

Table 7

Demographic Characteristics of Adults Insured Under Small-Group Policies

Characteristic	Percent	Characteristic	Percent
1. Gender		5. Occupation	
	Female 50%	Managers & professionals	45%
	Male 50%	Technical, sales, administrative support	8%
2. Age		Service	4%
	Less than 30 23%	Agricultural	2%
	30 to 39 32%	Precision production, craft & repair	9%
	40 to 49 26%	Operators, fabricators & laborers	9%
	50 to 59 14%	Unemployed	1%
	60 to 64 4%	Other	23%
3. Annual Income		6. Health in General	
	Less than \$10,000 2%	Excellent	39%
	\$10,000-\$15,000 6%	Very Good	32%
	\$15,000-\$25,000 15%	Good	21%
	\$25,000-\$35,000 22%	Fair	6%
	\$35,000-\$45,000 18%	Poor	2%
	\$45,000-\$55,000 12%	7. Smoked Regularly within Last 2 Yrs.	
	More than \$55,000 26%	Yes	29%
4. Work Status		8. Number of Visits to Doctor within Last 12 Mos.	
	Work outside home 62%	0	21%
	If work, part-time 15%	1 to 2	46%
		3 to 4	17%
		5 to 6	8%
		More than 6	9%

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

Table 8

Health Status of Adults Insured Under Small-Group Policies

Response	Gets Sick Easier	Healthy as Anyone	Health Expected to Worsen	Excellent Health	Overall Health Index Score	Percent
Definitely True	3%	59%	5%	55%	I (best health)	64%
Mostly True	6%	30%	14%	33%	II	26%
Mostly False	23%	7%	22%	9%	III	8%
Definitely False	69%	4%	59%	4%	IV (worst health)	2%

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

Table 9

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

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

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

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

Source: 1996 Health Insurance Survey, with 1,307 adults covered under small-group policies.

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

Table 10

Market Share of Companies Offering Small-Group Policies

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

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

Knowledge of Changes in the Law

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

Employer Mail Survey

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

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

Table 11
Characteristics of Small-Group Policies

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

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

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

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

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

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

Table 12

**Knowledge of Changes in Kentucky Insurance Laws
Small-Group Policyholders**

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

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

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

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

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

UNINSURED

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

Number of Uninsured

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

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

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

The most recent point estimates of the percentage of uninsured in Kentucky by the Bureau of the Census from the CPS were 15.2% in 1994 and 14.6% in 1995.¹⁷ Taken at face value this would indicate that the percentage of Kentuckians who are uninsured declined from 1994 to 1995. However, because the percentages represent estimates of the characteristics of the state's population based on a sample of about 650 respondents, the standard error on either of the estimates is 1.3 percent. This means there is a 90 percent chance that the 1995 rate of uninsured could range from 13.3% to 15.9%. Based on the estimated 1995 Kentucky population, this means that there is a 90% probability that the actual number of uninsured in the state is between 510,000 and 610,000 people, with the 1995 point estimate at 560,000. (This represents 16.7% of the non-elderly population.)

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

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

Table 13

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

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

* Includes Alternative Health Delivery Systems policies.

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

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

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

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

Characteristics of the Uninsured

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

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

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

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

Characteristics of the Newly Uninsured

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

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

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

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

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

Table 14

Comparison of Characteristics of Uninsured and Privately Insured Adults*

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

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

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

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

Table 15

Duration and Reasons for Periods of Uninsured Status

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

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

Uninsured Children

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

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

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

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

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

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

Table 16

Characteristics of Newly Uninsured Adults

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

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

Table 17

DEMOGRAPHIC CHARACTERISTICS OF UNINSURED CHILDREN

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

Sources: A A rounded average of the Bureau of the Census estimates made from the 1991 - 1996 March Current Population Surveys. Family income as a percent of FPL from 1993-1995 CPS.
 B 1996 Health Insurance Survey, with 548 households with uninsured children.

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

Table 18

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

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

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

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

SENATE MEMBERS

Walter Blevins, Jr.
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
Minority Whip

LEGISLATIVE RESEARCH COMMISSION

State Capitol

Frankfort, Kentucky 40601

502-564-8100

Capitol FAX 1-502-223-5094
Annex FAX 1-502-564-6543
Larry Saunders, Senate President
Jody Richards, House Speaker
Chairmen

Don Cetrulo
Director

MEMORANDUM

HOUSE MEMBERS

Larry Clark
Speaker Pro Tem
Gregory D. Stumbo
Majority Floor Leader
Danny R. Ford
Minority Floor Leader
Jim Callahan
Majority Caucus Chairman
Stan Cave
Minority Caucus Chairman
Joe Barrows
Majority Whip
Woody Allen
Minority Whip

To: Representative Jim Gooch
From: Ginny Wilson, Ph.D.
LRC Chief Economist
Subject: Information Regarding Effects of HB 250 and SB 343
on the Individual Insurance Market
Date: April 3, 1997

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

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

Background

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

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

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

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

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

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

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

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

Based on a survey of residents, it is estimated that approximately 5.5% of the total Kentucky population, or about 210,000 individuals, were covered under a non-group private insurance policy in the summer of 1996. The group was found to be 53% male, with an average age of 43 and a median household income between \$25,000 and \$35,000. Eighty-five percent scored in the best two out of the four categories of a standard health status index, while 5% scored in the worst category. One-fourth of the individual policies reported by respondents were identified as a standard plan, meaning that three-fourths of the policies did not conform to the provisions of HB 250.³

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

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

Rate Effects

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

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

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

Change in Rating Provisions

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

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

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

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

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

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

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

Model Estimates

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

⁴Legislative Research Commission, Research Memorandum No. 474.

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

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

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

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

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

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

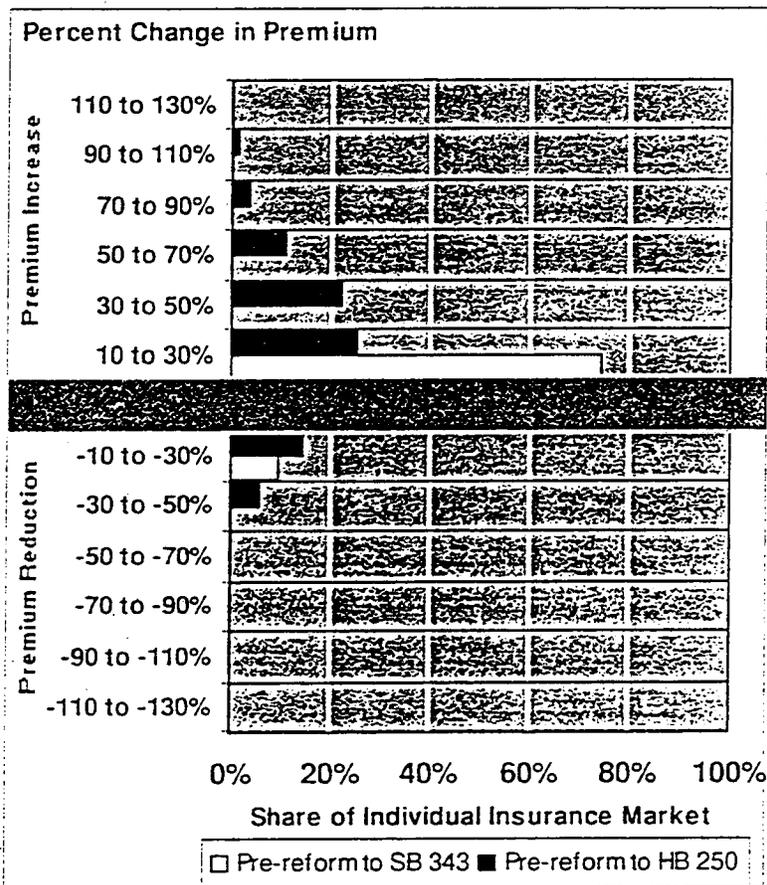
Most noteworthy in the chart is the large share of the market that experienced premium increases. If it was assumed that all 210,000 individually insured had come under the provisions of the two laws, then the bars above the gray line would represent about 130,000 individually insured who would have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

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

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

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

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



Note: The following rate band assumptions were used:

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

Change in Benefits

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

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

Guaranteed Issue

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

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

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

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

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

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

Change in Pricing for Families

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

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

Market Uncertainty

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

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

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

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

Exemption of Associations from Rating Provisions

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

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

Other Factors

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

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

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

Increases in the Number of Uninsured

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

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

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

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

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

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

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

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

Table 2

Household Incomes of the Uninsured and Privately Insured

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

Source: LRC staff analysis the Spring 1996 Kentucky Survey.

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

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

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

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

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

Change in Business Conditions

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

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

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

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

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

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

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

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

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

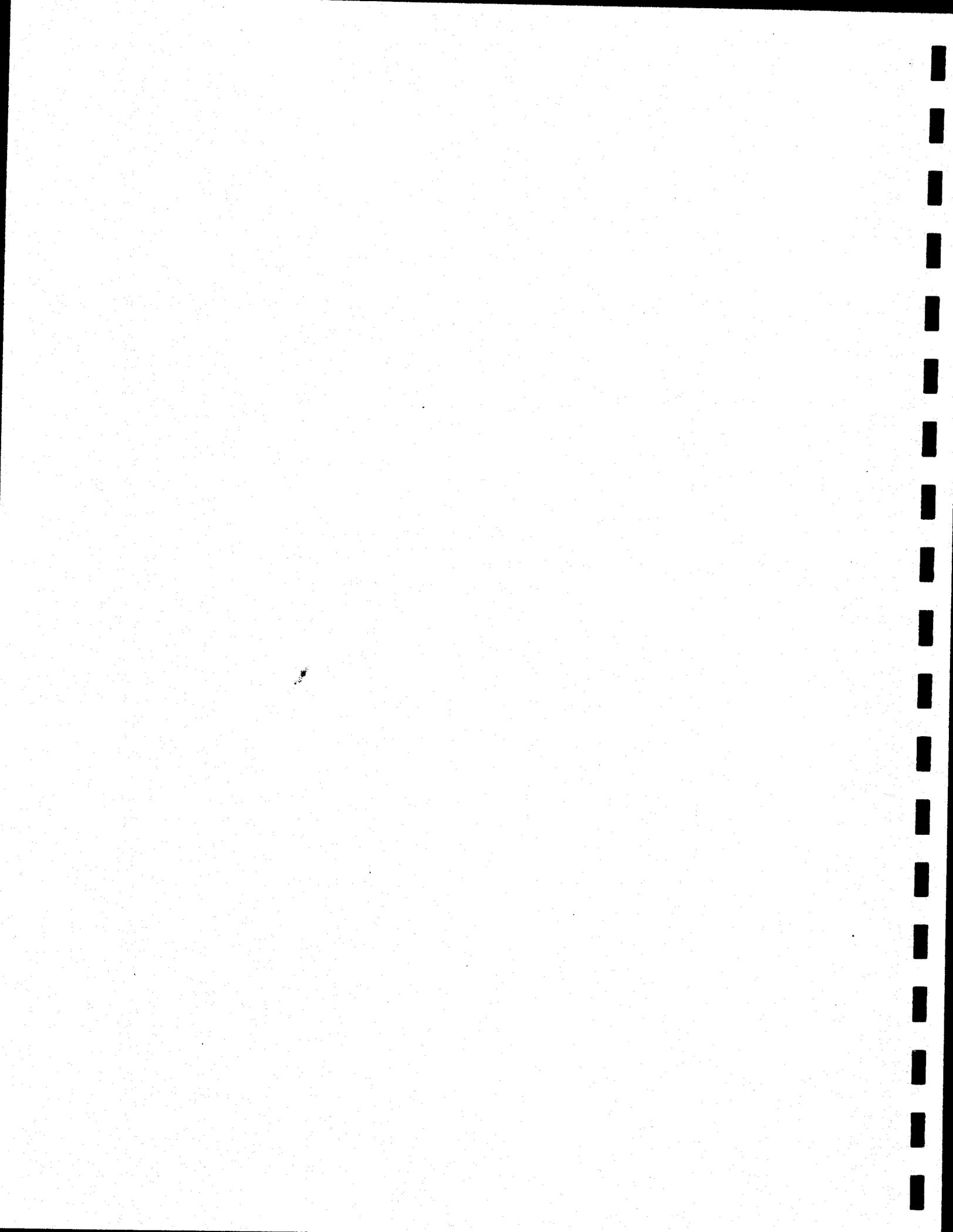
Kentucky Kare is all that prevents a monopoly situation in the community-rated individual market. Given that its reserves have declined by \$50 million since it began selling private individual coverage, it is questionable as to whether it can long remain financially viable in its current form. According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

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



Kentucky Department of Insurance

APPENDIX H



NATIONAL DATA

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

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

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

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

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

individuals, were insured by firms with less than 50 employees. They also estimated that 14.65%, or about 560,000 people, were uninsured in 1995. Of those uninsured in Kentucky who responded to the Legislative Research Commission survey, over two-thirds said they were uninsured because of cost, while only 5% said they were uninsured because of a medical condition. It is worth noting here that the survey took place after implementation of the 1994 reforms and before the 1996 reforms were in place.

