

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

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

**December 15, 2010**

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## EXECUTIVE SUMMARY

This Tenth 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 2009 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 2010, historical information on plan designs, legislative mandates, and commentary on the KGHIB's focus in a post-federal healthcare reform world.

### Highlights of the 2009 KEHP Experience

- **KEHP costs continue to escalate, but at a lower rate than the previous year.**
  - ✓ In 2009 the KEHP paid claims cost for providing medical and pharmacy benefits to members was \$1,341,000,000 in total. In aggregate this cost was 7.6% higher than the plan cost in 2008. A portion of the plan cost increase was due to a 2.5% 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 5.0% from 2008 to 2009. The medical claims PMPM increase was 5.3% and the pharmacy PMPM increase was 4.1%. KEHP costs trended lower than in prior years, largely due to the introduction of new plan designs in 2009 and increased member cost sharing.
- **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) for an employee's health insurance coverage ("single" tier of coverage) has increased from \$9.72 per month in 1972 to \$607 in 2009 and to an estimated \$662 in 2010. The employee's portion of the cost has risen from \$101.24 in 2009 to \$108.36 in 2010.
  - ✓ On a percentage basis, in 2009 KEHP paid 96.3% of single coverage healthcare costs and 75.4% of employee plus dependent(s) coverage<sup>1</sup> healthcare costs. These percentages vary from government sector benchmarks (as provided by the Kaiser-HRET annual survey). KEHP offers more generous single-tier cost sharing than the average governmental entity which pays an average of 89% of healthcare costs. On the other hand, KEHP offers slightly less rich employee plus dependent(s) cost sharing than the national average of 77% of costs.

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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.

- **KEHP membership is growing and the average age of membership continued to drop in 2009.**

  - ✓ From 2008 to 2009 KEHP membership grew by 2.5%. The average employee age increased from 47.7 to 47.9, however the average member age dropped from 38.0 to 37.9. This slight decrease in age results in an improved plan cost. For each year reduction in the average age of plan members, plan costs decrease an estimated 2.0%.
  - ✓ KEHP continued to have fewer enrolled dependents than national averages, with 66% of coverage provided through the "Single" tier of coverage. The lower dependent enrollment may be due, in part, to higher than average employee contributions for dependent coverage.
  
- **KEHP spends the largest portion of its total claims cost for hospital outpatient care and this service component's cost continues to increase.**

  - ✓ The KEHP claims distribution across inpatient hospital, outpatient hospital, physician, other medical, and pharmacy goods and services remained relatively consistent from 2008 to 2009.
  - ✓ KEHP's outpatient claims, the largest component of cost, increased at a rate of 6.8%. Inpatient services increased 7.8%, and pharmacy costs grew 4.1%.
  
- **Clinical conditions related to heart disease, arthritis and similar conditions, and respiratory conditions, such as asthma, continue to be prevalent in the KEHP population.**

  - ✓ A significant portion of plan cost has been attributable to largely the same clinical conditions since 2004. Circulatory conditions, or conditions related to the heart, musculoskeletal conditions such as arthritis, joint disorders and spinal/back disorders, respiratory conditions such as asthma, and COPD top the list.
  - ✓ Members with these clinical conditions are responsible for 58% of the plan's 2009 medical claims cost.
  - ✓ 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; this has resulted in the need for increased member cost sharing.**

  - ✓ Allowed prescription drug charges, defined as total discounted charges less charges for non-covered drugs, increased by 8.8% in 2009, compared to a 10.8% increase in 2008.
  - ✓ In 2009 the KEHP portion of the total pharmacy costs rose by 6.7%.
  - ✓ In 2009 members paid 23.4% more per prescription drug claim than in 2008, due to increased co-payments associated with the new plan options.

## **A Look at the First Six Months of 2010**

Claims and enrollment experience for the first six months of 2010 indicates that many of the 2009 trends continue.

- **KEHP costs continue to rise. Enrollment also continues to increase steadily.**
  - ✓ KEHP PMPM plan costs for the first six months of 2010 increased by 5.6% compared to the first six months of 2009.
  - ✓ Plan membership increased by 3.5%, and the number of individuals waiving coverage decreased by 5.2%.
- **Pharmacy benefit cost and utilization continue to increase, and members continue to contribute a larger portion of the cost.**
  - ✓ The total number of prescriptions increased by 3.1% for the first half of 2010 versus the first six months of 2009. However, on a per member basis, there has been a slight decrease of 0.4% in the average number of prescriptions.
  - ✓ The percentage of pharmacy claims paid by members decreased during the first six months of 2010. However, due to increased pharmacy copayments implemented in 2009, members continued to contribute a larger portion of the cost than they had in 2008 and prior.
- **The distribution of types of services (inpatient hospital, outpatient hospital, physician, pharmacy) being utilized in 2010 is similar to prior years.**

## **Maintaining a Sustainable Kentucky Employees' Health Plan in the Face of Kentucky's Budget Challenges and in a Post-Federal Healthcare Reform World**

The KEHP provides healthcare 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. In order to continue to provide valuable health benefits and maintain financial solvency in the coming years, the KEHP will need to reassess current strategies and approaches related to health benefits. This reassessment must be made in light of the emerging healthcare system and market dynamics driven by health reform in the US and in light of the Commonwealth's continuing budget challenges.

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 the Commonwealth's population.

KEHP's assessment of the most beneficial balance in this new post health reform world will reflect its unique government plan dynamics, financial challenges, and participating employers' talent management and rewards strategies. While, in some ways, KEHP's approaches will build on the lessons learned and successes of the past few decades, they will also leverage the new opportunities presented in a post-reform world.

To successfully manage benefits programs and cost, KEHP will continue to incorporate the strategic and compliance requirements of health reform into planning and program management processes. This includes considering grandfathered status, the required plan design changes, reporting requirements to HHS, employee communications, new eligibility requirements, pay or play penalties, available subsidies, multiple tax issues and the implications of the dramatic changes which will evolve in the US healthcare system. KEHP will also continue to address financial solvency issues related to the Commonwealth's budget challenges.

### **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
- Strive to hold down costs for family and dependent coverage
- Provide plans with unlimited lifetime maximums

The Board continues to support the recommendations made in last year's Ninth Annual Report. These recommendations are detailed below along 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 has continued to evaluate data and information related to the plan's cost, members' use of services, and the clinical conditions prevalent in the population. Challenges and*

*opportunities for improving both the cost to the plan and members and for improving members' health have been evaluated and implemented. Several strategic alternatives, including implementing approaches to improve and integrate disease and care management programs, strategies to increase the use of generic drugs and manage specialty drug use, and expansion of wellness and prevention programs were evaluated and implemented. DEI continues to evaluate alternatives for implementation in 2011, including evaluating additional incentive programs to improve members' participation and engagement in wellness and care management programs. 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 have been implemented and DEI continues to monitor the results. Increased active participation in wellness and disease management programs has been achieved in 2010. Care management vendors meet quarterly with DEI to discuss results and potential additional efforts to manage care.*

- KEHP should evaluate programs and options for improving the clinical and administrative quality of programs and services. This study should consider practical steps to evaluate and improve administrative services including claims payment, customer service and others. It should consider programs to measure and improve quality of care currently available in the marketplace.

*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. Further 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 implemented increased communications processes in 2009 and 2010. 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 further recommends:

- 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 healthcare 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 healthcare reform measures once the scope and detail of reform programs are known.

*DEI has evaluated the impact of federal healthcare reform law and regulations as information became available during the course of 2010. DEI will continue to evaluate the emerging impact of the law as regulations are finalized and market impact information becomes available.*

# 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 tenth 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 2009 KEHP experience
- A look at plan experience for the first six months of 2010
- A perspective on sustainability in a post-reform world
- Board Recommendations

The appendix to this report contains the following information:

- 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
- A glossary of terms

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

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

## **2009 KEHP Experience**

This section of the Annual Report provides a summary of cost and usage trends experienced by KEHP in 2009. The 2008-2010 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 2010 Claims Experience**

At the time that this report was written, 2010 claims data were available through June 2010. In exhibits that estimate complete 2010 experience, calendar year 2010 claims experience was estimated by applying the claims seasonality observed in 2009 to the six months of claims experience available in 2010. "Seasonality" refers to variations over the course of the year in

enrollment patterns and claims payments 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. Furthermore, all references to claims and KEHP subsidies exclude the experience related to the stand-alone Waiver HRA plan, unless otherwise noted. Analyses included in this annual report do not include the financial impacts of third party claims administration or network access fees.

### **A Summary of KEHP Program Costs, Plan Subsidies and Employee Contributions - 2000 to 2010**

#### **Highlights**

- Total paid claims cost rose by 7.6% in 2009. This includes the impact of both increased claims cost and utilization and an increase in membership. On a per member per month basis (PMPM) paid claims cost increased by 5.0% (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 percentage of claims cost that the plan paid in 2006. In 2007, 2008, and again in 2009, KEHP and employees shared the cost increases, returning to an 85%/15% KEHP/employee cost split.
- In 2009, KEHP's subsidies covered 85.7% of budget rates (96.3% for Single Coverage, 75.4% blended for the employee + dependent coverage tiers). KEHP subsidies for single coverage are 7.3 points higher than national averages. Subsidies for employee plus dependent(s) coverage tiers are 1.6 points lower than national averages.
- The 2009 incentive to encourage individuals to waive coverage remained unchanged from 2008, at \$175 per month. At its peak in early 2006, the incentive was \$234. The incentive reduction, along with the rise in healthcare 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 healthcare costs continue to increase, fewer members will waive the KEHP benefits coverage.

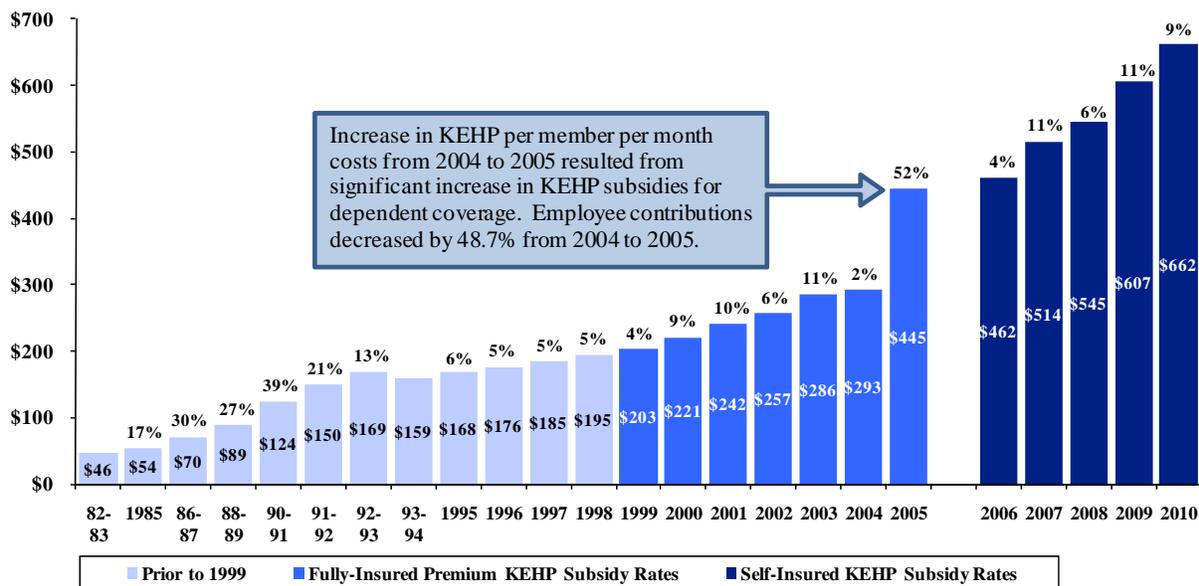
#### **Historical Per Employee KEHP Subsidies**

The KEHP's per employee per month (PEPM) subsidy (the amount paid by the plan, excluding the amount paid by the participant) from 1982 through 2010 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, and is estimated to increase to

\$662 per month for 2010. 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: Ninth Annual Report and KEHP's enrollment and claims data aggregated by Thomson Reuters.

