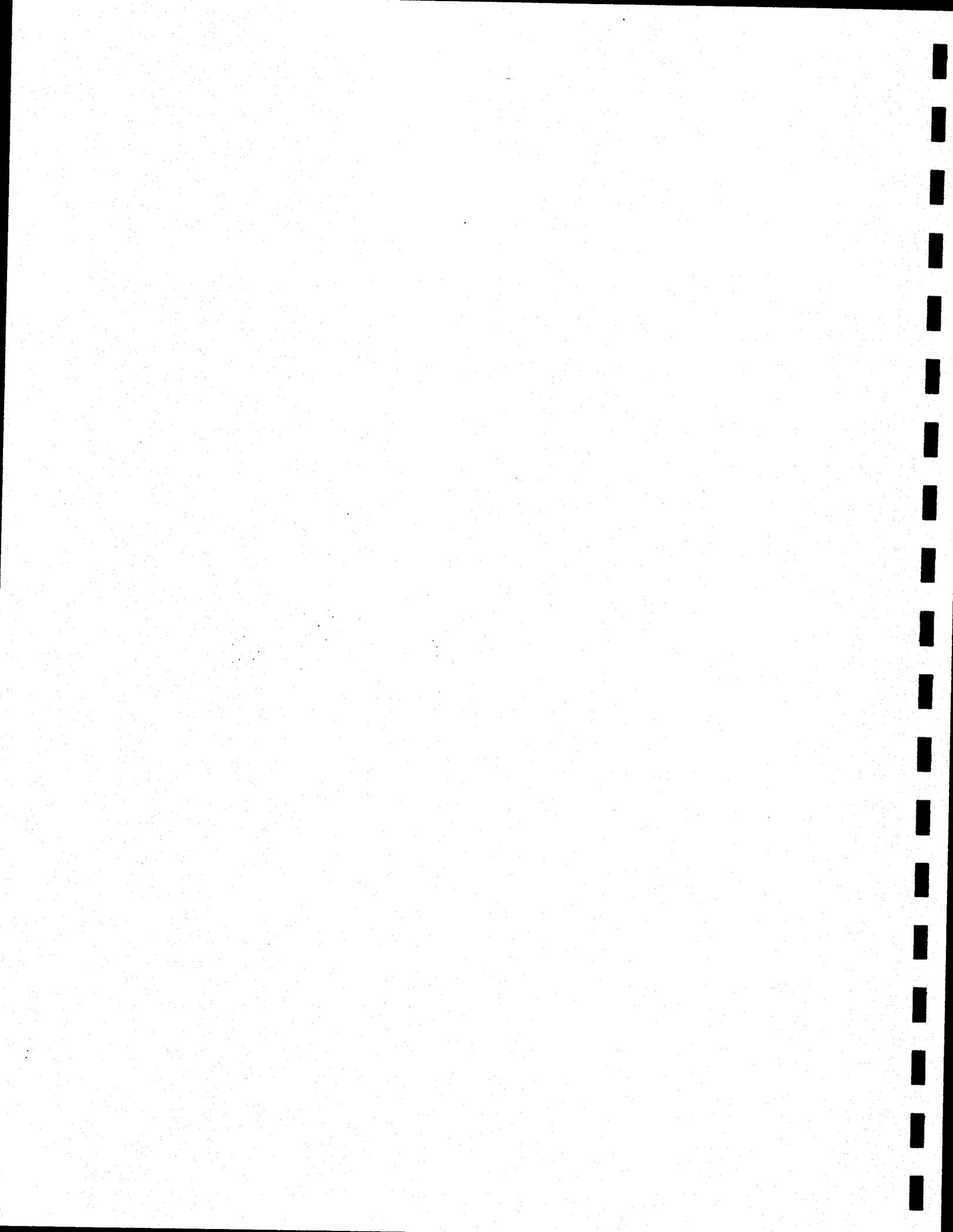
UNINSURED CHILDREN

- 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



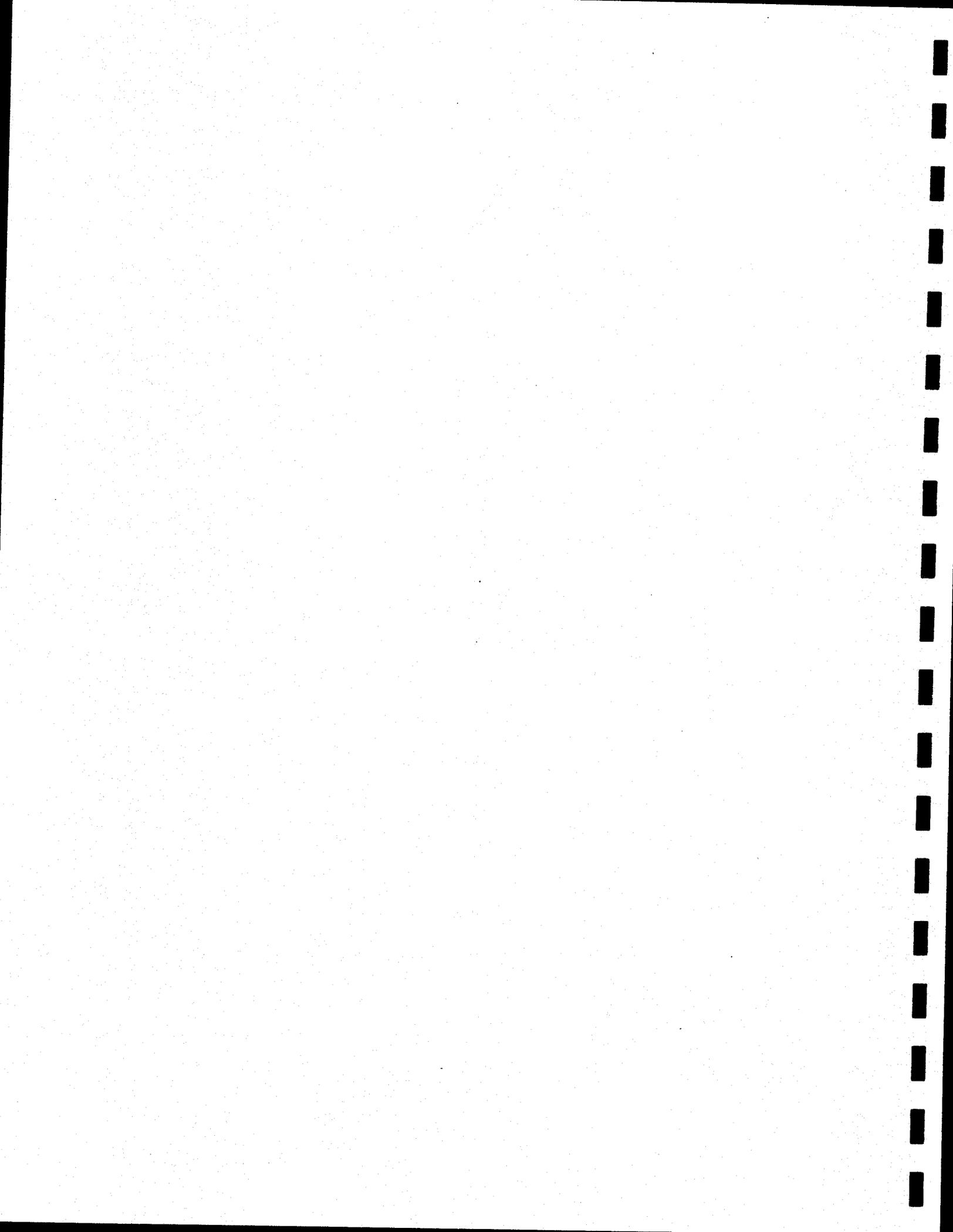
DEMOGRAPHICS OF KENTUCKY RESIDENTS

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 as 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.