KENTUCKY DEMOGRAPHICS

The Commonwealth of Kentucky is primarily a state with a workforce consisting of many small employers, a workforce lower than the national average in educational achievement, and containing a population that is substantially less healthy than the national average. Each of these factors will have an adverse effect upon the population to have, or afford, private health insurance. Each factor will be analyzed from the viewpoint of impact of providing affordable insurance and insurance reform for the citizens of Kentucky. National data as well as the Legislative Research Commission survey released in march 1997 will be utilized.

POPULATION

According to the State Data Center at the University of Louisville, both the United States and Kentucky have traditionally had a pyramid shaped population demographic where the younger generation is larger and better educated than the one preceding it. Currently, those Kentuckians in their 30's and 40's are greater in number than the younger generation. The "baby boomers" waited longer to have children, and had fewer per household than older generations. This phenomenon, coupled with the fact that Americans are living longer and healthier, has resulted in a squaring of the population pyramid. Consequently, the younger generations are significantly smaller in number. This decline will impact our social and economic policies in several ways.

A national study was released using data gathered between 1982 and 1994 which shows the percentage of adults over 65 considered disabled has dropped from 24.9% to 21.3%, or an estimated difference of 1.2 million people. This study was produced by the National Long Term Care Survey and Duke University looked at chronic disability among a sample of more than 20,000 persons aged 65 and older. This study, if corroborated, may have important implications for Social Security and expenditures for Medicare and private insurance coverage. According to this study, published in the Proceedings of the National Academy of Sciences in March, 1997, if the percentage of elderly persons in institutions in 1982 remained the same, the 1994 population would total 2.1 million individuals in nursing homes or other facilities. Instead, there are 1.7 million individuals in these institutions. If it is assumed that the nursing home cost per person is approximately \$43,300 per year in 1994 as stated in the report, the 400,000 fewer persons in these facilities results in a savings to the nation of \$17.3 billion in nursing home costs.

Technology and the employment market are rapidly changing, and our work force will change with it. Today, the employed worker is the worker who continues their education, either in school or on the job. Older workers, combined with fewer children, will dramatically affect the educational, medical care, and insurance delivery systems of the state in the future.

Along with the changing workplace, people are living longer. They are also faced with older retirement ages. As people work longer, they have more insurance options. Medicare eligibility continues to become effective at age 65, while many employees are working well into their seventies and beyond. These workers will have, as long as Congress does not change the eligibility criteria, more insurance coverage options from which to choose.

EDUCATION

The people of Kentucky have traditionally viewed the educational process as a tool to provide needed skills for the workplace. With the economy centered primarily around manufacturing and mining, these jobs have provided high wages for individuals with a high school diploma or less. This economic mix has not provided an economic incentive for continuing educational achievement.

According to the 1996 Current Population Survey from the U.S. Census Bureau utilizing 1995 data, the Commonwealth placed in the lower end nationally for high school graduation rates. The high school graduation rates for individuals 25 years of age and older ranged from a low of 72.7% (with a standard deviation of plus or minus 1.8%) for West Virginia to a high of 92.1% (with a standard deviation of plus or minus 1.3%) for Alaska. Kentucky had a high school graduation rate of 76.7% (with a standard deviation of plus or minus 2.3%). At the 90% confidence level, this means the percentage of Kentuckians completing high school ranged from 74.4% to 79.0%. The 90% confidence level is a statistical tool used to determine the probability that the findings would reflect the survey results if the entire population of Kentucky were questioned. With the relatively small sample size, in 18 out of 20 cases, it can be assumed the findings of the poll would have shown high school graduation rates would be between 74.4% and 79.0%.

According to the same Census Bureau survey, those individuals with a bachelor's degree or greater ranged from a low of 12.7% (with a standard deviation of plus or minus 1.8%) for West Virginia to a high of 38.2% (with a standard deviation of plus or minus 3.0%) for the District of Columbia. Kentucky had a bachelor's degree or greater completion rate of 19.3% (with a standard deviation of plus or minus 2.2%). At the 90% confidence level, this means the percentage of Kentuckians completing a bachelors degree or greater ranged from 17.1% to 21.5%.

For comparative purposes, the following table shows the relative high school and bachelor's degree completion rates for the states contiguous to Kentucky:

STATE	HIGH SCHOOL COMPLETION RATE	BACHELORS DEGREE COMPLETION RATE
IN	81.6	16.9
IL	82.3	24.6
OH	83.4	19.7
VA	82.7	26.0
NC	76.3	20.6
TN	77.4	17.8
MO	82.2	21.9

High school and college graduation rates, while showing the emphasis placed on education, only start to explain the relationship between education and ability to purchase insurance. The relationship between educational achievement and earnings potential is well documented. It has been well documented that the ability to purchase insurance is relative to earnings. According to the Bureau of Economic Analysis, in 1980, high school dropouts earned 17.3% less than high school graduates and they earned 32.2% less than college graduates. In 1990, high school dropouts earned 15.9% less than high school graduates and they earned 59.5% less than college graduates. So while the 1980's provided little incentive to complete high school, it provided a great incentive to attend college. This survey was based on 1800 interviews during the decade and was controlled for race, marital status, and time of interview.

EMPLOYMENT

As important as the educational achievement of Kentuckians is, the types of jobs available to Kentucky's residents are equally important. The Bureau of Economic Analysis has made estimates of the job structure in Kentucky by industrial classification from 1989 to 2005. Among those industries expecting to show gains are all government (a gain from 298,000 to 345,000), services (410,000 to 625,000), financial, insurance, and real estate (95,000 to 111,000), wholesale and retail (397,000 to 491,000), and the construction industry (99,000 to 125,000).

Those industries expecting to show declines are manufacturing (a decline from 291,000 to 217,000), coal mining (31,000 to 17,000), and farming (127,000 to 115,000).

As evidenced above, the manufacturing and coal mining industries, traditionally utilizing low skill and low educational achievement workers making high wages are expected to experience a significant decline. Experience since 1989 has tended to prove these predictions accurate. The service, wholesale and retail, and service industries tend to use higher educated workers but traditionally do not pay as well as mining or manufacturing. With under-education and a changing education-earnings ratio, Kentucky could conceivably lose ground in its attempt to improve its economic condition in relation to other states. Less income can translate into less ability to afford insurance.

According to the 1994 County Business Patterns, Kentucky has a workforce that works predominately for small employers. This survey, taken each year during the week of March 12th, attempts to measure employment by size of employer and industry division on both the statewide and county levels. Kentucky has 26.32% of its workers employed by firms with 19 or fewer employees. This segment of the workforce earns only 22.74% of the estimated \$28,324,513,000 paid in 1994. Employers with 49 or fewer employees make up 43.04% and they earn only 37.39% of the payroll. Those who work for employers of 500 or greater make up only 17.86% of employees and earn 24.36% of the payroll of Kentucky. This study does not include most government employees, railroad employees, and the self employed. The employment size class that measures 1 to 4 employees includes establishments who have payroll but no employees during this mid-March pay period.

HEALTH OF KENTUCKIANS

1996 ReliaStar State Health Rankings

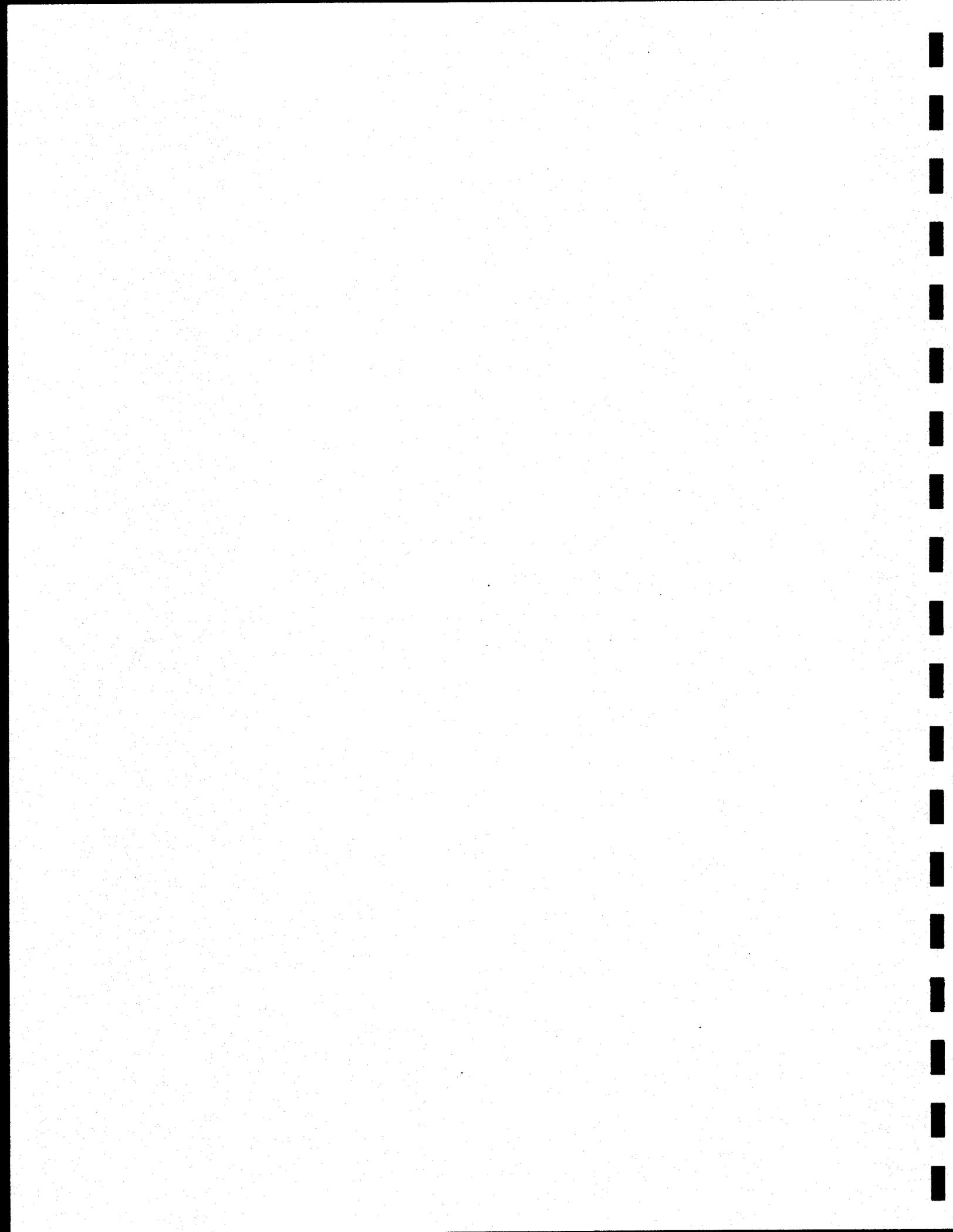
The ReliaStar State Health Rankings are an annual study that uses 17 components to measure the overall health rankings of each state according to such factors as prevalence of deadly diseases, lifestyle factors, access to health care, occupational safety and disability, and mortality. Prior to 1995, this study was known as "The NWNL State Health Rankings". Kentucky's ranking has remained relatively unchanged since 1990. In 1990, Kentucky was rated the 39th healthiest state in the nation. In 1995, Kentucky was tied for 38th, along with Florida, New York, and Tennessee. Tennessee and West Virginia were the only contiguous states to Kentucky to rank lower in overall health. In the 1996 study, Kentucky was rated the 40th healthiest state. For comparative purposes, Virginia was rated 10th, Ohio was tied for 14th, Indiana was tied for 17th, Illinois was tied for 24th, North Carolina was rated 28th, and Missouri was rated 34th in the nation. The following states were rated lower than Kentucky: Tennessee was rated 42nd and West Virginia was rated 47th healthiest state in the nation.