Prior to 2005, KEHP did not provide subsidies for dependent coverage. Effective for 2005, KEHP began to provide subsidies for dependent coverage, hence the large increase seen in KEHP subsidy levels from 2004 to 2005 in Exhibit I (as well as in Exhibits II and III).

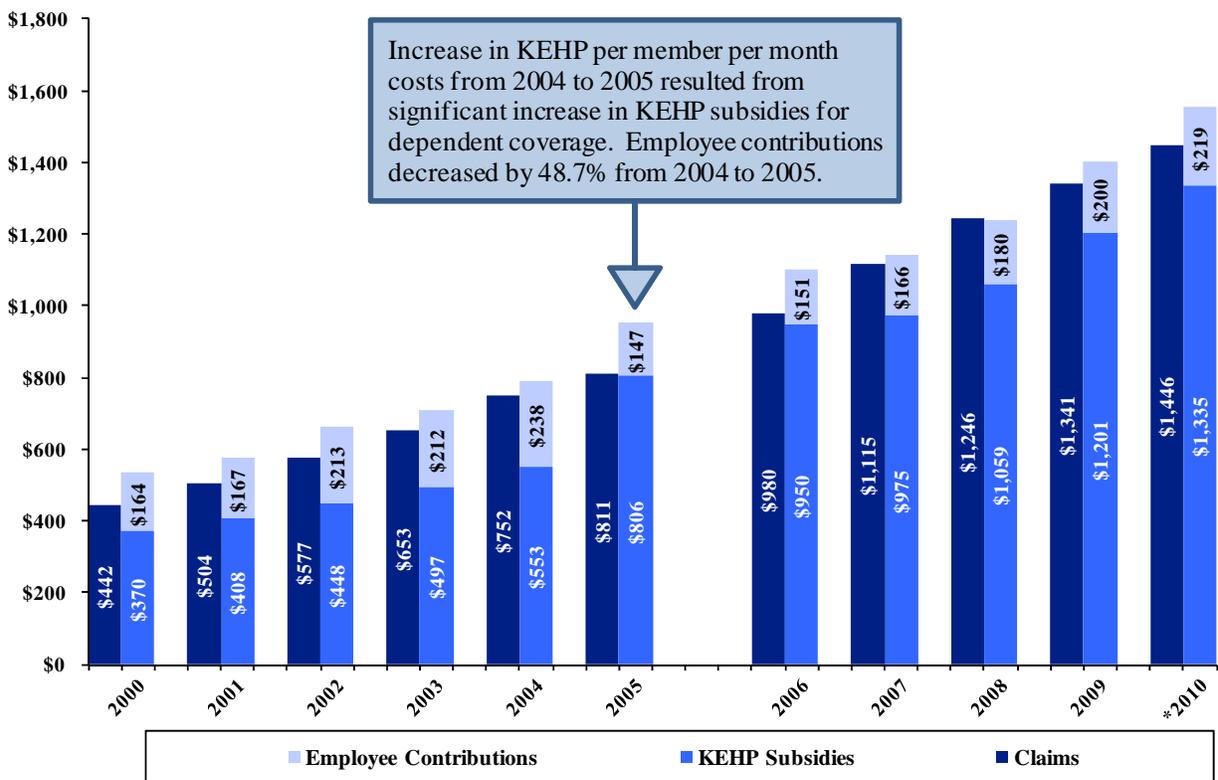
KEHP subsidies through 2005 were the portion of the fully-insured premium amounts paid by the PEHI/KEHP program minus employee contributions. In 2006, the benefit plans' funding was transitioned from fully-insured to self-insured, which removed the insurance company margin that KEHP was previously covering in its premiums. The self-insured costs in 2006 through 2010 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 KEHP's self-funded program in 2006 through 2009 are identified as "Claims" in Exhibit II. For 2010, the annual claims have been estimated based on the 2010 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 bar includes the plan's portion of incurred claims and administrative fees, and the employee contributions bar includes the employee's portion of claims and administrative fees.

Exhibit II identifies the total subsidy amounts KEHP paid in 2000 through 2010 (estimated) for all members of the KEHP program, the total annual employee contributions and the aggregate claims costs incurred. The figures included in this exhibit represent millions of dollars.

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 2010 shows this trend continuing. This observation may change as the 2010 plan year progresses.

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



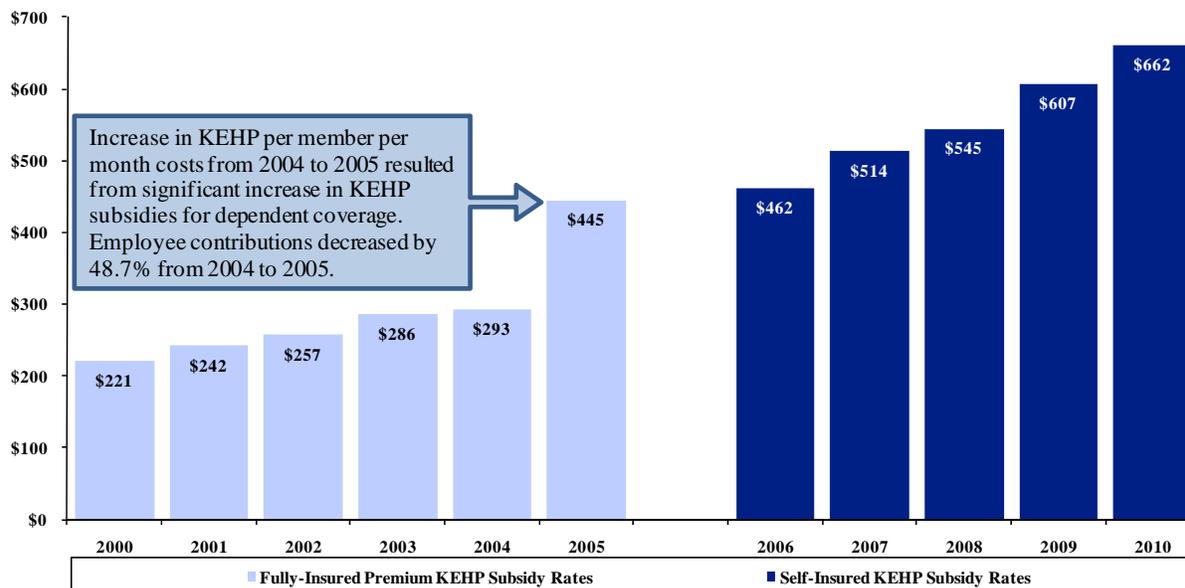
Source: Claims reported by KEHP’s insurers and administrators and compiled by Thomson Reuters and enrollment reported by the Commonwealth. Employee Contributions for 2000 through 2010 provided by the DEI.

\* 2010 figures reflect estimates based on six months of 2010 claims experience, seasonally adjusted to year end.

KEHP significantly increased its subsidy for employee health insurance in 2005, as shown in Exhibit III. In 2009, KEHP and members shared the cost increase to the KEHP program.

**Exhibit III**

**KEHP Per Employee Per Month (PEPM) Subsidy 2000-2010**



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

In 2009, KEHP covered 85.7% of total costs (96.3% for single coverage, 75.4% blended for the employee + dependent coverage tiers). Exhibit IV compares the KEHP subsidies to national averages for the government sector. Since 2007, 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 2009, the KEHP subsidy was 7.3 percentage points higher than national averages for single coverage and 1.6 points lower than national averages for employee plus dependent(s) coverage. For 2010 KEHP employee only subsidies are estimated to be 6.1% higher than national averages. Subsidies for employee and dependents tiers are 2.8% lower than averages.

**Exhibit IV**

**KEHP Subsidies Compared to Government Sector Benchmarks**

	2007		2008		2009		2010	
	Kaiser	KEHP	Kaiser	KEHP	Kaiser	KEHP	Kaiser	KEHP
Employee Only	87.0%	97.2%	88.0%	97.3%	89.0%	96.3%	90.0%	96.1%
Employee + Dependents	78.0%	71.5%	78.0%	71.6%	77.0%	75.4%	79.0%	76.2%
Overall	82.7%	85.0%	83.2%	84.9%	82.9%	85.7%	84.4%	85.9%

Source: Benchmarks from 2007, 2008, 2009, and 2010 Kaiser Family Foundation Employer Health Benefits survey

Exhibit V provides monthly employee contribution rates for 2009 and 2010 by plan option, coverage tier, and non-smoker versus smoker status.

**Exhibit V**  
**2009 and 2010 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>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
<b>2010 Rates</b>					
<b>Standard PPO:</b>					
<b>Non-Smoker</b>	\$0.00	\$282.18	\$8.28	\$288.44	\$0.00
<b>Smoker</b>	\$24.00	\$330.18	\$56.28	\$336.44	\$24.00
<b>Capitol Choice:</b>					
<b>Non-Smoker</b>	\$5.00	\$444.12	\$144.02	\$525.84	\$12.88
<b>Smoker</b>	\$29.00	\$492.12	\$192.02	\$573.84	\$36.88
<b>Optimum PPO:</b>					
<b>Non-Smoker</b>	\$27.50	\$469.52	\$176.52	\$561.16	\$28.34
<b>Smoker</b>	\$51.50	\$517.52	\$224.52	\$609.16	\$52.34
<b>Maximum Choice:</b>					
<b>Non-Smoker</b>	\$0.00	\$334.66	\$108.86	\$398.32	\$9.66
<b>Smoker</b>	\$24.00	\$382.66	\$156.86	\$446.32	\$33.66

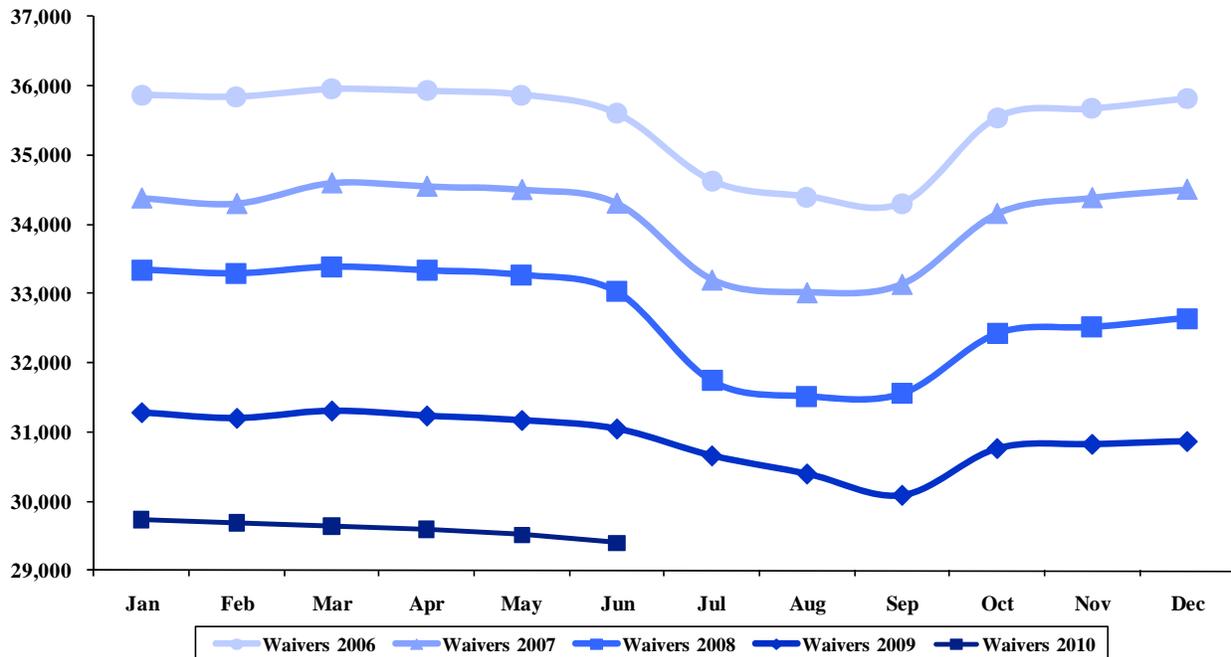
Source: 2009 and 2010 KEHP Employee Contribution Rates

**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. In 2006 the monthly deposit was \$234 for the months January through June, and then decreased to \$200 for the remainder of 2006; in 2007, the amount decreased to \$175 per month, and it has remained at that level through 2010. Exhibit VI shows the monthly waiver participation for the period January 2006 through June 2010.