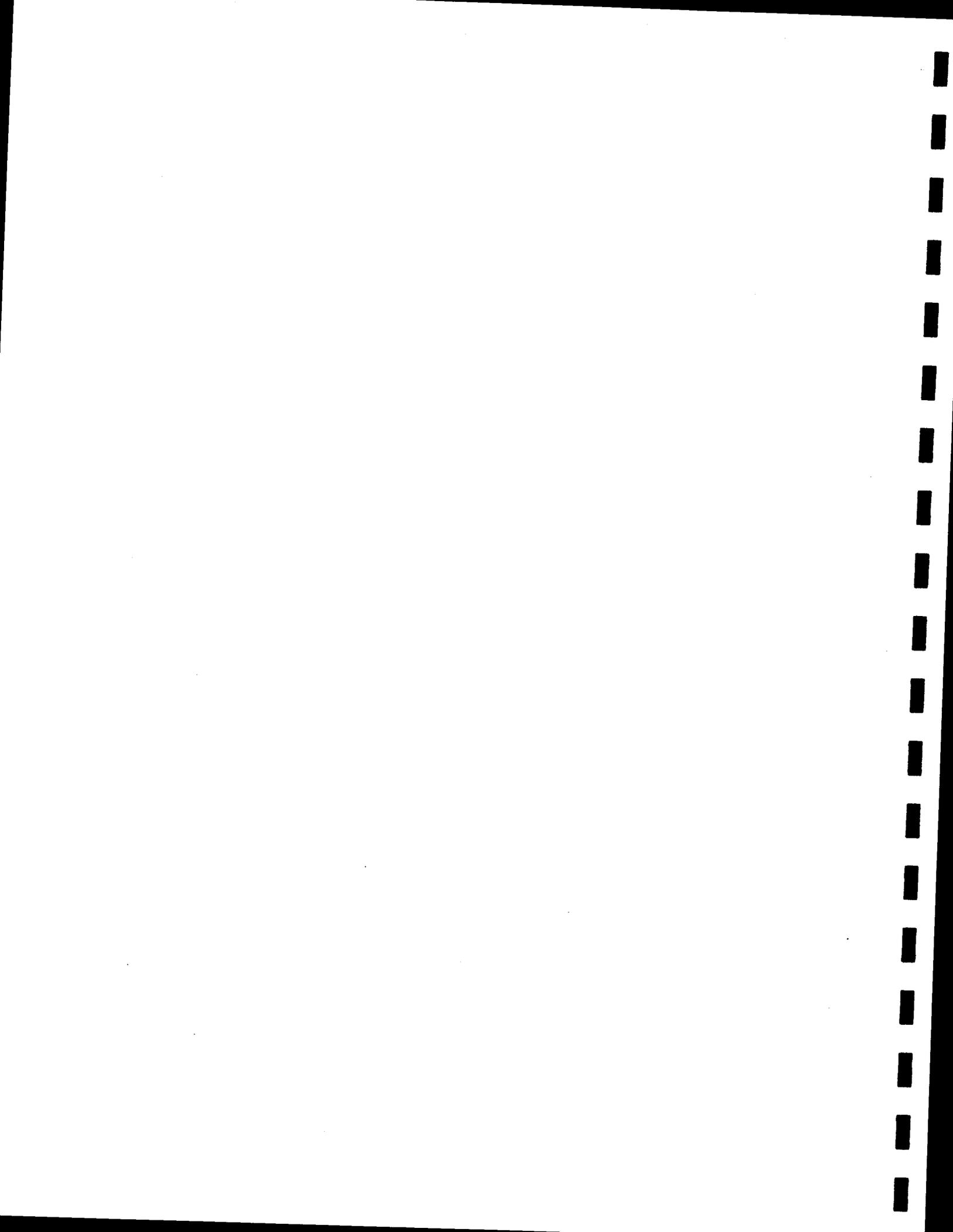
Market fragmentation and purchaser confusion:

- 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 community 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

Kentucky Department of Insurance

APPENDIX A

ASSOCIATION REPORTING

Association Name	Covered Lives
Kentucky Business Group <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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

