

**Commonwealth of Kentucky**  
**Kentucky Group Health Insurance Board**  
**Kentucky Employees' Health Plan**  
**Ninth Annual Report**

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

**October 1, 2009**

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## EXECUTIVE SUMMARY

This Ninth Annual Report of the Kentucky Group Health Insurance Board (KGHIB), prepared for the Governor, General Assembly, and Chief Justice of the Supreme Court of the Commonwealth of Kentucky, provides an overview of the 2008 Kentucky Employees' Health Plan (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 2009, historical information on plan designs, legislative mandates, and commentary on the KGHIB continued focus on sustainable health plan solutions.

### Highlights of the 2008 KEHP Experience

- **KEHP costs continue to escalate, but at a lower rate than the previous year.**
  - ✓ In 2008 the KEHP paid claims cost for providing medical and pharmacy benefits to members was \$1,245,900,000 in total. In aggregate this cost was 11.8% higher than the plan cost in 2007. A portion of the plan cost increase was due to a 3.1% growth in average annual membership.
  - ✓ On a per member per month (PMPM) basis, which adjusts for the increased enrollment, the KEHP paid claims cost increased 8.4% from 2007 to 2008. The medical claims PMPM increase was 8.1% and the pharmacy PMPM increase was 9.4%.
- **KEHP continues to pay a greater percentage of the cost for employees than national averages; however, the percentage of costs paid for members in employee plus dependent(s) tiers is below national averages.**
  - ✓ KEHP costs are shared by KEHP and its members. The KEHP's average monthly subsidy (or portion of the total cost paid by the plan) of an employee's health insurance coverage ("employee-only" tier of coverage) has increased from \$9.72 per month in 1972 to \$545 in 2008 and to an estimated \$607 in 2009. The member's portion of cost has risen from \$92.69 in 2008 to \$101.06 in 2009.
  - ✓ On a percentage basis, in 2008 KEHP paid 97.3% of single coverage health care costs and 71.6% of employee plus dependent(s) coverage<sup>1</sup> health care costs. These percentages vary from government sector benchmarks (as provided by the Kaiser-HRET annual survey) of 88% for employee-only coverage and 78% for employee plus dependent(s) coverage.
- **KEHP membership is growing and the average age continued to drop in 2008.**
  - ✓ From 2007 to 2008 KEHP membership grew by 3.1%. The average employee age decreased from 45.9 to 45.3 and the average member age dropped from 36.7 to 35.8. This decrease in age results in an improved plan cost. For each year

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

reduction in average age of plan members, plan costs decrease from what they would have been by an estimated 2.0%.

- ✓ KEHP continued to have fewer enrolled dependents than national averages, with 67% of coverage provided through the "Single" tier of coverage. The lower enrollment in dependent plans may be due in part to the higher employee contributions for dependent coverage compared to national averages.
- **KEHP spends the largest portion of its total claims 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 continued to remain relatively consistent in 2007 and 2008.
  - ✓ KEHP's outpatient claims, the largest component of cost, are increasing at the highest rate, 10.6%. This is notably higher than inpatient claims at 7.9%.
- **Clinical conditions related to heart disease, arthritis and similar conditions, and respiratory conditions such as asthma continue to be prevalent in the KEHP population.**
  - ✓ The membership's clinical conditions that resulted in a significant portion of the plan's costs in 2008 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 2008 medical claims costs.
  - ✓ Given that the KEHP plan provides coverage to a significant percentage of the people of Kentucky, these conditions reflect the health challenges of the overall Commonwealth population.
- **Pharmacy benefit costs continue to rise, and KEHP is picking up more of the cost as member cost sharing continued to decline.**
  - ✓ 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 by 10.7% in 2008, up from a 9.8% increase in 2007.
  - ✓ In 2008 the KEHP portion of the total pharmacy costs rose by 12.9%. Members paid 8.2% per claim less than in 2007.

### **A Look at the First Six Months of 2009**

The claims and enrollment information for the first six months of 2009 indicates that many of the trends observed in 2008 are continuing into 2009, with the exception of pharmacy costs. Some

changes were made in the design of medical and pharmacy benefits from 2008 to 2009 as new plans were introduced.

- **KEHP costs continue to rise, but at a lower rate. Enrollment continues to increase steadily.**
  - ✓ KEHP PMPM plan costs for the first six months of 2009 increased by 5.0% compared to the first six months of 2008.
  - ✓ Plan membership has increased by 2.5% and the number of individuals who have waived coverage decreased by 4.5%.
- **Pharmacy benefits continue to increase in cost and usage, and members are beginning to contribute a larger portion of the costs.**
  - ✓ The total number of scripts has increased by 2.7% for the first half of 2009 versus the first six months of 2008. However, on a per member basis, there has only been a slight increase of 0.2%.
  - ✓ The portion of pharmacy claims paid by members has increased during the first six months of 2009, a change from prior years, and a start at reversing the historical trend of KEHP paying an increasing share of pharmacy costs each year.
- **The distribution of types of services (inpatient hospital, outpatient hospital, physician, pharmacy) being utilized in 2009 is similar to prior years.**

### **The Board Continues to Focus on the Positive Impact of Prevention and Health Improvement on Maintaining a Secure and Sustainable Plan**

The KEHP plan provides health care benefits and programs to a significant portion of the citizens of the Commonwealth of Kentucky. Its programs and benefits are critical to maintaining the health and vitality of its members and contribute to the health of the overall Commonwealth population.

The Board continues to focus on KEHP initiatives that support short and long-term security and sustainability for the plan and its members. Given that the plan provides coverage to a significant percentage of the people of Kentucky, 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.

The Board supports the Department of Employee Insurance (DEI) in the development and implementation of important preventive care and health improvement benefits and programs. Several programs were implemented in 2009 and are gaining in participation. An update on these programs is provided in this report. Further, the DEI is developing data and methodologies for monitoring the impact of these programs and the general health of the plan members.

In last year's Annual Report the Board identified many additional benefits for school systems, quasi-governmental agencies, state agencies, and retirement systems that participate in KEHP. These include wellness incentives, care management programs, and improvements in areas such as communication and clinical and administrative quality of programs and services. This continues to be a primary focus for 2009 and beyond. 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' health and has advised the DEI to consider additional emphasis on wellness and prevention programs for 2010. These programs will continue to 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
- Offer a lower cost PPO option
- Provide an improved subsidy for family and dependent coverage
- Provide plans with unlimited lifetime maximums

The Board continues to support the recommendations made in last year's Eighth Annual Report. These recommendations are provided below with a summary of progress made over the course of this year in furthering objectives.

- 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.

*DEI conducted a detailed annual plan cost driver analysis that identified challenges and opportunities for improving both the cost to the plan and members and for improving members' health. The results of this study led to the evaluation and implementation of several strategic alternatives, including evaluation of improved disease and care management approaches, strategies to improve the use of generic drugs and manage specialty drug use, expanded wellness and prevention programs, and more. DEI provided the results of the study to the Board in March 2009 and continued to evaluate alternatives for implementation in 2010. DEI will continue to monitor plan experience and evaluate alternatives for improvement.*

- 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.

*A study was conducted in June 2009 addressing the effectiveness of current care management programs and identifying alternatives to improve programs. Utilization review services, case management services and disease management services were evaluated. Several alternatives for improving programs were identified and are currently under evaluation.*

- 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.

*DEI continues to evaluate the administrative quality of services provided to support the KEHP. As referenced above, an evaluation of clinical programs was conducted in July 2009. Evaluation of administrative services is under consideration.*

- 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.

*During the active open enrollment process in 2008, DEI attained contact information for the majority of KEHP members and is in the process of developing improved communications processes. Communications have been e-mailed directly to members and continue to be provided through Insurance Coordinators. Several improvements have been made to the KEHP web site, and a focus on improved communications will continue over the course of this next year.*

- 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 Board further recommends:

- Members of the Board discussed that the \$50M transfer from the Public Employee Health Insurance Trust Fund pursuant to House Bill 143 raises the issue about the appropriate levels of plan reserves that should be maintained by the Trust.

Pursuant to KRS 18A.2254(3)(a), there are significant limitations on the use of any of the prior year trust fund surplus balances. Members of the Board noted that KRS 18A.2254(3)(a) has an effect on the level of plan reserves that should be maintained. Board members further discussed that adequate funds should continue to be budgeted by the General Assembly and adequate plan reserves should be maintained by the Trust to address annual health care inflation.

The Board acknowledges that adequate reserves are necessary for all self-insured plans. It was requested by Board members that PwC determine what adequate reserves are needed for self-funded plans similar to the Kentucky Employees' Health Plan bearing in mind the statutory limitations of using prior year surplus balances.

- KEHP should conduct a study to evaluate the impact of any federal health care reform measures once the scope and detail of reform programs are known.

## THE KENTUCKY EMPLOYEES' HEALTH PLAN - AN OVERVIEW OF PLAN EXPERIENCE

### 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 ninth 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. The report contains information 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 2008 KEHP experience
- A look at plan experience for the first six months of 2009
- A perspective on 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.

Throughout this report, the charts and tables have been color-coded according to the types of data portrayed:

- Charts and tables in **blue** reflect KEHP Per Employee Per Month (PMPM) metrics
- Charts and tables in **green** reflect KEHP Per Member Per Month (PMPM) metrics
- Charts and tables in **red** reflect KEHP aggregate metrics
- Charts and tables in **brown** reflect survey or benchmark metrics
- Charts and tables in **violet** reflect other metrics (vary based on specific chart or table)

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

## **2008 KEHP Experience**

This section of the Annual Report provides a summary of cost and usage trends experienced by KEHP in 2008. The 2007-2009 information is based on self-insured KEHP claims reported by the plan administrators. These claims and enrollment data were compiled by the Thomson Reuters data warehouse.

### **A Note about 2009 Claims Experience**

At the time that this report was written, 2009 claims data were available through June 2009. In exhibits that estimate complete 2009 experience, calendar year 2009 claims experience was estimated by applying the claims seasonality observed in 2008 to the six months of claims experience available in 2009. "Seasonality" refers to variations in enrollment patterns and claims payments over the course of a year that result 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 "paid claims" mean claims incurred within the specified time frame regardless of when the claims were paid.

## **A Summary of KEHP Program Costs, Plan Subsidies and Employee Contributions - 1999 to 2009**

### **Highlights**

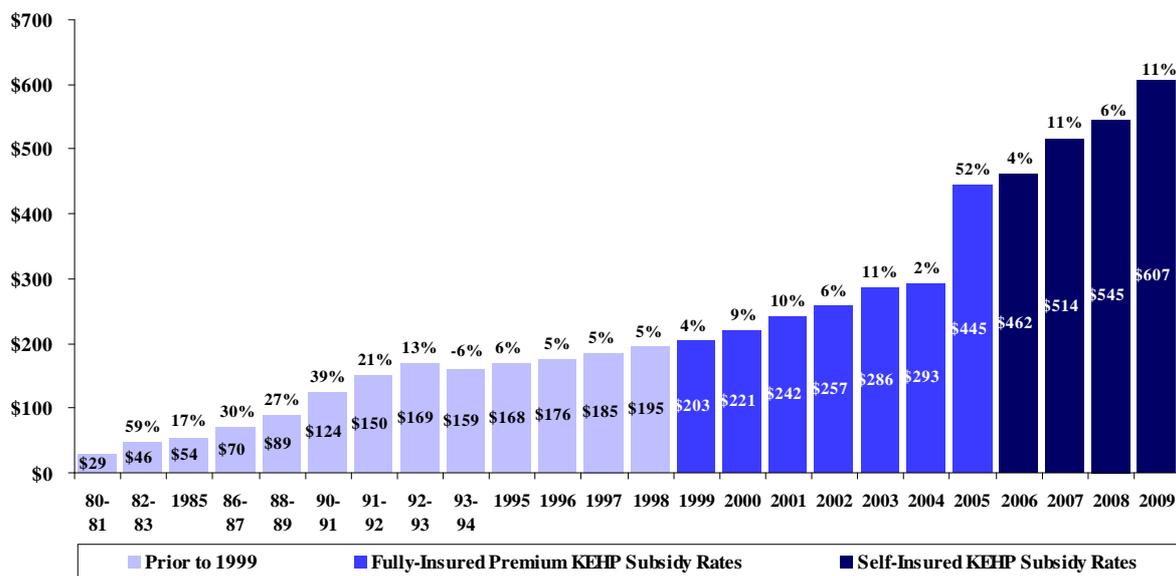
- Total claims paid claims cost rose by 11.8% in 2008. This includes the impact of both increased claims cost and utilization and an increase in membership. On a per member per month basis (PMPM) claims increased by 8.4% (adjusted for cross reference employees and spouses).
- In 2006, KEHP absorbed the 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 and again in 2008, KEHP and employees shared the cost increase, returning to an 85%/15% KEHP/employee cost split.
- In 2008, KEHP's subsidies covered 85.0% of budget rates (97.3% for Single Coverage, 71.6% blended for the employee + dependent coverage tiers). KEHP subsidies for employee-only coverage are 9.3 points higher than national averages. Subsidies for dependent coverage are 6.4 points lower than national averages.
- The 2008 incentive to encourage individuals to waive coverage remained unchanged from 2007, at \$175 per month. At its peak, in early 2006, the incentive was \$234. The incentive reduction, along with the rise in health care costs and the economic decline, has resulted in fewer people waiving coverage. Even though the waiver incentive has not decreased over the past two years, the number of individuals waiving coverage has continued to decline. This suggests that, as health care costs continue to increase, fewer members will waive the KEHP benefits coverage.

## Historical Per Employee KEHP Subsidies

The KEHP's per employee per month (PEPM) subsidy (the amount paid by the plan, excluding the amount paid by the participant) from 1980 through 2009 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 (not shown), to \$445 in 2005, \$462 in 2006, \$514 in 2007, \$545 in 2008, and is estimated to increase to \$607 per month for 2009. Also shown in Exhibit I are the percentage increases in the KEHP PEPM subsidy from year to year.

### Exhibit I

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



Source: Eighth 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, 2008, and 2009 reflect incurred claims plus administrative fees, and do not include an insurance company margin.

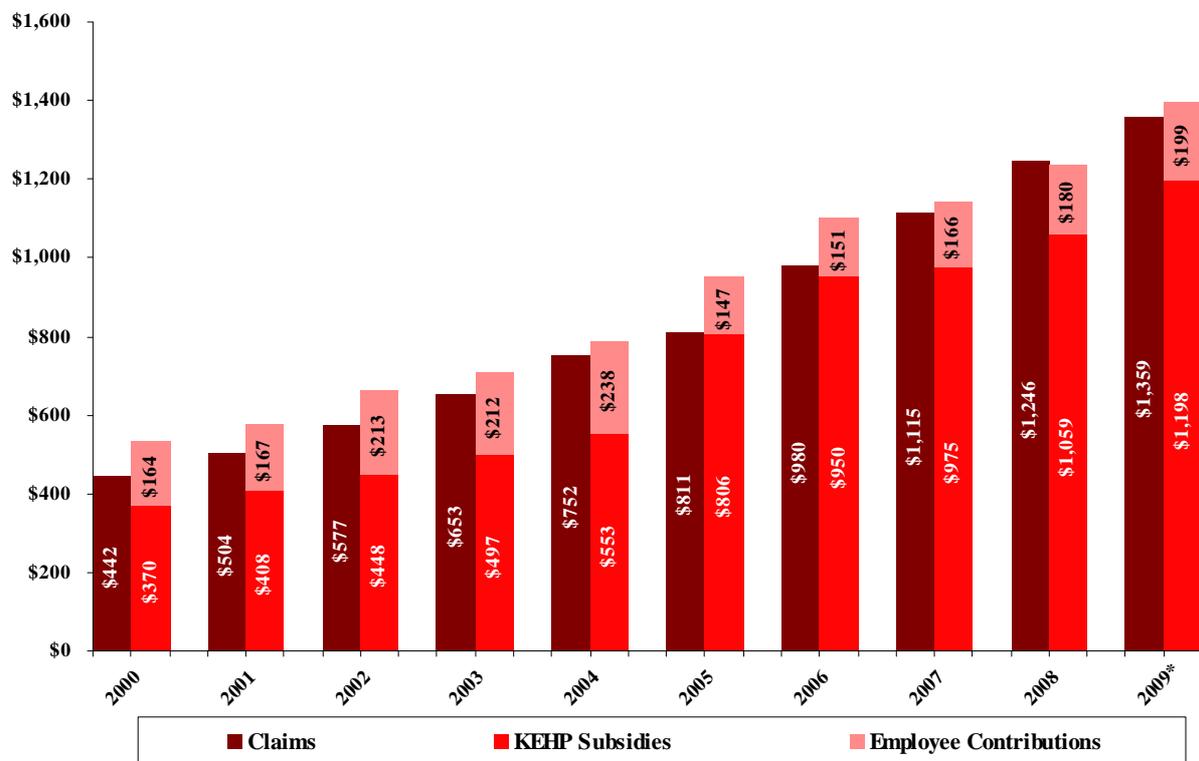
The total incurred claims paid by the insurers for the KEHP program in 2000 through 2005 and by the KEHP's self-funded program in 2006, 2007, and 2008 are identified as "Claims" in Exhibit II. For 2009, the annual claims have been estimated based on the 2009 paid claim experience year to date (with an adjustment for incurred but not reported claims), and then estimated 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 total subsidy amounts KEHP paid in 2000 through 2009 (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 actual KEHP claims and administrative expenses have been close to the budgeted costs. A look at the first six months of available data for 2009 shows this trend continuing. This observation may change as the 2009 plan year continues.

**Exhibit II**

**Annual Aggregate KEHP Paid Claim Costs versus KEHP Subsidies and Employee Contribution (\$Millions)**



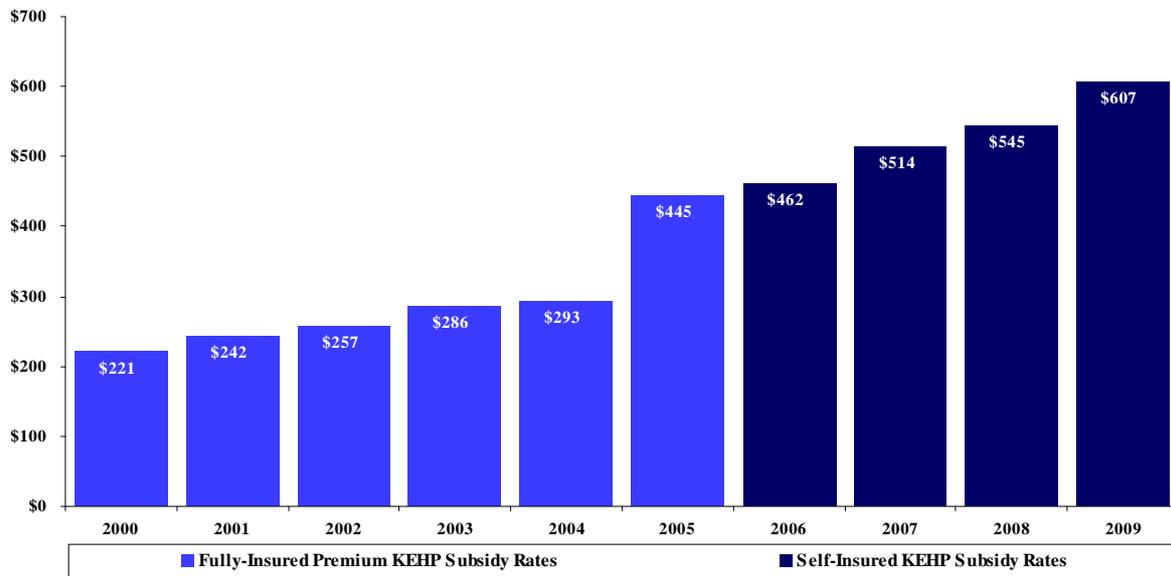
Source: Claims reported by KEHP’s insurers and administrators and compiled by Thomson Reuters and enrollment reported by the Commonwealth. Employee Contributions for 2000 through 2009 provided by the DEI.

\* 2009 figures reflect estimates based on six months of 2009 claims experience, seasonally adjusted to year end.

KEHP significantly increased its subsidy for employee health insurance in 2005, as shown in Exhibit III. In 2008, KEHP and members shared the cost increase to the KEHP program.

**Exhibit III**

**KEHP Per Employee Per Month (PEPM) Subsidy 2000-2009**



Source: Eighth Annual Report and KEHP’s enrollment and claims data aggregated by Thomson Reuters.

In 2008, KEHP covered 85.0% of total costs (97.3% for single coverage, 71.6% blended for the employee + dependent coverage tiers). Exhibit IV compares the KEHP subsidies to national averages for the government sector. Since 2006, the KEHP subsidy for enrollees with single coverage has been higher compared to government sector averages, while the subsidy for those with dependent coverage has been lower. In 2008, the KEHP subsidy for single coverage was 9.3 percentage points higher than national averages and 6.4 points lower for employee plus dependent(s) coverage.

**Exhibit IV**

**KEHP Subsidies Compared to Government Sector Benchmarks**

	2006		2007		2008		2009	
	Kaiser	KEHP	Kaiser	KEHP	Kaiser	KEHP	Kaiser	KEHP
<b>Employee Only</b>	94.0%	97.3%	87.0%	97.2%	88.0%	97.3%	89.0%	96.3%
<b>Employee + Dependents</b>	82.0%	72.5%	78.0%	71.5%	78.0%	71.6%	77.0%	73.2%
<b>Overall</b>	88.4%	85.8%	82.7%	85.0%	83.2%	84.9%	83.2%	85.2%

Source: Benchmarks from 2006, 2007, 2008, and 2009 Kaiser Family Foundation Employer Health Benefits survey

Employee contribution rates have increased in each of the years reviewed. Exhibit V provides monthly employee contribution rates for 2008 and 2009 by plan option, coverage tier, and non-smoker versus smoker status.