Kentucky was rated in the bottom 10 in the nation for the following measures:

- Prevalence of smoking - 25.5 % of Kentucky's citizens are smokers. This is measured by the percentage of the population over 18 that smokes tobacco products regularly.
- Risk for heart disease - This is a measure of three criteria: obesity, hypertension, and sedentary lifestyle. All three factors are known to contribute to heart disease.
- Support for public health care - we rank 45th in the country. This measure is derived by calculating the percentage of the state budget spent on welfare, health care, and related services divided by the percentage of the population with an annual income of less than \$15,000.
- Worker Disability Status - Kentucky ranks 48th in the country with 7.3% of the population with disabilities severe enough to prevent employment.
- Heart Disease - Kentucky is ranked 46th in the United States with 171 deaths per 100,000 population. This measurement is derived by using a three year average, adjusted for age and race, death rate due to heart disease.
- Cancer Cases - This factor utilizes copyright information from the American Cancer Society. It reports the number of projected cases for the current year divided by the estimated total population of the state to get a rate of cancer cases per 100,000 population. Kentucky is ranked 44th in the United States with 601 deaths per 100,000 population.

Kentucky Department of Insurance

APPENDIX I



**INSURANCE COMPANIES REPORTED KENTUCKY BUSINESS
AS OF THE DATE OF WITHDRAWAL FROM THE MARKET
(in response to Bulletin 95-10 and
(subsequent requests from the Department of Insurance)**

COMPANY NAME	DATE OF DECISION TO WITHDRAW FROM MARKET	NUMBER OF AFFECTED POLICIES	NUMBER OF AFFECTED COVERED LIVES (estimated)	COMMENTS
Aid Association for Lutherans		27	54	
American National Insurance Co.	6/26/95	402	804	participated in the individual market only
American National Insurance Co. of Texas	6/26/95	66	132	participated in the individual market only
American Pioneer Life Insurance Co.	7/6/95	108	216	(the date refers to a letter in which they stated they would non-renew if they were not permitted to continue their existing business)
American Republic Insurance Co.	6/21/95	180	360	participated in the individual market
Bankers Life & Casualty Co.	7/13/95	4	8	participated in the individual market only
Life Insurance Co. of North America (CIGNA)	9/26/95	0	0	
Insurance Co. of North America (CIGNA)	9/26/95	4	8	these policies were group policies
Central Reserve Life Insurance Co.	8/11/95	369	738	
Continental Life Insurance Co.	6/27/95	29	58	participated in the individual market

Revised 9/9/97

Kentucky, Department of Insurance

Celtic Life Insurance Company	9/3/96	561	1122	no new business issued since 7/15/95; participated in both group and individual markets
Centennial Life Insurance Company	12/31/96	2,233	4466	
Central Reserve Life Insurance Co.	8/11/95	369	738	
Community National Assurance Co.	5/95	3119	6239	
Cuna Mutual Insurance Society	2/25/97	19	36	participated in the group market only
Fortis Benefits Insurance Company (Time)	5/25/96	6458	12916	
General American Life Insurance Company	8/28/96			participated in the group market
Golden Rule Insurance Co.	6/11/96	5869	11738	
The Guardian Life Insurance Co.	8/14/96	95	190	participated in the group market only
Heritage National Healthplan, Inc.		17	34	
Life of Georgia	9/13/95	8	16	
Hartford Life & Accident Co.	7/12/94	10	20	these are individual policies
John Alden Life Insurance Co.	12/28/95	3383	6766	
John Hancock	3/97	0	0	business sold to Unicare
Metropolitan Life Insurance Co.	11/30/95	338	676	
MidAmerica Mutual Life Insurance Company	3/19/96	57	114	
Mutual of Omaha	7/7/95	917	1834	participated in the individual market only

Revised 9/9/97

Kentucky Department of Insurance

The Mutual Life Insurance Co. of New York	7/5/95	0	0	
New York Life Insurance Co.	1995	69	138	these are group policies (sm, lg, and assn. They did not participate in the individual market)
National Financial Insurance Co.	8/16/95	20	40	
National Casualty Co.	8/22/95	711	1422	
Nationwide Life Insurance Co.	7/10/95	300	600	participated in both group and individual markets
Nippon Life Insurance Co.	6/10/96	10	20	participated in the group market only
Pan American Life Insurance Co.	7/3/95	52	104	participated in the group market only
Philadelphia American Life Insurance Co.	7/14/95	28	56	
Physicians Mutual Insurance Co.	7/6/95	227	454	
Phoenix Home Life Mutual Insurance Co.	6/30/95	4	8	
PM Group Life Insurance Co.	7/14/95	27	54	participated in the group market only
Preferred Risk Life Insurance Co.	7/26/95	15	30	participated in individual market only
Principal Mutual Life Insurance Co.	7/14/96	1677	3354	participated in the individual and group markets
Pyramid Life Insurance Co.	6/29/95	387	774	
Provident Indemnity Life Insurance Co.	7/14/95	133	266	

Revised 9/9/97

Kentucky Department of Insurance

Security Life Insurance Co. of America	8/24/95	9	18	participated in the group market only
Sentry Life Insurance Co.	7/12/95	90	180	
Shelter Life Insurance Co.	2/17/95	500	1000	
State Farm Mutual Insurance Co.	4/94	8923	17846	
The Travelers Insurance Co.	7/17/94	518	9672	participated in group market only; sold business to MetraHealth (now United HealthCare)
Trustmark Insurance Co.	4/19/96	248	496	participated in the group market only
Union Bankers Insurance Co.	6/29/95	104	208	participated only in the individual market
United World Life Insurance Company	7/12/95	172	344	
Washington National Life Insurance Co.	early 1995	2,380	4,760	
TOTAL		40,906	91,129	

Revised 9/9/97

Kentucky Department of Insurance



AID ASSOCIATION FOR LUTHERANS

4321 North Ballard Road, Appleton, WI 54919
(414) 734-5721

RECEIVED
DEPT. OF INSURANCE

APR 13 12 28 PM '97

George Nichols III, Commissioner
Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Dear Mr. Nichols:

Thank you for the opportunity to provide feedback regarding the Individual Health Insurance market in the commonwealth of Kentucky. As you know, AAL no longer offers medical insurance to individuals under age 65 in Kentucky. We do, however, market other forms of individual health insurance including long term care insurance and disability insurance. You may wish to keep in mind that health insurance is more than just major medical insurance.

AAL decided in 1993 to discontinue sales of major medical insurance in all states. Our decision was not directly related to the reform measures being contemplated in Kentucky. However, the various state reform measures did contribute to our decision since it was becoming more and more difficult to be a nationwide provider of individual major medical insurance. It is unlikely that any changes to your current law would lead us to consider reentering this market.

I regret that we will be unable to be present at your meeting. We wish you the best of luck as you deliberate the future of medical insurance in your state.

Sincerely,

Brian Leonhardt
Director and Assistant Actuary
Health Solutions

April 14, 1997



**AMERICAN
MEDICAL SECURITY**
R for Good Health[®]

March 25, 1997

Commissioner George Nichols III
Commonwealth of Kentucky
Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517

Re: United Wisconsin Life Insurance Company / American Medical Security

Dear Commissioner Nichols:

Thank you for your letter dated March 21, 1997. We enjoyed having an opportunity to speak with you at the recent NAIC meeting in Orlando.

As you are aware, American Medical Security (AMS) designs, markets, and administers group health insurance plans that are underwritten by United Wisconsin Life Insurance Company (UWLIC). Please note UWLIC has not withdrawn from the individual health insurance market in Kentucky. As conveyed in our meeting on February 14, 1997, we are supportive of your efforts towards legislative reform in the health insurance market, and hope to remain in the market until we have an opportunity to evaluate these efforts and their impact on us.

Even though UWLIC has not withdrawn from the individual market, it is probable we share many of the same concerns of the departed carriers. Obviously, the primary concern of all carriers is an apparent lack of ability to obtain a reasonable rate of return. Most carriers, including UWLIC, attribute this to the present mechanism for granting premium rate changes. The requirement that public hearings be conducted for every rate filing exceeding the medical CPI plus 3 percent has created a two-fold dilemma. It has been effective in reducing carriers average renewal premium rate adjustments. On the other hand, it is the primary reason nearly 40 companies have left the health insurance market. As we have previously discussed, the lack of competition in the individual market is already having a detrimental impact on the insurance consumer in Kentucky.

At our meeting on February 14, 1997, you presented an interesting "rebuttal" to many carrier's demands for legislative relief on rating restrictions. We concur with your statements that some of the carriers are blaming their dismal rate of returns on the legislative restrictions, rather than their own pricing inadequacies. Obviously, UWLIC wishes it would have been able to establish a higher "floor", so it could better operate under the current rating mechanism. However, the ability to compensate for unexpected losses is a basic principle which needs to be employed so any carrier can remain in any given market. We strongly urge

**AMERICAN
MEDICAL SECURITY**
R for Good Health[®]

Page 2
March 25, 1997

you, your task force, and the legislators to amend the rating criteria so carriers, including UWLIC, may re-establish itself in the marketplace.

We realize rating restrictions are necessary in a market where insurance coverage is guarantee issued. If certain restrictions are not implemented, the cost of coverage may increase to the point health insurance becomes inaccessible to the insurance consumer (especially in a market that lacks competition). However, if the guaranteed coverage mechanism is changed from guarantee issuance in the individual market to a high risk pool, the need for such stringent rating restrictions is alleviated. Therefore, we are supportive of a high risk pool. Based on our previous meetings, you seem to be heading in this direction.

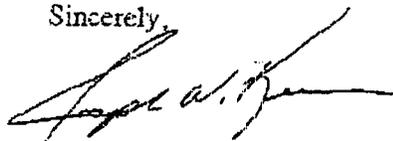
Obviously, we would prefer the high risk pool be supported by general revenue dollars. This would mean all citizens of the state would be supporting the high risk pool. Assessments on carriers would mean only a small portion of the state's population would be supporting the pool. The uninsured and those plans governed by ERISA would provide no support.

