

**Commonwealth of Kentucky
Kentucky Employees Health Plan
Eighth Annual Report**

**Prepared for:
Commonwealth of Kentucky
Governor
General Assembly
and
Chief Justice of the Supreme Court**

October 1, 2008

Table of Contents

EXECUTIVE SUMMARY	1
THE KENTUCKY EMPLOYEES HEALTH PLAN	7
INTRODUCTION	7
2007 KEHP EXPERIENCE.....	7
KEHP PROGRAM COSTS, PLAN SUBSIDIES AND EMPLOYEE CONTRIBUTIONS - 1999 TO 2007	8
HISTORICAL PER EMPLOYEE SUBSIDIES	9
MEDICAL & PHARMACY TRENDS FOR 2007	14
ENROLLMENT/DEMOGRAPHIC ANALYSIS	19
REVIEW OF KEHP USE OF SERVICES.....	28
POPULATION HEALTH ISSUES	34
KEHP PHARMACY BENEFITS EXPERIENCE	48
A LOOK AHEAD: FIRST SIX (6) MONTHS OF 2008.....	56
SUSTAINABILITY IN AN INCREASINGLY CHALLENGING ENVIRONMENT – THE IMPACT AND OPPORTUNITY FOR KEHP	62
A SUSTAINABLE HEALTH PLAN AND MORE: BUILDING A HEALTHY AND VITAL MEMBERSHIP HAS BROADER BENEFITS	62
BOARD RECOMMENDATIONS	73
KGHIB BEST PRACTICES COMMITTEE RECOMMENDATIONS	74
APPENDIX.....	1
MODIFICATIONS TO THE KEHP PROGRAM AND PLAN DESIGN PROVISIONS BY YEAR, 2000 - 2008 ...	1
LEGISLATIVE MANDATES.....	8
GLOSSARY.....	1

EXECUTIVE SUMMARY

This Eighth Annual Report of the Kentucky Employees Health Plan (KEHP), prepared for the Governor, General Assembly, and Chief Justice of the Supreme Court of the Commonwealth of Kentucky, provides an overview of the 2007 KEHP cost and service usage as well as a look at changes in plan performance from prior years. The report also includes a look at the first six months of plan experience in 2008, historical information on plan designs, legislative mandates, and commentary on the Kentucky Group Health Insurance Board's (KGHIB) current focus on sustainable health plan solutions.

Highlights of the 2007 KEHP Experience

- **KEHP plan costs continue to escalate but at a lower rate than the previous year.**
 - ✓ In 2007 the KEHP cost for providing medical and pharmacy benefits to members was \$1,104,811,380 in total. This cost was 13.5% higher than the plan cost in 2006. A portion of the plan cost increase was due to a 3.6% growth in average annual membership.
 - ✓ On a per member per month (PMPM) basis, which adjusts for the increased enrollment, the KEHP cost increased 9.6% from 2006 to 2007. The medical claims PMPM trend was 10.2% and the pharmacy PMPM trend was 7.6%.
- **KEHP continues to pay a greater percentage of the cost for employees than national averages.**
 - ✓ KEHP costs are shared by KEHP and its members. The KEHP's average monthly subsidy (or portion paid of the total cost) of an employee's health insurance coverage ("employee-only" tier of coverage) has increased from \$9.72 per month in 1972 to \$514 in 2007 and to an estimated \$544 in 2008. The member's portion of cost has risen from \$ 87.31 in 2007 to \$92.31 in 2008.
 - ✓ On a percentage basis, in 2007 KEHP paid 97.2% of single coverage health care costs and 71.5% of employee plus dependent(s) coverage¹ health care costs. These percentages vary from government sector benchmarks (as provided by the Kaiser-HRET annual survey) of 87% for single coverage and 78% for employee plus dependent(s) coverage.
- **The KEHP membership is growing and the average age of members is getting younger.**
 - ✓ From 2006 to 2007, the average employee age decreased from 45.9 to 45.5 and the average member age dropped from 37.8 to 36.7. This decrease in age results in a significantly improved plan cost. For each year reduction in average age of

¹ "Employee Plus Dependent(s)" coverage is comprised of the KEHP Couple, Parent Plus, Family, and Cross Reference coverage tiers.

plan members, plan costs decrease from what they would have been by an estimated 2.0%.

- ✓ The Plan continues to have fewer enrolled dependents than national averages, with more than 67% of coverage provided through the "Single" tier of coverage. However, this percentage is shifting slightly as more dependents join the plan.
- **KEHP spends the largest portion of its total costs for hospital outpatient care and this service component's cost is increasing faster than other types of care.**
 - ✓ The KEHP claims distribution for inpatient hospital, outpatient hospital, physician, other, and pharmacy goods and services has remained relatively consistent in 2006 and 2007.
 - ✓ KEHP's outpatient claims, the largest component of cost, are trending at the highest rate; 12.1%. This is significantly higher than inpatient claims at 6.8%.
- **Clinical conditions related to heart disease, arthritis and similar conditions, and respiratory conditions such as asthma continue to be prevalent in the population.**
 - ✓ The membership's clinical conditions that resulted in a significant portion of the plan's costs in 2007 were largely the same as have been experienced since 2004. Circulatory conditions, or conditions related to the heart, musculoskeletal conditions such as arthritis and spinal/back disorders, respiratory conditions such as asthma, and COPD, are at the top of the list.
 - ✓ Members with these clinical conditions consumed 58% of the plan's 2007 claims costs.
- **Pharmacy benefit costs continue to rise, but at a slower rate than in previous years.**
 - ✓ Allowed charges, defined as both the plan and participant's cost after charges are reduced for discounts or non-covered services, for prescription drugs increased PMPM by 14.8% in 2006 and 9.8% in 2007.
 - ✓ In 2007 the KEHP portion of the total pharmacy costs rose by 11.5%. Members paid 6.3% per claim less than in 2006.
 - ✓ In 2007 10% of KEHP enrolled families had more than 75 prescriptions and were eligible for the reduced co-pay benefit.

A Look at the First Six Months of 2008

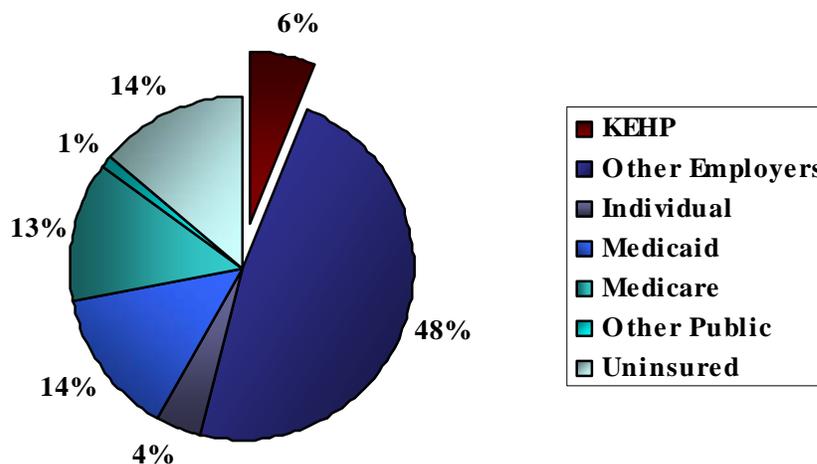
The claims and enrollment information for the first six months of 2008 indicates that many of the trends observed in 2007 are continuing into 2008. There were no changes in the design of medical and pharmacy benefits from 2007 to 2008.

- **KEHP costs continue to rise, but at a lower rate. Enrollment continues to increase at levels similar to 2007.**
 - ✓ KEHP per member plan costs for the first six months of 2008 increased by 6.5% compared to the first six months of 2007.
 - ✓ Plan membership has increased by 3.5% and the number of individuals who have waived coverage decreased by 3.4%.
- Pharmacy benefits continue to increase in cost and use, but members are paying a smaller proportion of prescription drug cost.
 - ✓ There has been a 4.2% increase in the number of prescriptions per member per year from 2007 to 2008.
 - ✓ The portion of pharmacy claims paid by members continues to decline, down 9% per claim from 2007. This is because pharmacy co-pay amounts have remained unchanged over the past several years and the cost of medications has increased. Therefore the KEHP plan pays a greater share of the cost.
- The types of services being used in 2008 are similar to 2007.

Considerations for Maintaining a Secure and Sustainable Plan

The KEHP plan provides health care benefits and programs to approximately 6% of the citizens of the Commonwealth of Kentucky. No other plan sponsor or group of employers affect the health of the population as much as KEHP, and its programs and benefits are critical to maintaining the health and vitality of its members and the overall population.

Commonwealth of Kentucky Healthcare Coverage Distribution



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey, www.statehealthfacts.org; KEHP 2007 enrollment data

Given that the plan provides coverage to this significant portion of the population, its benefits, prevention and wellness programs, and cost management efforts impact Kentucky's healthcare infrastructure, funding, and the health status of citizens. Improving the health of KEHP members not only supports the ability to maintain a sustainable health plan over the long term, but also supports the productivity and vitality of Commonwealth's population.

There are additional benefits for school systems, quasi-governmental agencies, state agencies, and retirement systems that participate in KEHP. Controlling plan cost and improving the health of members positively impacts the productivity of participating employers' workforces, improves their ability to hire and retain valued employees, and improves their annual cost for benefits. Participating retirement systems' overall sustainability is impacted as well. Supporting healthier future retirees and managing the cost and quality of care while they are actively employed positively impacts the Retiree Systems' future liabilities and solvency.

The Board has carefully considered the issue of future sustainability for the plan and its members and has advised the Department of Employee Insurance to consider changes to the program for 2009. These changes will set the foundation for improving the health of members over the long term while continuing to provide valuable health benefits for members in need of care.

Kentucky Group Health Insurance Board Recommendations

The Board recommends that the KEHP continue to follow the guiding principles stated below:

- Provide uniform coverage across the Commonwealth
- Encourage wellness and healthy lifestyles
- Provide preventive care at little or no cost
- Improve chronic disease care
- Educate members about plans that are more appropriate for their health needs
- Provide plan alternatives that are accessible for retirees
- Provide a quality PPO option
- Provide a subsidy for family and dependent coverage
- Provide plans with unlimited lifetime maximums

The Board further recommends:

- KEHP should continue to explore alternative methods for controlling and managing the cost of the plans and improving the health of members. A study on alternative approaches for health improvement (wellness initiatives), prevention of chronic conditions and other critical programs across the spectrum of members' health needs should be evaluated. Approaches that consider aligned incentives to encourage members' health behavior changes and to improve providers support for wellness should be evaluated. Resource requirements and potential outcomes of varying approaches should be considered.
- A study should be conducted to broadly consider the potential impact of care management programs (including wellness programs, case management programs, disease management programs, etc.) to better manage chronic illnesses, to improve care for the acutely ill and to assist in end of life care.
- KEHP should evaluate programs and options for improving the clinical and administrative quality of programs and services. This study should consider practical steps to evaluate and improve administrative services including claims payment, customer service and others. It should consider programs to measure and improve quality of care currently available in the marketplace.
- KEHP should develop a plan to improve communications, both directly to members and through Insurance Coordinators. The plan should consider different types of communications for different groups of members (internet communications, mailings, other) based on the best potential success with each group.
- The Board recommends that the due date for the Annual Report to the Governor be extended from October 1 to December 1 beginning in 2009.

The KGHIB Best Practices Committee

In 2008, the Kentucky Group Health Insurance Board (KGHIB) convened a "Best Practices Committee" to enable health insurance experts in private sectors to share their best practices in health insurance and assess whether these practices may benefit the KEHP. Members of the committee include representatives of Benefits Decisions, Inc., EON U.S., Kentuckiana Health Alliance, UAW/Ford Community Healthcare Initiative, United Auto Workers Local 862 (UAW 862) and the United Food and Commercial Workers Local Union 227 (UFCW L/U 227). The Committee has met on six occasions to date and provided recommendations for inclusion in this report.

- Miscellaneous oral recommendations from the entire committee on general plan issues, wellness and communication are provided
- The UAW-Ford Community Healthcare Initiative provided written recommendations related to improving employees' health while helping to contain cost. These recommendations address smoking, health risk assessments, prescription drug use, incentives for disease management, and accountability for worksite wellness programs
- EON U.S. provided recommendations on responsibility for health, wellness offerings, program evaluation, communication and education, leadership support, partnerships and marketing of programs
- The UFCW L/U 227 provided short term goals that included consolidation of health care plans and assessing cost saving potential, and implementation of wellness, chronic disease, and preventive health care management. They also provided long term recommendations on board oversight of the health care plans, assessing the carve out of specialty health programs, health care claim reviews, continuing education for administrators, and improvement of coordination/integration of the vendors.

A detailed description of the history of the KEHP plan, legislative mandates and a glossary of terms are included in the appendix of this report.

THE KENTUCKY EMPLOYEES HEALTH PLAN

Introduction

In accordance with the provisions of KRS 18A.226(5)(b) enacted by the 2000 General Assembly as a part of Senate Bill 288, this document comprises the eighth Annual Report from the Kentucky Group Health Insurance Board (KGHIB), or the Board, to the Governor, the General Assembly, and the Chief Justice of the Supreme Court on the status of the Public Employee Health Insurance Program (PEHI), renamed the Kentucky Employees Health Plan (KEHP) in 2007.

The report includes:

- A review of the 2007 KEHP program experience
- A look at Plan experience for the first six months of 2008
- A perspective on creating and maintaining a sustainable healthcare program
- A review of the history and development of the KEHP Program
- A summary of legislated health insurance benefit mandates and other mandates passed by recent General Assemblies that affect the KEHP
- Board Recommendations

To prepare this report, research was jointly conducted by the Department of Employee Insurance (DEI) and PricewaterhouseCoopers LLP (PwC). It has been reviewed by the Board and modified to incorporate a full and accurate representation of the Board's findings and recommendations.

Please refer to the *Glossary* at the end of this report for definitions of terms used in the body of the report.

2007 KEHP Experience

This section of the annual report provides a summary of cost and usage trends experienced by KEHP in 2007. The 2006-2008 information is based on self-insured KEHP claims reported by the plan administrators. These claims and enrollment data were compiled by the data warehouse.

A Note about 2008 Claims Experience

At the time of the writing of this report, 2008 claims data were available through June 2008. Calendar year 2008 claims experience was estimated by applying the claims seasonality observed in 2007 to the six months of claims experience available in 2008. "Seasonality" refers to variations in enrollment patterns and claims payments over the course of a year that results from the timing of members meeting deductibles (lower levels of claims early in the year) and maximum out-of-pocket limits (higher levels of claims later in the year).

Throughout this report, unless otherwise noted, references to "claims" mean claims incurred within the specified time frame regardless of when the claims were paid.

KEHP Program Costs, Plan Subsidies and Employee Contributions - 1999 to 2007

Highlights

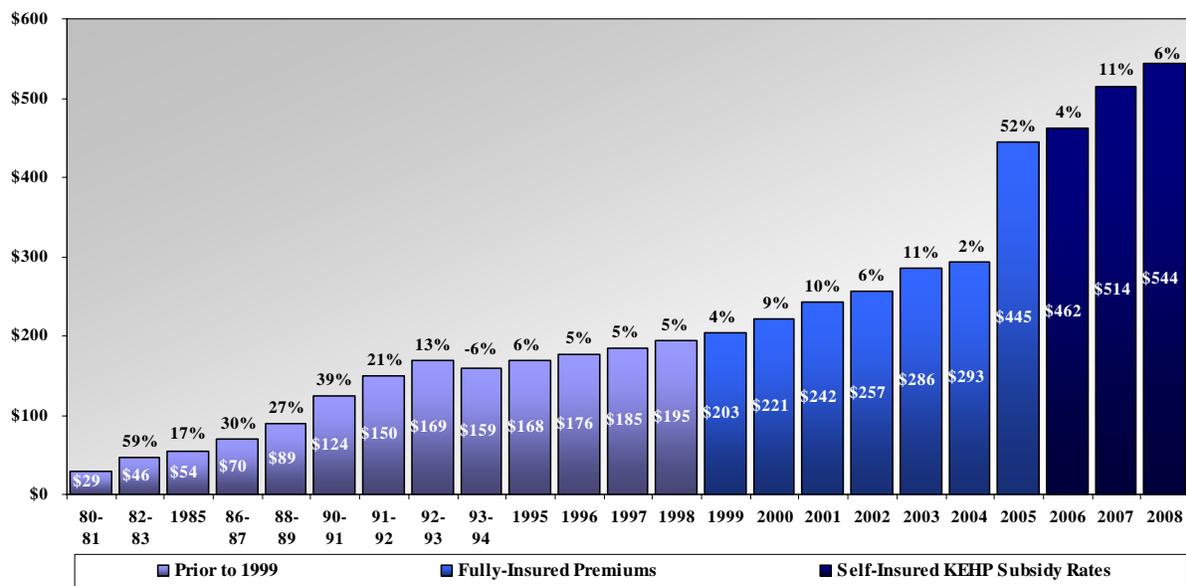
- Total claims cost rose by 13.5% in 2007.
- In 2006, KEHP absorbed the increase in healthcare costs from 2005 by maintaining the employee contributions at the 2005 dollar amount. This significantly increased the Plan's subsidy. In 2007, KEHP and employees shared the cost increase, returning to an 85%/15% employer/employee cost split for employee only coverage.
- In 2007, KEHP's subsidies covered 85.0% of budget rates (97.2% for Single Coverage, 71.5% blended for the employee + dependent coverage tiers). KEHP subsidies for employee-only coverage are 10 points higher than national averages. Subsidies for dependent coverage are 6.5 points lower than national averages.
- The 2007 incentive to encourage individuals to waive coverage decreased to \$175 per month. At its peak, in early 2006, the incentive was \$234. The incentive reduction, along with the rise in health care costs, has resulted in fewer people waiving coverage.
- The waiver incentive for 2008 has not decreased from the level in 2007. Yet fewer members are waiving coverage. This suggests that, as health care costs continue to increase, fewer members will be willing to waive the KEHP benefits.

Historical Per Employee Subsidies

The KEHP's per employee subsidy (the amount paid by the plan, excluding the amount paid by the participant) from 1980 through 2008 is illustrated in Exhibit I below. The KEHP average monthly subsidy toward the cost of an employee's health insurance coverage has risen from \$9.72 per month in 1972 to \$445 in 2005, \$462 in 2006, \$514 in 2007, and is estimated to increase to \$544 per month for 2008. Also shown in Exhibit I is the percentage increase in KEHP PEPM subsidy from year to year.

Exhibit I

Historical KEHP Per Employee Per Month (PEPM) Health Benefit Subsidy For Those Electing Coverage



Source: Seventh Annual Report and KEHP's enrollment and claims data aggregated by Thomson Reuters.

KEHP subsidies through 2005 were the portion of the fully-insured premium amounts paid by the PEHI/KEHP program minus employee contributions. In 2006, the benefit plans' funding was transitioned from fully-insured to self-insured, which removed the insurance company margin that KEHP was previously covering in its premiums. The self-insured costs in 2006, 2007, and 2008 reflect incurred claims plus administrative fees, and do not include an insurance company margin.

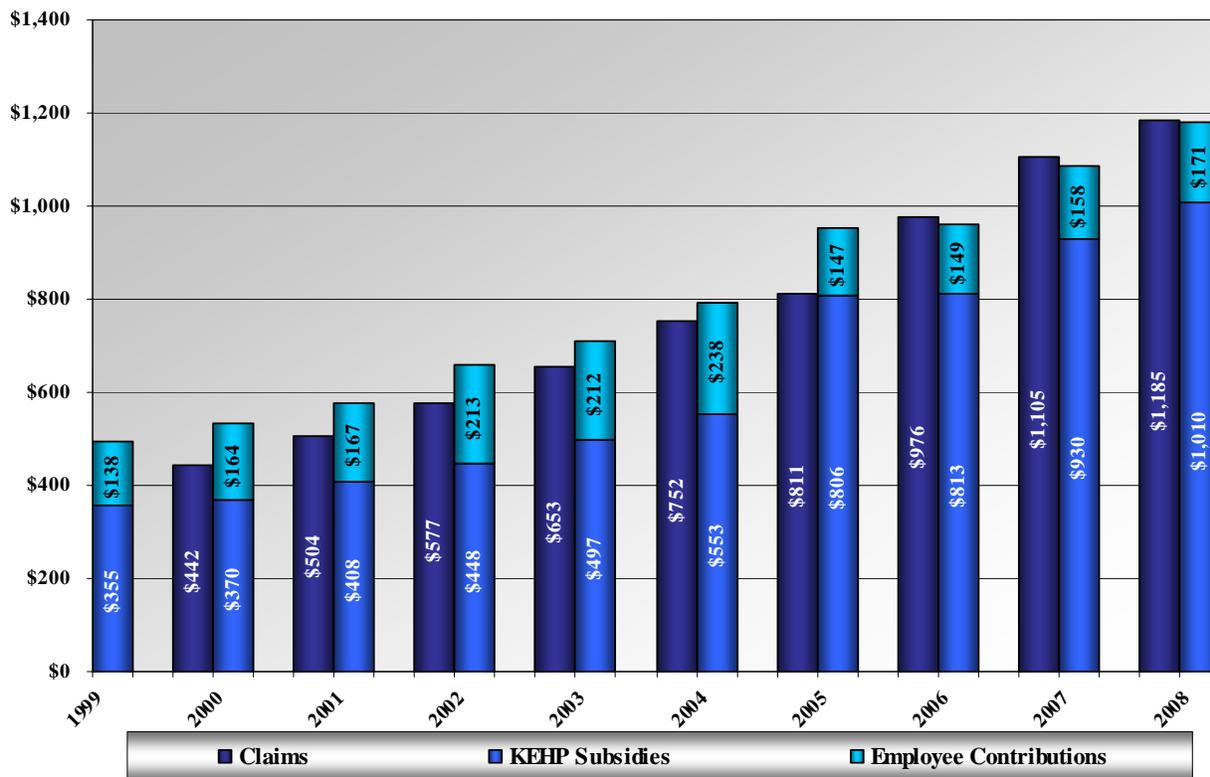
The total incurred claims paid by the insurers for the KEHP Program in 1999 through 2005 and by the KEHP's self-funded program in 2006 and 2007 are identified as "Claims" in Exhibit II. For 2008, the annual claims have been estimated based on the 2008 paid claim experience year to date (with an adjustment for incurred but not reported claims), and then projected to the end of the year. The KEHP subsidy includes the Plan's portion of incurred claims and administrative

fees while the employee contribution bar includes the employee's portion of claims and administrative fees.

Exhibit II includes the subsidy amounts KEHP paid in 1999 through 2008 (estimated) for all members of the KEHP Program. The figures included in this exhibit represent millions of dollars. The section of each bar labeled “KEHP Subsidies” shows the amounts subsidized by KEHP for those individuals covered by the KEHP program.

Since KEHP changed the funding from fully insured to self insured, the KEHP claims and administrative expenses have been close to the budgeted amount. A look at the first six months of available data for 2008 shows this trend continuing. This observation may change as the 2008 plan year continues.

Exhibit II
Annual KEHP Claim Costs versus KEHP's Subsidies and Employee Contribution
 (\$Millions)



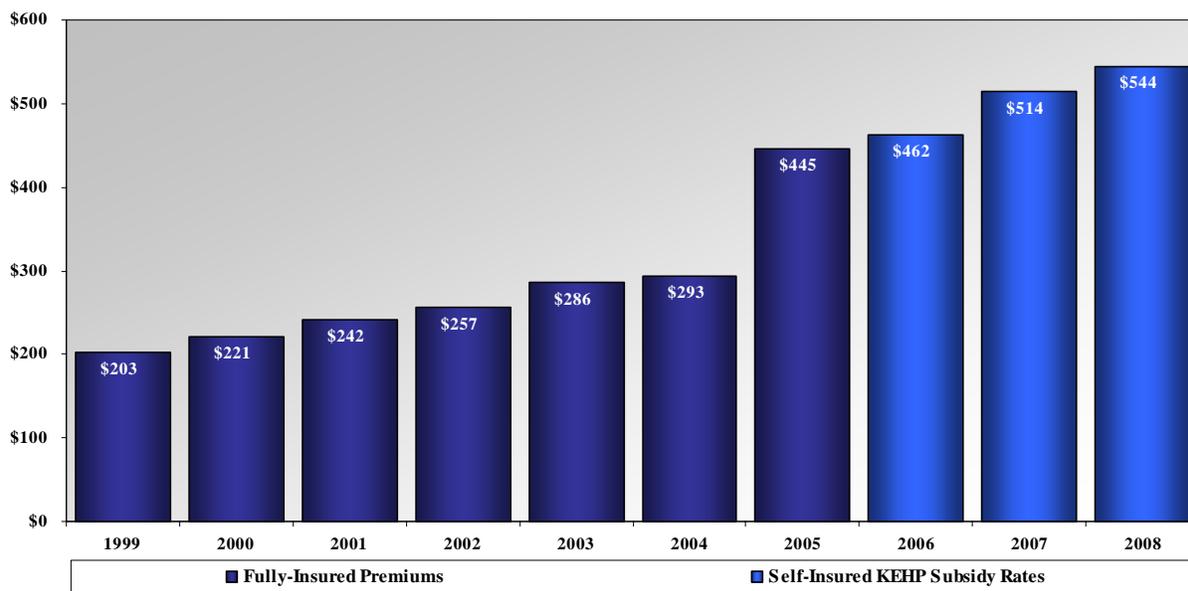
Source: Claims reported by KEHP's insurers and administrators and compiled by Thomson Reuters and enrollment reported by the Commonwealth. Employee Contributions for 1999 through 2008 provided by the DEI.

* 2008 figures reflect estimates based on January through June 2008 claims experience, projected to year end.

KEHP significantly increased its subsidy for employee health insurance in 2005, as shown in Exhibit III. In 2007, KEHP and members shared the cost increase to the KEHP Program.

Exhibit III

KEHP Per Employee Per Month (PEPM) Subsidy over the Decade



Source: Seventh Annual Report and KEHP's enrollment and claims data aggregated by Thomson Reuters.

In 2007, KEHP covered 85.0% of total costs (97.2% for Single Coverage, 71.5% blended for the employee + dependent coverage tiers). Exhibit IV compares the KEHP subsidies to 2007 national averages for the government sector. (The 2008 comparison will be updated when Kaiser's data become available in mid to late September.) Compared to government sector averages the KEHP subsidy for enrollees, is 10.2 percentage points higher for employee only coverage, and 6.5 points lower for dependent coverage.

Exhibit IV

KEHP Subsidies Compared to Government Sector Benchmarks

	2007		2008	
	Kaiser	KEHP	Kaiser	KEHP
Employee Only	87.0%	97.2%	88.0%	97.3%
Employee + Dependents	78.0%	71.5%	78.0%	71.6%

Source: Benchmark s from 2007 and 2008 Kaiser Family Foundation Employer Health Benefits surveys.

Employee contribution rates have increased in each of the years reviewed. Exhibit V provides monthly employee contribution rates for 2007 and 2008 by plan option, coverage tier, and non-smoker versus smoker status.

Exhibit V
2006 through 2008 Monthly Employee Contribution Rates

	Monthly Employee Contribution Rates				
	Single	Couple	Parent Plus	Family	Cross Ref
2007 Rates					
Essential Plan:					
Non-Smoker		\$274.90	\$58.26	\$339.12	\$0.00
Smoker		\$306.68	\$90.04	\$370.90	\$15.88
Enhanced Plan:					
Non-Smoker	\$0.00	\$378.92	\$120.76	\$454.72	\$10.30
Smoker	\$15.88	\$410.70	\$152.54	\$486.50	\$26.18
Premier Plan:					
Non-Smoker	\$19.28	\$422.30	\$180.48	\$502.90	\$35.04
Smoker	\$35.16	\$454.08	\$212.26	\$534.68	\$50.92
Select Plan:					
Non-Smoker	\$0.00	\$285.54	\$92.88	\$341.58	\$7.74
Smoker	\$12.50	\$309.48	\$117.32	\$365.46	\$19.66
2008 Rates					
Essential Plan:					
Non-Smoker		\$290.84	\$61.64	\$358.80	\$0.00
Smoker		\$324.48	\$95.26	\$392.42	\$16.80
Enhanced Plan:					
Non-Smoker	\$0.00	\$400.90	\$127.76	\$481.10	\$10.90
Smoker	\$16.80	\$434.52	\$161.38	\$514.72	\$27.70
Premier Plan:					
Non-Smoker	\$20.40	\$446.80	\$190.94	\$532.08	\$37.08
Smoker	\$37.20	\$480.42	\$224.56	\$565.70	\$53.88
Select Plan:					
Non-Smoker	\$0.00	\$302.10	\$98.26	\$361.38	\$8.18
Smoker	\$13.22	\$327.44	\$124.12	\$386.66	\$20.80

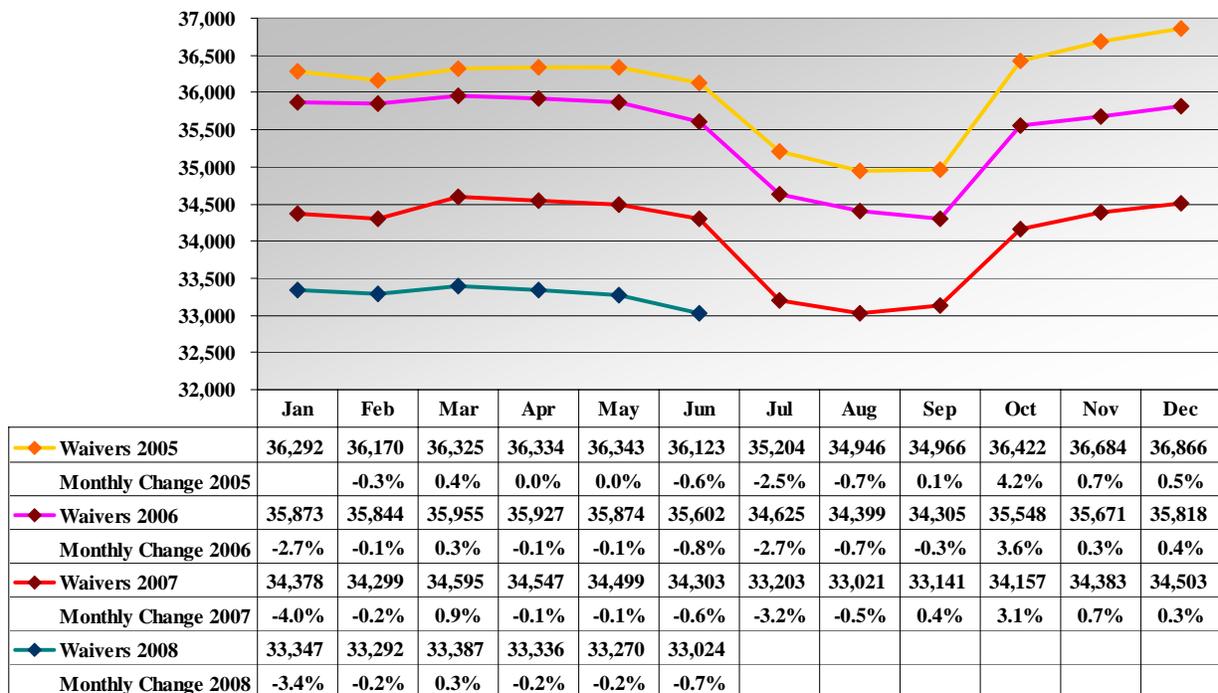
Source: 2007 and 2008 KEHP Employee Contribution Rates

Historical KEHP Waivers

KEHP provides a monthly waiver deposit into the HRA accounts of employees who waive KEHP coverage. These accounts are intended to pay for eligible out-of-pocket healthcare expenses. For 2005 the monthly amount was \$234; for 2006 the \$234 amount was continued for the months January through June, and then decreased to \$200 per month for the remainder of 2006; for 2007, the amount decreased to \$175 per month and remained at that level for 2008. Exhibit VI shows the monthly waiver participation for the period January 2005 through June 2008. The incentive reduction, along with the rise in health care costs has resulted in fewer people waiving coverage each year.

Exhibit VI

2005 through June 2007 Monthly Coverage Waiver Participation



Source: KEHP enrollment data.

Medical & Pharmacy Trends for 2007

Key Findings & Considerations

- In aggregate, KEHP claims costs increased by 13.5% from 2006 to 2007. The number of enrollees increased by 3.6%.
- KEHP's per member per month cost increased by 9.6% from 2006 to 2007; 10.2% for medical and 7.6% for pharmacy. Over the last three years, the KEHP average annual trend was 11.0%.

Medical and Pharmacy Claims Cost Trends

Overall, the KEHP's annual per member per month cost increased by 9.6% from 2006 to 2007. As shown in Exhibit VII, the KEHP experienced a 4.4point decrease in annual per member per month medical trend from 14.6% in 2006, to 10.2% in 2007. Experience under the pharmacy program improved by 18points. In 2007, pharmacy annual per member per month pharmacy trend was 7.6% compared to 25.3% in 2006.