**Exhibit V**  
**2008 through 2009 Monthly Employee Contribution Rates**

<b>Monthly Employee Contribution Rates</b>					
	<b>Single</b>	<b>Couple</b>	<b>Parent Plus</b>	<b>Family</b>	<b>Cross Ref</b>
<b>2008. Rates</b>					
<b>Essential Plan:</b>					
<b>Non-Smoker</b>		\$290.84	\$61.64	\$358.80	\$0.00
<b>Smoker</b>		\$324.48	\$95.26	\$392.42	\$16.80
<b>Enhanced Plan:</b>					
<b>Non-Smoker</b>	\$0.00	\$400.90	\$127.76	\$481.10	\$10.90
<b>Smoker</b>	\$16.80	\$434.52	\$161.38	\$514.72	\$27.70
<b>Premier Plan:</b>					
<b>Non-Smoker</b>	\$20.40	\$446.80	\$190.94	\$532.08	\$37.08
<b>Smoker</b>	\$37.20	\$480.42	\$224.56	\$565.70	\$53.88
<b>Select Plan:</b>					
<b>Non-Smoker</b>	\$0.00	\$302.10	\$98.26	\$361.38	\$8.18
<b>Smoker</b>	\$13.22	\$327.44	\$124.12	\$386.66	\$20.80
<b>2009 Rates</b>					
<b>Standard PPO:</b>					
<b>Non-Smoker</b>	\$0.00	\$305.38	\$64.72	\$376.72	\$0.00
<b>Smoker</b>	\$21.00	\$347.38	\$106.72	\$418.72	\$21.00
<b>Capitol Choice:</b>					
<b>Non-Smoker</b>	\$0.00	\$420.96	\$134.14	\$498.44	\$12.20
<b>Smoker</b>	\$21.00	\$462.96	\$176.14	\$540.44	\$33.20
<b>Optimum PPO:</b>					
<b>Non-Smoker</b>	\$25.00	\$445.04	\$167.32	\$531.92	\$26.86
<b>Smoker</b>	\$46.00	\$487.04	\$209.32	\$573.92	\$47.86
<b>Maximum Choice:</b>					
<b>Non-Smoker</b>	\$0.00	\$317.22	\$103.18	\$379.44	\$9.16
<b>Smoker</b>	\$21.00	\$359.22	\$145.18	\$421.44	\$30.16

Source: 2008 and 2009 KEHP Employee Contribution Rates

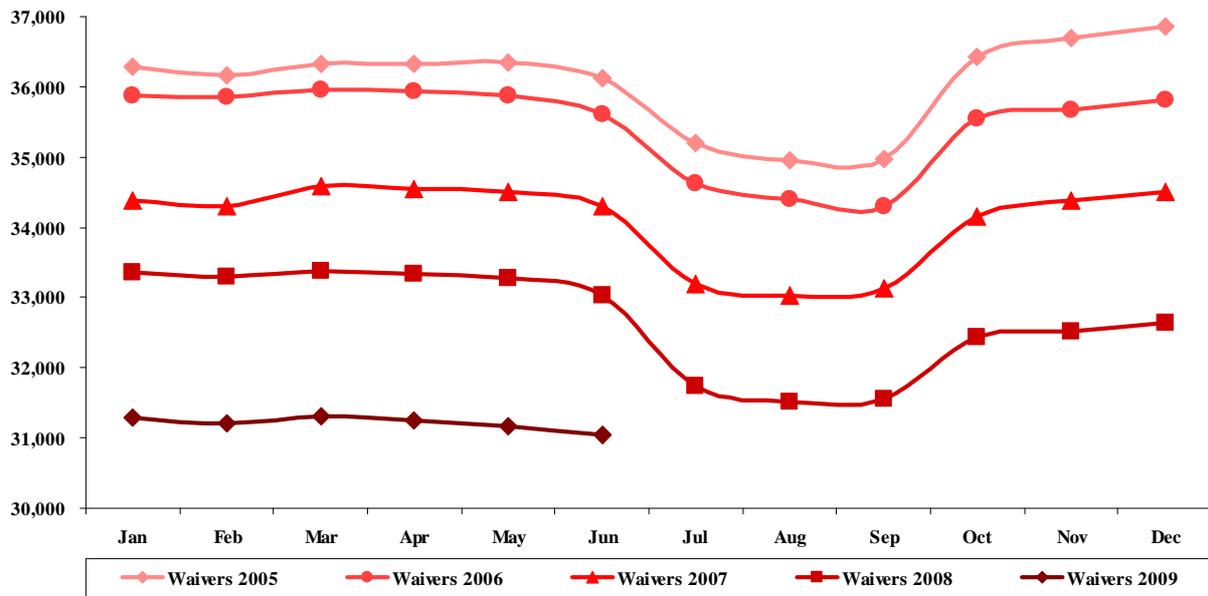
**Historical Number of Eligible Individuals Who Waive Enrollment in KEHP**

KEHP provides a monthly waiver deposit into a Health Reimbursement Account (HRA) for eligible employees who waive KEHP coverage. These accounts are intended to pay for eligible out-of-pocket healthcare expenses. For 2006 the monthly amount was \$234 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 has remained at that level through 2009. Exhibit VI shows the monthly waiver participation for the period January 2006 through June 2009.

The incentive reduction, along with the rise in health care costs has resulted in fewer people waiving coverage each year. With the \$175 waiver per month remaining constant since 2007, the value of the waiver incentive has continued to decline as inflation remains positive.

Additionally, KEHP spouses who were provided healthcare coverage through their employer may have lost their jobs due to the economic decline. These factors have all contributed to the steady decline in waiver participation.

**Exhibit VI**  
**2006 through June 2009 Monthly Coverage Waiver Participation**



KEHP Waivers					
	2005	2006	2007	2008	2009 (6 Months)
Average	36,056	35,453	34,086	32,674	31,210
Change		-1.7%	-3.9%	-4.1%	-6.2%

Source: KEHP enrollment data.

**Medical & Pharmacy Trends for 2008**

**Key Findings & Considerations**

- In aggregate, KEHP claims costs increased by 11.8% from 2007 to 2008. The number of enrollees increased by 3.1%.
- KEHP's per member per month cost increased by 8.4% from 2007 to 2008; 8.1% for medical and 9.4% for pharmacy. Over the last three years, the KEHP average annual increase was 9.1%.

## Medical and Pharmacy Claims Cost Increases

Overall, the KEHP's annual per member per month cost increased by 8.4% from 2007 to 2008. As shown in Exhibit VII, the KEHP experienced a 2.3 point decrease in annual per member per month medical trend from 10.4% in 2007, to 8.1% in 2008. Cost increases under the pharmacy program increased slightly by 1.8 points, after a significant improvement from 2006 to 2007. In 2008, the annual per member per month pharmacy cost increase was 9.4% compared to 7.6% in 2007.

### Exhibit VII

#### 2006 – 2008 Paid Claims Experience

KEHP Paid Claims Experience						
	2006	% Chg	2007	% Chg	2008	% Chg
<b>Aggregate</b>						
Medical Claims	\$744,309,131	17.7%	\$851,491,315	14.4%	\$948,789,918	11.4%
Rx Claims	\$236,146,421	29.7%	\$263,263,348	11.5%	\$297,099,706	12.9%
<b>Total Claims</b>	<b>\$980,455,552</b>	<b>20.4%</b>	<b>\$1,114,754,663</b>	<b>13.7%</b>	<b>\$1,245,889,625</b>	<b>11.8%</b>
Covered Lives	236,038	2.7%	244,581	3.6%	252,197	3.1%
<b>PMPM</b>						
Medical Claims	\$263	14.6%	\$290	10.4%	\$314	8.1%
Rx Claims	\$83	26.3%	\$90	7.6%	\$98	9.4%
<b>Total Claims</b>	<b>\$346</b>	<b>17.2%</b>	<b>\$380</b>	<b>9.7%</b>	<b>\$412</b>	<b>8.4%</b>

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

The table below contains the results of PwC's 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. Nationally, the growth in medical cost trend drops from 9.9% in 2008 to 9.6% in 2009, and is expected to continue to drop slightly to 9.0% in 2010.

### Exhibit VIII

#### 2008 – 2010 National Claims Trend Expectation

PricewaterhouseCoopers Trend Survey	2008	2009	2010
Medical Cost Trend	9.9%	9.6%	9.0%

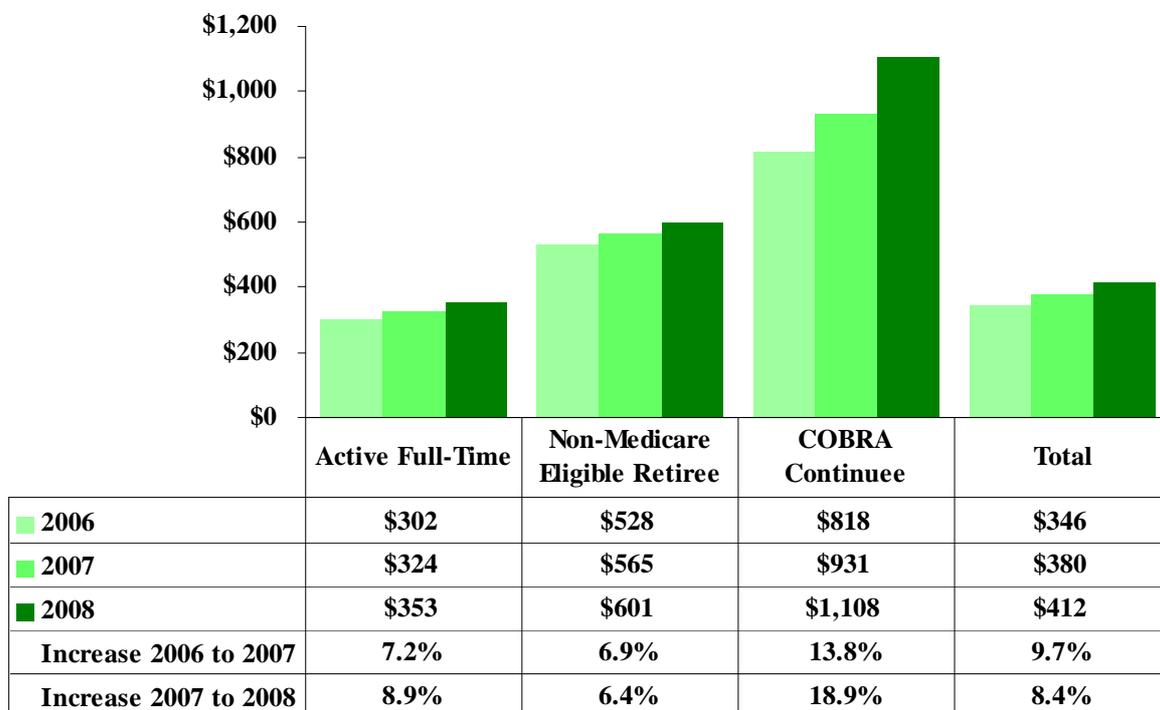
Source: PwC "Behind the Numbers: Medical Cost Trends" 2008, 2009, 2010.

## Claims Payments by Employee Status

As noted in Exhibit VII, combined medical and pharmacy claims increased by 8.4% PMPM from 2007 to 2008. Exhibits IX, X and XI provide PMPM cost increases for 2006 through 2008 for active employees, non-Medicare eligible retirees, and COBRA participants. Please note 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 non-Medicare eligible retiree costs are both trending below national averages (as noted in Exhibit VIII), although from a significantly different base cost.

### Exhibit IX

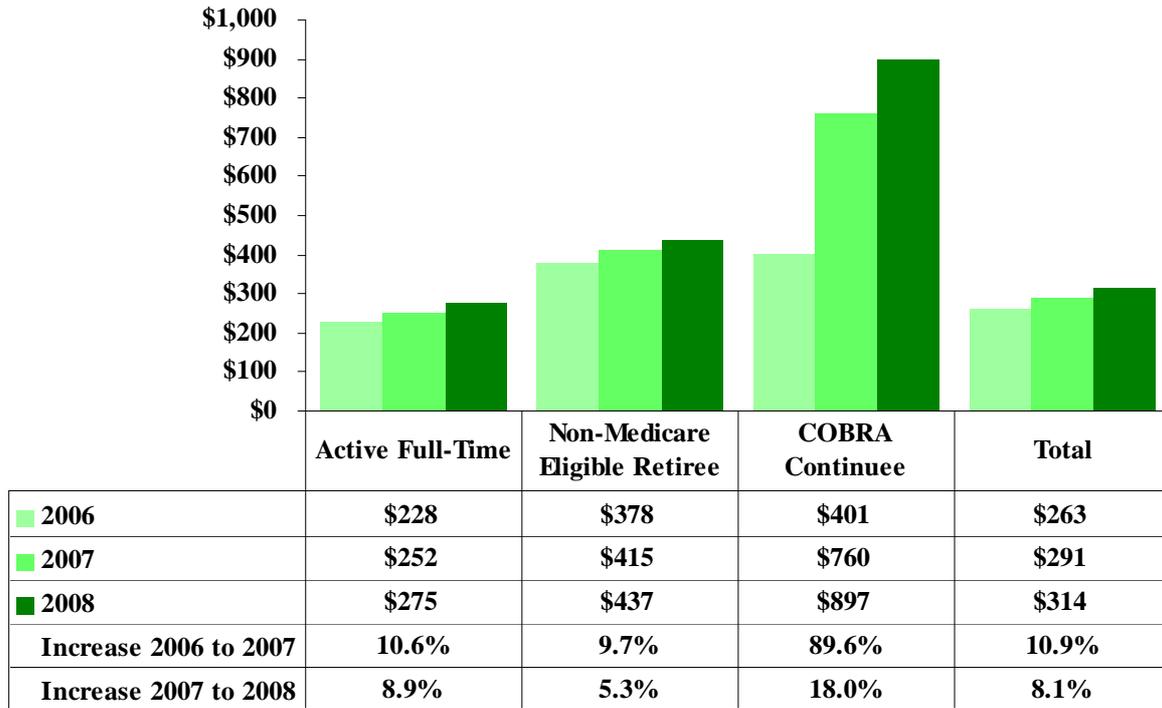
#### Medical and Pharmacy Paid Claims Per Member Per Month (PMPM)



Source: Claims reported by 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 2007 to 2008 was 8.9% for the active employee group, and 5.3% for the non-Medicare eligible retiree group. The 2008 non-Medicare eligible retiree medical claims cost PMPM is 59% higher than the active claims cost.

**Exhibit X**  
**Medical Paid Claims Per Member Per Month (PMPM)**

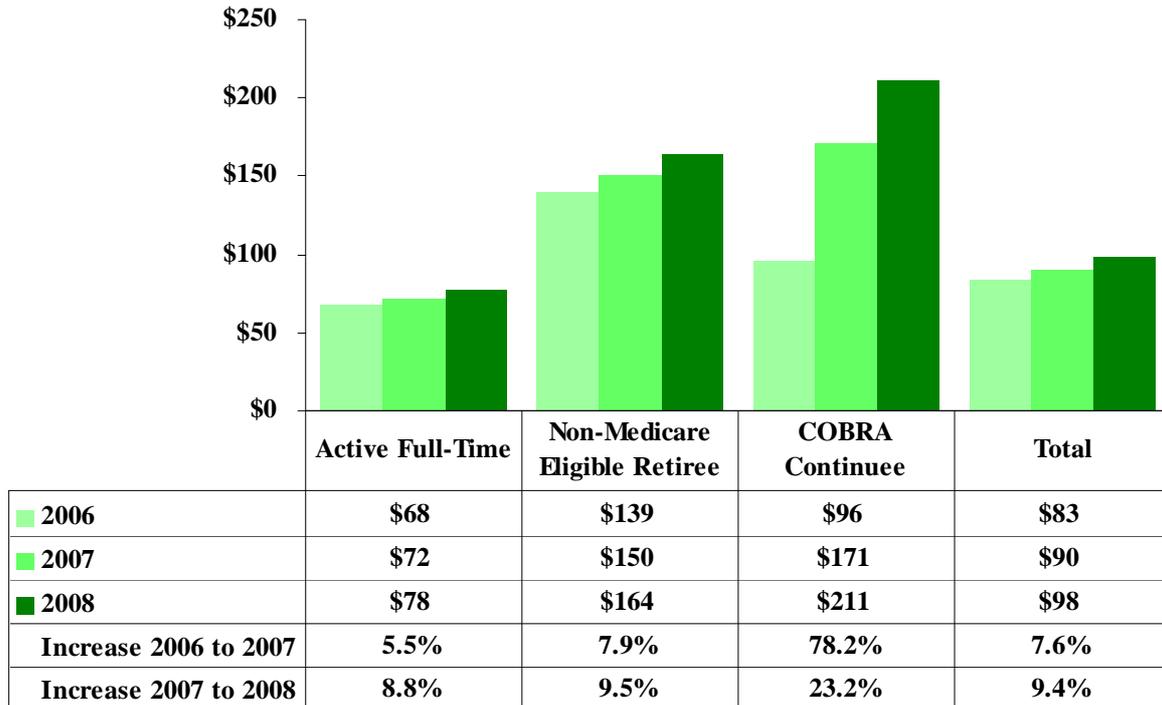


*Source: Claims reported by KEHP's insurers and administrators and enrollment reported by the Department of Employee Insurance, compiled by Thomson Reuters.*

The average pharmacy claims only (Exhibit XI) PMPM increase for 2007 to 2008, for active employee and non-Medicare eligible retiree groups, was 8.8% and 9.5%, respectively. The 2008 non-Medicare eligible retiree pharmacy claims cost PMPM is 110% higher than the active claim cost PMPM.

**Exhibit XI**

**Pharmacy Paid Claims Per Member Per Month (PMPM)**



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

## Enrollment/Demographics Analysis

### **Key Findings & Considerations**

- Overall, there was a 3.1% increase in enrollment from 2007 to 2008 and an increase of 2.5% in the first six months of 2009.
- From 2007 to 2008, the average employee age decreased from 45.9 to 45.3 years, continuing a trend toward younger employees. However, the first six months of 2009 has seen a slight uptick in the average employee age, to 45.8 years. Average member age (including employees and dependents), from 2007 to 2008, decreased from 36.7 to 35.8. Based on actuarial benchmarks and the proportion of non-Medicare eligible retirees, every year above or below the benchmark age impacts costs by approximately 2%.
- Non-Medicare eligible retirees and their dependents comprised 23.1% of the group in 2008, an increase of 5.1% from 2007. Due to the impact that age has on an individual's healthcare costs this increase in membership has significant cost implications for the KEHP program.
- Normative statistics show that female health care claim costs between the ages of 20 to 50 are approximately 1.4 times higher than the cost for males in the same age group. For ages 50 and older, female health care claims are comparable to those for males. With a high percentage of 20 to 50 year old women participating in the KEHP program, the KEHP claims experience reflects this higher demographic cost factor.
- Enrollment by plan option remained relatively consistent between 2007 and 2008.
- The frozen employee contributions in 2006 may have contributed to the continued shift into dependent coverage tiers in 2007, 2008, and 2009.
- As expected, the PMPM costs for the two Retirement Systems, KRS at \$563 and KTRS at \$632, are the highest among the group. The School Boards are the largest group representing 49.2% of the KEHP covered population, and have the lowest PMPM among all groups, at \$339 in 2008.

From 2007 to 2008, the average employee age decreased from 45.9 to 45.3 years, continuing a trend toward younger employees; however, there has been a slight increase in average age thus far in 2009 to 45.8 years. 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 20 and 50, average health care claim costs are approximately 1.4 higher than the costs for males. With a high percentage of women participating in the KEHP program in the age 20 to 50 cohort, the KEHP claims experience reflects this demographic cost factor.

**Exhibit XII**

**Population Demographics—Key Statistics**

<b>Actives, Non-Medicare Eligible Retirees, and COBRA</b>	<b>KEHP Membership</b>		
	<b>2007</b>	<b>2008</b>	<b>2009</b>
<b>Average Age:</b>			
Employees	45.9	45.3	45.8
Members	36.7	35.8	36.1
<b>Demographic Splits:</b>			
Employee Percentage Male	35.0%	34.9%	34.7%
Member to Employee Ratio	1.6	1.6	1.6
<b>% of Covered Members Who Are:</b>			
Adult Male	27.0%	26.8%	26.6%
Adult Female	46.7%	46.2%	45.9%
Children	26.3%	27.0%	27.4%

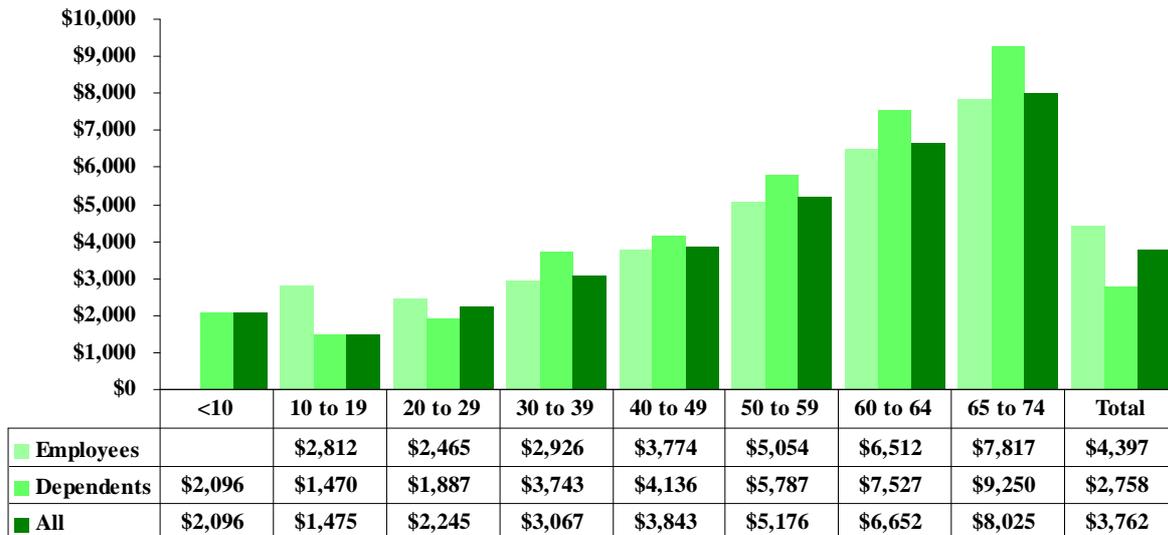
*Source: KEHP's enrollment data aggregated by Thomson Reuters.*

The average member age dropped from 36.7 in 2007 to 35.8 years in 2008. Consistent with the 2008 average employee age, there has been only a slight increase in average member age in the first half of 2009.