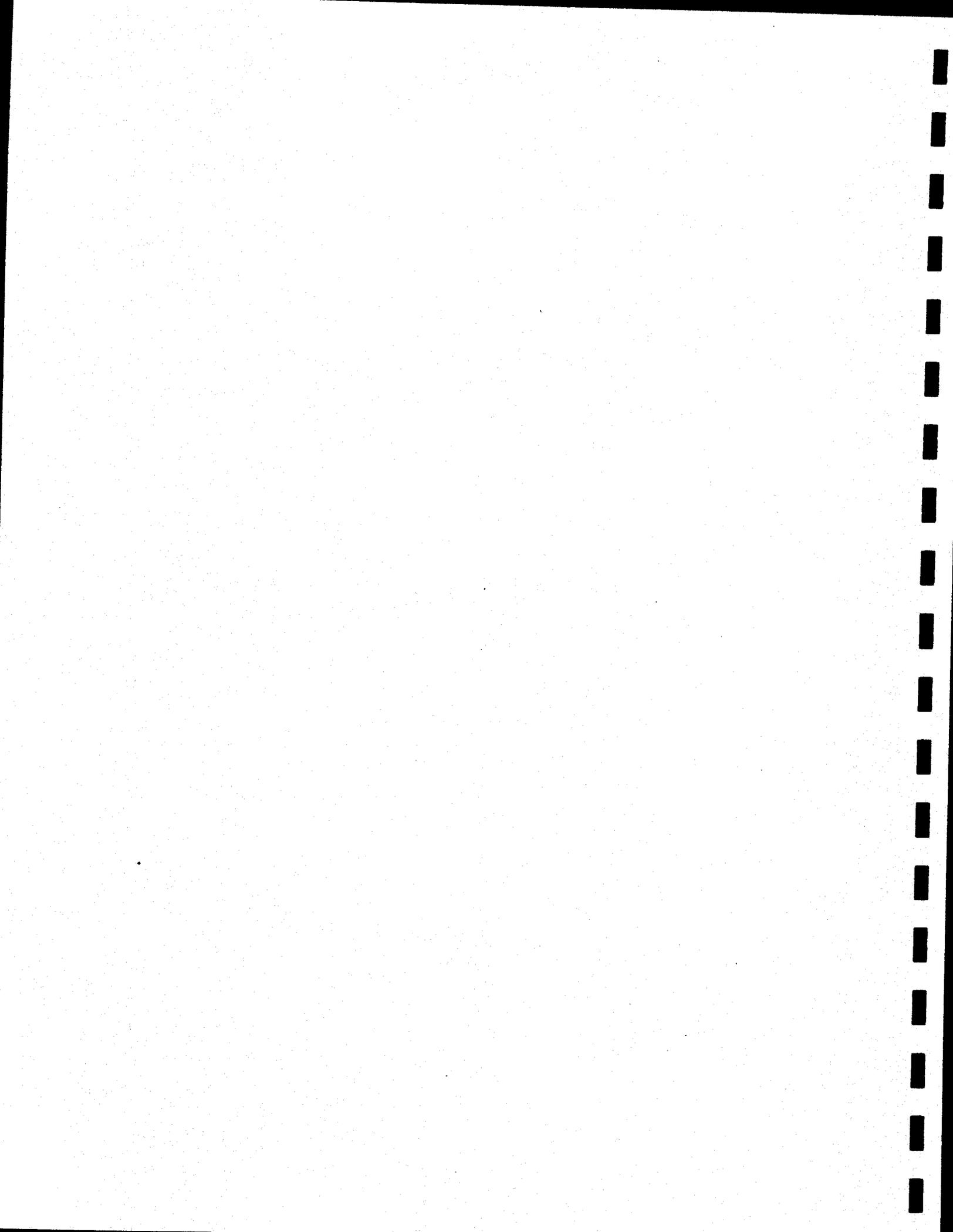
1. Anthem Blue Cross Blue Shield
2. Humana, Inc.
3. Mega Life and Health Insurance Company/Midwest National Life Insurance Company
4. Continental General Insurance Company
5. New York Life Insurance Company
6. John Deere Insurance Company
7. John Hancock Mutual Life Insurance Company
8. ChoiceCare Health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