Exhibit VII

2005 – 2007 Claims Experience

Public Employee Health Insurance Program Historic Experience						
	2005	% Change	2006	% Change	2007	% Change
Aggregate						
Medical Claims	\$628,633,392	7.6%	\$737,096,039	17.7%	\$841,583,539	14.2%
Rx Claims	\$182,085,476	8.3%	\$236,132,970	29.7%	\$263,227,841	11.5%
Total Claims	\$810,718,868	7.8%	\$973,229,009	20.4%	\$1,104,811,380	13.5%
Covered Lives	229,867	0.9%	236,038	2.7%	244,581	3.6%
Per Member Per Month						
Medical Claims	\$228	6.5%	\$260	14.6%	\$287	10.2%
Rx Claims	\$66	8.2%	\$83	26.3%	\$90	7.6%
Total Claims	294	6.9%	344	17.2%	376	9.6%

Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

The table below contains the results of PricewaterhouseCoopers' analysis of medical cost trend data from analyst reports for publicly held national health insurers, and a PricewaterhouseCoopers Health Research Institute (HRI) survey of more than 500 employers and private not-for-profit health plans. The growth in medical cost trend drops from 11.9% in 2007 to 9.9% in 2008, and is expected to drop slightly to 9.6% in 2009.

Exhibit VIII

2007 – 2009 National Claims Trend Expectation

PricewaterhouseCoopers Trend Survey	2007	2008	2009
Medical Cost Trend	11.9%	9.9%	9.6%

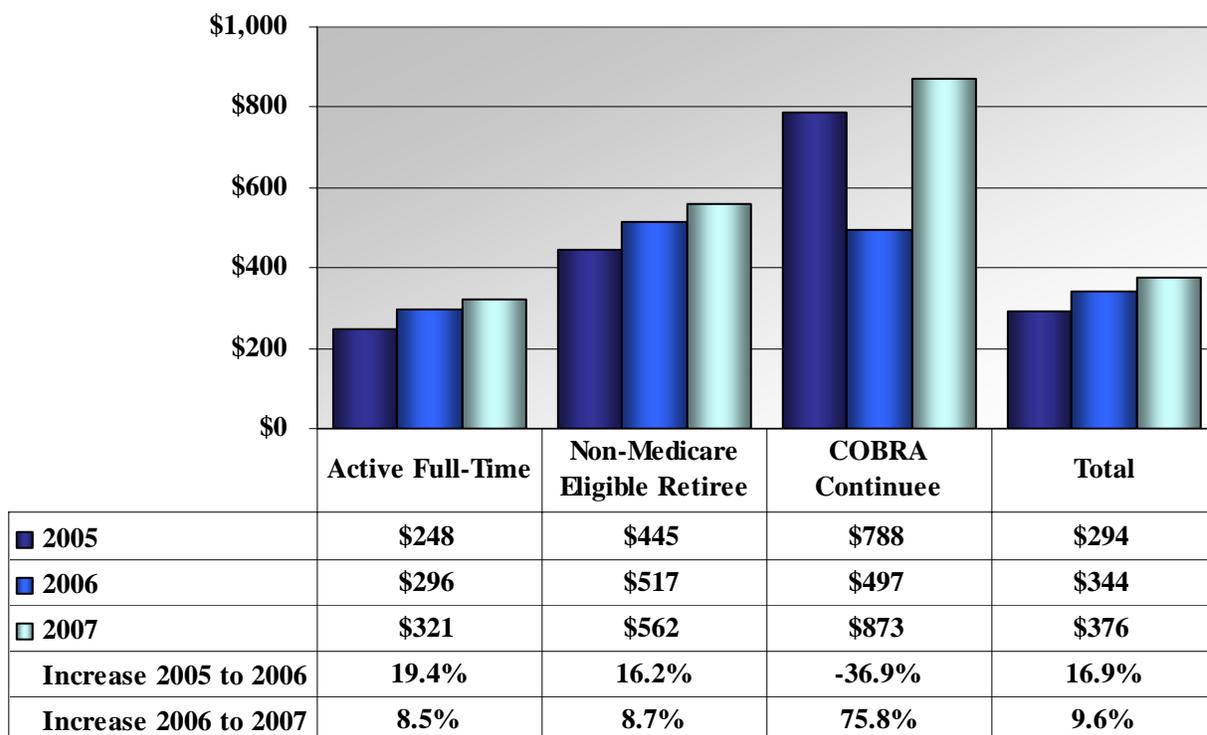
Source: PwC Barometer Survey, 2007, 2008, 2009.

Claims Payment by Employee Status

As noted in Exhibit VII, combined medical and pharmacy claims increased by 9.6% PMPM from 2006 to 2007. Exhibits IX, X and XI provide PMPM cost increases for 2005 through 2007 for actives, non-Medicare eligible retirees, and COBRA participants. It should be noted that the number of COBRA participants is relatively small each year, and that no conclusions can be drawn from the trend figures provided for that group. Active employee and retiree costs are trending at a similar pace, although from a significantly different base cost.

Exhibit IX

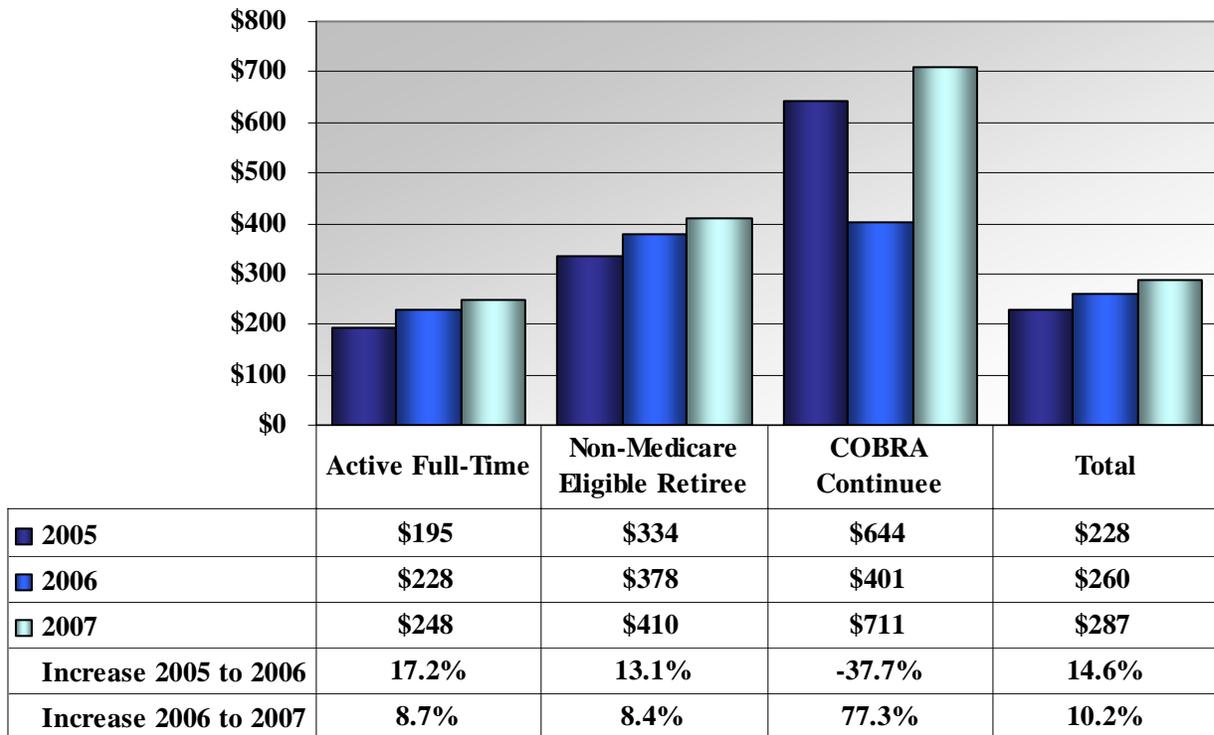
Paid Per Member Total Medical and Pharmacy Claims Per Month (PMPM)



Source: Claims reported KEHP's insurers and administrators and enrollment reported by the Department of Employee Insurance compiled by Thomson Reuters

The average medical claims PMPM change (Exhibit X) from 2006 to 2007 was 8.7% for the active employee group, and 8.4% for the non-Medicare eligible retiree group. The non-Medicare eligible retiree medical claims cost PMPM is 65 % higher than the active claims cost.

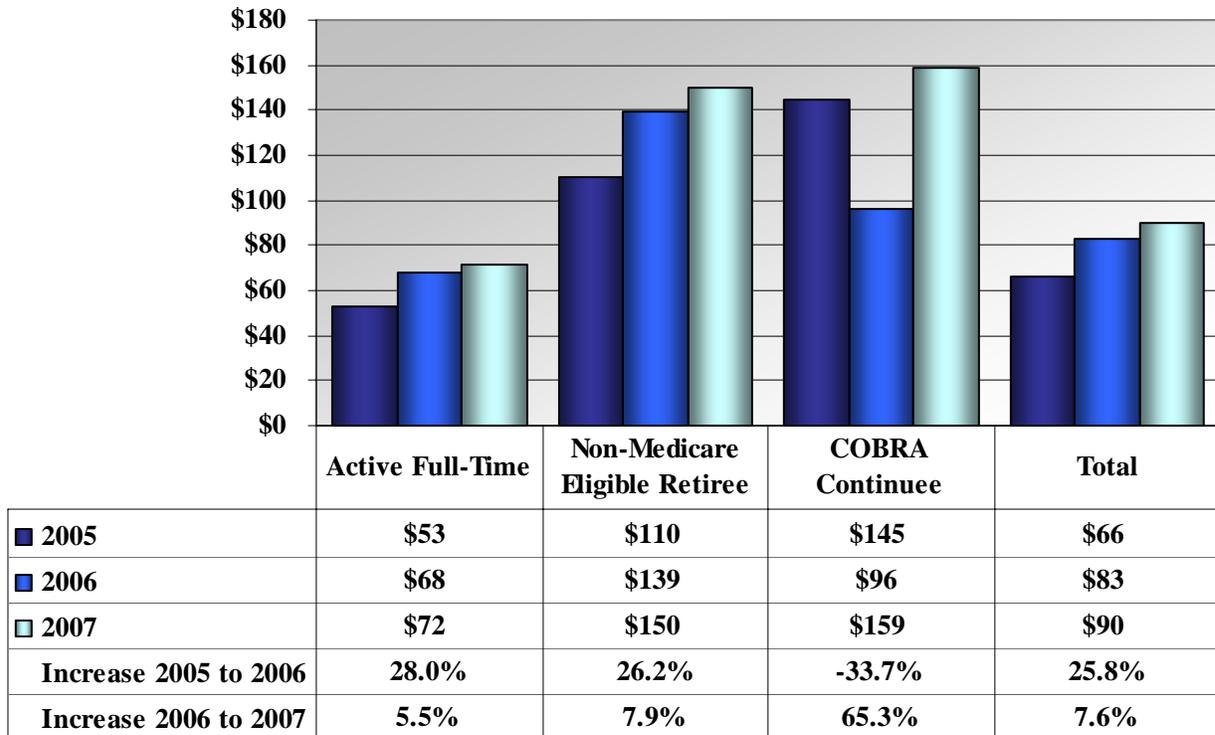
Exhibit X
Medical Claims Paid Per Member Per Month



Source: Claims reported by KEHP's insurers and administrators and enrollment reported by the Department of Employee Insurance compiled by Thomson Reuters.

The average pharmacy claims only (Exhibit XI) PMPM increase for 2006 to 2007, for active employee and non-Medicare eligible retiree groups was 5.5% and 7.9%, respectively. The non-Medicare eligible retiree pharmacy claims cost PMPM is 109% higher than the active claim cost PMPM.

Exhibit XI
Pharmacy Claims Paid Per Member Per Month



Source: Claims reported by KEHP's insurers and administrators and enrollment reported by the Department of Employee Insurance compiled by Thomson Reuters.

Enrollment/Demographic Analysis

Key Findings & Considerations

- Overall, there was a 3.6% increase in enrollment from 2006 to 2007 and a corresponding increase of 2.8% in the first six months of 2008.
- From 2006 to 2007, the average employee age decreased from 45.9 to 45.5 years, continuing a trend toward younger employees. Based on actuarial benchmarks and the proportion of non-Medicare eligible retirees, every year above or below the benchmark impacts costs by approximately 2%.
- Retirees and their dependents comprised 22.6% of the group in 2007, an increase of 5.1% from 2006. Due to the impact that age has on an individual's healthcare costs this increase in retiree membership has significant cost implications for the KEHP program.
- Normative statistics show that female health care claim costs for ages 21 to 50 are approximately 1.8 times higher than the cost of males in the same age group. After age 50, female health care claims are comparable to those for males. With a high percentage of 21 to 50 year old women participating in the KEHP Program, the KEHP claims experience reflects this higher demographic cost factor.
- Since 2006, there has been a small migration from the Essential and Premier plans to the Enhanced and Select plans.
- The frozen employee contributions in 2006 may have contributed to the slight shift into dependent coverage tiers in 2007 and 2008.
- As expected, the PMPM costs for the two Retirement Systems, KERS at \$537 and KTRS at \$603, are the highest among the group. However, the School Boards (49% of population) and KCTCS (4.9% of population), had the largest increase in medical and pharmacy cost in 2007, 12.1% and 11.3% respectively.

From 2006 to 2007, the average employee age decreased from 45.9 to 45.5 years, continuing a trend toward younger employees. A combination of actuarial benchmarks and the proportion of non-Medicare eligible retirees indicate that a one year change above or below the benchmark age impacts costs by approximately 2%. The composition of the group (male, female, and child) has remained consistent over the last three years. KEHP data show that, for females between the ages of 21 and 50, average health care claim costs are approximately 1.8 higher than the costs for males. With a high percentage of women participating in the KEHP Program in the age 21 to 50 cohort, the KEHP claims experience reflects this demographic cost factor.

Exhibit XII

Population Demographics—Key Statistics

Actives, Non-Medicare Eligible Retirees, and COBRA Participants	Commonwealth		
	2006	2007	2008
Average Employee Age	46.9	45.9	45.5
Average Member Age	37.8	36.7	36.2
Employee Percentage Male	35.2%	35.0%	34.8%
Member to Employee Ratio	1.6	1.6	1.6
% of Covered Members Who Are:			
Adult Male	27.1%	27.0%	26.8%
Adult Female	46.8%	46.7%	46.5%
Children	26.1%	26.3%	26.7%

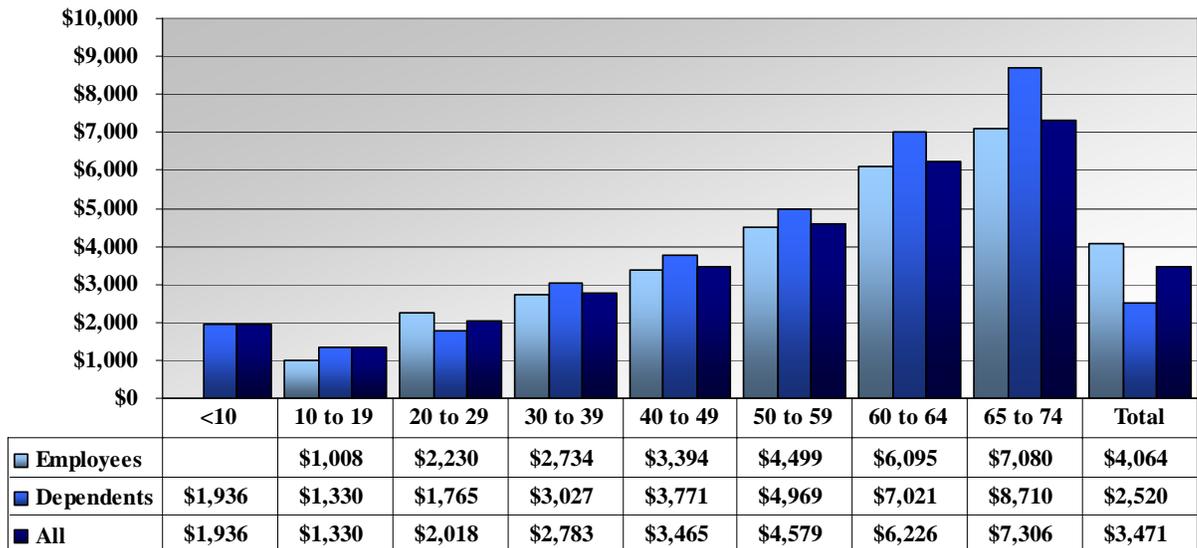
Source: KEHP's enrollment data aggregated by Thomson Reuters.

The average member age dropped from 37.8 to 36.7 years. This trend toward lower average age seems to be continuing in 2008 and should continue to positively impact medical cost trends.

As shown in Exhibit XIII, the cost per dependent increases with dependent age. Dependents under age 30 represent 71% of total dependents enrolled in the plan and 45% of dependent costs. On the other hand, dependents 30 and older represent 29% of the total dependents and 55% of the dependent costs. Dependents between the ages of 50 - 59 are only 11% of the dependent population, but their costs represent 22% of the total dependent cost.

Exhibit XIII

2007 Demographics—Employee and Dependent Member Medical Claims by Age



Member Counts

Employees		65	14,078	25,565	33,070	50,382	23,188	4,371	150,719
Dependents	23,684	30,613	11,857	5,130	7,701	10,341	3,833	702	93,862
Total	23,684	30,678	25,935	30,696	40,771	60,723	27,021	5,073	244,581

Aggregate Claims (\$ Millions)

Employees		\$0.1	\$31.4	\$69.9	\$112.2	\$226.6	\$141.3	\$30.9	\$612.5
Dependents	\$45.9	\$40.7	\$20.9	\$15.5	\$29.0	\$51.4	\$26.9	\$6.1	\$236.5
Total	\$45.9	\$40.8	\$52.3	\$85.4	\$141.3	\$278.0	\$168.2	\$37.1	\$849.0

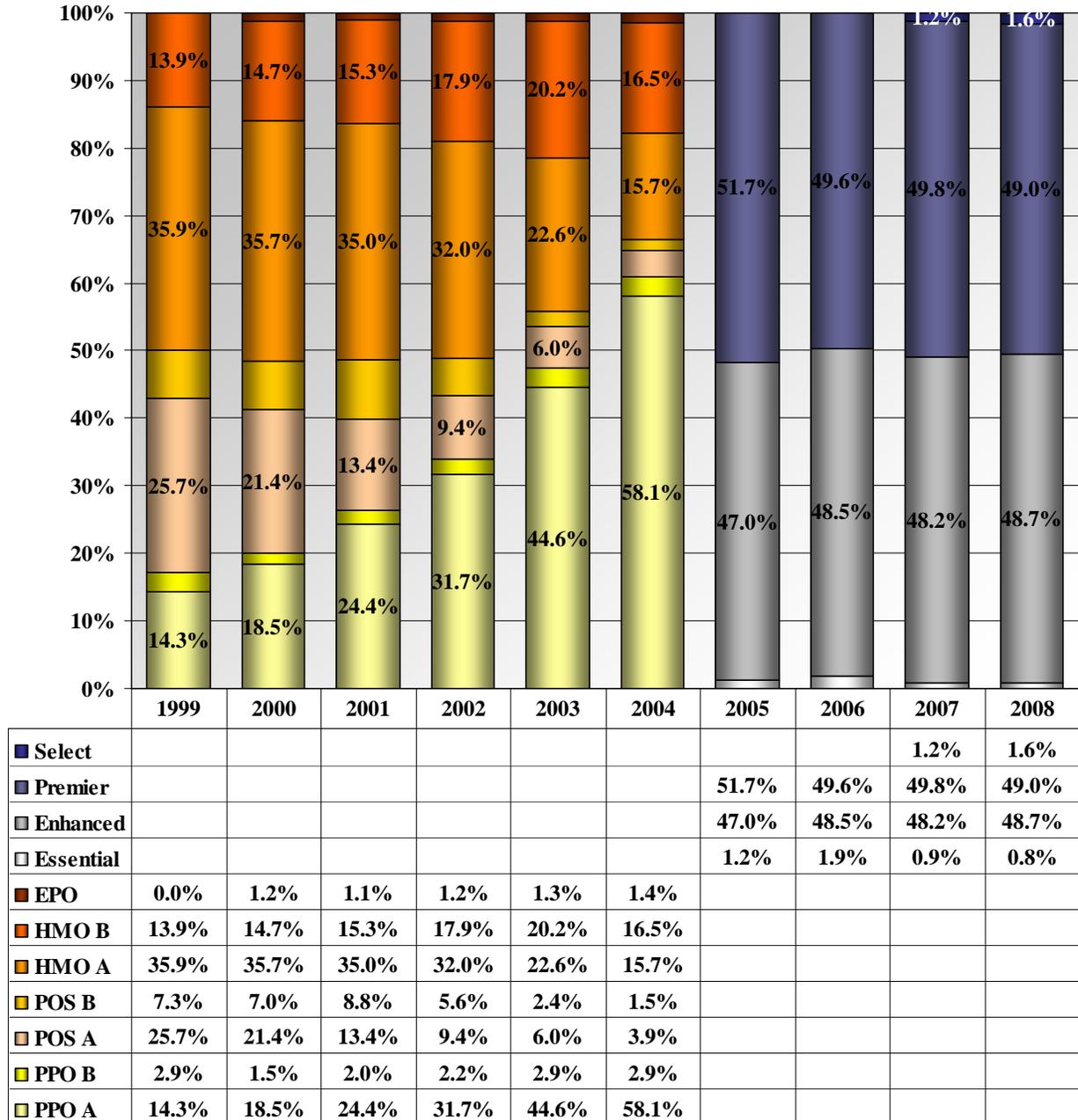
Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

Enrollment by Plan Option

Exhibit XIV shows the KEHP enrollment by plan option from 1999 through the first six months of 2008. Since 2006, there has been a small migration from the Essential and Premier Plans to the Enhanced and Select plans.

Exhibit XIV

1999 - 2008 Enrollment By Plan Option

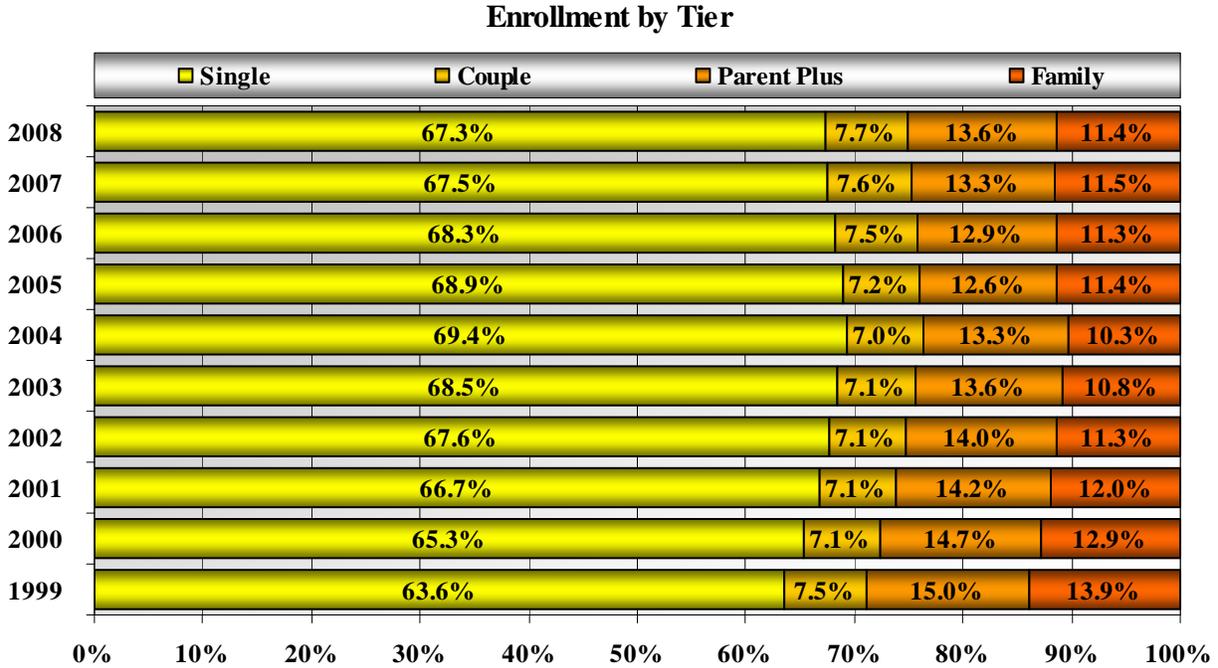


Source: KEHP's enrollment aggregated by Thomson Reuters.

* January through June 2008 data only.

Exhibit XV shows the percentage of employees and non-Medicare eligible retirees enrolling in single coverage has declined since 2005. The number electing health insurance coverage for dependents and spouses has increased. The frozen employee contributions in 2006 may have contributed to the slight shift into dependent coverage tiers in 2007 and 2008.

Exhibit XV
Enrollment By Coverage Tier



Source: KEHP's enrollment reported by the Department of Employee Insurance and aggregated by Thomson Reuters.

Group Composition

The covered group's composition changed very little from 2006 to 2008. Overall, there was a 3.6% increase in enrollment in 2007 and an increase of 2.8% in the first six months of 2008. The increase in actives from 2006 to 2007 was 3.2% compared to 2.2% for actives from 2005 to 2006. Retirees and their dependents made up 22.6% of the group in 2007, an increase of 5.1% from 2006. This increase in retiree membership has cost implications for the KEHP program because as people age, their healthcare costs go up.

Exhibit XVI

Average Number of Covered Members By Group

Average Covered Members by Group (Includes Dependents)									
	2006			2007			2008 (6 Months)		
	Average Lives	% of Total	% Change	Average Lives	% of Total	% Change	Average Lives	% of Total	% Change
By Covered Group									
State Employees	52,805	22.4%	0.8%	53,110	21.7%	0.6%	54,520	21.7%	2.7%
School Boards	115,944	49.1%	3.4%	120,625	49.3%	4.0%	124,536	49.6%	3.2%
Health Departments	4,045	1.7%	-0.1%	4,221	1.7%	4.4%	4,429	1.8%	4.9%
KERS	33,281	14.1%	5.9%	35,655	14.6%	7.1%	36,852	14.7%	3.4%
KTRS	19,386	8.2%	2.0%	19,590	8.0%	1.1%	19,251	7.7%	-1.7%
KCTCS	4,960	2.1%	9.5%	5,205	2.1%	4.9%	5,384	2.1%	3.4%
Quasi/Local Govt	5,030	2.1%	-11.4%	5,500	2.2%	9.3%	5,735	2.3%	4.3%
COBRA	481	0.2%	-28.5%	557	0.2%	15.8%	491	0.2%	-11.8%
Sub-total	235,931		2.6%	244,463		3.6%	251,199		2.8%
Unknown/Missing	107			118			240		
Grand Total	236,038		2.7%	244,581		3.6%	251,439		2.8%
By Covered Status									
Actives	182,783	77.5%	2.2%	188,681	77.1%	3.2%	194,764	77.5%	3.2%
Retirees	52,667	22.3%	4.4%	55,343	22.6%	5.1%	56,184	22.3%	1.5%
COBRA	481	0.2%	-28.5%	557	0.2%	15.8%	491	0.2%	-11.8%
Sub-total	235,931		2.6%	244,581		3.7%	251,439		2.8%
Unknown/Missing	107			0			0		
Grand Total	236,038		2.7%	244,581		3.6%	251,439		2.8%

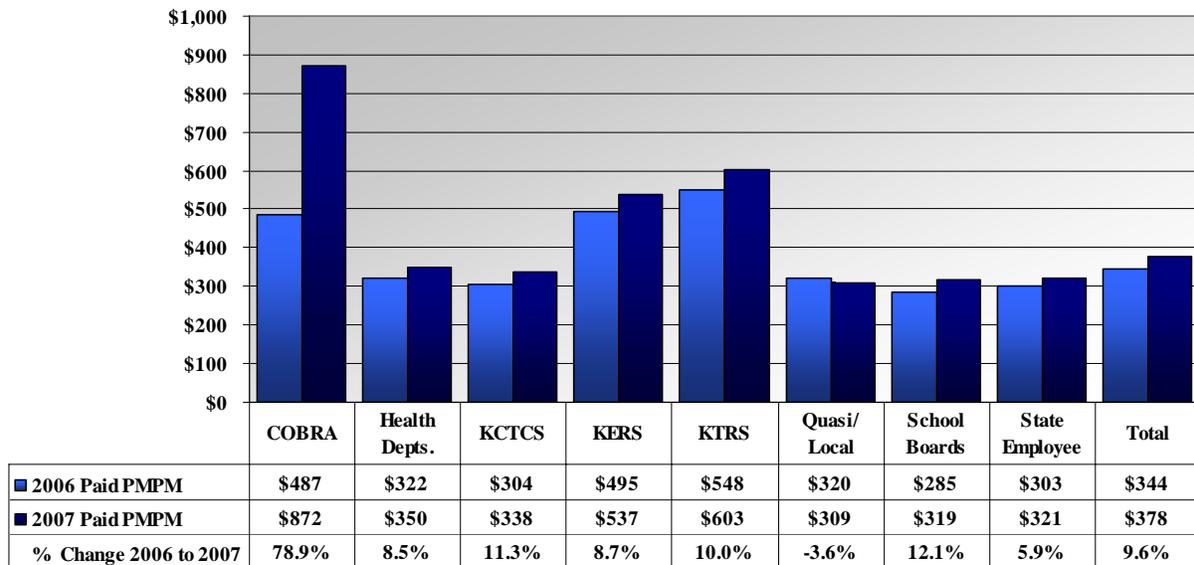
Source: KEHP's enrollment data aggregated by Thomson Reuters.

Exhibits XVII, XVIII, and XIX illustrate the per member per month costs for medical plus pharmacy, medical only, and pharmacy only, respectively, for the covered groups in 2006 and 2007. As expected, the PMPM cost for KERS of \$537 and for KTRS of \$603 are the highest among the group. The School Boards and KCTCS, had the largest increase in medical and pharmacy cost in 2007, 12.1% and 11.3% respectively.

The School Boards is the largest group and represented 49.3% of the population in 2007. In 2006, the School Boards PMPM cost of \$285 was the lowest among all groups. However, in 2007 their PMPM cost of \$319 is the second lowest among the groups, with quasi/local groups lowest at \$309.