The incentive reduction, along with the rise in healthcare 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 employers may have lost their jobs due to the economic decline. These factors may have all contributed to the steady decline in waiver participation.

**Exhibit VI**  
**2006 through June 2010 Monthly Coverage Waiver Participation**



	KEHP Waivers				
	2006	2007	2008	2009	2010 (6 Months)
Average	35,453	34,086	32,674	30,905	29,599
Change	-1.7%	-3.9%	-4.1%	-5.4%	-4.2%

Source: KEHP enrollment data.

## Medical & Pharmacy Trends for 2009

### Key Findings & Considerations

- In aggregate, KEHP paid claims costs increased by 7.6% from 2008 to 2009. The number of enrollees increased by 2.5%.
- KEHP's per member per month paid claims cost increased by 5.0% from 2008 to 2009; 5.3% for medical and 4.1% for pharmacy. Over the last three years, the KEHP average annual increase was 7.9%. The decrease in trend for KEHP can largely be attributed to the change in plan options and benefits in 2009.

### Medical and Pharmacy Claims Cost Increases

Overall, the KEHP's annual per member per month paid claims costs increased by 5.0% from 2008 to 2009. As shown in Exhibit VII, the KEHP experienced a 3.2 point decrease in annual per member per month medical trend from 8.5% in 2008, to 5.3% in 2009. Pharmacy benefits trend decreased by 6.4 points. In 2009, the annual per member per month pharmacy cost increase was 4.1% compared to 10.5% in 2008.

An important contributing factor to the decrease in both the medical and pharmacy trend is the change in plan designs that took place in 2009. As discussed in later sections of the report, four new plans were introduced in 2009, and members were actively required to select plan options during open enrollment. Enrollment jumped for the consumer directed Maximum Choice plan (formerly the Select plan), and enrollment also increased slightly for the Standard plan (formerly the Essential plan). Both of these plans require higher cost sharing for members and this is reflected in the lower KEHP trends from 2008 to 2009. The majority of members have elected the Optimum plan, which offers the lowest deductible and cost sharing provisions and is most similar to the Premier and Enhanced plan designs.

### *Exhibit VII*

#### 2007 – 2009 Paid Claims Experience

	KEHP Paid Claims Experience					
	2007	% Chg	2008	% Chg	2009	% Chg
<b>Aggregate</b>						
Medical Claims	\$850,061,028	14.4%	\$946,785,361	11.4%	\$1,021,818,490	7.9%
Rx Claims	\$263,411,276	11.5%	\$298,709,346	13.4%	\$318,753,656	6.7%
Total Claims	\$1,113,472,304	13.7%	\$1,245,494,707	11.9%	\$1,340,572,146	7.6%
Covered Lives	244,581	3.6%	251,024	2.6%	257,400	2.5%
<b>PMPM</b>						
Medical Claims	\$290	10.4%	\$314	8.5%	\$331	5.3%
Rx Claims	\$90	7.6%	\$99	10.5%	\$103	4.1%
Total Claims	\$379	9.7%	\$413	9.0%	\$434	5.0%

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

Exhibit VIII, 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 700 employers and private not-for-profit health plans. Nationally, medical cost trend increased from 9.2% in 2009 to 9.5% in 2010, and is expected to fall slightly to 9.0% in 2011.

***Exhibit VIII***  
**2009 – 2011 National Claims Trend Expectation**

<b>PricewaterhouseCoopers Trend Survey</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Medical and Pharmacy Cost Trend	9.2%	9.5%	9.0%

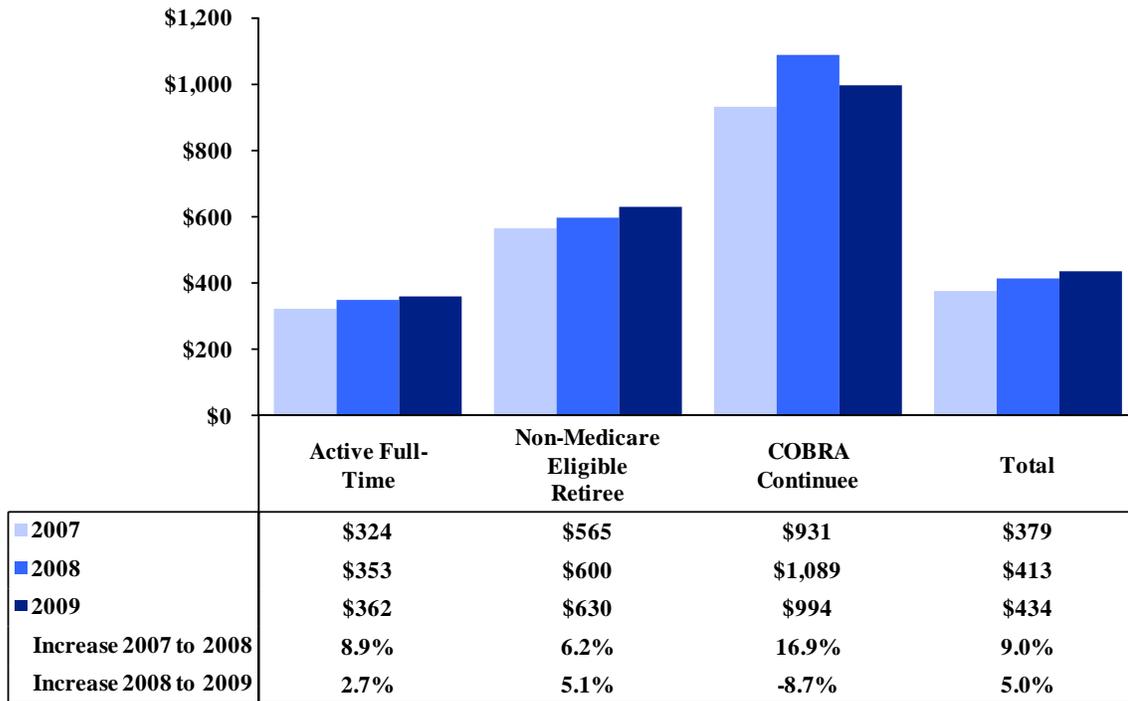
*Source: PwC "Behind the Numbers: Medical Cost Trends" 2011.*

**Claims Payments by Employee Status**

As noted in Exhibit VII, combined medical and pharmacy paid claims increased by 5.0% PMPM from 2008 to 2009. Exhibits IX, X and XI provide PMPM cost increases for 2007 through 2009 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)**

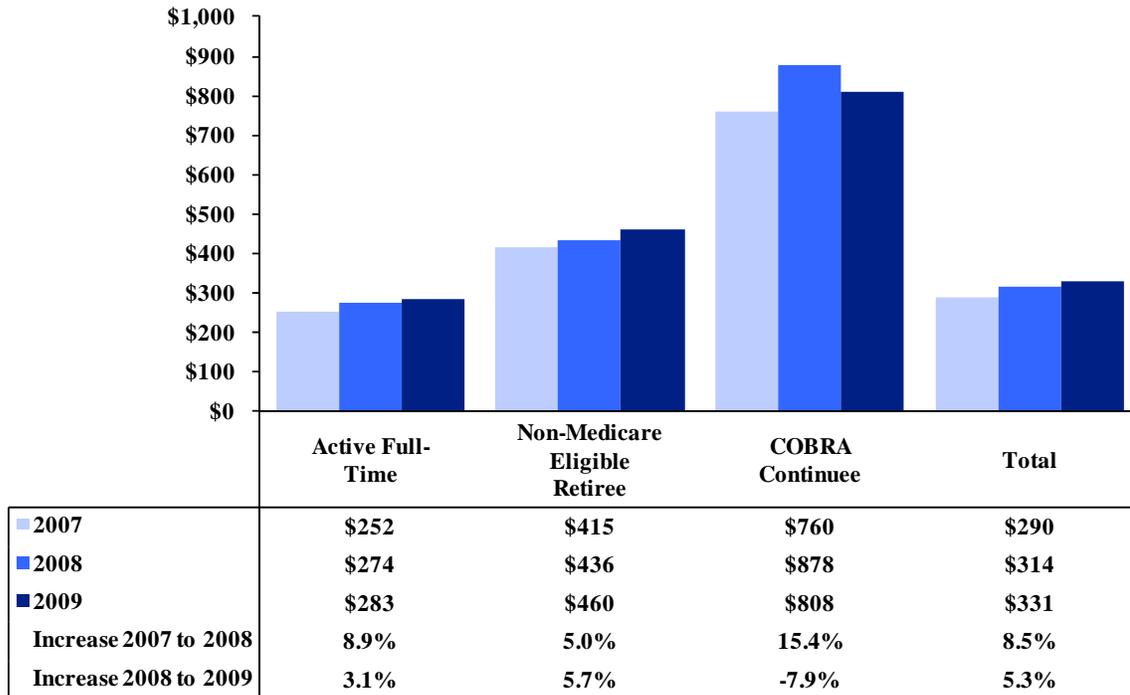


Source: Claims reported by KEHP's insurers and administrators and enrollment reported by the Department of Employee Insurance, compiled by Thomson Reuters

The average medical claims PMPM change (Exhibit X) from 2008 to 2009 was 3.1% for the active employee group and 5.7% for the non-Medicare eligible retiree group. The 2009 non-Medicare eligible retiree medical claims cost PMPM is 62.5% higher than the active claims cost.

**Exhibit X**

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

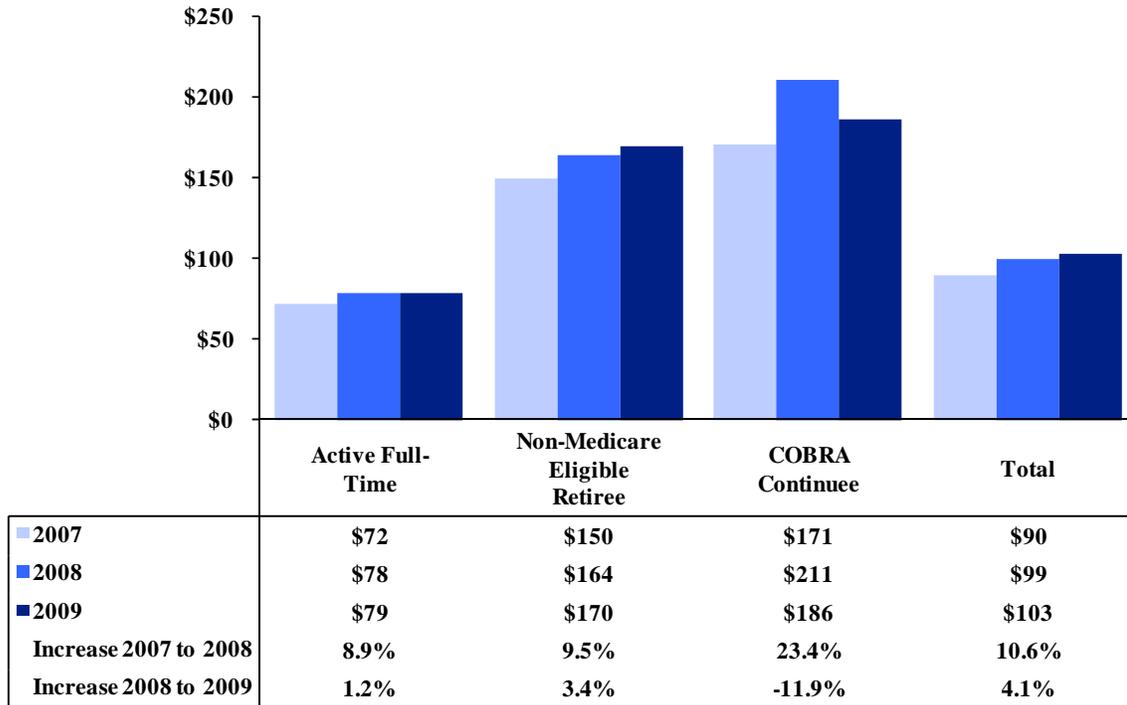


Source: Claims reported by KEHP's insurers and administrators and enrollment reported by the Department of Employee Insurance, compiled by Thomson Reuters.

