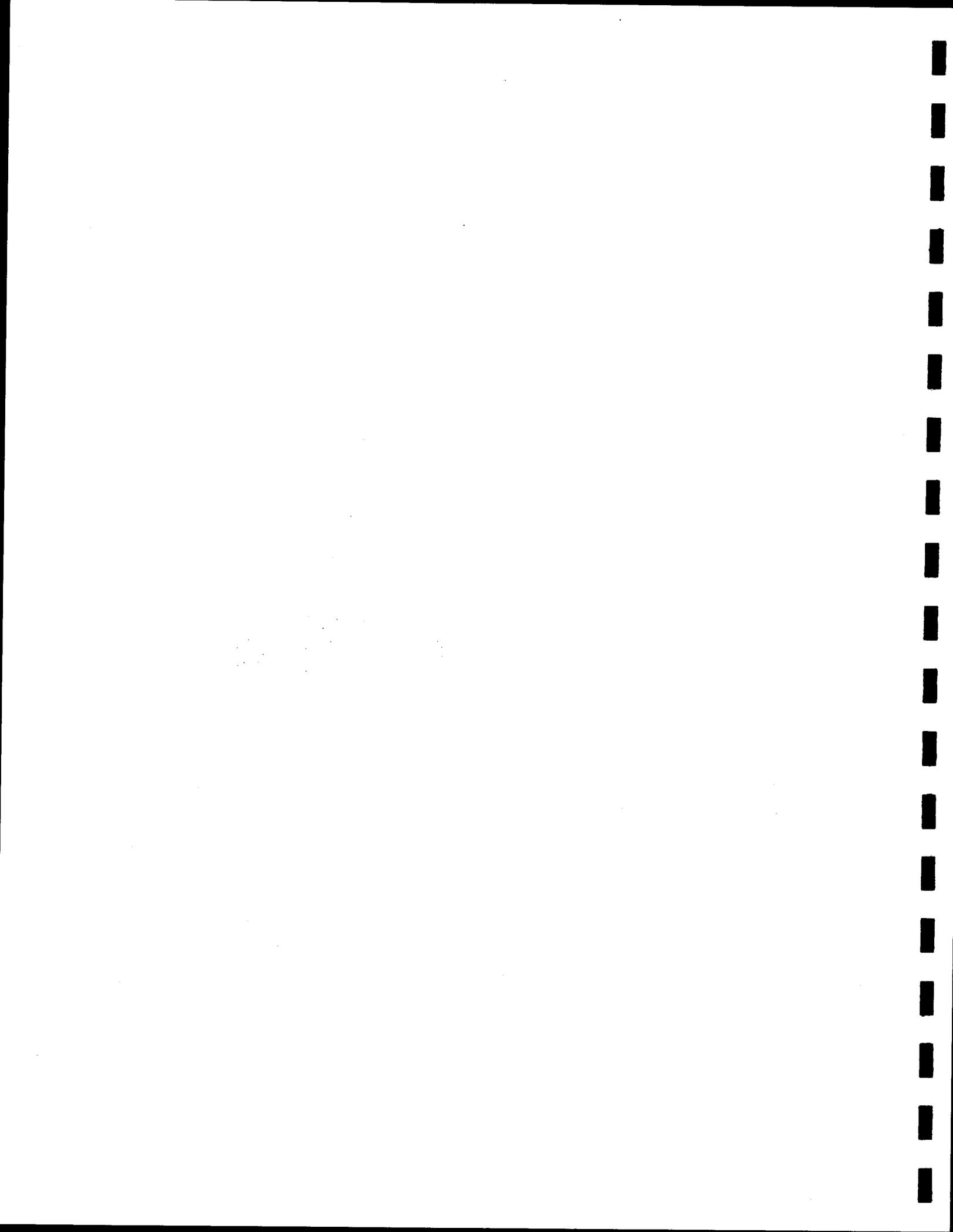


Recap Premium Income for Licensed HMO's  
For the Year 1993

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

Recap Claims Loss Ratios for Licensed HMO's  
For the Year 1993

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



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

Recap Premium Income for Licensed HMO's  
For the Year 1992

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

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



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

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

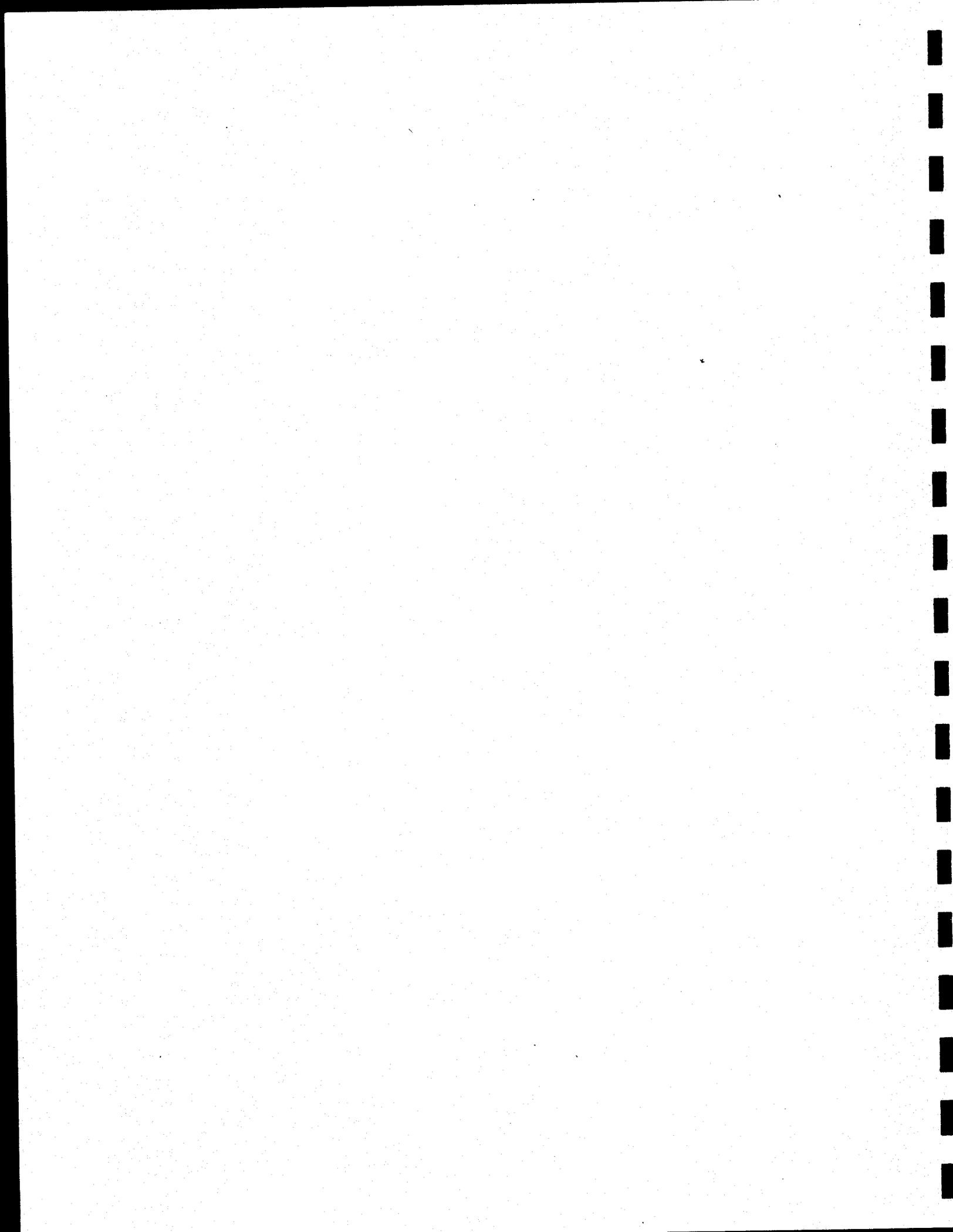
Recap Claims Loss Ratios for Licensed HMO's			
For the Year 1991			
Name of HMO	Company-Wide Business	Kentucky-Wide Business	
<u>Domestic Companies:</u>			
<u>Blue Cross - Blue Sheild Plans:</u>			
Alternative Health Delivery System	84.49%	85.29%	
Southeastern United Medigroup	83.51%	83.48%	
Subtotal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



*Kentucky Department of Insurance*

# APPENDIX D

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

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

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

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

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

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

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

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

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

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

**Companies Selling Individual Health Coverage Prior to HB 250**

**Claims Loss Ratios 1991 to 1996**

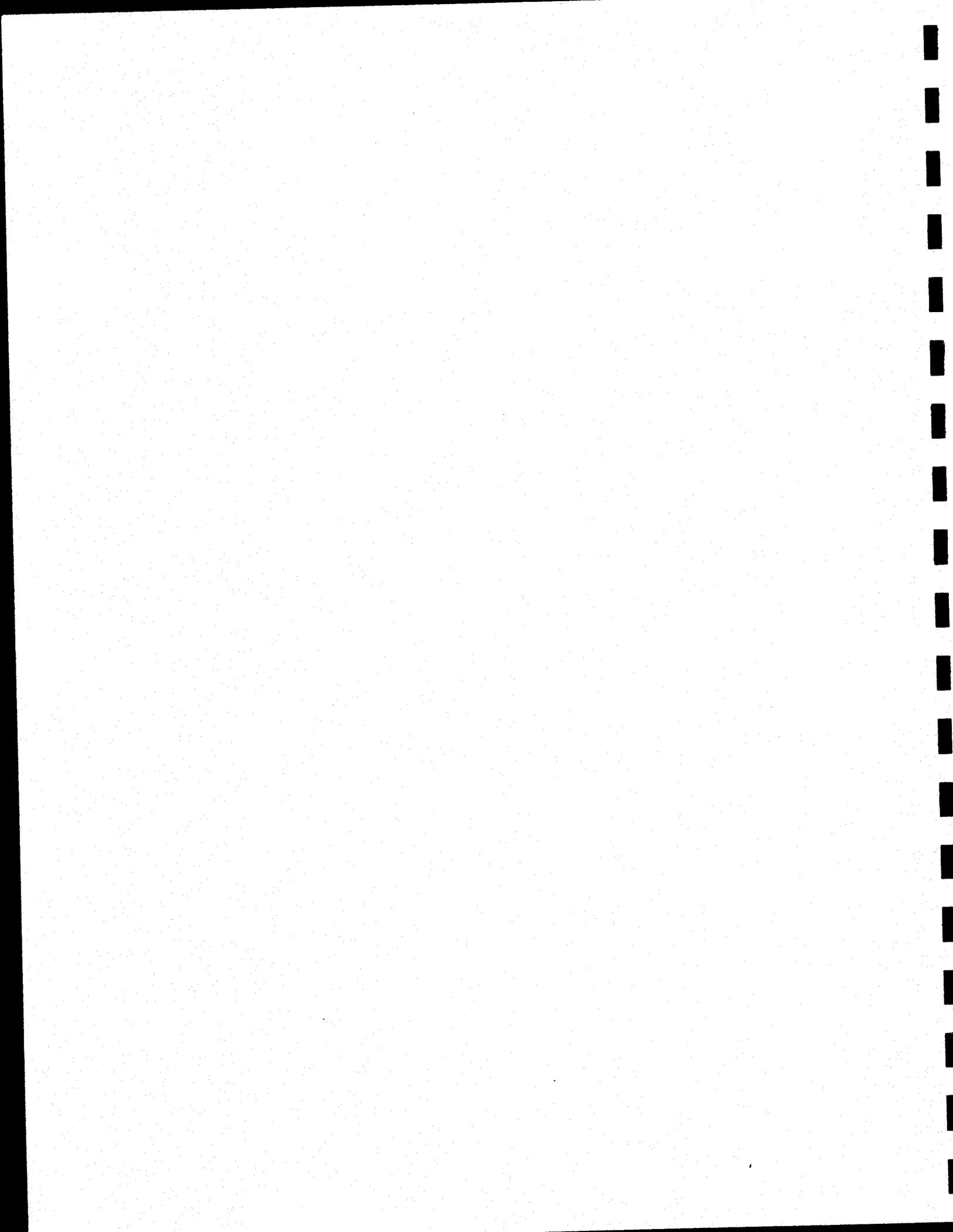
Company	1996	1995	1994	1993	1992	1991
Metropolitan Life Ins Co	62.71%	94.19%	84.59%	93.49%	75.90%	85.28%
Mid-West National Life Ins Co of TN	8.89%	8.89%	93.40%	18.08%	123.18%	149.94%
Mutual of Omaha Ins Co	80.54%	65.64%	65.00%	65.29%	59.35%	61.64%
New York Life Ins Co	77.29%	86.12%	80.11%	81.80%	85.57%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

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

*Kentucky Department of Insurance*

# APPENDIX E

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**INDEMNITY PLANS**

Effective January 1, 1997

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

\*\* THE BUDGET LOW AND HIGH PLANS DO NOT PROVIDE COVERAGE FOR ALLERGY TESTING.  
 \*\* PPO PLANS OUT-OF-NETWORK COVERAGE IS LIMITED TO USUAL, CUSTOMARY AND REASONABLE CHARGES.  
 PPO PLANS OUT-OF-NETWORK COVERAGE IS NOT AVAILABLE FOR INFILTRITY SERVICES AND PREVENTIVE CARE.  
 PPO PLANS OUT-OF-NETWORK COVERAGE FOR TRANSPLANTS, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES IS SUBJECT TO CERTIFICATION.