Exhibit XVII

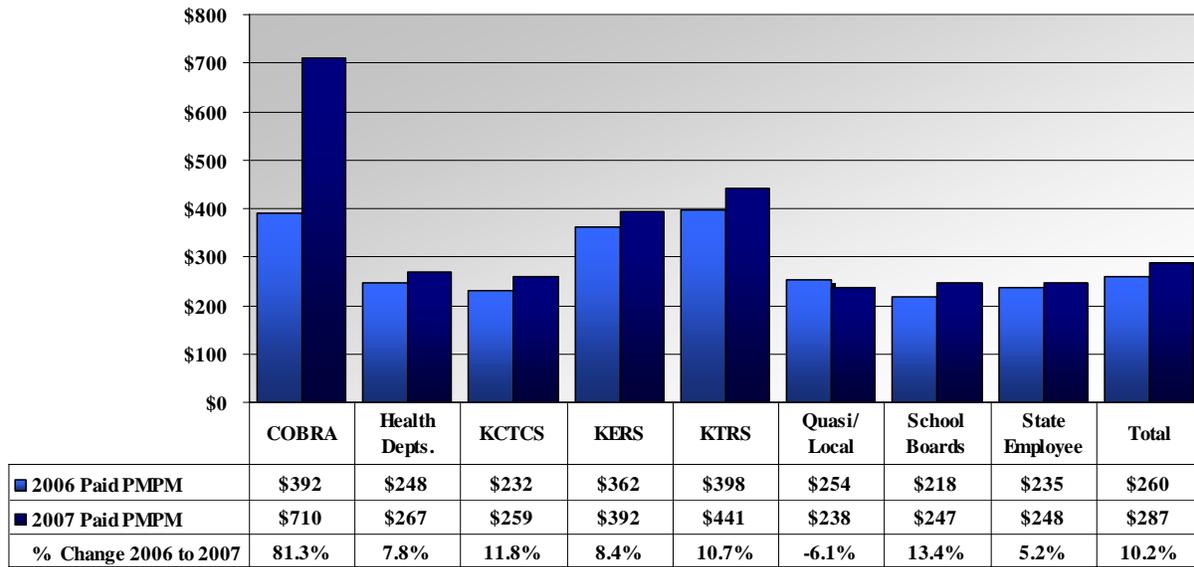
Medical and Pharmacy Claims Paid Per Member Per Month—Covered Groups



Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

Exhibit XVIII

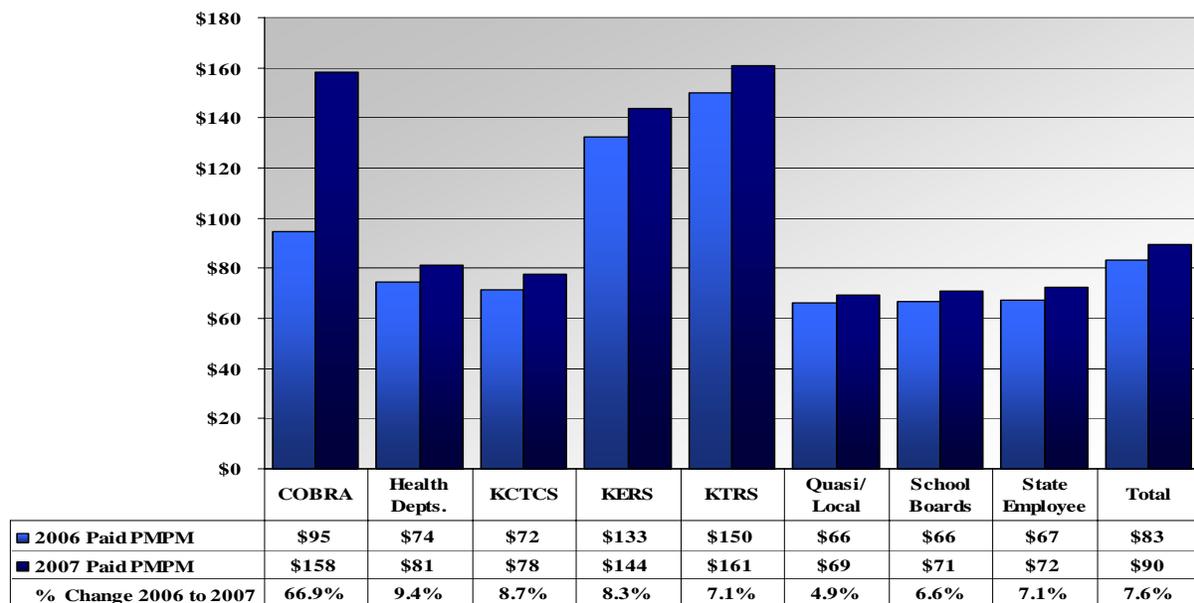
Medical Claims Paid Per Member Per Month—Covered Groups



Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

Exhibit XIX

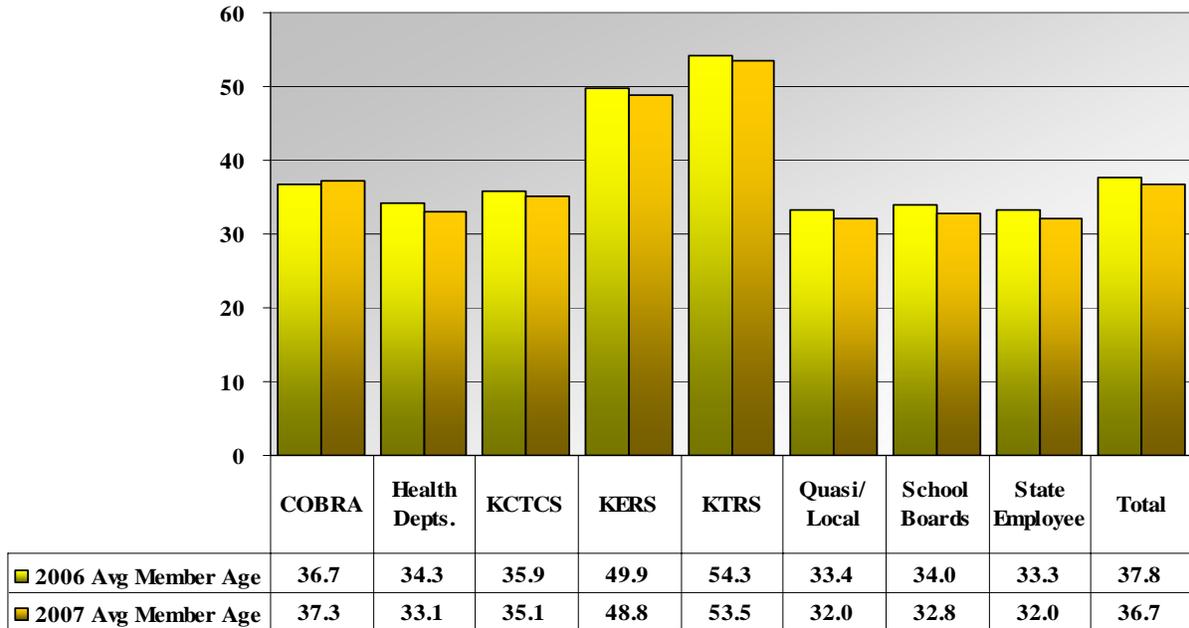
Pharmacy Claims Paid Per Member Per Month—Covered Groups



Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

Exhibit XX provides the average ages of the members in 2006 and 2007 for each coverage group. In general the average age for members has gone down significantly from 2006 to 2007.

Exhibit XX
2006 and 2007 Average Member Age—By Group



Source: KEHP's enrollment data aggregated by Thomson Reuters.

Review of KEHP Use of Services

Key Findings & Considerations

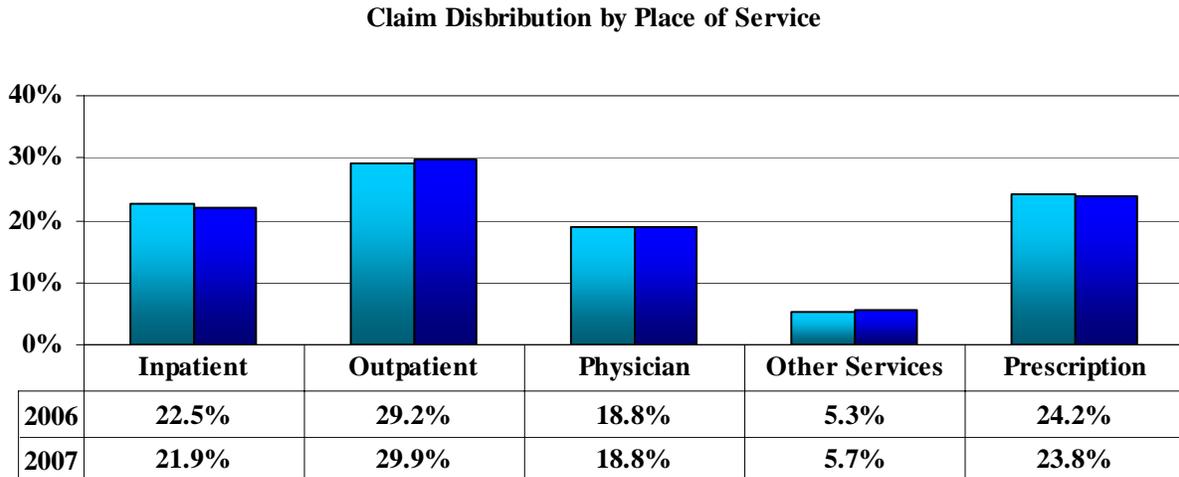
- KEHP's distribution of claims by "place of service" (inpatient, outpatient, physician, other services, and pharmacy) has remained relatively consistent from 2006 to 2007.
 - Claims costs in all places of service are growing at a lower rate in 2007 than 2006, with the exception of "other services". The most noticeable improvement is with prescription drugs moving from a 26.2% increase in 2006 to 7.4% increase in 2007.
 - Claims for care provided in outpatient settings, such as outpatient surgery centers, etc., comprise the largest portion of claims when compared to inpatient, physician, pharmacy, and other. Nearly 30% of all claims are outpatient. Further, these services increased at the highest rate from 2006 to 2007. Outpatient services claims increased by 12.1% compared to 6.8% for inpatient, 7.4% for pharmacy, and 9.4% for physician.
 - Close to 60% of claims costs continue to be incurred for treatment of participants with diagnoses that fall into a short list of major diagnostic categories. The list, which has remained the same since 2004, indicates that disease management efforts should focus on circulatory, musculoskeletal, and respiratory conditions as well as weight management.
 - Nearly 41% of members who had claims in 2007 incurred less than \$1,000 in net payments. Conversely, nearly 21% of the members with claims consumed close to 80% of net payments. This is a common distribution among health plans.

Utilization By Place of Service

According to a recent PwC study, 87 % of medical cost is related to actual medical expenditures and 13% is for administrative expenses of health plans. Exhibit XXI shows the KEHP paid claims distribution by place of service.

Exhibit XXI

Claims Distribution by Place of Service

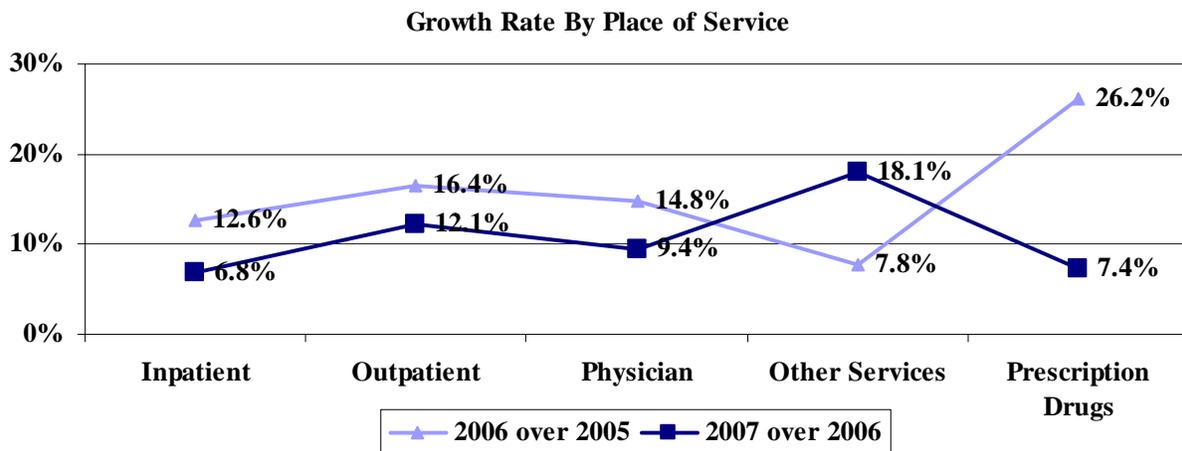


Source: KEHP's claims data aggregated by Thomson Reuters

KEHP's distribution of claims by place of service has remained consistent over the last several years. The key impact on cost trends is not the distribution of the expenditure, but the rate of increase in cost by component. Exhibit XXII, shows the KEHP growth rate by place of service from 2005 to 2006 and 2006 to 2007. All of the places of services identified are trending at a lower rate in 2007 than 2006, with the exception of "other services". Outpatient hospital, the largest component of the KEHP's claims is trending at 12.1% from 2006 to 2007. This is a much higher trend rate than inpatient hospital, physician, and pharmacy, which are trending at 8.8%, 9.4%, and 7.4% respectively.

Exhibit XXII

Growth Rate in Claim Distribution by Place of Service



Source: KEHP claims data aggregated by Thomson Reuters; adjusted for incurred but not reported claims

Different forces affect the trends for each component of medical care. For inpatient and outpatient hospital services, increases are due primarily to new technology, increased utilization, new construction, and cost-shifting from Medicare/Medicaid/Uninsured. Physician services are primarily driven by Medicare reimbursements. Prescription drug spending growth is expected to increase due to leveling off of the growth in the generic dispensing rate and new drugs continuing to come on the market.

Outpatient services continue to be the largest component of claims and are increasing at the highest rate due to a combination of both increased utilization and increased cost for services.

Utilization by Diagnostic Categories

Close to 60% of claims are for treatment of members whose diagnoses fall into a short list of Major Diagnostic Categories (MDCs). This list has remained constant from 2005 to 2007: Musculoskeletal, Circulatory, Digestive, Skin & Breast, and Nervous. Also included in this short list is “Health Status”; however, Thomson Reuters' categorization of Health Status is a “catch all” category (e.g., Preventive/Administrative Health Encounters, Signs/Symptoms/others).

This distribution of claims by MDC is reflective of the high average age of the covered population as well as indicative of a population with a significant prevalence of health risks and chronic conditions.

When viewing the number of patients that have diagnoses in these top six MDCs, it is clear that many patients have multiple conditions that fall within more than one MDC or clinical condition as noted in Exhibit XXIII.

Exhibit XXIII

Utilization by Major Diagnostic Categories

2006 Claim Distribution			2007 Claim Distribution		
Major Diagnostic Category	Commonwealth Medical Claims	Patients	Major Diagnostic Category	Commonwealth Medical Claims	Patients
Musculoskeletal	\$113,143,000	89,062	Musculoskeletal	\$131,552,839	94,296
Circulatory	\$106,256,214	68,948	Circulatory	\$113,669,476	71,741
Digestive	\$75,558,880	53,221	Digestive	\$83,919,005	55,749
Health Status	\$51,559,810	144,484	Health Status	\$62,124,265	155,256
Skin, Breast	\$43,760,414	79,606	Skin, Breast	\$51,568,545	85,096
Nervous	\$43,399,961	34,523	Nervous	\$45,465,012	36,275
Total	\$737,096,039	890,844	Total	\$841,583,539	945,273
Top 6 as % of Total	59%		Top 6 as % of Total	58%	

The clinical conditions of the top three MDCs are included in Exhibit XXIV. Gastrointestinal Disorder, Coronary Artery Diseases, and Osteoarthritis are the top conditions associated with the highest costs MDCs.

Exhibit XXIV Clinical Conditions by Major Diagnostic Categories (MDC)

Major Diagnostic Category	Clinical Condition	Commonwealth Medical Claims	Number of Patients
Musculoskeletal	Spinal/Back Disorders, NEC	\$29,822,977	32,230
	Osteoarthritis	\$28,579,566	18,649
	Arthropathies/Joint Disord NEC	\$27,291,002	56,348
	Fracture/Disloc - Upper Extrem	\$8,214,597	7,174
	Injury - Knee	\$6,257,319	4,187
	Injury - Head/Spinal Cord	\$4,081,995	8,572
	Fracture/Disloc - Ankle/Foot	\$3,848,755	5,913
	Bursitis	\$3,716,865	9,106
	Rheumatoid Arthritis	\$2,774,543	1,578
	Fracture/Disloc - Hip/Fem Head	\$2,474,617	755
	Total	\$131,552,839	
	As a % of Total Cost/Patients	16%	
Major Diagnostic Category	Clinical Condition	Commonwealth Medical Claims	Number of Patients
Circulatory	Coronary Artery Disease	\$36,698,986	8,764
	Respiratory Disord, NEC	\$23,206,856	18,710
	Cardiac Arrhythmias	\$9,402,888	5,581
	Hypertension, Essential	\$8,939,085	46,300
	Signs/Symptoms/Oth Cond, NEC	\$6,291,951	7,384
	Cardiovasc Disord, NEC	\$6,131,340	9,357
	Congestive Heart Failure	\$3,778,804	1,302
	Vascular Disorders, Arterial	\$3,567,814	1,886
	Vascular Disorders, Venous	\$3,498,223	2,999
	Rheumatic Fever/Valvular Dis	\$3,410,389	3,227
	Total	\$113,669,476	
As a % of Total Cost	14%		
Major Diagnostic Category	Clinical Condition	Commonwealth Medical Claims	Number of Patients
Digestive	Gastroint Disord, NEC	\$32,685,001	35,933
	Hernia/Reflux Esophagitis	\$9,855,988	12,342
	Cancer - Colon	\$7,091,024	512
	Tumors - Gastroint, Benign	\$6,239,843	6,183
	Gastritis/Gastroenteritis	\$5,540,511	11,670
	Diverticular Disease	\$4,270,942	3,010
	Functional Digest Disord, NEC	\$2,900,807	7,559
	Appendicitis	\$2,840,482	393
	Crohns Disease	\$2,800,037	662
	Hemorrhoids	\$1,366,325	2,049
	Total	\$83,919,005	
As a % of Total Cost	10%		

The high relative cost of Musculoskeletal, Circulatory, and Digestive MDCs suggest that care management and managed pharmacy programs related to these diagnoses should be encouraged.

For example, targeted low back, heart disease, and ulcer disease management programs or pharmaceutical step therapies, with high participation rates, can help manage these costs as well as improve the health of patients who have these diagnoses.

Utilization by User-Type

In 2007 nearly 41% of members who had claims incurred less than \$1,000 in net payments. This percentage has decreased largely due to health care cost increases from year to year. 21% of individuals with claims were high or very high users, consuming close to 80% of claims cost.

Exhibit XXV

2007 Utilization by “User-Type”

		Low Users	Medium Users	High Users	Very High Users
		\$0 - \$1,000	\$1,000 - \$5,000	\$5,000 - \$100,000	>\$100,000
Commonwealth	% Payments	3.2%	17.2%	64.2%	15.4%
2007 Net Payments	% Members	40.7%	38.8%	20.3%	0.3%
2007 Paid Claims	% Members	57.4%	24.9%	17.3%	0.4%
Benchmarks					
Difference	% Members	(16.8%)	13.9%	3.0%	(0.1%)

Source: Benchmark paid claims per Thomson Reuters' comparative national data (all industries). The benchmarks shown are based on PricewaterhouseCoopers' normative claims distribution data encompassing sixteen million lives.

Population Health Issues

Key Findings & Considerations

- From 2006 to 2007, the only improvement in wellness screenings in the active population was for cervical cancer, improving by 1%. Mammograms and colon screenings dropped by 1% and 2% respectively, and cholesterol screenings remained the same. In the non-Medicare eligible retiree population, there was a 6% improvement in 2007 for cervical screenings and a 4% improvement in cholesterol screenings. For mammograms and colon screenings, however, there was a 1% drop in each.
- The KEHP members' overall wellness screening utilization when compared to target rates for actives and non-Medicare eligible retirees are good for cervical screenings and fair for cholesterol screenings. However, improvements are needed in the categories of mammograms and colon screenings.
- In 2007, 92,768 members, or 37% of the total membership, were identified as targeted members for the ActiveHealth Management Informed Care Management (ICM) program, indicating they had a disease or condition that qualified them for disease management services. This is up significantly from 40,199 in 2006. During the year, 83,507 KEHP members received program and disease information either via mail or telephonically, up from 14,446 in 2006. During the year, 6,682 were engaged with a nurse telephonically, compared to 3,595 in 2006.

Wellness Screening Utilization

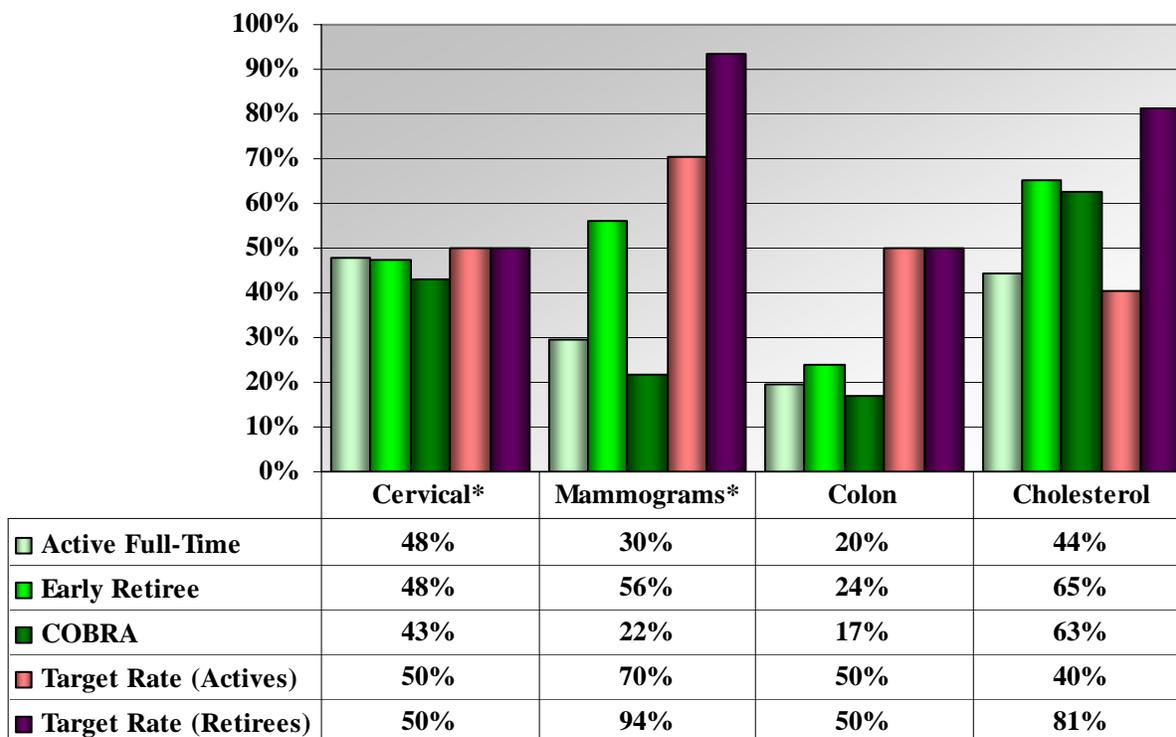
"Healthy People 2010" is a set of national health objectives for the U.S. to achieve by 2010. Created by government and non-government experts, it identifies a wide range of public health priorities and specific, measurable objectives. These priorities and objectives can be used to focus health improvement strategies on the state, community, or organizational level in order to reach the ultimate goals of increasing the quality and years of healthy life and eliminating health disparities.

In Exhibit XXVI, the preventive care screening rates for the KEHP members in 2007 are compared to "Healthy People 2010" and other clinically accepted targets. In cases where the frequency guidelines vary by age, the targets have been adjusted to reflect the actual KEHP age distribution (illustrated by the different target levels for actives versus non-Medicare eligible retirees for mammograms and cholesterol screenings).

From 2006 to 2007, the only improvement in screenings in the active population was for cervical cancer, which improved by 1%. Mammograms and colon screenings dropped by 1% and 2%, respectively, and cholesterol screening remained the same. In the non-Medicare eligible retiree population, there was a 6% improvement in 2007 for cervical screenings and a 4% improvement in cholesterol. Mammograms and colon screenings dropped by 1%.

The KEHP members' overall wellness screening utilization compared to target rates for actives and retirees are good for cervical screenings and fair for cholesterol screenings. However, improvements are needed in the categories of mammograms and colon screenings. The DEI may want to consider plan design changes which would encourage its membership to have such screenings.

Exhibit XXVI
2007 Wellness Screening Utilization



Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

Informed Care Management Program

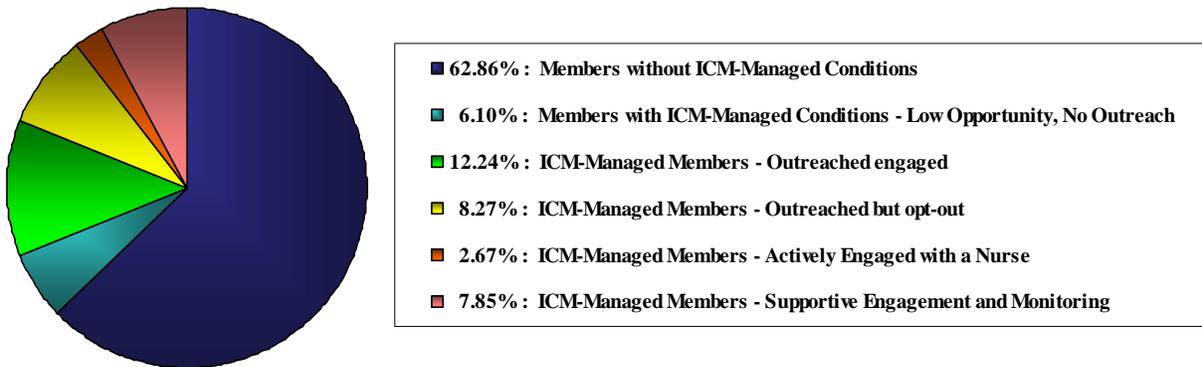
The KEHP includes a disease management program managed by ActiveHealth Management and Humana, called Informed Care Management (ICM). This program provides disease management to members who have one or more of over 30 identified chronic conditions. In 2007, 92,786 KEHP members had at least one of the identified conditions and 82,540 were targeted for outreach. Based on results in 2006, ActiveHealth worked closely with KEHP to increase the accuracy of phone numbers and contact information as well as focusing on the particular clinical conditions that were driving plan cost. Through this effort, the ICM program was able to increase its outreach by over 470% in 2007 from 14,446 to 82,540. At the end of 2007, over 10% of the total KEHP population was engaged in the program at some level and throughout the year.

Last year's recommendations regarding the ICM program drove changes to improve engagement in the program. In 2007, over 12% of the population had received outreach but had not engaged with a nurse, up from 4% in 2006. Over 2.6% of the population was actively engaged with scheduled nursing calls, up from 1.5% in 2006. The following chart indicates the percentage of KEHP members in the following categories:

- Members without ICM-Managed Conditions: those who do not have conditions that make them eligible for the program
- Members with ICM-Managed Conditions: Low Opportunity, No Outreach: those who have targeted conditions but, based on the predictive model, are unlikely to benefit from the program.
- Outreached engaged: those who have been targeted and have received welcome letters, condition-specific brochures, newsletters, etc. but have not yet started talking to a nurse via telephone
- Outreached but opt out: those who have received outreach information but have chosen to not participate in the program
- Actively Engaged with a Nurse: those who are working with a nurse telephonically on a scheduled basis
- Supportive Engagement and Monitoring: those who receive care considerations, newsletters, etc. but are not talking with a nurse on a scheduled basis. These people may have worked with a nurse and successfully achieved their health care goals or may have chosen to just receive information and not have scheduled sessions with a nurse.

Exhibit XXVII

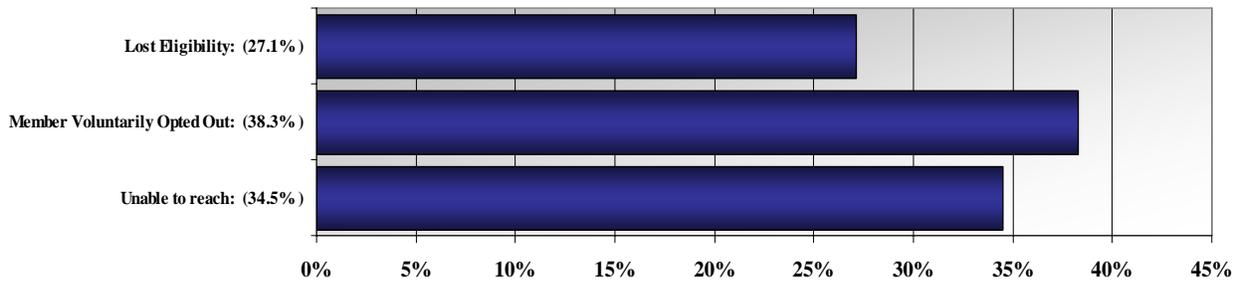
ICM Engagement Summary



Source: KEHP's participation data reported by ActiveHealth Management as of December 31, 2007

In 2007, 20,656 targeted members were not enrolled in the ICM program after outreach was attempted. Of these, 38% voluntarily opted out, down from 85% in 2006. This indicates a significant change in the enrollment messaging, communication, and potential long-term impact in the ICM program in 2007.

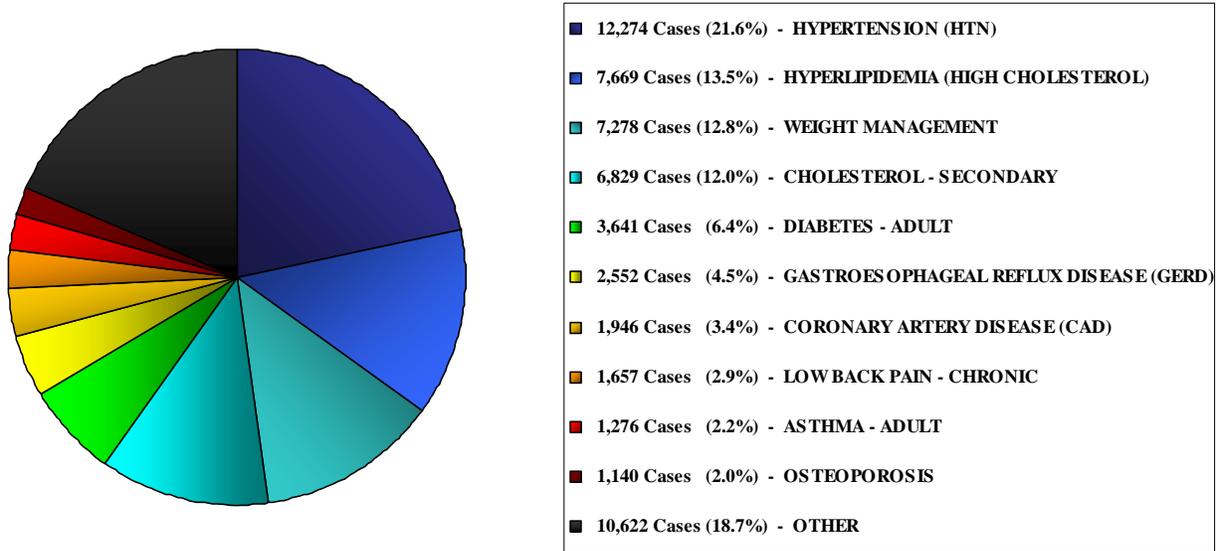
Exhibit XXVIII
ICM Reason for Opt-Out



Source: KEHP's participation data reported by ActiveHealth Management as of December 31, 2007

The conditions being addressed by the ICM program are highlighted in Exhibit XXIX. The top five conditions, based on number of engaged people, are hypertension, high cholesterol, weight management, secondary high cholesterol, and adult diabetes. This indicates a change from 2006 when diabetes was the top condition in the engaged population while weight management and high cholesterol, significant issues in the KEHP population, were not even in the top 10. Based on the population's top health conditions and cost drivers of the KEHP healthcare plan, this shift should more closely address the priorities in the population.

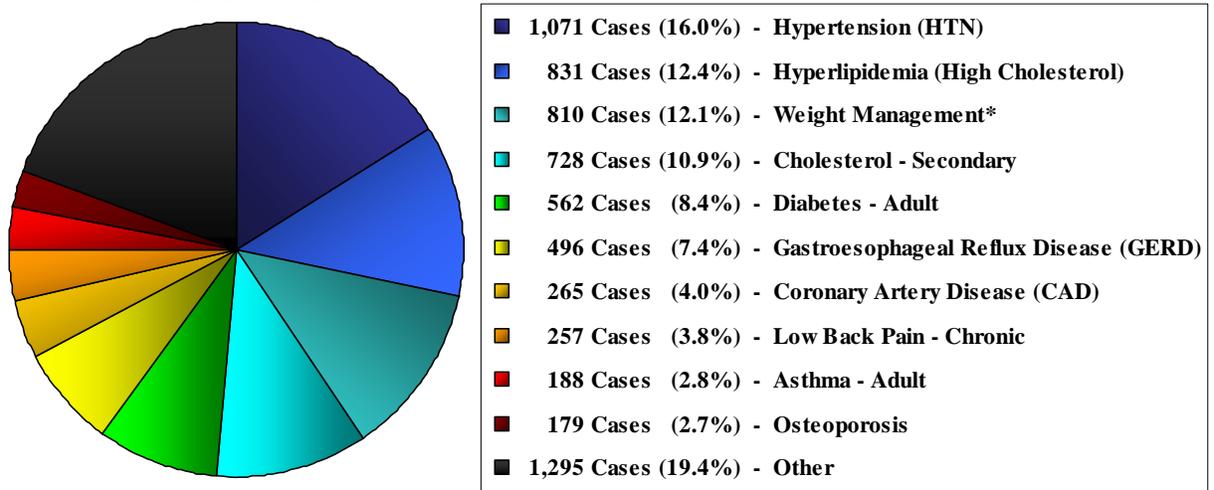
Exhibit XXIX
ICM Total Engaged Population



Source: KEHP's participation data reported by ActiveHealth Management for the period January through December 2007.

Exhibit XXX provides an overview of the members who are engaged in the ICM program through nurse counseling. In this group, identified members are participating in scheduled calls with nurses to discuss their conditions and receive education and assistance in managing those conditions. As with the total engaged population, there is a shift from 2006 to focusing on areas that most significantly impact the KEHP population. Hypertension, high cholesterol, and weight management interventions account for approximately half of the cases that are managed by a nurse.

Exhibit XXX
ICM Nurse Engaged Population



Source: KEHP's participation data reported by ActiveHealth Management for the period January through December 2007.

Also, in 2007, a total of 311 individuals self-referred themselves to the nurse engaged population through the Why Weight Kentucky program, indicating that the communication of that initiative and the integration with the ICM program are motivating the population.