1996 HEALTH RATE FILINGS
LIFE & HEALTH DIVISION
DEPARTMENT OF INSURANCE

Company Name	Product			1996 Final Composite	1997 Trend
Advantage Care	Group	POS	ALLIANCE	-4.50%	1.40%
Advantage Care	Individual	HMO	ALLIANCE (RENEWAL ONLY)	-4.48%	1.40%
Advantage Care	Group	HMO	NON ALLIANCE	-4.10%	1.40%
Advantage Care	Group	POS	NON ALLIANCE	-4.10%	1.40%
Advantage Care	Individual	HMO	NON ALLIANCE (RENEWAL ONLY)	4.22%	1.40%
Advantage Care	Group	HMO	ALLIANCE	-4.51%	1.40%
Aetna Health Plans of Ohio	Group	Mang Care	LARGE GROUP		
Aetna Life Ins. Co.	Group	PPO	NON ALLIANCE	3.48%	2.48%
Aetna Life Ins. Co.	Group	Indemnity	LARGE GROUP		
Aetna Life Ins. Co.	Group	FFS	NON ALLIANCE	2.85%	2.48%
Alternative Health D.S.	Group	PPO	NON ALLIANCE	-1.00%	2.50%
Alternative Health D.S.	Group	PPO	ALLIANCE	3.32%	2.50%
Alternative Health D.S.	Group	POS	ALLIANCE	-0.51%	2.50%
Alternative Health D.S.	Group	Mang Care	PRE STANDARD	12.75	
Alternative Health D.S.	Group	HMO	NON ALLIANCE	-1.07%	2.50%
Alternative Health D.S.	Group	POS	NON ALLIANCE	-0.62%	2.80%
Alternative Health D.S.	Group	HMO	ALLIANCE	-1.98%	-8.50%
Bluegrass Family Health	Group	POS	ALLIANCE	n/a	2.75%
Bluegrass Family Health	Group	HMO	ALLIANCE	0.78%	2.75%
Bluegrass Family Health	Group	POS	NON ALLIANCE	new	2.75%
Bluegrass Family Health	Group	HMO	NON ALLIANCE	2.80%	2.75%
Bluegrass Family Health	Group	Mang Care	PRE STANDARD	0.50%	2.75%
Bluegrass Family Health	Group	Mang Care	LARGE GROUP	5.60%	2.75%
Bluegrass Family Health	Group	Mang Care	LARGE GROUP	5.60%	new
Bluegrass Family Health	Group	Mang Care	LARGE GROUP	0.50%	2.75%
CHA Health	Group	POS	NON ALLIANCE	-1.38%	2.69%
CHA Health	Group	POS	ALLIANCE	0.96%	2.69%
CHA Health	Group	HMO	ALLIANCE	-3.40%	2.69%
CHA Health	Group	HMO	NON ALLIANCE	-6.02%	2.69%
CHA Health	Group	Mang Care	LARGE GROUP	n/a	
Choice Care	Group	Mang Care	LARGE GROUP	3.89%	2.26%
CUNA Mutual Society	Group	PPO	NON ALLIANCE	-2.81%	2.80%
CUNA Mutual Society	Group	Indemnity	LARGE GROUP		
CUNA Mutual Society	Group	FFS	NON ALLIANCE	-3.02%	2.80%
FHP Health Care	Group	HMO	NON ALLIANCE	3.17%	2.50%
FHP Health Care	Group	HMO	ALLIANCE	3.04%	2.50%
General American Life Ins. Co.	Group	PPO	NON ALLIANCE	3.00%	2.70%
General American Life Ins. Co.	Group	Indemnity	PRE STANDARD	8.0 -13.6%	
General American Life Ins. Co.	Group	FFS	NON ALLIANCE	3.00%	2.70%
Healthsource Kentucky	Group	Mang Care	LARGE GROUP	-0.10%	6.00%
Healthwise of Kentucky	Group	POS	NON ALLIANCE	3.10%	2.70%
Healthwise of Kentucky	Group	POS	ALLIANCE	0.89%	2.70%
Healthwise of Kentucky	Group	HMO	ALLIANCE	1.26%	2.70%
Healthwise of Kentucky	Group	HMO	NON ALLIANCE	3.15%	2.70%
Healthwise of Kentucky	Group	Mang Care	LARGE GROUP	-4.34%	2.70%
Heritage National Health Plan	Group	HMO	NON ALLIANCE	2.99%	
Heritage National Health Plan	Group	Mang Care	LARGE GROUP	3.21%	
Humana Health Plan, Inc.	Group	PPO	ALLIANCE	-2.50%	1.34%
Humana Health Plan, Inc.	Group	HMO	ALLIANCE	3.31%	2.80%
Humana Health Plan, Inc.	Group	POS	ALLIANCE	3.17%	2.80%
Humana Health Plan, Inc.	Group	HMO	ALLIANCE	2.94%	2.77%