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

INDEMNITY PLANS

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

\* PPO PLANS OUT-OF-NETWORK COVERAGE FOR TRANSPLANT SERVICES IS SUBJECT TO CERTIFICATION.

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

\*\*\* PPO PLANS OUT-OF-NETWORK COVERAGE FOR INFERTILITY SERVICES IS NOT AVAILABLE.

\*\*\*\* FOR PPO PLANS IN-NETWORK COVERAGE, THE INITIAL OFFICE VISIT IN WHICH PREGNANCY IS DIAGNOSED IS SUBJECT TO THE PROVIDER OFFICE VISIT CO-PAYMENT. NO ADDITIONAL CO-PAYMENTS WILL BE APPLIED TO PRENATAL VISITS. ALL OTHER IN-NETWORK MATERNITY EXPENSES ARE SUBJECT TO THE DEDUCTIBLE AND COINSURANCE EXCEPT AS NOTED BELOW.

\*\*\*\*\* FOR PPO PLANS IN-NETWORK COVERAGE, NO DEDUCTIBLE APPLIES TO THE HOSPITAL ADMISSION (STANDARD HIGH PLAN ONLY).

INDEMNITY PLANS

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

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

**INDEMNITY PLANS**

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

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

INDEMNITY PLANS

BENEFIT	BUDGET		ECONOMY		STANDARD		ENHANCED	
	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH
OTHER SERVICES Prescription Drugs	Not Covered	Not Covered	40% Coinsurance 1 Month Supply Deductible Applies	30% Coinsurance 1 Month Supply Deductible Applies	20% Coinsurance 1 Month Supply Deductible Applies	20% Coinsurance 1 Month Supply Deductible Applies	15% Coinsurance 1 Month Supply Deductible Applies	10% Coinsurance 1 Month Supply Deductible Applies
Contraceptives (PPO Coverage In-Network Only)	Not Covered	Not Covered	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs			
Dental	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Vision	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	10% Coinsurance for annual exam every year to age 18 and every other year after age 18
Physical/Occupational/Cardiac Rehabilitation Therapy	Not Covered	Not Covered	40% Coinsurance 13 Weeks Plan Yr. Limit Deductible Applies	30% Coinsurance 13 Weeks Plan Yr. Limit Deductible Applies	20% Coinsurance 28 Weeks Plan Yr. Limit Deductible Applies	20% Coinsurance 28 Weeks Plan Yr. Limit Deductible Applies	15% Coinsurance 28 Weeks Plan Yr. Limit Deductible Applies	10% Coinsurance 28 Weeks Plan Yr. Limit Deductible Applies
Speech Therapy	Not Covered	Not Covered	48% Coinsurance 13 Weeks Plan Yr. Limit Deductible Applies	30% Coinsurance 13 Weeks Plan Yr. Limit Deductible Applies	20% Coinsurance 28 Weeks Plan Yr. Limit Deductible Applies	20% Coinsurance 28 Weeks Plan Yr. Limit Deductible Applies	15% Coinsurance 28 Weeks Plan Yr. Limit Deductible Applies	10% Coinsurance 28 Weeks Plan Yr. Limit Deductible Applies
Horne Health	Not Covered	Covered in Full When Substituted for Hospitalization - 10 Visits Per Plan Yr. Limit Deductible Applies	Covered in Full When Substituted for Hospitalization - 20 Visits Per Plan Yr. Limit Deductible Applies	Covered in Full When Substituted for Hospitalization - 20 Visits Per Plan Yr. Limit Deductible Applies	Covered in Full When Substituted for Hospitalization - 40 Visits Per Plan Yr. Limit Deductible Applies	Covered in Full When Substituted for Hospitalization - 100 Visits Per Plan Yr. Limit Deductible Applies	Covered in Full When Substituted for Hospitalization - 100 Visits Per Plan Yr. Limit Deductible Applies	Covered in Full When Substituted for Hospitalization - 100 Visits Per Plan Yr. Limit Deductible Applies
Skilled Nursing Facilities	Not Covered	Not Covered	40% Coinsurance - 14 Days Per Plan Yr. Limit Deductible Applies	30% Coinsurance - 14 Days Per Plan Yr. Limit Deductible Applies	20% Coinsurance - 14 Days Per Plan Yr. Limit Deductible Applies	20% Coinsurance - 28 Days Per Plan Yr. Limit Deductible Applies	15% Coinsurance - 40 Days Per Plan Yr. Limit Deductible Applies	10% Coinsurance - 60 Days Per Plan Yr. Limit Deductible Applies
DME and Prosthetic Devices	Not Covered	Not Covered	40% Coinsurance Deductible Applies	30% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	20% Coinsurance Deductible Applies	15% Coinsurance Deductible Applies	10% Coinsurance Deductible Applies
Hospice	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies	Medicare Hospice Benefit Deductible Applies

**MANAGED CARE PLANS**

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

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

MANAGED CARE PLANS

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

\* POS PLANS OUT-OF-NETWORK TRANSPLANT COVERAGE IS SUBJECT TO CERTIFICATION.

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

\*\*\* FOR HMO AND POS PLANS IN-NETWORK COVERAGE, THE INITIAL OFFICE VISIT IN WHICH PREGNANCY IS DIAGNOSED IS SUBJECT TO THE PROVIDER OFFICE VISIT COPAYMENT. NO ADDITIONAL COPAYMENTS WILL BE APPLIED TO PRENATAL CARE VISITS.

MANAGED CARE PLANS

BENEFIT	BUDGET		ECONOMY		STANDARD		ENHANCED	
	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH
EMERGENCY SERVICES Hospital Emergency Room (Coinsurance Waived if Admitted)	\$160 Copay Per Visit	\$125 Copay Per Visit	\$100 Copay Per Visit	\$75 Copay Per Visit	\$50 Copay Per Visit	\$50 Copay Per Visit	\$50 Copay Per Visit	\$25 Copay Per Visit
	\$75 Copay Per Use	\$75 Copay Per Use	\$75 Copay Per Use	\$75 Copay Per Use	\$50 Copay Per Use	\$50 Copay Per Use	\$25 Copay Per Use	\$25 Copay Per Use
PREVENTIVE SERVICES Ambulance (Ground Only)	Not Covered	See Office Visit Copay						
	Not Covered	See Office Visit Copay						
Well Child Care (Ages 0 through 18) *	Screening Mammogram Coverage Only - \$50 Plus Mammogram Limit (No Copay)	Age and Periodicity Limits May Apply						
	Age and Periodicity Limits May Apply	Age and Periodicity Limits May Apply	Age and Periodicity Limits May Apply	Age and Periodicity Limits May Apply	Age and Periodicity Limits May Apply	Age and Periodicity Limits May Apply	Age and Periodicity Limits May Apply	Age and Periodicity Limits May Apply
Well Adult Care *	Periodic Routine Physical Examination and Annual Gynecological Examination	See Office Visit Copay						
	Early Detection Mammogram, Pap Test, Cardiac Risk, PSA, Sigmoidoscopy, Glucose Serum, EKG	Age and Periodicity Limits May Apply						

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

MANAGED CARE PLANS

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

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

MANAGED CARE PLANS

BENEFIT	BUDGET		ECONOMY		STANDARD		ENHANCED		
	LOW	HIGH	LOW	HIGH	LOW	HIGH	LOW	HIGH	
OTHER SERVICES	Not Covered	Not Covered	\$15 Copay (1 Month Supply Unless Mail Order is Available)	\$12 Copay (1 Month Supply Unless Mail Order is Available)	\$10 Copay (1 Month Supply Unless Mail Order is Available)	\$10 Copay (1 Month Supply Unless Mail Order is Available)	\$7 Copay (1 Month Supply Unless Mail Order is Available)	\$5 Copay (1 Month Supply Unless Mail Order is Available)	
			Covered Same as Prescription Drugs	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs	Covered Same as Prescription Drugs			
			Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
			Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Contraceptives (POS Coverage In-Network Only)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	
									Not Covered
Dental	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	
									Vision
Physical/Occupational/Cardiac Rehabilitation Therapy	Not Covered	Not Covered	\$30 Copay Per Visit 10 Visit Limit Per Plan Year	\$30 Copay Per Visit 10 Visit Limit Per Plan Year	\$30 Copay Per Visit 20 Visit Limit Per Plan Year	\$20 Copay Per Visit 20 Visit Limit Per Plan Year	\$10 Copay Per Visit 30 Visit Limit Per Plan Year	\$10 Copay Per Visit 30 Visit Limit Per Plan Year	
			Speech Therapy	Not Covered	Not Covered	\$30 Copay Per Visit 10 Visit Limit Per Plan Year	\$30 Copay Per Visit 10 Visit Limit Per Plan Year	\$30 Copay Per Visit 20 Visit Limit Per Plan Year	\$20 Copay Per Visit 20 Visit Limit Per Plan Year
Home Health	Not Covered	Not Covered				Covered In Full When Substituted for Hospitalization - Up To 20 Visits Per Plan Year	Covered In Full When Substituted for Hospitalization - Up To 20 Visits Per Plan Year	Covered In Full When Substituted for Hospitalization - Up To 40 Visits Per Plan Year	Covered In Full When Substituted for Hospitalization - Up To 40 Visits Per Plan Year
			Skilled Nursing Facility	Not Covered	Not Covered	\$700 Copay Per Admission 20 Day Limit Per Plan Year	\$350 Copay Per Admission 20 Day Limit Per Plan Year	\$300 Copay Per Admission 20 Day Limit Per Plan Year	\$150 Copay Per Admission 30 Day Limit Per Plan Year
DME and Prosthetic Devices Hospice	Not Covered	Not Covered				40% Coinsurance	40% Coinsurance	30% Coinsurance	20% Coinsurance
			Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit	Medicare Hospice Benefit

**MEDICAL SAVINGS ACCOUNT (MSA) PLAN**

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

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

<sup>2</sup> The allowable range for a federal MSA is \$1,500 - \$2,250.

<sup>3</sup> The allowable range for a federal MSA is \$3,000 - \$4,500.

<sup>4</sup> This amount is prescribed by the Kennedy-Kassebaum Bill.

<sup>5</sup> This amount is prescribed by the Kennedy-Kassebaum Bill.