The average pharmacy paid claims (Exhibit XI) PMPM increase for 2008 to 2009, for active employee and non-Medicare eligible retiree groups, was 1.2% and 3.4%, respectively. The 2009 non-Medicare eligible retiree pharmacy claims cost PMPM is 115% 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 2.5% increase in enrollment from 2008 to 2009.
- From 2008 to 2009, the average employee age increased slightly, from 47.7 to 47.9 years. Average member age (including employees and dependents), from 2008 to 2009, decreased slightly from 38.0 to 37.9 years. 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 24.1% of the group in 2009, an increase of 7.5% from 2008. Due to the impact that age and retiree utilization patterns have on an individual's healthcare costs, this increase in membership has significant cost implications for the KEHP program.
- Normative statistics show that female healthcare claim costs between the ages of 20 and 50 are approximately 1.4 times higher than the cost for males in the same age group. For ages 50 and older, female healthcare claims are statistically 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.
- New plan designs and plan names were introduced in 2009. Enrollment in the consumer directed high deductible plan increased significantly; however, the majority of members elected coverage through the Optimum plan which has the lowest deductible and cost sharing.
- As expected, the PMPM costs for the two Retirement Systems, KRS at \$604 and KTRS at \$697, are the highest among the group. The School Boards are the largest group representing 49.1% of the KEHP covered population, and have the lowest PMPM among all groups, at \$363 in 2009.

From 2008 to 2009, the average employee age increased slightly from 47.7 to 47.9 years. This could be partially due to fewer young individuals entering the workforce, a result of the economic downturn and hiring freezes. A combination of actuarial benchmarks and the proportion of non-Medicare eligible retirees indicates 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 healthcare 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**

Actives, Non-Medicare Eligible Retirees, and COBRA Participants	KEHP Membership		
	2008	2009	2010
<b>Average Age:</b>			
Employees	47.7	47.9	48.0
Members	38.0	37.9	37.8
<b>Demographic Splits:</b>			
Employee Percentage Male	34.9%	34.7%	34.4%
Member to Employee Ratio	1.6	1.7	1.7
<b>% of Covered Members Who Are:</b>			
Adult Male	26.8%	26.6%	26.4%
Adult Female	46.2%	45.8%	45.5%
Children	27.0%	27.7%	28.2%

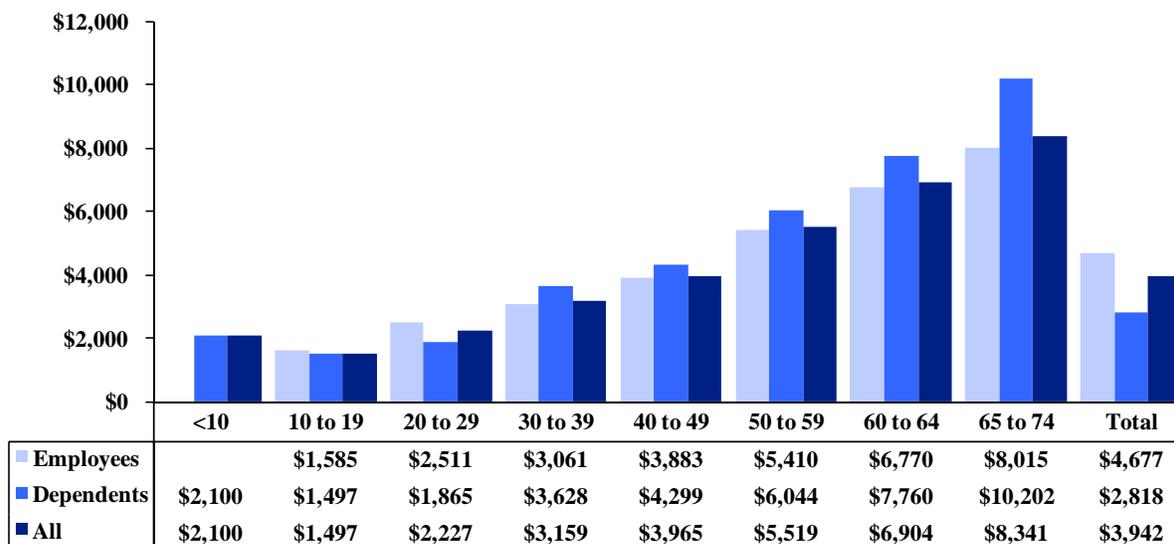
*Source: KEHP's enrollment data aggregated by Thomson Reuters.*

The average member age dropped slightly from 38.0 in 2008 to 37.9 years in 2009. The first six months of 2010 has seen another slight decrease, to 37.8 years.

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 45% of dependent costs. On the other hand, dependents 30 and older represent 29% of the total dependents and 55% of the dependent costs. Dependents between the ages of 50 - 59 are only 10% of the dependent population, but their costs represent 22% of the total dependent paid claims.

**Exhibit XIII**

**2009 Demographics—Employee and Dependent Paid Medical Claims by Age**



2009 Member Counts									
Employees		74	14,986	26,499	33,726	51,088	26,387	2,896	155,656
Dependents	27,557	33,364	11,752	5,594	8,257	10,568	4,144	507	101,743
All	27,557	33,438	26,738	32,093	41,983	61,656	30,531	3,403	257,400

2009 Aggregate Paid Claims (\$ Millions)									
Employees		\$0.1	\$37.9	\$81.7	\$131.9	\$278.3	\$179.9	\$23.4	\$733.1
Dependents	\$58.3	\$50.3	\$22.1	\$20.4	\$35.7	\$64.3	\$32.4	\$5.2	\$288.7
All	\$58.3	\$50.4	\$60.0	\$102.1	\$167.6	\$342.6	\$212.2	\$28.6	\$1,021.8

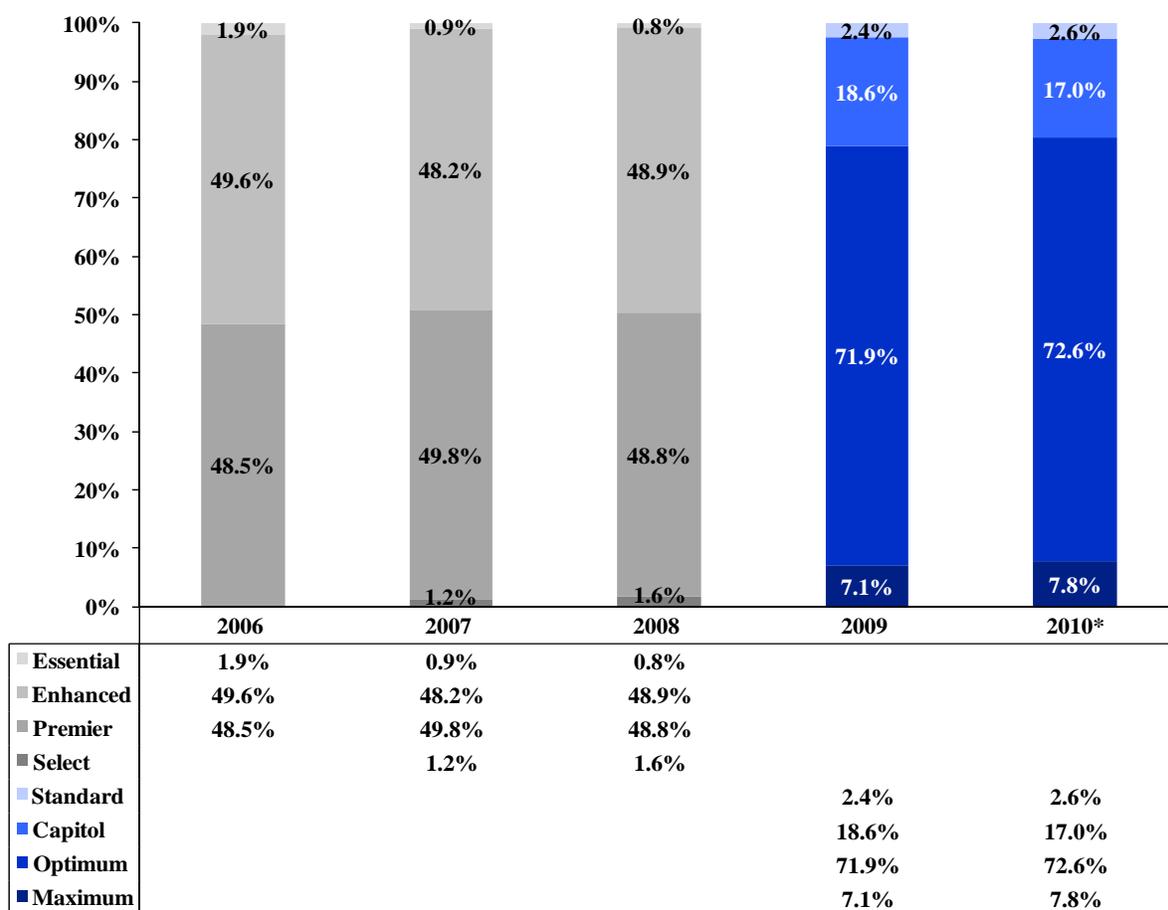
Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

## Enrollment by Plan Option

Exhibit XIV shows the KEHP enrollment by plan option from 2006 through the first six months of 2010. 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 7.1% and has risen again in 2010. The majority of members (72.6%) have elected the Optimum plan which offers the lowest deductible and cost sharing provisions.

**Exhibit XIV**  
**2006 - 2010 Enrollment By Plan Option**

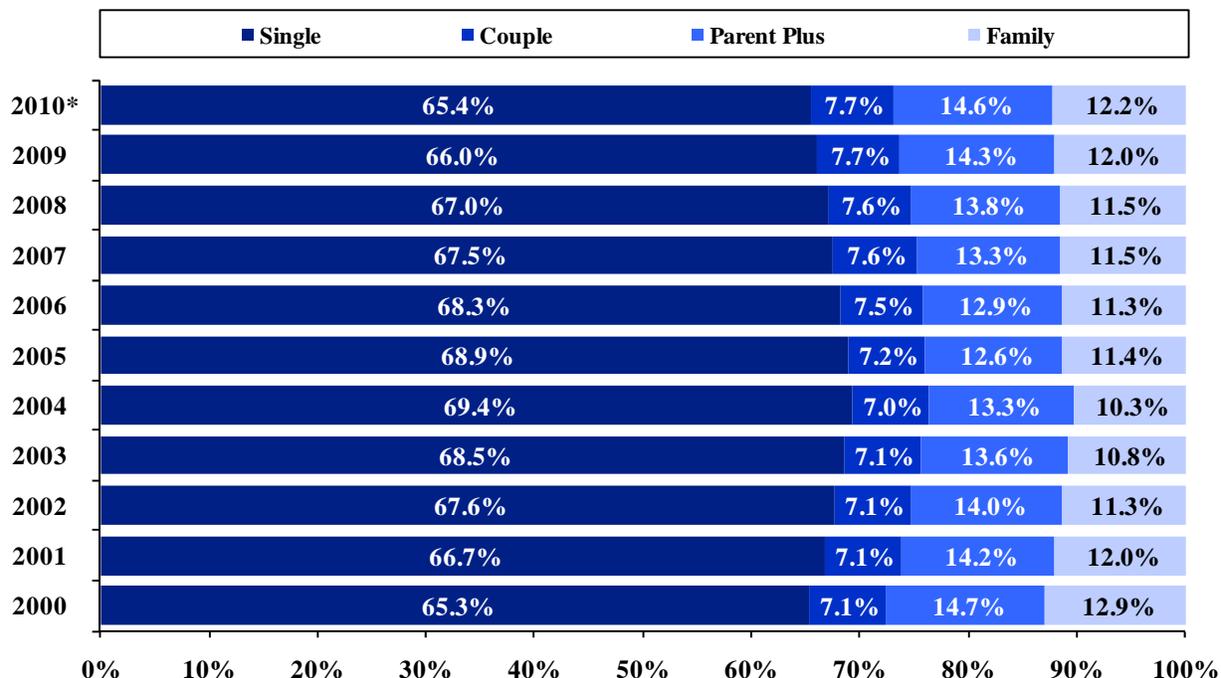


Source: KEHP's enrollment aggregated by Thomson Reuters.  
\* January through June 2010 data only.