1996 HEALTH RATE FILINGS
LIFE & HEALTH DIVISION
DEPARTMENT OF INSURANCE

<u>Company Name</u>	<u>P r o d u c t</u>		1996 Final Composite	1997 Trend
Humana Health Plan, Inc.	Group	HMO NON ALLIANCE	0.80%	2.80%
Humana Health Plan, Inc.	Group	HMO NON ALLIANCE	-6.30%	2.80%
Humana Health Plan, Inc.	Group	PPO NON ALLIANCE	-1.19%	2.80%
Humana Health Plan, Inc.	Group	POS NON ALLIANCE	-6.77%	2.80%
Humana Health Plan, Inc.	Group	Mang Care LARGE GROUP	7.70%	2.70%
Humana Health Plan, Inc.	Group	Mang Care LARGE GROUP	5.00%	n/a
John Deere Ins. Co	Group	Mang Care LARGE GROUP	8.00%	2.70%
John Deere Ins. Co.	Group	Indemnity LARGE GROUP	3.21%	6.00%
John Deere Ins. Co.	Group	FFS NON ALLIANCE	3.00%	2.70%
Mass Mutual Life	Group	PPO NON ALLIANCE	3.00%	2.70%
Mass Mutual Life	Group	FFS NON ALLIANCE	-1.48%	2.73%
MetraHealth Ins. Co.	Group	PPO NON ALLIANCE	-1.83%	2.73%
MetraHealth Ins. Co.	Group	FFS NON ALLIANCE	3.10%	3.25%
New York Life Ins. Co.	Group	PPO NON ALLIANCE	4.57%	3.25%
Owensboro Community Health	Group	Indemnity LARGE GROUP	14.50%	n/a
Prudential Health Care	Group	HMO NON ALLIANCE	n/a	1.50%
Prudential Health Care	Group	HMO NON ALLIANCE	3.16%	1.49%
Prudential Health Care	Group	POS NON ALLIANCE	1.77%	1.49%
Prudential Health Care	Group	HMO ALLIANCE	-3.30%	2.00%
Prudential Health Care	Group	POS ALLIANCE	-3.29%	2.00%
Southeastern United Medigroup, Inc.	Individual	Indemnity PRE STANDARD	7.42%	
Southeastern United Medigroup, Inc.	Group	HMO ALLIANCE	-2.97%	2.50%
Southeastern United Medigroup, Inc.	Group	POS ALLIANCE	-2.47%	1.98%
Southeastern United Medigroup, Inc.	Group	Mang Care PRE STANDARD	11.05-13.46	
Southeastern United Medigroup, Inc.	Group	HMO NON ALLIANCE	-13.28%	2.50%
Southeastern United Medigroup, Inc.	Group	HMO NON ALLIANCE	3.25%	2.50%
Southeastern United Medigroup, Inc.	Group	POS NON ALLIANCE	2.91%	2.50%
Southeastern United Medigroup, Inc.	Group	HMO NON ALLIANCE	2.20%	2.50%
Southeastern United Medigroup, Inc.	Group	HMO ALLIANCE	1.03%	-1.50%
Southeastern United Medigroup, Inc.	Group	POS NON ALLIANCE	3.24%	2.50%
Southeastern United Medigroup, Inc.	Group	POS NON ALLIANCE	-13.19%	2.50%
Southeastern United Medigroup, Inc.	Group	HMO ALLIANCE	-2.40%	1.98%
TriPoint Health Plan, Inc.	Group	Mang Care LARGE GROUP	new	2.50%
TriPoint Health Plan, Inc.	Group	HMO NON ALLIANCE	new	2.50%