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

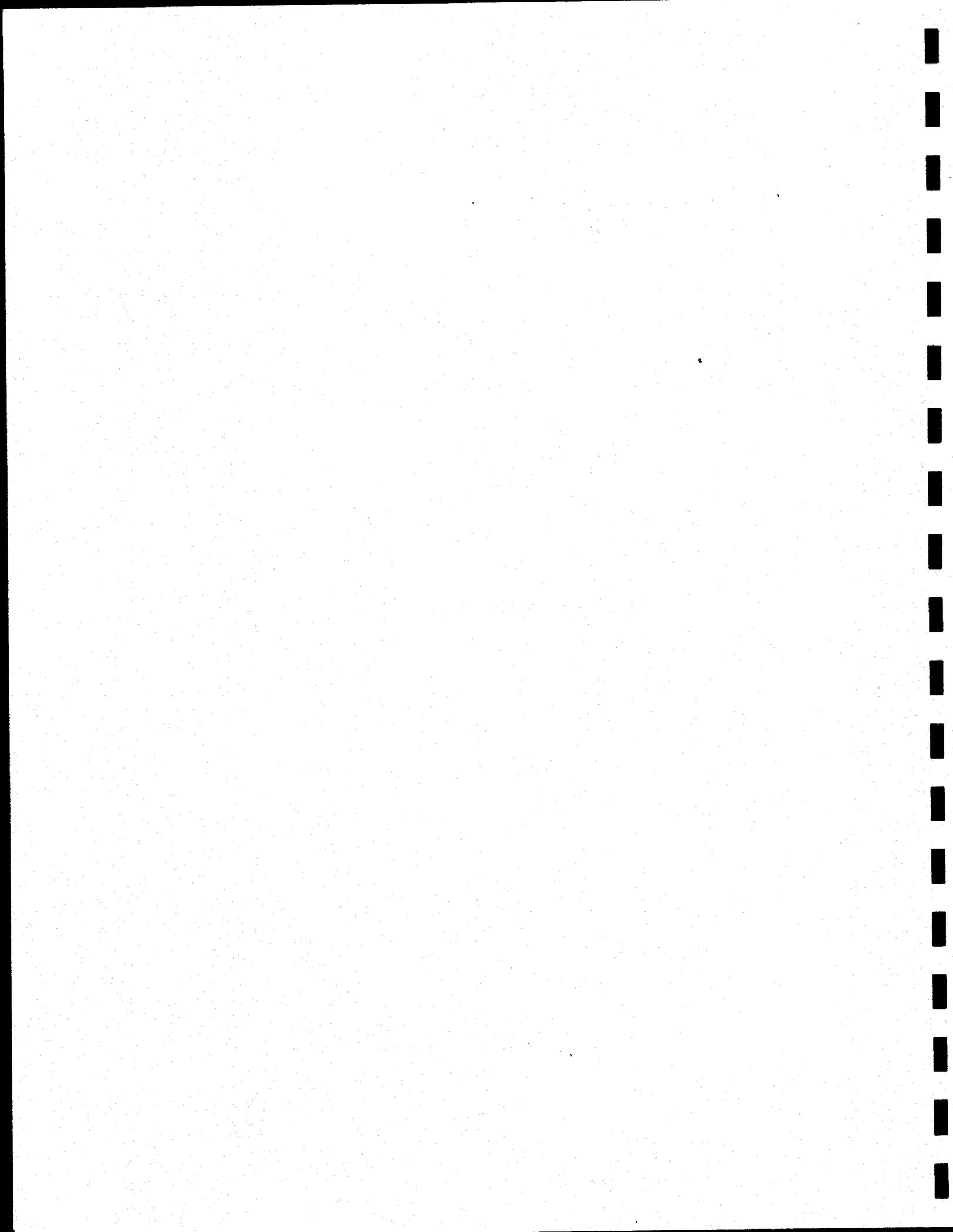
MENTAL HEALTH			
Inpatient	20% coinsurance  Maximum 5 days/ plan year  1 admission/ plan year  Day treatment or Intensive outpatient can be substituted for inpatient days on a 2 for 1 basis	20% coinsurance  Maximum 5 days/ plan year  1 admission/ plan year  Day treatment or Intensive outpatient can be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



*Kentucky Department of Insurance*

# APPENDIX F

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

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KASSEBAUM-KENNEDY	REQUIREMENT
<p>Title I - Health Care Access, Portability, and Renewability            Subtitle A - Group Market Rules            Part I - Portability, Access and Renewability            Section 101, ERISA</p>	<p style="text-align: center;"><u>ALL REFERENCES APPLICABLE TO ERISA ONLY</u></p> <p>Amends ERISA by adding a new Part 7, Group Plan Portability, Access and Renewability requirements.</p>
<p>Section 701 - Increased Portability Through Limitation on Preexisting Condition Exclusions</p>	<p>Requires employer group plans to comply with the following provisions as applicable to insurers and discussed in detail in the Group Market Reform Section 2701:</p> <ul style="list-style-type: none"> <li>• Preexisting conditions;</li> <li>• Recognition and calculation of prior creditable coverage;</li> <li>• Certification of prior creditable coverage;</li> <li>• Special enrollment periods; and</li> <li>• HMO affiliation periods to the extent that employers are enabled to purchase such plans.</li> </ul>
<p>Section 702 - Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status</p>	<p>Requires employer group plans to comply with the following provisions as applicable to insurers and discussed in detail in the Group Market Reform Section 2702:</p> <ul style="list-style-type: none"> <li>• Health factors may not be considered as a basis for eligibility or continued eligibility; and</li> <li>• Higher premiums may not be charged to similarly situated individuals based on health status.</li> </ul>
<p>Section 703 - Guaranteed Renewability in Multiemployer Plans and MEWAS</p>	<p>Requires multiemployer plans and MEWAS to guarantee to renew under the same provisions as Group Market Reform Section 2712, (except association membership) and adds:</p> <ul style="list-style-type: none"> <li>• additional language regarding service areas; and</li> <li>• a nonrenewal provision regarding failure to comply or renew collective bargaining agreements and related agreements.</li> </ul>
<p>Section 704 - Preemption, State Flexibility, Construction</p>	<p>Applies the requirements of Group Market Reforms Section 2723, to multiemployers plans and MEWAS.</p>
<p>Section 705 - Special Rules Relating to Group Health Plans</p>	<p>Omits references in Group Market Reforms Section 2721, to governmental and nongovernmental plans and otherwise applies Section 2721 provisions to multiemployer plans and MEWAS.</p>
<p>Section 706 - Definitions</p>	<p>Omits definition of Individual Health Insurance and provides ERISA related definitions not discussed in Group Market Reforms Section 2791.</p>
<p>Section 707 - Regulations</p>	<ul style="list-style-type: none"> <li>• Provides for the Secretary to promulgate regulations and otherwise enforce provisions specific to ERISA; imposes reporting requirements, imposes penalties, and enables coordination of implementation.</li> </ul>

KASSEBAUM-KENNEDY	REQUIREMENT
<p>Title XXVII Assuring Portability, Availability and Renewability of Health Insurance Coverage  Part A - Group Market Reforms  Subpart 1 - Portability, Access and Renewability Requirements  Section 2701 - Increased Portability Through Limitation of Preexisting Condition Requirements  (Rules Apply to Small and Large Group)</p>	<p style="text-align: center;"><u>ALL REFERENCES APPLICABLE TO GROUP MARKET ONLY</u></p> <p><u>PREEXISTING CONDITION PROVISIONS</u></p> <ul style="list-style-type: none"> <li>• Groups may impose a preexisting exclusion only if such exclusion relates to “a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date.”</li> <li>• The preexisting exclusion is not more than 12 months or 18 months for late entrants.</li> <li>• Preexisting is reduced by aggregate period of creditable coverage as later defined, applicable as of the enrollment date.</li> <li>• The term preexisting condition exclusion means, with respect to coverage, “a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.”</li> <li>• Genetic information not be to considered without a diagnosis.</li> <li>• A newborn child, or a child under 18 adopted or placed for adoption may not be imposed a preexisting waiting period if covered under creditable coverage as of the last day of the 30 day period beginning with the date of birth, adoption or placement.</li> <li>• Pregnancy is not a preexisting condition.</li> </ul> <p><u>AFFILIATION PERIODS IN LIEU OF PREEXISTING CONDITIONS (HMOS ONLY)</u></p> <ul style="list-style-type: none"> <li>• A HMO that imposes no preexisting condition can impose an affiliation period which is defined as “a period which, under the terms of the health insurance coverage offered by the HMO, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.”</li> <li>• Affiliation period may be imposed only if: (a) the period is applied uniformly without regard to any health status related factors and (b) the period does not exceed 2 months (3 months for late entrants).</li> <li>• The affiliation period begins on the enrollment date and run concurrently with any waiting periods.</li> <li>• Other alternatives can be approved by the Commissioner</li> </ul>

DEFINITIONS APPLICABLE TO THESE AREAS

Enrollment Date: (With respect to an individual) "The date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment."

Late Enrollee: "A participant or beneficiary who enrolls under the plan other than during (a) the first period in which the individual is eligible to enroll under the plan, or (b) a special enrollment period..."

Waiting Period: "The period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan."

Creditable Coverage: "Coverage of the individual under any of the following: (a) a group health plan; (b) health insurance coverage (per definition does not include short-term/HIAA report says should be considered per conferees); (c) Part A or B of title XVII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) Chapter 55 of title 10, USC; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state risk pool; (h) a health plan offered under chapter 89 of title 5, USC; (i) a public health plan (as defined in regulations); and (j) a health benefit plan under section 5(e) of the Peace Corps Act.

Creditable coverage does not include "excepted benefits" under one or more (or any combination of):

- Benefits not subject to requirements:
  - (a) Accident only or disability income or combination thereof.
  - (b) Supplements to liability insurance.
  - (c) Liability, including general and automobile liability.
  - (d) Workers compensation or similar insurance.
  - (e) Automobile medical payment insurance.
  - (f) Credit-only insurance.
  - (g) Coverage for on-site medical clinics.
  - (h) Other similar insurance, *specified in regulations*, under which benefits for medical care are secondary or incidental.
- Benefits not subject to requirements if offered separately:
  - (a) Limited scope dental or vision benefits.
  - (b) Benefits for long term care, nursing home care, home health care, community based care, or any combination thereof
  - (c) Such other similar, limited benefits as are *specified in regulations*.
- Benefits not subject to requirements if offered as independent, noncoordinated benefits:
  - (d) Coverage only for a specified disease or illness
  - (e) Hospital indemnity or other fixed indemnity insurance
- Benefits not subject if offered as a separate insurance policy:
  - (f) Medicare supplement and similar coverage provided under a group health plan.

KASSEBAUM-KENNEDY	REQUIREMENT
	<p data-bbox="532 174 1170 205"><u>COUNTING PERIODS OF CREDITABLE COVERAGE</u></p> <ul data-bbox="532 237 1528 422" style="list-style-type: none"> <li data-bbox="532 237 1528 327">• A period of creditable coverage will not be counted if after the period of coverage, and before the enrollment date, there was a 63 day period during which the individual was not covered under any creditable coverage.</li> <li data-bbox="532 359 1528 422">• Waiting periods or affiliation periods (HMO) are not taken into account in determining continuous coverage.</li> </ul> <p data-bbox="532 453 1442 485"><u>TWO METHODS FOR COUNTING PERIODS OF CREDITABLE COVERAGE</u></p> <p data-bbox="532 516 1490 579">Standard Method: Count a period of creditable coverage without regard to specific benefits covered during the period.</p> <p data-bbox="532 611 1523 695">Alternative Method: Plan or issuer can elect to apply aggregate period of creditable coverage to coverage of benefits <i>specified in regulations</i> rather than without regard to specific benefits.</p> <ul data-bbox="621 726 1528 999" style="list-style-type: none"> <li data-bbox="621 726 1528 758">• Must be uniform for all participants.</li> <li data-bbox="621 789 1528 884">• Under such an election, the health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.</li> <li data-bbox="621 915 1528 999">• Must disclose to the beneficiary and plan sponsor the election of the alternative method at the time of enrollment and describe the effect of the alternative method.</li> </ul> <p data-bbox="521 1041 1393 1104"><u>REQUIREMENTS FOR CERTIFICATION OF PERIODS OF CREDITABLE COVERAGE</u></p> <ul data-bbox="521 1136 1539 1839" style="list-style-type: none"> <li data-bbox="521 1136 1539 1199">• Periods of creditable coverage through certifications or in other manners as may be <i>prescribed by regulations</i>.</li> <li data-bbox="521 1230 1539 1409">• The period of coverage and COBRA (if applicable) and the waiting/affiliation periods (if applicable) are to be certified by the plan or issuer: <ul data-bbox="662 1283 1458 1409" style="list-style-type: none"> <li data-bbox="662 1283 1458 1314">(a) when plan coverage ceases and COBRA is available;</li> <li data-bbox="662 1314 1458 1346">(b) when COBRA ceases; and</li> <li data-bbox="662 1346 1458 1409">(c) on request made not later than 24 months after the end of these coverages, whichever is later.</li> </ul> </li> <li data-bbox="521 1440 1539 1503">• Notices can be consistent with the time frames of COBRA notices to the extent practical.</li> <li data-bbox="521 1535 1539 1661">• The certifications should include: <ul data-bbox="613 1566 1511 1661" style="list-style-type: none"> <li data-bbox="613 1566 1511 1598">(a) the period of coverage under the plan and COBRA (if applicable);</li> <li data-bbox="613 1598 1511 1661">(b) the waiting period (if any) and the affiliation period (if applicable) imposed on the individual;</li> </ul> </li> <li data-bbox="521 1692 1539 1839">• An issuer which elects to implement the Alternative Method of crediting coverage (discussed above) can request, from the entity issuing the certification, information on the coverage of classes and categories of health benefits under the prior plan. This information should be disclosed promptly. The requesting plan can be charged reasonable costs for disclosing the information.</li> </ul>