As shown in Exhibit XIII, the paid claims per dependent increases with dependent age. Dependents under age 30 represent 71% of total dependents enrolled in the plan and 46% of dependent costs. On the other hand, dependents 30 and older represent 29% of the total dependents and 54% 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 paid claims.

**Exhibit XIII**

**2008 Demographics—Employee and Dependent Member Medical Claims by Age**



2008 Member Counts									
Employees		120	16,012	26,535	34,318	52,052	22,785	2,666	154,488
Dependents	27,518	32,229	9,896	5,518	8,066	10,382	3,647	452	97,709
All	27,518	32,350	25,908	32,053	42,384	62,434	26,432	3,118	252,197

2008 Aggregate Paid Claims (\$ Millions)									
Employees		\$0.3	\$39.5	\$77.7	\$129.5	\$263.1	\$148.4	\$20.8	\$679.3
Dependents	\$57.7	\$47.4	\$18.7	\$20.7	\$33.4	\$60.1	\$27.5	\$4.2	\$269.5
All	\$57.7	\$47.7	\$58.2	\$98.3	\$162.9	\$323.2	\$175.8	\$25.0	\$948.8

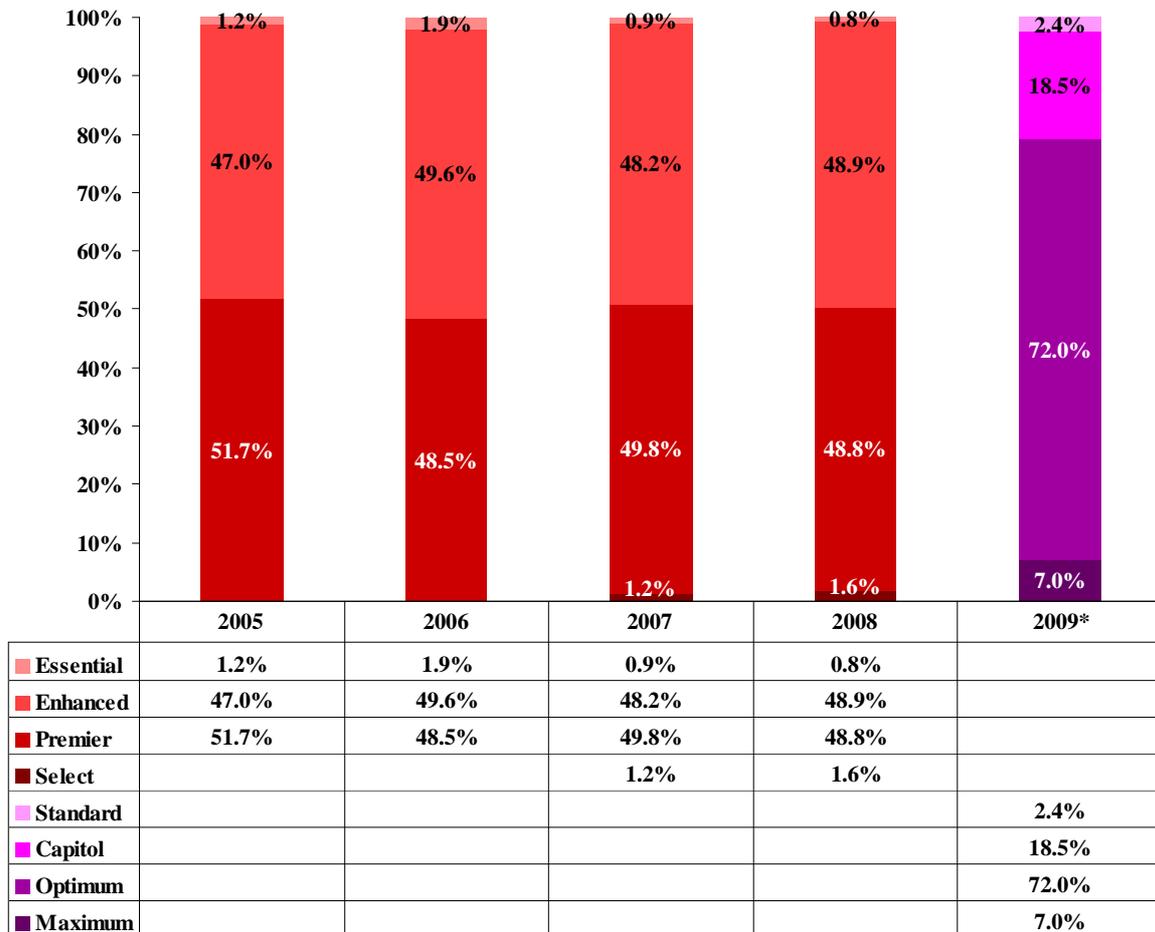
Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

## Enrollment by Plan Option

Exhibit XIV shows the KEHP enrollment by plan option from 2005 through the first six months of 2009. Enrollment between the plans remained relatively consistent from 2007 to 2008. For comparison purposes, the Standard plan introduced in 2009 is the replacement for the 2008 Essential plan, the 2009 Optimum plan is the replacement for the 2008 Enhanced and Premier plans, the 2009 Maximum Choice plan is replacement for the 2008 Select plan, and the Capitol Choice plan is a new option.

The DEI has focused on improving and expanding communication and education for KEHP members, and the open enrollment for the 2009 plan year required all members to actively select plan options. As seen below, enrollment in the consumer-directed Maximum Choice plan increased significantly in 2009 to 7.0%. The majority of members (72.0%) have elected the Optimum plan, which offers the lowest deductible and cost sharing provisions.

**Exhibit XIV**  
**2005 - 2009 Enrollment By Plan Option**

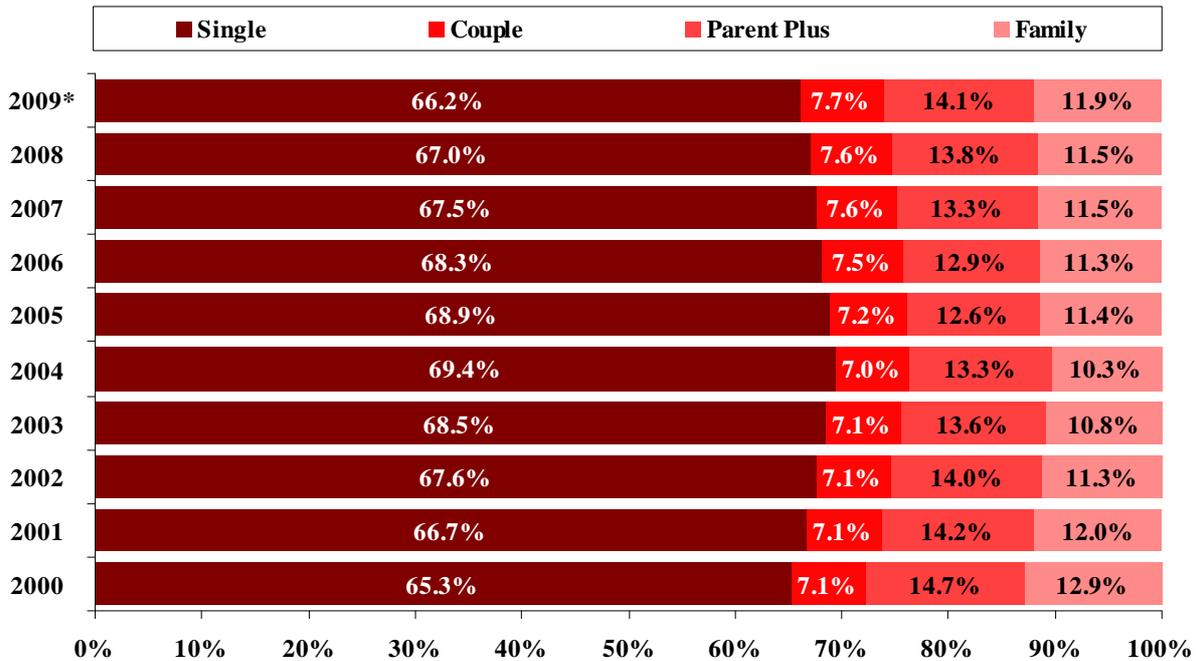


Source: KEHP's enrollment aggregated by Thomson Reuters.

\* January through June 2009 data only.

Exhibit XV shows the percentage of employees and non-Medicare eligible retirees enrolling in single coverage steadily declined from 2004 to 2009. The frozen employee contributions in 2006 may have contributed to the continued shift into dependent coverage tiers in 2007, 2008, and 2009.

**Exhibit XV**  
**2000 - 2009 Enrollment By Coverage Tier**



Source: KEHP's enrollment reported by the Department of Employee Insurance and aggregated by Thomson Reuters.  
 \* January through June 2009 data only.

**Group Composition**

The participating groups' composition changed very little from 2007 to 2009. In total (across all participating groups), there was a 3.1% increase in enrollment in 2008 and an increase of 2.2% in the first six months of 2009. The increase in actives from 2007 to 2008 was 2.6% compared to 3.2% for actives from 2006 to 2007. Retirees and their dependents represent 23.1% of KEHP membership in 2008, an increase of 5.1% from 2007. This increase in retiree membership has cost implications for the KEHP program as healthcare costs tend to increase with age.

**Exhibit XVI**

**Average Number of Covered Members By Group**

	Average KEHP Members by Group (Includes Dependents)								
	2007			2008			2009 (6 Months)		
	Average Lives	% of Total	% Change	Average Lives	% of Total	% Change	Average Lives	% of Total	% Change
<b>By Covered Group</b>									
State Employees	53,110	21.7%	0.6%	53,705	21.3%	1.1%	52,154	20.2%	-2.9%
School Boards	120,625	49.3%	4.0%	124,029	49.2%	2.8%	126,952	49.3%	2.4%
Health Departments	4,221	1.7%	4.4%	4,434	1.8%	5.0%	4,492	1.7%	1.3%
KRS	35,655	14.6%	7.1%	38,444	15.2%	7.8%	42,292	16.4%	10.0%
KTRS	19,590	8.0%	1.1%	19,694	7.8%	0.5%	19,987	7.8%	1.5%
KCTCS	5,205	2.1%	4.9%	5,387	2.1%	3.5%	5,457	2.1%	1.3%
Quasi/Local Govt	5,500	2.2%	9.3%	5,946	2.4%	8.1%	5,996	2.3%	0.8%
COBRA	557	0.2%	15.8%	505	0.2%	-9.3%	393	0.2%	-22.2%
<b>Sub-total</b>	<b>244,463</b>		<b>3.6%</b>	<b>252,143</b>		<b>3.1%</b>	<b>257,722</b>		<b>2.2%</b>
Unknown/Missing	118			53			35		
<b>Grand Total</b>	<b>244,581</b>		<b>3.6%</b>	<b>252,197</b>		<b>3.1%</b>	<b>257,757</b>		<b>2.2%</b>
<b>By Covered Status</b>									
Actives	188,681	77.1%	3.2%	193,529	76.7%	2.6%	195,085	75.7%	0.8%
Retirees	55,343	22.6%	5.1%	58,179	23.1%	5.1%	62,279	24.2%	7.0%
COBRA	557	0.2%	15.8%	488	0.2%	-12.4%	393	0.2%	-19.5%
<b>Grand Total</b>	<b>244,581</b>		<b>3.7%</b>	<b>252,197</b>		<b>3.1%</b>	<b>257,757</b>		<b>2.2%</b>
Unknown/Missing	0			0			0		
<b>Grand Total</b>	<b>244,581</b>		<b>3.6%</b>	<b>252,197</b>		<b>3.1%</b>	<b>257,757</b>		<b>2.2%</b>

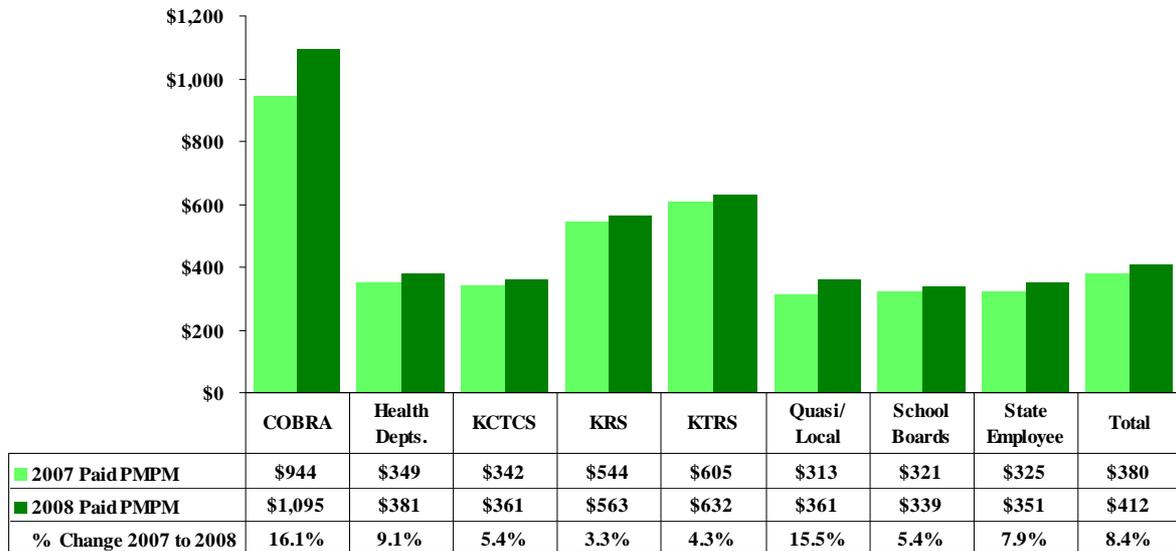
Source: KEHP's enrollment data aggregated by Thomson Reuters.

Exhibits XVII, XVIII, and XIX illustrate the per member per month costs for medical plus pharmacy, medical only, and pharmacy only, respectively, for the participating groups in 2007 and 2008. As expected, the PMPM cost for KRS of \$563 and for KTRS of \$632 are the highest among all the groups (the two groups consisting of retirees). The Quasi/Local and Health Department groups had the largest increase in medical and pharmacy cost in 2008, 15.5% and 9.1% respectively.

The School Boards is the largest group and represented 49.2% of the population in 2008. They also have the lowest PMPM among all groups, at \$339 in 2008.

**Exhibit XVII**

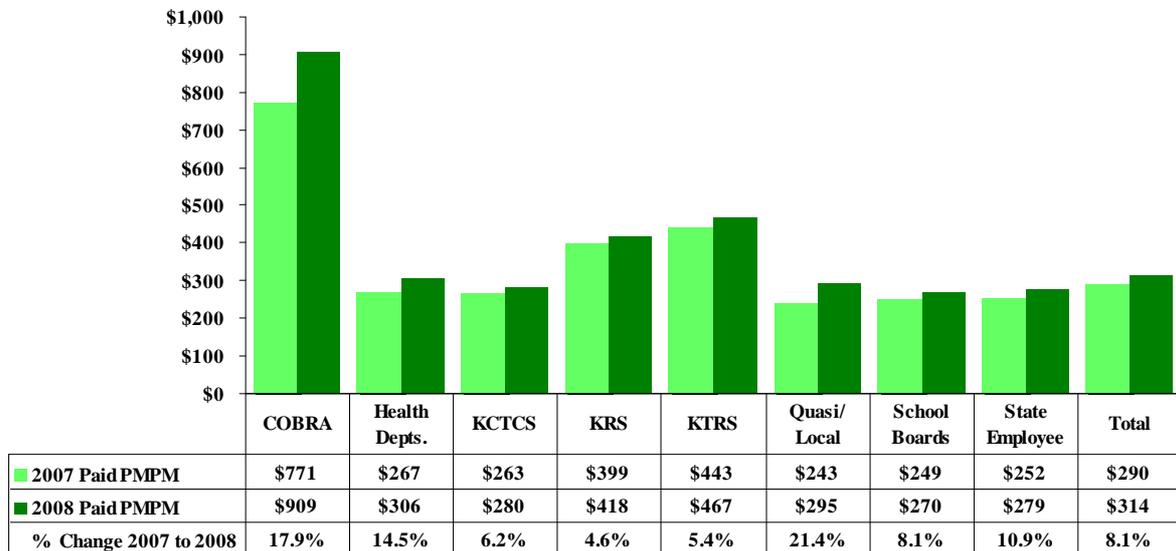
**Medical and Pharmacy Claims Paid Per Member Per Month—Participating Groups**



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

**Exhibit XVIII**

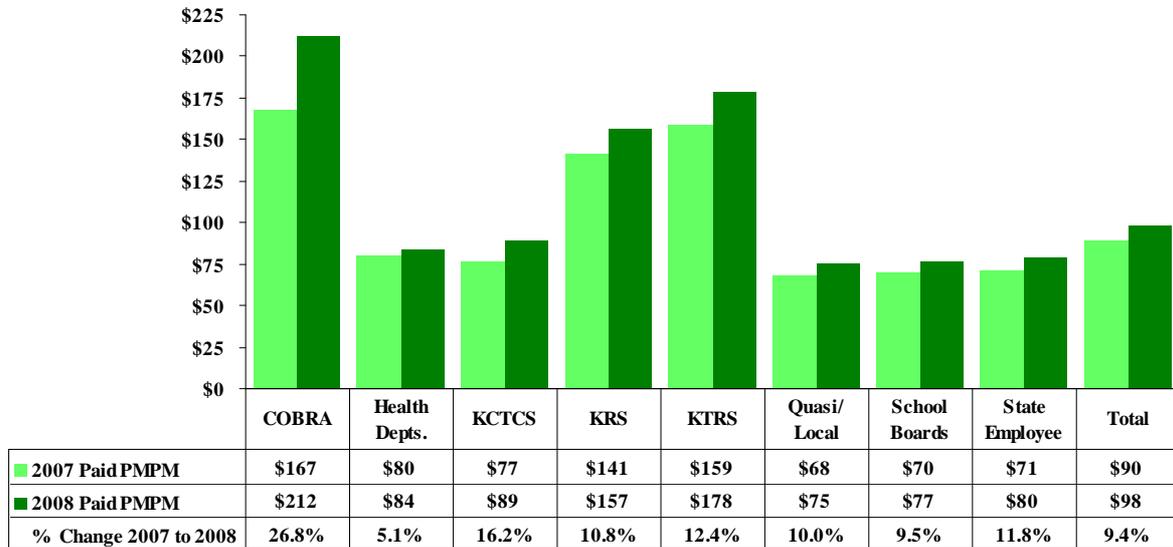
**Medical Claims Paid Per Member Per Month—Participating Groups**



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

**Exhibit XIX**

**Pharmacy Claims Paid Per Member Per Month—Participating Groups**

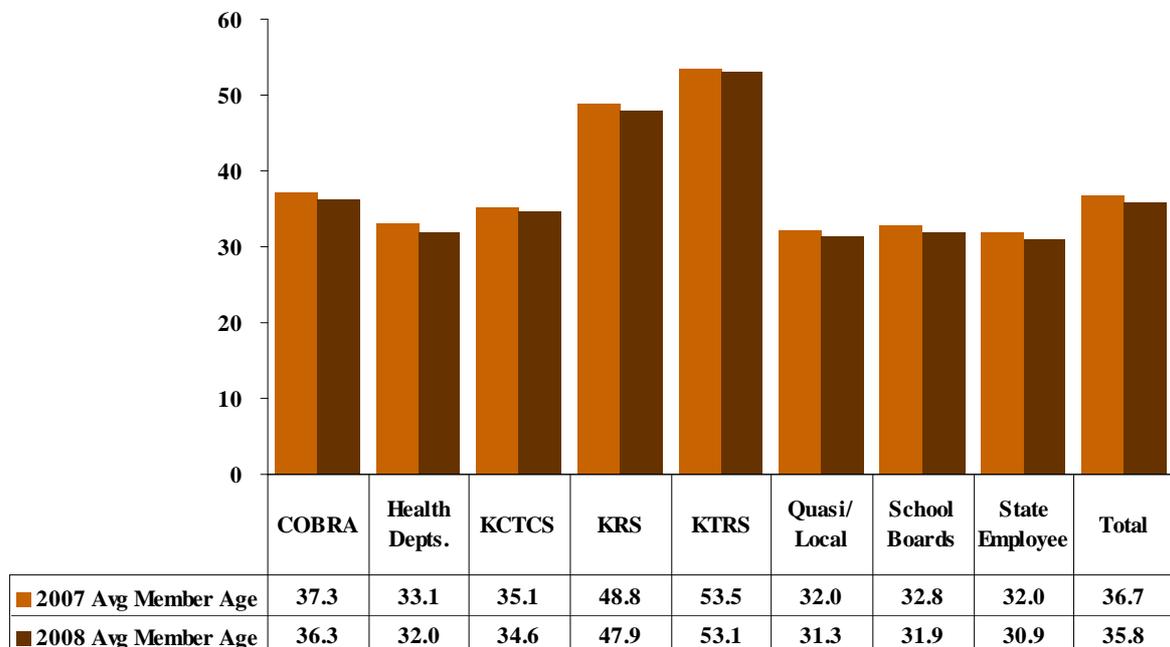


Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

Exhibit XX provides the average ages of the members in 2007 and 2008 for each covered group.