If carrier assessments are used, the assessments should be proportionate to their participation in the market. There should be some protection against excess assessments against carriers in the event of unusually large claims.

We are sure our concerns due not differ greatly from many other carriers. However, the one thing that sets us apart is our intentions to "stay and wait". We currently have nearly 3,800 total individual insured lives in the state of Kentucky. Hopefully, the market will change to such an extent that we can expand on this block of business, and re-establish a strong marketing force in your state.

Again, we are supportive of your efforts, and are willing to assist you in any way we can. If you should have any questions or comments, please feel free to contact me at 1-800-232-5432, extension 13327.

Sincerely,



Joseph W. Keen
Director, Regulatory Affairs

cc: Timothy J. Moore, Senior Vice President & General Counsel
Edward R. Skoldberg, Executive Vice President & Chief Operating Officer



**AMERICAN
NATIONAL**

AMERICAN NATIONAL INSURANCE COMPANY

*Grant
DS*

CHARLES J. JONES, RHU, HIA, ALHC, VICE PRESIDENT, HEALTH UNDERWRITING AND NEW BUSINESS ISSUE
ONE MOODY PLAZA GALVESTON, TEXAS 77550-7999 BUS: (409) 766-6657 FAX: (409) 766-6646

March 25, 1997

Mr. George Nichols, III 
Commissioner
Department of Insurance
P. O. Box 517
Frankfort, KY 40602-0517

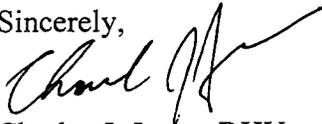
Dear Commissioner Nichols:

This information is being provided in response to your request for an outline of the reasons that the Company withdrew from the individual health insurance market in Kentucky.

1. Modified community rating.
2. Renewing plans to one of the prescribed health plans on a guaranteed renewable basis.
3. Guaranteed issue of prescribed health plans.
4. Change in the pre-existing condition period.
5. Portability and its impact on the pre-existing provision of the policy.

If you require any further clarification, please contact me.

Sincerely,



Charles J. Jones, RHU
Vice President
Health Administration

CJJ

cc: G. Noelle
G. Tolman

RECEIVED
DEPT. OF INSURANCE
MAR 31 3 02 PM '97



American Republic Insurance Company



GP

NATIONAL HEADQUARTERS: DES MOINES, IOWA 50334
WATSON POWELL, JR., CHAIRMAN OF THE BOARD
AND CHIEF EXECUTIVE OFFICER

RODERICK E. TURNER, F.S.A., M.A.A.A.
VICE PRESIDENT
A&H PRODUCT MANAGER

April 15, 1997

Mr. George Nichols, III, Commissioner
Co-Chair, Task Forces on Individual
Health Insurance
State of Kentucky
Department of Insurance
Post Office Box 517
Frankfort, KY 40602-0517

Dear Mr. Nichols:

Since a representative from American Republic Insurance Company will be unable to attend the Joint Task Force meeting on April 18, 1997, the following reasons outline why we left the health insurance market in Kentucky.

1. Renewability - Need the ability to change the policy to implement changes in the ever changing healthcare environment; i.e., changes in network or required benefits provided by a managed care network. HIPAA addresses this issue by allowing a company to offer a replacement policy or modify a policy at renewal.
2. Limiting rating to 300% for age forces younger people in their early earning years to subsidize people who in most cases have been in the workplace for years and have established careers.
3. Not allowing substandard rating or waivers.
4. Limitation on rate variation to 30% above or below the index community rate, reducing to no deviation after July 1, 2000.
5. Excessive municipality taxes.

Comment: All of the above restrict the ability of a company to make the product affordable. If an individual health product is not affordable, people in the individual market simply choose not to buy the product. They don't see the "value."

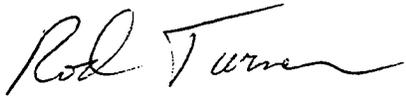
April 15, 1997

6. Standardized plans restrict innovation and the ability of a company to meet the needs of an individual. Individual purchasers make decisions to buy based on many factors. They cannot be pigeonholed into plans that may not fit their needs, or that are too expensive for them.
7. Guaranteed issue further reduces the incentive to purchase insurance while healthy.

The experience in other states has shown a company cannot offer a health insurance product profitably in the individual marketplace under these conditions listed above.

I apologize for the brevity of this letter, but I wanted to get it to the committee before your meeting.

Sincerely,



Rod E. Turner, F.S.A., M.A.A.A.
Vice President
Product Manager

RET/meh

BANKERS LIFE AND CASUALTY COMPANY

P.O. Box 1915 • Carmel, IN 46032-4915
(317) 817-6500

April 18, 1997

Honorable George Nichols III
Commissioner of Insurance
Kentucky Department of Insurance
215 West Main
P.O. Box 517
Frankfort, Kentucky 40602

RECEIVED
DEPT OF INSURANCE
APR 22 10 47 AM '97

Dear Commissioner Nichols:

We appreciate the opportunity to explain why our company has had to withdraw from the major medical health market in Kentucky. The continued de-emphasis of this product within our company and the changes to the product and rating requirements as a result of the Kentucky legislation led to our decision to withdraw.

Bankers Life and Casualty Company's primary market has been Medicare Supplement, Long Term Care and other senior marketing products. However, we have had a market for INDIVIDUAL comprehensive health products for many years. (We are not in the small group business in Kentucky.) But in recent years, we have reduced our presence in the major medical market. In 1994 we issued 174 comprehensive or hospital-surgical policies in Kentucky. These policies were first developed and sold on a nationwide basis in 1989. By so doing, we could spread development costs based on nationwide production levels.

HB 250 required changes to our product, limited our ability to underwrite the risks we were to assume, and provided further restrictions of premium rate structures.

Based on projected sales volume alone, it was difficult for us to justify the cost of developing and maintaining a product with specified benefits, different from our nationwide product.

In addition, HB 250 has mandated a guaranteed issue situation. When we can underwrite our policies, we have some control over the risk we assume. We understand that the Kentucky Health Policy Board has set up a risk adjustment mechanism so that no carrier will have a disproportionate share of the unhealthy risks. However, because the Board sets the risk sharing rules and standards, the Board basically exercises control over our profits in Kentucky.

Honorable George Nichols III

April 18, 1997

Page 2

The Rate Filing Procedures under 806.KAR 17:14OE which implements SB 343 Section 16, require very detailed information. The data would be extremely difficult to provide and would lead to considerable administrative expense. The profit information requested is proprietary. Providing such numbers is not public domain, nor should they be. In addition, the providing of loss ratios, expense levels, and profit margins would allow the state to control a carrier's profit levels.

SB 343 subsection 16(2)(c) requires a hearing for any rate increase which exceeds Medical CPI plus 3%, which would essentially require rate hearings for every rate request. Even without the special requirements of guaranteed issue and modified community rating, we would expect trends to generally exceed this guideline. It does not consider increases that occur due to the additional risk that a carrier assumes when writing new business under reform. The claim costs and loss ratio experience under the inforce medical plans is not indicative of what experience will be under the standard plans. Initial pricing of the standard plans is very difficult. This makes the limits on rate increases especially onerous as rate problems cannot be easily corrected.

Therefore, in summary, the provisions of HB 250 required significant enough changes in product and our ability to manage the risk to cause us to withdraw. The additional restrictions imposed by SB 343 only reinforced that decision. We would have strongly preferred to stay in the market in Kentucky. But, we believe it is extremely difficult, if not impossible, for any insurance carrier to successfully manage their products under such severe rating restrictions.

Sincerely,



Donald F. Gongaware
President

DFG/cjn

CELTIC

Celtic Group, Inc.

March 25, 1997

Sears Tower
233 South Wacker Drive, Suite 700
Chicago, Illinois 60606 6393
312-332-5401George Nichols III
Commissioner of Insurance
Department of Insurance
Post Office Box 517
215 West Main Street
Frankfort, Kentucky 40602

Re: Kentucky Health Care Reform

Dear Commissioner Nichols:

This is in response to your letter, dated March 21, 1997. I am attaching a copy of a letter that I sent to you on January 10, 1997. That letter briefly offers a critique of Kentucky insurance reform. Given this opportunity, I will reiterate some of the thoughts and arguments contained in that letter. We, in the insurance industry, face tremendous pressure from consumers, health care providers and politicians to provide universal, affordable health insurance coverage. In attempting to implement this goal, we need to acknowledge the lessons afforded by the implementation of other government programs such as public education. If politicians create a public health insurance entitlement while prohibiting the private health insurance market, standards of care will suffer, consumer choice will be curtailed and costs will go unchecked. At the root of any public entitlement program is the problem of efficiency. Simply put, the free market acts more efficiently than does a controlled market.

Rate guarantees, rate restrictions and a restricted rate approval process are the features of the Kentucky health insurance reform that we weighed most heavily in our decision to stop the solicitation of health insurance in Kentucky. Guaranteed issuance of mandated plans, guaranteed renewability and guaranteed portability were factors that we very seriously considered in our analysis.

Celtic Life Insurance Company stopped issuing major medical health insurance coverage in Kentucky because the market reforms that the Kentucky legislature enacted, eliminated free market efficiency. Health insurance carriers could no longer underwrite risk, price for risk or even choose which benefits to offer in Kentucky. Such a health insurance market cannot hope to attract profit making enterprises. As we stated in our prior correspondence, the particular reforms enacted in Kentucky, taken individually, serve to impair the efficiency of the health care market. Taken together, the reform package creates a virtual public health insurance entitlement program that lacks the room for insurance companies.

We cannot too greatly emphasize our support for the goal of universal, affordable health insurance coverage. We recommend the utilization of a health insurance safety net,

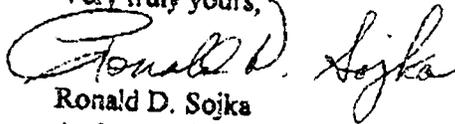
CELTIC

George Nichols III
Commissioner of Insurance
Page 2

funded by general revenues to accomplish this goal. We commend the approach taken by a number of states, who have implemented comprehensive health insurance pools. Such markets offer the best of both worlds. On the one hand, such markets efficiently handle health insurance by encouraging competition in the health insurance market, while on the other hand, those who truly need but cannot afford or qualify for health care are able to obtain it via the comprehensive health insurance pool. We hope that the Kentucky legislature opens the Kentucky health insurance market to competition and concurrently provides for those in need by creating a comprehensive health insurance pool funded by general revenues.

We appreciate the opportunity you have provided us to express our views on Kentucky health insurance reform. Thank you.

Very truly yours,



Ronald D. Sojka
Assistant Vice President, Counsel
Legal and Regulatory Matters

RDS/rs



Celtic Life Insurance Company

January 10, 1997

Sears Tower
233 South Wacker Drive, Suite 700
Chicago, Illinois 60606-6393
312-332-5401

George Nichols III
Commissioner of Insurance
Department of Insurance
Post Office Box 517
215 West Main Street
Frankfort, Kentucky 40602

Re: Kentucky Health Care Reform

Dear Commissioner Nichols:

At the Winter NAIC meeting, you met with members of the insurance industry to discuss Kentucky health care reform. This letter is to follow up that discussion. As we noted at the meeting, it is the general consensus of the insurance industry that Kentucky politicians have faced the politician's health care dilemma and opted to force the insurance industry to subsidize health care. The problem with health care is that everyone agrees that everyone should have it, but nobody wants to pay for it. The political dilemma then, is to choose between raising taxes to fund an entitlement program for those who cannot obtain or afford health care coverage in an open market or pushing insurance "reform" that ultimately raises the cost of coverage for the average consumer. Since the points we wish to make are not new and have been made better by others, our discussion of the specific deficiencies of the Kentucky reform package are very briefly outlined below, along with our recommendation.