**KASSEBAUM-KENNEDY****REQUIREMENT**

**Section 2702 - Prohibiting  
Discrimination Against  
Individual Participants and  
Beneficiaries Based on  
Health Status  
(Rules Apply to Small and  
Large Group)**

SPECIAL ENROLLMENT PERIODS

- Individuals who lose other coverage (eligible employees or eligible dependents) may enroll in a plan at a later date if:
  - (a) They were covered under a group health plan or had other health insurance coverage at the time the plan was offered;
  - (b) They stated in writing (if written statement required and the consequences of rejection were disclosed) that other coverage was the reason for declining;
  - (c) The other coverage was COBRA which is exhausted or not COBRA and loss of coverage resulted from separation, divorce, death, termination of employment, reduction in hours or termination of employer contribution; and
  - (d) The request is made not later than 30 days after the date of exhaustion of previous coverage.
- A special enrollment for dependent beneficiaries exists if the plan provides dependent coverage:
  - (a) An eligible employee and/or spouse may enroll upon acquiring a new dependent through marriage, birth, adoption or placement for adoption.
  - (b) The special period is not less than 30 days from the later of (1) the date coverage is made available or (2) the date of marriage, birth, adoption or placement for adoption.
  - (c) The effective dates are (1) marriage - 1<sup>st</sup> day of the 1<sup>st</sup> month after receipt of the request for enrollment and (2) the date of birth, adoption or placement for adoption.
- Special enrollees are exempt from the definition of late enrollee.

ELIGIBILITY TO ENROLL

- A group health plan or insurance issuer may not establish rules for eligibility or continued eligibility of an individual or dependent based on the following health factors:
  - (a) Health status;
  - (b) Medical condition (physical and/or mental);
  - (c) Claims experience;
  - (d) Receipt of health care;
  - (e) Medical history;
  - (f) Genetic information;
  - (g) Evidence of insurability (including domestic violence);
  - (h) Disability.
- To the extent consistent with preexisting rules, this does not require the inclusion of special benefits or prevent establishing limits or restrictions on benefits or coverage for similarly situated individuals.

PREMIUM CONTRIBUTIONS

- A higher premium or contribution may not be charged to similarly situated individuals based on health status.
- This is not intended to restrict the amount charged by a health plan or to prohibit discounts or rebates or other modifications, copayments or deductibles in relation to healthy lifestyles.

KASSEBAUM-KENNEDY	REQUIREMENT
<p>PART A - Subpart 2  Section 2711 - Guaranteed Availability of Coverage for Employers in the Group Market  (Technical Rules Apply to Small Group Only)</p>	<p><u>PROVISIONS APPLICABLE ONLY TO HEALTH INSURANCE ISSUERS</u></p> <p><u>SMALL GROUP MARKET</u></p> <ul style="list-style-type: none"> <li>• Subject to network rules, application of financial capacity limits, failure to meet participation or contribution rules or association exceptions, issuers in the small group market must: <ul style="list-style-type: none"> <li>(a) accept every small employer (as later defined) in the state that applies;</li> <li>(b) accept every eligible individual who applies during the period in which the individual first becomes eligible without imposing any restrictions inconsistent with Section 2702; except</li> <li>(c) as provided in Section 2711(f), this does not apply to an issuer who offers small group coverage only through one or more bona fide associations.</li> </ul> </li> <li>• An eligible individual in relation to a small employer is determined: <ul style="list-style-type: none"> <li>(a) in accordance with the terms of such plan;</li> <li>(b) as provided by the issuer under its rules which are applied uniformly to small employers in the state; and</li> <li>(c) in accordance with state laws.</li> </ul> </li> </ul> <p><u>LARGE GROUP MARKET</u></p> <ul style="list-style-type: none"> <li>• The Governor shall submit to the Secretary of HHS by 12/31/2000 and every 3 years thereafter a report on the availability of coverage for large employers.</li> <li>• The Secretary of HHS will report to Congress.</li> <li>• The GAO will study and report to Congress not later than 18 months from the effective date of this Act.</li> </ul> <p><u>NETWORK RULES/FINANCIAL CAPACITY RULES</u></p> <ul style="list-style-type: none"> <li>• In the small group market, an issuer may: <ul style="list-style-type: none"> <li>(a) limit employers to those with individuals who live, work or reside in the service area;</li> <li>(b) deny coverage if the issuer does not have the capacity to deliver services to new groups and this is applied uniformly to all new applicants and is not based on medical experience;</li> <li>(c) which must be demonstrated to the appropriate state authority; and</li> <li>(d) if coverage is denied due to network capacity, the issuer may not offer coverage in the small group market in that service area for 180 days.</li> <li>(e) deny coverage based on financial capacity if applied uniformly and demonstrated, if required, to the state authority; and</li> <li>(f) if coverage is denied due to financial capacity, issuers may not issue coverage in the small group market for 180 days or until financial ability is demonstrated.</li> </ul> </li> <li>• Exceptions: <ul style="list-style-type: none"> <li>(a) issuers are not precluded from establishing employer contribution or group participation rules as allowed by state law and as defined.</li> <li>(b) issuers to associations only do not have to comply with 2711 (a).</li> </ul> </li> </ul>

KASSEBAUM-KENNEDY	REQUIREMENT
<p>Section 2712 - Guaranteed Renewability of Coverage for Employers in the Group Market (Rules Apply to Small and Large Group)</p>	<p><u>GENERAL RULES FOR DISCONTINUANCE</u></p> <ul style="list-style-type: none"> <li>• Coverage in the small or large group market must be renewed or continued in force except for one or more of the following reasons (defined more explicitly in the bill): <ul style="list-style-type: none"> <li>(a) nonpayment of premiums;</li> <li>(b) fraud;</li> <li>(c) violation of participation or contribution rules;</li> <li>(d) termination of coverage;</li> <li>(e) movement outside the service area;</li> <li>(f) association membership ceases.</li> </ul> </li> </ul> <p><u>Discontinuance of a Type of Coverage</u></p> <ul style="list-style-type: none"> <li>• When an issuer determines to discontinue the offer of a particular type of coverage in the small or large group market, the type of coverage can be discontinued in accordance with state law if: <ul style="list-style-type: none"> <li>(a) notice is provided to each plan sponsor, participant and beneficiary at least 90 days prior to the date of discontinuance;</li> <li>(b) the issuer offers to each plan sponsor the option to purchase all (or in the case of a large employer, any) other coverage currently offered by the issuer in the group market;</li> <li>(c) when exercising discontinuance and offering other coverage, the issuer acts uniformly without regard to claims experience of sponsors or health factors of participants or beneficiaries.</li> </ul> </li> </ul> <p><u>Discontinuance of All Coverage</u></p> <ul style="list-style-type: none"> <li>• When an issuer determines to discontinue offering all health insurance coverage in the small or large, or both markets in a state, coverage must be terminated in accordance with state law and if: <ul style="list-style-type: none"> <li>(a) notice is provided to the applicable state authority and to each plan sponsor, participant and beneficiary at least 180 days prior to the date of discontinuance;</li> <li>(b) all health insurance issued or delivered for issuance in the state in such market or markets is discontinued and not renewed; and</li> <li>(c) when coverage is discontinued in a market, the issuer may not reenter the market for a period of 5 years beginning on the date of discontinuance of the last coverage not renewed.</li> </ul> </li> </ul>
<p>Section 2713 - Disclosure of Information (Rules Apply to Small Group)</p>	<p><u>EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE</u></p> <ul style="list-style-type: none"> <li>• At the time of renewal, an issuer may modify the coverage of a product offered to a group health plan: <ul style="list-style-type: none"> <li>(a) in the large group market; or</li> <li>(b) in the small group market if, for coverage that is available other than only through one or more associations, the modification is consistent with state law and effective uniformly among group health plans with that product.</li> </ul> </li> </ul> <p><u>INFORMATION TO BE DISCLOSED WITH THE OFFERING OF COVERAGE TO A SMALL EMPLOYER</u></p> <ul style="list-style-type: none"> <li>• The following information is to be provided as part of sales and solicitation materials and upon the request of a small employer: <ul style="list-style-type: none"> <li>(a) provisions concerning the issuer's right to change premiums and the factors that would affect premium changes;</li> <li>(b) renewability provisions;</li> </ul> </li> </ul>

KASSEBAUM-KENNEDY	REQUIREMENT
<p>PART A - Subpart 3 Exclusion of Plans; Enforcement; Preemption Section 2721 - Exclusion of Certain Plans</p>	<ul style="list-style-type: none"> <li>(c) information concerning preexisting conditions; and</li> <li>(d) the benefits and premiums of all coverage for which the employer is qualified.</li> <li>• The information should be made available in a manner determined to be understandable by the average small employer and sufficient to advise the small employers of their rights.</li> <li>• This section does not require the disclosure of information that is proprietary or trade secret under state law.</li> <li>• The requirements of Subparts 1 and 2 do apply to nonfederal governmental plans (defined as a governmental plan established or maintained for its employees by the U.S. Government, etc.)</li> <li>• The requirements of Subparts 1 and 2 do apply to church and governmental plans.</li> <li>• The sponsor of a nonfederal governmental plan may elect, <i>in a form and manner to be prescribed by regulations</i>, to be excluded from the Provisions of Subparts 1 and 2: <ul style="list-style-type: none"> <li>(a) for a single specified plan year which may be extended through subsequent elections; or</li> <li>(b) for the term of a collective bargaining agreement if applicable.</li> </ul> </li> <li>• If such election is made, the plan must provide for: <ul style="list-style-type: none"> <li>(a) notice to enrollees (annually and at enrollment) of the fact and consequences of the elections; and</li> <li>(b) certification and disclosure of creditable coverage as discussed in Section 2701.</li> </ul> </li> <li>• Subparts 1 and 2 do not apply to the excepted benefits enumerated in Section 2791 and listed earlier under Section 2701.</li> <li>• Partnerships are to be considered as group health plans.</li> </ul>
<p>Section 2722 - Enforcement</p>	<p><u>STATE ENFORCEMENT</u></p> <ul style="list-style-type: none"> <li>• Subject to Section 2723, each state may require that health insurance issuers that issue, sell, renew or offer health insurance coverage in the small and large group markets meet the requirements of this part (Part A).</li> <li>• If the Secretary determines that a state has failed to substantially enforce this Part the Secretary may undertake enforcement. Limitations, liabilities, penalties, administrative and judicial review are discussed in detail in this Section.</li> </ul>
<p>Section 2723 - Preemption; State Flexibility; Construction</p>	<ul style="list-style-type: none"> <li>• Except as noted, no provision of state law is superseded which establishes, implements, or continues any standard or requirement solely relating to health insurance issuers in the group market (unless the state law prevents the application of this Part).</li> <li>• Nothing in this part affects or modifies Section 514 of ERISA with respect to group health plans.</li> <li>• In relation to health insurance coverage offered by an issuer, this part does not supersede state law to the extent that state law: <ul style="list-style-type: none"> <li>(a) substitutes a preexisting "lookback" period of less than 6 months;</li> <li>(b) substitutes a preexisting waiting period of less than 12 months or 18 months for late entrants;</li> <li>(c) substitutes a number of days greater than 63 concerning breaks in coverage;</li> <li>(d) substitutes a period greater than 30 days for adding an adopted child;</li> <li>(e) prohibits the imposition of preexisting exclusions in cases not described in 2701(d) or expands the exceptions of that section;</li> </ul> </li> </ul>