**Exhibit XX**

**2007 and 2008 Average Member Age—By Group**



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

## **Review of KEHP Use of Services**

### **Key Findings & Considerations**

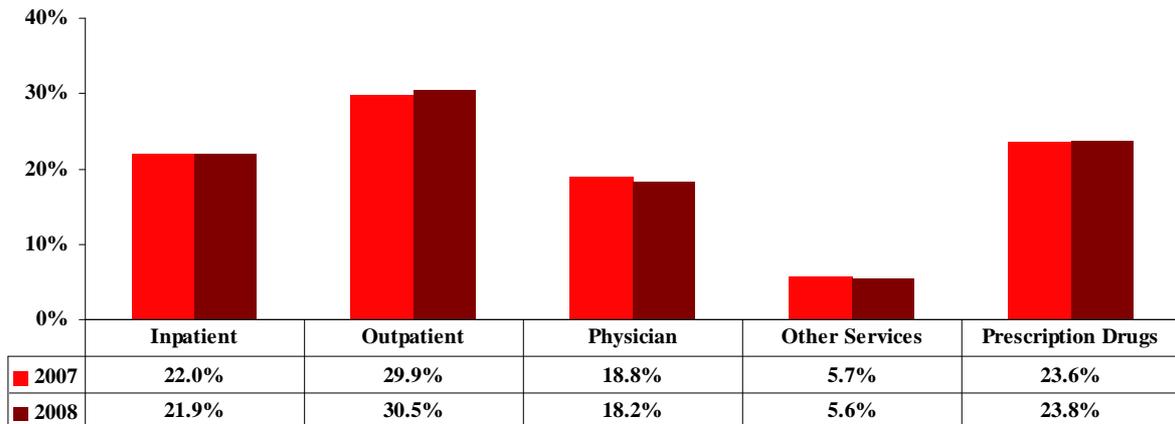
- KEHP's distribution of claims by "place of service" (inpatient, outpatient, physician, other services, and pharmacy) remained relatively consistent from 2007 to 2008.
- Claims costs in all places of service are growing at a lower rate in 2008 than 2007, with the exception of prescription drugs and a very slight difference in inpatient hospital claims.
- 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. 30% of all claims are outpatient. Further, these services increased at the highest rate from 2007 to 2008. Outpatient services claims increased by 10.6% compared to 7.9% for inpatient, 9.6% for pharmacy, and 5.0% 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 has been consistent since 2004.
- Slightly more than 39% of members who had claims in 2008 incurred less than \$1,000 in net payments. Conversely, 22% of the members with claims consumed close to 81% of net payments. This is a common distribution across health plans.

### **Utilization By Place of Service**

Exhibit XXI shows the KEHP paid claims distribution by place of service. 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 XXI**

**Paid Claims Distribution by Place of Service**

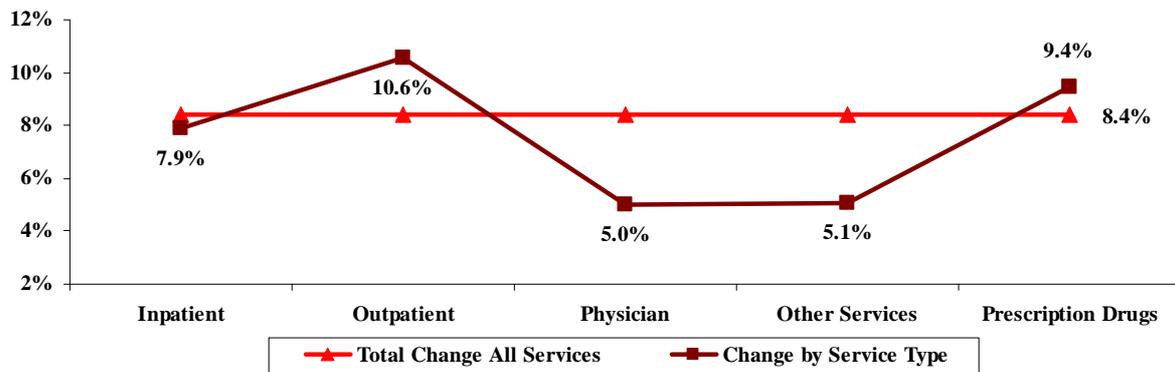


Source: KEHP's claims data aggregated by Thomson Reuters

Exhibit XXII shows the change in KEHP claims cost by place of service from 2007 to 2008. Outpatient hospital, the largest component of the KEHP's claims increased by 10.6% from 2007 to 2008. This is a much higher increase than inpatient hospital, physician, and pharmacy. Outpatient spending has increased throughout the industry, a result of technological advances that allow procedures to be done in outpatient settings, patients wanting to avoid inpatient hospital stays, as well as hospitals establishing and marketing their own outpatient facilities.

**Exhibit XXII**

**Change in KEHP Per Member Per Month (PMPM) Paid Claims 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 increased utilization, increased cost for services, and continued shifting of services from inpatient to outpatient facilities.

**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 2008: 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 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**

2007 Paid Claims Distribution			2008 Paid Claims Distribution		
Major Diagnostic Category	KEHP Medical Paid Claims	Patients	Major Diagnostic Category	KEHP Medical Paid Claims	Patients
Musculoskeletal	\$132,895,554	94,467	Musculoskeletal	\$154,307,241	100,225
Circulatory	\$114,508,774	71,837	Circulatory	\$123,044,443	75,394
Digestive	\$85,105,348	55,863	Digestive	\$96,576,041	58,603
Health Status	\$63,045,207	155,673	Health Status	\$73,114,293	163,778
Skin, Breast	\$52,387,494	85,304	Skin, Breast	\$55,320,969	89,710
Nervous	\$45,950,077	36,372	Nervous	\$51,955,899	37,852
<b>Total</b>	<b>\$851,491,315</b>	<b>947,385</b>	<b>Total</b>	<b>\$948,789,918</b>	<b>1,002,113</b>
<b>Top 6 as % of Total</b>	<b>58%</b>		<b>Top 6 as % of Total</b>	<b>58%</b>	

Source: KEHP's claims data aggregated by Thomson Reuters

The clinical conditions that are grouped into the top three MDCs are included in Exhibit XXIV. Similar to last year, Gastrointestinal Disorder, Coronary Artery Diseases, and Osteoarthritis are the top conditions associated with the highest cost MDCs.

*Exhibit XXIV*

**Clinical Conditions by Major Diagnostic Categories (MDC)**

<b>2008 Paid Claims Distribution</b>			
<b>Major Diagnostic Category</b>	<b>Clinical Condition</b>	<b>KEHP Medical Paid Claims</b>	<b>Patients</b>
<b>Musculoskeletal</b>	<b>Osteoarthritis</b>	<b>\$34,893,717</b>	<b>21,848</b>
	<b>Spinal/Back Disord, Low Back</b>	<b>\$27,073,921</b>	<b>31,898</b>
	<b>Arthropathies/Joint Disord NEC</b>	<b>\$26,548,702</b>	<b>52,529</b>
	<b>Spinal/Back Disord, Ex Low</b>	<b>\$14,758,574</b>	<b>22,614</b>
	<b>Fracture/Disloc - Upper Extrem</b>	<b>\$9,767,035</b>	<b>7,807</b>
	<b>Injury - Knee</b>	<b>\$7,266,804</b>	<b>4,647</b>
	<b>Bursitis</b>	<b>\$4,390,618</b>	<b>9,801</b>
	<b>Musculosk Disord, Congenital</b>	<b>\$4,279,153</b>	<b>2,205</b>
	<b>Fracture/Disloc - Ankle/Foot</b>	<b>\$4,112,910</b>	<b>6,179</b>
	<b>Rheumatoid Arthritis</b>	<b>\$3,116,945</b>	<b>1,629</b>
	<b>Total</b>	<b>\$154,307,241</b>	
	<b>As a % of Total Cost/Patients</b>	<b>16%</b>	

<b>2008 Paid Claims Distribution</b>			
<b>Major Diagnostic Category</b>	<b>Clinical Condition</b>	<b>KEHP Medical Paid Claims</b>	<b>Patients</b>
<b>Circulatory</b>	<b>Coronary Artery Disease</b>	<b>\$38,837,027</b>	<b>8,976</b>
	<b>Respiratory Disord, NEC</b>	<b>\$17,804,454</b>	<b>18,074</b>
	<b>Cardiovasc Disord, NEC</b>	<b>\$16,030,951</b>	<b>16,126</b>
	<b>Cardiac Arrhythmias</b>	<b>\$10,083,781</b>	<b>5,952</b>
	<b>Hypertension, Essential</b>	<b>\$9,918,023</b>	<b>48,824</b>
	<b>Signs/Symptoms/Oth Cond, NEC</b>	<b>\$5,208,382</b>	<b>4,865</b>
	<b>Rheumatic Fever/Valvular Dis</b>	<b>\$4,048,552</b>	<b>3,583</b>
	<b>Congestive Heart Failure</b>	<b>\$3,916,534</b>	<b>1,282</b>
	<b>Vascular Disorders, Arterial</b>	<b>\$3,865,460</b>	<b>2,040</b>
	<b>Condition Rel to Tx - Med/Surg</b>	<b>\$3,482,341</b>	<b>463</b>
	<b>Total</b>	<b>\$123,044,443</b>	
	<b>As a % of Total Cost</b>	<b>13%</b>	

<b>2008 Paid Claims Distribution</b>			
<b>Major Diagnostic Category</b>	<b>Clinical Condition</b>	<b>KEHP Medical Paid Claims</b>	<b>Patients</b>
<b>Digestive</b>	<b>Gastroint Disord, NEC</b>	<b>\$36,919,876</b>	<b>37,815</b>
	<b>Hernia/Reflux Esophagitis</b>	<b>\$11,347,412</b>	<b>13,167</b>
	<b>Cancer - Colon</b>	<b>\$8,918,885</b>	<b>515</b>
	<b>Tumors - Gastroint, Benign</b>	<b>\$7,377,792</b>	<b>6,698</b>
	<b>Gastritis/Gastroenteritis</b>	<b>\$6,280,011</b>	<b>12,020</b>
	<b>Diverticular Disease</b>	<b>\$4,476,276</b>	<b>3,087</b>
	<b>Appendicitis</b>	<b>\$3,792,499</b>	<b>466</b>
	<b>Functional Digest Disord, NEC</b>	<b>\$3,177,308</b>	<b>7,713</b>
	<b>Crohns Disease</b>	<b>\$2,802,216</b>	<b>694</b>
	<b>Cancer - Gastroint Ex Colon</b>	<b>\$2,050,537</b>	<b>128</b>
	<b>Total</b>	<b>\$96,576,041</b>	
	<b>As a % of Total Cost</b>	<b>10%</b>	

Source: KEHP's claims data aggregated by Thomson Reuters

The high relative cost of Musculoskeletal, Circulatory, and Digestive MDCs suggest that care management and managed pharmacy programs related to these diagnoses should continue to be encouraged. For example, targeted low back pain, heart disease, and reflux 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 2008, slightly more than 39% of members had net paid claims of less than \$1,000. This percentage has decreased largely due to health care cost increases from year to year. 22% of individuals who had claims during the year were high or very high users, accounting for 81% of claims costs. As shown in the exhibit below, the KEHP experience is consistent with benchmark paid claims distributions among health plans.

#### *Exhibit XXV*

#### 2008 Utilization by User-Type

		2008 Paid Claims Distribution			
		Low Users	Medium Users	High Users	Very High Users
		\$0 - \$1,000	\$1,000 - \$5,000	\$5,000 - \$100,000	>\$100,000
<b>2008 Paid Claims Benchmarks</b>	% Members	38.5%	32.5%	28.6%	0.4%
<b>KEHP</b>	% Members	39.1%	38.5%	22.1%	0.3%
<b>2008 Net Payments</b>	% Payments	2.9%	16.0%	64.6%	16.4%
<b>Difference</b>	% Members	0.6%	5.9%	(6.4%)	(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**

- The non-Medicare eligible retiree population had average preventive screening rates around 50% for all adult preventive screens, with the possible exception of colon cancer. When compared to the active population, early retirees achieved higher screening rates for all adult screens, aside from cervical cancer.
- Improvements in preventive care screening utilization are especially needed in the categories of colon cancer, cholesterol, and well child screenings.
- In 2008, 95,441 members, or 38% 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. At the end of 2008, over 15% of the total KEHP population was engaged in the program at some level and throughout the year, up from 10% in 2007.
- 4% of KEHP members were actively engaged with a nurse in 2008, compared to 2.7% during the prior year. The data demonstrates significant improvements in various clinical indicators for those members who were involved in active nurse engagement.

### **Preventive Care Screenings**

"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.

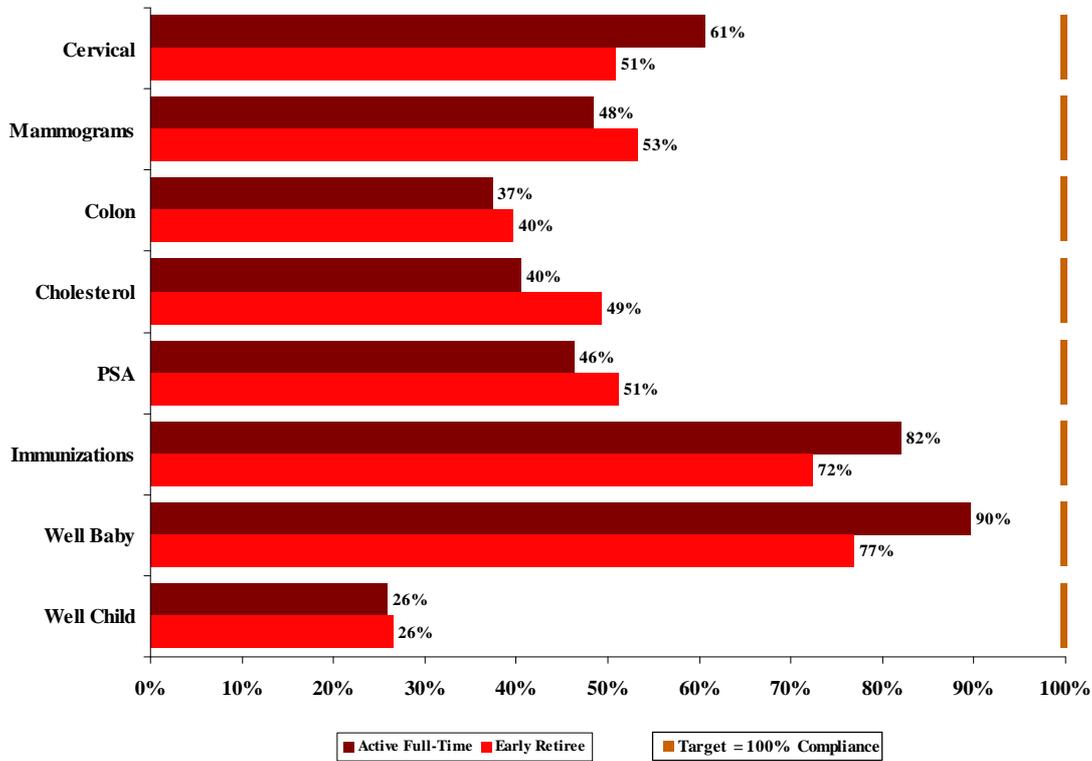
In Exhibit XXVI, the preventive care screening rates for the KEHP members in 2008 are shown for active members and for non-Medicare eligible retirees. Exhibit XXVII provides a more detailed comparison of screening rates for active employees only, other covered members, and in total. Due to data limitations, three-year colon cancer screening rates were extrapolated based on two and a half years of data, thus the results shown may be slightly understated. Mammogram and cholesterol screenings were assessed based on a target frequency of once a year for all age groups, and thus may be slightly understated as well.

The KEHP non-Medicare eligible retiree population achieved higher screening rates for all adult preventive measures, with the exception of cervical cancer screens, when compared to actives. For early retirees, the screening rates averaged around 50% for all adult screens besides colon cancer. The targeted active population had a 61% screening rate for cervical cancer, while all other adult preventive measures fell under 50%. When comparing targeted employees versus other targeted covered members, employees utilized the screening measures slightly more than spouses, partners, and dependents.

Improvements in preventive care screenings are especially needed in the categories of colon cancer, cholesterol, and well child screenings. The DEI may want to consider plan design changes which would encourage its membership to have such screenings.

**Exhibit XXVI**

**2008 Preventive Care Screening Utilization**



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

**Exhibit XXVII**

**2008 Preventive Care Screenings - Utilization and Targets**

Preventive Screening	Target Group	Target Frequency (100% Goal)	Active Full-Time			Early Retiree		
			Employees	Spouses / Dependents	All Members	Employees	Spouses / Dependents	All Members
Cervical	Women Aged 21 to 64	Every 2 Years	61%	60%	61%	51%	50%	51%
Mammograms	Women Aged 40 to 49	Every 2 Years	49%	46%	48%	54%	48%	53%
	Women Aged 50+	Every Year						
Colon Cancer	All Aged 50 to 80	Every 3 Years	39%	32%	37%	40%	36%	40%
Cholesterol	Women 45-49, Men 35-49	Every 2 Years	41%	39%	40%	50%	45%	49%
	Women and Men 50+	Every Year						
Prostate	Men Aged 50 to 70	Every 2 Years	47%	45%	46%	52%	47%	51%
Immunizations	All Aged 0 to 2	Once	N/A	82%	82%	N/A	72%	72%
Well Baby	All Aged 0 to 2	Ongoing	N/A	90%	90%	N/A	77%	77%
Well Child	All Aged 3 to 6	Every Year	N/A	26%	26%	N/A	26%	26%

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

## **Disease Management and Care Management**

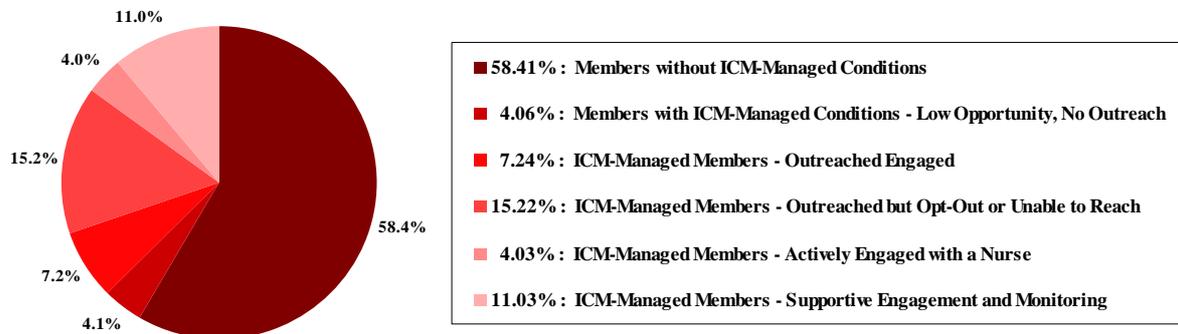
The KEHP includes disease and care management programs managed by ActiveHealth Management and Humana. The Informed Care Management (ICM) program provides disease management to members who have one or more of over 30 identified chronic conditions. In 2008, 105,777 KEHP members had at least one of the identified conditions and 95,441 (38% of all members, and 90% of members with at least one of the identified conditions) were targeted for outreach. Through continuing efforts to increase the accuracy of phone numbers and contact information as well as focusing on the particular clinical conditions that were driving plan cost, the ICM program was able to increase its outreach by nearly 16% from 2007 to 2008. At the end of 2008, over 15% of the total KEHP population was engaged in the program at some level and throughout the year, up from 10% in 2007.

As part of the ICM program, Care Considerations (CC) is a program which relays confidential communication to the member / and or physician regarding important clinical information that is identified for the patient, and directed at improving health outcomes. Over 57,000 care considerations were sent in 2008, resulting in slightly more than \$6 PMPM in savings as reported by ActiveHealth Management.

In addition to improving outreach and contact with members, significant changes were made in 2007 to also improve active engagement in the ICM program. Improvement has continued in 2008, with 4.0% of the population being actively engaged with a nurse, compared to 2.7% in 2007. 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 or unable to reach: those who have received outreach information but have chosen to not participate in the program, or those who could not be reached
- 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 XXVIII**  
**ICM Engagement Summary**



Source: KEHP's participation data reported by ActiveHealth Management as of December 31, 2008

A closer look at those members who were actively engaged with a nurse shows that substantial improvements in key clinical indicators were observed compared to members who only received care considerations or educational mailings. Improvements were seen for members who received care considerations and mailings, albeit not as significant. Exhibit XXIX compares the pre-nurse engagement values to results after the program for some key clinical indicators.

**Exhibit XXIX**  
**Clinical Indicators**

Clinical Indicator	Active Nurse Engagement		Low-Intensity Engagement / Educational Materials	
	Pre-Engagement	Current Compliance	Pre-Engagement	Current Compliance
<b>Vascular</b>				
Met LDL Cholesterol Target for Vascular Condition or Improved by	62%	91%	73%	79%
<b>Diabetes</b>				
HbA1C Under 7% or Improved by 1	61%	70%	46%	55%
<b>Hypercholesterolemia</b>				
Appropriate Use of Lipid-Lowering	75%	83%	61%	59%

Source: ActiveHealth Management's Annual Review Report for KEHP, 2008

The top conditions being addressed by the ICM program are hypertension, high cholesterol, diabetes, and obesity, similar to the top conditions in 2007. The largest percentage of Care Considerations sent to members in 2008 was related to diabetes. This is evidence that the program is focusing on the priorities and relevant health conditions pertaining to the KEHP population.

In addition, members continue to enroll in the Why Weight Kentucky program, also managed through Active Health. There were 582 new enrollees in 2008, bringing the total number of members enrolled to 1,419 since the program was introduced in August 2006. As of December 31, 2008, the average weight loss was 16.3 pounds for those members who lost weight.

### 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 XXX.

### Exhibit XXX

#### 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 XXXI 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 XXXI**

**2008 Chronic Disease States PMPM versus KEHP Aggregate PMPM**

<b>Disease State</b>	<b>2008 PMPM Allowed Charges</b>	<b>2008 Disease State vs 2008 Aggregate Allowed Charges</b>
<b>KEHP Aggregate</b>	\$463.82	N/A
<b>Asthma Moderate</b>	\$919.20	98.2%
<b>Asthma Severe</b>	\$2,036.23	339.0%
<b>Diabetes Low</b>	\$1,216.08	162.2%
<b>Diabetes Moderate</b>	\$1,709.30	268.5%
<b>Diabetes Severe</b>	\$3,297.01	610.8%
<b>HBP</b>	\$905.39	95.2%
<b>Depression</b>	\$1,031.63	122.4%
<b>Bariatric</b>	\$1,596.87	244.3%
<b>Low Back</b>	\$1,011.54	118.1%
<b>GERD</b>	\$1,293.04	178.8%
<b>High Cholesterol</b>	\$750.01	61.7%
<b>Weight Management</b>	\$1,621.47	249.6%
<b>Coronary Artery Disease</b>	\$2,020.07	335.5%

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

Based on PwC disease state financial models and the average cost of members within each disease state, there is the potential for significant savings from the management of care for 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.

**KEHP Pharmacy Benefits Detailed Experience**

**Key Findings & Considerations**

- Allowed charges for prescription drugs increased 9.8% from 2006 to 2007 and 10.7% from 2007 to 2008. The 2008 trend rate for the KEHP's portion of the cost in total is 12.9% due to member cost sharing declining by 14.0%.
- Scripts per employee per year grew at a very low rate, increasing by only 0.1% from 2007 to 2008 versus 4.2% from 2006 to 2007. The 2008 average number of scripts per member per year was 20.3.
- Consistent with industry trends, the number of brand scripts utilized continued to decline while generics continued to increase.
- 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.