Exhibit XV shows the percentage of employees and non-Medicare eligible retirees enrolling in single coverage has steadily declined from 2004 to 2010.

**Exhibit XV**

**2000 - 2010 Enrollment By Coverage Tier**



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

\* January through June 2010 data only.

**Group Composition**

The participating groups' composition changed very little from 2008 to 2010. In total (across all participating groups), there was a 2.8% increase in enrollment in 2009 and an increase of 2.9% in the first six months of 2010. The increase in actives from 2008 to 2009 was 1.4% compared to 4.2% for actives thus far this year. Retirees and their dependents represent 24.1% of KEHP membership in 2009, an increase of 7.5% from 2008. This increase in retiree membership has cost implications for the KEHP program as healthcare costs tend to increase with age and retirees generally utilize more healthcare services than active employees of the same age.

**Exhibit XVI**

**Average Number of Covered Members by Group**

	Average KEHP Members by Group (Includes Dependents)								
	2008			2009			2010 (6 Months)		
	Average Lives	% of Total	% Change	Average Lives	% of Total	% Change	Average Lives	% of Total	% Change
<b>By Covered Group</b>									
State Employees	53,705	21.3%	1.1%	52,696	20.3%	-1.9%	54,646	20.5%	3.7%
School Boards	124,029	49.2%	2.8%	127,347	49.1%	2.7%	132,857	49.8%	4.3%
Health Departments	4,434	1.8%	5.0%	4,549	1.8%	2.6%	4,783	1.8%	5.2%
KRS	38,444	15.2%	7.8%	42,301	16.3%	10.0%	41,902	15.7%	-0.9%
KTRS	19,694	7.8%	0.5%	20,225	7.8%	2.7%	19,814	7.4%	-2.0%
KCTCS	5,387	2.1%	3.5%	5,483	2.1%	1.8%	5,731	2.1%	4.5%
Quasi/Local Govt	5,946	2.4%	8.1%	6,083	2.3%	2.3%	6,280	2.4%	3.2%
COBRA	504	0.2%	-9.3%	476	0.2%	-5.5%	627	0.2%	31.6%
<b>Subtotal</b>	<b>252,142</b>		<b>3.1%</b>	<b>259,160</b>		<b>2.8%</b>	<b>266,639</b>		<b>2.9%</b>
Unknown/Missing	70			36			101		
<b>Grand Total</b>	<b>252,213</b>		<b>3.1%</b>	<b>259,196</b>		<b>2.8%</b>	<b>266,740</b>		<b>2.9%</b>
<b>By Covered Status</b>									
Actives	193,529	76.7%	2.6%	196,194	75.7%	1.4%	204,397	76.6%	4.2%
Retirees	58,179	23.1%	5.1%	62,526	24.1%	7.5%	61,716	23.1%	-1.3%
COBRA	504	0.2%	-12.4%	476	0.2%	-5.5%	627	0.2%	31.6%
<b>Grand Total</b>	<b>252,213</b>		<b>3.1%</b>	<b>259,196</b>		<b>2.8%</b>	<b>266,740</b>		<b>2.9%</b>
Unknown/Missing	0			0			0		
<b>Grand Total</b>	<b>252,213</b>		<b>3.1%</b>	<b>259,196</b>		<b>2.8%</b>	<b>266,740</b>		<b>2.9%</b>

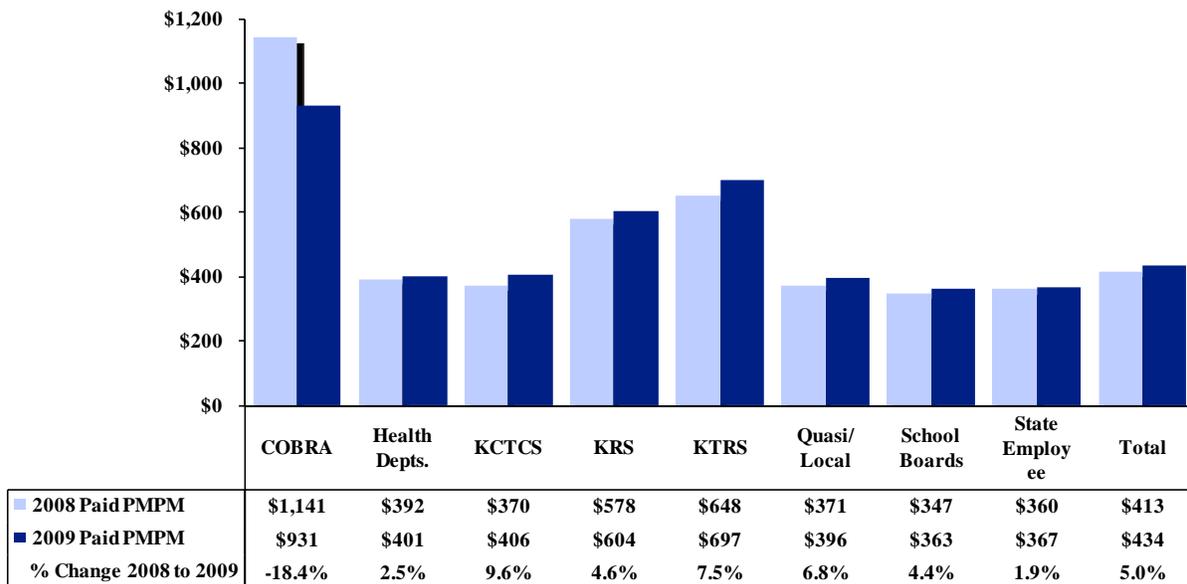
Source: KEHP's enrollment data aggregated by Thomson Reuters.

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 2008 and 2009. As expected, the PMPM costs for KRS of \$604 and for KTRS of \$697 are the highest among all the groups (the two groups consisting of retirees). The KCTCS and KTRS groups had the largest increase in medical and pharmacy cost in 2009, 9.6% and 7.5% respectively.

The School Boards is the largest group and represented 49.1% of the population in 2009. They also have the lowest PMPM among all groups, at \$363 in 2009.

**Exhibit XVII**

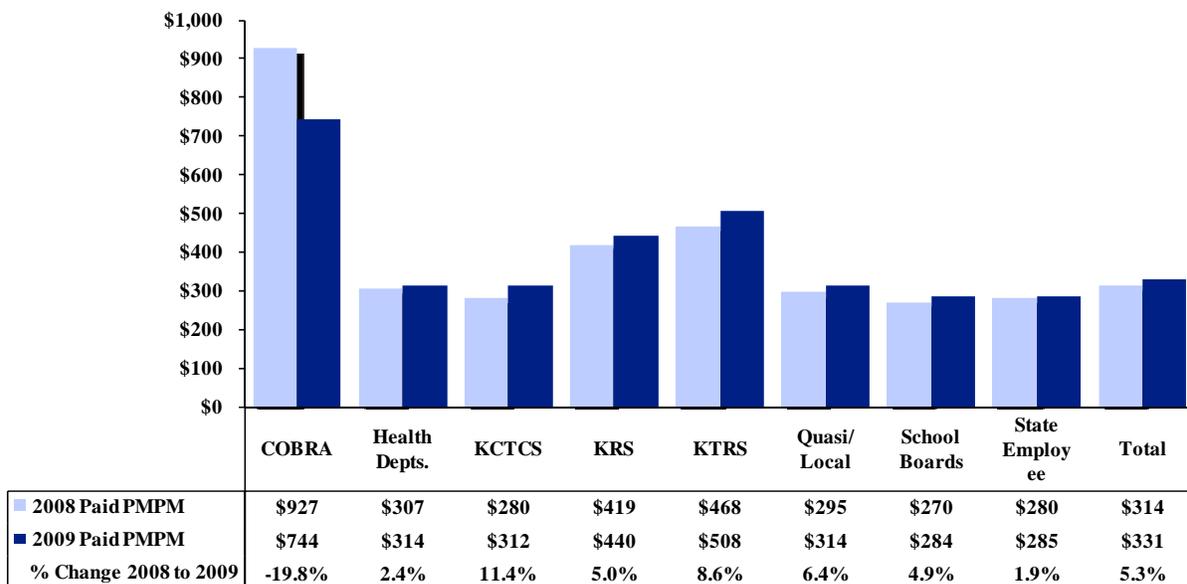
**Medical and Pharmacy Claims Paid Per Member Per Month—Participating Groups**



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

**Exhibit XVIII**

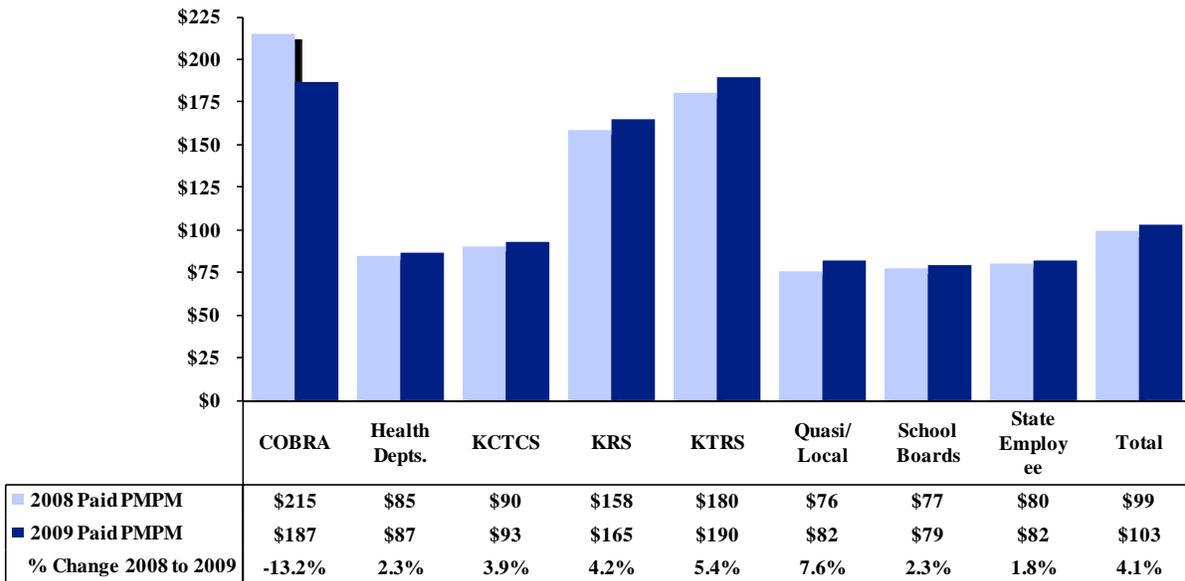
**Medical Claims Paid Per Member Per Month—Participating Groups**