KASSEBAUM-KENNEDY	REQUIREMENT
<p>PART C - Definitions; Miscellaneous provisions Section 2791 - Definitions</p>	<p>(f) requires additional special enrollment periods; (g) reduces the period of time applicable to HMO affiliation periods.</p>
<p>Section 2792 - Regulations</p>	<ul style="list-style-type: none"> <li>• Nothing in this Part should be construed to require a group health plan or insurance issuer to provide specific benefits.</li> <li>• This section defines numerous terms in addition to those defined throughout the bill.</li> <li>• The HMO Act is amended to enable affiliation periods.</li> <li>• Except as provided, Part A of Title XXVII shall apply to group health plans for plan years beginning after 6/1/97.</li> <li>• No period before 7/1/96 shall be taken into account in determining creditable coverage, but the Secretary of HHS will establish a process where individuals can be credited for such coverage through documents, etc.</li> <li>• Certification requirements apply to event occurring after 6/30/96.</li> <li>• Certification is not required to be provided before 6/1/97.</li> <li>• For events occurring after 6/30/96 and before 10/1/96 certification is not required unless requested in writing.</li> <li>• Except for certification requirements, collective bargaining agreements are not subject to Part A of Title XXVII until plan years beginning before the later of: <ul style="list-style-type: none"> <li>(a) the date when the last collective bargaining agreement relating to the plan terminates (without regard to any extension agreed to after the date of this Act; or</li> <li>(b) July 1, 1997.</li> </ul> </li> <li>• The Secretary of HHS will issue regulations not later than 4/1/97.</li> <li>• No enforcement actions will be taken regarding violations before 1/1/98 if the plan or issuer has made a good faith effort to comply.</li> <li>• References to revisions of the IRS Code and cross references.</li> <li>• Enables Secretaries of HHS, Treasury and Labor to co-administer and coordinate efforts of implementation.</li> </ul>
<p>Section 103 - IRS Code</p>	
<p>Section 104 - Assuring Coordination</p>	
<p>Subtitle B - Part B - Individual Market Rules Section 2741 - Guaranteed Availability of Individual Health Insurance Coverage to Certain Individual With Prior Group Coverage</p>	<p style="text-align: center;"><u>ALL REFERENCES APPLICABLE TO INDIVIDUAL MARKET ONLY</u></p> <ul style="list-style-type: none"> <li>• Issuers that offer individual coverage may not: <ul style="list-style-type: none"> <li>(a) decline coverage to an eligible individual under the fallback provisions; or</li> <li>(b) impose a preexisting condition exclusion as defined in Section 2701(b)(1)(A) on an eligible individual.</li> </ul> </li> <li>• Preexisting exclusion is defined in the area noted above as: "... a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date."</li> </ul>

KASSEBAUM-KENNEDY	REQUIREMENT
<p>Sections 2742 and 2743</p> <p>Section 2744 - State Flexibility in Individual Market Reforms</p>	<ul style="list-style-type: none"> <li>• An eligible individual: <ul style="list-style-type: none"> <li>(a) has 18 months aggregate prior creditable coverage as defined in Section 2701(c), the most recent of which was with a group, government or church plan, or coverage offered in connection with such plan;</li> <li>(b) is not eligible for group coverage, Medicare, Medicaid, and does not have other health insurance coverage.</li> <li>(c) did not lose the most recent coverage for "a factor described in Section 2712(b), paragraphs (1) and (2) relating to fraud and nonpayment of premium.</li> <li>(d) was offered COBRA or state continuation, elected such coverage and such coverage is exhausted.</li> </ul> </li> </ul> <p><u>Rules for States With No Acceptable Alternative Mechanism (AAM)</u></p> <ul style="list-style-type: none"> <li>• If a state elects not to implement an AAM (later defined and discussed), an individual health insurance issuer may elect to limit the coverage offered to eligible individuals, it may limit the offered coverage so long as it offers at least two different policy forms which: <ul style="list-style-type: none"> <li>(a) "are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the issuer;" and</li> <li>(b) are either the most popular policy forms or are policy forms which provide representative coverage as defined; and</li> <li>(c) this election is applied uniformly and for a period of not less than 2 years.</li> </ul> </li> <li>• If an Acceptable Alternative Mechanism is not adopted and the previous rules are followed, the following apply: <ul style="list-style-type: none"> <li>(a) Special Rules for Network Plans as described for the Small Group Market;</li> <li>(b) Financial Capacity Limits as described for the Small Group Market;</li> <li>(c) Issuers selling group only and/or through bona fide associations are not required to offer to individuals;</li> <li>(d) Issuers offering conversion policies are not required to offer to individuals;</li> <li>(e) The rules do not restrict the premium charges or the opportunity to offer healthy lifestyle discounts, etc.</li> </ul> </li> <li>• These sections are outlined following Section 2744.</li> </ul> <p><u>Rules for State Which Adopt An Acceptable Alternative Mechanism (AAM)</u></p> <ul style="list-style-type: none"> <li>• Section 2741 requirements are waived for states that implement an AAM which: <ul style="list-style-type: none"> <li>(a) provides a choice of health insurance to eligible individuals;</li> <li>(b) does not impose a preexisting exclusion on such coverage; and</li> <li>(c) includes at least one form of coverage which is comparable to comprehensive health insurance offered in the group market or that is comparable to a standard group or individual option available under state law; and</li> <li>(d) the state must implement either: <ul style="list-style-type: none"> <li>• the NAIC Small Employer and Individual Health Insurance Availability Act or the NAIC Individual Health Insurance Portability Model Act, both adopted 6/3/96;</li> <li>• a qualified high risk pool which provides coverage to all eligible individuals that does not impose a preexisting exclusion for eligible individuals and provides for premiums and benefits consistent with the NAIC Model Health Plan for Uninsurable Individuals; or</li> <li>• an alternative mechanism which provides for risk adjustment, risk spreading or a risk spreading mechanism.</li> </ul> </li> </ul> </li> </ul>

**KASSEBAUM-KENNEDY****REQUIREMENT**

- The following are discussed as potential AAMs (or a combination thereof):
  - (a) a private or public individual health insurance mechanism;
  - (b) mandatory group conversion plans;
  - (c) guarantee issue of one or more plans;
  - (d) open enrollment.
- The time frame to implement an AAM is discussed in this section but is not outlined in this document.

GENERAL RULES FOR DISCONTINUANCE

- Coverage in the individual market must be renewed or continued in force except for one or more of the following reasons (defined more explicitly in the bill):
  - (a) nonpayment of premiums;
  - (b) fraud;
  - (c) termination of coverage;
  - (d) movement outside the service area; or
  - (e) association membership ceases.

Discontinuance of a Type of Coverage

- When an issuer determines to discontinue the offer of a particular type of coverage in the individual market, the type of coverage can be discontinued in accordance with state law only if:
  - (a) notice is provided to each covered individual at least 90 days prior to the date of discontinuance;
  - (b) the issuer offers to each individual the option to purchase all other coverage currently offered by the issuer in the group market; and
  - (c) when exercising discontinuance and offering other coverage, the issuer acts uniformly without regard to claims experience of individuals enrolled or who may become enrolled.

Discontinuance of All Coverage

- When an issuer determines to discontinue offering all health insurance coverage in the individual market in a state, coverage must be terminated in accordance with state law and only if:
  - (a) notice is provided to the applicable state authority and to each individual at least 180 days prior to the date of discontinuance;
  - (b) all health insurance issued or delivered for issuance in the state in such market or markets is discontinued and not renewed; and
  - (c) when coverage is discontinued in a market, the issuer may not reenter the market for a period of 5 years beginning on the date of discontinuance of the last coverage not renewed.

EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE

- At the time of renewal, an issuer may modify the coverage of a product offered to an individual:
  - (a) if the modification is consistent with state law and applied uniformly; and
  - (b) the reference to "individual" includes a reference to the association of which the individual is a member.

KASSEBAUM-KENNEDY	REQUIREMENT
<p>Section 2743 - Certification of Coverage</p> <p>Section 2745 - Enforcement</p> <p>Section 2746 - Preemption</p> <p>Section 2747 - General Exceptions</p>	<ul style="list-style-type: none"> <li>The provisions of Small Group Market Section 2701(e) are applicable to the individual market.</li> <li>Except as provided in Section 2746, each state may require that health insurance issuers meet the requirements of Part B - Individual Market Rules. If the Secretary determines that a state has failed to enforce the requirements, the Secretary can enforce the requirements.</li> <li>Nothing in this part affects or modifies Section 514 of ERISA with respect to group health plans.</li> <li>The Individual Market Rules do not apply to the excepted benefits for Small Group Market outlined in Section 2791.</li> <li>Except as provided in Title XXVII, Part B(a), this Part is effective for coverage issued, sold, offered or renewed after 6/30/97, regardless of when a period of creditable coverage occurs. (Note (a) discusses the application of an AAM).</li> <li>Section 102(d)(2) of this Act applies to Section 2743 in the same manner as it applies to Section 2701(e).</li> </ul>
<p>Title III - Tax Related Health Provisions</p> <p>Sections 300, 301 and 220(a) through (c)(1) - Revisions to IRS Code Unless Otherwise Provided, Subtitles A&amp;B,</p>	<p>Most of Title III, Subtitles A&amp;B, discusses the manner in which the IRS will evaluate tax deductions for MSA plans (exempt payments, qualified employers/beneficiaries, transfer of account due to death, divorce, etc., what may or may not be reimbursed by the spending account, reporting requirements, penalties, limitations on spending accounts, etc.</p> <ul style="list-style-type: none"> <li>Defines High Deductible Health Plan (HDHP): <ul style="list-style-type: none"> <li>Single Deductible - \$1500 - \$2250</li> <li>Family Deductible - \$300 - \$4500</li> <li>Single OOP - \$3000</li> <li>Family OOP - \$5500</li> </ul> </li> <li>The definition of HDHP does not include coverage for: <ul style="list-style-type: none"> <li>(a) any benefit provided by permitted insurance; or</li> <li>(b) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long term care.</li> </ul> </li> <li>Permitted insurance means: <ul style="list-style-type: none"> <li>(a) medicare supplemental insurance;</li> <li>(b) insurance coverage if substantially all of the coverage relates to liabilities incurred under workers comp, tort, ownership or use of property, or similar liability as the Secretary may <i>prescribe by regulation</i>, insurance for a specified disease or illness or insurance paying an indemnity for hospitalization.</li> </ul> </li> <li>HDHP does not fail to qualify as a MSA if it does not have a deductible for preventive care as required by state law.</li> <li>Small employer means, in general, any employer who employed an average of 50 or fewer employees during either of the preceding 2 calendar years. Exceptions are made for employers not in business during the preceding year and employers who later exceed 50 employees.</li> </ul>
<p>Section 301</p>	<ul style="list-style-type: none"> <li>Study effects of MSAs on small group market</li> <li>Monitoring of participation in MSAs</li> </ul>
KASSEBAUM-KENNEDY	REQUIREMENT

**Title IV - Application & Enforcement of Group Health Plan Requirements**  
Subtitle A, Sec. 401(a)

**Chapter 100 - Group Health Portability, Access and Renewability Requirements**

**Section 9801 - Increased Portability Through Limitation of Preexisting Condition Exclusions**

**Section 9802 - Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status**

**Section 9803 - Guaranteed Renewability in Multiemployer and Certain MEWAS**

**Section 9804 - General Exceptions**

**Section 9805 - Definitions**

**Section 9806 - Regulations**

**Section 402 - Penalty On Failure to Meet Certain Group Health Plan Requirements**

**Subtitle B - Clarification of Certain Continuation Coverage Requirements**  
Sec. 421 - Cobra Clarifications

Adds a new Chapter 100 to Subtitle K of the IRS Code. This chapter reiterates the provisions of Title XXVII except as noted.