A summary of year over year trends for the KEHP's pharmacy claims experience is illustrated in Exhibits XXXII and XXXIII.

As shown in Exhibit XXXII, the total allowed charges for prescription drugs increased 9.8% in 2007 and 10.7% in 2008. Member cost sharing continues to decline, decreasing by 14% from 2007 to 2008.

The observed 2008 trend rate for the KEHP's portion of the pharmacy cost in total is 12.9% versus the overall 2008 trend on pharmacy allowed charges of 10.7%. 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 XXXII***

#### **Key Pharmacy Benefits Aggregate Cost Statistics**

	2006	2007	2008	2007 vs. 2006	2008 vs. 2007
<b>Total Eligible Members</b>	236,038	244,581	252,197	3.6%	3.1%
<b>Total Allowed Charges</b>	\$273,147,067	\$300,003,516	\$332,107,712	9.8%	10.7%
<b>Total Net Paid Claims</b>	\$236,146,421	\$263,263,348	\$297,099,706	11.5%	12.9%

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

### ***Exhibit XXXIII***

#### **Key Pharmacy Benefits Cost Per Claim and Cost Share Statistics**

	2006	2007	2008	2007 vs. 2006	2008 vs. 2007
<b>Total Copayment per Claim</b>	\$9.71	\$9.11	\$8.36	(6.3%)	(8.2%)
<b>Retail Copayment per Claim</b>	\$9.42	\$8.82	\$8.06	(6.3%)	(8.7%)
<b>Mail Copayment per Claim</b>	\$24.33	\$22.57	\$20.75	(7.2%)	(8.1%)
<b>Total Member Cost Share</b>	15.9%	14.6%	12.6%	(7.7%)	(14.0%)
<b>Retail Member Cost Share</b>	15.9%	14.7%	12.6%	(7.8%)	(14.1%)
<b>Mail Member Cost Share</b>	14.7%	13.8%	12.1%	(5.9%)	(12.1%)
<b>Plan Cost:</b>					
<b>Per Member Per Year (PMP)</b>	\$1,000.46	\$1,076.39	\$1,178.05	7.6%	9.4%
<b>PMPM</b>	\$83.37	\$89.70	\$98.17	7.6%	9.4%
<b>Per Claim</b>	\$51.34	\$52.99	\$57.92	3.2%	9.3%

The number of scripts per member per year was 19.5 in 2006, 20.3 in 2007, and again 20.3 in 2008. The generic dispensing rate continued to increase from 55.5% in 2006 to 59.9% in 2007 to 63.5% in 2008, consistent with the total number of generic scripts increasing and brand scripts decreasing.

**Exhibit XXXIV**  
**Key Pharmacy Utilization Statistics**

	2006	2007	2008	2007 vs. 2006	2008 vs. 2007
<b>Scripts PMPY</b>	<b>19.5</b>	<b>20.3</b>	<b>20.3</b>	<b>4.2%</b>	<b>0.1%</b>
<b>Total Scripts</b>	<b>4,599,904</b>	<b>4,967,740</b>	<b>5,129,169</b>	<b>8.0%</b>	<b>3.2%</b>
Retail Scripts	4,508,038	4,864,480	5,006,866	7.9%	2.9%
Mail Order Scripts	91,866	103,260	122,303	12.4%	18.4%
Brand Scripts	2,048,578	1,992,613	1,874,419	(2.7%)	(5.9%)
Generic Scripts	2,551,326	2,975,127	3,254,750	16.6%	9.4%
<b>Generic Utilization:</b>					
Generic Dispensing Rate	55.5%	59.9%	63.5%	8.0%	6.0%
Generic Substitution Rate	90.6%	89.6%	89.0%	(1.2%)	(0.6%)
<b>Mail Order Utilization</b>	<b>2.0%</b>	<b>2.1%</b>	<b>2.4%</b>	<b>4.1%</b>	<b>14.7%</b>
<b>Days Supply:</b>					
Days Supply Total	130,069,819	141,607,810	147,961,701	8.9%	4.5%
Days Supply per Claim	28.3	28.5	28.8	0.8%	1.2%

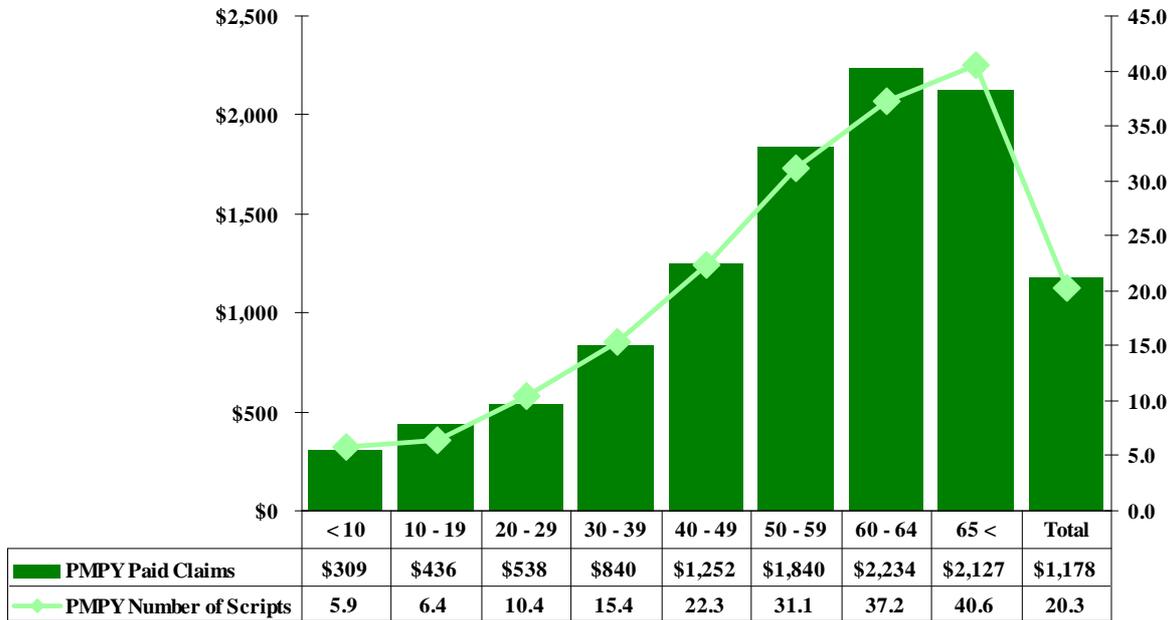
Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

**Demographic Impact on Pharmacy Experience**

In 2008, the KEHP average member age was 35.8. For that age, there was an average of 15.4 scripts and \$840 in prescription claims paid during the year. These are both up from 2007, where the number of prescriptions was 14.8 and the claims paid were \$738. Exhibit XXXV 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 XXXV**

**2008 Distribution of Pharmacy Claims and Number of Prescriptions, PMPY by Age**



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

**Prescription 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.

As the employee cost share per drug has remained relatively stable over the past few years and pharmacy costs have continued to escalate, this demonstrates again that KEHP is absorbing more and more of the pharmacy cost increase.

**Exhibit XXXVI**  
**Top 10 Drugs**

2006						
Product Name	Category	Rank	Net Pay (Total)	Scripts Rx	Net Pay (Per Script)	Employee Cost Share
Nexium	GERD	1	\$3,617,827	23,108	\$156.56	\$15.13
Singulair	Asthma/Allergies	3	\$2,694,171	29,991	\$89.83	\$14.87
Crestor	Cholesterol	7	\$1,993,638	24,618	\$80.98	\$15.11
Enbrel	Rheumatoid Arthritis	4	\$2,540,676	1,384	\$1,835.75	\$16.22
Prevacid	GERD	5	\$2,454,644	14,904	\$164.70	\$15.04
Effexor-XR	Depression/Anxiety	6	\$2,191,285	16,994	\$128.94	\$14.81
Topamax	Anticonvulsant	9	\$1,812,616	8,008	\$226.35	\$14.31
Plavix	Cirulatory	43	\$642,976	5,133	\$125.26	\$14.46
Humira	Rheumatoid Arthritis	23	\$1,030,788	593	\$1,738.26	\$15.88
Cymbalta	Depression/Anxiety	19	\$1,081,531	9,054	\$119.45	\$14.16

2007						
Product Name	Category	Rank	Net Pay (Total)	Scripts Rx	Net Pay (Per Script)	Employee Cost Share
Nexium	GERD	1	\$7,958,521	47,791	\$166.53	\$15.61
Singulair	Asthma/Allergies	2	\$6,264,901	65,809	\$95.20	\$15.21
Crestor	Cholesterol	5	\$4,807,897	54,221	\$88.67	\$15.62
Enbrel	Rheumatoid Arthritis	3	\$5,094,825	2,610	\$1,952.04	\$16.23
Prevacid	GERD	4	\$5,034,685	29,351	\$171.53	\$15.44
Effexor-XR	Depression/Anxiety	6	\$4,743,696	33,987	\$139.57	\$15.14
Topamax	Anticonvulsant	8	\$4,282,039	17,702	\$241.90	\$14.87
Plavix	Cirulatory	10	\$3,512,932	27,456	\$127.95	\$15.08
Humira	Rheumatoid Arthritis	11	\$3,251,915	1,687	\$1,927.63	\$16.27
Cymbalta	Depression/Anxiety	12	\$3,237,154	24,721	\$130.95	\$14.79

2008						
Product Name	Category	Rank	Net Pay (Total)	Scripts Rx	Net Pay (Per Script)	Employee Cost Share
Nexium	GERD	1	\$9,103,219	49,456	\$184.07	\$15.69
Singulair	Asthma/Allergies	2	\$6,733,268	64,922	\$103.71	\$15.36
Crestor	Cholesterol	3	\$5,775,215	56,957	\$101.40	\$15.82
Enbrel	Rheumatoid Arthritis	4	\$5,545,068	2,742	\$2,022.27	\$16.18
Prevacid	GERD	5	\$5,459,499	28,802	\$189.55	\$15.51
Effexor-XR	Depression/Anxiety	6	\$5,454,207	34,756	\$156.93	\$15.35
Topamax	Anticonvulsant	7	\$5,413,667	19,686	\$275.00	\$15.03
Plavix	Cirulatory	8	\$4,666,509	32,697	\$142.72	\$15.31
Humira	Rheumatoid Arthritis	9	\$4,458,923	2,115	\$2,108.24	\$16.61
Cymbalta	Depression/Anxiety	10	\$4,454,644	30,076	\$148.11	\$14.84

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 XXXVII). Use of brand single source drugs is on the decline, and the use of generics is increasing.

**Exhibit XXXVII**

**Prescription Drug Utilization Detail by Drug Classification**

	Average Scripts Per Member Per Year		
	2007	2008	% Change
<b>Retail and Mail Order</b>			
Brand Single Source	6.7	5.8	(13.2%)
Brand Multi Source	1.4	1.6	12.1%
Total Brand	8.1	7.4	(8.8%)
Generic	12.2	12.9	6.1%
<b>Total All</b>	<b>20.3</b>	<b>20.3</b>	<b>0.1%</b>
<b>Retail</b>			
Brand Single Source	6.5	5.7	(13.5%)
Brand Multi Source	1.4	1.5	11.7%
Total Brand	7.9	7.2	(9.1%)
Generic	12.0	12.6	5.7%
<b>Total Retail</b>	<b>19.9</b>	<b>19.9</b>	<b>(0.2%)</b>
<b>Mail Order</b>			
Brand Single Source	0.2	0.2	(2.7%)
Brand Multi Source	0.0	0.0	33.5%
Total Brand	0.2	0.2	2.2%
Generic	0.2	0.3	27.5%
<b>Total Mail Order</b>	<b>0.4</b>	<b>0.5</b>	<b>14.9%</b>

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 XXXVIII).

**Exhibit XXXVIII**

**Five-Year Schedule of Prescription Drugs Losing Patent Protection**

<b>Year</b>	<b>Brand Name</b>	<b>Manufacturer</b>	<b>Use</b>
2009	Adderall XR	Shire Pharmaceuticals	ADHD
	Ambien CR	Sanofi-Aventis	Sleep Disorders
	Casodex	AstraZeneca	Prostate Cancer
	Depakote ER	Abbott Laboratories	Seizure Disorders
	Prevacid	TAP Pharmaceuticals Inc.	Acid Reflux Disease
	Topamax	Ortho-McNeil	Depression
	Valtrex	GlaxoSmithKline	Genital Herpes
2010	Aricept	Pfizer	Alzheimer's
	Arimidex	AstraZeneca	Breast Cancer
	Astelin	MedPointe Pharmaceuticals	Seasonal Allergies
	Cozaar/Hyzaar	GlaxoSmithKline	High blood pressure
	Effexor	Wyeth Pharmaceuticals	Depression
	Mirapex	Boehringer-Ingelheim	Parkinson's Disease
	Sanctura	Odyssey/Indevus	Overactive Bladder
2011	Actos	Takeda Pharmaceuticals	Type 2 diabetes
	Advair	GlaxoSmithKline	Asthma
	Caduet	Pfizer	Cholesterol Lowering
	Levaquin	Ortho-McNeil	Pneumonia/Bronchitis
	Lipitor®	Pfizer	Cholesterol Lowering
	Patanol	Alcon Laboratories Inc.	Antihistamine
	Xalatan	Pfizer	Glaucoma
	Zyprexa	Eli, Lilly and Company	Dementia
2012	Avandia	GlaxoSmithKline	Type 2 diabetes
	Avapro	Sanofi-Aventis	High blood pressure
	Detrol LA	Pfizer	Overactive Bladder
	Diovan HCT	Novartis	High blood pressure
	Geodon	Pfizer	Schizophrenia
	Lexapro	Pfizer	Schizophrenia
	Viagra	Pfizer	Erectile Dysfunction
	Plavix®	Bristol-Myers Squibb/ Sanofi Pharmaceuticals	Platelet Inhibitors
	Provigil®	Cephalon	Sleep Disorders
	Seroquel	AstraZeneca	Dementia
	Singulair	Merck	Asthma
	Viagra	Pfizer	Erectile Dysfunction
	2013	AcipHex	Eisai Inc.
Avodart		GlaxoSmithKline	Enlarged prostate
Cymbalta		Eli, Lilly and Company	Depression
Namenda		Forest Pharmaceuticals	Alzheimer's
Niaspan		Kos Pharmaceuticals	Cholesterol Lowering
OxyContin		Purdue Pharma	Painkiller
Propecia		Merck	Male pattern hair loss
Sustiva		Bristol-Myers Squibb	HIV/AIDS
Xopenex		Sepracor	Asthma

Source: Express Scripts, 2009

## A LOOK AHEAD: FIRST SIX (6) MONTHS OF 2009

### Key Findings & Considerations

- The KEHP claims cost increase per member per month is 5.0% from 2008 to 2009 (six months 2008 versus six months 2009).
- Enrollment increased by 2.5%.
- Active full-time employee costs are increasing at a higher rate than costs for non-Medicare eligible retirees. The medical increase is 3.9% for actives and 2.2% for retirees. However, retirees' pharmacy trend of 14.0% is higher than actives' pharmacy trend of 3.7%.
- Utilization of services by place of service from 2008 to 2009 remains consistent. Outpatient hospital claims continue to be the largest component. The growth rate for physician services dropped 3.5% from 2008 to 2009.
- The number of mail order scripts used increased by 7.9%, while retail scripts increased by 2.6%.
- Employee cost sharing per script for pharmacy increased by 27.1%, from an average of \$8.65 per script in 2008 to an average of \$11.00 per script in 2009.

In order to identify the emerging trends in 2009 we analyzed the claims experience for January through June of 2008 compared to the same period in 2009. However, using 6 months of data may not show the same results as a full year experience due to the effect of seasonality.

### Exhibit XXXIX

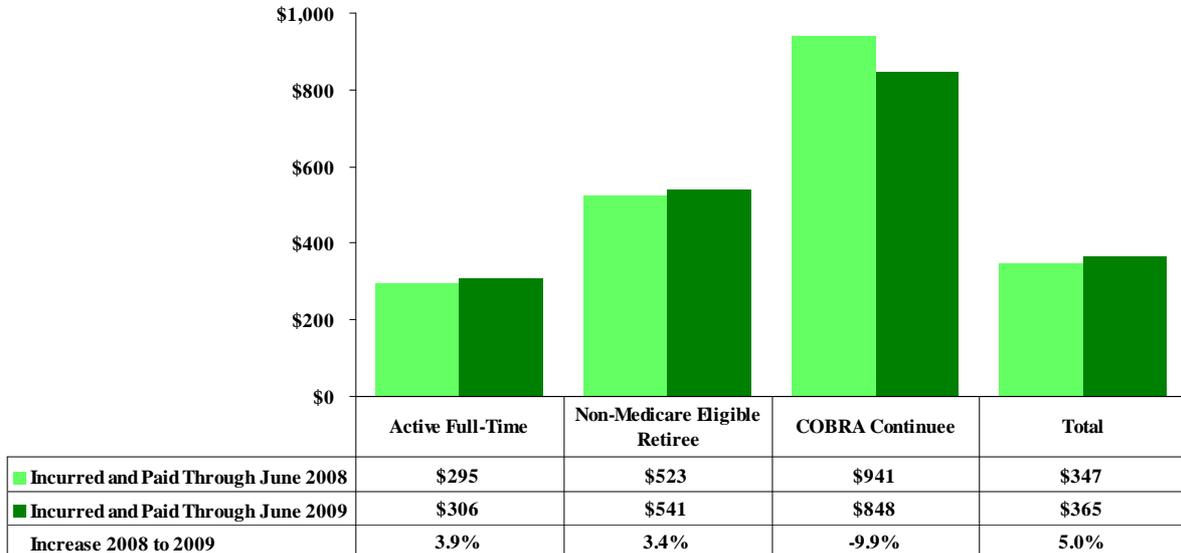
#### 2008 - 2009 Six Months Aggregate Paid Claims Experience

	Incurred and Paid through June 2008	Incurred and Paid through June 2009	% Change
<b>Aggregate</b>			
Medical Claims	\$387,296,124	\$414,880,214	7.1%
Rx Claims	\$136,953,680	\$149,347,171	9.0%
<b>Total Claims</b>	<b>\$524,249,804</b>	<b>\$564,227,385</b>	<b>7.6%</b>
Covered Lives	251,439	257,757	2.5%
<b>Per Member Per Month</b>			
Medical Claims	\$257	\$268	4.5%
Rx Claims	\$91	\$97	6.4%
<b>Total Claims</b>	<b>\$347</b>	<b>\$365</b>	<b>5.0%</b>

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

**Exhibit XL**

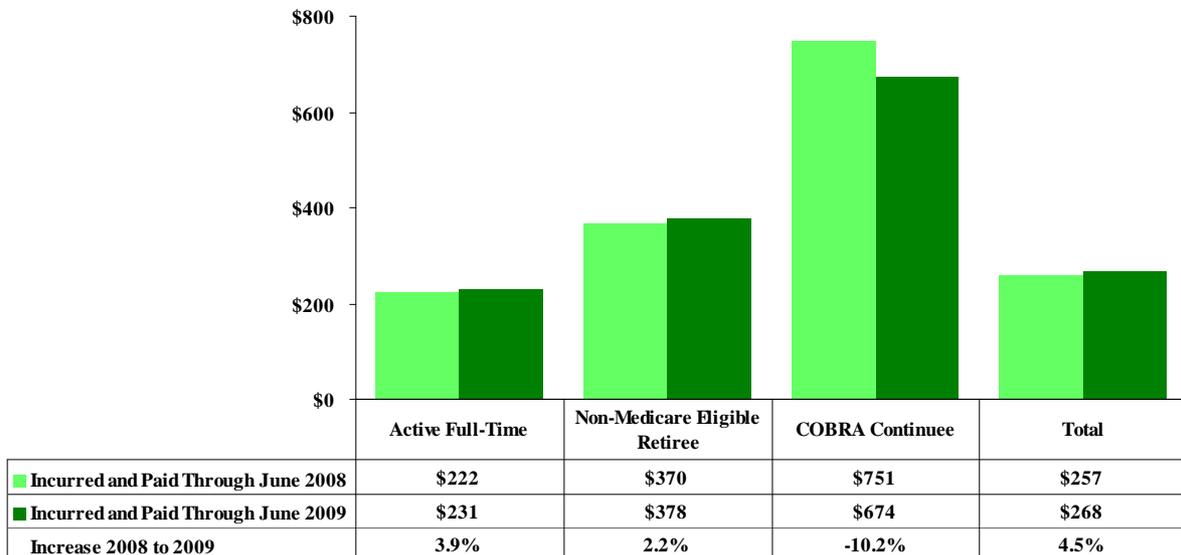
**2008 - 2009 Six Months Medical and Pharmacy Paid Claims Per Member Per Month (PMPM)**



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

**Exhibit XLI**

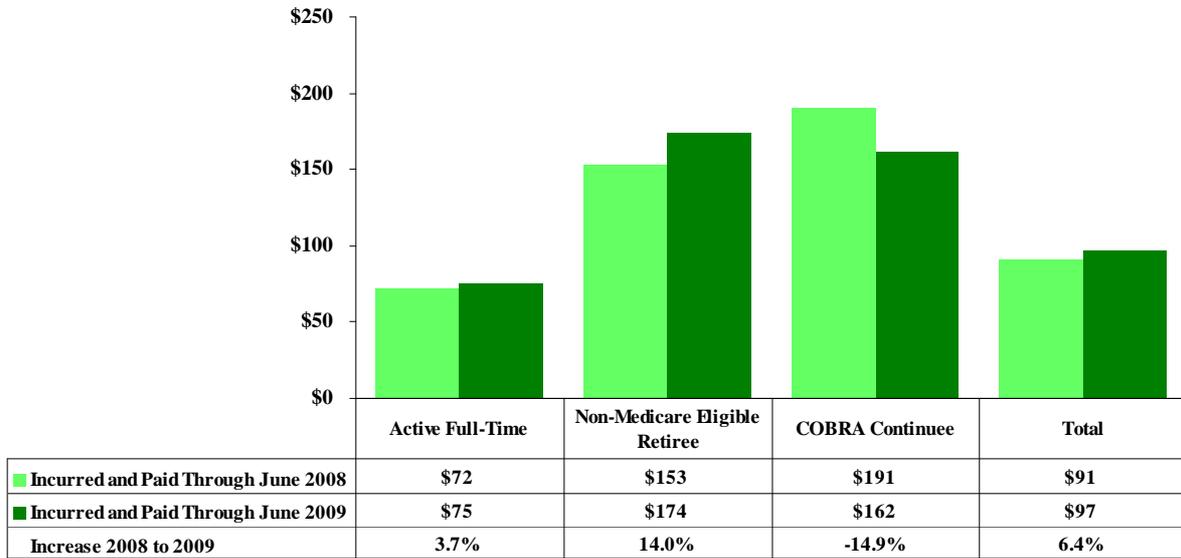
**2008 - 2009 Six Months Medical Paid Claims Per Member Per Month (PMPM)**