Mandated Plans

Kentucky requires insurers to offer only its mandated plans. Legislators substituted their choice over consumer choice. This attitude, that big brother knows what is best for the consumer, pervades many entitlement programs and once pervaded some quite large economic systems. Consumers who may be happy with their health insurance coverage are forced to obtain coverage that does not meet their needs. Insurers are thus forced to sell policies that do not satisfy consumer demand.

Guaranteed Issuance of Mandated Plans

Kentucky requires insurers to guarantee issue its mandated plans. The analogy oft used to illustrate the problem with guarantee issue, relates it to home owners coverage for fire. That is, guaranteed issue of health insurance is like allowing a homeowner to buy fire insurance while the homeowner's house is on fire. People will not buy health insurance in a guaranteed issue market until they need it. This will undoubtedly raise the claims experience, in turn raising loss ratios and the cost of the insurance. Guaranteed issue eliminates good underwriting, the proper assessment of risk, and the heart of the insurance industry.

CELTIC

George Nichols III
Commissioner of Insurance
Page 2

Modified Community Rating and Rate Guarantees

Community rating, however it is modified, simply shifts the cost of coverage to the people least able to pay it. That is, community rating forces the young, healthy population to subsidize the older, less healthy population. This public policy choice too often is driven by the group who stands to gain by being subsidized. The closer a rating system gets to true community rating, the closer it gets to becoming an entitlement program. In a free market system, people pay for what they get. Most people consider it only fair to get what is paid for.

Rate guarantees penalize an insurer for making bad predictions about the cost of future medical services or future claims. The longer the rate guarantee the greater the penalty. Reality dictates that rates that hope to take into account future projected increases in the cost of medical services or increases in claims experience cannot hope to pass insurance department scrutiny. Balancing an acceptable loss ratio against the risk of unknowable expenses has in our New Jersey experience taught us a very expensive lesson. We have lost money attempting to administer products with 12 month rate guarantees. We do not believe it can be done. We are not in business to lose money. At this time, we will not attempt to do business in a jurisdiction that does not allow rate flexibility.

Guaranteed Renewability

In a guaranteed issue market there is no need for guaranteed renewability. If someone is not renewed they can obtain insurance coverage from another insurer.

Pre-existing Conditions

The shorter the time period allowed for exclusion of pre-existing conditions, the more likely it is that a sick individual will wait until they begin incurring claims to obtain insurance coverage. Couple this with an insured's ability to switch plans at will and one can see that the cheapest plans will allow access to the market for those at high risk, who will switch to the richest plan as soon as they begin to incur claims. As rates increase, healthy individuals become less inclined to subsidize the sick and eventually the entire market may enter a death spiral.

Portability

Credit for time already spent under a prior insurance policy forces an insurer to live with someone else's underwriting. In a guaranteed issue market, portability of coverage like renewability of coverage is of very little practical importance.



George Nichols III
Commissioner of Insurance
Page 3

Outlook

Although we do not believe that most of the Kentucky reforms benefit consumers, we also do not consider most of them, on an individual basis, to prevent the functioning of the health insurance market. Rating inflexibility and rating restrictions, for us, are key features that do weigh heavily in our analysis of market profitability. Taken in the aggregate, however, we believe that the entire Kentucky reform package is unworkable.

From the prior discussion, our pre-disposition to a free market insurance market should be clear. No matter how hard the Kentucky legislature tries, it cannot reform the laws of economics. One need only recall college economics to be reminded that a free market, as if by an "invisible hand," rations scarce economic resources. The entitlement program implemented by the Kentucky legislature has already shown the kind of rationing of resources that it will engender. Turning the entire health insurance market into an entitlement program will inevitably lead to shortages of needed medical services and the highest possible costs.

Recommendation

We support the public policy goal of providing a safety net for those people who cannot obtain health insurance coverage. We believe that such a safety net, should be funded by general revenues, since a safety net by its very nature needs to be some form of entitlement program. The program that we believe best suits the needs of the public is some form of comprehensive health insurance pool. Such a pool should be open only to those people who meet strict qualifications for health status, residency and income. Otherwise, the pool will fail to serve its intended purpose.

We believe that Kentucky consumers demand a free market and we believe that a free market best serves consumers. We hope that you are able to persuade the Kentucky legislature to open up the Kentucky health insurance market to competition. We look forward to re-establishing a profitable presence in the Kentucky health insurance market. Thank you for affording us the opportunity to express our views on Kentucky health care reform.

Very truly yours,

A handwritten signature in cursive script that reads "Ronald D. Sojka".

Ronald D. Sojka
Assistant Vice President, Counsel
Legal and Regulatory Matters



Joan A. Markoe, Esq.
Senior Counsel
CIGNA Group Insurance

RECEIVED
DEPT OF INSURANCE



CIGNA

APR 21 12 16 PM '97

April 17, 1997

21TLP
Two Liberty Place
1601 Chestnut Street
P.O. Box P.O. Box 7716
Philadelphia, PA 19192-2211
Telephone 215.761.1980
Facsimile 215.761.5563

George Nichols III, Commissioner
Co-Chair, Task Forces on Individual Health Insurance
Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Dear Commissioner Nichols:

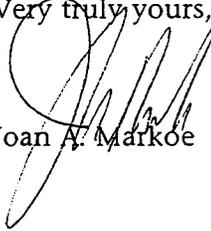
I am responding to your letters of April 3, 1997 to John Leonard, President, Life Insurance Company of North America (LINA) and Richard Franklin, President, Insurance Company of North America (INA), in which you inquired why these companies left the health insurance market in Kentucky and what changes would need to be made to the current law for the companies to re-enter.

In recent years, health insurance has not been a core product line for LINA and INA. The companies wrote health insurance in a few niche group markets; they did not write at all in the individual market. The proliferation of new health insurance requirements in a number of states, including Kentucky, prompted the companies to evaluate whether they could afford the significant compliance and actuarial resources necessary to support the health insurance business, given the relatively small amount of business which they wrote. This evaluation resulted in a decision to withdraw from the health insurance market in certain states.

Since LINA and INA were never in the individual market, their withdrawal would have had no impact on the individual market in Kentucky. And, since LINA and INA were such a small, niche writers in the group market, it is unlikely that their withdrawal had much impact in the group market in Kentucky. The companies have recently revised their business strategy and they are not going to focus on the health insurance market in the future, with the possible exception of student health insurance. In light of this strategic direction, there is no change in the current law which would cause LINA and INA to re-enter the health insurance market.

The companies will not be represented at your meeting, but they do appreciate the opportunity to share these thoughts with you.

Very truly yours,


Joan A. Markoe

cc: John Leonard, Richard Franklin



Metropolitan Life Insurance Company
One Madison Avenue, New York, NY 10010-3690
Tel 212 578-2640 Fax 212 578-8869



Timothy J. Ring
Government Relations Assistant
Government and Industry Relations

Via Overnight Mail

Hon. George Nichols III
Commissioner
Department of Insurance
215 West Main Street
Frankfort, Kentucky 40602-3630

RECEIVED
DEPT. OF INSURANCE
JUN 16 2 29 PM '97

Dear Commissioner Nichols:

I am glad we had an opportunity to meet at the recent NAIC meeting. As I mentioned to you when we spoke, your recent letter to Harry Kamen, the Chairman, President and Chief Executive Officer of MetLife, has been forwarded to me. In your letter, you requested our assistance in providing information about our withdrawal from the health insurance market in Kentucky, in an effort to create a comprehensive market study that may lead to regulatory reforms in the health insurance market.

MetLife did not actually withdraw from the health insurance market in Kentucky. Rather, we entered into a transaction with Travelers whereby the health insurance business of each company was combined into a new company, MetraHealth. That company has subsequently been acquired by United Healthcare.

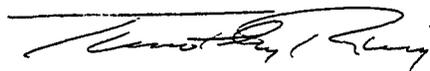
The decision to enter into this transaction was not motivated by the laws and regulations governing health insurance in any single state. It was a strategic corporate decision based on financial considerations and a desire to focus our resources on what we consider our core business - the sale of life insurance and annuity products. Also, in the formation of MetraHealth, most of the individuals at MetLife knowledgeable about health insurance issues left and became employees at the new company. As a result, we simply no longer have the expertise and experience in the health insurance area that we once had.

While we support your efforts, and commend your progressive and forward-looking approach, we are unable to provide you with the type of assistance you are requesting.

You also asked about the number of non-standard health insurance plan contracts and covered lives in effect for our company as of May 1, 1997. At that time, there was only one contract in effect in Kentucky, representing one life.

If there is anything I may be able to do, or if you have any questions, please feel free to contact me directly.

Sincerely,

A handwritten signature in cursive script, appearing to read "Timothy Ring".

Timothy Ring

June 13, 1997



Galen F. Ullstrom
Vice President
State Government Relations
(402) 351-5235
Fax: (402) 351-5710

April 16, 1997

via: Facsimile and Post

The Honorable George Nichols III
Commissioner of Insurance
Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Dear Commissioner Nichols:

This letter is in response to your letters of April 3, 1997, to John Weekly, President of Mutual of Omaha Insurance Company and Thomas Sawicz, President of United World Life Insurance Company.

Unfortunately we will be unable to attend the joint task force meeting on April 18, 1997, but please feel free to share our letter to you of March 25, 1997 (copy attached) with other members of the task force. If you would like us to expand on any of the information provided, we would be happy to do so.

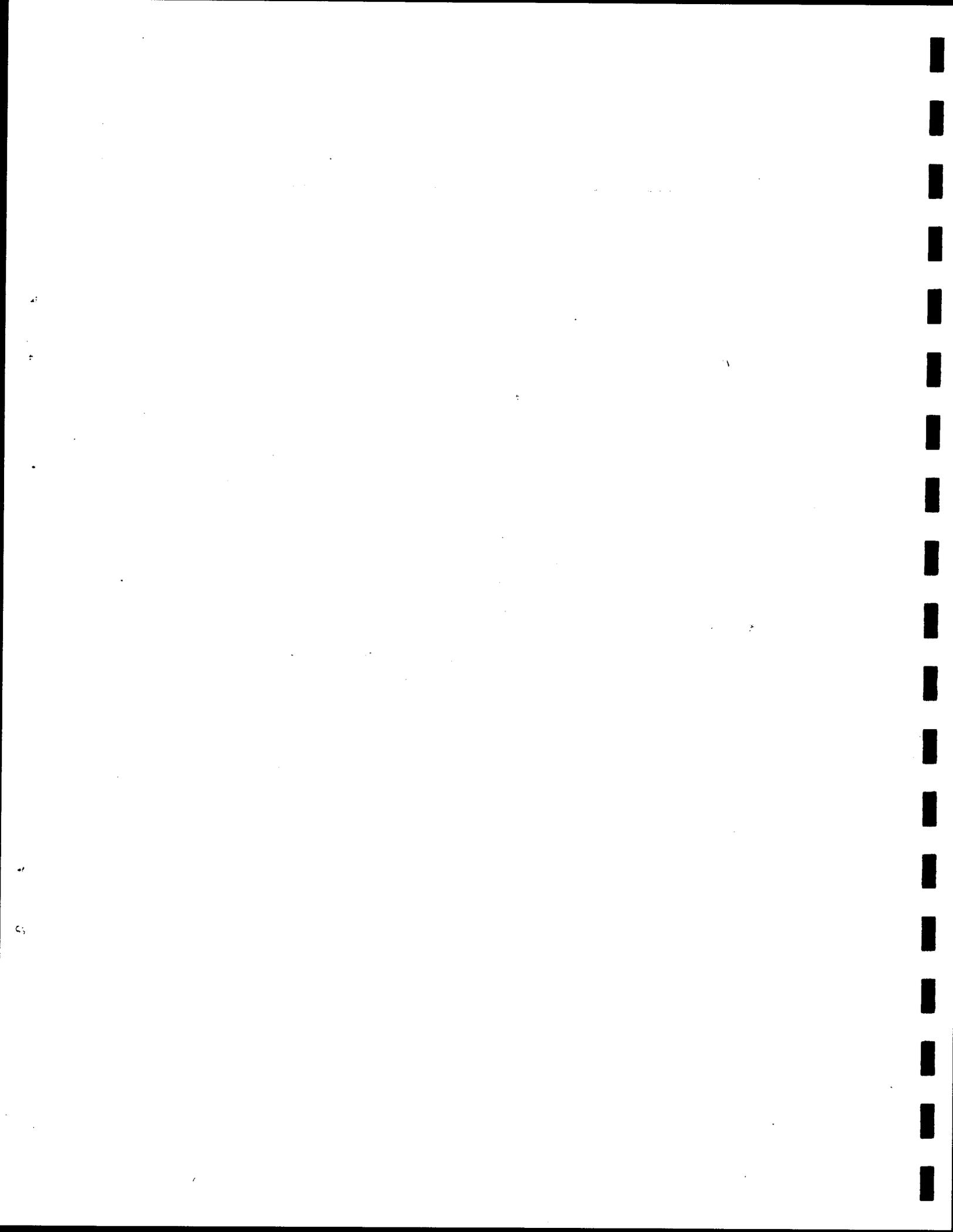
If you have any questions, please contact me.