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

**Exhibit XIX**

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

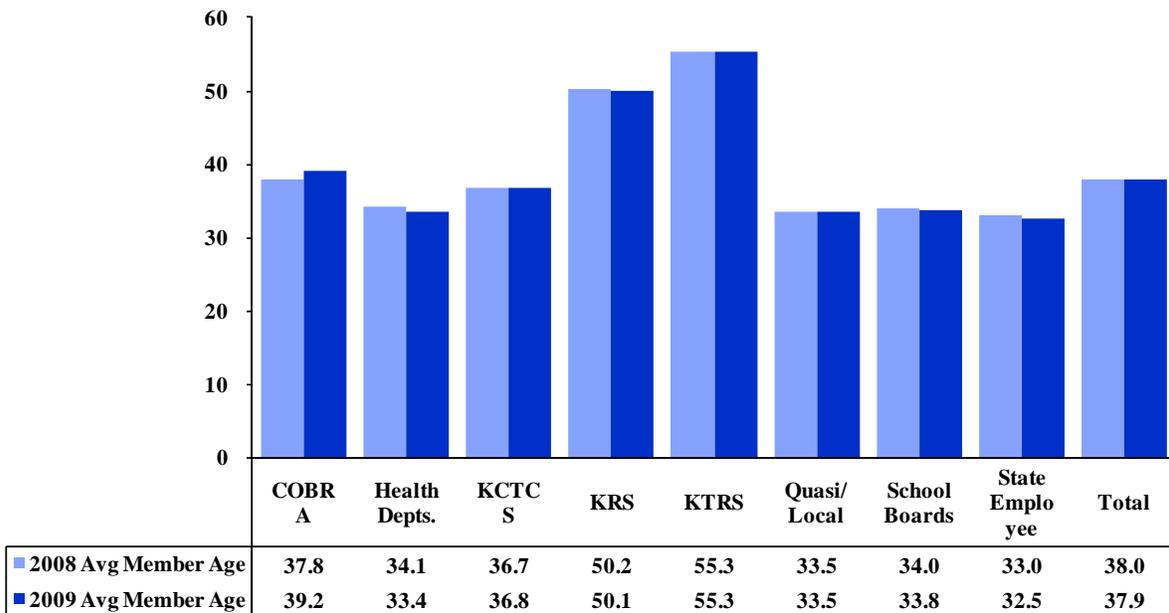


Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

Exhibit XX provides the average ages of the members in 2008 and 2009 for each covered group.

**Exhibit XX**

**2008 and 2009 Average Member Age—By Group**



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

## Review of KEHP Cost and Utilization by Place of Service, MDC and Other

### Key Findings & Considerations

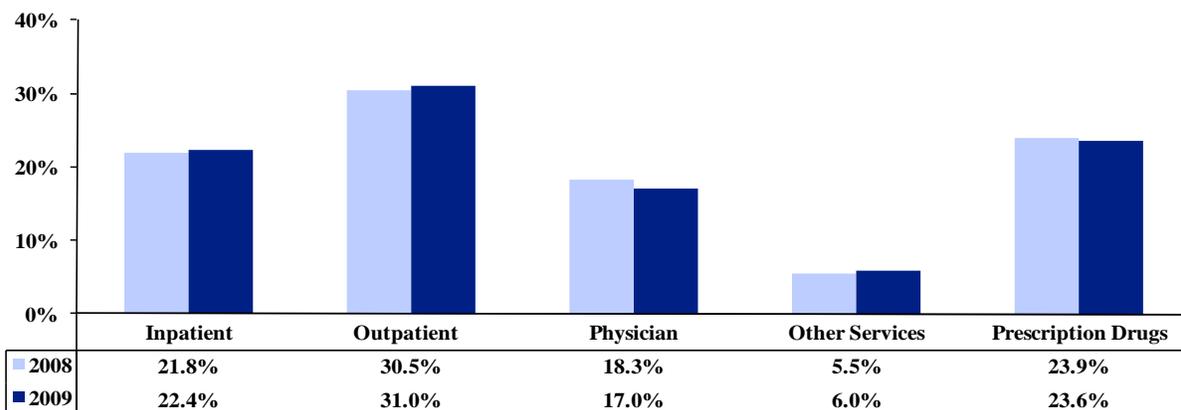
- KEHP's distribution of claims by "place of service" (inpatient, outpatient, physician, other services, and pharmacy) remained relatively consistent from 2008 to 2009.
- Claims for care provided in outpatient settings, such as outpatient surgery centers, etc., comprise the largest portion of claims when compared to inpatient, physician, pharmacy, and other. 31% of paid claims costs are outpatient. The cost of services increased at a rate of 6.8% from 2008 to 2009, compared to 7.8% for inpatient, 4.1% for pharmacy, and -2.6% 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.
- Close to 40% of members who had claims in 2009 incurred less than \$1,000 in net payments. Conversely, 23% of the members with claims consumed almost 80% of net payments. When compared to national benchmarks, KEHP has a notably higher number of medium and high users.

### Paid Claims 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



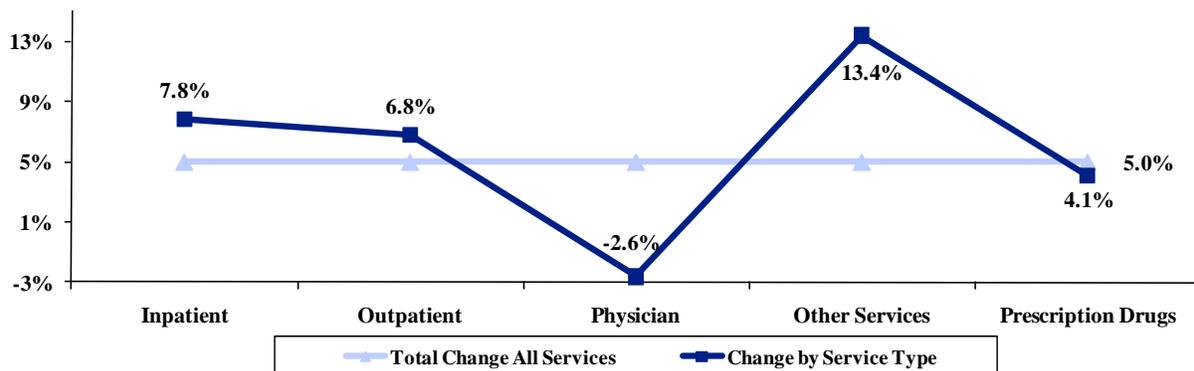
Source: KEHP's claims data aggregated by Thomson Reuters

Exhibit XXII shows the change in KEHP claims cost by place of service from 2008 to 2009. Outpatient hospital, the largest component of KEHP's claims, increased by 6.8% from 2008 to 2009. 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.

Examples of the largest components of spending for "other" services include ambulatory surgical centers, ambulances, independent laboratories, and patient homes.

**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. The cost of physician services is 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 brand and specialty drugs continuing to enter the market.

Outpatient services continue to be the largest component of claims and are continuing to increase at a high rate due to a combination of increased utilization, increased cost for services, and continued shifting of services from inpatient to outpatient facilities.

Exhibit XXIII shows the changes in utilization measures for inpatient, outpatient, and professional services. For inpatient hospital services, charges on a per admission basis grew by 4.8% from 2008 to 2009 and charges per day increased by 3.9%. This resulted in an overall increase in allowed charges PMPM of 6.8%. Inpatient hospital admissions grew by 1.9% from 2008 to 2009. Case mix is an indicator of the severity of illness of patients during their inpatient stays, which typically affects medical costs. The 2.0% increase indicates that inpatient stays were for a moderately sicker group of people than for inpatient care in the previous year. Given this increase, increases in length of stay, cost per admission, and cost per day would be expected.

As noted above, outpatient hospital utilization continues to increase, with a 3.6% growth in visits in 2009. The average cost for each outpatient hospital visit increased 4.4% from 2008 to 2009 and on a per service basis this increase was 9.1%. Allowed charges PMPM increased 8.2%.

On the other hand, allowed charges per member per month for professional services decreased slightly from 2008 to 2009. The average cost per visit fell 2.8% and the average cost per service dropped 2.8%. Professional provider utilization increased 2.0% for visits and 2.2% for services.

**Exhibit XXIII**

**Utilization by Place of Service on an Allowed Charges Basis**

	<b>Inpatient Hospital</b>		
	<b>2008</b>	<b>2009</b>	<b>Increase 2008 to 2009</b>
<b>Utilization Statistics:</b>			
Admits Per 1,000 Lives	79.0	80.5	1.9%
Days Per 1,000 Lives	304.3	312.8	2.8%
Average Length of Stay (Days)	3.9	3.9	0.9%
Case Mix Index	1.313	1.339	2.0%
Average Cost per Admit	\$12,422	\$13,021	4.8%
Average Cost per Day	\$3,225	\$3,351	3.9%
Allowed Charges PMPM	\$82	\$87	6.8%

	<b>Outpatient Hospital</b>		
	<b>2008</b>	<b>2009</b>	<b>Increase 2008 to 2009</b>
<b>Utilization Statistics:</b>			
Visits Per 1,000 Lives	1,741.3	1,804.0	3.6%
Services Per 1,000 Lives	9,903.5	9,819.0	-0.9%
Services Per Visit	5.7	5.4	-4.3%
Average Cost per Visit	\$805	\$840	4.4%
Average Cost per Service	\$142	\$154	9.1%
Allowed Charges PMPM	\$117	\$126	8.2%

	<b>Professional Services</b>		
	<b>2008</b>	<b>2009</b>	<b>Increase 2008 to 2009</b>
<b>Utilization Statistics:</b>			
Visits Per 1,000 Lives	8,530.9	8,705.7	2.0%
Services Per 1,000 Lives	18,140.0	18,537.4	2.2%
Services Per Visit	2.1	2.1	0.1%
Average Cost per Visit	\$120	\$117	-2.7%
Average Cost per Service	\$57	\$55	-2.8%
Allowed Charges PMPM	\$86	\$85	-0.7%

Source: KEHP's claims data aggregated by Thomson Reuters

## Paid Claims Cost by Diagnostic Categories

Close to 60% of claim costs 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 2009: 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 XXIV.

### *Exhibit XXIV*

#### Utilization by Major Diagnostic Categories

2008 Paid Claims Distribution			2009 Paid Claims Distribution		
Major Diagnostic Category	KEHP Medical Paid Claims	Patients	Major Diagnostic Category	KEHP Medical Paid Claims	Patients
Musculoskeletal	\$153,974,163	100,427	Musculoskeletal	\$173,155,880	103,039
Circulatory	\$122,937,084	75,513	Circulatory	\$134,518,582	76,940
Digestive	\$96,529,341	58,737	Digestive	\$96,862,300	58,595
Health Status	\$72,024,652	164,064	Health Status	\$78,164,442	172,172
Skin, Breast	\$55,245,232	89,926	Skin, Breast	\$58,889,957	91,835
Nervous	\$53,045,701	130,872	Nervous	\$55,360,294	138,274
<b>Total</b>	<b>\$946,785,361</b>	<b>1,001,946</b>	<b>Total</b>	<b>\$1,021,818,490</b>	<b>1,045,983</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 most prevalent clinical conditions that are grouped into the top three MDCs are included in Exhibit XXV. Similar to last year, Gastrointestinal Disorders, Coronary Artery Diseases, and Osteoarthritis are the top conditions associated with the highest cost MDCs.