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

**Exhibit XLII**

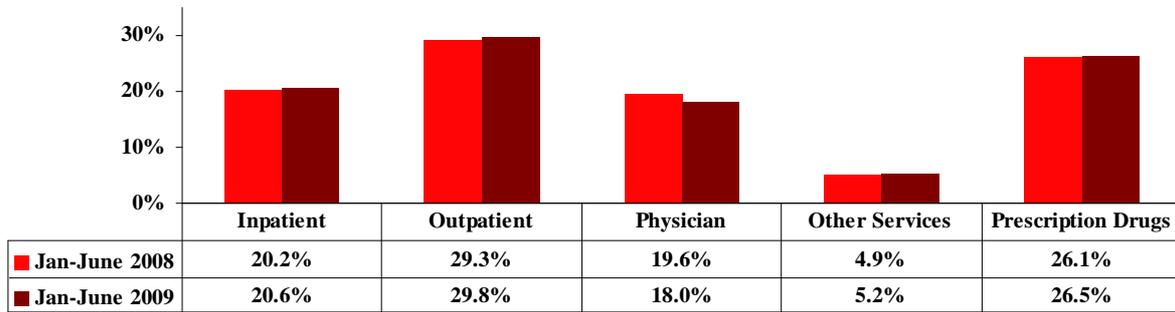
**2008 - 2009 Six Months Pharmacy Paid Claims Per Member Per Month (PMPM)**



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

**Exhibit XLIII**

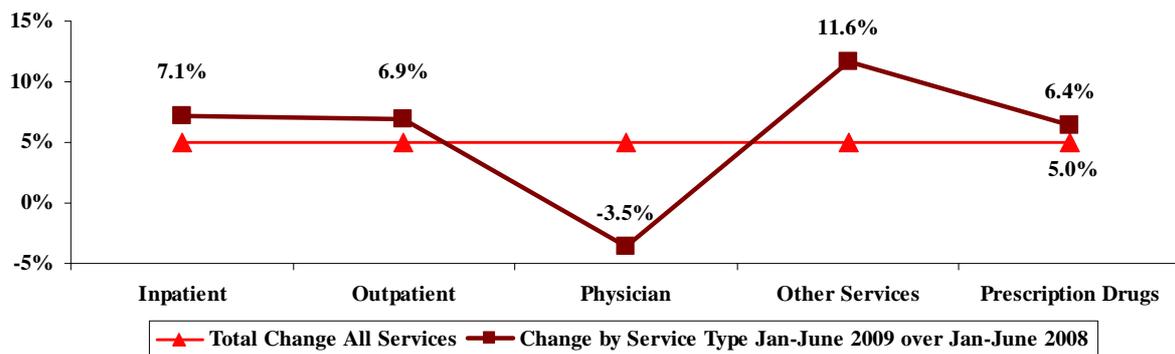
**2008 - 2009 Paid Claims Distribution by Place of Service**



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

**Exhibit XLIV**

**2008 - 2009 Change in KEHP Per Member Per Month (PMPM) Paid Claims by Place of Service**



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

**Exhibit XLV****2008 - 2009 Key Pharmacy Benefits Aggregate Cost Statistics**

	Incurred and Paid Through June		
	2008	2009	2009 vs. 2008
Total Eligible Members	251,439	257,757	2.5%
Total Allowed Charges	\$154,097,368	\$173,516,226	12.6%
Total Net Paid Claims	\$136,953,680	\$149,347,171	9.0%

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

**Exhibit XLVI****2008 - 2009 Key Pharmacy Benefits Cost Per Claim and Cost Share Statistics**

	Incurred and Paid Through June		
	2008	2009	2009 vs. 2008
Total Copayment per Claim	\$8.65	\$11.00	27.1%
Retail Copayment per Claim	\$8.36	\$10.57	26.5%
Mail Copayment per Claim	\$21.15	\$28.25	33.6%
Total Member Cost Share	13.5%	15.7%	16.6%
Retail Member Cost Share	13.6%	15.8%	16.6%
Mail Member Cost Share	12.7%	14.9%	17.3%
<b>Plan Cost:</b>			
Per Member Per Year (PMP)	\$544.68	\$579.41	6.4%
PMPM	\$45.39	\$48.28	6.4%
Per Claim	\$55.41	\$58.83	6.2%

**Exhibit XLVII****2008 - 2009 Key Pharmacy Utilization Statistics**

	Incurred and Paid Through June		
	2008	2009	2009 vs. 2008
Scripts Per Member Per 6 Months	9.8	9.8	0.2%
Total Scripts	2,471,701	2,538,591	2.7%
Retail Scripts	2,415,141	2,477,535	2.6%
Mail Order Scripts	56,560	61,056	7.9%
Brand Scripts	915,672	874,073	(4.5%)
Generic Scripts	1,556,029	1,664,518	7.0%
<b>Generic Utilization:</b>			
Generic Dispensing Rate	63.0%	65.6%	4.2%
Generic Substitution Rate	88.9%	90.2%	1.5%
Mail Order Utilization	2.3%	2.4%	5.1%
<b>Days Supply:</b>			
Days Supply Total	70,109,003	74,000,814	5.6%
Days Supply per Claim	28.4	29.2	2.8%

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

**Exhibit XLVIII**

**2008 - 2009 Prescription Drug Utilization Detail by Drug Classification**

	<b>Average Scripts Per Person (6 Months)</b>		
	<b>Incurred and Paid Through</b>		<b>2009 vs. 2008</b>
	<b>June 2008</b>	<b>June 2009</b>	
<b>Retail and Mail Order</b>			
Brand Single Source	2.9	2.7	(6.1%)
Brand Multi Source	0.8	0.7	(9.8%)
Total Brand	3.6	3.4	(6.9%)
Generic	6.2	6.5	4.4%
<b>Total All</b>	<b>9.8</b>	<b>9.8</b>	<b>0.2%</b>
<b>Retail</b>			
Brand Single Source	2.8	2.6	(6.4%)
Brand Multi Source	0.8	0.7	(10.2%)
Total Brand	3.5	3.3	(7.2%)
Generic	6.1	6.3	4.3%
<b>Total Retail</b>	<b>9.6</b>	<b>9.6</b>	<b>0.1%</b>
<b>Mail Order</b>			
Brand Single Source	0.1	0.1	4.5%
Brand Multi Source	0.0	0.0	6.3%
Total Brand	0.1	0.1	4.8%
Generic	0.1	0.1	5.7%
<b>Total Mail Order</b>	<b>0.2</b>	<b>0.2</b>	<b>5.3%</b>

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

## THE KGHIB CONTINUES TO FOCUS ON THE POSITIVE IMPACT OF PREVENTION AND HEALTH IMPROVEMENT IN MAINTAINING A SECURE AND SUSTAINABLE PLAN

The Board devoted a section of last year's Annual Report to addressing the critical need to improve the overall health of KEHP members in order to maintain a secure and sustainable plan for today and for the future. The report outlined a framework for identifying and addressing key initiatives that will positively impact members' health and the plan's financial security. Since the delivery of that report last October, the urgency for focusing on initiatives to support plan sustainability and security has only increased. As the economic downturn has intensified the Commonwealth is faced with more and more budget pressures, affecting both the financial viability of the KEHP and the financial security of each of its members. As our nation deliberates over approaches to national health care reform, alternatives under debate address many of the same challenges as those faced by KEHP, critical to long term sustainability of our nation's health care system. In light of both the critical local and national concerns, the Board continues to focus on initiatives that will maintain the KEHP, providing security for members.

Historically, plan sponsors have focused efforts to maintain plans' financial viability 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, the KEHP, like other plan sponsors nationwide is going beyond a concentration on treating disease and also focusing programs, benefits and communications on improving members' health to improve the long term sustainability of the plan.

The framework for sustainability reviewed in last year's report is built on the following four cornerstones:

- Health and Wellbeing - 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
- People Centricity - Focusing on improving each member's ability to manage their own health and make responsible decisions regarding their care is key to changing the underlying demand for and need for care
- Value and Performance - 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
- Member Engagement and Loyalty - Supporting members' ability to be productive and loyal to their employers through provision of wellness and prevention programs leads to sustainability for KEHP and also for its participating employers, retirement systems and members.

Over the course of this year the DEI has implemented several programs and approaches to addressing each cornerstone. The primary focus has been on health and wellbeing, but progress has been made on other cornerstones as well. Later in this section of the report each of the

cornerstones will be briefly described and the programs and approaches implemented for KEHP membership will be identified. First, to underscore the critical importance of health to the security of the plan, the following information on the people of Kentucky's health status is provided.

### **Population Health Statistics for the Commonwealth of Kentucky**

The following paragraphs and charts provide information on some of the key health risks and indicators that are prevalent in Kentucky's overall population.

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 a significant portion of the total Commonwealth population, these behaviors and indicators are also evident in the plan population.

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. 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 key for each exhibit is as follows:

- Kentucky: Shown in Red.
- Kentucky (Prior Year): Shown in Brown. In cases where the state data has been updated since provided in the report last year, the comparable metric from last year's report is shown. In some cases, the update may reflect a change that occurred over several years (e.g., a metric in the report last year may have been based on a 2006 survey, and this year is based on a 2008 survey).
- 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.

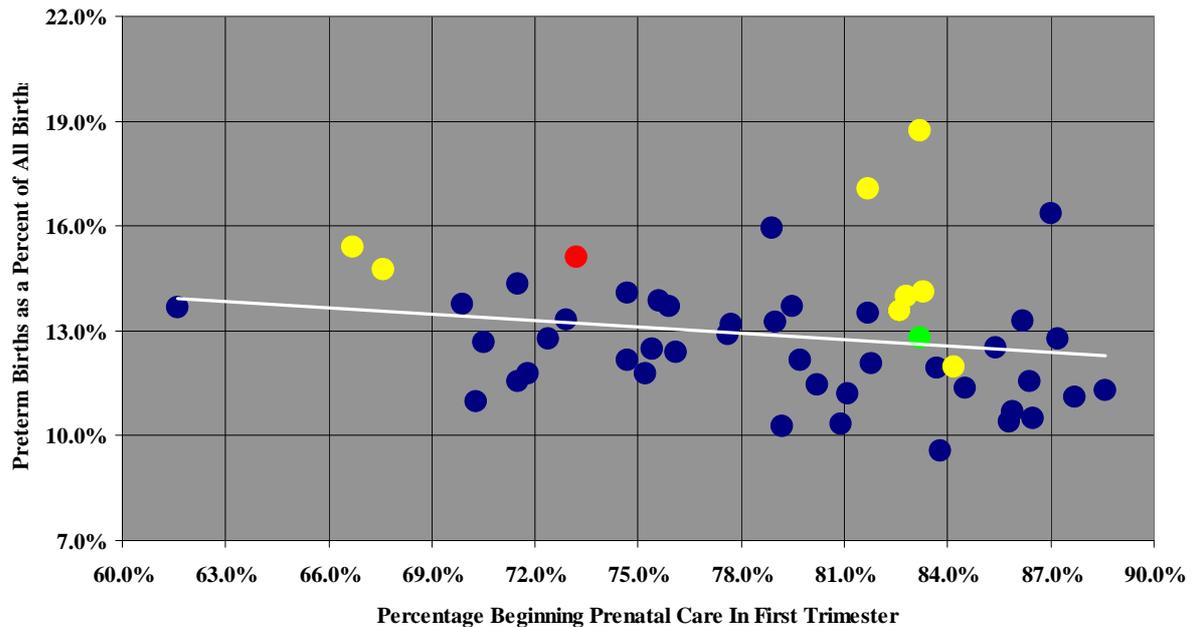
For each chart in the exhibit a correlation line has been included to illustrate the approximate correlation between the two factors shown on each chart.

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. These charts also note the year the Kaiser survey was performed for each specific metric as reported in this year versus as reported in last year's Annual Report.

Kentucky's population has demonstrated improvements in some key areas, as identified below. Progress towards reaching and exceeding national averages will significantly impact the underlying cost of health care and demonstrates a significant opportunity and goal for the Commonwealth's population and for KEHP membership.

**Exhibit XLIX**

**Correlation Between First Trimester Prenatal Care and Preterm Births**

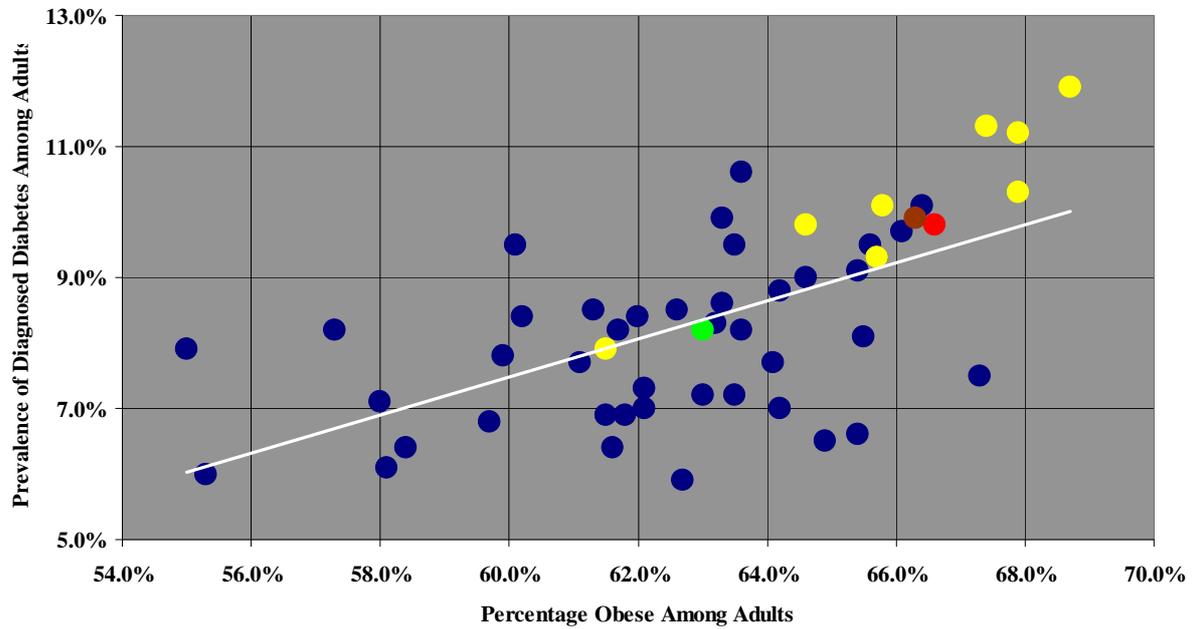


	Percentage Beginning Prenatal Care In First Trimester	Preterm Births as a Percent of All Births
Kentucky (Current Survey)	73.2%	15.1%
Kentucky (Prior Survey)	N/A	12.0%
Alabama	81.7%	17.1%
Georgia	83.3%	14.1%
Mississippi	83.2%	18.7%
North Carolina	82.6%	13.6%
South Carolina	66.7%	15.4%
Tennessee	67.6%	14.8%
Virginia	84.2%	12.0%
West Virginia	82.8%	14.0%
United States	83.2%	12.8%
Current Survey Year	2006	2006
Prior Survey Year	2005	2005
	1 Year Update	1 Year Update

Source: Kaiser Family Foundation, www.statehealthfacts.org, 2006 data.

**Exhibit L**

**Correlation Between Adult Obesity and Prevalence of Adult Diabetes**

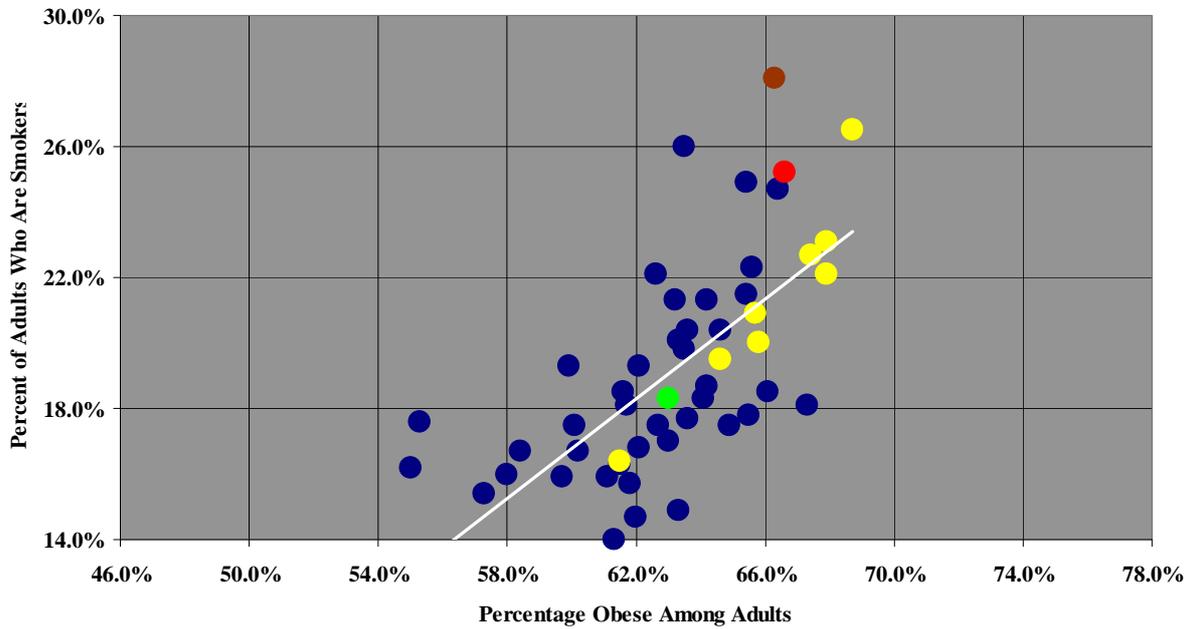


	Prevalence of Obesity Among Adults	Prevalence of Diagnosed Diabetes Among Adults
Kentucky (Current Survey)	66.6%	9.8%
Kentucky (Prior Survey)	66.3%	9.9%
Alabama	67.9%	11.2%
Georgia	64.6%	9.8%
Mississippi	67.4%	11.3%
North Carolina	65.7%	9.3%
South Carolina	65.8%	10.1%
Tennessee	67.9%	10.3%
Virginia	61.5%	7.9%
West Virginia	68.7%	11.9%
United States	63.0%	8.2%
Current Survey Year	2008	2008
Prior Survey Year	2007	2007
	1 Year Update	1 Year Update

Source: Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org), 2008 data.

**Exhibit LI**

**Correlation Between Adult Obesity and Percent of Adults Who Are Smokers**

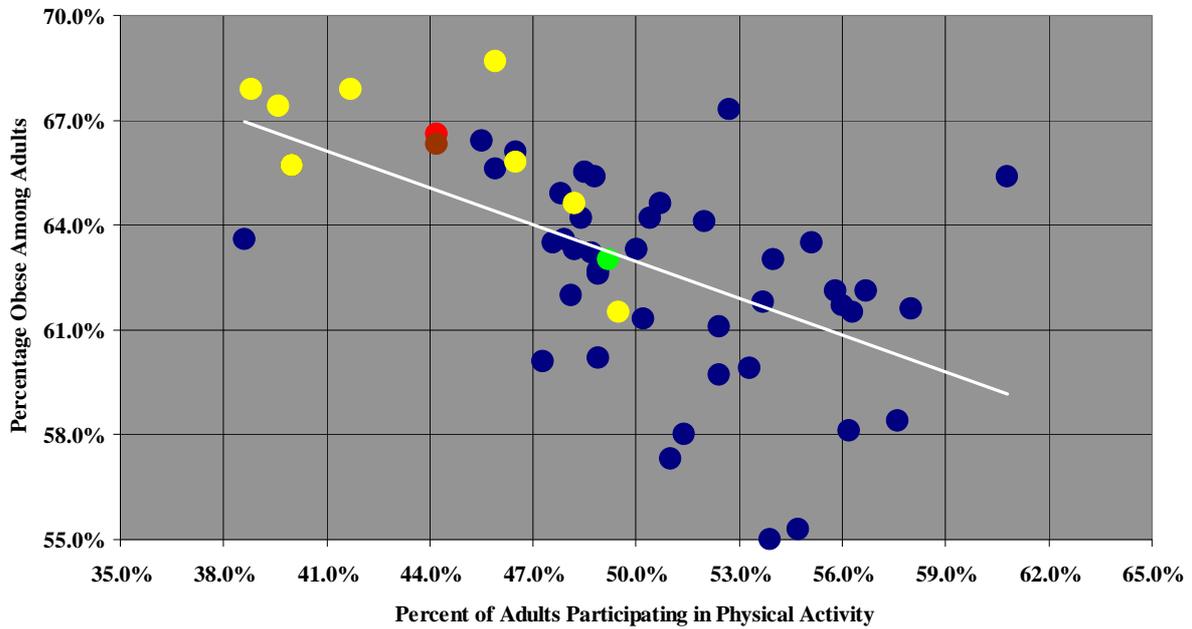


	Prevalence of Obesity Among Adults	Percent of Adults Who Are Smokers
Kentucky (Current Survey)	66.6%	25.2%
Kentucky (Prior Survey)	66.3%	28.1%
Alabama	67.9%	22.1%
Georgia	64.6%	19.5%
Mississippi	67.4%	22.7%
North Carolina	65.7%	20.9%
South Carolina	65.8%	20.0%
Tennessee	67.9%	23.1%
Virginia	61.5%	16.4%
West Virginia	68.7%	26.5%
United States	63.0%	18.3%
Current Survey Year	2008	2008
Prior Survey Year	2007	2007
	1 Year Update	1 Year Update

Source: Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org), 2008 data.