Chronic Conditions

The Health Management Research Center (HMRC) at the University of Michigan has conducted studies for more than 20 years on the relationship between health risks, health status and healthcare costs. Health risks that have been shown to contribute to higher healthcare claims are shown in Exhibit XXXI.

Exhibit XXXI

Health Risks and Behaviors

Health Risk Measure	High Risk Criteria
Alcohol	More than 14 drinks/week
Blood Pressure	Systolic >139 mmHg or Diastolic >89 mmHg
Body Weight	Body mass index (BMI) at or more than 27.5%
Cholesterol	Greater than 239 mg/dl
Existing Medical Problem	Heart, Cancer, Diabetes, Stroke
HDL	Less than 35 mg/dl
Illness Days	>5 days last year
Life Satisfaction	Partly or not satisfied
Perception of Health	Fair or poor
Physical Activity	Less than one time/week
Safety Belt Usage	Using safety belt less than 100% of time
Smoking	Current smoker
Stress	High

Source: University of Michigan Health Management Research Center study

These health risks contribute directly to the onset of chronic disease. Therefore, programs focused on long term behavior change and incentives for people to participate in wellness programs that impact these health behaviors, significantly improve the development of chronic diseases in a population, thereby avoiding cost and improving the health and vitality of members.

Exhibit XXXII displays the difference in per member per month allowed charges (the cost to both the plan and member combined) between the average KEHP member and those with specified chronic conditions.

Exhibit XXXII

2007 Chronic Disease States PMPM versus KEHP Aggregate PMPM

Disease State	2007 Allowed Charges	2007 Disease State vs 2007 Aggregate Allowed Charges
KEHP Aggregate	\$430.70	N/A
Asthma Moderate	\$746.74	73.4%
Asthma Severe	\$1,751.00	306.6%
Diabetes Low	\$1,038.28	141.1%
Diabetes Moderate	\$1,467.54	240.7%
Diabetes Severe	\$3,310.86	668.7%
HBP	\$828.35	92.3%
Depression	\$916.53	112.8%
Bariatric	\$1,420.72	229.9%
Low Back	\$989.30	129.7%

Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

Based on PwC models and the average cost of members within each disease state, there is the potential for significant savings from the management of those with chronic diseases. Assisting these members with accessing appropriate care, discussing concerns and questions with their physicians, maintaining compliance with maintenance medications, and gaining additional education through the disease management program will significantly improve health and cost in the plan.

Comparison of Health Behaviors and Indicators

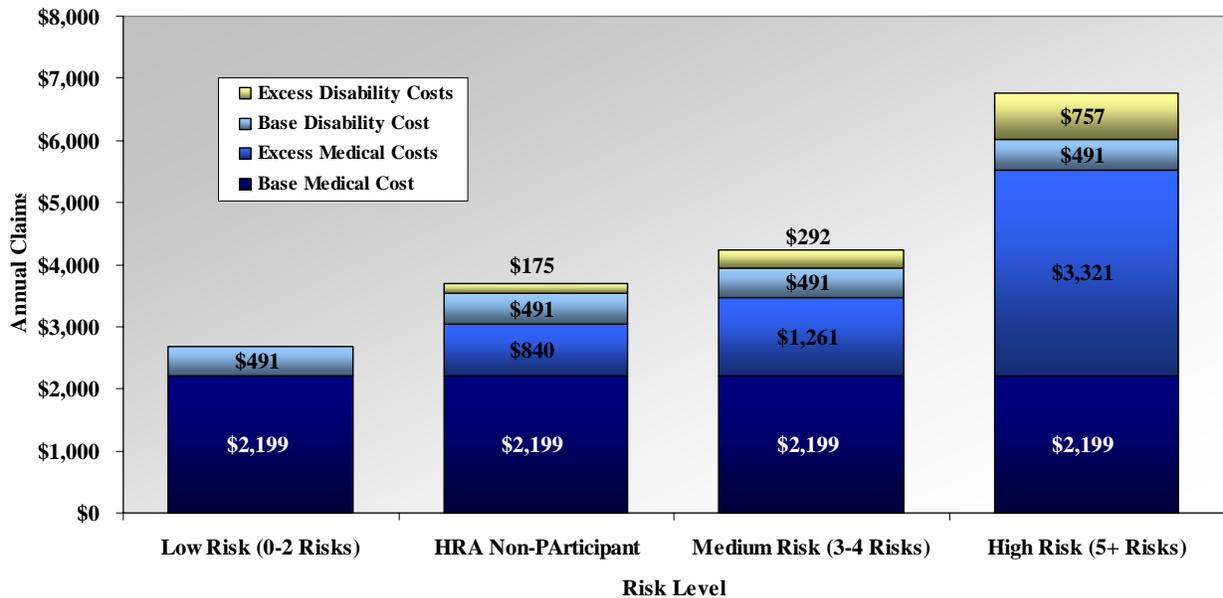
The Kaiser Family Foundation has tabulated, state by state, the prevalence of certain health behaviors and indicators that adversely affect the health of individuals. These behaviors and indicators correlate closely to health status. Given that KEHP covers 6% of the total Commonwealth population, these behaviors are also evident in the plan population. Many plan sponsors are focusing efforts on improving the overall health of their covered population, as measured by these indicators, in order to promote a healthy membership.

The University of Michigan Health Management Research Center (HMRC) defined “Low Risk” individuals as people who have 2 or less of the high risks listed in Exhibit XXV, “Medium Risk” individuals as those with 3 or 4 of the above risks, and “High Risk” individuals as those with 5 or more of the above risks. On average, Medium Risk individuals incur healthcare claims at 1½ times the level of Low Risk individuals. High Risk individuals incur healthcare claims at over

2½ times the level of Low Risk individuals. The impact to medical cost based on the above risk classifications are shown in Exhibit XXXIII.

Exhibit XXXIII

An Example of the Impact of Multiple Health Risks on Cost



Source: PricewaterhouseCoopers projection of Edington Excess Health Costs 2003

The exhibits that follow provide several correlations using data compiled by the Kaiser Family Foundation. Note that the data provided here are state-wide population information, and not specific to the KEHP program or its members. However, since the KEHP membership makes up nearly 6% of the total Commonwealth population, it is likely that there is a similar distribution between these populations.

Some of the exhibits focus on four of the health risk measures: body weight, existing medical problem, physical activity, and smoking. In addition, data regarding pre-natal care and birth outcomes are included as this is an additional health indicator that is relevant to the measurement of health and healthy behaviors in a population.

The following is included in each exhibit:

- Kentucky: Shown in Red.
- Kentucky (Prior Year): Shown in Brown. In cases where the state data has been updated since last year, the comparable metric from last year's report is shown.
- Neighboring States: Shown in Yellow. Consists of Alabama, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

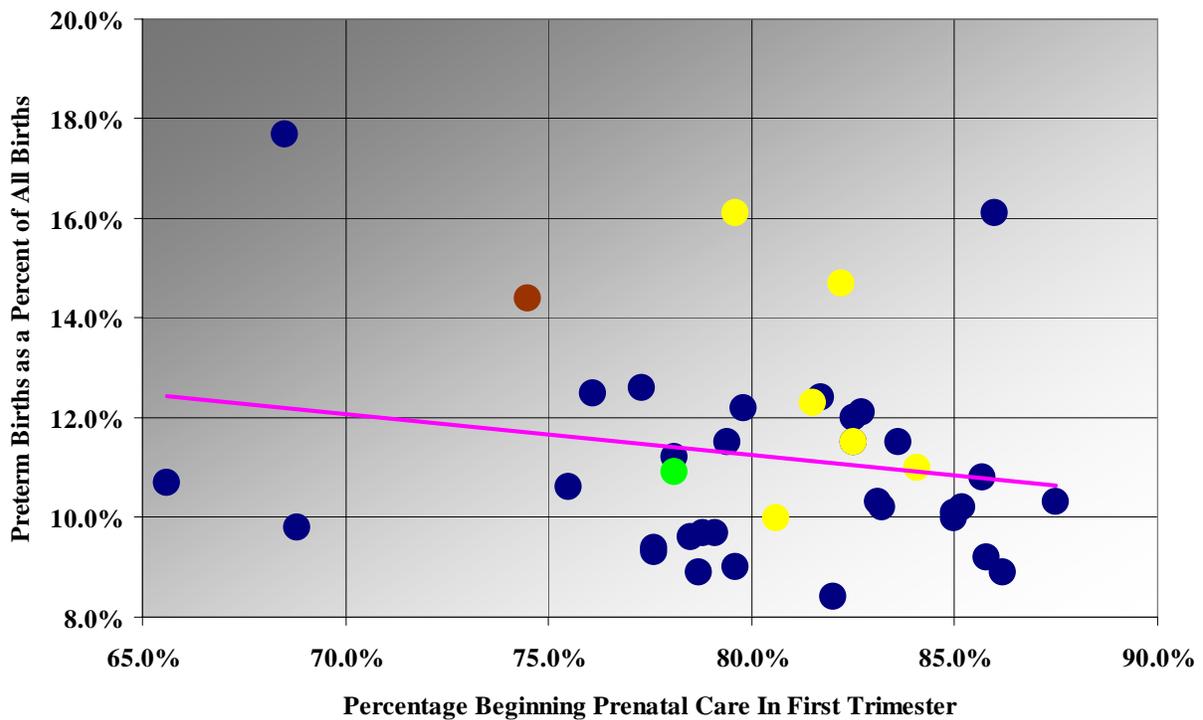
- All Other States: Shown in Blue.
- US National Average: Shown in Green.

For each chart in the exhibit a correlation line has been included to illustrate the approximate correlation between the two factors shown on each chart.

A more detailed table follows each chart in the exhibit providing the Kentucky, Neighboring State, and US National Average measures for the lifestyle and health status metrics.

Exhibit XXXIV

Correlation Between First Trimester Prenatal Care and Preterm Births

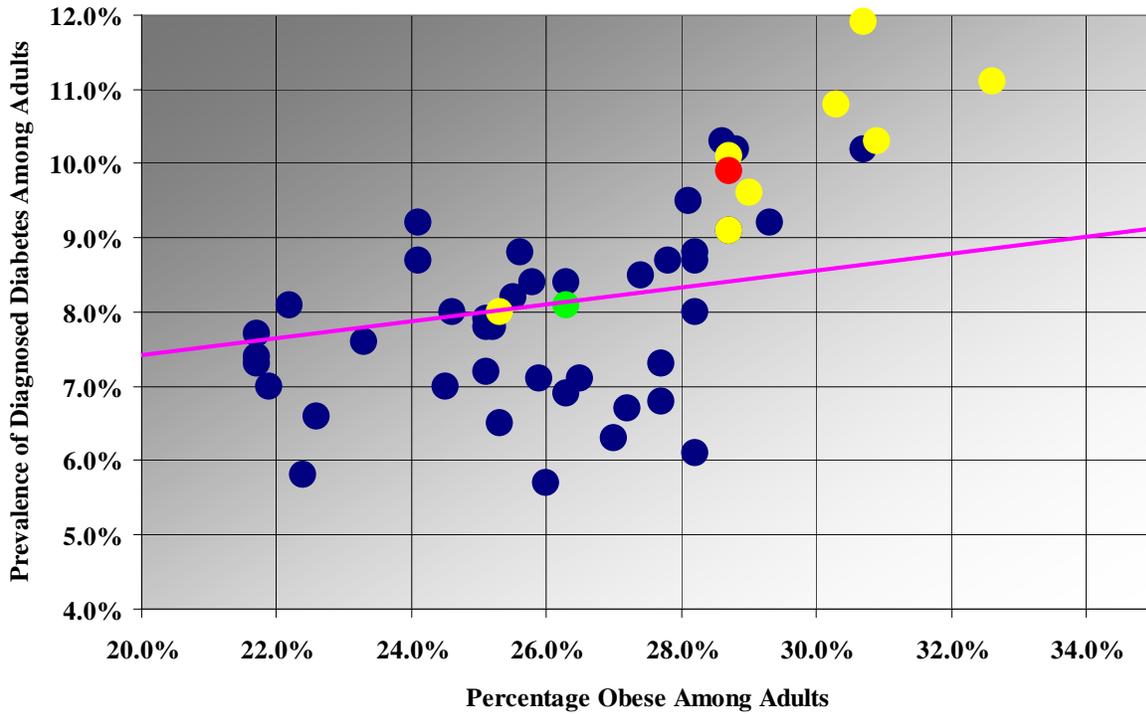


	Percentage Beginning Prenatal Care In First Trimester	Preterm Births as a Percent of All Births
Kentucky	74.5%	12.0%
Alabama	82.2%	14.7%
Georgia	80.6%	10.0%
Mississippi	79.6%	16.1%
North Carolina	82.5%	11.5%
South Carolina	N/A	12.6%
Tennessee	N/A	12.9%
Virginia	84.1%	11.0%
West Virginia	81.5%	12.3%
United States	78.1%	10.9%

Source: Kaiser Family Foundation, www.statehealthfacts.org, 2005 data.

Exhibit XXXV

Correlation Between Adult Obesity and Prevalence of Adult Diabetes

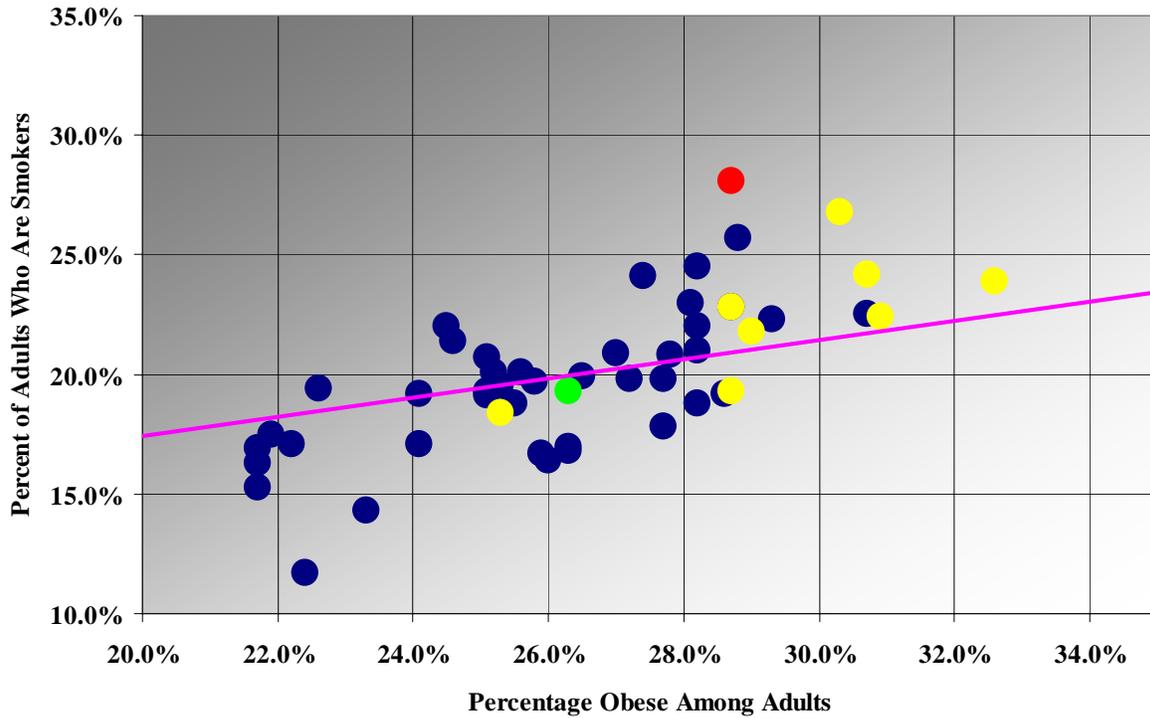


	Prevalence of Obesity Among Adults	Prevalence of Diagnosed Diabetes Among Adults
Kentucky	28.7%	9.9%
Alabama	30.9%	10.3%
Georgia	28.7%	10.1%
Mississippi	32.6%	11.1%
North Carolina	28.7%	9.1%
South Carolina	29.0%	9.6%
Tennessee	30.7%	11.9%
Virginia	25.3%	8.0%
West Virginia	30.3%	10.8%
United States	26.3%	8.1%

Source: Kaiser Family Foundation, www.statehealthfacts.org, 2007 data.

Exhibit XXXVI

Correlation Between Adult Obesity and Percent of Adults Who Are Smokers

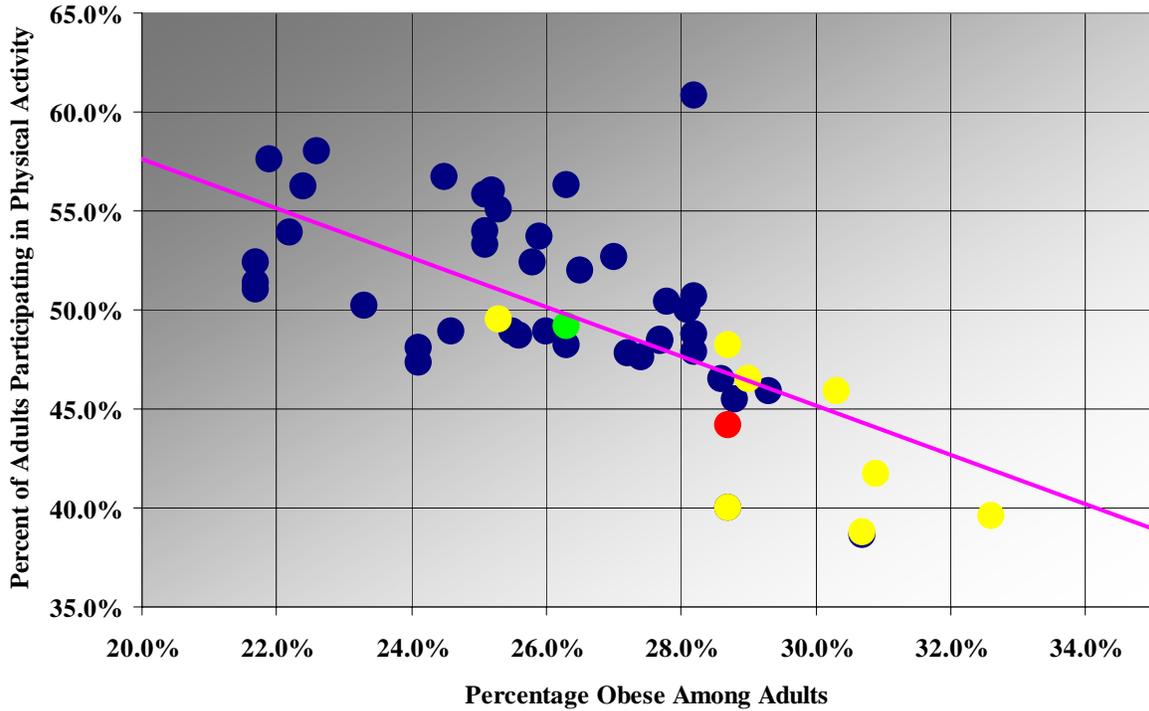


	Prevalence of Obesity Among Adults	Percent of Adults Who Are Smokers
Kentucky	28.7%	28.1%
Alabama	30.9%	22.4%
Georgia	28.7%	19.3%
Mississippi	32.6%	23.9%
North Carolina	28.7%	22.8%
South Carolina	29.0%	21.8%
Tennessee	30.7%	24.2%
Virginia	25.3%	18.4%
West Virginia	30.3%	26.8%
United States	26.3%	19.3%

Source: Kaiser Family Foundation, www.statehealthfacts.org, 2007 data.

Exhibit XXXVII

Correlation Between Adult Obesity and Adults Participating in Physical Activity

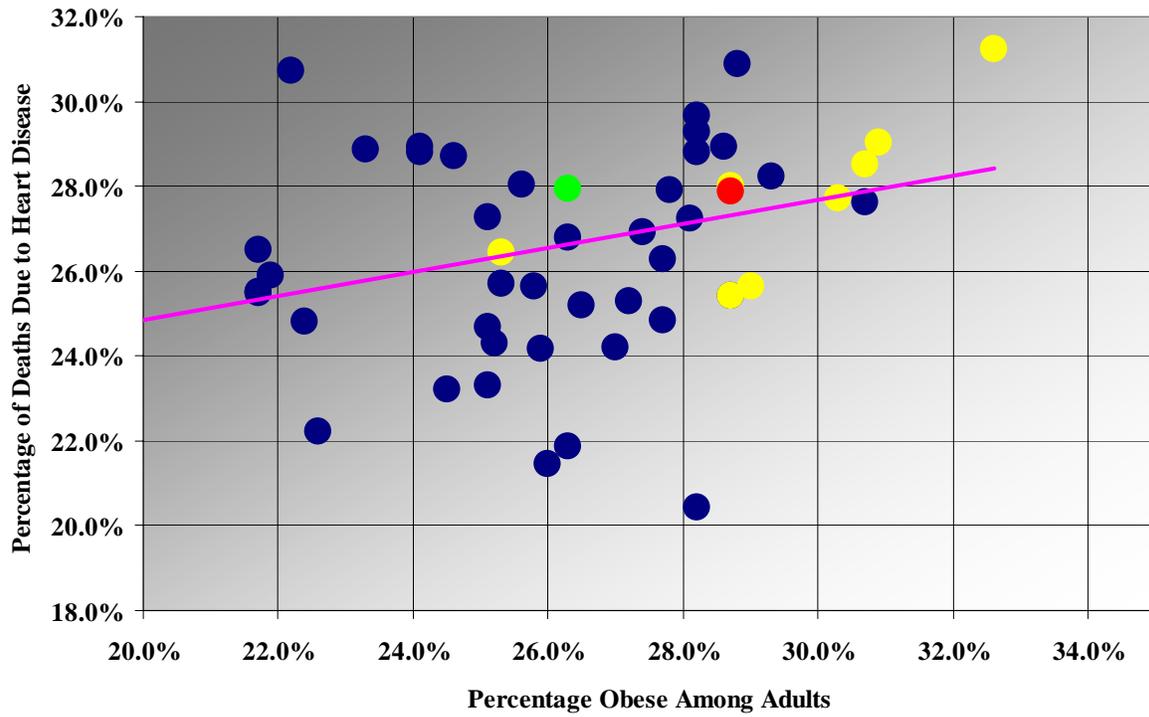


	Prevalence of Obesity Among Adults	Percent of Adults Who Are Participating In Physical Activity
Kentucky	28.7%	44.2%
Alabama	30.9%	41.7%
Georgia	28.7%	48.2%
Mississippi	32.6%	39.6%
North Carolina	28.7%	40.0%
South Carolina	29.0%	46.5%
Tennessee	30.7%	38.8%
Virginia	25.3%	49.5%
West Virginia	30.3%	45.9%
United States	26.3%	49.2%

Source: Kaiser Family Foundation, www.statehealthfacts.org, 2007 data.

Exhibit XXXVIII

Correlation Between Adult Obesity and Deaths Due to Heart Disease or Stroke



	Prevalence of Obesity Among Adults	Percent of Deaths Due To Heart Disease
Kentucky	28.7%	27.9%
Alabama	30.9%	29.0%
Georgia	28.7%	28.0%
Mississippi	32.6%	31.2%
North Carolina	28.7%	25.4%
South Carolina	29.0%	25.6%
Tennessee	30.7%	28.5%
Virginia	25.3%	26.4%
West Virginia	30.3%	27.7%
United States	26.3%	27.9%

Source: Kaiser Family Foundation, www.statehealthfacts.org, 2007 and 2003 data

KEHP Pharmacy Benefits Experience

Key Findings & Considerations

- Allowed charges for prescription drugs increased 14.8% from 2005 to 2006 and 9.8% from 2006 to 2007. The 2007 trend rate for the KEHP's portion of the cost in total is 11.5% due to member cost sharing declining by 7.7%.
- Scripts per employee per year grew at a lower rate, increasing by 4.2% from 2006 to 2007 versus 9.0% from 2005 to 2006. The 2007 average number of scripts per member per year was 20.3.
- Although the number of brand drugs decreased, the generic dispensing rate increased from 55.5% in 2006 to 59.9% in 2007.
- 15,041 families had more than 75 retail scripts in 2007 and qualified for reduced prescription drug co-pays, though this comprises almost 34% of all retail scripts.
- Top drugs utilized year over year correlate to the clinical conditions identified earlier and further contribute to the potential for cost and health improvement through coordinated disease management and incentives.

Detailed Findings - Pharmacy Benefits

A summary of year over year trends for the KEHP's pharmacy claims experience are illustrated in Exhibits XXXIX and XL.

As shown in Exhibit XXXIX, the total allowed charges for prescription drugs increased 14.8% in 2006 and 9.8% in 2007. Member cost sharing continues to decline, decreasing by 7.7% from 2006 to 2007.

The observed 2007 trend rate for the KEHP's portion of the pharmacy cost in total is 11.5% versus the overall 2007 trend on pharmacy allowed charges of 9.8%. The decrease in employee cost share is due to the co-payments for members remaining unchanged, which, as costs increase, results in a larger subsidy by the KEHP.

Exhibit XXXIX

Key Pharmacy Cost Statistics

	Key Pharmacy Cost Statistics				
	2005	2006	2007	2006 vs. 2005	2007 vs. 2006
Total Eligible Members	229,867	236,038	244,581	2.7%	3.6%
Total Allowed Charges	\$237,950,244	\$273,147,067	\$299,969,209	14.8%	9.8%
Total Net Paid Claims	\$182,085,476	\$236,132,970	\$263,227,841	29.7%	11.5%
Total Scripts	4,108,930	4,599,904	4,967,732	11.9%	8.0%
Mail Order Scripts	69,359	91,866	103,260	32.5%	12.4%
Retail Scripts	4,039,571	4,508,038	4,864,472	11.6%	7.9%
Retail Copayment per Claim	\$14.89	\$9.42	\$8.82	(36.8%)	(6.3%)
Retail Member Cost Share	25.9%	15.9%	14.7%	(38.6%)	(7.8%)
Mail Copayment per Claim	\$29.31	\$24.33	\$22.57	(17.0%)	(7.2%)
Mail Member Cost Share	15.8%	14.7%	13.8%	(7.0%)	(5.9%)
Total Copayment per Claim	\$15.14	\$9.71	\$9.11	(35.8%)	(6.3%)
Total Member Cost Share	25.4%	15.9%	14.6%	(37.5%)	(7.7%)
Plan Cost per Member	\$792.13	\$1,000.40	\$1,076.24	26.3%	7.6%
Plan Cost PMPM	\$66.01	\$83.37	\$89.69	26.3%	7.6%
Plan Cost per Claim	\$44.31	\$51.33	\$52.99	15.8%	3.2%

Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

The number of scripts per member per year was 17.9 in 2005, 19.5 in 2006, and 20.3 in 2007. The generic dispensing rate increased from 55.5% in 2006 to 59.9% in 2007, consistent with the total number of generic scripts increasing and brand scripts decreasing.

Exhibit XL

Key Pharmacy Utilization Statistics

	Key Pharmacy Utilization Statistics				
	2005	2006	2007	2006 vs. 2005	2007 vs. 2006
Total Eligible Members	229,867	236,038	244,581	2.7%	3.6%
Total Allowed Charges	237,950,244	273,147,067	299,969,209	14.8%	9.8%
Total Net Paid Claims	182,085,476	236,132,970	263,227,841	29.7%	11.5%
Total Scripts	4,108,930	4,599,904	4,967,732	11.9%	8.0%
Mail Order Scripts	69,359	91,866	103,260	32.5%	12.4%
Retail Scripts	4,039,571	4,508,038	4,864,472	11.6%	7.9%
Brand Scripts	2,083,938	2,048,578	1,992,611	(1.7%)	(2.7%)
Generic Scripts	2,024,992	2,551,326	2,975,121	26.0%	16.6%
Days Supply	112,438,024	130,069,819	141,598,347	15.7%	8.9%
Days Supply per Claim	27.4	28.3	28.5	3.3%	0.8%
Generic Dispensing Rate	49.3%	55.5%	59.9%	12.5%	8.0%
Generic Substitution Rate	88.2%	90.6%	88.1%	2.8%	(2.8%)
Mail Order Utilization	1.7%	2.0%	2.1%	18.3%	4.1%
Scripts PMPY	17.9	19.5	20.3	9.0%	4.2%

Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

Distribution of Annual Retail Scripts Per Household In 2007

Households with more than 75 retail scripts per year qualify for reduced prescription drug co-payments after the 75th script. Exhibit XLI shows the distribution of retail scripts per household per year.

Exhibit XLI

Distribution of Annual Number of Scripts Per Household In 2007

Number of Retail Scripts	Number of Families	% of Families	Total Retail Scripts	% of Retail Scripts
0 - 75	133,352	89.86%	3,216,808	67.39%
76 - 80	2,105	1.42%	161,308	3.39%
81 - 85	1,825	1.23%	148,763	3.14%
86 - 90	1,537	1.04%	132,976	2.73%
91 - 95	1,258	0.85%	114,953	2.35%
96 - 100	1,103	0.74%	106,785	2.19%
101 - 125	3,647	2.46%	401,634	7.92%
126 - 150	1,802	1.21%	243,036	4.69%
151 - 175	851	0.57%	136,257	2.56%
176 - 200	472	0.32%	87,674	1.58%
201 - 225	210	0.14%	44,205	0.81%
226 - 250	100	0.07%	23,616	0.41%
251 - 275	61	0.04%	15,905	0.29%
over 275	70	0.05%	30,552	0.56%
Total	148,393		4,864,472	
Over 75	15,041	10.1%	1,647,664	33.9%

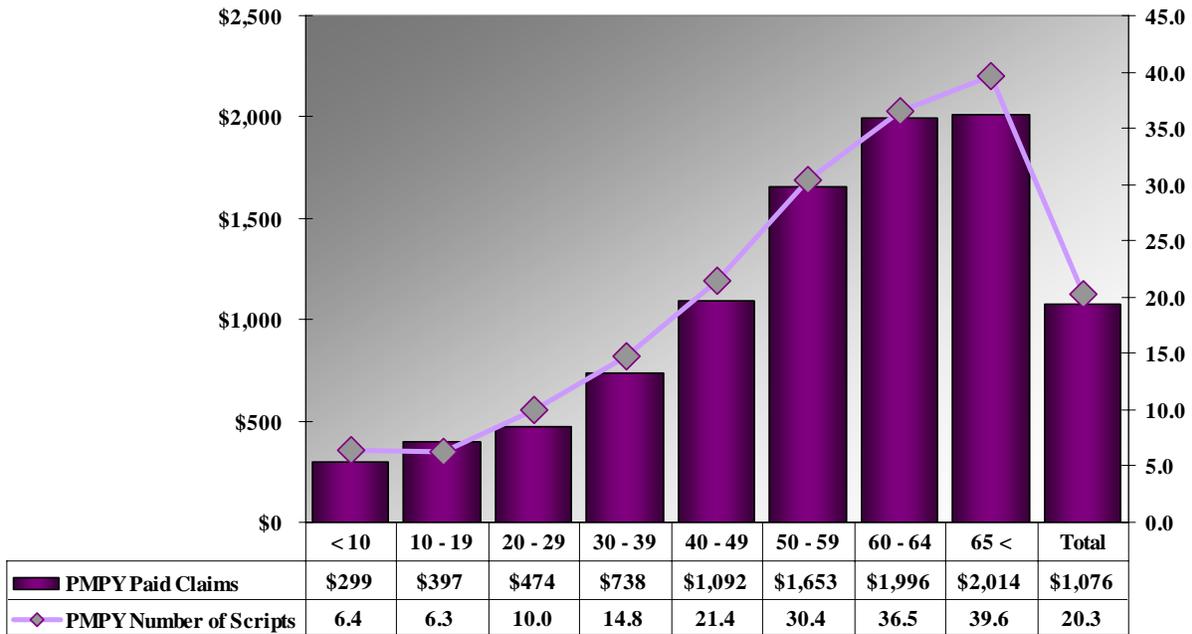
Source: KEHP's claims data aggregated by Thomson Reuters.

Demographic Impact on Pharmacy Experience

In 2007, the average member age for KEHP was 36.7. For that age, there was an average of 14.8 scripts and \$740 in prescription claims paid during the year. These are both up from 2006, where the number of prescriptions was 13.6 and the claims paid were \$641. Exhibit XLII illustrates the increase in medication usage with each increasing age band. This increase is due to the natural progression of people's health status as they age.

Exhibit XLII

2006 Distribution of Pharmacy Claims and Number of Prescriptions, PMPY by Age



Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

Drug Utilization and Disease States

The top drugs utilized year over year correlate to MDC findings and further contribute to the potential for cost and health improvement through coordinated disease management and incentives.

A review of the top ten drugs and the employee cost share per drug demonstrates again that KEHP is absorbing more and more of the pharmacy cost increase.