Very truly yours,

Galen F. Ullstrom

G0411197/sam
Attachment

APR 16 11 09 AM '97
RECEIVED
INSURANCE





Galen F. Ullstrom
Vice President
State Government Relations
(402) 351-5235
Fax: (402) 351-5710

March 25, 1997

The Honorable George Nichols III
Commissioner of Insurance
Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Dear Commissioner Nichols:

In response to your letter of March 21, 1997, the following are the primary reasons why our company chose to withdraw from the health insurance market in Kentucky effective July 15, 1995.

The primary reason was the requirement that we guarantee issue up to eight standardized health plans and that no other health plans could be offered. We were concerned that certain of the plans included low deductible options and unlimited lifetime benefits which were plans that our company was not offering in the individual market at that time. We were very concerned about the anti-selection which would occur by requiring guarantee issue of these plans in a voluntary environment (as opposed to a mandatory universal environment) which would allow individuals to stay out of the market until they became sick.

In addition, based upon our experience in other states, we were concerned that the requirement that the insurance commissioner hold a public hearing on every rate filing proposing a rate increase exceeding the percentage change in the Medical Care Consumer Price Index plus 3% would create a political atmosphere that would not allow appropriate or justified rate increases to be granted or at least be an expensive process and could result in considerable delay.

I hope the above provides the information you requested, however, if I can provide any further information, please let me know.

Sincerely,

Galen F. Ullstrom

G0325197/sam





Nationwide Life Insurance Company
One Nationwide Plaza
Columbus, Ohio 43215

April 16, 1997

The Honorable George Nichols III, Commissioner
Department of Insurance
PO Box 517
Frankfort KY 40602-0517

Dear Mr. Nichols:

Thank you for extending an invitation to our president to speak at your Joint Task Force for Individual Health Insurance. He will be unable to attend but asked me to share our thoughts and concerns. We respect the important responsibilities and goals which you are pursuing. We believe that affordable health care for all is very desirable.

From an insurer's view, it has become very difficult to make even a small profit in health insurance. Volatility is unnerving and losses are frequent. In spite of this, it is common for insurers to be blamed for high costs and it is implied that they are making big profits at the expense of sick people.

It is rudimentary that investors will only support businesses that are expected to be adequately profitable. Rating agencies such as Moody's and Standard & Poors generally give much lower ratings to insurers involved with health. The present regulatory environment makes it most probable that insurers will lose money in the Kentucky market. This is true both for business sold in years past and for prospective sales. Note the following:

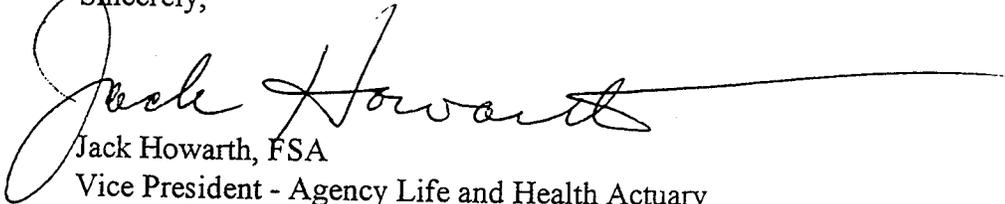
1. Recent rate regulation has ignored the cost increases which insurers face. Denied rate increases guarantee losses for insurers who need long term stability and fairness in rate regulation. Insurers will have to be convinced that they will be permitted to charge adequate premiums to sustain profitable operations or they will be forced to invest their capital in products that will, at a minimum, assure some level of profitability.
2. Requirements to issue insurance coverage, regardless of health, both helps people with above average health care needs to obtain insurance and encourages healthy people to delay the purchase of insurance until a claim seems likely. Both of these cause claims costs to increase significantly and decrease the number of persons covered. Premium rates would decline if all healthy people purchased insurance. As a practical matter, however, universal coverage will not happen in a voluntary market.

RECEIVED
DEPT OF INSURANCE
APR 21 11 54 AM '97

3. In Kentucky, municipality taxes as high as 14% siphon off policyholder premiums from their intended goal of health care coverage. They also give insurers a very difficult administrative problem which further increases costs. Tax compliance is far more complex in Kentucky than in any other state.
4. While we may all prefer lower costs, individual solicitation, sale, enrollment, billing and administration is more expensive for an individual than for a member of a large group. Adverse selection causes claims costs to be higher for individuals, too. The regulatory environment must accommodate this in some manner or insurers will gravitate to more profitable opportunities.
5. It is important to adequately recognize in premium rates those factors which influence costs. Such factors include age, sex, location and health status.

I hope your task force is successful in the pursuit of its laudable goals.

Sincerely,

A handwritten signature in cursive script that reads "Jack Howarth". The signature is written in black ink and extends across the width of the page.

Jack Howarth, FSA
Vice President - Agency Life and Health Actuary
Nationwide Life Insurance Company

P.S. Please accept these comments on behalf of our sister company, National Casualty Company for which I have related responsibilities for Individual Health.



Joy S. Jakelis, F.S.A.
Vice President & Actuary
Pan American Life Insurance Co.
601 Poydras Street
New Orleans, LA 70130

Telephone: (504) 566-3304
Fax: (504) 522-5393

RECEIVED
DEPT OF INSURANCE
APR 21 11 17 AM '97

April 16, 1997

George Nichols, III
Commissioner of Insurance
Department of Insurance
P.O. Box 517
Frankfort KY 40602-0517

Dear Commissioner Nichols,

I am responding to your April 3, 1997, letter to John Roberts inviting a representative from Pan American to speak at an April 18 Joint Task Force meeting. We thank you for your invitation but feel we would not be an ideal choice to speak because we are not in the individual health insurance business.

We did withdraw our small group product from the Kentucky market in 1995. We did so because we believed that the requirements of Kentucky's small group law were so restrictive that the potential existed to lose significant amounts of money by remaining in the market. In particular, we were concerned with the combination of guaranteed issue, severe restrictions on the use of pre-existing conditions exclusions and no latitude in rates to compensate for the resultant anti-selection.

We appreciate your asking for our input and would be more than happy to discuss our concerns with respect to the small group law in more detail.

Sincerely,

Joy S. Jakelis, F.S.A.
Vice President & Actuary

JSJ:bjp/41697.doc

cc: John K. Roberts, Jr., FSA, President and Chief Executive Officer
Ronald MacInnis, Executive Vice President, Health Insurance Operations





**SHELTER
INSURANCE
COMPANIES**

JAMES A. OFFUTT
EXECUTIVE VICE PRESIDENT
(314) 874-4271

April 10, 1997

George Nichols III, Commissioner
Co-Chair, Task Forces on Individual Health Insurance
Department of Insurance
P. O. Box 517
Frankfort, KY 40602-0517

Dear Commissioner Nichols:

Shelter Life Insurance Company has received your letter of April 3, 1997, addressed to Mr. Robert Maupin, concerning the Industry Task Forces on Individual Health meeting of April 18, 1997. We will not be attending the meeting and would like to provide you with the information you requested concerning its withdrawal from the health insurance market in Kentucky.

In 1990, Shelter Life Insurance Company discontinued the sale of its principal individual health insurance policy in all thirteen of the states in which it operates. Shelter Life Insurance Company had not been a significant writer of health insurance in Kentucky or elsewhere. We did continue to renew the existing Comprehensive Health insurance policies, but upon the passage of House Bill 250, this was no longer feasible because it would have required us to re-enter the active insurance market. For this reason, Shelter Life Insurance Company withdrew from the health insurance market in Kentucky.

Sincerely,


JAMES A. OFFUTT

RECEIVED
DEPT OF INSURANCE
APR 14 3 22 PM '97





Time Insurance Company
501 West Michigan
P.O. Box 624
Milwaukee, WI 53201-0624
Tel: (414) 271-3011

Direct Number:
(414) 299-7722

VIA FACSIMILE (502) 564-6090

March 24, 1997

The Honorable George Nichols III
Commissioner of Insurance
Kentucky Department of Insurance
P. O. Box 517,
Frankfort, Kentucky 40602-0517

Re: Reasons for Withdrawing from the Individual Health Insurance Market in Kentucky

Dear Commissioner Nichols:

In response to your letter of March 21, 1997, the following represents an outline of the reasons why Time Insurance Company (Time) withdrew from the individual health insurance market in Kentucky.

1. Guarantee Issue Environment

In analyzing House Bill 250 and Senate Bill 343, Time officials were concerned with the provision in those laws which would restrict the company to selling only standardized guarantee issued products in Kentucky.

As an individual insurer licensed in 47 states, Time has a significant amount of experience in guarantee-issue only states, and the results have not always been very credible. The following chart shows Time's loss ratio experience in two guarantee issue environments, Maine and New Jersey.

<u>Year</u>	<u>Maine</u>	<u>New Jersey</u>
1994	46.9%	98.8%
1995	72.8%	117.3%
Thru 6/96	89.0%	148.3%

In Maine, Time was allowed to market its own products, but they were guarantee issued. In New Jersey, Time could only offer five state designated guarantee issued plans.

Commissioner Nichols
Reasons for Withdrawal
March 25, 1997
Page 2

As the chart demonstrates, a guarantee issue requirement in the individual medical marketplace causes severe pressures on this market. This is due to the individual market being smaller in size to the small group market and much more vulnerable to fluctuations in premium increases, largely because consumers who purchase individual medical products pay the entire cost of their health insurance premiums as opposed to small employers, who generally pay the largest proportion of small group premiums.

In an guarantee issue environment, individuals, previously denied coverage, suddenly have the ability to purchase individual medical coverage. It is not long before these individuals begin incurring claims, which adds to the block's overall loss ratio. As premiums increase, healthy individuals tend to leave the market because they no longer can afford the premiums. Those who remain generally are those individuals incurring the most claims, thus creating a "death spiral" for the block of business.

Maine provides a very good case study in this regard. On February 26, 1996, the state of Maine approved a rate increase for Time of 44 percent on average to account for the rapidly worsening experience the company was incurring in that state. The effect of the rate increase was a 65 percent decrease in covered insureds in one year's time.