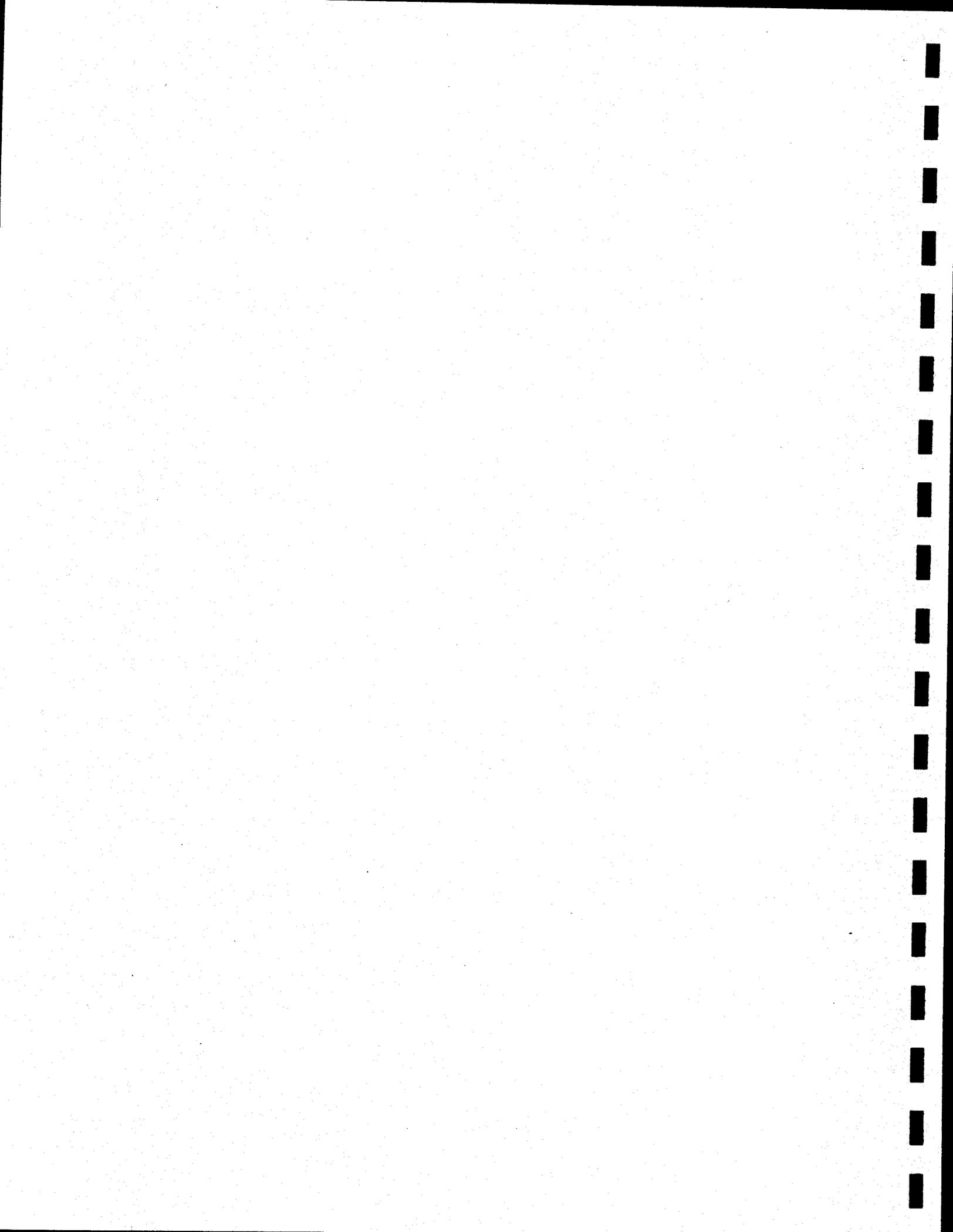
1997 HEALTH RATE FILINGS
LIFE & HEALTH DIVISION
DEPARTMENT OF INSURANCE

Company Name	P r o d u c t				1996	1997
					Final	Trend
					Composite	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%