Exhibit XLIII Top 10 Drugs

Product Name	MDC	2005				2006				2007			
		Rank	Net Pay	Scripts Rx	Employee Cost Share	Rank	Net Pay	Scripts Rx	Employee Cost Share	Rank	Net Pay	Scripts Rx	Employee Cost Share
Nexium	GERD	4	\$3.62	26,489	\$23.28	1	\$7.10	45,432	\$15.62	1	\$7.96	47,791	\$15.61
Singulair	Respiratory	5	\$3.56	47,575	\$21.07	3	\$5.26	58,640	\$15.33	2	\$6.26	65,809	\$15.21
Enbrel	Musculokeletal	2	\$4.15	2,615	\$26.82	5	\$4.75	2,839	\$15.70	3	\$5.09	2,610	\$16.23
Prevacid	GERD	9	\$2.95	22,095	\$29.25	4	\$4.87	30,273	\$15.53	4	\$5.03	29,351	\$15.44
Crestor	Cirulatory	35	\$1.06	17,887	\$28.62	7	\$3.66	44,966	\$15.55	5	\$4.81	54,221	\$15.62
Effexor-XR	Nervous	3	\$3.90	33,677	\$15.41	6	\$4.38	34,827	\$15.21	6	\$4.74	33,979	\$15.14
Vytorin	Cirulatory	36	\$1.06	14,794	\$17.92	10	\$3.44	42,275	\$15.68	7	\$4.43	49,800	\$15.78
Topamax	Nervous	14	\$2.36	12,279	\$20.25	12	\$3.34	14,919	\$14.86	8	\$4.28	17,703	\$14.87
Actos	Cirulatory	13	\$2.41	16,408	\$20.66	15	\$2.64	18,056	\$30.47	9	\$3.54	20,201	\$15.31
Plavix	Cirulatory	11	\$2.48	22,261	\$20.94	18	\$2.26	17,759	\$15.49	10	\$3.51	27,456	\$15.08

Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

Breaking the average number of prescriptions per person into single source brand, multi-source brand and generics, trends are similar to those seen in overall data (Exhibit XLIV). Use of brand single source and brand multi source drugs is on the decline, and the use of generics is increasing.

Exhibit XLIV

Prescription Drug Utilization Detail by Drug Classification

	Average Scripts Per Person		
	2006	2007	% Change
Retail and Mail Order			
Brand Single Source	7.6	6.7	(11.0%)
Brand Multi Source	1.1	1.4	26.9%
Total Brand	8.7	8.1	(6.1%)
Generic	10.8	12.2	12.5%
Total All	19.5	20.3	4.2%
Retail			
Brand Single Source	7.4	6.5	(11.1%)
Brand Multi Source	1.1	1.4	26.6%
Total Brand	8.5	7.9	(6.2%)
Generic	10.6	12.0	12.3%
Total Retail	19.1	19.9	4.1%
Mail Order			
Brand Single Source	0.2	0.2	(9.0%)
Brand Multi Source	0.0	0.0	43.5%
Total Brand	0.2	0.2	(4.3%)
Generic	0.2	0.2	25.0%
Total Mail Order	0.4	0.4	8.5%

Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

Contributing to the mix of drugs used by the members are environmental changes, such as the introduction of new specialty drugs (driving a higher plan cost) and new generics (lowering plan cost). Based on the Program's historical experience, continuing to maximize the utilization of generics represents a significant opportunity to manage overall plan cost.

While patent expiration does not equal generic availability, several highly utilized drugs are scheduled for patent expiration over the next several years (Exhibit XLV).

Exhibit XLV

Drugs Losing Patent Protection

Year	Brand Name	Manufacturer	Use
2007	Norvasc	Pfizer	Hypertension
	Ambien	Sanofi-Aventis	Insomnia
	Zyrtec	Pfizer	Allergies
	Imitrex	GlaxoSmithKline	Migraine headache
	Lotrel	Novartis	High blood pressure
	Paxil CR	GlaxoSmithKline	Depression
	Coreg	GlaxoSmithKline	Hypertension
	Proscar	Merck	BPH
	Precose	Bayer	Type 2 diabetes
2008	Advair Diskus	GlaxoSmithKline	Asthma, COPD
	Risperdal	Janssen	Schizophrenia
	Fosamax	Merck	Osteoporosis
	Depakote	Abbott	Seizure disorder, bipolar disorder
	Mobic	Boehringer Ingelheim	Arthritis
	Serevent	GlaxoSmithKline	Asthma, COPD
	Effexor	Wyeth-Ayerst	Depression, anxiety
	Tegretol-XR	Novartis	Seizures
	Lamictal tablets	GlaxoSmithKline	Seizures, bipolar disorder
	Trileptal	Novartis	Seizures
	Casodex	AstraZeneca	Prostate cancer
	Sonata	King	Insomnia
	Zerit	Bristol-Myers-Squibb	HIV/AIDS
	Topamax	Ortho-McNeil	Seizures, migrane
2009	Prevacid	Novartis	Ulcers,GERD
	AcipHex tablets	Eisai	Ulcers,GERD
	Imitrex tablets	GlaxoSmithKline	Migrane headache
	Prandin	Novo Nordisk	Type 2 diabetes
	Acular	Allergan	Allergic conjunctivitis
Aceon	Solvay	High blood pressure	
2010	Arimidex	AstraZeneca	Breast Cancer
	Advair	GlaxoSmithKline	Asthma
	Cozaar/Hyzaar	GlaxoSmithKline	High blood pressure
	Femara	Novartis	Breast Cancer
	Aricept	Pfizer	Alzheimer's
	Taxotere	Sanofi-Aventis	Prostate Cancer/Chemotherapy
	RemeronSolTab®	Organon	Antipsychotic
	Lipitor®	Pfizer	Cholesterol Lowering
2011	Seroquel	AstraZeneca	Schizophrenia
	US Plavix	Bristol-Myers Squibb	Heart Attack
	Xalatan	Pfizer	Glaucoma
	US Plavix	Sanofi-Aventis	Heart Attack
	Avapro	Sanofi-Aventis	High blood pressure
	Plavix®	Bristol-Myers Squibb/Sar	Platelet Inhibitors
	Provigil®	Cephalon	Sleep Disorders
2012	Avandia	GlaxoSmithKline	Type 2 diabetes
	Singulair	Merck	Asthma
	Diovan	Novartis	High blood pressure
	Viagra	Pfizer	Erectile Dysfunction
	Detrol	Pfizer	Overactive Bladder
	Geodon	Pfizer	Schizophrenia
	Lovenox	Sanofi-Aventis	Heart Attack

Source: 2006 Medco Drug Trend Report, Walgreens Health Initiatives' 2007 Trend Report, AXA Framlington

A LOOK AHEAD: FIRST SIX (6) MONTHS OF 2008

Key Findings & Considerations

- The KEHP claims cost trend per member per month is 6.5% from 2007 to 2008 (six months 2007 versus six months 2008)
- Enrollment increased by 3.5%
- Active full-time employee costs are trending at a higher rate than costs for non-Medicare eligible retirees. Medical increase is 7.0% for active and 5.2% for retirees. However, retirees' pharmacy trend of 8.5% is higher than actives' pharmacy trend of 5.8%
- Utilization of claims by place of service and the growth rate from 2007 to 2008 remain consistent. Outpatient hospital claims continue to be the largest component and are trending at the highest rate.
- The number of mail order scripts used increased by 30.5%, while retail scripts increased by 2.3%
- Employee cost sharing for pharmacy declined by 9%, from \$9.51 in 2007 to \$8.65 in 2008

In order to identify the emerging trends in 2008 we analyzed the claims experience for January through June of 2007 compared to the same period in 2008. Using 6 months of data may not show the same results as a full year experience due to the effect of seasonality.

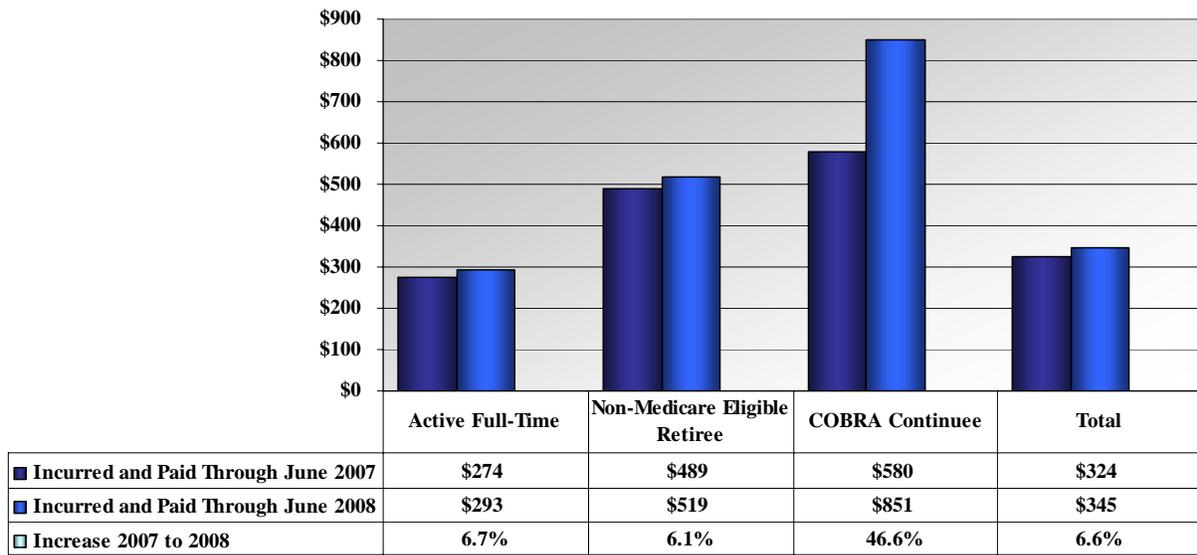
Exhibit XLVI 2007 - 2008 Claims Experience

Kentucky Employees Health Plan			
	Incurred and Paid through June 2007	Incurred and Paid through June 2008	% Change
Aggregate			
Medical Claims	\$348,730,995	\$384,134,389	10.2%
Rx Claims	\$123,924,699	\$136,953,680	10.5%
Total Claims	\$472,655,694	\$521,088,069	10.2%
Covered Lives	243,029	251,439	3.5%
Per Member Per Month			
Medical Claims	\$239	\$255	6.5%
Rx Claims	\$85	\$91	6.8%
Total Claims	\$324	\$345	6.6%

Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

Exhibit XLVII

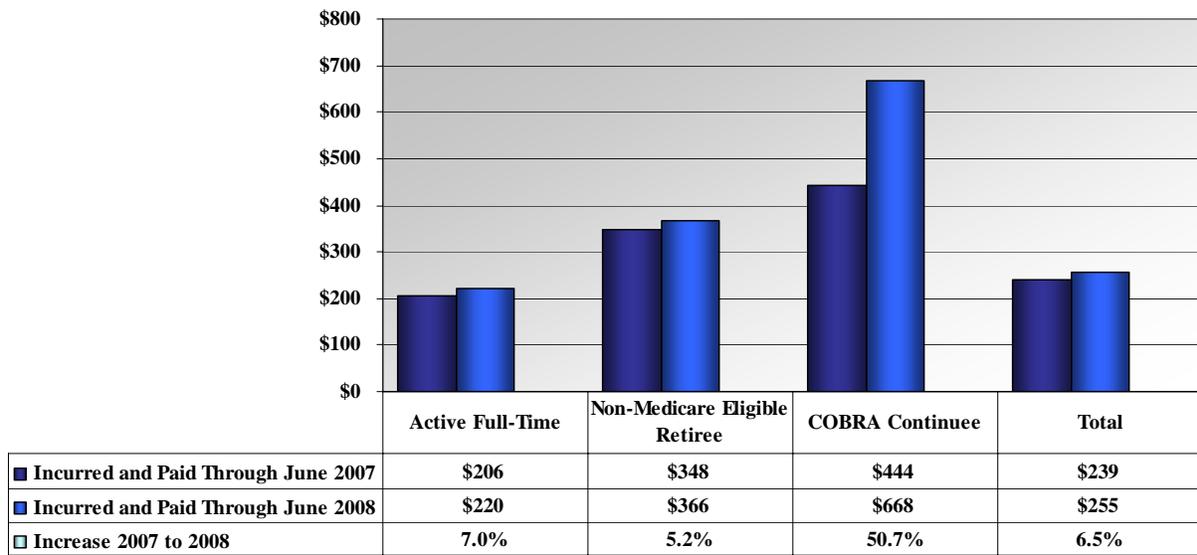
2007 - 2008 Medical and Pharmacy Claims Per Month



Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

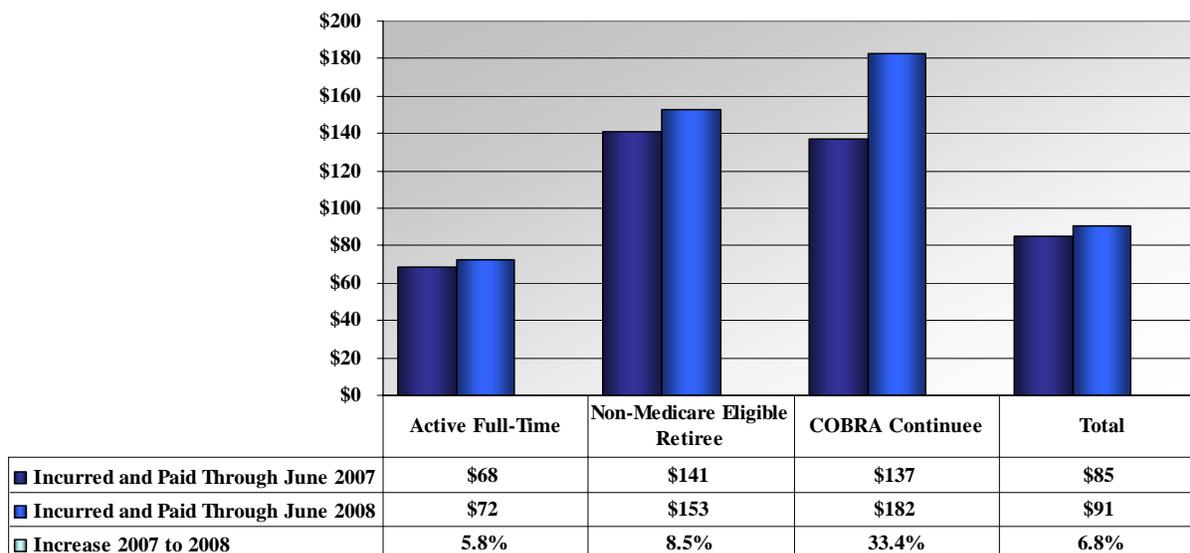
Exhibit XLVIII

2007 - 2008 Six Months Medical Claims Per Month



Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

Exhibit XLIX
2007 - 2008 Pharmacy Claims Per Month



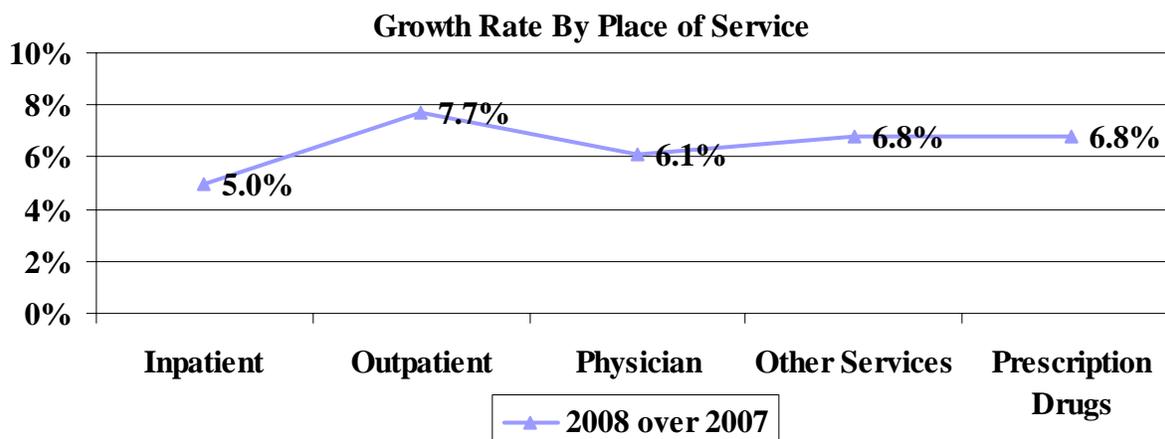
Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

Exhibit L
2007 - 2008 Claim Distribution by Place of Service

Kentucky Employees Health Plan Historic Experience Split by Place of Service				
	Incurred and Paid through June 2007	% of Total	Incurred and Paid through June 2008	% of Total
Paid Claims				
Inpatient Hospital	\$96,795,826	20.5%	\$105,137,034	20.2%
Outpatient Hospital - ER	\$20,892,268	4.4%	\$24,777,819	4.8%
Outpatient Hospital - Non-ER	\$115,603,937	24.5%	\$127,314,110	24.4%
Other Facility (e.g. SNF, Hospice, ESRD)	\$454,509	0.1%	\$444,165	0.1%
Professional - Office	\$92,636,975	19.6%	\$101,712,585	19.5%
All Other	\$22,347,480	4.7%	\$24,748,675	4.7%
Prescription Drugs	\$123,924,699	26.2%	\$136,953,680	26.3%
Total Claims	\$472,655,694		\$521,088,069	

Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

Exhibit LI
2007 - 2008 Growth Rate by Place of Service



Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

Exhibit LII
2007 - 2008 Key Pharmacy Cost Statistics

	Key Pharmacy Cost Statistics		
	Incurred and Paid through June 2007	Incurred and Paid through June 2008	2008 vs. 2007
Total Eligible Members	243,029	251,439	3.5%
Total Allowed Charges	\$142,332,257	\$154,097,368	8.3%
Total Net Paid Claims	\$123,924,699	\$136,953,680	10.5%
Total Scripts	2,403,190	2,471,701	2.9%
Mail Order Scripts	43,336	56,560	30.5%
Retail Scripts	2,359,854	2,415,141	2.3%
Retail Copayment per Claim	\$9.26	\$8.36	(9.7%)
Retail Member Cost Share	15.6%	13.6%	(13.2%)
Mail Copayment per Claim	\$23.32	\$21.15	(9.3%)
Mail Member Cost Share	14.4%	12.7%	(11.8%)
Total Copayment per Claim	\$9.51	\$8.65	(9.0%)
Total Member Cost Share	15.6%	13.5%	(13.2%)
Plan Cost per Member	\$509.92	\$544.68	6.8%
Plan Cost PMPM	\$42.49	\$45.39	6.8%
Plan Cost per Claim	\$51.57	\$55.41	7.5%

Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

2007 - 2008 Key Pharmacy Utilization Statistics

	Key Pharmacy Utilization Statistics		
	Incurred and Paid through June 2007	Incurred and Paid through June 2008	2008 vs. 2007
Total Eligible Members	243,029	251,439	3.5%
Total Allowed Charges	142,332,257	154,097,368	8.3%
Total Net Paid Claims	123,924,699	136,953,680	10.5%
Total Scripts	2,403,190	2,471,701	2.9%
Mail Order Scripts	43,336	56,560	30.5%
Retail Scripts	2,359,854	2,415,141	2.3%
Brand Scripts	992,310	918,323	(7.5%)
Generic Scripts	1,410,880	1,553,378	10.1%
Days Supply	67,334,127	70,109,003	4.1%
Days Supply per Claim	28.0	28.4	1.2%
Generic Dispensing Rate	48.1%	62.8%	30.6%
Generic Substitution Rate	90.3%	88.9%	(1.6%)
Mail Order Utilization	1.8%	2.3%	26.9%
Scripts Per Member (6 Months)	9.9	9.8	(0.6%)

Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

Exhibit LIV

2007 - 2008 Prescription Drug Utilization Detail by Drug Classification

	Average Scripts Per Person (6 Months)		
	Incurred and Paid through June 2007	Incurred and Paid through June 2008	2008 vs. 2007
Retail and Mail Order			
Brand Single Source	3.5	2.9	(18.2%)
Brand Multi Source	0.6	0.8	36.7%
Total Brand	4.1	3.7	(10.6%)
Generic	5.8	6.2	6.4%
Total All	9.9	9.8	(0.6%)
Retail			
Brand Single Source	3.4	2.8	(18.6%)
Brand Multi Source	0.6	0.8	35.7%
Total Brand	4.0	3.5	(11.1%)
Generic	5.7	6.1	5.9%
Total Retail	9.7	9.6	(1.1%)
Mail Order			
Brand Single Source	0.1	0.1	1.6%
Brand Multi Source	0.0	0.0	97.4%
Total Brand	0.1	0.1	11.2%
Generic	0.1	0.1	42.3%
Total Mail Order	0.2	0.2	26.1%

Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

SUSTAINABILITY IN AN INCREASINGLY CHALLENGING ENVIRONMENT – THE IMPACT AND OPPORTUNITY FOR KEHP

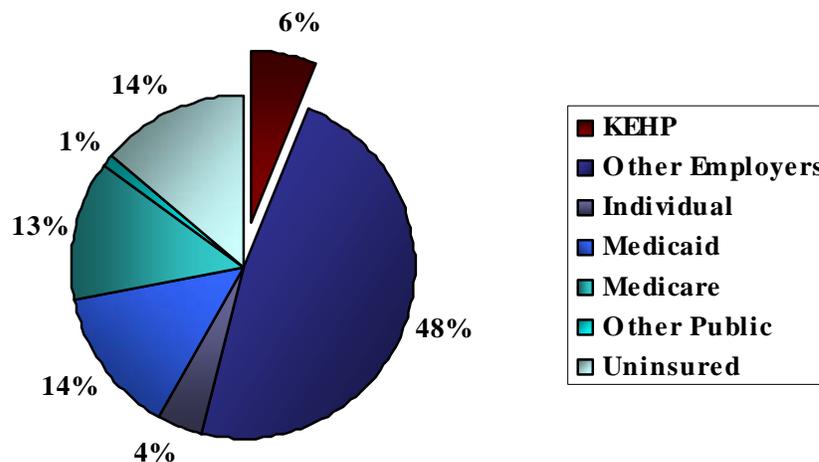
A Sustainable Health Plan and More: Building a Healthy and Vital Membership has Broader Benefits

In a world with constantly changing technology, an aging population, strict cost control pressures and an escalating war for talent, can focusing on the health and vitality of members and their families really make a difference? Health benefit plan sponsors of all sizes and in all industries are betting on it. Historically plan sponsors have focused efforts to control cost on shifting costs to members through plan design changes, negotiating deep discounts with providers, and implementing strong medical management approaches. While these efforts are still critical to plans' viability, plan sponsors are going beyond concentration on treating disease and focusing on health improvement to fundamentally change and improve the long term sustainability of the plans. Focusing efforts on keeping healthy members healthy and helping those with health issues improve their health will alter the long-term health and cost of the population.

KEHP's Importance to the Commonwealth's Population, Participating Employers and Retirement Systems

The KEHP provides health care benefits and programs to approximately 6% of the citizens of the Commonwealth of Kentucky. As such, the plan's programs, benefits, and focus on health improvement can significantly impact efforts to improve the health and vitality of not only plan members but also the citizens of Kentucky.

Commonwealth of Kentucky Healthcare Coverage Distribution



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey, www.statehealthfacts.org; KEHP 2007 enrollment data

Given that the plan provides coverage to this significant portion of the population, the plan's focus on health improvement and prevention will affect the health status of a significant portion of the Commonwealth's citizens. Improving the health of KEHP members not only supports the ability to maintain a sustainable health plan over the long term, but also supports the productivity and vitality of Commonwealth's broader population.

There are additional benefits for school systems, quasi-governmental agencies, state agencies and retirement systems that participate in KEHP. Controlling plan cost and improving the health of members positively impacts the productivity of participating employers' workforce; improves their ability to hire and retain valued employees and improves their annual cost for benefits. Participating Retirement Systems' overall sustainability is impacted as well. The Plan's support for active employees creates healthier future retirees. Management of health, cost and quality of care positively before retirements impacts the Retirement Systems' future liabilities and solvency. Briefly, health improvement and prevention initiatives will benefit:

- KEHP: by controlling cost to improve the long term availability of benefits to its membership
 - Reduces the uncertainty related to annual benefit design changes and incremental cost shifting
 - Allows consistent messaging to participants related to improving their health, choosing and using health care appropriately, and leadership support of a healthy population
- Members of KEHP: through assistance in improving and maintaining their health
 - In addition to improving quality of life for individuals, their own cost for healthcare will be lower when the population is healthier
 - The Commonwealth's broader population benefits from the leadership and healthy example of this prominent plan
- Participating employers: by improved productivity, hiring and retention.
 - Individuals who feel that their plan sponsor and employer is interested in their wellbeing are more likely to be loyal and engaged in their work
 - The cost of benefits for healthier employees is less than that for employees with more health problems
- Participating Retirement Systems: by improved future liability and lower cost for healthier retirees when they enroll in the System's retiree medical plans.

Health benefits plans, employers, and community organizations around the world are providing tools, information, and benefits that improve both the health and the health literacy of their people. A more health conscious and informed population will positively impact the plan and participants in the short-term as well as proving long-term sustainability. The Board is responsible for oversight of healthcare benefits for the KEHP plan members. Yet, the Board also

considers the impact that health has on productivity, human capital activities and overall success of the organizations their members work for or participate in as retirees.

The leaders of participating organizations benefit from a focus on the health of their members for multiple reasons:

- Over 75% of the nation's health care cost is for people with chronic diseases. These diseases are widely prevalent and largely preventable through reductions of health risks and appropriate use of screening and preventive services². Without intervention this epidemic is predicted to increase by 17% over the next 10 years while contagious disease decreases. As discussed earlier in this report, the Kaiser Foundation has found that in Kentucky in 2007 28.7% of adults are obese; 55.8% of adults are inactive, 28.1% of adults smoke. These health behaviors are critical contributors to chronic disease, leading to the epidemic of chronic disease growth in Kentucky and across the nation.
- An employer's cost of lost productivity due to chronic diseases and health risks can be as much as four times the cost of related health benefits costs. These risks and diseases directly impact the costs of unplanned absences and disabilities, reduced workplace safety, and reduced effectiveness while at work.
- Participants feel more valued, engaged and loyal when their employer demonstrates a concern and support for their overall health and wellbeing by providing health improvement and wellness support. Demonstrating support for health improvement has become a key component of employer's efforts to become a "great place to work" - improving hiring and retention.
- Organizational social responsibility and public reputation are enhanced when "good health" is integrated into the overall agenda of an organization and its communities.
- With the impending retirement of the baby boomer population, retiree health care is a concern for employers. Focusing on the health of the actives can result in a healthier future retiree population, allowing sustainability to roll over into the Retirement Systems.

Developing a Framework for Sustainability

Several complex factors influence a health plan's sustainability. With today's continued cost escalation, economic challenges, and changing workforces (membership) a framework that is build on following cornerstones addresses these complexities:

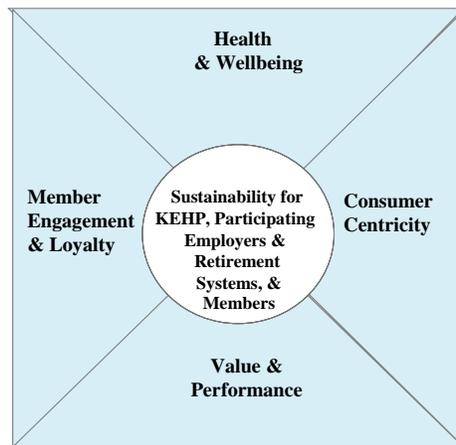
- Improving the population health and wellness, fundamentally changing the need for care by helping healthy people maintain their health and assisting those with health challenges in improving their compliance with treatment, thereby improving their health – Health and Wellness

²National Center for Chronic Disease Prevention and Health Promotion, www.cdc.gov, 2005.

- Focusing on the member's ability to manage their own health and make responsible decisions regarding their care is key to changing the underlying demand for care – People Centricity
- Driving excellent value and performance in all aspects of the provision of care services, from evidence based quality improvement for providers, to best practices in administration from plan administrators is critical; higher quality costs less – Value and Performance
- Supporting members' ability to be productive and loyal to their employers through provision of wellness and prevention programs leads to sustainability for not just KEHP, but also the participating employers, retirement systems and members.

Overview of the Cornerstones to Sustainability

A Framework for Sustainability



Health and Wellbeing

Healthcare benefits and wellness initiatives are critical to developing and maintaining an engaged and productive population.

Health improvement and wellness initiatives focus on preventing the onset of chronic diseases and improving the care for those that already have these diseases. In the United States, treatment of people with chronic diseases accounts for more than 75% of the nation's \$2 trillion medical spend³. The impact of chronic disease is placing an increasing burden on health plans and their members. Further, the risk factors that lead to chronic diseases are cumulative, as are the costs associated with them. For example, individuals who are obese and have other health risks such as stress or depression have two to nine times higher prevalence of chronic diseases^{4 5 6}. Therefore, programs that focus on improving health risks such as obesity have a cumulative impact on health care costs and quality of life.

Productivity losses associated with chronic disease are as much as four times more than the cost of medical treatment for chronic disease. Losses in productivity result in increases in disability, unplanned absences, reduced workplace effectiveness, increased accidents and negative impacts on work quality or customer service. These losses negatively impact the employers that participate in the KEHP program.

The most costly conditions and health risk factors that impact a person's productivity are depression, back and neck pain, fatigue and sleeping problems – conditions or risks that are often the result of chronic diseases.⁷

Wellness Programs

Wellness programs are increasingly being used by organizations to address health risks that lead to chronic diseases and drive up health and productivity costs. Wellness programs are intended to maintain and improve health through behavior changes that impact modifiable health risks such as smoking, poor nutrition, lack of exercise, etc. These programs focus in two areas:

- **Population based programming:** these are programs which all people can participate in regardless of their health risk status. Some of these programs include health screenings, walking programs, "no weight gain" programs and "know your numbers" programs. These types of activities are intended to motivate the entire eligible population to maintain their good health habits and reduce their poor ones.
- **Individually focused programming:** these programs are intended to assist individuals with multiple risk behaviors or specific health risks (e.g. smoking)

³ National Center for Chronic Disease Prevention and Health Promotion, www.cdc.gov, 2005.

⁴ "The Costs of Metabolic Syndrome in Italy", by Carlo Lucioni et al, *High Blood Pressure & Cardiovascular Prevention*, vol 13 no 2, 2006.

⁵ "Metabolic Syndrome Costing Four Times That for All Other Patients", *News-Medical Net*, May 9, 2005, <http://www.news-medical.net/?id=9870>.

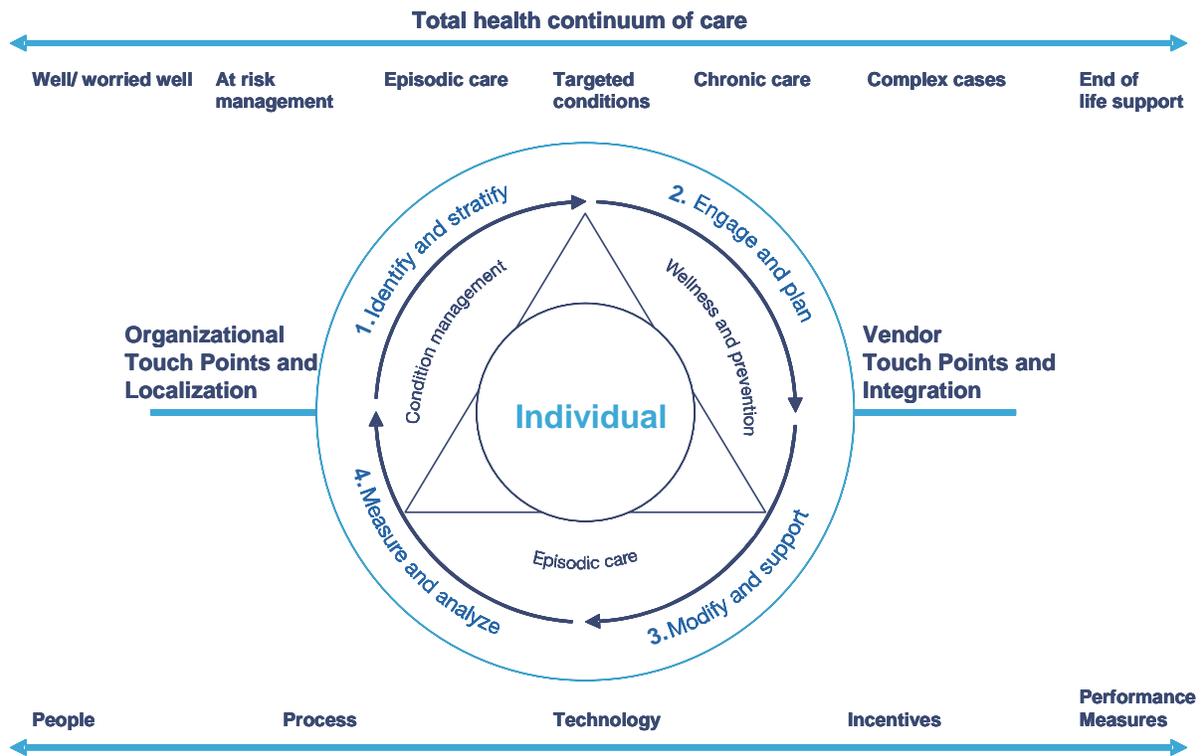
⁶ "Metabolic Syndrome and Employer-Sponsored Medical Benefit: An Actuarial Analysis", by Kathryn Fitch et al, *Milliman*, March 2006.