2. Community Rating

Time is of the opinion that community rating does not work in the individual marketplace. If a company is forced to charge the same rate to its insureds, regardless of age, the net result is that younger, healthier individuals end up subsidizing the premiums of older, and generally less healthy individuals. This may not cause a disruption in the marketplace until such time as the claims experience begins to worsen. When that happens, a carrier will generally seek a rate increase, which means that younger insureds will bear a disproportionate share of those increases. With less discretionary income than older individuals, younger insureds tend to simply exit the market because they can no longer afford the premiums.

3. Rate Approval Process

Time is of the opinion that to be successful in a given market, the company must have the ability to adjust its price to the developing experience of its block of business. If the trend rate used in pricing a product is not estimated properly, a company needs the ability to correct its rates for any deficiencies. In analyzing House Bill 250 and Senate Bill 343, Time officials had a concern that the laws did not give the company the opportunity to make rating adjustments in a timely fashion, particularly with the rate approval process being scrutinized by the Attorney General's office.

Commissioner Nichols
Reasons for Withdrawal
March 25, 1997
Page 3

I hope this letter explains some of the reasons behind Time's decision to withdraw from the individual market in Kentucky. This was not an easy decision on Time's part, but given its experience in other states, the company concluded that it could no longer successfully compete in the individual market in Kentucky. Time is hopeful the recommendations you may make in your white paper and any subsequent legislation to amend current law will cause Time to re-consider its decision to write individual insurance in Kentucky.

If I can be of any further help in this matter, please let me know.

Very truly yours,

David B. Reddick

David B. Reddick
Government Relations Officer



TravelersLife and Annuity
A Member of *TravelersGroup*

One Tower Square
Hartford, CT 06183
860 277-1716
FAX: 860 277-7631

Katherine McG. Sullivan
Senior Vice President and General Counsel
Law and Regulatory Affairs

RECEIVED
INSURANCE
APR 24 10 42 AM '97

April 17, 1997

George Nichols III, Commissioner
Commonwealth of Insurance
State of Kentucky
P. O. Box 517
Frankfort, Kentucky 40602-0517

Dear Commissioner Nichols:

The Travelers Insurance Company appreciates your invitation to be a guest speaker at the April 18, 1997 Joint Task Force meeting regarding Travelers reasons for leaving the health insurance market in Kentucky and provisions of current law that would need changing for Travelers to reenter the market. Travelers is no longer engaged in the health insurance market in Kentucky or anywhere else in the United States. We sold that line of business in 1995. Accordingly, Travelers is unable to accept your offer to be a guest speaker or to attend the task force meeting.

Sincerely,



Katherine McG. Sullivan

KMG:ac



Trustmark

INSURANCE COMPANY

Arnold I. Munson, JD
Assistant General Counsel

400 Field Drive • Lake Forest, Illinois 60045
Phone (847) 615-1500 • FAX (847) 615-3909

April 18, 1997

DEPT. RECEIVED
INSURANCE
APR 21 3 15 PM '97

George Nichols III
Commissioner/Co-Chair
Task Forces on Individual Health Insurance
Kentucky Department of Insurance
P O Box 517
Frankfort, KY 40602-0517

Dear Mr. Nichols:

In response to your letter dated April 3, 1997 to Donald Peterson I have prepared the following comments for consideration by you and the Task Force.

The main reasons for leaving the Kentucky individual health insurance market place start with the requirement that all plans are guaranteed issue. This takes away any control over the risk assumed. The second reason relates to rate controls. Rates are a function of health care provider charges and actual utilization by our insureds. We may exert limited influence on both of those factors through managed care programs, however, we must still be allowed the ability to adjust our rates to meet our costs. In addition, community rating, as it may limit the variation in rates by age, will tend to drive young healthy lives out of the market due to lack of affordability and thus rates for the remaining insureds will be driven higher. If community rating requirements are too severe many insurers will withdraw.

In order for Trustmark to reenter the market I urge the following two suggestions. First, underwriting must be allowed. Mandating guaranteed issue policies is not the only way to accomplish the goal of coverage for everyone. The best approach to the problem can be found in Illinois for example where a high risk pool was established allowing anyone rejected for individual insurance to purchase coverage for a modest surcharge. Even though only a small percentage of applicants are denied coverage by individual insurers the risk represented by this small segment must still be spread in some manner, and there is no way to price for this risk in a guaranteed issue market place. The second suggestion is that rates may be regulated, but not completely controlled or mandated.

I offer this further comment which I trust will be helpful. Creation of a uniform market by allowing only a few specified plans limits consumer options and innovative product development and improvement. Consider requiring all carriers to offer specified plans, but at the same time allow other alternative products as well, which would be priced consistently with the specified plans.

Thank you for giving me this opportunity to comment.

Very truly,



Arnold I. Munson, JD

AIM/as

cc: E. Fattes
R. Solomon
K. Schmidt





Security Life
Insurance Company of America



SECURITY AMERICAN FINANCIAL ENTERPRISES, INC.



Congress Life
Insurance Company

April 21, 1997

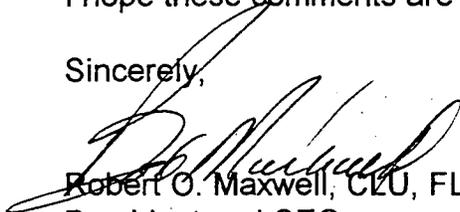
Mr. George Nichols III, Commissioner
Commonwealth of Kentucky
Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

Dear Commissioner Nichols:

Thank you for your April 3, 1997 letter. Security Life Insurance Company of America elected to withdraw from Kentucky due to our company's plan to withdraw from the medical insurance business throughout the country. I appreciate your offer as a guest speaker, but I am passing on that offer.

I hope these comments are helpful.

Sincerely,


Robert O. Maxwell, CLU, FLMI
President and CEO

/sle

RECEIVED
DEPT. OF INSURANCE
APR 23 10 03 AM '97



thePrincipal®

Financial
Group

Government
Relations

April 16, 1997

The Honorable George Nichols III
Commonwealth of Kentucky
PO Box 517
215 West Main Street
Frankfort, KY 40602

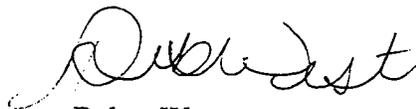
Dear Commissioner Nichols

Thank you for including us in your on-going effort to implement reforms to Kentucky's health laws. We appreciate the opportunity to express our views.

Enclosed please find a copy of a March 24, 1997 letter to you from our company which outlines The Principal's concerns. Our position is unchanged from that stated in the letter and we continue to have the same concerns.

Please contact me at the number listed below if I can be of assistance to you on this or any other matter.

Sincerely



Debra West
Counsel
Government Relations
1-800-325-2532 Ext. 7-0962

DKW:vlc
S:\h022\vlc\dkw\10415gn

Enc
cc

David Drury
Tom Graf
Lucia Riddle
Merle Pederson
State File

RECEIVED
DEPT OF INSURANCE
APR 22 11 15 AM '97



March 24, 1997

VIA FACSIMILE and REGULAR MAIL

The Honorable George Nichols III
Commissioner
Kentucky Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517

Re Your March 21, 1997, Correspondence

Dear Commissioner Nichols

Thank you for your letter dated March 21, 1997, addressed to Ms. Deb West in our department. Since Ms. West is out of the office and because your correspondence required immediate response, I have taken the liberty to respond to your request to outline Principal Mutual's reasons for withdrawing from the individual health insurance market in Kentucky.

As you will recall, representatives from Principal Mutual discussed these reasons in detail with you at the December 17, 1996, meeting in Atlanta. There are two primary reasons for Principal Mutual's decision to withdraw from the Kentucky individual health insurance market. First, the Kentucky reform law required that companies guarantee issue their individual health insurance plans in the state. And more specifically, the guarantee issue period was not limited but rather a continuous year around open enrollment with no risk adjustment mechanism. This, in essence, means that carriers with richer benefit plans, excellent customer service, and superior claims paying capabilities are very much adversely selected against and have no mechanism to share their disproportionate share of high claims. Second, Principal Mutual was concerned about the new rate approval process in the Kentucky law which permits rate increases not to exceed CPI + 3%. Anything above that would have required expensive rate hearings with what appeared to be an adversarial involvement on the part of the Attorney General's Office. This perceived rate cap in combination with continuous guarantee issue and no risk adjustment mechanism made the Kentucky health insurance market a tenuous place to continue doing business. Despite that, our decision to withdraw from the Kentucky market was not an easy one.

Finally, Principal Mutual has just recently made a strategic business decision to withdraw from the individual health insurance market on a nationwide basis. This, obviously, had nothing to do with Kentucky's new insurance reforms, but rather was based on The Principal's decision to focus its health insurance business on employer group sponsored managed care products.

I hope this information is helpful to you in creating your white paper. Please contact me at 1-800-325-2532 ext. 82186 if you have any questions.

Sincerely



Merle T. Pederson
Counsel

MTP:cld

cc Lucia Riddle
Deb West ✓
Kentucky State File

S:\h022\cld\mtp\l0324gn

RECEIVED
DEPT OF INSURANCE
Apr 22 11 16 AM '97





515-267-5000
1111 Ashworth Road
West Des Moines, IA 50265-3537

April 8, 1997

George Nichols III, Commissioner
Commonwealth of Kentucky
Department of Insurance
PO Box 517
Frankfort, KY 40602

RE: Kentucky Health Insurance Market

Dear Commissioner Nichols:

Thank you for your kind request to speak at the Joint Task Force Meeting on 4/18/97. We respectfully decline, but would be happy to explain the reasons for Preferred Risk Life Insurance Company's withdrawal from Kentucky. In reviewing our Kentucky Insurance Department file, it appears that we withdrew our Major Medical and Medicare Supplement products both when legislation was enacted in 1986 requiring long term care coverage to be provided in conjunction with any expense incurred health insurance product. Since that time, we have not filed or sold any health insurance product in Kentucky. We are not currently marketing any expense incurred health insurance products in any state, and have no plans to do so in the future. If further information is needed, please feel free to contact me at 800-688-3640.

Sincerely,

Carla Meiners
Staff Attorney

APR 11 2 36 PM '97
DEPT. OF INSURANCE
FRANKFORT, KY 40602





Physicians Mutual Insurance Company[®]
Physicians Life Insurance Company[®]

2600 Dodge • Omaha, Nebraska 68131-2671

RECEIVED
DEPT OF INSURANCE

APR 14 12 19 PM '97

April 10, 1997

Honorable George Nichols III
Commissioner
Commonwealth of Kentucky
Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517

Re: Your Letter of April 3, 1997 to Robert Reed, President

Dear Commissioner Nichols,

Mr. Reed has asked that I respond to your recent letter.

At the time legislation was enacted to reform the individual health care market in Kentucky, the types of policies that we sold that were affected by the law had to be nonrenewed and, by law, we could not sell them. They did not comply with the mandates for standardized products.