*Exhibit XXV*

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

2009 Paid Claims Distribution			
Major Diagnostic Category	Clinical Condition	KEHP Medical Paid Claims	Patients
Musculoskeletal	Osteoarthritis	\$42,543,156	22,937
	Spinal/Back Disord, Low Back	\$29,348,426	32,845
	Arthropathies/Joint Disord NEC	\$27,603,613	54,251
	Spinal/Back Disord, Ex Low	\$16,163,195	23,427
	Fracture/Disloc - Upper Extrem	\$10,453,274	7,823
	Injury - Knee	\$7,857,701	4,771
	Fracture/Disloc - Ankle/Foot	\$4,986,992	6,267
	Bursitis	\$4,729,918	9,863
	Condition Rel to Tx - Med/Surg	\$4,068,305	498
	Musculosk Disord, Congenital	\$3,565,922	2,171
	<b>Total</b>	<b>\$173,155,880</b>	
As a % of Total Cost/Patients		17%	

2009 Paid Claims Distribution				
Major Diagnostic Category	Clinical Condition	KEHP Medical Paid Claims	Patients	
Circulatory	Coronary Artery Disease	\$43,510,719	9,113	
	Respiratory Disord, NEC	\$18,119,399	18,047	
	Cardiovasc Disord, NEC	\$17,622,669	16,852	
	Cardiac Arrhythmias	\$11,316,203	6,437	
	Hypertension, Essential	\$10,551,129	50,250	
	Rheumatic Fever/Valvular Dis	\$5,056,552	3,511	
	Signs/Symptoms/Oth Cond, NEC	\$4,915,623	4,938	
	Congestive Heart Failure	\$4,570,691	1,366	
	Vascular Disorders, Arterial	\$4,454,634	2,221	
	Vascular Disorders, Venous	\$4,006,543	3,071	
	<b>Total</b>	<b>\$134,518,582</b>		
	As a % of Total Cost		13%	

2009 Paid Claims Distribution				
Major Diagnostic Category	Clinical Condition	KEHP Medical Paid Claims	Patients	
Digestive	Gastroint Disord, NEC	\$37,862,241	38,075	
	Hernia/Reflux Esophagitis	\$11,867,333	13,436	
	Gastritis/Gastroenteritis	\$6,627,606	11,808	
	Tumors - Gastroint, Benign	\$6,281,731	6,133	
	Cancer - Colon	\$6,169,762	521	
	Diverticular Disease	\$5,186,013	2,959	
	Crohns Disease	\$3,589,791	693	
	Appendicitis	\$3,529,871	420	
	Functional Digest Disord, NEC	\$3,402,210	7,837	
	Cancer - Gastroint Ex Colon	\$1,600,626	144	
	<b>Total</b>	<b>\$96,862,300</b>		
	As a % of Total Cost		9%	

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 joint replacement, 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.

### **Paid Claims by User-Type**

The KEHP paid claims distribution in 2009 is very similar to the prior year. Slightly more than 39% of members had net paid claims of less than \$1,000. 23% of individuals who had claims during the year were high or very high users, accounting for 79% of claims costs. As shown in the exhibit below, the KEHP experience has a notably higher number of medium and high users than low users when compared to national benchmarks.

#### ***Exhibit XXVI***

#### **2009 Paid Claims by User-Type**

		<b>2009 Paid Claims Distribution</b>			
		<b>Low Users</b>	<b>Medium Users</b>	<b>High Users</b>	<b>Very High Users</b>
		<b>\$0 - \$1,000</b>	<b>\$1,000 - \$5,000</b>	<b>\$5,000 - \$100,000</b>	<b>&gt;\$100,000</b>
<b>2009 Paid Claims Benchmarks</b>	<b>% Members</b>	<b>60.1%</b>	<b>25.9%</b>	<b>13.7%</b>	<b>0.3%</b>
<b>KEHP</b>	<b>% Members</b>	<b>39.7%</b>	<b>37.2%</b>	<b>22.7%</b>	<b>0.4%</b>
<b>2009 Net Payments</b>	<b>% Payments</b>	<b>3.0%</b>	<b>18.0%</b>	<b>65.4%</b>	<b>13.6%</b>
<b>Difference</b>	<b>% Members</b>	<b>(20.4%)</b>	<b>11.3%</b>	<b>9.0%</b>	<b>0.0%</b>

*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 between 50% and 58% for all adult preventive screens, with the possible exception of colon cancer. When compared to the active population, non-Medicare eligible retirees achieved higher screening rates for all adult screens, aside from cervical cancer.
- Improvement in the utilization of preventive care screenings is especially needed in the categories of colon cancer, cholesterol, prostate cancer, and well child.
- In 2009, 118,765 members, or 45.2% 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 2009, over 18% of the total KEHP population was engaged in the program at some level, up from 15% in 2008.
- 5.3% of KEHP members were actively engaged with a nurse in 2009, compared to 4.0% 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" and "Healthy People 2020" are sets of national health objectives for the U.S. to achieve by the respective target years - 2010 and 2020. Created by government and non-government experts, they identify a wide range of public health priorities and specific, measurable objectives. These priorities and objectives can be used to focus health improvement strategies at 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.

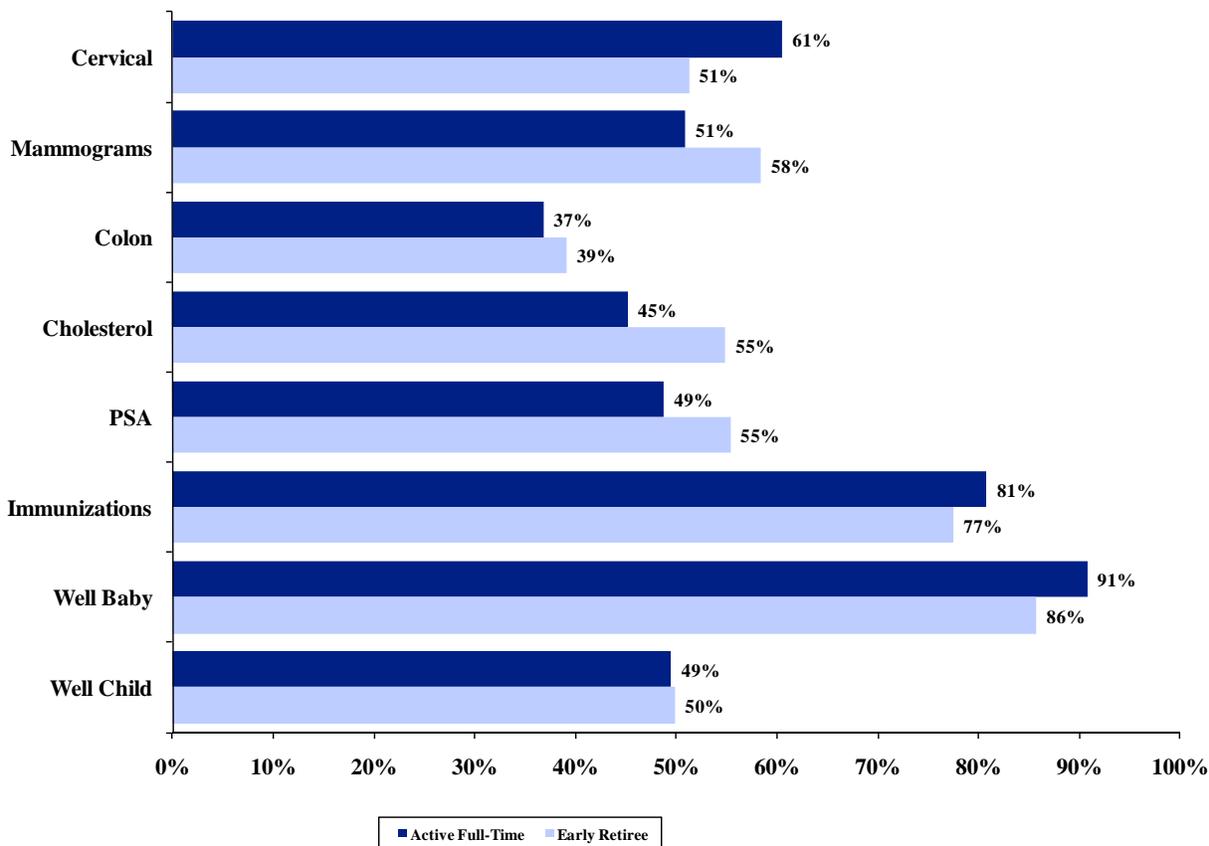
In Exhibit XXVII, the preventive care screening rates for the KEHP members in 2009 are shown for active members and for non-Medicare eligible retirees. Exhibit XXVIII provides a more detailed year over year comparison of screening rates for active employees only, other covered members, and in total. 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 50-58% 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 around 50% or below. When comparing targeted employees versus other targeted covered members, employees utilized the screenings slightly more than spouses, partners, and dependents.

Preventive care screening rates improved in 2009 compared to the prior year. Mammograms, cholesterol, and prostate cancer screens increased about 3-5% in 2009, while cervical and colon cancer screens remained relatively consistent with screenings in 2008.

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

**Exhibit XXVII**  
**2009 Preventive Care Screening Utilization**



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

For each of the preventive screenings, the desired target compliance rate is 100% for the respective target groups and screening frequencies per "Healthy People 2010" and "Healthy People 2020". Exhibit XXVIII notes the target group for each screening and the recommended target frequency for each screening, many of which vary by age group within the overall target population. For each preventive screening, the screening utilization rate and the desired target compliance rate (100%) are based only on those covered members within that screening category age range and gender.

## Exhibit XXVIII

### 2008 and 2009 Preventive Care Screenings - Utilization and Targets

Preventive Screening	Target Group	Target Frequency (100% Goal)	2009 - Active Full-Time			2009 - Early Retiree		
			Employees	Spouses / Dependents	All Members	Employees	Spouses / Dependents	All Members
Cervical Cancer	Women Aged 21 to 64	Every 2 Years	61%	59%	61%	51%	51%	51%
Mammograms	Women Aged 40 to 49	Every 2 Years	51%	48%	51%	59%	53%	58%
	Women Aged 50+	Every Year						
Colon Cancer	All Aged 50 to 80	Every 3 Years	38%	32%	37%	40%	36%	39%
Cholesterol	Women 45-49, Men 35-49	Every 2 Years	45%	45%	45%	56%	50%	55%
	Women and Men 50+	Every Year						
Prostate Cancer	Men Aged 50 to 70	Every 2 Years	49%	48%	49%	56%	51%	55%
Immunizations	All Aged 0 to 2	Once	N/A	81%	81%	N/A	77%	77%
Well Baby	All Aged 0 to 2	Ongoing	N/A	91%	91%	N/A	86%	86%
Well Child	All Aged 3 to 6	Every Year	N/A	49%	49%	N/A	50%	50%

Preventive Screening	Target Group	Target Frequency (100% Goal)	2008 - Active Full-Time			2008 - Early Retiree		
			Employees	Spouses / Dependents	All Members	Employees	Spouses / Dependents	All Members
Cervical Cancer	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 Cancer	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 provides 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 2009, 118,769 KEHP members had at least one of the identified conditions and nearly 100% of those members identified (45.2% of all members) were targeted for outreach. Through continuing efforts to increase the accuracy of phone numbers and contact information as well as the focus on the particular clinical conditions that were driving plan cost, the ICM program was able to increase its outreach by nearly 20% from 2008 to 2009. At the end of 2009, over 18% of the total KEHP population was engaged in the program at some level, up from 15% in 2008.

As part of the ICM program, Care Considerations 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 70,000 care considerations were sent in 2009 (compared to 57,000 in 2008), resulting in slightly less than \$5 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

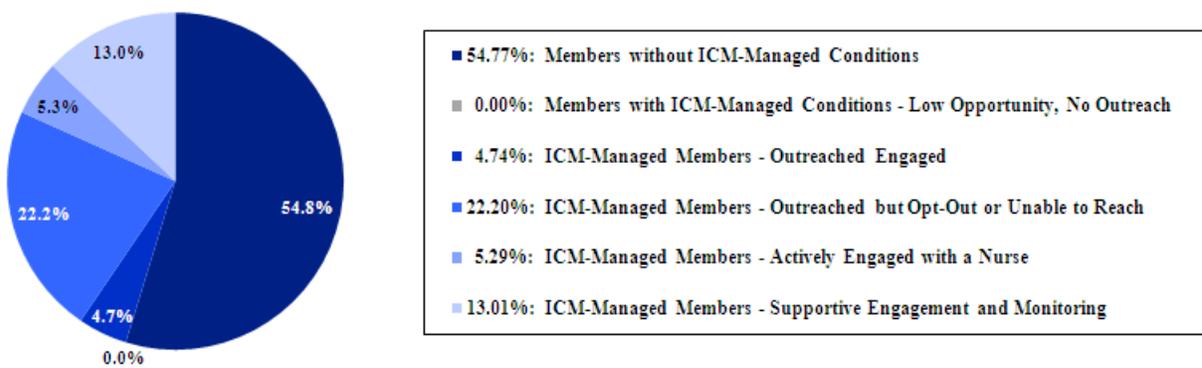
through 2009, with 5.3% of the population being actively engaged with a nurse, compared to 4.0% in 2008 and 2.7% in 2007.