- Basically restates the provisions of Title XXVII, Section 2701, with wording changes specific to the IRS Code.
- Omits the requirement of issuer notice of Alternative Method of crediting prior coverage.
- Omits references to HMO affiliation periods.

- Basically restates the provisions of Title XXVII, Section 2702, with working changes specific to the IRS Code.

- Requires multiemployer plans and MEWAS to guarantee renewal under the same provisions as Title XXVII, Section 2712, (except association membership) and adds:
  - (a) additional language regarding service areas; and
  - (b) a nonrenewal provision regarding failure to comply or renew collective bargaining agreements and related agreements.

- Basically restates the provisions of Title XXVII, Section 2712, with working changes particular to the IRS Code.
- Omits references to church and nongovernmental plans.
- Omits references to treatment of partnerships.

Omits definition of group health insurance, individual health insurance, appropriate state authority, beneficiary, bona fide association, employee, employer, church plan, federal government plan, nonfederal government plan, health status related factor, participants, plan sponsor, state and other market related terms.

- Provides for the Secretary to promulgate regulations and otherwise enforce the provisions required to implement this Title.

- Specifies tax penalties.
- Provides exception for church plans.
- Allows for correctional periods.
- Addresses unintentional failures to comply.
- Not applicable to certain small employer plans.

Makes clarifications to COBRA and ERISA by inserting revisions to referenced federal statutes. The full impact is not stated in the bill. HIAA Report "Implementing Kassebaum-Kennedy," September 11, 1996, discusses COBRA changes effective 1/1/97:

- The extended maximum coverage period (29 months) due to disability applies to disabled qualified beneficiaries.
- Extended disability coverage applies if disability exists at any time during the first 60 days of COBRA (previously at time of qualifying event) - determination still must be made and notice given during the period of COBRA coverage.

**KASSEBAUM-KENNEDY**

**REQUIREMENT**

**Newborns and Mothers  
Health Protect Act**  
Effective 1/1/98

- COBRA can be terminated if beneficiary becomes covered under another group plan with a pre-existing clause if the new plan exclusion does not apply by reason of prior creditable coverage.
- Qualified beneficiary includes adopted children, enabling plan changes upon adoption of a child.
- Group health plans/insurers may not:
  - (a) restrict benefits for any hospital stay in connection with childbirth for the mother or the newborn to less than 48 hours for a normal vaginal delivery or 96 hours for a cesarean section although the provider and mother in consultation may agree to an earlier discharge;
  - (b) require that a provider obtain preauthorization to assure these lengths of stay;
  - (c) deny eligibility to avoid this Act;
  - (d) provide payments or rebates to mothers to accept less limits;
  - (e) penalize or reduce reimbursement to providers due to compliance;
  - (f) provide incentives to providers to encourage noncompliance; or
  - (g) restrict benefits.
- The Act does not:
  - (a) require the mother to give birth in a hospital or to stay in the hospital for the specified times;
  - (b) prevent the application of deductibles, coinsurance, copays, etc., although the deductibles, coinsurance, etc., related to the extended stay may not be greater than the basic charges; or
  - (c) prohibit negotiation of provider charges.

**Mental Health Parity Act**  
(Amends HIPAA)

Effective for plan years  
beginning 1/1/98 and  
Sunsets 9/30/2001.

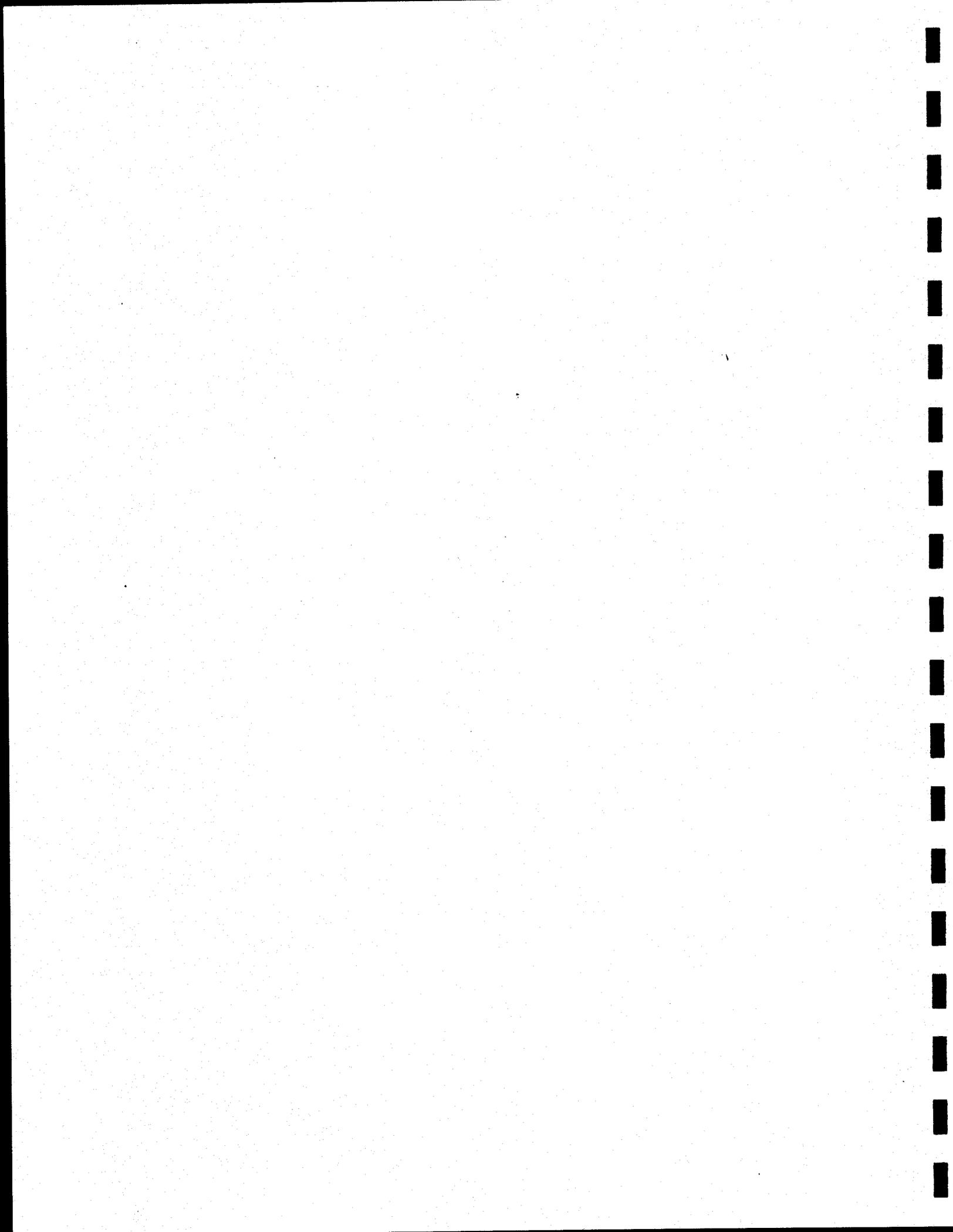
- Group health plans which provide medical, surgical and mental health benefits may not impose an aggregate dollar lifetime limit on mental health benefits if it does not impose such a limit on medical and surgical benefits.
- If there is an aggregate dollar lifetime limit on substantially all medical and surgical benefits, the plan must either:
  - (a) apply one limit equally to all benefits; or
  - (b) use equal limits for medical-surgical/mental health benefits.
- Group health plans which do not impose an annual dollar limit on medical and surgical benefits may not impose an annual limit on mental health benefits.
- Group health plans which do impose an annual dollar limit on substantially all medical and surgical benefits must either:
  - (a) apply one limit equally to all benefits; or
  - (b) use equal limits for medical-surgical/mental health benefits.
- If none of the above apply, the Secretary will establish rules for compliance.
- The Act does not require that mental health benefits be provided.
- The Act does not affect the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage and medical necessity) except as expressed above regarding parity in aggregate/annual benefit limits.
- The Act does not apply to small employers (2-50) and rules are provided for computing employer status.
- The Act does not apply to a group health plan if application would result in a cost increase of at least 1% .



*Kentucky Department of Insurance*

# APPENDIX G

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**SENATE MEMBERS**

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President Pro Tem

David K. Karem  
Majority Floor Leader

Dan Kelly  
Minority Floor Leader

Nick Kafoglis  
Majority Caucus Chairman

Richard L. "Dick" Roeding  
Minority Caucus Chairman

Fred Bradley  
Majority Whip

Elizabeth Tori  
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Jim Callahan  
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Stan Cave  
Minority Caucus Chairman

Joe Barrows  
Majority Whip

Woody Allen  
Minority Whip

**MEMORANDUM**

To: Members of the General Assembly

From: Ginny Wilson, Ph.D. *[Signature]*  
LRC Chief Economist

Subject: Health Insurance Data

Date: August 12, 1997

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

**Current Insurance Status**

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

<sup>1</sup> Legislative Research Commission, *Number and Characteristics of the Individually Insured, Small-Group Insured, and Uninsured in Kentucky*, Research Memorandum No. 474, March 1997.

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

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

#### Uninsured

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

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

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

<sup>3</sup> Estimates from the March 1997 CPS, with data for 1996 will be released this fall.

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

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

#### Privately Insured

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

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

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

#### Buy-In Group

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

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

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

<sup>5</sup> SB 343 defined small employers as those with fewer than 50 employees.

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

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

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

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

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

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

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

## High-Risk Pools

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

### 1995 Operations

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

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

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

### Changes in Operations

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

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

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

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

Table 1

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

Table 2

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

Table 3

Summary of State High-Risk Pool Characteristics  
1995

State	1995 Participants	Year Operational	Max Lifetime Benefits	Waiting Period (Months)	Condition Period (Months)	Funding of Deficit	Premium Cap (% of Standard)	Agent Fee	Enrollment Cap
Alaska	179	1993	\$ 1,000,000	6	3	assessment in proportion to % total premiums	200	25	None
California	19,200	1991	500,000	3	6	\$30 million per year from state cigarette and tobacco surtax rev	125	50	Budget
Colorado	1,572	1991	500,000	6	6	unclaimed business association property	150 - 175	25	None
Connecticut	1,419	1976	1,000,000	12	6	premium assessments	125 - 150	50	None
Florida	1,689	1983	500,000	12	6	premium assessments	200 - 250	50	Closed
Illinois	4,805	1989	500,000	6	6	General Fund appropriation	135	50	5000
Indiana	4,483	1982	---	6	6	premium assessments with tax offset	150	25	None
Iowa	1,099	1987	250,000	6	6	premium assessments with 20% tax offset	150	0	None
Kansas	952	1993	500,000	3	6	premium assessments with 80% tax offset	strict	50	None
Louisiana	532	1992	500,000	6	6	\$2 per day hospital fee; \$1 per day outpatient surgery	150 - 200	None	None
Minnesota	30,470	1976	1,500,000	6	3	premium assessments	125	50	None
Mississippi	835	1992	250,000	6	6	\$1 per policy per month (incl); \$1 per emp. per mo (gr)	150 - 175	100	None
Missouri	1,107	1992	1,000,000	12	6	premium assessment not exceeding 1%	150 - 200	None	None
Montana	321	1987	250,000	12	60	premium assessment with tax offset	150 - 200	100	None
Nebraska	3,366	1986	500,000	6	6	premium assessment with tax offset	135	25	None
New Mexico	858	1988	750,000	6	6	premium assessment with 30% tax offset for payments over \$75,000	150	None	None
North Dakota	1,334	1982	1,000,000	6	3	premium assessment with tax offset	135	25	None
Oregon	4,422	1990	1,000,000	6	6	insurance and reinsurance premium assessment	100 - 125	25	None
South Carolina	1,078	1990	250,000	6	6	premium assessment with \$5 million max tax offset	200 - 300	NA	None
Utah	690	1991	500,000	6	6	state appropriations	150	None	None
Washington	862	1988	500,000	6	6	premium assessment with tax offset	150	None	None
Wisconsin	9,512	1981	500,000	6	6	premium assessment with no tax offset, but with a direct appropriation	60% of costs	25	None
Wyoming	279	1991	300,000	12	6	max premium assessment of \$2.5M with graduated tax offset	125 - 200	35	None
<b>Total</b>	<b>91,084</b>							<b>30</b>	<b>None</b>