Kentucky Department of Insurance

APPENDIX C



Recap Claims 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
<u>Domestic Companies:</u>				
<u>Blue Cross - Blue Shield Plans:</u>				
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%
<u>Humana Plans:</u>				
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%
<u>Other Plans:</u>				
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%
<u>Foreign Companies:</u>				
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

Name of HMO	Company-Wide Business	Kentucky-Wide Business	KY-Wide Domestic	KY-Wide All Co's
<u>Domestic Companies:</u>				
<u>Blue Cross - Blue Sheild Plans:</u>				
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%
<u>Humana Plans:</u>				
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%
<u>Other Plans:</u>				
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%
<u>Foreign Companies:</u>				
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	
<u>Domestic Companies:</u>			
<u>Blue Cross - Blue Sheild Plans:</u>			
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%	
<u>Humana Plans:</u>			
HMPK, Inc.	92.30%	92.20%	
HPLAN, Inc.	90.70%	90.69%	
Humana Health Plan	85.48%	81.08%	
Subtotal	85.74%	82.44%	
<u>Other Plans:</u>			
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%	
<u>Foreign Companies:</u>			
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				
Name of HMO	Company-Wide Business	Kentucky-Wide Business	KY-Wide Domestic	KY-Wide All Co's
<u>Domestic Companies:</u>				
<u>Blue Cross - Blue Sheild Plans:</u>				
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%
<u>Humana Plans:</u>				
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%
<u>Other Plans:</u>				
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%
<u>Foreign Companies:</u>				
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

Name of HMO	Company-Wide Business	Kentucky-Wide Business	KY-Wide Domestic	KY-Wide All Co's
<u>Domestic Companies:</u>				
<u>Blue Cross - Blue Sheild Plans:</u>				
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%
<u>Humana Plans:</u>				
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%
<u>Other Plans:</u>				
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%
<u>Foreign Companies:</u>				
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

Name of HMO	Company-Wide Business	Kentucky-Wide Business		
<u>Domestic Companies:</u>				
<u>Blue Cross - Blue Sheild Plans:</u>				
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%		
<u>Humana Plans:</u>				
HMPK, Inc.	89.17%	89.17%		
HPLAN, Inc.	98.11%	98.13%		
Humana Health Plan	83.67%	82.64%		
Subtotal	84.32%	84.60%		
<u>Other Plans:</u>				
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%		
<u>Foreign Companies:</u>				
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				
	Company-Wide	Kentucky-Wide	KY-Wide	KY-Wide
Name of HMO	Business	Business	Domestic	All Co's
<u>Domestic Companies:</u>				
<u>Blue Cross - Blue Sheild Plans:</u>				
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%
<u>Humana Plans:</u>				
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%
<u>Other Plans:</u>				
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%
<u>Foreign Companies:</u>				
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
<u>Domestic Companies:</u>				
<u>Blue Cross - Blue Sheild Plans:</u>				
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%
<u>Humana Plans:</u>				
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%
<u>Other Plans:</u>				
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%
<u>Foreign Companies:</u>				
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	
<u>Domestic Companies:</u>			
<u>Blue Cross - Blue Sheild Plans:</u>			
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%	
<u>Humana Plans:</u>			
HMPK, Inc.	76.93%	76.93%	
HPLAN, Inc.	97.72%	97.27%	
Humana Health Plan	82.08%	78.02%	
Subtotal	82.30%	79.22%	
<u>Other Plans:</u>			
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%	
<u>Foreign Companies:</u>			
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
<u>Domestic Companies:</u>				
<u>Blue Cross - Blue Shield Plans:</u>				
Alternative Health Delivery System	88,977,738	76,197,140		
Blue Cross & Blue Shield 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%
<u>Humana Plans:</u>				
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%
<u>Other Plans:</u>				
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%
<u>Foreign Companies:</u>				
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%