⁷ "The Top Ten Drivers of Health and Productivity Costs Source: "Health and Productivity as a Business Strategy", by Ronald Loeppke et al, *Journal of Occupational & Environmental Medicine*, July 2007.

through interventions that are tailored to their level of "readiness to change" and individual needs. These interventions can include telephonic or face to face health coaching, online educational modules, or mail programs.

Going Beyond Wellness Programs

Plan sponsors and other health care stakeholders have recognized that a focus only on wellness or only on acute care does not go far enough in changing the population's health. Holistic programs, which address the needs of individuals across their lifetime of health needs, are needed to significantly improve population health needs, from programs that benefit the healthy to care for those with end of life needs.



Improving the underlying health of plan members is a critical cornerstone to plan sustainability, and provides significant additional benefit to participating employers and retirement systems.

People Centricity

Enabling people to become better consumers of health care resources is fundamental to any sustainable program.

People centricity is built on Consumerism

Consumerism *is* about transforming the healthcare system into one that:

- Puts economic purchasing power and decision-making in the hands of individuals;
- Provides the information, tools and support they need to make those decisions; and,
- Establishes financial incentives, rewards, and other benefits that encourage personal involvement in altering health and healthcare purchasing behaviors.

Consumerism *is not* a single product, but a strategic process that involves constant evaluation of the programs, tools and techniques being made available to consumers. Consumers have shown a dramatic increase in awareness of the value of behavior changes and using health care appropriately and are catching up to employer initiatives. According to the American Association of Preferred Provider Organizations (AAPPO), enrollment in Consumer Directed Plans grew by 25 percent in 2007, from 10 million Americans to 12.5 million. 7.5 million were enrolled in health reimbursement accounts (HRA) and 5 million in health savings accounts (HSAs).

Despite this increase, there is still a gap in what is needed to create well-informed consumers – though information on medical conditions is widely offered, there is still a need for more information on provider quality and cost as well as assistance in treatment decisions.

Creating well-informed health care consumers will allow plan sponsors and employers to realize not just improved health care cost, but also a high performing workforce that is healthy and vital for the organizations they support.

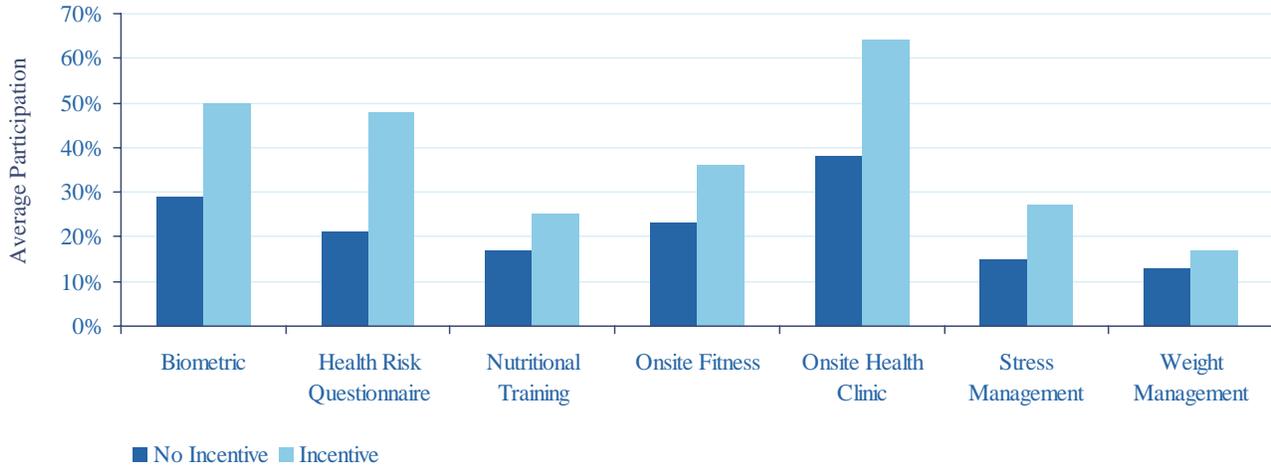
In order to move towards a culture that supports consumer centric healthcare, plan sponsors must undertake:

- a realignment of member and sponsor roles
- new consumer designs and incentives
- a thoughtful plan of consumer education, and
- execution of a disciplined change strategy

In order for any changes or programs to have an impact, members and their families must participate. According to the PwC Touchstone survey, less than 30% of eligible individuals participate in wellness programs offered by their employers. Wellness incentives, including cash, prizes, gift certificates, etc., are not used by a majority of the employers to increase participation, however, when incentives are utilized, participation significantly increases.

Wellness Programs With and Without Incentive Programs

Incentives Drive Participation



Value and Performance

Managing the value and performance of health care providers and administrators continues to be a critical issue.

A Shift Towards Rewarding Quality in Health Care

Currently in the U.S. healthcare market, there is wide variation in medical treatments, cost and quality of care. Up to 30% of healthcare spending is for ineffective, inappropriate, or redundant treatment⁸. The system as it is currently configured does not reward quality of care; rather it rewards the volume of services. Further, are not sensitive to the different costs and/or quality of treatments because they have not been educated to consider this, and their cost sharing does not vary depending on which treatment is provided.

The Federal government's Medicare program, commercial insurers and health plans are developing arrangements that are based on aligning incentives to increase quality and cost, otherwise termed "value in health care." Incentives for hospitals, physicians and other health care providers are being altered to reward those who deliver higher quality, more effective care. Plan sponsors are working with their insurance administrators to drive "value based" contracting and purchasing of health care services. They are:

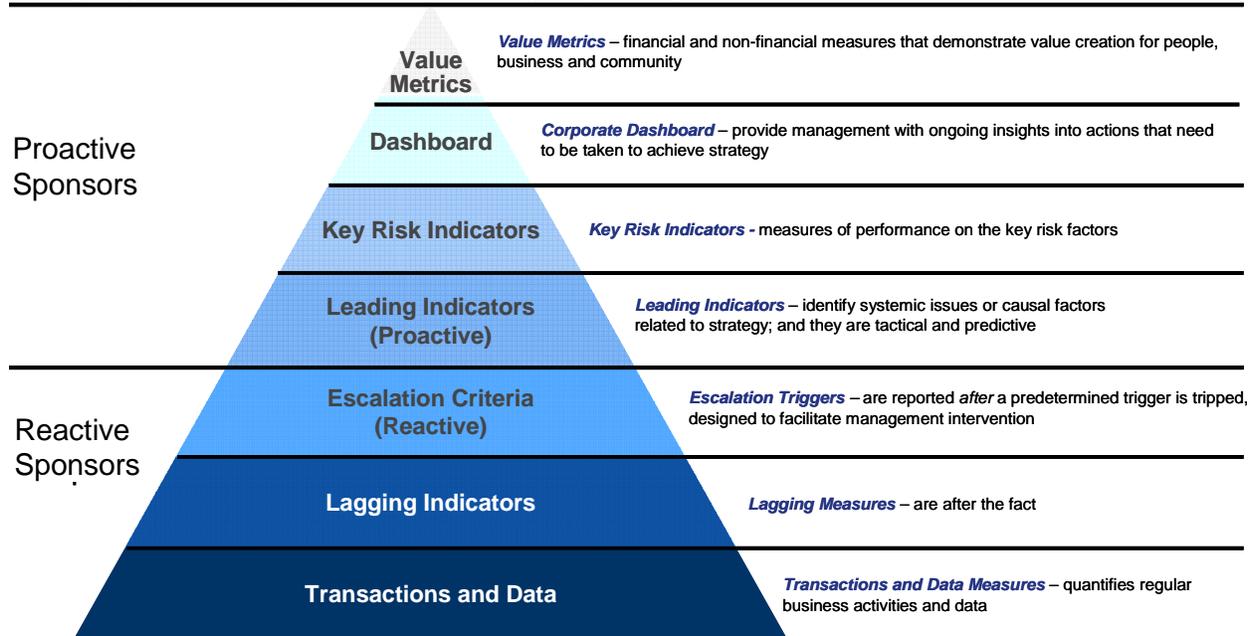
⁸ Fisher, E., Wennberg, D., et al., *The Implications of Regional Variations in Medicare Spending: Part 2, Health Outcomes and Satisfaction with Care*, *Annals of Internal Medicine* 2003; 138:288-98.

- focusing on measuring the quality of care and making this information available to the public
- using quality metrics to drive provider contracting, often called "Pay for Performance" arrangements
- educating members about quality issues, and
- providing incentives for high quality or disincentives for poor quality providers.

The evaluation of value and performance in healthcare has largely fallen on the shoulders of plan sponsors and is often based on the performance guarantees that are offered by health plan administrators. The sponsors who have become more proactive in purchasing healthcare for their members are focusing on integrating both financial and non-financial measures into their overall business strategies in order to predict risks in both the system and the membership in order to develop plans to mitigate those risks.

Managing Value and Performance

Designing, Evaluating and Continuously Improving What Matters



Member Engagement and Loyalty

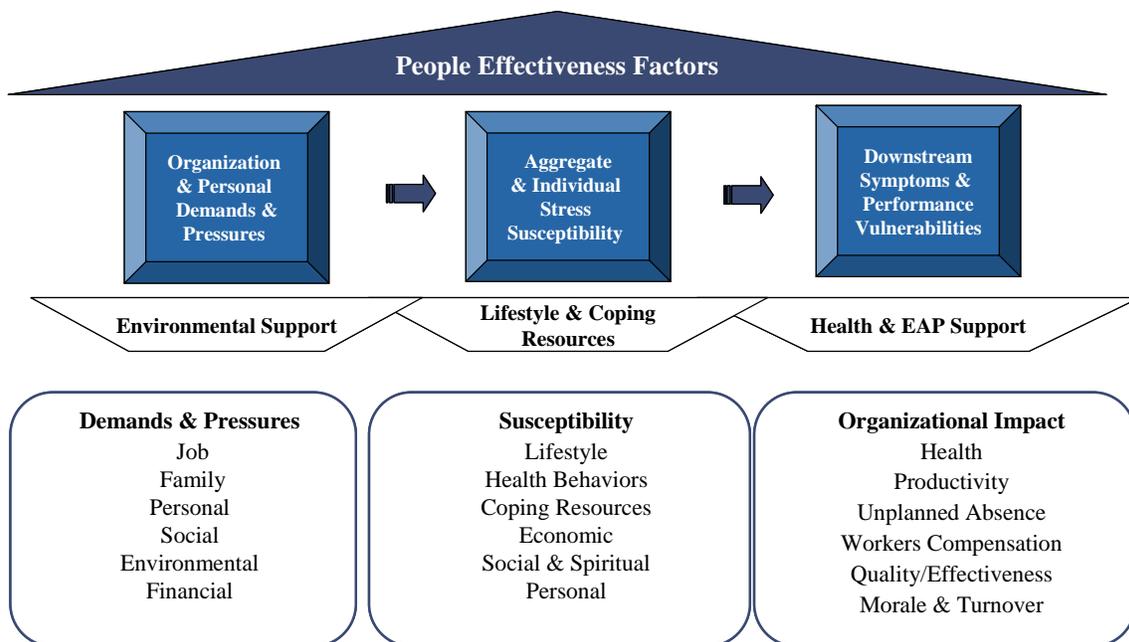
Poor Health Impacts People - Our Most Important Asset

Building and sustaining a culture of health and vitality will benefit KEHP, its participating employers, participating Retirement Systems and members. Providing tools and resources to the

KEHP membership will make them feel that both KEHP and the participating employers and Systems value them and support the health and well being of themselves and their families.

Work and life environmental factors are intertwined in impacting the investment that employers make in their employees as well as the KEHP membership's health and vitality. For example, stress is an area that strongly affects the wellbeing of individuals and thus can impact the work engagement for participating employers. Stress management interventions are often included within an overall healthcare benefits strategy and focus on both the sources of stress and the susceptibilities of individuals to stress. Not all stress causing “demands and pressures” that impact membership can be fixed by benefits or programs. Some work/life “realities” can be better managed by the individual while other root cause factors can be mitigated by the employers. There is potential for the plan sponsor to work in partnership with the participating employers in areas such as workers compensation or environmental health as well as through support of on-site health and wellness champions to address these issues.

The figure below shows the factors that impact people effectiveness. If the plan sponsor helps its membership deal with some of these factors before they get to the area of "organizational impact," they can potentially drive down not just health care spending, but also volatility in their membership. Also, the loyalty that a member may feel towards the Commonwealth and their participating employers can result in a positive public perception of all entities involved.

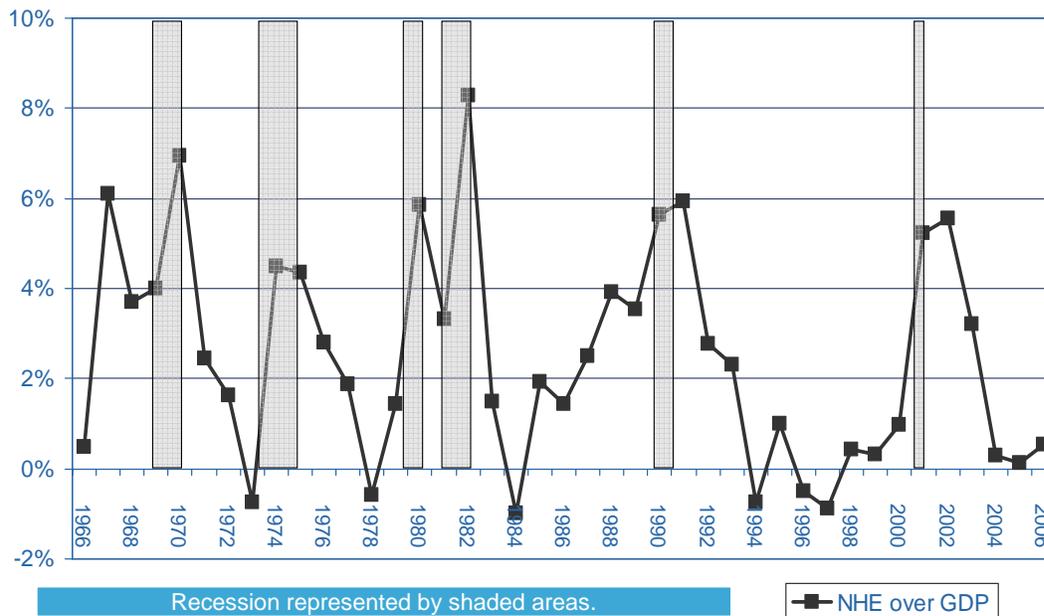


In Summary, KEHP, Plan Sponsor, Employer and Individual Sustainability

Focusing on Sustainability has become a must, not an option

The current environment is increasingly difficult. The competing forces of a recessionary economy and the workforce drain resulting from the retirement of baby boomers are creating changing priorities for plan sponsors, employers and Retirement Systems that are providing healthcare coverage for populations that are impacted by these forces. History has shown that health care costs increase in similar times.

Burden of Healthcare Increases in Recession



The Board supports the continued development of KEHP programs and benefits that improve the health and well being of the membership. Over time this effort will support the plan's, member's, participating employers and Retirement Systems sustainability.

BOARD RECOMMENDATIONS

The Board recommends that the KEHP continue to follow the guiding principles:

- Provide uniform coverage across the Commonwealth
- Encourage wellness and healthy lifestyles
- Provide preventive care at little or no cost
- Improve chronic disease care
- Educate members about plans that are more appropriate for their health needs
- Provide plan alternatives that are accessible for retirees
- Provide a quality PPO option
- Provide a subsidy for family and dependent coverage
- Provide plans with unlimited lifetime maximums

The Board further recommends:

- KEHP should continue to explore alternative methods for controlling and managing the cost of the plans and improving the health of members. A study of alternative approaches for health improvement (wellness initiatives), prevention of chronic conditions and other critical programs across the spectrum of members' health needs should be evaluated. Approaches that consider aligned incentives to encourage members' health behavior changes and providers improved support for wellness should be evaluated. Resource requirements and potential outcomes of varying approaches should be considered.
- A study should be conducted to broadly consider the potential impact of care management programs (including wellness programs, case management programs, disease management programs, etc.) to better manage chronic illnesses, to improve care for the acutely ill and to assist in end of life care.
- KEHP should evaluate programs and options for improving the clinical and administrative quality of programs and services. This study should consider practical steps to evaluate and improve administrative services including claims payment, customer service and others. It should consider programs to measure and improve quality of care that are available in the marketplace.
- KEHP should develop a plan to improve communications directly to members and through Insurance Coordinators. The plan should consider different types of communications for different groups of members (internet communications, mailings, other) based on the best potential success with each group.
- The Board recommends that the due date for the Annual Report be extended from October 1 each year to December 1.

KGHIB BEST PRACTICES COMMITTEE RECOMMENDATIONS

The Kentucky Group Health Insurance Board (KGHIB) "Best Practices Committee" was created by KGHIB on March 25, 2008. The inaugural Committee meeting was held on April 11 in the Capitol Annex.

The Committee is Chaired by Finance and Administration Secretary Jonathan Miller, and consists of representatives of Benefits Decisions, Inc.; EON U.S.; Kentuckiana Health Alliance; UAW/Ford Community Healthcare Initiative; United Auto Workers Local 862; United Food and Commercial Workers Local Union 227.

The principal role of the Committee is to enable health insurance experts from organizations in the private sector to share "best practices" from their health insurance programs, so that the Commonwealth can determine whether the implementation of similar practices might benefit the Kentucky Employees Health Plan (KEHP).

Thus far, the Committee has met on six (6) occasions. During the course of those meetings, members of the Committee have offered the following recommendations:

Oral Recommendations

General

- KEHP should be run by an independent board which would be free of political influence and which would permit management and staff to transcend changes in administration.
- The Commonwealth tends to determine the level of benefits to be offered to government employees, and then figures out a way to fund that level of benefits. This process should be reversed, *i.e.*, funding should be determined first and then the level of benefits which will work within that funding.
- Condense the KEHP health care plan choices.
- Behavioral Health Issues should be addressed; could be underlying problem that leads to disease management problems.
- Each of the following should be considered as a means of overcoming some of the barriers confronting KEHP: improvement of communication with KEHP Insurance Coordinators; insistence on management support for wellness activities; promotion of management accountability for wellness activities; and making time available for members to engage in wellness activities.

Communications

- KEHP should develop a reliable means of communication, preferably electronic, with each eligible employee to maximize marketing of health and wellness programming.
- Organized labor and employee associations should be partners in an educational effort targeting plan participants on the basics of self-insurance, fundamental issues surrounding health care costs, and the impact of individual choice on costs.

- Marketing material design should be reviewed and revised to assure concise and easy-to-read content.
- Develop a reliable form of communication with KEHP members to maximize marketing of KEHP health and wellness programs.

Wellness

- Encouragement/incentives for local initiatives should be utilized to take advantage of peer support and to promote the development of a culture of health within the employee population.
- Local/District Departments of Health should be considered as a potential resource/active partner and/or administrator for local health and wellness programming.
- Foster management support for wellness programs; make managers accountable for supporting wellness programs; give employees time at work to focus on wellness; engage employees to assist with wellness activities in order to overcome current barriers.
- Offer incentives for members to participate in the Health Risk Assessment and Disease Management programs.
- Higher premiums for smokers; penalty for those members who are not honest when making the election as a smoker/non-smoker.
- Require generic substitution where possible.

UAW-Ford Community Healthcare Initiative

Written Recommendations

Currently, Americans spend 16% of their gross national product (GDP) on health care. Experts predict this to rise to nearly 20% by 2015. In dollars, this represents \$2.1 TRILLION in 2006 and \$4.1 TRILLION in 2015. The magnitude of this spending can be captured in other terms:

- In 2004, health care spending was 4.3 times higher than spending on national defense.
- Despite devoting 16% of the GDP to health care, nearly 47 million Americans are uninsured. In contrast, all other industrialized countries spend much less of their GDP and some also provide universal health care, e.g. Germany (10.7 %), Canada (9.77 %), and France (9.5 %).
- Employer-based health insurance premiums have risen four times faster than workers' earnings over the past six years. In 2006 alone, premiums rose 7.7%, twice the rate of inflation. Workers now pay \$1,094 *more* in annual premiums for family coverage than they did in 2000.

A number of factors contribute to the continued rise in national health care spending. Many are imbedded in the complex processes and choices by which Americans provide and receive care. Recently, communities, employers, and citizens have begun to recognize one avenue to control spending: lower the rate of chronic disease by changing the behavioral factors that influence them.

Chronic Diseases and Behavior

Health care for people with chronic diseases accounted for 75% of the nation's total health care cost in 2004. Adjusted to the year 2000 population, these five chronic diseases caused 66.7% of the deaths in the U.S.: heart disease, cancers, stroke, chronic lower respiratory disease (including asthma), and diabetes. In Kentucky, these diseases caused 68% of deaths.

Behavior contributes significantly to the development and progression of many chronic diseases. Poor diet, lack of regular exercise, and smoking are considered the most important contributors to preventable disease and premature death in the U.S.

Obesity - Poor Diet and Lack of Regular Exercise

Obesity is a direct result of poor diet and/or lack of regular exercise. It promotes a number of chronic diseases including cardiovascular disease, type 2 diabetes, several types of cancer, musculoskeletal disorders, sleep apnea, and gallbladder disease. Physically inactive people are almost twice as likely to develop heart disease as active people.

The national prevalence of adult obesity was 25.6% in 2006; in Kentucky, it was 28.6%. Both figures are expected to continue to rise.

In 2002, the total medical cost of obesity was \$117 billion, \$61 billion in direct costs and \$56 billion in indirect costs. This represented 9.1% of annual health care spending and rivaled that attributable to cigarette smoking.

Cigarette Smoking

Cigarette smoking causes more preventable disease and death in the U.S. than any other single factor. It is a major contributor to heart disease, stroke, lung and other cancers, and chronic lung disease.

Nationally, smoking in the U.S. declined to a low of 20.8% in 2006.

Kentucky, however, ranked 49th among the states with a prevalence of 28.7%.

A 1999 study published in JAMA (the Journal of the American Medical Association) offered further proof that low physical activity, obesity and smoking were associated with increased health care charges and work-related problems. It suggested that interventions be

considered to reduce these risk factors. A 2006 study confirmed that smokers cost employers more in both direct and indirect costs than do former smokers and nonsmokers.

Although behavior is often viewed as a matter of personal choice, it is strongly influenced by other factors, including family, culture, environment and the individual's work situation. Workplace wellness programs are specifically designed to change those behaviors that lead to disease and/or exacerbate existing diseases or conditions.

Workplace Wellness Programs - The Business Case

The Washington Business Group on Health has developed a 40 page guide to help employers develop and implement health and preventive services and tailor them to their employees. They offer these supportive arguments:

- Employers often bear the direct costs (i.e. medical claims) and indirect costs (i.e. absenteeism and low productivity) of diseases, disorders and conditions that could have been prevented or more effectively treated by behavioral and/or clinical interventions.
- Prevention efforts improve health. Prevention efforts increase productivity. Prevention efforts reduce costs.
- Experts believe that reducing high-risk behavior and maintaining low-risk behavior could potentially reduce medical claims by a third.
- Studies show that employers who have implemented prevention programs for cardiovascular disease have seen, on average, a:
 - 28% reduction in sick leave
 - 26% reduction in health care costs
 - 30% reduction in workers' compensation and disability cost

The following recommendations are steps in moving employees to better health while helping contain cost:

- Higher premiums for smokers – The CDC reported \$76 billion were spent in medical expenditures attributed to cigarette smoke from 1995-1999. However, smoking cessation options should be made available as a benefit for employees.
- Yearly HRA's should be encouraged through incentives – This would help identify employees in early stages of diseases, many of which may be controlled and can help contain cost. Free and low cost HRA can be found online, your healthcare provider may also provide one on their website. Hospitals and other vendors provide this service for a fee which include blood pressure readings, glucose and cholesterol test. The HRA's give the employee a better picture of his/her total health. Employers that provide incentives for employee participation in the HRA have higher numbers of employees involved.

- Require generic substitution where possible – General Motors Community Health Initiative reported every 1% shift to generics = \$12 million in savings.
- Offer incentives for employees to participate in disease management programs.
- Prescription – Adherence to medication is a must for patients with chronic disease. Only 50% of patients adhere to physician recommendations of prescriptions. Lower out-of-pocket prescription cost for chronically-ill employees and disease management programs lower cost of health care. The Asheville, NC project designed their program to encourage pharmacists to provide low-cost, high quality disease management service to their city employees. In 1997, a diabetes management program was launched with local pharmacists and joined by Mission-St. Joseph Health System in 1999. Participating employees agreed to meet monthly with specially-trained pharmacists who gave them basic physical exams and help to ensure they adhere to medications and maintain their health. If a problem was detected, the pharmacists referred them to their physician. Participating employees had no co-pays for pharmacist visits, drugs for the disease, or supplies. However, if they failed to adhere to the program guidelines, they were removed from the program and responsible for co-pays. Total mean direct medical costs for diabetes decreased every year compared to the baseline. Participants' sick days dropped by more than 50%, and a higher percentage of participants improved their clinical measures. During a five year period, the diabetes program saved the city between \$1,200 and \$1,872 per patient per year. (Total Value Total Return)
- Assign person/persons to be in charge and responsible for a worksite wellness program at worksites and hold persons accountable. While conducting a year long pilot on Worksite Wellness, the Kentuckiana Health Alliance, convened by UAW/Ford Community Health Care Initiative, found having personnel accountable at the worksite made the program more successful. To view the full report, go to www.kentuckianahealthalliance.org.

EON U.S.

Written Recommendations

- The responsibility and accountability for health and wellness offerings for KEHP should be clearly designated to an employee within an appropriate existing state agency. Performance expectations for program design, implementation, measurement, evaluation, and reporting should be established for that employee.
- Program evaluation processes should be developed to determine program effectiveness and be reviewed on an established basis.
- The KEHP should develop a reliable means of communication, preferably electronic, with each eligible employee to maximize marketing of health and wellness programming.
- The Governor's office should demonstrate support and encouragement for active participation in wellness offerings.

- Organized labor and employee associations should be partners in an educational effort targeting plan participants on the basics of self-insurance, fundamental issues surrounding health care costs, and the impact of individual choice on costs.
- Encouragement/incentives for local initiatives should be utilized to take advantage of peer support and to promote the development of a culture of health within the employee population.
- Local/District Departments of Health should be considered as a potential resource/active partner for local health and wellness programming.
- Marketing material design should be reviewed and revised to assure concise and easy-to-read content.

UFCW L/U 227

Written Recommendations

- Short-term goals – my recommendation is that the state condenses health care plans down to three choices from the current four. Two of the plans are currently very similar and just add complexity to the administration of the state program.
- The state employee organizations, the state administration, and consultants should sit down with an actuarial menu to modify the three remaining programs to look for cost savings without shifting undue burden to state employees. One tool we have successfully used is to accept higher up-front deductibles and/or doctor co-pays in exchange for lowering the cap on the out-of-pocket maximum expense per year. Many people are willing to pay a little more on routine health care in exchange for greater protection on extreme health care.
- The low hanging fruit to obtain substantial savings for the state, is better implementation of the wellness, chronic disease, and preventive health care management. This would have to be costed on a five-year time horizon. The large number of career state employees will result in substantial savings if the state administrators get aggressive on a successful wellness, chronic disease, and preventive health care management program. Need to use the carrot and stick with rewards to those who comply. Disincentives to those that refuse to comply. Health care programs have successfully used decreases in deductibles, co-pays, as incentives for people who comply and on the disincentives use increased weekly premiums, deductibles and co-pays, as incentives for those who refuse. The state currently has all the right tools in place but it appears that there is very little communication on the shop floor on the need to be engaged in wellness, chronic disease management, and preventive health care by the employees of the state.

For the state to realize any long-term savings they need to start looking at minimum of a three-five year budgeting cost analysis cycle on health care.

- Ideally the state should have an independent board administration of the health care plans, were the legislative and government only have to deal with the cost rather than delivery.
- Review the viability of having a vendor administer the wellness, chronic disease, and preventive health care management that is independent of the claims payer or network providers.
- Review the viability of retaining third party organizations to review claims paid and look for improper codes, failure to coordinate, and subrogation issues that could result in a net savings to the state. Many of these vendors agree to perform this for a percentage of the money recovered, so there is no upfront expense to the state, These vendors work with claims 18 to 24 months old, which is well after the claims payer's internal review has been completed. This would ensure the state would receive true money back over and above what they may already be receiving from the current vendors.
- Require the administrators of the state health care plan to attend continuous education on best practices. The International Foundation of Employee Benefits puts on excellent three to four day training sessions in numerous locations around the country that specifically deal with public employee health care issues.
- I was impressed with the structure of the state plan, the quality of many of the vendors, and the dedication of many of the folks who administer the plan. However, it appears that there is an overall opportunity to improve the coordination between the various vendors. There also appears to be an opportunity and a real challenge to educate the workforce on the need to take more responsibility for their health and use the tools that are currently in existence and hopefully enhance in the future.

These recommendations are meant to be broad brush and I hope the KGHIB Best Practice Committee has further opportunity to explore more specific ideas to improve the state benefit plans while controlling cost.

APPENDIX

Modifications to the KEHP Program and Plan Design Provisions by Year, 2000 - 2008

Beginning in 1999, the KEHP Program offered two HMO options (A and B), two POS options (A and B) and two PPO options (A and B) through insured arrangements with seven insurance carriers including Advantage Care, Aetna, Anthem, Bluegrass Family Health, CHA Health, Humana, and PacifiCare. In addition, two indemnity plan options were offered to out-of-state retirees through Anthem.

In 2000:

All of these plan options continued to be offered, with the following principle adjustments:

- An EPO option was added to provide KEHP Program members with the choice of a plan with a lower employee premium contribution.
- The insurance carrier, Aetna, was no longer offered by the Program as an outcome of the 2000 Request for Proposal (RFP) process.
- A feature was added to all plan options that reduced the prescription drug co-payments after a member pays 50 co-payments in a year for themselves or covered family members.
- Coverage of outpatient mental health/chemical dependency services was expanded from:
 - 30 to 45 visits annually for the “A” options, and
 - 21 to 36 visits annually for the “B” options.
- Out-of-state retirees were allowed to enroll in any POS or PPO option offered by any of the Commonwealth’s insurance carriers since no carrier was willing to insure an indemnity plan for those retirees.
- The Commonwealth revised its member subsidy policy to provide for a subsidy that was at least equal to the Single premium rate for the lowest cost Option A in every county.

In 2001:

- The insurance carriers offering health insurance coverage to members of the KEHP Program changed as follows:
 - Aetna was re-introduced as a healthcare option for the KEHP Program in twenty-eight Kentucky counties.
 - Anthem expanded its PPO service area for members by fourteen counties.
 - Advantage Care ceased to exist.
 - PacifiCare stopped offering health insurance to anyone in Kentucky.
 - Bluegrass Family Health expanded its service area for members by nine counties.
 - CHA withdrew its HMO and POS options from twenty-three counties; however, it introduced PPO options in four eastern counties in eastern Kentucky where it previously offered only HMO and POS options.
 - Humana discontinued its KPPA HMO for KEHP Program members.

- The following changes were made to the benefits offered by the plan:
 - Prescription drug co-payments in the PPO B option were reduced. For generic drugs, the member's co-payment decreased from \$15 to \$10, for brand name drugs from \$20 to \$15, and for non-formulary drugs from \$40 to \$30.
 - The cost for members in the PPO A option for diagnostic tests, performed in a setting other than a physician's office, was changed from a 20% co-insurance after meeting the annual deductible, to a flat \$10 co-payment.
 - Inpatient (per day) and outpatient (per visit) limits on mental health and substance abuse services were eliminated from all the KEHP Program's health insurance options, in accordance with House Bill 268 enacted by the 2000 General Assembly.
 - Benefit coverage for amino acid preparations and low-protein modified food products was added to all of the KEHP Program's plan options pursuant to House Bill 202 enacted by the 2000 General Assembly.