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

Table 4

Operations of State High-Risk Pools

1995

State	1995 Participants	Premiums Collected	Per Capita Premiums	Claims Paid	Per Capita Claims	Assessments to Members	Per Capita Assessment	Administration Costs	Per Capita Admin	Per Capita Deficit	Premium as % Total Costs
Alaska	179	\$ 479,001	\$ 2,676	\$ 1,903,747	\$ 10,635	\$ 1,775,615	\$ 9,920	\$ 178,909	\$ 999	\$ 8,959	23%
California	19,200	46,687,879	2,432	70,092,413	3,651			4,400,000	229	1,448	63%
Colorado	1,572	4,474,798	2,847	6,897,480	4,388			717,432	456	1,998	59%
Connecticut	1,419	6,160,495	4,341	10,649,749	7,505	7,481,031	5,272	505,818	356	3,520	55%
Florida	1,689	6,769,508	4,008	13,450,724	7,964			571,665	338	4,294	48%
Illinois	4,805	19,242,682	4,005	30,007,144	6,245			2,526,158	526	2,766	59%
Indiana	4,483	15,787,366	3,522	30,327,965	6,765	17,479,402	3,899	1,595,978	356	3,600	49%
Iowa	1,099	4,725,141	4,299	5,325,226	4,846	3,000,000	2,730	256,489	233	779	85%
Kansas	952	1,569,407	1,649	2,263,636	2,378			209,200	220	949	63%
Louisiana	532	1,265,709	2,379	2,100,773	3,949			443,901	834	2,404	50%
Minnesota	30,470	52,352,000	1,718	94,608,000	3,105	48,000,000	1,575	6,563,213	215	1,602	52%
Mississippi	835	1,919,833	2,299	2,356,366	2,822	1,091,535	1,199	200,640	240	763	75%
Missouri	1,107	4,382,362	3,959	6,229,528	5,627	1,472,583	1,330	219,190	198	1,867	68%
Montana	321	916,000	2,854	955,449	2,976			73,964	230	353	89%
Nebraska	3,366	7,976,611	2,370	12,881,649	3,827	8,200,000	2,436	627,948	187	1,644	59%
New Mexico	858	3,630,614	4,231	5,556,788	6,476	1,200,000	1,399	322,636	376	2,621	62%
North Dakota	1,334	3,077,624	2,307	4,247,364	3,184	1,250,000	937	201,809	151	1,028	69%
Oregon	4,422	9,326,627	2,109	15,054,852	3,405	7,323,089	1,656	806,328	182	1,478	59%
South Carolina	1,078	4,849,351	4,498	6,058,870	5,620	1,490,700	1,383	546,618	507	1,629	73%
Utah	680	2,093,506	3,078	2,952,634	4,342			311,122	458	1,721	64%
Washington	862	1,857,293	2,155	8,422,077	9,770	6,308,228	7,318	311,910	362	7,978	21%
Wisconsin	9,512	23,720,229	2,494	47,623,069	5,007	29,932,000	3,147	1,847,775	194	2,707	48%
Wyoming	279	545,205	1,954	1,071,636	3,841	997,000	3,573	21,406	77	1,964	50%
<b>Total</b>	<b>91,054</b>	<b>\$ 223,809,341</b>	<b>\$ 2,458</b>	<b>\$ 381,037,139</b>	<b>\$ 4,185</b>	<b>\$ 136,911,183</b>	<b>\$ 1,504</b>	<b>\$ 23,460,109</b>	<b>\$ 258</b>	<b>\$ 1,984</b>	<b>55%</b>

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

Table 5

## Population Coverage of State High-Risk Pools

1995

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

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

Table 6

State High-Risk Pool Pricing Factors  
1995

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

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

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

Table 7

Standard and High-Risk Monthly Premiums State High-Risk Pools 1995						
Males						
\$1,000 Deductible Policy						
State	Under Age 30		Age 60 - 64		High Risk Premium as % of Standard	
	Standard	High-Risk	Standard	High-Risk		
Minnesota*	\$ 54	\$ 67	\$ 151	\$ 189	125	
Oklahoma	76	96	344	430	125	
Illinois	150	203	608	821	135	
North Dakota*	80	108	249	336	135	
Montana*	110	165	348	522	150	
New Mexico*	89	133	381	571	150	
Louisiana*	78	156	303	605	200	
Females						
\$1,000 Deductible Policy						
State	Under Age 30		Age 60 - 64		High Risk Premium as % of Standard	
	Standard	High-Risk	Standard	High-Risk		
Minnesota*	\$ 54	\$ 67	\$ 151	\$ 189	125	
Oklahoma	115	143	315	394	125	
Illinois	188	254	496	670	135	
North Dakota*	80	108	249	336	135	
Montana*	110	165	348	522	150	
New Mexico*	114	171	323	484	150	
Louisiana*	108	216	268	536	200	

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

Notes:

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

Table 8

Participants  
State High Risk Pools  
1990 - 1995

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

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

Table 9

**Per Capita Premiums  
State High-Risk Pools  
1990 - 1995**

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

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

Table 10

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

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

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

Table 11

**Per Capita Deficits  
State High-Risk Pools  
1990 - 1995**

State	Per Capita Deficits					Percent Change in Per Capita Deficits					
	1990	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995
Alaska	\$		\$	\$	\$	\$					
California		1,693	1,544	1,234	1,869	8,959		-9%	-20%	-27%	379%
Colorado		-594	-392	55	635	1,448		-34%	-114%	1055%	46%
Connecticut	4,209	5,992	4,258	4,143	5,216	4,347	35%	-25%	-3%	26%	215%
Florida	3,033	5,862	6,436	2,074	4,245	4,294	93%	10%	-68%	105%	1%
Illinois	3,185	3,048	2,715	2,136	2,243	2,766	-4%	-11%	-21%	5%	23%
Indiana	3,025	2,179	3,571	2,939	2,021	3,600	-28%	64%	-18%	-31%	78%
Iowa	434	931	1,043	1,462	1,095	779	115%	12%	40%	-25%	-29%
Kansas				217	814	935				275%	15%
Louisiana			9,355	1,610	2,626	2,404			-83%	63%	-8%
Minnesota	1,060	972	1,132	1,170	1,335	1,602	-8%	16%	3%	14%	20%
Mississippi			425	-799	363	763			-288%	-145%	110%
Missouri			-118	792	2,015	1,867			-771%	154%	-7%
Montana	-20	350	637	297	-573	353	-1836%	82%	-53%	-293%	-162%
Nebraska	909	1,162	569	1,552	1,603	1,644	28%	-51%	173%	3%	3%
New Mexico	1,205	1,547	1,804	2,140	3,001	2,621	28%	17%	19%	40%	-13%
North Dakota	1,174	1,533	1,059	928	1,152	1,778	31%	-31%	-12%	24%	54%
Oregon	155	547	716	1,194	1,146	1,478	253%	31%	67%	-4%	29%
South Carolina	461	2,056	1,467	820	1,909	1,629	346%	-29%	-44%	133%	-15%
Utah			489	618	1,709	1,721			26%	177%	1%
Washington	1,086	958	1,984	1,979	10,504	7,978	-12%	107%	0%	431%	-24%
Wisconsin	566	982	1,560	1,216	1,873	2,707	73%	59%	-22%	54%	45%
Wyoming		-394	-596	1,351	1,885	1,964		52%	-327%	40%	4%
<b>Total</b>	<b>1,477</b>	<b>1,605</b>	<b>1,698</b>	<b>1,412</b>	<b>1,665</b>	<b>1,988</b>	<b>9%</b>	<b>6%</b>	<b>-17%</b>	<b>18%</b>	<b>19%</b>

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

Table 12

**Total Assessments  
State High-Risk Pools  
1990 - 1995**

State	Total Assessments					Percent Change in Total Assessments					
	1990	1991	1992	1993	1994	1995	1991	1992	1993	1994	1995
Alaska	\$	\$	\$	\$	\$	\$					
California											
Colorado											
Connecticut	8,337,592	6,076,638	6,258,544	9,197,942	8,365,979	7,481,631	-4%	3%	47%	-9%	-11%
Florida	33,354,379	5,583,791	7,138,078	5,796,035	11,814,627	1	-83%	28%	-19%	104%	-100%
Illinois											
Indiana	7,316,933	13,256,885	15,912,425	14,326,415	10,717,539	17,479,402	81%	20%	-10%	-25%	63%
Iowa	2,088,517	2,000,000	1	2,707,377	3,000,000	3,000,000	-4%	-100%	0%	11%	0%
Kansas											
Louisiana											
Minnesota	22,167,000	24,239,000	32,074,000	40,626,525	44,424,903	48,000,000	9%	32%	27%	9%	8%
Mississippi											
Missouri											
Montana											
Nebraska	4,000,000	4,723,292	2,500,000	6,300,000	6,200,000	8,200,000	18%	-47%	152%	-2%	32%
New Mexico	2,513,710	2,145,509	2,772,086	2,790,871	3,426,625	1,200,000	-15%	29%	1%	23%	-65%
North Dakota	1,699,880	2,075,220	2,792,720	1,987,960	1,500,000	1,250,000	22%	35%	-29%	-25%	-17%
Oregon	1,112,762	1,361,877	3,345,705	4,121,024	3,997,238	7,323,089	22%	146%	23%	-3%	83%
South Carolina	90,400	2,205,171	4,083,000	1,627,301	1	1,490,700	2339%	85%	-60%	-100%	149069900%
Utah											
Washington	2,999,470	2,499,451	10,199,088	10,198,943	11,499,657	6,308,228	-17%	308%	0%	13%	-45%
Wisconsin	7,330,245	10,386,725	22,887,094	17,545,905	17,107,689	29,932,000	42%	120%	-23%	-2%	75%
Wyoming											
<b>Total</b>	<b>\$91,010,858</b>	<b>\$76,853,559</b>	<b>\$117,357,617</b>	<b>\$122,300,851</b>	<b>\$126,527,319</b>	<b>\$136,911,784</b>	<b>-16%</b>	<b>53%</b>	<b>4%</b>	<b>3%</b>	<b>8%</b>

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

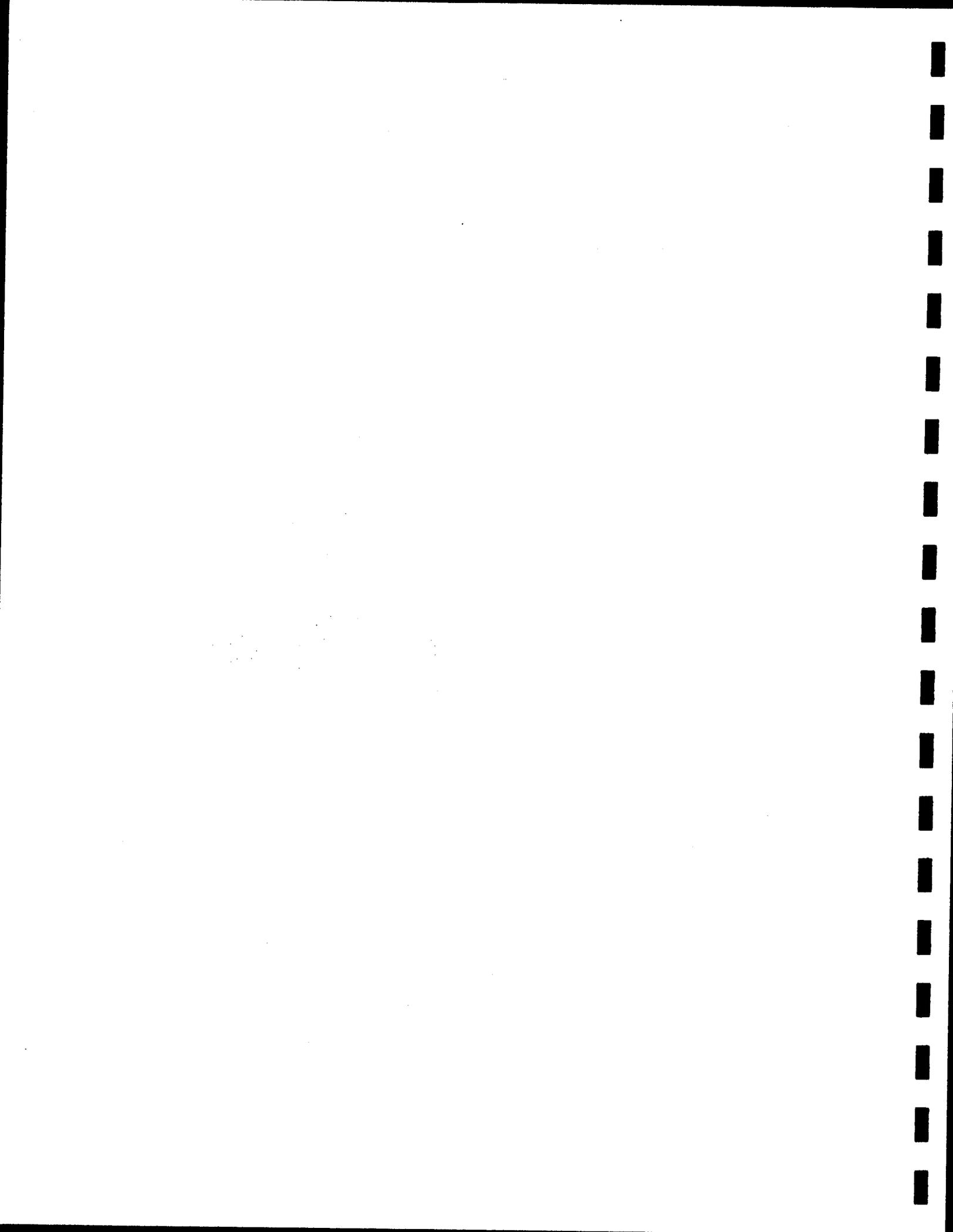
Note: For states which had assessments in one year, but not the next, that year's assessment was set equal to \$1, rather than zero, so the percent change formula would accurately reflect the change. However, an effect of that was to yield the fantastically large one-year percentage increases observed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