**Exhibit LII**

**Correlation Between Adults Participating in Physical Activity and Adult Obesity**

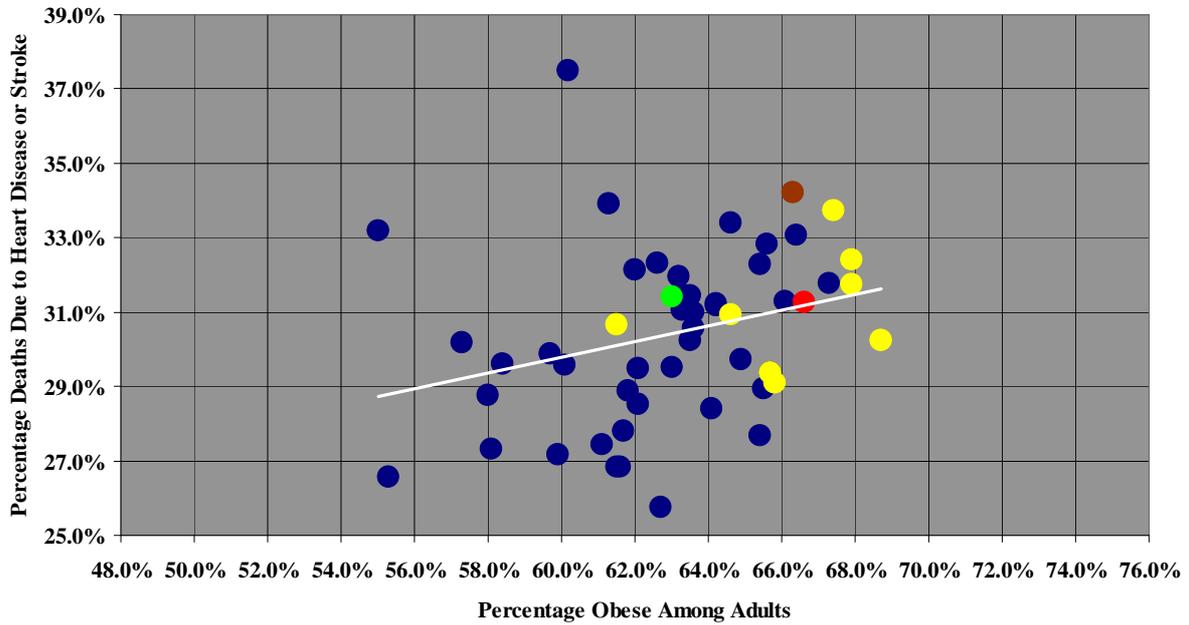


	Percent of Adults Who Are Participating In Physical Activity	Prevalence of Obesity Among Adults
Kentucky (Current Survey)	44.2%	66.6%
Kentucky (Prior Survey)	44.2%	66.3%
Alabama	41.7%	67.9%
Georgia	48.2%	64.6%
Mississippi	39.6%	67.4%
North Carolina	40.0%	65.7%
South Carolina	46.5%	65.8%
Tennessee	38.8%	67.9%
Virginia	49.5%	61.5%
West Virginia	45.9%	68.7%
United States	49.2%	63.0%
Current Survey Year	2007	2008
Prior Survey Year	2007	2007
		1 Year Update

Source: Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org), 2007 and 2008 data.

**Exhibit LIII**

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

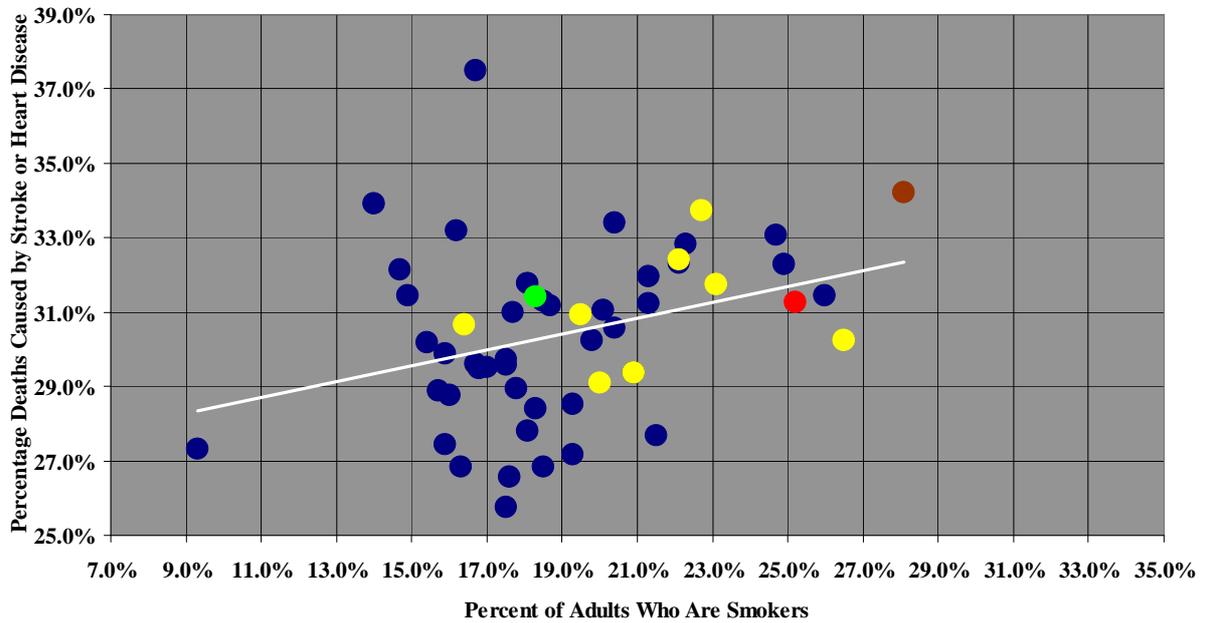


	Prevalence of Obesity Among Adults	Percent of Deaths Due to Heart Disease or Stroke
Kentucky (Current Survey)	66.6%	31.3%
Kentucky (Prior Survey)	66.3%	34.2%
Alabama	67.9%	32.4%
Georgia	64.6%	30.9%
Mississippi	67.4%	33.7%
North Carolina	65.7%	29.4%
South Carolina	65.8%	29.1%
Tennessee	67.9%	31.7%
Virginia	61.5%	30.7%
West Virginia	68.7%	30.2%
United States	63.0%	31.4%
Current Survey Year	2008	2006
Prior Survey Year	2007	2003
	1 Year Update	3 Year Update

Source: Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org), 2008 and 2006 data

**Exhibit LIV**

**Correlation Between Smoking and Deaths Due to Heart Disease or Stroke**



	Percent of Adults Who Are Smokers	Percent of Deaths Due to Heart Disease or Stroke
Kentucky (Current Survey)	25.2%	31.3%
Kentucky (Prior Survey)	28.1%	34.2%
Alabama	22.1%	32.4%
Georgia	19.5%	30.9%
Mississippi	22.7%	33.7%
North Carolina	20.9%	29.4%
South Carolina	20.0%	29.1%
Tennessee	23.1%	31.7%
Virginia	16.4%	30.7%
West Virginia	26.5%	30.2%
United States	18.3%	31.4%
Current Survey Year	2008	2006
Prior Survey Year	2007	2003
	1 Year Update	3 Year Update

Source: Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org), 2008 and 2006 data

## **KEHP Continues to Focus on a Framework for Sustainability - Some Statistics and Progress**

As detailed in the Eighth Annual Report last year, the Board continues to focus on a framework to support the security and sustainability of the KEHP plans and programs. The Board supports the critical need to continue efforts to embed health improvement, prevention and wellness initiatives into KEHP programs and plans. The Board believes this will be fundamental to the long-term sustainability of the plan.

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 are 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 organizations with employees and retirees participating in the KEHP benefit from a focus on members' health 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 services<sup>2</sup>. Without intervention this epidemic is predicted to increase dramatically over the next 10 years even while contagious disease decreases.
- 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 employers' 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 approaching 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.

Following is a brief review of the cornerstones and information on progress towards improvement for the KEHP in each area.

### **Cornerstone: 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. 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<sup>3 4 5</sup>. Therefore, programs that focus on

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<sup>2</sup> National Center for Chronic Disease Prevention and Health Promotion, [www.cdc.gov](http://www.cdc.gov), 2009.

<sup>3</sup> *The Costs of Metabolic Syndrome in Italy*", by Carlo Lucioni et al, *High Blood Pressure & Cardiovascular Prevention*, vol 13 no 2, 2006.

<sup>4</sup> *Metabolic Syndrome Costing Four Times That for All Other Patients*", *News-Medical Net*, May 9, 2005, <http://www.news-medical.net/?id=9870>.

<sup>5</sup> *Metabolic Syndrome and Employer-Sponsored Medical Benefit: An Actuarial Analysis*", by Kathryn Fitch et al, *Milliman*, March 2006.

improving health risks such as obesity have a cumulative impact on health care costs and quality of life.

**Highlights of National Plan Sponsors' Wellness and Health Improvement Approaches - The 2009 PwC Touchstone Health and Wellbeing Survey**

Employers and plan sponsors nationwide are implementing and improving programs focused on wellness and health improvement. The following information is drawn from the 2009 PwC Touchstone survey results. The survey provides information reported by nearly 700 organizations nationwide, detailing their health plan, pharmacy plan, wellness, care management and other programs. Following are highlights.

- **The majority of participants provide wellness and disease management programs and many provide incentives for member participation**
  - 71% offer wellness programs. The most commonly offered programs are employee assistance programs (86%), health risk assessments (76%), fitness & weight management (63%), tobacco cessation (64%) and stress management (45%)
  - 67% offer disease management programs. Most offer programs related to heart disease (69%), diabetes (73%), asthma (66%) and lower back pain (49%)
  - 64% offer incentives related to wellness programs
  - Participation in programs is much greater when incentives are offered
  - Few participants (<10%) believe their current wellness initiatives are very effective at mitigating healthcare costs, improving performance and productivity or enhancing employee engagement, but the majority of participants indicate that improving wellness and prevention programs is their primary future strategy for their plans
    - About half of participants indicated their wellness initiatives are at least somewhat effective

**Wellness and Disease Management programs offering incentives**

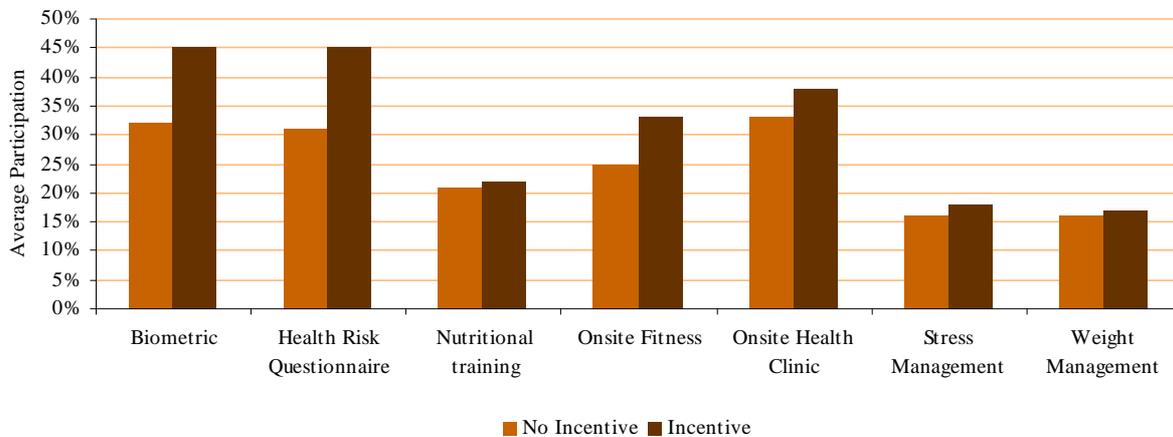
Plan sponsors are continuing to implement incentives to encourage participation in wellness and disease management programs, and the incentives have proven to increase members use.

Wellness programs – % with incentives:

	2009	2008
Biometric	48%	46%
Health Risk Questionnaire	64%	57%
Nutritional Training	22%	17%
Onsite Fitness	15%	17%
Onsite Health Clinic	14%	5%
Stress Management	12%	15%
Weight Management	36%	29%

## Wellness programs with and without incentive programs

Impact of Incentives on participation:



% of employers who offer incentives:

	Biometric	Health Risk Questionnaire	Nutritional Training	On-site Fitness	On-Site Health Clinic	Stress Management	Weight Management
2009	48%	64%	22%	15%	14%	12%	36%
2008	46%	57%	17%	17%	5%	15%	29%

## Highlights of Survey Participants' Wellness Programs Incentives

While a majority of respondents do not yet provide wellness incentives to increase participation in their wellness programs, participants indicate that when incentives are utilized, participation in wellness programs significantly increases.

Incentives Offered by Survey Participants:

- Cash or gift cards in the amounts of \$50 – \$299.
- Annual Premium Incentives in amounts of \$50 – \$500.
- Gifts and/or Raffles for large gifts were generally not offered as incentives.

## The DEI Has Made Progress in Implementing Key Wellness Programs for KEHP Members

The DEI has implemented wellness programs and has made progress in providing support to members working to improve and/or maintain their health. Following are some results of the wellness initiatives that have been implemented for the KEHP members.

## **Journey to Wellness**

The Journey to Wellness program was implemented in 2008 as a pilot conducted in the Personnel Cabinet. Governor Beshear requested an Agency-wide launch for January 1, 2009. This wellness program is designed to serve all state agency employees throughout the Commonwealth. The program is voluntary and focuses on building a culture of wellness.

The program has four phases:

- Know Your Numbers
- Fitness Challenge
- Weight Management Challenge
- Prevention

To date, the primary activities completed in Journey to Wellness have been:

- A letter issued by the Secretary indicating support for the program
- Relationship/support building on multiple levels
- Awareness and Education
  - Wear Red Day
  - St. Patrick's Day Parade
  - Presentations
- Engagement and Empowerment
  - Summit screenings
  - Fitness Challenge
  - Farmers' Market event
  - Cafeteria intervention
- Utilization of Humana and Virgin HealthMiles products
- Future program expansion is planned to address weight management and prevention.

## Journey to Wellness Goals/Progress

The following progress to goals have been achieved for the program

Goal	Status	Description
Offer Summit screenings to at least 50% of state agency employee population (16,500) With 20% participation in screenings (3,300)	In progress	Scheduled screenings currently reaching 8,020 employees (49% of goal) Hosted screenings have had 634 participants to date (19% of goal)
Offer a minimum of three awareness building activities	Satisfied	Completed four (Wear Red and Wear Blue Days, Heart Health pres. Small Steps pres., etc.)
Successfully implement at least two cultural changes	In progress	Cafeteria intervention complete and second received approval
Have at least 15% of the state agency employee population participate in at least one Journey to Wellness/Humana activity (4,950)	In progress	Estimating that we have had close to 2,000 different participants to date (6% or 40% of goal)
Reduce number of people in moderate and high risk categories for (BP, cholesterol, etc.) risks	Pending	Requires 2008/2009/2010 data comparison

## Virgin HealthMiles

The Virgin HealthMiles program is a web-based initiative available to all members of the KEHP. This incentive based program rewards participants for activities, measures health indicators and issues challenges to encourage participation.

- Participation
  - Participants have walked the equivalent of 1,674,597 miles, burning 167,459,758 calories or 47,845 pounds
  - 97.3% of participants have completed health assessment
  - 83.2% of participants visit the website eight or more times per month
- Incentives
  - Participants receive rebates in the form of HealthCash; the rebate amount increases with the participant's activity level
- Participant Feedback
  - 96.25% would likely or definitely recommend the program
  - 97.5% are very satisfied or delighted with the program

Progress towards Virgin HealthMiles goals is as follows:

Goals	Status	Description
Total enrollment 10,000	In progress	Current enrollment: 6,318 Efforts through Humana and JTW
Percentage of 1st Qtr. participants to achieve level 3 at 30%	Satisfied	Level 1: 41% Level 2: 30% Level 3: 28.4% Level 4: 0.6%
Percentage to be eligible for monthly drawings at 60%	In progress	Current percentage: 58%

### Why Weight Kentucky Program

Members continue to enroll in the Why Weight Kentucky program. There were 582 new enrollees in 2008, bringing the total number of members enrolled to 1,419 since the program was introduced in August 2006. As of December 31, 2008, the average weight loss was 16.3 pounds for those members who lost weight.

### Cornerstone: 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. Despite this increase in awareness, 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.

## **The KEHP Program Has Made Progress in Building Consumerism into Plans and Programs**

The DEI has focused in 2009 on improving and expanding communications and education for KEHP members and has made significant progress in communicating with more members more frequently. The open enrollment process in 2008 required each employee and retiree to actively select plan options - the first time in several years. This increased members' awareness. Further, with the redesign of plans for 2009 a larger number of participants selected the Maximum Choice plan, a consumerism model. The Maximum Choice plan (previously the Select plan) grew in membership from 1.6% of the population to 7.0% of employees. The new Capitol Choice plan, a plan with some consumerism provisions was selected by 18% of employees and non-Medicare eligible retirees.

### **Cornerstone: Value and Performance**

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

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 treatment<sup>6</sup>. The system as it is currently configured does not reward quality of care; rather it rewards the volume of services. Further, consumers 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 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. Those 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.

The DEI continues to focus on assuring that program administrative vendors are providing high quality administrative services and value.

### **In Summary, The Board Continues to Focus on Initiatives to Support Long-Term Security and Sustainability for KEHP Members and for the People of Kentucky**

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, members', participating employers' and Retirement Systems' sustainability.

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<sup>6</sup> 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.

## 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
- Offer a lower cost PPO option
- Provide a subsidy for family and dependent coverage
- Provide plans with unlimited lifetime maximums

The Board continues to support the recommendations made in last year's Eighth Annual Report. These recommendations are provided below with a summary of progress made over the course of this year in furthering objectives.

- 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.

*DEI conducted a detailed annual plan cost driver analysis that identified challenges and opportunities for improving both the cost to the plan and members and for improving members' health. The results of this study led to the evaluation and implementation of several strategic alternatives, including evaluation of improved disease and care management approaches, strategies to improve the use of generic drugs and manage specialty drug use, expanded wellness and prevention programs, and more. DEI provided the results of the study to the Board in March 2009 and continued to evaluate alternatives for implementation in 2010. DEI will continue to monitor plan experience and evaluate alternatives for improvement.*

- 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.

*A study was conducted in June 2009 addressing the effectiveness of current care management programs and identifying alternatives to improve programs. Utilization review services, case management services and disease management services were evaluated. Several alternatives for improving programs were identified and are currently under evaluation.*

- 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.

*DEI continues to evaluate the administrative quality of services provided to support the KEHP. As referenced above, an evaluation of clinical programs was conducted in July 2009. Evaluation of administrative services is under consideration.*

- 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.

*During the active open enrollment process in 2008, DEI attained contact information for the majority of KEHP members and is in the process of developing improved communications processes. Communications have been e-mailed directly to members and continue to be provided through Insurance Coordinators. Several improvements have been made to the KEHP web site, and a focus on improved communications will continue over the course of this next year.*

- The Board recommends that the due date for the Annual Report be extended from October 1 each year to December 1.

The Board further recommends:

- Members of the Board discussed that the \$50M transfer from the Public Employee Health Insurance Trust Fund pursuant to House Bill 143 raises the issue about the appropriate levels of plan reserves that should be maintained by the Trust.

Pursuant to KRS 18A.2254(3)(a), there are significant limitations on the use of any of the prior year trust fund surplus balances. Members of the Board noted that KRS 18A.2254(3)(a) has an effect on the level of plan reserves that should be maintained. Board members further discussed that adequate funds should continue to be budgeted by the General Assembly and adequate plan reserves should be maintained by the Trust to address annual health care inflation.

The Board acknowledges that adequate reserves are necessary for all self-insured plans. It was requested by Board members that PwC determine what adequate reserves are needed for self-funded plans similar to the Kentucky Employees' Health Plan bearing in mind the statutory limitations of using prior year surplus balances.

- KEHP should conduct a study to evaluate the impact of any federal health care reform measures once the scope and detail of reform programs are known.