In 2002:

- In response to requests from Legislators and members of the Commonwealth's KEHP Program, the Commonwealth adopted two new requirements that must be met before a prospective health plan (bidding as part of the RFP process) could be offered to members of the KEHP Program in a particular county. Before it can be offered in a county, a health plan must:
 - Include at least one hospital in that county in its network, provided one or more hospitals exist in the county and any other bidder includes at least one of those hospitals in its network; and
 - Include at least 25% of the largest number of physicians in any other bidder's network for that county.
- In an effort to lessen the potential impact of adverse selection (i.e., when a person takes the likelihood that they'll need medical care into account when choosing a health plan, often resulting in "more costly" individuals in one option and "less costly" in another), the Commonwealth stipulated that a health plan's B option premium rates must be at least 5% lower, but no more than 10% lower than the A option premium rates for the same plan type (i.e., HMO, POS or PPO) and coverage level (i.e., Single, Parent Plus, Couple or Family).
- The following changes in carrier offerings occurred:
 - As in 2001, Anthem expanded its PPO service area for KEHP Program members by fourteen counties.
 - Aetna was discontinued as an offering for KEHP Program members in eleven counties.
 - While Bluegrass Family Health's HMO and POS options were newly offered in five counties, these options were discontinued in three counties. Bluegrass Family Health's PPO option was no longer available in one county where it was available in 2001. However, this option was newly introduced in eight counties.
 - CHA's HMO and POS options were discontinued in fourteen counties and newly added in thirteen counties. Its PPO options were added in four counties, but discontinued in the four counties where offered in 2001, due to provider contracting difficulties.
 - Humana's HMO and POS options were no longer available in three counties where offered in 2001 and its PPO options were discontinued in ten counties.

2002 Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-insurance amounts for dental, vision, audiometric, and autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$1,000 Family: \$2,000	Single: \$1,500 Family: \$3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	\$100 co-pay	\$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit)—visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay	\$20 co-pay
	Diagnostic Testing (per visit)—laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay	\$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit)—outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$50 co-pay	\$125 co-pay
Emergency Services	Hospital Emergency Room (per visit)—Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	\$50 co-pay	\$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	\$20 co-pay	\$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	\$10 co-pay Hospital in-patient co-pay also applies.	\$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	\$10 generic \$15 brand \$30 non-formulary
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person, per plan year; one set of bitewing x-rays per person per plan year.	50% co-insurance; \$100 maximum benefit per plan year.	Not covered
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-insurance; \$75 maximum benefit per plan year.	Not covered
Other Services	Audiometric—Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit)—No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay	\$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice—Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Respite Services—\$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	50% co-insurance
	Physical Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Occupational Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Cardiac Rehabilitation Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Speech Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
Skilled Nursing Facility (per admission)—Limit 30 days per year.	\$100 co-pay	\$250 co-pay	

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2002 Public Employee Health Insurance Program Benefit Provisions (continued)

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: \$500 Family: \$1,000	None	Single: \$1,000 Family: \$2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-insurance amounts for dental, vision, audiometric, and autism respite services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$1,000 Family: \$2,000	Single: \$2,500 Family: \$5,000	Single: \$1,500 Family: \$3,000	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	\$100 co-pay (per admission)	40% co-ins*	\$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$50 co-pay (per visit)	40% co-ins*	\$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room-\$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay (per visit)	\$50 co-pay plus 40% co-ins	\$50 co-pay (per visit)	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
		Hospital in-patient co-pay also applies.	Hospital in-patient co-ins* also applies.	Hospital in-patient co-pay also applies.	Hospital in-patient co-ins* also applies.
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins \$100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins \$75 maximum benefit per year		Not covered	
Other Services	Audiometric-Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit)-No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Respite Services-\$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	50% co-insurance*	50% co-insurance	50% co-insurance*
	Hospice - Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Occupational Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Speech Therapy (per visit) -Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
Skilled Nursing Facility (per admission) -Limit 30 days per year.	\$100 co-pay	40% co-ins*	\$250 co-pay	50% co-ins*	

2002 Public Employee Health Insurance Program Benefit Provisions (continued)

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: \$250 Family: \$500	Single: \$500 Family: \$1,000	Single: \$500 Family: \$1,000	Single: \$1,000 Family: \$2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits and coinsurance amounts for dental, vision, audiometric and autism respite services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: \$1,250 Family: \$2,500	Single: \$2,500 Family: \$5,000	Single: \$2,000 Family: \$4,000	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
		\$400 maximum benefit per year		\$300 maximum benefit per year	
	Diagnostic Testing (per visit) - laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room—\$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay plus 20% co-ins	\$50 co-pay plus 40% co-ins	\$50 co-pay plus 25% co-ins	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	\$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins* \$100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins* \$75 maximum benefit per year		Not covered	
Other Services	Audiometric—Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit)—No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Respite Services—\$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-ins*	50% co-ins*	50% co-ins*	50% co-ins*
	Hospice—Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Skilled Nursing Facility (per visit)—Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*	

2002 Public Employee Health Insurance Program Benefit Provisions (continued)

Exclusive Provider Option		Option C
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Coinsurance amounts for autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	\$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	\$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician’s office).	\$500 co-pay (per visit)
	Diagnostic Testing (per visit)–laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician’s office in conjunction with an office visit are only subject to the physician office visit co-pay; separate diagnostic testing co-pay will not apply.	\$25 co-pay (per visit)
	Preventive Testing*–Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations*–All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit)–Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	\$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	\$50 co-pay (per visit)
	Ambulance (per use)	\$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	\$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	\$25 generic \$35 brand \$50 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit)–No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Respite Services–\$500 maximum monthly benefit for children 2 - 21 years of age for respite and rehabilitative care.	50% co-insurance
	Hospice – Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit)–Limit 20 visits per year.	\$30 co-pay (per visit)
	Occupational Therapy (per visit)–Limit 20 visits per year.	\$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit)–Limit 20 visits per year.	\$30 co-pay (per visit)
	Speech Therapy (per visit)–Limit 20 visits per year.	\$30 co-pay (per visit)
Skilled Nursing Facility (per admission)–Limit 20 days per year.	\$1,500 co-pay	

In 2003:

- Again, in response to requests from Legislators and members of the KEHP Program, the Commonwealth tightened the network requirements applicable to 2003 bids:
 - The 2002 RFP hospital requirement was continued.
 - However, to qualify as an offered health plan in a particular county in 2003, a health plan's network had to:
 - Include at least 25% of the largest number of primary care physicians in any other bidder's network bidding for the same plan type (i.e., HMO, POS or PPO) for that county; and
 - Include at least 40% of the largest number of specialist physicians in any other bidder's network bidding for the same plan type (i.e., HMO, POS or PPO) for that county, provided any bidder has more than five specialists in a county.
- Aetna did not respond to the Commonwealth's RFP, as it was not willing to continue to provide health insurance to members of the Commonwealth's KEHP Program. This affected eighteen counties and about 8,500 employees/retirees.
- Anthem withdrew from fifty counties, affecting around 15,600 employees and retirees.
- Bluegrass Family Health extended coverage to eight additional counties; however, due to either the Commonwealth's more stringent network requirements or termination of some providers' contracts, Bluegrass Family Health wasn't an option in six counties in 2003 where it was available in 2002.
- While CHA did not extend its service area to include more Commonwealth counties in its 2003 bid, it did extend its HMO and POS options to six additional counties and its PPO option to 46 additional counties. However, it failed to meet the Commonwealth's 2003 network requirements in two counties where it was available in 2002.
- Humana extended coverage (PPO only) to two additional Western Kentucky counties. However, due to its failure to meet the Commonwealth's 2003 network requirements, Humana failed to qualify in 2003 as an option in fourteen counties where it had been available in 2002.
- The following changes were made to the benefits offered by the plan:
 - Coverage of dental services was limited to care required as a result of an accidental injury, including anesthesia and hospital services that are medically required to safely provide dental care for children below the age of nine and persons with serious mental or physical conditions.
 - As specified in SB 152, enacted by the 2002 General Assembly, coverage was added for hearing aids and related services for persons under the age of eighteen, up to one hearing aid per impaired ear, up to \$1,400 every 36 months.
 - Coverage limits were revised for low-protein modified foods and medical formulas for individuals with inherited metabolic diseases.
 - Coverage of routine vision care was eliminated.
 - A mail order pharmacy feature was added to allow members to receive a 3-month supply of maintenance prescription drugs for a 2-month co-payment.

- Finally, as enacted by the 2002 General Assembly:
 - Through HB 821, KEHP members were allowed to select coverage in a contiguous county and receive the Commonwealth's subsidy for that county, if the hospital in the county where member lived and worked did not offer certain services and a hospital in the contiguous county did.
 - Through HB 846:
 - restricted KEHP employees and retirees to one state subsidy for health insurance,
 - required entities participating in the KEHP Program to sign a contract with the Personnel Cabinet, and
 - allowed KEHP members to select coverage in a contiguous county and receive the Commonwealth's subsidy for that county, if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does (same provision as HB 821).

2003 Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$1,000 Family: \$2,000	Single: \$1,500 Family: \$3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	\$100 co-pay	\$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit)—visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay	\$20 co-pay
	Diagnostic Testing (per visit)—laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay	\$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit)—outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$50 co-pay	\$125 co-pay
Emergency Services	Hospital Emergency Room (per visit)—Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	\$50 co-pay	\$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	\$20 co-pay	\$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	\$10 co-pay Hospital in-patient co-pay also applies.	\$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	\$10 generic \$15 brand \$30 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary	\$20 generic \$30 brand \$60 non-formulary
Dental		Not Covered	Not covered
Vision		Not Covered	Not covered
Other Services	Audiometric—Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit)—No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay	\$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services-\$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	\$10 co-pay 50% co-insurance	\$20 co-pay 50% co-insurance
	Physical Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Occupational Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Cardiac Rehabilitation Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Speech Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
Skilled Nursing Facility (per admission)—Limit 30 days per year.	\$100 co-pay	\$250 co-pay	

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: \$500 Family: \$1,000	None	Single: \$1,000 Family: \$2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$1,000 Family: \$2,000	Single: \$2,500 Family: \$5,000	Single: \$1,500 Family: \$3,000	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	\$100 co-pay (per admission)	40% co-ins*	\$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit)-outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$50 co-pay (per visit)	40% co-ins*	\$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room-\$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay (per visit)	\$50 co-pay plus 40% co-ins	\$50 co-pay (per visit)	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	\$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	\$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary		\$20 generic \$30 brand \$60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric-Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit)-No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services-\$500 maximum monthly benefit. For children 2 through 21 years of age				
	<ul style="list-style-type: none"> • Rehabilitative and Therapeutic care • Respite Care 	\$10 co-pay 50% co-insurance	40% co-ins* 50% co-insurance*	\$20 co-pay 50% co-insurance	50% co-ins* 50% co-insurance*
	Hospice - Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Occupational Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Speech Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
Skilled Nursing Facility (per admission)-Limit 30 days per year.	\$100 co-pay	40% co-ins*	\$250 co-pay	50% co-ins*	

* Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.

Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: \$250 Family: \$500	Single: \$500 Family: \$1,000	Single: \$500 Family: \$1,000	Single: \$1,000 Family: \$2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: \$1,250 Family: \$2,500	Single: \$2,500 Family: \$5,000	Single: \$2,000 Family: \$4,000	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)—visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)—laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room—\$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay plus 20% co-ins	\$50 co-pay plus 40% co-ins	\$50 co-pay plus 25% co-ins	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	\$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary		\$20 generic \$30 brand \$60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric—Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit)—No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services—\$500 maximum monthly benefit. For children 2 through 21 years of age				
	• Rehabilitative and Therapeutic care	\$10 co-pay 50% co-ins*	40% co-ins* 50% co-ins*	25% co-ins* 50% co-ins*	50% co-ins* 50% co-ins*
	• Respite Care				
	Hospice—Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Skilled Nursing Facility (per visit)—Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*	

* Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.

Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.

Prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

EPO Plan		
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	\$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit)—visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	\$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit)—outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$500 co-pay (per visit)
	Diagnostic Testing (per visit)—laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations*—All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit)—Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	\$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	\$50 co-pay (per visit)
	Ambulance (per use)	\$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	\$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	\$25 generic \$35 brand \$50 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$50 generic \$70 brand \$100 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit)—No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Services—\$500 maximum monthly benefit. For children 2 through 21 years of age <ul style="list-style-type: none"> • Rehabilitative and Therapeutic care • Respite Care 	\$25 co-pay (per visit) 50% co-insurance
	Hospice—Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit)—Limit 20 visits per year.	\$30 co-pay (per visit)
	Occupational Therapy (per visit)—Limit 20 visits per year.	\$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit)—Limit 20 visits per year.	\$30 co-pay (per visit)
	Speech Therapy (per visit)—Limit 20 visits per year.	\$30 co-pay (per visit)
	Skilled Nursing Facility (per admission)—Limit 20 days per year.	\$1,500 co-pay

* Health Departments shall be given the right of first refusal. Note: Only services from network providers are covered. Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$1,000 Family: \$2,000	Single: \$1,500 Family: \$3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	\$100 co-pay	\$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit)—visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay	\$20 co-pay
	Diagnostic Testing (per visit)—laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay	\$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit)—outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$50 co-pay	\$125 co-pay
Emergency Services	Hospital Emergency Room (per visit)—Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	\$50 co-pay	\$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	\$20 co-pay	\$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	\$10 co-pay Hospital in-patient co-pay also applies.	\$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	\$10 generic \$15 brand \$30 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary	\$20 generic \$30 brand \$60 non-formulary
Dental		Not Covered	Not covered
Vision		Not Covered	Not covered
Other Services	Audiometric—Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit)—No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay	\$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice—Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services—\$500 maximum monthly benefit. For children 2 through 21 years of age <ul style="list-style-type: none"> • Rehabilitative and Therapeutic care • Respite Care 	\$10 co-pay 50% co-insurance	\$20 co-pay 50% co-insurance
	Physical Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Occupational Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Cardiac Rehabilitation Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	\$100 co-pay	\$250 co-pay

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: \$500 Family: \$1,000	None	Single: \$1,000 Family: \$2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$1,000 Family: \$2,000	Single: \$2,500 Family: \$5,000	Single: \$1,500 Family: \$3,000	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	\$100 co-pay (per admission)	40% co-ins*	\$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit)-outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$50 co-pay (per visit)	40% co-ins*	\$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room-\$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay (per visit)	\$50 co-pay plus 40% co-ins	\$50 co-pay (per visit)	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	\$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	\$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary		\$20 generic \$30 brand \$60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric-Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit)-No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services-\$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	\$10 co-pay 50% co-insurance	40% co-ins* 50% co-insurance*	\$20 co-pay 50% co-insurance	50% co-ins* 50% co-insurance*
	Hospice - Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit		Covered same as Medicare benefit	
	Physical Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Occupational Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Speech Therapy (per visit) -Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) -Limit 30 days per year.	\$100 co-pay	40% co-ins*	\$250 co-pay	50% co-ins*

* Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.

Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: \$250 Family: \$500	Single: \$500 Family: \$1,000	Single: \$500 Family: \$1,000	Single: \$1,000 Family: \$2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: \$1,250 Family: \$2,500	Single: \$2,500 Family: \$5,000	Single: \$2,000 Family: \$4,000	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)—visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit) - laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit)—outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room—\$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay plus 20% co-ins	\$50 co-pay plus 40% co-ins	\$50 co-pay plus 25% co-ins	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	\$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary		\$20 generic \$30 brand \$60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric—Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit)—No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services—\$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	\$10 co-pay 50% co-ins*	40% co-ins* 50% co-ins*	25% co-ins* 50% co-ins*	50% co-ins* 50% co-ins*
	Hospice – Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit)—Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

* Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.

Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.

Prior approval may be required for some services. Please contact your Carrier.

2003 Public Employee Health Insurance Program Benefit Provisions (continued)

EPO Plan		
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	\$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit)—visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam—visit only—see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	\$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit)—outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$500 co-pay (per visit)
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$25 co-pay (per visit)
	Preventive Testing*—Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations*—All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit)—Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	\$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	\$50 co-pay (per visit)
	Ambulance (per use)	\$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	\$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	\$25 generic \$35 brand \$50 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$50 generic \$70 brand \$100 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit)—No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Services—\$500 maximum monthly benefit. For children 2 through 21 years of age <ul style="list-style-type: none"> • Rehabilitative and Therapeutic care • Respite Care 	\$25 co-pay (per visit) 50% co-insurance
	Hospice – Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit)—Limit 20 visits per year.	\$30 co-pay (per visit)
	Occupational Therapy (per visit)—Limit 20 visits per year.	\$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit)—Limit 20 visits per year.	\$30 co-pay (per visit)
	Speech Therapy (per visit)—Limit 20 visits per year.	\$30 co-pay (per visit)
	Skilled Nursing Facility (per admission)—Limit 20 days per year.	\$1,500 co-pay

* Health Departments shall be given the right of first refusal. Note: Only services from network providers are covered. Referrals and/or prior approval may be required for some services. Please contact your Carrier.

In 2004:

- The 2003 RFP hospital requirement was continued; however, the physician network requirements were modified such that the specialist physician network requirement only had to be met in counties where at least one bidder reported ten or more specialists, rather than in counties with five or more specialists as applied in 2003.
- The point at which members' prescription drug co-payments are reduced was increased from 50 co-payments per year, for a member and all his/her covered family members combined, to 75.
- Coverage was not available through Anthem under the KEHP Program. This affected sixteen counties where Anthem offered PPO coverage to KEHP members in 2003
- Humana:
 - Discontinued offering HMO or POS options to KEHP members, except in six northern Kentucky counties.
 - Failed to meet the Commonwealth's network requirements, with respect to its PPO options, in three counties where it offered PPO coverage to KEHP members in 2003.
 - Extended PPO coverage options in forty counties.
- Bluegrass Family Health failed to meet the Commonwealth's network requirements in one county where it offered PPO coverage to KEHP members in 2003; however, it extended PPO coverage options in eight counties, and HMO and POS options in four counties.
- CHA newly offered HMO, POS, and PPO options in two counties.
- Through the Governor's executive order, the Commonwealth provided a health insurance subsidy for employees electing the PPO A option dependent health insurance under the lowest cost carrier in the 21 counties where the cost of this coverage exceeded the cost in the other 99 counties. This subsidy was set to an amount in each affected county that resulted in all employees paying the same employee contribution, for all coverage tiers, for the lowest cost PPO A option.
- Legislation enacted by the 2003 General Assembly:
 - Through HB 95, the requirement that an employee's employment must be in the same county as his/her residence for the employee to be eligible to elect coverage in an adjacent county and receive the Commonwealth's subsidy for that county, if the hospital in the county where the member lives does not offer certain services and a hospital in the adjacent county does, was removed.
 - Through HB 430, the service required for KRS participants to be eligible to participate in the KEHP Program was increased from five years to ten years for individuals hired on or after July 1, 2003.

2004 Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$1,000 Family: \$2,000	Single: \$1,500 Family: \$3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	\$100 co-pay	\$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit)—visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay	\$20 co-pay
	Diagnostic Testing (per visit)—laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay	\$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit)—outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$50 co-pay	\$125 co-pay
Emergency Services	Hospital Emergency Room (per visit)—Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	\$50 co-pay	\$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	\$20 co-pay	\$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	\$10 co-pay Hospital in-patient co-pay also applies.	\$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	\$10 generic \$15 brand \$30 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary	\$20 generic \$30 brand \$60 non-formulary
Dental		Not Covered	Not covered
Vision		Not Covered	Not covered
Other Services	Audiometric—Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay	\$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice—Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services—\$500 maximum monthly benefit. For children 2 through 21 years of age <ul style="list-style-type: none"> • Rehabilitative and Therapeutic care • Respite Care 	\$10 co-pay 50% co-insurance	\$20 co-pay 50% co-insurance
	Physical Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Occupational Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Cardiac Rehabilitation Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Speech Therapy (per visit)—Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Skilled Nursing Facility (per admission)—Limit 30 days per year.	\$100 co-pay	\$250 co-pay

2004 Public Employee Health Insurance Program Benefit Provisions (continued)

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: \$500 Family: \$1,000	None	Single: \$1,000 Family: \$2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$1,000 Family: \$2,000	Single: \$2,500 Family: \$5,000	Single: \$1,500 Family: \$3,000	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	\$100 co-pay (per admission)	40% co-ins*	\$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit)-outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$50 co-pay (per visit)	40% co-ins*	\$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room-\$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay (per visit)	\$50 co-pay plus 40% co-ins	\$50 co-pay (per visit)	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	\$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	\$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
	Retail				
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary		\$20 generic \$30 brand \$60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric-Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit)-No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services-\$500 maximum monthly benefit. For children 2 through 21 years of age				
	<ul style="list-style-type: none"> • Rehabilitative and Therapeutic care • Respite Care 	\$10 co-pay 50% co-insurance	40% co-ins* 50% co-insurance*	\$20 co-pay 50% co-insurance	50% co-ins* 50% co-insurance*
	Hospice - Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Occupational Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Speech Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
Skilled Nursing Facility (per admission)-Limit 30 days per year.	\$100 co-pay	40% co-ins*	\$250 co-pay	50% co-ins*	

2004 Public Employee Health Insurance Program Benefit Provisions (continued)

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: \$250 Family: \$500	Single: \$500 Family: \$1,000	Single: \$500 Family: \$1,000	Single: \$1,000 Family: \$2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: \$1,250 Family: \$2,500	Single: \$2,500 Family: \$5,000	Single: \$2,000 Family: \$4,000	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)—visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
		\$400 maximum benefit per year		\$300 maximum benefit per year	
	Diagnostic Testing (per visit) - laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit)—outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room – \$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay plus 20% co-ins	\$50 co-pay plus 40% co-ins	\$50 co-pay plus 25% co-ins	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	\$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary		\$20 generic \$30 brand \$60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric—Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit)—No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services—\$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	\$10 co-pay 50% co-ins*	40% co-ins* 50% co-ins*	25% co-ins* 50% co-ins*	50% co-ins* 50% co-ins*
	Hospice—Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit		Covered same as Medicare benefit	
	Physical Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit)—Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit)—Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

2004 Public Employee Health Insurance Program Benefit Provisions (continued)

EPO Plan		
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	\$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit)–visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	\$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician’s office).	\$500 co-pay (per visit)
	Diagnostic Testing (per visit)–laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician’s office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$25 co-pay (per visit)
	Preventive Testing*–Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations*–All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit)–Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	\$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	\$50 co-pay (per visit)
	Ambulance (per use)	\$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	\$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	\$25 generic \$35 brand \$50 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$50 generic \$70 brand \$100 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit)–No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Services-\$500 maximum monthly benefit. For children 2 through 21 years of age <ul style="list-style-type: none"> • Rehabilitative and Therapeutic care • Respite Care 	\$25 co-pay (per visit) 50% co-insurance
	Hospice – Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit)–Limit 20 visits per year.	\$30 co-pay (per visit)
	Occupational Therapy (per visit)–Limit 20 visits per year.	\$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit)–Limit 20 visits per year.	\$30 co-pay (per visit)
	Speech Therapy (per visit)–Limit 20 visits per year.	\$30 co-pay (per visit)
	Skilled Nursing Facility (per admission)–Limit 20 days per year.	\$1,500 co-pay

In 2005:

- The Request for Proposal (RFP) was released with the following benefit changes:
 - The benefit options for the HMO, POS, and EPO plan types were removed.
 - The RFP included three (3) PPO Options for which bids were requested. These options include and are entitled:
 - “Commonwealth Essential”
 - “Commonwealth Enhanced”
 - “Commonwealth Premier”

(Please refer to the 2005 Plan section of Appendix A for a description of each of these options.)

- The RFP was released requesting carrier bids across six different scenarios. The scenarios were:
 - One vendor, per geographic region, under a fully-insured arrangement;
 - One vendor, statewide, under a self-insured arrangement;
 - One vendor, per geographic region, under a self-insured arrangement;
 - One vendor, statewide, under a fully-insured arrangement;
 - One vendor, per geographic region, under a fully-insured arrangement (with alternate network access requirements, noted below); and
 - One vendor, per geographic region, under a self-insured arrangement (with alternate network access requirements, noted below).

Please refer to Appendix B, 2005 Geographic Regions, for a map showing the geographic regions.

A *fully-insured arrangement* is the type of healthcare funding arrangement currently used by the Commonwealth. It requires insurers to assume the full risk of all the state employee healthcare costs in exchange for premium payments from the state. In contrast, a *self-insured arrangement* is one in which no insurance company collects premiums or assumes risk. Instead, the state would—in effect—act as its own insurance company, assume the cost risk and pay actual claims with the money normally earmarked for insurance company premiums.

- For scenarios one through four, the following network requirements had to be met:
 - Hospital Requirement: If one or more hospitals exist in a county, the vendor must have at least one of the county’s hospitals in its network, unless no bidder for the county, under the scenario being considered, have any of that county’s hospitals in its network.
 - Physician Requirement: The vendor must have at least 25% of the county’s PCP’s in its network. If there are ten or more specialist physicians submitted as practicing in the county, the vendor must have at least 40% of the county’s specialist physicians in its network.
- For scenarios one and three the following requirements were in addition to the above:
 - Must meet both hospital and physician network requirements in 85% of the counties within the region and in counties where at least 85% of the group members reside.

- For scenarios two and four, the following requirements were in addition to the above:
 - Must meet both hospital and physician network requirements in each of the eight in-state regions in 85% of the counties within a region and in counties where at least 85% of the group members reside.
- For scenarios five and six, the following network requirements had to be met:
 - Hospital Network Requirement: The vendor must have at least one network hospital in 75% of the counties having a hospital in each region.
 - PCP Network Requirement: The vendor must have at least eight PCPs per 1,000 eligible Commonwealth members per region. Additionally, each vendor must have at least one PCP in each county where it has a hospital.
 - Specialist Network Requirement: Vendor must have at least six specialists per 1,000 eligible Commonwealth members per region.
- Contracts were signed and the following carriers were awarded the following regions:
 - Anthem was awarded Region 1 and Region 2 under a self-insured basis.
 - United Healthcare was awarded Region 3 and Region 6 under a fully-insured basis.
 - Bluegrass Family Health was awarded Region 4 and Region 5 under a fully-insured basis.
 - CHA Health was awarded Region 7 and Region 8 under a fully-insured basis.
- For the first time in many years, Humana was not awarded any area in the Commonwealth.
- For the first time, the employee's cost for health insurance was based on their salary.
- For the first time, the Commonwealth offered an additional subsidy to employees that did not smoke.
- Out-of-state retirees were assigned to the county of their last employment for purposes of selecting healthcare. This created concern from the out-of-state retirees who worked for the state or for those that retired from Regions 4, 5, 7 and 8 because Bluegrass Family Health and CHA Health were regional carriers and did not immediately have a nationwide network. This caused members to accept out-of-network benefits.
- Because this was the first major benefit change in a number of years, state employees and teachers (led by the Kentucky Education Association) held protests throughout the Commonwealth, many were bused to Frankfort for a day of protest and teachers threatened to strike.
- After several weeks, Governor Fletcher called the General Assembly into a special session to deal with the shortage of money available to fund the program. As a result of the special session, HB 1 was passed. In summary, HB 1 made the following:
 - Retained the Commonwealth Essential Option Plan and removed the Commonwealth Preferred and Commonwealth Premium Options.
 - Restored the 2004 PPO A plan benefits as the Commonwealth Enhanced Option.
 - Offered the Commonwealth Premier Option.
 - Provided additional funding for these three options, including additional dependent subsidies.
 - Set the employee contributions as outlined in HB 1.

- Restored the employer contribution to the healthcare FSA for employees waiving coverage to \$234.
- Required the Personnel Cabinet to submit the benefits for the 2006 Plan Year to the Employee Advisory Committee thirty (30) days prior to the release of the Request for Proposal.
- Created the Blue Ribbon Panel on Public Employee Health Benefits for the purpose of examining all aspects of health benefits available to public employees including the procurement process, benefits offered, plan membership, implementation, maintenance and administration of the plan; alternative methods of providing benefits and services, and any other issues related to public employee health benefits the panel determines to be relevant.

2005 Public Health Insurance Program Benefit Provisions	Commonwealth Essential	
	In-Network	Out-of-Network
Covered Services		
Annual Deductible	Single - \$750 Family - \$1,500	Single - \$1,500 Family - \$3,000
Out-of-pocket maximum (excludes prescription drug expenses and emergency room co-payments)	Single - \$3,500 Family - \$7,000	Single - \$7,000 Family - \$14,000
Lifetime maximum	Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas, or mental health and chemical dependency services)	25%*	50%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy; injections, lab fees, X-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	25%*	50%*
Diagnostic testing – laboratory tests, X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*
Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician’s office.	25%*	50%*
Preventive care – annual gynecological exam, well child care, and routine physical early detection tests, subject to age and periodicity limits.	Plan pays 100% up to a maximum of \$200 per covered individual. Plan pays 100% of eligible immunizations.	
Emergency services		
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*
Emergency room physician charges	25%*	50%*
Urgent care center treatment	25%*	50%*
Ambulance services	25%*	50%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval.	25%*	50%*
Prescription drugs – Retail (30 day supply)	25%	
	Min	Max
Generic	\$10	\$25
Preferred Brand	\$20	\$50
Non-preferred Brand	\$35	\$100
Prescription drugs – Mail Order (90 day supply)	25%	
	Min	Max
Generic	\$20	\$50
Preferred Brand	\$40	\$100
Non-preferred Brand	\$70	\$200
Audiometric services in conjunction with a disease, illness or injury	25%*	50%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*
Autism Service		
Rehabilitative and therapeutic care services	25%*	50%*
Respite care for children ages two through 21 (\$500 maximum per month)	25%*	50%*
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*
Prosthetic devices	25%*	50%*
Home health – limited to 60 visits per year	25%*	50%*
Physical therapy – limited to 30 visits per year	25%*	50%*
Occupational therapy – limited to 30 visits per year	25%*	50%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*
Speech therapy – limited to 30 visits per year	25%*	50%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of \$1,400 per ear	25%*	50%*

*services subject to deductible

Covered Services	Commonwealth Enhanced		Commonwealth Premier	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (excludes office visit co-pay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - \$250 Family - \$500	Single - \$500 Family - \$1,000	Single - \$250 Family - \$500	Single - \$500 Family - \$1,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - \$1,250 Family - \$2,500	Single - \$2,500 Family - \$5,000	Single - \$1,000 Family - \$2,000	Single - \$2,000 Family - \$4,000
Lifetime maximum	Unlimited		Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	10%*	30%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	\$10 co-pay	40%*	\$10 co-pay	30%*
Outpatient diagnostic testing – laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	\$10 co-pay	40%*	\$10 co-pay	30%*
Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	20%*	40%*	10%*	30%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	\$10 co-pay per visit	40%*	\$10 co-pay per visit	30%*
	\$400 maximum benefit per covered individual per plan year		\$400 maximum benefit per covered individual per plan year	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 20%	\$50 co-pay plus 40%	\$50 co-pay plus 10%	\$50 co-pay plus 30%*
Emergency room physician charges	20%	40%	10%	30%*
Urgent care center treatment	\$20 co-pay	40%*	\$20 co-pay	30%*
Ambulance services	20%*	20%*	10%*	30%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit co-pay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no co-pay required.	\$10 co-pay	40%*	\$10 co-pay	30%*
Prescription drugs – Retail (30 day supply)				
Generic	\$10**	40%	\$10**	30%
Preferred Brand	\$15**	40%	\$15**	30%
Non-preferred Brand	\$30**	40%	\$30**	30%
Prescription drugs – Mail Order (90 day supply)				
Generic	\$20		\$20	
Preferred Brand	\$30		\$30	
Non-preferred Brand	\$60		\$60	
Audiometric services in conjunction with a disease, illness or injury	50%*	50%*	10%*	30%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	\$10 co-pay	40%*	\$10 co-pay	30%*
Autism Service				
▪ Rehabilitative and therapeutic care services	\$10 co-pay	40%*	\$10 co-pay	30%*
▪ Respite care for children ages two through 21 (\$500 maximum per month)	50%*	50%*	10%*	30%*
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
Durable Medical Equipment	20%*	40%*	10%*	30%*
Prosthetic devices	20%*	40%*	10%*	30%*
Home health – limited to 60 visits per year	20%*	40%*	10%*	30%*
Physical therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Occupational therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Cardiac rehabilitation therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Speech therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*
Skilled nursing facility services – limited to 30 days per year	20%*	40%*	10%*	30%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of \$1,400 per ear	20%*	40%*	10%*	30%*

* Subject to annual deductible

** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to \$5 generic, \$10 preferred brand and \$20 non-preferred brand.