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

**RESEARCH MEMORANDUM NO. 474**

**LEGISLATIVE RESEARCH COMMISSION**

**MARCH, 1997**



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

**Prepared by:  
Ginny Wilson, Ph.D.  
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**Research Memorandum No. 474**

**Legislative Research Commission**

**March, 1997**

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**MEMORANDUM**

**TO:** Don Cetrulo, Director  
Legislative Research Commission

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

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

**DATE:** March 18, 1997

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

## EXECUTIVE SUMMARY

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

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

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

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

## INDIVIDUALLY INSURED

### 1. Number

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

### 2. Characteristics of Adults

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

### 3. Characteristics of Policies

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

### 4. Knowledge of Changes in the Law

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

## SMALL-GROUP INSURED

### 1. Number

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

### 2. Characteristics of Adults

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

### 3. Characteristics of Policies

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

### 4. Knowledge of Changes in the Law

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

## UNINSURED

### 1. Number

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

### 2. Characteristics

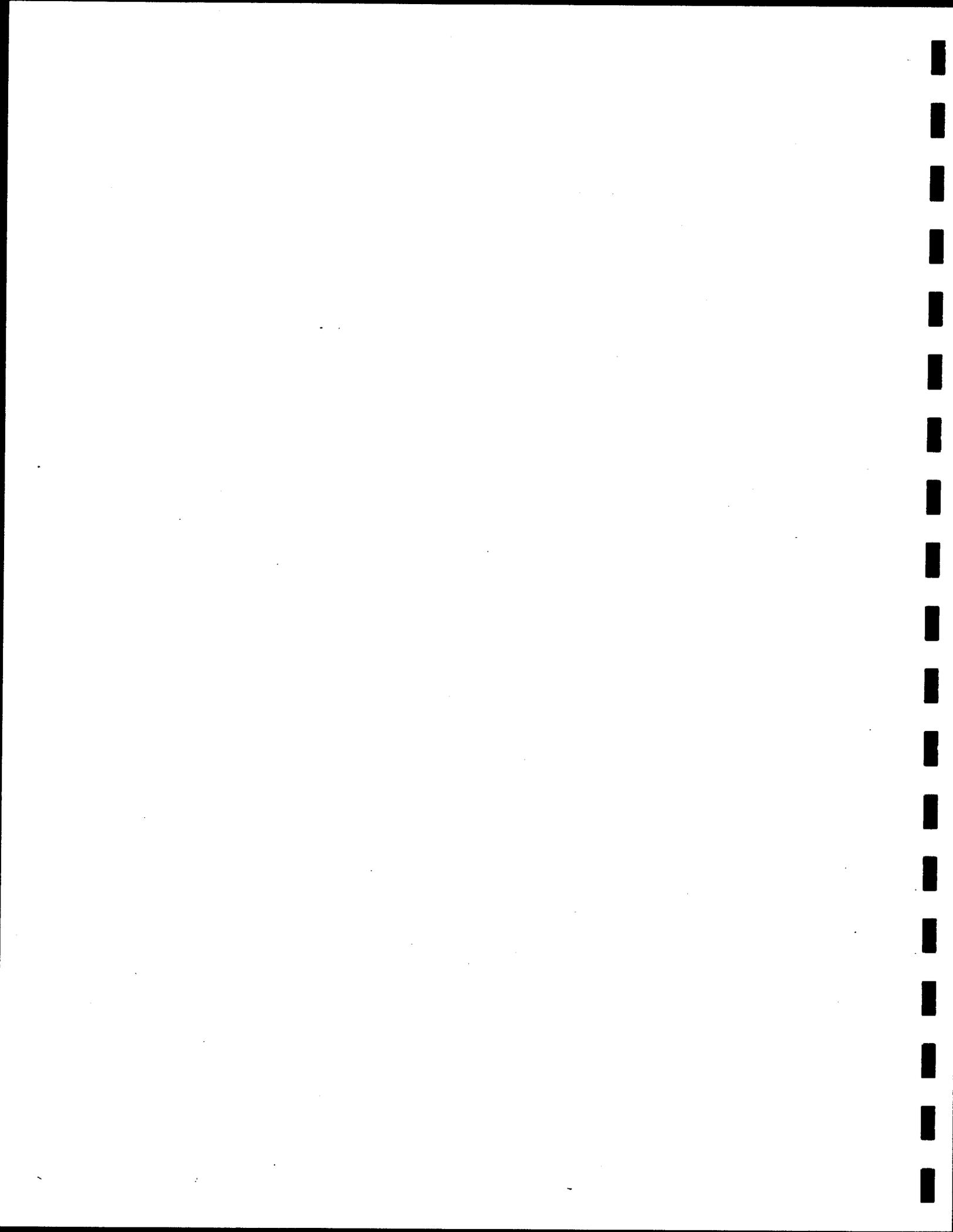
- Uninsured adults were significantly more likely to be younger, have less family income (median was \$10,000 - \$15,000), and not be currently employed than the privately insured.
- Uninsured adults were significantly more likely to have worse scores than insured adults on two items of a standard health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

### 3. Newly Uninsured within the Past 12 Months

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

## UNINSURED CHILDREN

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



## INTRODUCTION

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

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

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

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

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

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

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

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

## DATA SOURCES

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

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

### 1996 HEALTH INSURANCE SURVEY

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

## *Content*

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

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

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

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

## *Limitations*

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

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

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

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

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

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<sup>2</sup> Aday, Lu Ann, *Designing and Conducting Health Surveys, Second Edition*. San Francisco: Jossey-Bass Publishers, 1996.

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

<sup>4</sup> American Academy of Actuaries, *Health Risk Assessment and Health Risk Adjustment: Crucial Elements in Health Care Reform*. Monograph Number One, May 1993.

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

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

#### **SPRING 1996 KENTUCKY SURVEY**

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

#### **MARCH SUPPLEMENT TO THE CURRENT POPULATION SURVEY**

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

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

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

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

## DESCRIPTION OF INSURANCE MARKET SEGMENTS

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

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

### INDIVIDUAL MARKET

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

#### *Number Covered Under Individual Policies*

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

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

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

<sup>7</sup> U.S. General Accounting Office, *Private Health Insurance*, Washington, D.C., November, 1996.

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

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

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

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

<sup>9</sup> Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured*, EBRI Issue Brief Number 179, November 1996.

### *Characteristics of Adults Covered Under Individual Policies*

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

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

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

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

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

<sup>10</sup>U.S. General Accounting Office, *Private Health Insurance*, Page 3.

Table 1

Demographic Characteristics of Individually Insured Adults

Characteristic	Percent	Characteristic	Percent
<b>1. Gender</b>		<b>6. Occupation</b>	
Female	47%	Managers & professionals	30%
Male	53%	Technical, sales, & administrative support	5%
<b>2. Age</b>		Service	6%
Less than 30	23%	Agricultural	7%
30 to 39	20%	Precision production, craft & repair	5%
40 to 49	23%	Operators, fabricators & laborers	5%
50 to 59	22%	Unemployed	4%
60 to 64	11%	Other	38%
<b>3. Annual Household Income</b>		<b>7. Health in General</b>	
Less than \$10,000	8%	Excellent	33%
\$10,000-\$15,000	6%	Very Good	30%
\$15,000-\$25,000	19%	Good	21%
\$25,000-\$35,000	24%	Fair	10%
\$35,000-\$45,000	13%	Poor	6%
\$45,000-\$55,000	9%		
More than \$55,000	21%	<b>8. Smoked regularly in last 2 years.</b>	27%
<b>4. Family Income as a Percent of the Federal Poverty Level (FPL)</b>		<b>9. Number Dr. visits within last year</b>	
Less than 100% of FPL	10%	0	20%
100% to 149% of FPL	10%	1 to 2	40%
150% to 249% of FPL	44%	3 to 4	21%
250% or more of FPL	36%	5 to 6	7%
<b>5. Work Status</b>		More than 6	12%
Work outside home	55%		
If yes, work part-time	23%		

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

Table 2

Health Status of Individually Insured Adults

Response	Gets Sick Easier	Healthy as Anyone	Health Expected to Worsen	In Excellent Health	Overall Health Index Score	Percent
Definitely True	4%	56%	5%	47%	I (best health)	57%
Mostly True	8%	26%	17%	35%	II	28%
Mostly False	20%	11%	25%	11%	III	10%
Definitely False	68%	7%	53%	7%	IV (worst health)	5%

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

Table 3

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

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

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

Note: Column and row totals may not exactly equal summary figures shown in other tables due to rounding.

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

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

*Characteristics of Individual Policies*

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

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

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

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

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

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

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

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

**Table 4**

**Market Share of Companies Offering Individual Policies**

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

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

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

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

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

**Table 5**  
**Characteristics of Individual Policies**

<u>Characteristic</u>	<u>Percent</u>	<u>Characteristic</u>	<u>Percent</u>
<b>1. Physician Choice</b>		<b>4. Copayment for Doctor Visits</b>	
Same amount paid all physicians	54%	Yes	44%
Smaller amount paid physicians not on plan list	25%	<b>If Copayment Assessed:</b>	
Only paid physicians on plan list	21%	<b>Amount of Copayment</b>	
<b>2. Annual Deductible Included in Plan</b>		\$5 to \$9	18%
Yes	79%	\$10	52%
<b>If Deductible Assessed:</b>		\$15	15%
<b>Amount of Deductible</b>		More than \$15	15%
Less than \$200	21%	<b>5. Services Covered by Plan</b>	
\$201-\$400	23%	Hospital stay	98%
\$401-\$800	22%	Outpatient doctor visits	89%
\$801-\$1,000	8%	Prescriptions	70%
\$1,001-\$2,500	19%	Mental health	66%
More than \$2,500	6%	Vision	20%
<b>3. Percent of Medical Costs Paid by Plan</b>		Dental	14%
Less than 80%	4%		
80%	79%		
More than 80%	17%		

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

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

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

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

### *Knowledge of Changes in the Law*

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

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

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

Table 6

**Knowledge of Changes in Kentucky Insurance Laws  
Individual Policyholders**

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

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

**SMALL-GROUP MARKET**

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

***Number Covered Under Small-Group Policies***

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

### *Characteristics of Adults Covered Under Small-Group Policies*

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

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

### *Characteristics of Small-Group Policies*

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

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

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

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