## APPENDIX

### **Modifications to the KEHP Program and Plan Design Provisions by Year, 2000 - 2009**

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
<b>Annual Deductible</b>		None	None
<b>Maximum out-of-pocket for Covered Expenses</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited	Unlimited
<b>In Hospital Care</b>	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
<b>Outpatient Services</b>	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
<b>Emergency Services</b>	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
<b>Maternity Care</b>	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.
<b>Prescription Drugs</b>	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
<b>Dental</b>	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
<b>Vision</b>	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
<b>Other Services</b>	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
<b>Annual Deductible</b>		None	Single: \$500 Family: \$1,000	None	Single: \$1,000 Family: \$2,000
<b>Maximum Out-of-Pocket for Covered Expenses (including deductible)</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited	Unlimited	Unlimited	Unlimited
<b>In Hospital Care</b>	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*
<b>Outpatient Services</b>	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*
<b>Emergency Services</b>	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*
<b>Maternity Care</b>	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.
<b>Prescription Drugs</b>	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*
<b>Dental</b>	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	
<b>Vision</b>	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	
<b>Other Services</b>	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
<b>Annual Deductible</b>		Single: \$250 Family: \$500	Single: \$500 Family: \$1,000	Single: \$500 Family: \$1,000	Single: \$1,000 Family: \$2,000
<b>Maximum out-of-pocket for Covered Expenses (including deductible)</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited	Unlimited	Unlimited	Unlimited
<b>In Hospital Care</b>	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*
<b>Outpatient Services</b>	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*
<b>Emergency Services</b>	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*
<b>Maternity Care</b>	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*
<b>Prescription Drugs</b>	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 \$20 co-pay \$30 non-formulary	40% co-ins*	\$10 generic \$30 non-formulary	50% co-ins*
<b>Dental</b>	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	
<b>Vision</b>	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	
<b>Other Services</b>	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)**

<b>Exclusive Provider Option</b>		<b>Option C</b>
<b>Annual Deductible</b>		None
<b>Maximum out-of-pocket for Covered Expenses</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited
<b>In Hospital Care</b>	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)
<b>Outpatient Services</b>	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
<b>Emergency Services</b>	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)
<b>Maternity Care</b>	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.
<b>Prescription Drugs</b>	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
<b>Dental</b>		Not covered
<b>Vision</b>		Not covered
<b>Other Services</b>	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
<b>Annual Deductible</b>		None	None
<b>Maximum out-of-pocket for Covered Expenses</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited	Unlimited
<b>In Hospital Care</b>	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
<b>Outpatient Services</b>	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
<b>Emergency Services</b>	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
<b>Maternity Care</b>	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.
<b>Prescription Drugs Retail</b>	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
<b>Mail Order</b>	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
<b>Dental</b>		Not Covered	Not covered
<b>Vision</b>		Not Covered	Not covered
<b>Other Services</b>	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"> <li>• Rehabilitative and Therapeutic care</li> <li>• Respite Care</li> </ul>	\$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
<b>Annual Deductible</b>		None	Single: \$500 Family: \$1,000	None	Single: \$1,000 Family: \$2,000
<b>Maximum Out-of-Pocket for Covered Expenses (including deductible)</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited	Unlimited	Unlimited	Unlimited
<b>In Hospital Care</b>	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*
<b>Outpatient Services</b>	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*
<b>Emergency Services</b>	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*
<b>Maternity Care</b>	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.
<b>Prescription Drugs Retail</b>	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*
<b>Mail Order</b>	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	
<b>Dental</b>		Not Covered		Not covered	
<b>Vision</b>		Not Covered		Not covered	
<b>Other Services</b>	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"> <li>Rehabilitative and Therapeutic care</li> <li>Respite Care</li> </ul>	\$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
<b>Annual Deductible</b>		Single: \$250 Family: \$500	Single: \$500 Family: \$1,000	Single: \$500 Family: \$1,000	Single: \$1,000 Family: \$2,000
<b>Maximum out-of-pocket for Covered Expenses (including deductible)</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited	Unlimited	Unlimited	Unlimited
<b>In Hospital Care</b>	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*
<b>Outpatient Services</b>	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) \$400 maximum benefit per year	40% co-ins*	\$20 co-pay (per visit) \$300 maximum benefit per year	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*
<b>Emergency Services</b>	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*
<b>Maternity Care</b>	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*
<b>Prescription Drugs Retail</b>	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*
<b>Mail Order</b>	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	
<b>Dental</b>		Not Covered		Not covered	
<b>Vision</b>		Not Covered		Not covered	
<b>Other Services</b>	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)

<b>EPO Plan</b>		
<b>Annual Deductible</b>		None
<b>Maximum out-of-pocket for Covered Expenses</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited
<b>In Hospital Care</b>	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)
<b>Outpatient Services</b>	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; 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
<b>Emergency Services</b>	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)
<b>Maternity Care</b>	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.
<b>Prescription Drugs Retail</b>	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
<b>Mail Order</b>	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
<b>Dental</b>		Not covered
<b>Vision</b>		Not covered
<b>Other Services</b>	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	
	• Rehabilitative and Therapeutic care	\$25 co-pay (per visit)
	• Respite 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	

\* 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
<b>Annual Deductible</b>		None	None
<b>Maximum out-of-pocket for Covered Expenses</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited	Unlimited
<b>In Hospital Care</b>	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
<b>Outpatient Services</b>	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
<b>Emergency Services</b>	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
<b>Maternity Care</b>	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.
<b>Prescription Drugs Retail</b>	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
<b>Mail Order</b>	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
<b>Dental</b>		Not Covered	Not covered
<b>Vision</b>		Not Covered	Not covered
<b>Other Services</b>	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"> <li>• Rehabilitative and Therapeutic care</li> <li>• Respite Care</li> </ul>	\$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
<b>Annual Deductible</b>		None	Single: \$500 Family: \$1,000	None	Single: \$1,000 Family: \$2,000
<b>Maximum Out-of-Pocket for Covered Expenses (including deductible)</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited	Unlimited	Unlimited	Unlimited
<b>In Hospital Care</b>	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*
<b>Outpatient Services</b>	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*
<b>Emergency Services</b>	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*
<b>Maternity Care</b>	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.
<b>Prescription Drugs</b>	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	
<b>Dental</b>		Not Covered		Not covered	
<b>Vision</b>		Not Covered		Not covered	
<b>Other Services</b>	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	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	• Respite 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*	

**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
<b>Annual Deductible</b>		Single: \$250 Family: \$500	Single: \$500 Family: \$1,000	Single: \$500 Family: \$1,000	Single: \$1,000 Family: \$2,000
<b>Maximum out-of-pocket for Covered Expenses (including deductible)</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited	Unlimited	Unlimited	Unlimited
<b>In Hospital Care</b>	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*
<b>Outpatient Services</b>	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*
<b>Emergency Services</b>	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*
<b>Maternity Care</b>	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*
<b>Prescription Drugs Retail</b>	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*
<b>Mail Order</b>	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	
<b>Dental</b>		Not Covered		Not covered	
<b>Vision</b>		Not Covered		Not covered	
<b>Other Services</b>	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		
<b>Annual Deductible</b>		None
<b>Maximum out-of-pocket for Covered Expenses</b>	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
<b>Lifetime Maximum Benefit</b>		Unlimited
<b>In Hospital Care</b>	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)
<b>Outpatient Services</b>	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; 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
<b>Emergency Services</b>	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)
<b>Maternity Care</b>	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.
<b>Prescription Drugs Retail</b>	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
<b>Mail Order</b>	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
<b>Dental</b>		Not covered
<b>Vision</b>		Not covered
<b>Other Services</b>	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"> <li>• Rehabilitative and Therapeutic care</li> <li>• Respite Care</li> </ul>	\$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 Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Essential	
	In-Network	Out-of-Network
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

## 2005 Public Employee Health Insurance Program Benefit Provisions (continued)

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 75<sup>th</sup> 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

Covered Services	Commonwealth Essential	
	In-Network	Out-of-Network
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

## 2006 Public Employee Health Insurance Program Benefit Provisions (continued)

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 75<sup>th</sup> 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 4<sup>th</sup> 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.

## 2007 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Essential		Commonwealth Enhanced	
	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 - \$750 Family - \$1,500	Single - \$1,500 Family - \$3,000	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 - \$3,500 Family - \$7,000	Single - \$7,000 Family - \$14,000	Single - \$1,250 Family - \$2,500	Single - \$2,500 Family - \$5,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
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	25%*	50%*	20%*	40%*
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).	25%*	50%*	\$10 co-pay	40%*
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).	25%*	50%*	\$10 co-pay	40%*
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%*	20%*	40%*
Preventive care – annual gynecological exam, routine physical and 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.		\$10 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*	\$50 co-pay plus 20%	\$50 co-pay plus 40%
Emergency room physician charges	25%*	50%*	20%	40%
Urgent care center treatment	25%*	50%*	\$20 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
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.	25%*	50%*	\$10 co-pay	40%*
Prescription drugs – Retail (30 day supply)	25% Min Max			
Generic	\$10	\$25	\$5	40%
Preferred Brand	\$30	\$50	\$15**	40%
Non-preferred Brand	\$35	\$100	\$30**	40%
Prescription drugs – Mail Order (90 day supply)	25% Min Max			
Generic	\$20	\$50	\$10	
Preferred Brand	\$60	\$100	\$30	
Non-preferred Brand	\$70	\$200	\$60	
Audiometric services in conjunction with a disease, illness or injury	25%*	50%*	50%*	50%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*	\$10 co-pay	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	25%*	50%*	\$10 co-pay	40%*
▪ Respite care for children ages two through 21 (\$500 maximum per month)	25%*	50%*	50%*	50%*
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	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health – limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*	20%*	40%*
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%*	20%*	40%*

\* Subject to annual deductible

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

**2007 Public Employee Health Insurance Program Benefit Provisions (continued)**

Covered Services	Commonwealth Premier		Commonwealth Select	
	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 - \$2,000 Family - \$3,000	Single - \$2,000 Family - \$3,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - \$1,000 Family - \$2,000	Single - \$2,000 Family - \$4,000	Single - \$3,000 Family - \$4,500	Single - \$4,000 Family - \$6,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - \$1,000 Parent Plus - \$1,500 Couple - \$1,500 Family - \$2,000	
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	10%*	30%*	10%*	40%*
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	30%*	10%*	40%*
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	30%*	10%*	40%*
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.	10%*	30%*	10%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	\$10 co-pay per visit \$400 maximum benefit per covered individual per plan year	30%*	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 10%	\$50 co-pay plus 30%*	10%*	40%*
Emergency room physician charges	10%	30%*	10%*	40%*
Urgent care center treatment	\$20 co-pay	30%*	10%*	40%*
Ambulance services	10%*	10%*	10%*	10%*
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  in-hospital care co-insurance applies*	30%*	10%*	40%*
Prescription drugs – Retail (30 day supply)				
Generic	\$5**	30%	10%	30%
Preferred Brand	\$15**	30%	10%	30%
Non-preferred Brand	\$30**	30%	10%	30%
Prescription drugs – Mail Order (90 day supply)				
Generic	\$10		10%	
Preferred Brand	\$30		10%	
Non-preferred Brand	\$60		10%	
Audiometric services in conjunction with a disease, illness or injury	10%*	30%*	10%*	40%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	\$10 co-pay	30%*	10%*	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	\$10 co-pay	30%*	10%*	40%*
▪ Respite care for children ages two through 21 (\$500 maximum per month)	10%*	30%*	10%*	40%*
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	10%*	30%*	10%*	40%*
Prosthetic devices	10%*	30%*	10%*	40%*
Home health – limited to 60 visits per year	10%*	30%*	10%*	40%*
Physical therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Occupational therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Speech therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Skilled nursing facility services – limited to 30 days per year	10%*	30%*	10%*	40%*
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	10%*	30%*	10%*	40%*

\* Subject to annual deductible

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

**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.

## 2008 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Essential		Commonwealth Enhanced	
	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 - \$750 Family - \$1,500	Single - \$1,500 Family - \$3,000	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 - \$3,500 Family - \$7,000	Single - \$7,000 Family - \$14,000	Single - \$1,250 Family - \$2,500	Single - \$2,500 Family - \$5,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
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	25%*	50%*	20%*	40%*
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).	25%*	50%*	\$10 co-pay	40%*
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).	25%*	50%*	\$10 co-pay	40%*
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%*	20%*	40%*
Preventive care – annual gynecological exam, routine physical and 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.		\$10 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*	\$50 co-pay plus 20%	\$50 co-pay plus 40%
Emergency room physician charges	25%*	50%*	20%	40%
Urgent care center treatment	25%*	50%*	\$20 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
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.	25%*	50%*	\$10 co-pay	40%*
Prescription drugs – Retail (30 day supply)	25% Min Max			
Generic	\$10	\$25	\$5	40%
Preferred Brand	\$20	\$50	\$15**	40%
Non-preferred Brand	\$35	\$100	\$30**	40%
Prescription drugs – Mail Order (90 day supply)	25% Min Max			
Generic	\$20	\$50	\$10	
Preferred Brand	\$40	\$100	\$30	
Non-preferred Brand	\$70	\$200	\$60	
Audiometric services in conjunction with a disease, illness or injury	25%*	50%*	50%*	50%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*	\$10 co-pay	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	25%*	50%*	\$10 co-pay	40%*
▪ Respite care for children ages two through 21 (\$500 maximum per month)	25%*	50%*	50%*	50%*
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	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health – limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*	20%*	40%*
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%*	20%*	40%*

\* Subject to annual deductible

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

**2008 Public Employee Health Insurance Program Benefit Provisions (continued)**

Covered Services	Commonwealth Premier		Commonwealth Select	
	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 - \$2,000 Family - \$3,000	Single - \$2,000 Family - \$3,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - \$1,000 Family - \$2,000	Single - \$2,000 Family - \$4,000	Single - \$3,000 Family - \$4,500	Single - \$4,000 Family - \$6,000
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - \$1,000 Parent Plus - \$1,500 Couple - \$1,500 Family - \$2,000	
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	10%*	30%*	10%*	40%*
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	30%*	10%*	40%*
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	30%*	10%*	40%*
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.	10%*	30%*	10%*	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	\$10 co-pay per visit \$400 maximum benefit per covered individual per plan year	30%*	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 10%	\$50 co-pay plus 30%*	10%*	40%*
Emergency room physician charges	10%	30%*	10%*	40%*
Urgent care center treatment	\$20 co-pay	30%*	10%*	40%*
Ambulance services	10%*	10%*	10%*	10%*
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	30%*	10%*	40%*
Prescription drugs – Retail (30 day supply)				
Generic	\$5**	30%	10%*	40%*
Preferred Brand	\$15**	30%	10%*	40%*
Non-preferred Brand	\$30**	30%	10%*	40%*
Prescription drugs – Mail Order (90 day supply)				
Generic	\$10		10%*	
Preferred Brand	\$30		10%*	
Non-preferred Brand	\$60		10%*	
Audiometric services in conjunction with a disease, illness or injury	10%*	30%*	10%*	40%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	\$10 co-pay	30%*	10%*	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	\$10 co-pay	30%*	10%*	40%*
▪ Respite care for children ages two through 21 (\$500 maximum per month)	10%*	30%*	10%*	40%*
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	10%*	30%*	10%*	40%*
Prosthetic devices	10%*	30%*	10%*	40%*
Home health – limited to 60 visits per year	10%*	30%*	10%*	40%*
Physical therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Occupational therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Speech therapy – limited to 30 visits per year	10%*	30%*	10%*	40%*
Skilled nursing facility services – limited to 30 days per year	10%*	30%*	10%*	40%*
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	10%*	30%*	10%*	40%*

\* Subject to annual deductible

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

**In 2009:**

- The Commonwealth continued to offer four benefit plans; however, plans were re-designed and re-named.
  - Commonwealth Standard PPO – a \$750/\$1,500 Deductible PPO plan (formerly Commonwealth Essential, benefits remained the same);
  - Commonwealth Capitol Choice – a \$500/\$1,500 Deductible hybrid PPO plan with an up-front benefit allowance of \$500 per member (new in 2009);
  - Commonwealth Optimum PPO – a \$250/\$500 Deductible PPO plan (new in 2009, combined the former Enhanced and Premier plans);
  - Commonwealth Maximum Choice – a \$2,000/\$3,000 Deductible consumer-directed plan with an embedded Health Reimbursement Account (HRA) (formerly Commonwealth Select, benefits remained the same).
- The Commonwealth's contribution for employees who waive coverage was maintained at \$175 per month, the same amount as in 2008.

## 2009 Public Employee Health Insurance Program Benefit Provisions

Covered Services	Commonwealth Standard PPO		Commonwealth Capitol Choice	
	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 - \$750 Family - \$1,500	Single - \$1,500 Family - \$3,000	Single - \$500 Family - \$1,500	Single - \$1,000 Family - \$3,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - \$3,500 Family - \$7,000	Single - \$7,000 Family - \$14,000	Single - \$2,000 Family - \$6,000	Single - \$4,000 Family - \$12,000
Up-Front Benefit Allowance	Not Applicable		\$500/family member	Not Applicable
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Not Applicable	
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	25%*	50%*	\$100 co-pay plus 0%*	40%*
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).	25%*	50%*	20%*	40%*
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).	25%*	50%*	20%*	40%*
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%*	\$50 co-pay plus 0%*	40%*
Preventive care – annual gynecological exam, routine physical and 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.		\$15 co-pay per visit	40%*
Emergency services			\$400 maximum benefit per covered individual per plan year	
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*	\$100 co-pay plus 0%*	\$100 co-pay plus 0%*
Emergency room physician charges	25%*	50%*	0%*	0%*
Urgent care center treatment	25%*	50%*	\$50 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
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.	25%*	50%*	\$15 co-pay	40%*
Prescription drugs – Retail (30 day supply)	25% Min Max			
Generic	\$10	\$25	\$5	
Preferred Brand	\$20	\$50	\$20**	
Non-preferred Brand	\$35	\$100	\$40**	
Prescription drugs – Mail Order (90 day supply)	25% Min Max			
Generic	\$20	\$50	\$10	
Preferred Brand	\$40	\$100	\$40	
Non-preferred Brand	\$70	\$200	\$80	
Audiometric services in conjunction with a disease, illness or injury	25%*	50%*	50%*	50%*
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	25%*	50%*	\$15 co-pay	40%*
Autism Service				
▪ Rehabilitative and therapeutic care services	25%*	50%*	20%*	40%*
▪ Respite care for children ages two through 21 (\$500 maximum per month)	25%*	50%*	20%*	40%*
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	25%*	50%*	20%*	40%*
Prosthetic devices	25%*	50%*	20%*	40%*
Home health – limited to 60 visits per year	25%*	50%*	20%*	40%*
Physical therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Occupational therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Cardiac rehabilitation therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Speech therapy – limited to 30 visits per year	25%*	50%*	20%*	40%*
Skilled nursing facility services – limited to 30 days per year	25%*	50%*	20%*	40%*
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%*	20%*	40%*

\* Subject to annual deductible

\*\* After the 75<sup>th</sup> prescription has been filled, excluding mail order, the co-payment will reduce to \$15 preferred brand and \$30 non-preferred brand.

**2009 Public Employee Health Insurance Program Benefit Provisions (continued)**

Covered Services	Commonwealth Optimum PPO		Commonwealth Maximum Choice	
	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 - \$2,000 Family - \$3,000	Single - \$2,000 Family - \$3,000
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - \$1,125 Family - \$2,250	Single - \$2,250 Family - \$4,500	Single - \$3,000 Family - \$4,500	Single - \$4,000 Family - \$6,000
Up-Front Benefit Allowance	Not Applicable		Not Applicable	
Lifetime maximum	Unlimited		Unlimited	
Health Reimbursement Account Funds	Not Applicable		Single - \$1,000 Parent Plus - \$1,500 Couple - \$1,500 Family - \$2,000	
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	15% *	30% *	10% *	40% *
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	30% *	10% *	40% *
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	30% *	10% *	40% *
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.	15%	30% *	10% *	40% *
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	\$10 co-pay per visit \$400 maximum benefit per covered individual per plan year	30% *	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 15% *	\$50 co-pay plus 30% *	10% *	40% *
Emergency room physician charges	15%	30% *	10% *	40% *
Urgent care center treatment	\$20 co-pay	30% *	10% *	40% *
Ambulance services	15% *	15% *	10% *	10% *
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 in-hospital care co-insurance applies*	30% *	10% *	40% *
Prescription drugs – Retail (30 day supply)				
Generic	\$5**	30%	10% *	40% *
Preferred Brand	\$20**	30%	10% *	40% *
Non-preferred Brand	\$40**	30%	10% *	40% *
Prescription drugs – Mail Order (90 day supply)				
Generic	\$10		10% *	
Preferred Brand	\$40		10% *	
Non-preferred Brand	\$80		10% *	
Audiometric services in conjunction with a disease, illness or injury	10% *	30% *	10% *	40% *
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	\$10 co-pay	30% *	10% *	40% *
Autism Service				
▪ Rehabilitative and therapeutic care services	\$10 co-pay	30% *	10% *	40% *
▪ Respite care for children ages two through 21 (\$500 maximum per month)	15% *	30% *	10% *	40% *
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	15% *	30% *	10% *	40% *
Prosthetic devices	15% *	30% *	10% *	40% *
Home health – limited to 60 visits per year	15% *	30% *	10% *	40% *
Physical therapy – limited to 30 visits per year	15% *	30% *	10% *	40% *
Occupational therapy – limited to 30 visits per year	15% *	30% *	10% *	40% *
Cardiac rehabilitation therapy – limited to 30 visits per year	15% *	30% *	10% *	40% *
Speech therapy – limited to 30 visits per year	15% *	30% *	10% *	40% *
Skilled nursing facility services – limited to 30 days per year	15% *	30% *	10% *	40% *
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	15% *	30% *	10% *	40% *

\* Subject to annual deductible

\*\* After the 75<sup>th</sup> prescription has been filled, excluding mail order, the co-payment will reduce to \$15 preferred brand and \$30 non-preferred brand.

## 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*

<b>Kentucky Mandated Health Insurance Benefits</b>	
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.

<b>Kentucky Mandated Health Insurance Benefits</b>	
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*

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

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***

<b>Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program</b>		
<b>Year Enacted</b>	<b>Bill</b>	<b>Key Provisions</b>
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"> <li>▪ The Director of the Administrative Office of the Courts</li> <li>▪ KRS retiree</li> <li>▪ KTRS retiree</li> <li>▪ Active teacher</li> <li>▪ Active state employee</li> <li>▪ Active classified education support employee</li> </ul>
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"> <li>▪ Personnel Cabinet to study whether to allow health insurance bidders to bid different rates in different geographic areas of the Commonwealth.</li> <li>▪ 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.</li> </ul>

<b>Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program</b>		
<b>Year Enacted</b>	<b>Bill</b>	<b>Key Provisions</b>
2002	HB 846	<ul style="list-style-type: none"> <li>▪ Restricts individuals to one state subsidy for health insurance.</li> <li>▪ Entities participating in the Public Employee Health Insurance Program must sign a contract with the Personnel Cabinet.</li> <li>▪ 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.</li> <li>▪ 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.</li> <li>▪ Directs the LRC to study the Public Employee Health Insurance Program.</li> <li>▪ 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.</li> </ul>
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.

<b>Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program</b>		
<b>Year Enacted</b>	<b>Bill</b>	<b>Key Provisions</b>
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 406	Requires agencies to coordinate the timing of employer payments to KEHP in such a manner as to provide the agencies the flexibility to lapse \$7 million in General Fund moneys in each fiscal year.
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

<b>Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program</b>		
<b>Year Enacted</b>	<b>Bill</b>	<b>Key Provisions</b>
2008	SB 96	Requires all health insurance plans to provide for colorectal cancer screening based on current American cancer Society guidelines.
2009	HB 143	Allows the Governor to direct a one-time transfer of up to \$50 million from the Public Employee Health Insurance Trust Fund's surplus to the General Fund. Outlines the conditions under which the transfer is authorized.

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.

**PEPM (Per Employee Per Month):** A measure of costs as expressed as total costs divided by total number of employees.

**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.

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