In 2006:

- An RFP for the 2006 Plan Year was released, marking a dramatic change in the Commonwealth’s strategy for providing employee healthcare benefits. This RFP solicited bids for:
 - A single vendor to provide Third Party Administration (TPA) services on a state-wide basis;
 - A single vendor to provide Pharmacy Benefits Administration (PBA) services on a state-wide basis; and
 - A single vendor to provide administrative services for Flexibles Spending Accounts (FSA), HIPAA and COBRA. The contract for these services was to be awarded to the vendor for medical TPA services, but was structured as a separate contract to provide flexibility to the Commonwealth in future years.
- The Commonwealth moved from a program that had historically been fully-insured to a program that was self-insured statewide.
- Emphasis was placed on experience with a large employer group, having at least 100,000 covered lives.
- A national provider network was also critical to a successful bid, to ensure adequate provider networks for out-of-state retirees.
- To provide further emphasis to this change in direction, the plan was given a name change, and is now called the “Kentucky Employees Health Plan.”
- Benefits for 2006 would remain the same as those offered in 2005, with the same three benefit plan options available:
 - “Commonwealth Essential”
 - “Commonwealth Enhanced”
 - “Commonwealth Premier”
- Contracts were awarded and signed as follows:
 - Humana was awarded a contract for medical claims administration
 - Humana was also awarded a contract for administration of Flexible Spending Accounts, HIPAA and COBRA
 - Express Scripts was awarded a contract for pharmacy benefits administration
- For the first time, contracts were awarded for a multi-year term. The initial term of the contracts was 30 months, with eight (8) optional one-year renewals – meaning the contracts could be in place for ten and one-half years.
- None of the insurance carriers who had provided coverage in 2005 were awarded contracts for 2006:
 - Bluegrass Family Health and CHA Health did not meet the minimum vendor requirements and were ineligible to bid; and
 - Anthem and United HealthCare were not selected.
- The incentive for those employees who don’t smoke was continued in 2006, with a \$15 per month incentive for employees with single (employee-only) coverage, and a \$30 per month incentive for employees who chose to cover their dependents.

- Employee contributions did not change from 2005 to 2006. The Commonwealth absorbed any claims or other costs in 2006 that are above the employee contributions.
- The Commonwealth's contribution for those employees who waive coverage was reduced again, from \$234 per month, to \$200 per month, for the period July-December.
- Legislation passed during the 2006 Regular Session of the General Assembly (HB380) mandated a 12% reduction in the employer contribution amount for July-December, effectively reducing total monthly premium equivalents by about \$10 million per month, to about \$85 million. There was no corresponding decrease in employee contributions.

2006 Public Employee Health Insurance Program Benefit Provisions	Commonwealth Essential	
	In-Network	Out-of-Network
Covered Services		
Annual Deductible	Single - \$750 Family - \$1,500	Single - \$1,500 Family - \$3,000
Out-of-pocket maximum (excludes prescription drug expenses and emergency room co-payments)	Single - \$3,500 Family - \$7,000	Single - \$7,000 Family - \$14,000
Lifetime maximum	Unlimited	
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas, or mental health and chemical dependency services)	25%*	50%*
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy; injections, lab fees, X-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	25%*	50%*
Diagnostic testing – laboratory tests, X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	25%*	50%*
Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	25%*	50%*
Preventive care – annual gynecological exam, well child care, and routine physical early detection tests, subject to age and periodicity limits.	Plan pays 100% up to a maximum of \$200 per covered individual. Plan pays 100% of eligible immunizations.	
Emergency services		
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*
Emergency room physician charges	25%*	50%*
Urgent care center treatment	25%*	50%*
Ambulance services	25%*	50%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval.	25%*	50%*
Prescription drugs – Retail (30 day supply)	25%	
	Min	Max
Generic	\$5	\$25
Preferred Brand	\$15	\$50
Non-preferred Brand	\$30	\$100
Prescription drugs – Mail Order (90 day supply)	25%	
	Min	Max
Generic	\$10	\$50
Preferred Brand	\$30	\$100
Non-preferred Brand	\$60	\$200
Audiometric services in conjunction with a disease, illness or injury	25%*	50%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*
Autism Service		
Rehabilitative and therapeutic care services	25%*	50%*
Respite care for children ages two through 21 (\$500 maximum per month)	25%*	50%*
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program	
Durable Medical Equipment	25%*	50%*
Prosthetic devices	25%*	50%*
Home health – limited to 60 visits per year	25%*	50%*
Physical therapy – limited to 30 visits per year	25%*	50%*
Occupational therapy – limited to 30 visits per year	25%*	50%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*
Speech therapy – limited to 30 visits per year	25%*	50%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of \$1,400 per ear	25%*	50%*

*services subject to deductible

Covered Services	Commonwealth Enhanced		Commonwealth Premier		
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Annual Deductible (excludes office visit co-pay, preventive care services, outpatient diagnostic testing, urgent care center, prescription drugs, chiropractic services and hospital emergency room services)	Single - \$250 Family - \$500	Single - \$500 Family - \$1,000	Single - \$250 Family - \$500	Single - \$500 Family - \$1,000	
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - \$1,250 Family - \$2,500	Single - \$2,500 Family - \$5,000	Single - \$1,000 Family - \$2,000	Single - \$2,000 Family - \$4,000	
Lifetime maximum	Unlimited		Unlimited		
In-hospital care – provider services, inpatient care, semi-private room, transplant coverage (kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas), and mental health and chemical dependency services	20%*	40%*	10%*	30%*	
Outpatient services – physician or mental health provider office visits, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays; and mental health or chemical dependency services (members cost includes all services performed on the same day/same site).	\$10 co-pay	40%*	\$10 co-pay	30%*	
Outpatient diagnostic testing – laboratory tests, x-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury (members cost includes all services performed on the same day/same site).	\$10 co-pay	40%*	\$10 co-pay	30%*	
Ambulatory hospital and outpatient surgery services – outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.	20%*	40%*	10%*	30%*	
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	\$10 co-pay per visit	40%*	\$10 co-pay per visit	30%*	
	\$400 maximum benefit per covered individual per plan year		\$400 maximum benefit per covered individual per plan year		
Emergency services					
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 20%	\$50 co-pay plus 40%	\$50 co-pay plus 10%	\$50 co-pay plus 30%*	
Emergency room physician charges	20%	40%	10%	30%*	
Urgent care center treatment	\$20 co-pay	40%*	\$20 co-pay	30%*	
Ambulance services	20%*	20%*	10%*	30%*	
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit co-pay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no co-pay required.	\$10 co-pay	40%*	\$10 co-pay	30%*	
	in-hospital care co-insurance applies*		in-hospital care co-insurance applies*		
Prescription drugs – Retail (30 day supply)					
	Generic	\$5**	40%	\$5**	30%
	Preferred Brand	\$15**	40%	\$15**	30%
Non-preferred Brand	\$30**	40%	\$30**	30%	
Prescription drugs – Mail Order (90 day supply)					
	Generic	\$10		\$10	
	Preferred Brand	\$30		\$30	
Non-preferred Brand	\$60		\$60		
Audiometric services in conjunction with a disease, illness or injury	50%*	50%*	10%*	30%*	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	\$10 co-pay	40%*	\$10 co-pay	30%*	
Autism Service					
▪ Rehabilitative and therapeutic care services	\$10 co-pay	40%*	\$10 co-pay	30%*	
▪ Respite care for children ages two through 21 (\$500 maximum per month)	50%*	50%*	10%*	30%*	
Hospice care – subject to pre-certification by the plan	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program		
Durable Medical Equipment	20%*	40%*	10%*	30%*	
Prosthetic devices	20%*	40%*	10%*	30%*	
Home health – limited to 60 visits per year	20%*	40%*	10%*	30%*	
Physical therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*	
Occupational therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*	
Cardiac rehabilitation therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*	
Speech therapy – limited to 30 visits per year	20%*	40%*	10%*	30%*	
Skilled nursing facility services – limited to 30 days per year	20%*	40%*	10%*	30%*	
Hearing aids – individuals under 18 years of age, limited to one per ear every three years and a maximum benefit of \$1,400 per ear	20%*	40%*	10%*	30%*	

* Subject to annual deductible

** After the 75th prescription has been filled, excluding mail order, the co-payment will reduce to \$5 generic, \$10 preferred brand and \$20 non-preferred brand.

In 2007:

- The Commonwealth offered an additional 4th benefit plan option, Commonwealth Select. Commonwealth Select is a high-deductible PPO with an embedded Health Reimbursement Arrangement (HRA) funded by the employer, as follows:
 - Single coverage – \$1,000 contributed to the HRA;
 - Couple coverage – \$1,500 contributed to the HRA;
 - Parent-Plus coverage – \$1,500 contributed to the HRA; and
 - Family coverage – \$2,000 contributed to the HRA.
- Contracts with Humana (medical claims administration, flexible benefits, disease management, case management & utilization management, and HIPAA/COBRA administration) and Express Scripts, Inc. (pharmacy benefit administration) were maintained as in 2006. The current contracts expire June 30, 2008, and have eight (8) one-year renewal options.
- For the Essential, Enhanced, and Premier Plans, the benefits remained unchanged from the 2006 plan year.
- Premiums increased only 5.93% from 2006, reflecting a successful transition to self-insurance.

In 2008:

- The Commonwealth offered the same four benefit plans which were offered in 2007. The plans are:
 - Commonwealth Premier – a \$250/\$500 Deductible PPO plan;
 - Commonwealth Enhanced – a \$250/\$500 Deductible PPO plan;
 - Commonwealth Essential – a \$750/\$1,500 Deductible PPO plan;
 - Commonwealth Select – a \$2,000/\$3,000 Deductible consumer-directed plan with an embedded Health Reimbursement Account (HRA).
- The contracts with Humana (medical claims administration, flexible benefits, disease management, case management & utilization management, and HIPAA/COBRA administration) and Express Scripts, Inc. (pharmacy benefit administration) were renewed through December 31, 2009.
- \$54,000,000 in surplus funds from the 2006 plan year was used to lower the overall increases in 2008 employer and employee contributions from 10.40% to 5.80%.
- The incentive for employees who don't smoke was continued, with a \$15 per month incentive for employees with single (employee-only) coverage, and a \$30 per month incentive for employees who cover their dependents.
- The Commonwealth's contribution for employees who waive coverage was maintained at \$175 per month, the same amount as in 2007.

Legislative Mandates

The Department of Insurance provided the summary in Exhibit LV of twenty-nine mandated health insurance benefits that currently exist in Kentucky's statutes.

Exhibit LV

Kentucky Mandated Health Insurance Benefits	
Newborn Coverage	KRS 304.17-042, KRS 304.18-032, KRS 304.32-153, and KRS 304.38-199. Coverage for newborn children from the moment of birth, including necessary care and treatment of medically diagnosed inherited metabolic diseases for newborns—KRS 304.17A-139(2).
Inherited Metabolic Disease	KRS 304.17A-139(4). Coverage for amino acid modified preparation and low protein modified food products for treatment of inherited metabolic diseases for conditions listed in KRS 205.560, if prescription drugs are covered. Benefits can be limited to \$4,000 per year for low-protein modified foods and \$25,000 per year for medical formulas.
Ambulatory Surgical Centers	KRS 304.17-317, KRS 304.18-035, & KRS 304.32-156. Coverage for treatment at ambulatory surgical centers.
Optometrists, osteopaths, physicians, podiatrists, and chiropractors	KRS 304.17-035, KRS 304.18-095, KRS 304.32-157 & KRS 304.38-195. KRS 304.17A-275 requires that coverage be provided for services provided by osteopaths. Osteopaths can also be PCP's. Services of these providers to be covered as described.
Chiropractors	KRS 304.17A-170 & 171. Access to chiropractors in network plans.
Dentists	KRS 304.17-315, KRS 304.18-097, KRS 304.32-157 & KRS 304.38-1937. Services of dentists to be covered as described.
Temporomandibular Joint Disorder	KRS 304.17-319, KRS 304.18-0365, KRS 304.32-1585 & KRS 304.38-1937. Coverage for specific services related to TMJ and associated disorders. Also see Administrative Regulation 806 KAR 17:090.
Screening Mammography	KRS 304.17-316, KRS 304.18-098, KRS 304.32-1591 & KRS 304.38-1935. Screening mammography at specific intervals. KRS 304.17-316(2)(b) requires mammography coverage at any age for a covered person diagnosed with breast cancer.
Breast Cancer	KRS 304.17-3165, KRS 304.17A-135, KRS 304.18-0985, KRS 304.32-1595 & KRS 304.38-1936. Coverage for the treatment of breast cancer, including ABMT.
Breast reconstruction coverage, endometriosis and endometritis	KRS 304.17-3163, KRS 304.18-0983, KRS 304.38-1934, KRS 304.32-1593 & KRS 304.17A-134. Coverage for the treatment of breast reconstruction.

Kentucky Mandated Health Insurance Benefits

Psychologists and Clinical Social Workers	KRS 304.17-3185, KRS 304.18-0363, KRS 304.32-166 & KRS 304.38-1933. Services of these providers to be covered as described.
Registered nurse first assistant benefits	KRS 304.17A-146. Health benefit plans that cover surgical first assisting benefits or services must provide coverage for a registered nurse first assistant who performs the services within the scope of their license.
Conversion benefits	2002 Ky. Acts, Chapter 351, Section 9. Maximum benefits of at least \$500,000 for conversion policies—KRS 304.18-120(1). Minimum benefits—806 KAR 17:260.
Work Related Illness/Injuries	KRS 304.12-250. No contract can exclude coverage solely on the basis that the health condition is work related.
Disabled Children	KRS 304.17-310. Individual health insurance contracts must continue coverage for disabled children beyond the limiting age. Although this statute is applicable only to individual contracts, group carriers commonly use it.
Adopted Children	KRS 304.17-140. Coverage for legally adopted children or children under court-appointed guardianship.
Human Immunodeficiency Virus	KRS 304.12-013(5). No insurer or HMO may exclude or limit coverage for AIDS, etc.
Maternity Coverage	KRS 304.17A-145. Specified length of hospital stay following vaginal/cesarean deliveries.
Cochlear Implants	KRS 304.17A-131. Coverage for cochlear implants.
Autism	KRS 304.17A-143. Coverage for autism, including respite services.
Diabetes	KRS 304.17A-148. Coverage for diabetic services, supplies, and training.
Women’s Health	KRS 304.17A-134, KRS 304.17-3163, KRS 304.18-0983, KRS 304.32-1593 & KRS 304.38-1934. Breast reconstruction, endometriosis, endometritis, and bone density testing.
Domestic Violence	KRS 304.17A-155. Claims may not be denied or considered pre-existing on the basis of domestic violence.
Hospice	KRS 304.17A-250(8). Coverage for hospice care equal to Medicare benefits.
Telehealth services	KRS 304.17A-138. (Effective when the plans are issued or renewed after July 15, 2001.)
Mental health coverage	KRS 304.17A-661. Large group health benefit plans must cover mental illness the same as physical illness, if they provide mental illness benefits.

Kentucky Mandated Health Insurance Benefits	
Physician assistant benefits	KRS 304.17A-1473. Health Benefit Plans that cover surgical first assisting or intraoperative surgical care services must provide coverage for the services of a physician assistant. (Effective for Health Benefit Plans issued or renewed on or after July 15, 2001.)
Anesthesia and hospital or facility charges	2002 Ky. Acts, Chapter 199. Requires coverage for payment of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems in all health benefit plans that provide coverage for general anesthesia and hospitalization services.
Hearing aids and related services	2002 Ky. Acts, Chapter 106, Section 1(2). Requires coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to \$1,400 every 36 months.
Colorectal Cancer Detection	KY Act, Chapter 107 provides that all health benefit plans provide for colorectal cancer examinations and laboratory tests, specified in current American Cancer Society guidelines.

Source: Kentucky Department of Insurance

In addition to the mandated benefits outlined in Exhibit LV, there are other statutory requirements that affect the Public Employee Health Insurance Program. Exhibit LVI provides a brief outline of the key provisions of the mandates enacted by the 2000 General Assembly that apply to health insurance programs. The provisions of those bills for which there is no check mark in the column titled “Impacts Commonwealth Plan” were covered by the Commonwealth’s Public Employee Health Insurance Program prior to the enactment of the mandate.

Exhibit LVI

Health Insurance Mandates Enacted By 2000 General Assembly		
	Impacts KEHP Program	Key Provisions
HB 9		Mammography coverage
HB 177		Coverage of Telehealth services
HB 202	✓	<ul style="list-style-type: none"> ▪ Newborn coverage from moment of birth ▪ Treatment of inherited metabolic diseases including amino acid preparations and low-protein modified food products
HB 268	✓	Mental Health Parity
HB 281		Coverage of services provided by registered nurse first assistants
HB 390	✓	<ul style="list-style-type: none"> ▪ Utilization review rules ▪ Independent external review
HB 757	✓	<ul style="list-style-type: none"> ▪ Hold harmless and continuity of care upon contract termination ▪ Drug formulary summary required at enrollment ▪ Network access requirements modified ▪ Prudent lay person standard for emergency services
SB 279	✓	<ul style="list-style-type: none"> ▪ Prompt payment of medical claims
SB 335	✓	<ul style="list-style-type: none"> ▪ Coverage of certified surgical assistants

In addition to the health insurance mandates, Senate Bill 288, enacted by the 2000 General Assembly:

- Created the Kentucky Group Health Insurance Board.
- Required the Personnel Cabinet to develop healthcare data collection and analysis capabilities.
- Stipulated the conditions under which groups may leave the Public Employee Health Insurance Program.
- Revised the definition of “employee” with respect to the Commonwealth’s healthcare and flexible spending account benefits.
- Required the Personnel Cabinet to report annually to the General Assembly on the financial stability of the Commonwealth’s Public Employee Health Insurance Program.
- Required unused flexible spending account funds to be transferred to the state health insurance plan’s appropriation account.
- Required carriers bidding to offer healthcare coverage to members of the Public Employee Health Insurance Program to rate all such members as single entity, except for those retirees whose former employers insure their active employees outside the Public Employee Health Insurance Program.

- Precluded certain individuals who are eligible for participation in the Public Employee Health Insurance Program as a retiree from receiving the state health insurance subsidy as an active employee as well.

Additional mandates enacted by the 2001, 2002, and 2003 General Assemblies affect the Commonwealth's Public Employee Health Insurance Program. These are summarized briefly in Exhibit LVII.

Exhibit LVII

Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	Bill	Key Provisions
2001	HB 97	The Office of Public Employee Health Insurance was established under the Personnel Cabinet.
2001	HB 138	Coverage of physician assistants assisting in surgery.
2001	HB 145	Personnel Cabinet and Cabinet for Families and Children to prepare recommendations regarding allowing foster parents to participate in the Public Employee Health Insurance Program.
2002	HB 39	Coverage of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems.
2002	HB 163	Expands Kentucky Group Health Insurance Board to include: <ul style="list-style-type: none"> ▪ The Director of the Administrative Office of the Courts ▪ KRS retiree ▪ KTRS retiree ▪ Active teacher ▪ Active state employee ▪ Active classified education support employee
2002	HB 369	Mail order prescription drug coverage for Public Employee Health Insurance Program.
2002	HB 395	Revised caps for inherited metabolic diseases to be \$4,000 annually for low-protein modified foods and \$25,000 annually for medical formulas.
2002	HB 801	Entities that join the Kentucky Retirement System must join the Public Employee Health Insurance Program for their active employees.
2002	HB 821	<ul style="list-style-type: none"> ▪ Personnel Cabinet to study whether to allow health insurance bidders to bid different rates in different geographic areas of the Commonwealth. ▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state subsidy for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.

Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program

Year Enacted	Bill	Key Provisions
2002	HB 846	<ul style="list-style-type: none"> ▪ Restricts individuals to one state subsidy for health insurance. ▪ Entities participating in the Public Employee Health Insurance Program must sign a contract with the Personnel Cabinet. ▪ Expands the Advisory Committee of State Health Insurance Subscribers to include 2 members from the Kentucky Association of Counties and 2 from the Kentucky League of Cities. ▪ Directs the LRC to study the cost to members of the state health insurance group as a result of entities covering their retirees under the Public Employee Health Insurance Program but not their active employees and recommend administrative procedures to collect this cost from these entities. ▪ Directs the LRC to study the Public Employee Health Insurance Program. ▪ Allows Public Employee Health Insurance members to select coverage in a contiguous county and receive the state subsidy for that county if the hospital in the county where the member lives and works does not offer certain services and a hospital in the contiguous county does.
2002	SB 152	Coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to \$1,400 every 36 months.
2002	SCR 34	Directs the Interim Joint Committee on Banking and Insurance to study the feasibility of self-funding at least one health insurance option for state employees.
2003	HB 95	Removes the requirement that an employee's employment must be in the same county as his residence for the employee to be eligible to elect coverage in an adjacent county and receive the state subsidy for that county, if the hospital in the county where the member lives does not offer certain services and a hospital in the adjacent county does.
2003	HB 183	Requires that the sponsor of a bill that contains a mandated health benefit request, have prepared, and attach a financial impact statement before final consideration by a standing committee.
2003	HB 370	Required the Commonwealth's Public Employee Health Insurance Program to include a scenario that allows regional rating in its 2004 health insurance Request for Proposal, with regions defined as the partnership regions designated by the Department for Medicaid Services.
2003	HB 430	For individuals hired on or after July 1, 2003, increased the service required of participants KRS from a minimum of 5 years to 10 years to be eligible to participate in the Commonwealth's retiree health insurance program.
2006	HB131	Includes provision to pay optometrists the same amount as physicians or osteopaths when the services provided are rendered by an optometrist.
2006	HB131	Adds language requiring the Kentucky Employees Health Plan to be in compliance with certain provisions of the Insurance Code, including appeals & grievance procedures, utilization review, claims payment, and emergency medical care.
2006	HB380	Reduced the employer contribution for 2006 health insurance premiums by 12% for the period July – December, 2006.

Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	Bill	Key Provisions
2006	HB380	Provided explicit statutory authority to establish a self-insured health plan for public employees.
2006	HB380	Requires the plan to be established by administrative regulations.
2006	HB380	Provides appeal rights for formulary changes, and ensures independent review of any proposed changes in formulary.
2006	HB380	Establishes a Trust Fund for the plan, and defines the allowable expenses to be paid by the Trust Fund.
2006	HB380	Requires a Health Reimbursement Account to be provided for those employees who waive coverage under the Plan, to be funded by the employer at an amount no less than \$175 per month.
2006	HB380	Requires an audit of the Trust Fund within 90 days of the end of each Fiscal Year.
2006	HB380	Establishes quarterly reporting requirements for the Plan.
2007	SB22	Create a new section of KRS Chapter 18A to require the Personnel Cabinet, Department for Employee Insurance, to offer TRICARE supplement insurance to eligible TRICARE insurance beneficiaries; require the Commonwealth to pay for individual TRICARE supplement insurance; permit an employee eligible for TRICARE to choose between the Commonwealth sponsored TRICARE supplemental insurance or other coverage offered through the public employee health insurance program; permit the secretary of the Personnel Cabinet to promulgate administrative regulations. Note this legislation is pre-empted by Federal law which prohibits employers from offering incentives to employees if they elect coverage under a Federally-sponsored program.
2007	SB175	Amend KRS 304.17A-846 to direct health insurers to provide certain information to large group health benefit plans upon request of the plans; require the insurer to provide additional utilization data to help the employer measure costs in certain areas; provide under certain circumstances that nonpublic personal health information can be provided to large group health benefit plans in compliance with the Federal Health Insurance Portability and Accountability Act.
2007	HB378	Amend KRS 216B.175 to require history and physical examinations to be performed no more than 30 days, rather than 7 days before admission to an acute care or psychiatric hospital.
2008	HB 321	Provides the General Assembly with the authority to review trust fund expenditures and authorize spending for trust fund receipts. Outlines quarterly report content, formulary review changes, deadlines and other administrative regulations regarding the trust.
2008	HB 440	Requires the KEHP to allow parents to keep unmarried children on their health plans until age 25. Parents would have to pay premium on a post-tax basis
2008	SB 96	Requires all health insurance plans to provide for colorectal cancer screening based on current American cancer Society guidelines.

No additional benefit mandates were enacted by the 2004 General Assembly. In fact, House Bill 650 created a new statute in Subtitle 17A that imposed a 3-year moratorium on new mandated benefits beyond those statutorily required on July 13, 2004.

Many of the bills that were introduced during the 2007 Regular Session of the General Assembly would have had some impact on the Kentucky Employees Health Plan, but only a few were passed and enacted into Law. SB22 directly affected the plan, while SB175 and HB378 were directed at insurance plans in general.

There are a significant number of legislative mandates that apply to the Commonwealth's Public Employee Health Insurance Program. The impact of many of these mandates on the program's costs is difficult to discern. And, although the discernible cost of some mandates may be low in a given year, significant variation can result from year to year. Finally, the ability to determine the cost of discrete provisions is highly dependent on providers appropriately classifying the expenses and insurance carriers accurately recording the expenses. Therefore, the cost impact can easily be understated.

Glossary

Allowed Charge: The amount paid in total to a healthcare provider for services received by a health plan member. This amount includes both the health plan's payment and the member's cost sharing (deductible, co-payment, co-insurance, etc.). This is the total amount billed by a healthcare provider for a covered service, after the application of the health plan's negotiated discount, but prior to any member cost-sharing.

Brand Name Drug: A trademarked drug for which the manufacturer holds the patent or has purchased the rights to manufacture from the patent holder. Brand name drugs are generally more expensive than generics. A single-source brand name drug is a drug that is only produced by one manufacturer and for which a generic equivalent is not available. Multi-source brand name drugs are drugs produced by more than one manufacturer, as generic equivalents are available.

Capitation: A set amount of money paid to a provider of service based on membership demographics rather than payment based on services provided.

COBRA Beneficiaries: Individuals who no longer meet the eligibility requirements for healthcare coverage through a group health plan, but by federal statute, are eligible to continue their healthcare coverage for a period of time under the employer's healthcare program by paying 102% of the total premium rate.

Co-Payment: A stipulated dollar amount that a health plan member must pay out of pocket when healthcare services, supplies, or prescription drugs are received.

Coinsurance: A percentage of the cost of covered healthcare services, supplies, or prescription drugs that a health plan member must pay out of pocket.

Coverage Tier (also referred to as Coverage Level): The choices available to employees with respect to the individuals they wish to cover under an employer's health insurance program. Under the Commonwealth's Public Employee Health Insurance Program, the following tiers (or levels) apply:

- Single: coverage for only the employee or retiree
- Couple: coverage for the employee or retiree and his/her spouse
- Parent Plus: coverage for the employee or retiree and all eligible children
- Family: coverage for the employee or retiree, his/her spouse and all eligible children

Dependent Subsidy: When an employer specifically pays a portion, or all, of the dependent premium for an employee, this is an *explicit dependent* subsidy. When the differential between single and dependent healthcare premium rates is less than the differential between employee/retiree healthcare claims and dependents' healthcare claims, an *implicit dependent subsidy* exists.

Employee: References to "Employees" includes Active Employees, non-Medicare-eligible retirees, and COBRA participants. When meant to reflect only those employees still actively at work, the term "Active Employees" will be used.

Exclusive Provider Organization (EPO): These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Depending on the insurance carrier chosen, the participant may or may not have to designate a primary care physician to coordinate his/her care. Beginning January 1, 2000, EPO Option C was added to the Commonwealth's Public Employee Health Insurance Program.

Formulary: A preferred list of medications developed by a health plan or Pharmacy Benefit Manager (PBM) to guide physician prescribing and pharmacy dispensing. This list is periodically updated by the PBM to add or remove drugs.

Flexible Spending Account (FSA): A flexible spending account or reimbursement account is funded by employee salary reductions, employer contributions or both. Amounts placed in these accounts are used to provide reimbursement for eligible expenses incurred by the employee or eligible beneficiaries for specified benefits during a plan year.

Fully Insured (also referred to as Insured or Fully Funded): When a health plan assumes the financial risk associated with medical expenses for an employer group in exchange for the premiums paid by the group.

Generic Drug: A drug whose therapeutic ingredients are the same as a brand name drug, but which is sold under a name that is not trademarked. Generic drugs are usually less expensive than their brand name counterpart.

Health Maintenance Organization (HMO): These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Participants in these plans must select a primary care physician to coordinate their care. For the majority of the services covered by the HMO, participants pay a specified dollar amount (co-payment) at the time services are received.

Health Reimbursement Arrangement (HRA): IRS-sanctioned arrangements that allow an employer, as agreed to in the HRA plan document, to reimburse for medical expenses paid by participating employees. HRAs reimburse only those items (co-pays, coinsurance, deductibles and services) agreed to by the employer which are not covered by the company's selected standard insurance plan (any health insurance plan, not only high-deductible plans). These arrangements are described in IRS Section 105.

Medical Loss Ratio (also referred to as Loss Ratio): The ratio between the incurred claims paid by a health plan and the premium taken in by the health insurer. Example: An insurance company receives \$100,000 in premium for a month and pays out \$89,000 in claims—the Medical Loss Ratio is 89% ($\$89,000/\$100,000$).

Out-of-Pocket Limit: A specified dollar amount present in some health plan provisions that limits the amount of out-of-pocket expenses a plan participant pays in a Plan Year for covered healthcare services. Once the participant reaches the out-of-pocket limit, the health plan pays 100% of his/her covered healthcare expenses for most or all services.

Pharmacy Benefit Manager (PBM): An organization that functions as a third party administrator for a health plan's pharmacy claims, contracts and management.

PMPM (Per Member Per Month): A measure of costs as expressed as total costs divided by total number of covered lives (employees, spouses, and dependent children).

Point of Service (POS): These plans mimic the benefits of the HMO options, provided an individual receives services from a healthcare provider that has contracted with the health plan and services are coordinated through the primary care physician designated by the individual. Unlike the HMO options, the POS options provide coverage for services received from a provider that is not in the health plan's network, at a higher cost sharing percentage to the insured.

Preferred Provider Organization (PPO): These plans require lesser cost sharing from participants, if covered services are received from a healthcare provider that participates in the health plan's network. Coverage is provided for services received from a provider that is not in the health plan's network, with participants paying a larger proportion of the cost of covered services. Unlike POS plans, PPOs do not require referrals from a participant's primary care physician. The PPOs offered under the Commonwealth's Public Employee Health Insurance Program provide the same benefits for services received in a network physician's office and for prescription drugs as do the HMO and POS options. However, for services received in a network hospital or surgical center, PPO participants pay a percentage of the cost of services received (co-insurance) after paying an annual deductible, rather than a specified dollar co-payment. The amount of co-insurance that a participant pays annually is capped by the PPO plan's out-of-pocket limit.

Premium: The monetary amount paid by an employee or the employer for health insurance benefits. It is routinely paid on a monthly basis. In an insured program, the amount paid to an insurance company in exchange for its payment of all healthcare costs covered under the terms of the health plan and for administrative services. For large groups, like the Public Employee Health Insurance Program, premiums are determined based on the healthcare services consumed by the plan's members in the past and the prices charged by healthcare providers. If the premiums charged by the insurer are less than the actual healthcare costs incurred by the plan's members and the insurer's operating costs, the insurer loses money. The premium includes both the employer's subsidy and the employees' contributions for health insurance.

Premium Equivalent: Analogous to "Premiums," Premium Equivalents reflect the expected actuarial costs for a plan option and coverage tier under a self-insured arrangement.

Primary Care Physician: For purposes of the applying the Commonwealth's qualifying network requirements, a primary care physician includes: family practice physicians, general practice physicians, pediatricians, and internists.

Provider Network: A list of contracted healthcare providers, unique to a health plan, from which an insured can obtain services that are covered under an HMO or are covered at a preferred benefit level under a POS or PPO.

Self Insured (also referred to as Self Funded): A health plan whose medical claims' financial risk is assumed by the employer and not by the health plan.

Specialist Physician: For purposes of the applying the Commonwealth's qualifying network requirements, a specialist physician includes all physicians other than: family practice physicians, general practice physicians, pediatricians, and internists.

Stop Loss Coverage: Stop loss coverage is insurance that covers a health plan's expenses above a specified amount, either for each covered individual (specific coverage) or for the plan as a whole (in aggregate). This coverage is also referred to as **Excess Loss Coverage**.

Third Party Administrator (TPA): An organization that performs health insurance administrative functions (e.g. claims processing) for a plan or an employer. The TPA may also provide the healthcare provider network.

Unescorted Retirees: Individuals who participate in a state sponsored retirement program are eligible to participate in the Public Employee Health Insurance Program. These retirees include not only former employees of state agencies and school districts, but also former employees of cities, counties, and municipalities that participate in the County Employees Retirement System (CERS) and former employees of regional universities. Health insurance coverage for the pre-65 retirees of the Commonwealth's KTRS and KRS programs is provided through the same program that covers active state employees. However, active employees of the Commonwealth's regional universities do not participate in the Public Employee Health Insurance Program, neither do active employees of most of the cities, counties and municipalities that participate in the CERS program. Rather, these entities maintain separate health insurance programs for their active employees. In the analysis conducted by the Segal Company in October 2002 at the request of the Interim Joint Committee on State Government, the term "unescorted retirees" was assigned to this group of retirees.

Waiver: An eligible employee or retiree who declines healthcare coverage through his/her employer for a plan year. Often the employee obtains healthcare coverage through another means, typically a spouse's employer or an individual.