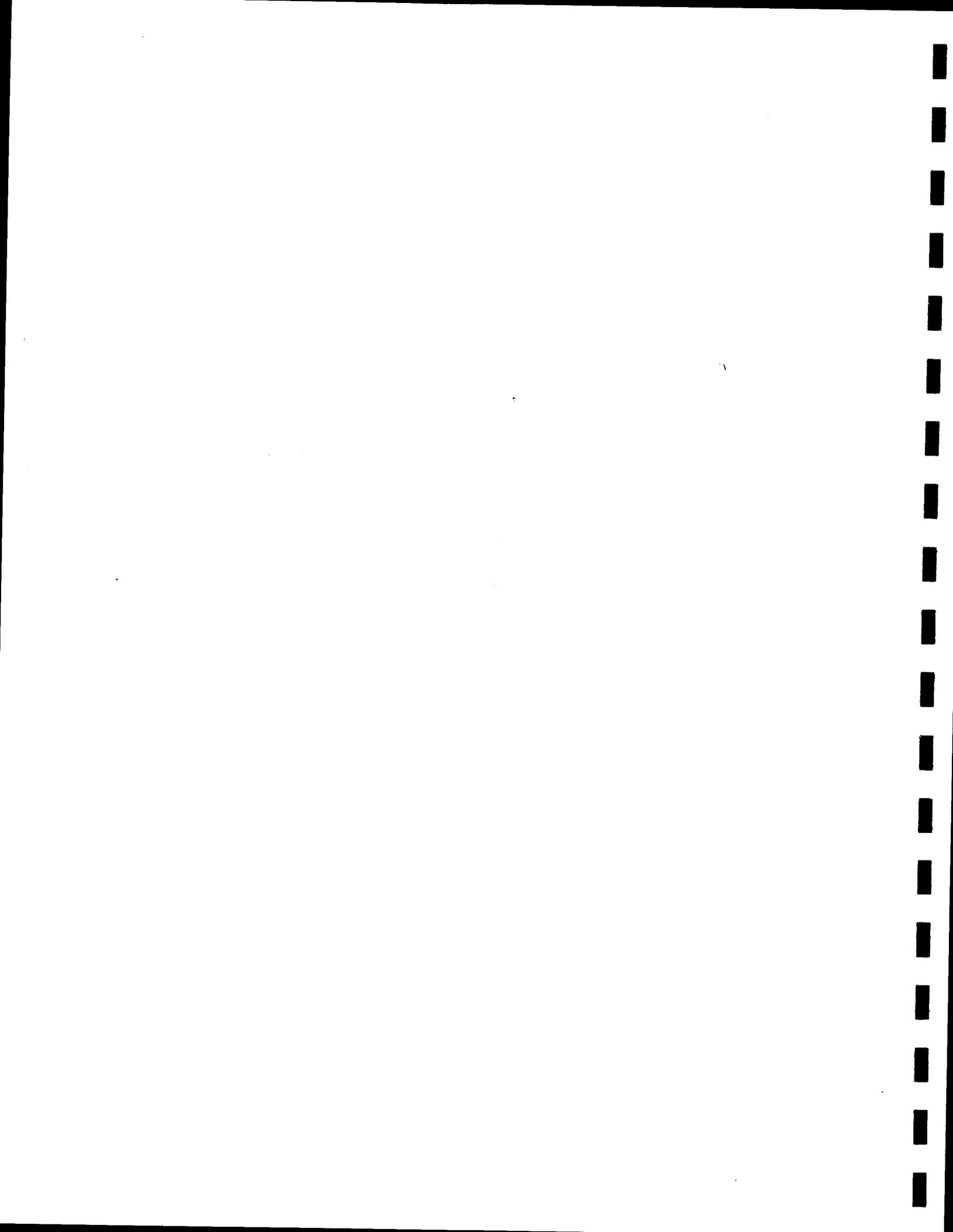
We chose not to stay in this market because we would have been prevented from underwriting and because we would not have been allowed to sell our own products.

We know from other states passing health care reform legislation that we probably would have remained in this Kentucky market if we could have continued to sell our own product, rather than a standardized product, and if we would have been allowed to underwrite. We have been able to remain in business with the products affected and still comply with limits on preex, portability for preex, modified community rating and limits on renewals.

I hope this provides you with the information you need. If not, please do not hesitate to contact me for anything additional you feel would help.

Sincerely,

Phil Powell CLU
Vice President, Compliance
(402) 633-1096





PM GROUP
A Pacific Mutual Company

RECEIVED
DEPT OF INSURANCE

APR 21 12 07 PM '97

WILLIAM L. FERRIS, FSA
President & CEO

April 10, 1997

George Nichols III, Commissioner
Co-Chair, Task Force on Individual Health Insurance
Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517

Dear Mr. Nichols:

Thank you for your letter of April 3, 1997 regarding the Industry Task Force on Individual Health Insurance. PM Group Life Insurance Company does not plan to attend the April 18, 1997 Joint Task Force Meeting. PM Group Life Insurance Company does not write individual health insurance. Historically, PM Group Life Insurance Company has had very limited market presence in Kentucky. As a matter of our limited resources and market priorities, we decided to leave the Kentucky health care market.

Primarily our concerns are centered on the limitations in the current reform law to offering only the statutory plans and the modified community rating provisions. We find that in the small group guarantee issue environment, we must have plan design flexibility and more rating flexibility to offer competitively priced products without unduly endangering underwriting results.

Thank you for offering us the opportunity to come and for your consideration of our response.

Sincerely,


W. L. Ferris

WLF:ro

wlfkentucky



Phoenix Home Life Mutual Insurance Company

One American Row
PO Box 5056
Hartford CT 06102-5056

Phone 860 403-5495or
860 253-1000
Fax 860 403-7203



GEORGE W. RIPLEY
Counsel

April 17, 1997

The Honorable George Nichols III
Commissioner of Insurance
Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

RE: **Consumer/Provider and Industry Task Forces on Individual Health Insurance**

Dear Commissioner Nichols:

I am writing in response to your April 3 letter to our President, Robert Fiondella. While it appears that the primary focus of the above task forces is individual health insurance, it is my understanding that information related to our decision to leave the group health insurance market would also be helpful.

At the time Kentucky's health reform law passed, Phoenix Home Life and its subsidiary, Phoenix American Life, only insured a small number of employer groups in Kentucky for medical coverage. Thus, the Kentucky group medical market was not a large market for us.

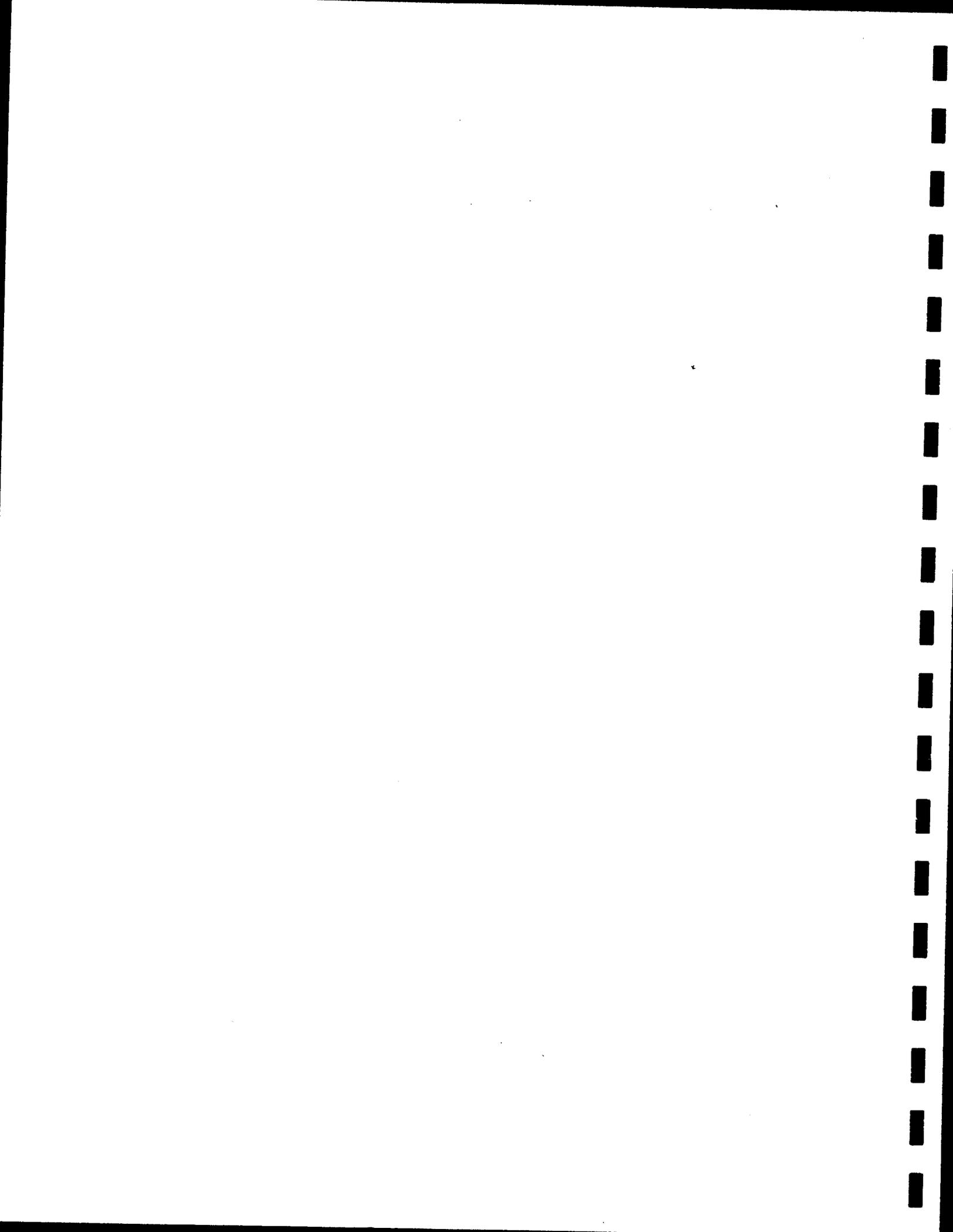
The primary reasons for us leaving the market were: (1) the cost of compliance with the new health care reform law; and (2) the rating restrictions imposed under the new law. First, the standard statutory plan which we would be required to offer under the new law was significantly different in design from the plans that Phoenix Home Life and Phoenix American Life typically offer. Developing the standard plan and reprogramming the claim system to administer benefits under the plan would have resulted in significant cost to the Company. Second, given the requirements to community rate and guaranty issue plans in the small employer market, we did not believe we could continue to write such business on a profitable basis. Restrictions on our ability to change rates on a timely basis was also a factor in our decision. The overall cost of compliance from both an administrative expense and risk assumption standpoint could not be absorbed given our small block of business in Kentucky.

Thank you for soliciting our views on this subject and if you have any questions, please feel free to contact me.

Sincerely,

A handwritten signature in dark ink, appearing to read "GWR", written over the name "George W. Ripley".
George W. Ripley

RECEIVED
DEPT OF INSURANCE
APR 21 11 25 AM '97





PHILADELPHIA
AMERICAN
LIFE INSURANCE COMPANYSM

P.O. Box 2465 • Houston, Texas 77252 • (713) 871-4600

April 16, 1997

Honorable George Nichols III, Commissioner
Co-Chair, Task Forces on Individual Health Insurance
Kentucky Department of Insurance
P. O. Box 517
Frankfort, Kentucky 40602-0517

RE: Your letter dated April 3, 1997

Dear Mr. Nichols:

Thank you for the invitation to voice our concerns and reasons for leaving the health insurance market in Kentucky.

Our decision to leave was in large part due to 1994 House Bill 250. It was our desire to continue marketing health insurance in your state; however, we did not feel we could effectively market and administer products at a reasonable cost to comply with these regulations.

The main concern affecting our decision deals with your requirement to offer mandated health benefit plans on a guaranteed issue basis with restrictive rating methodologies.

Please do not hesitate to let me know if there are any questions or if you need additional information by contacting me at 800-713-4680.

Respectfully,

Bill S. Chen, Ph.D., FSA
President/ Chief Executive Officer
Philadelphia American Life Insurance Company

RECEIVED
KENTUCKY DEPARTMENT OF INSURANCE
APR 24 10 39 AM '97