The ActiveHealth Book of Business benchmark for 2009 is 3.2% which represents a blend of primarily non-incented programs plus a small number of DM Incentive Programs.

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 healthcare goals or may have chosen to just receive information and not schedule sessions with a nurse.

**Exhibit XXIX**  
**ICM Engagement Summary**



Source: KEHP's participation data reported by ActiveHealth Management as of December 31, 2009

For the majority of clinical measures, members who were engaged with a nurse showed improvements in key clinical indicators. Members with vascular conditions showed the greatest

improvement in appropriate use of lipid lowering agents and use of beta-blockers after MI. Members with diabetes made improvements in nephropathy screening and foot and eye exams. In addition, the number of members utilizing an asthma action plan improved substantially.

ActiveHealth conducted an analysis of the ICM members who opted out in 2009, and found that primarily a member opts-out based on the member's sense that they are managing their condition with their doctor.

Exhibit XXX compares the pre-nurse engagement compliance to results after program engagement for some key clinical indicators.

**Exhibit XXX**  
**Clinical Indicators**

Clinical Indicator	Members Measured	Pre-Engagement Compliance	Current Compliance	Change
<b>Vascular</b>				
Appropriate use of lipid-lowering agents	3,719	44%	58%	14%
Use of beta-blockers after myocardial infarction	82	76%	84%	8%
Met blood pressure target for vascular condition or improved by 10 mm Hg systolic	1,214	47%	51%	4%
<b>Diabetes</b>				
HbA1C monitoring	650	88%	91%	3%
Nephropathy screening	154	30%	44%	14%
Foot exam	349	85%	91%	6%
<b>Asthma</b>				
Asthma action plan	70	59%	70%	11%

Source: ActiveHealth Management's Annual Review Report for KEHP, 2009

Among the top conditions being addressed by the ICM program are hypertension, GERD, diabetes, and obesity, similar to the top conditions in 2008. The largest percentage of Severity 1 Care Considerations sent to members in 2009 was related to movement disorders. 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 906 new enrollees in 2009, bringing the total number of members enrolled to 2,325 since the program was introduced in August 2006. As of December 31, 2009, the average weight loss was 14.3 pounds for those members who lost weight. ActiveHealth indicates that, based on URAC accreditation standards, the acceptable measure of weight loss is represented by one BMI shift. The average loss observed is 1 to 2 BMI shifts, which translates to 14-16 pounds.

## Chronic Conditions

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

### *Exhibit XXXI*

#### Health Risks and Behaviors

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

*Source: University of Michigan Health Management Research Center study*

These health risks contribute directly to the onset of chronic disease. Therefore, programs focused on long term behavior change related to these risks and that offer participation incentives will improve the population's chronic disease state -- avoiding costs and improving member health and vitality.

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

**Exhibit XXXII****2009 Chronic Disease States PMPM versus KEHP Aggregate PMPM**

<b>Disease State</b>	<b>2009 PMPM Allowed Charges</b>	<b>2009 Disease State vs 2009 Aggregate Allowed Charges</b>
<b>KEHP Aggregate</b>	\$488.16	N/A
<b>Asthma Moderate</b>	\$955.55	95.7%
<b>Asthma Severe</b>	\$2,162.70	343.0%
<b>Diabetes Low</b>	\$1,287.83	163.8%
<b>Diabetes Moderate</b>	\$1,813.45	271.5%
<b>Diabetes Severe</b>	\$3,434.63	603.6%
<b>HBP</b>	\$962.37	97.1%
<b>Depression</b>	\$1,100.40	125.4%
<b>Bariatric</b>	\$1,682.80	244.7%
<b>Low Back</b>	\$1,067.46	118.7%
<b>GERD</b>	\$1,340.55	174.6%
<b>High Cholesterol</b>	\$794.92	62.8%
<b>Weight Management</b>	\$1,944.33	298.3%
<b>Coronary Artery Disease</b>	\$2,674.17	447.8%

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

Based on PwC disease state financial models, and given the average cost of members within each disease state, there is potential for significant savings through effective management of chronic diseases. Assisting members with accessing appropriate care, discussing concerns with their physicians, maintaining medication compliance, and gaining additional education through the disease management program will significantly improve member health and plan cost.

To determine disease management savings ActiveHealth calculates the number of high-intensity, nurse-engaged participants and average ActiveHealth book of business savings. ActiveHealth has calculated the average per participant per year savings at \$2,365. Additionally, KEHP trend has been consistently below national average trend.

ActiveHealth reports that a recent RAND study suggests that prescription drug compliance shifts are not the result of changes in cost share contributions but rather the complexity of the drug itself. ActiveHealth's metric analysis for 2008 to 2009 does not yield any known correlations between cost share shifts and total prescription drug compliance. A further study measuring the relationship between high volume Care Considerations messaged and prescription drug compliance (for Corticosteroids, Beta blockers, and ACE inhibitors) also yielded few impactful changes. These findings suggest that a 12 month period is insufficient time to measure cost share, Care Consideration, or even demographic impact on prescription drug compliance.

## Population Health Statistics for the Commonwealth of Kentucky

The Kaiser Family Foundation has tabulated, state by state, the prevalence of certain 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 or its members. The exhibits focus on four of the health risk measures: body weight, existing medical problems, 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.

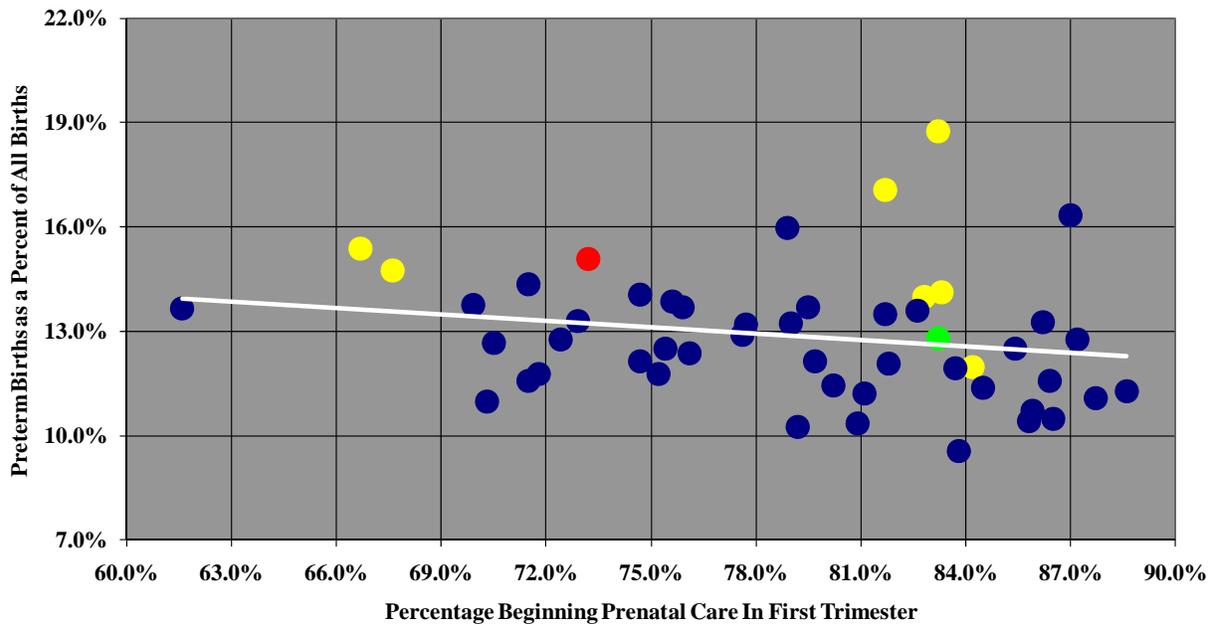
For each chart in the exhibit a correlation line has been included to illustrate the approximate correlation between the two factors considered.

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 in which the Kaiser survey was performed for each specific metric.

Kentucky's population has demonstrated improvements in some key areas, as identified below. However, consistent with the health issues affecting the KEHP members, the Commonwealth still lags behind national averages for metrics such as obesity, diabetes, and smoking. Progress towards reaching and exceeding national averages will significantly impact the underlying cost of healthcare and demonstrate a significant opportunity and goal for the Commonwealth's population and for KEHP membership.

**Exhibit XXXIII**

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

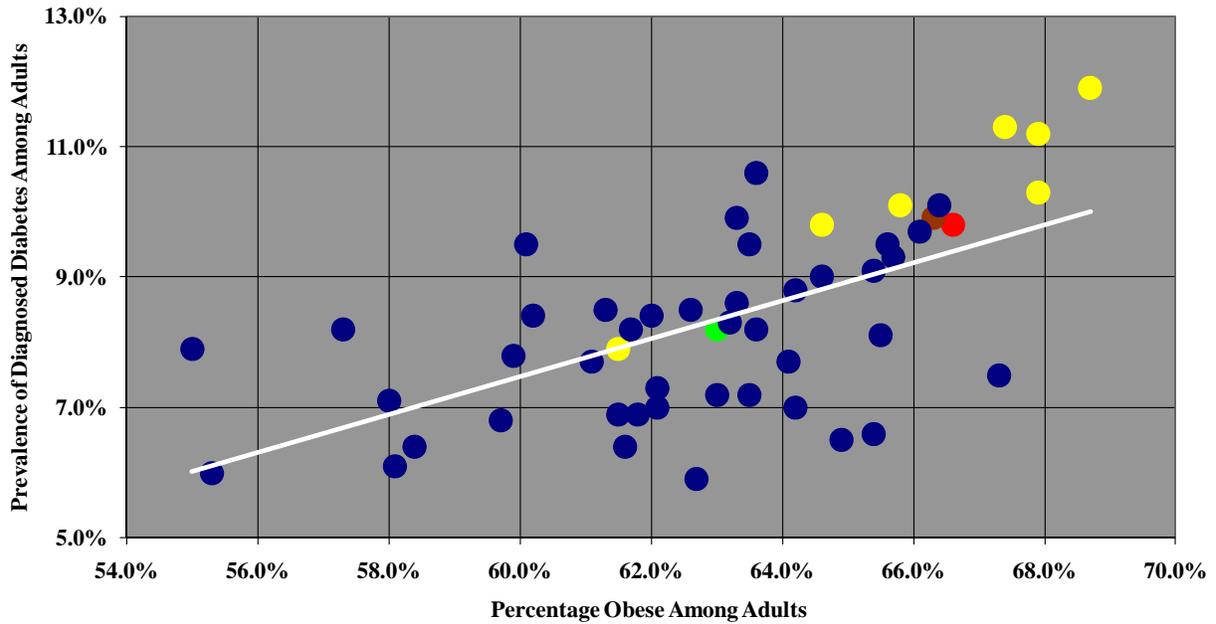


	Percentage Beginning Prenatal Care In First Trimester	Preterm Births as a Percent of All Births
Kentucky (Current Survey)	73.2%	15.1%
Kentucky (Prior Survey)	N/A	12.0%
Alabama	81.7%	17.1%
Georgia	83.3%	14.1%
Mississippi	83.2%	18.7%
North Carolina	82.6%	13.6%
South Carolina	66.7%	15.4%
Tennessee	67.6%	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	2006	2006

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

**Exhibit XXXIV**

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

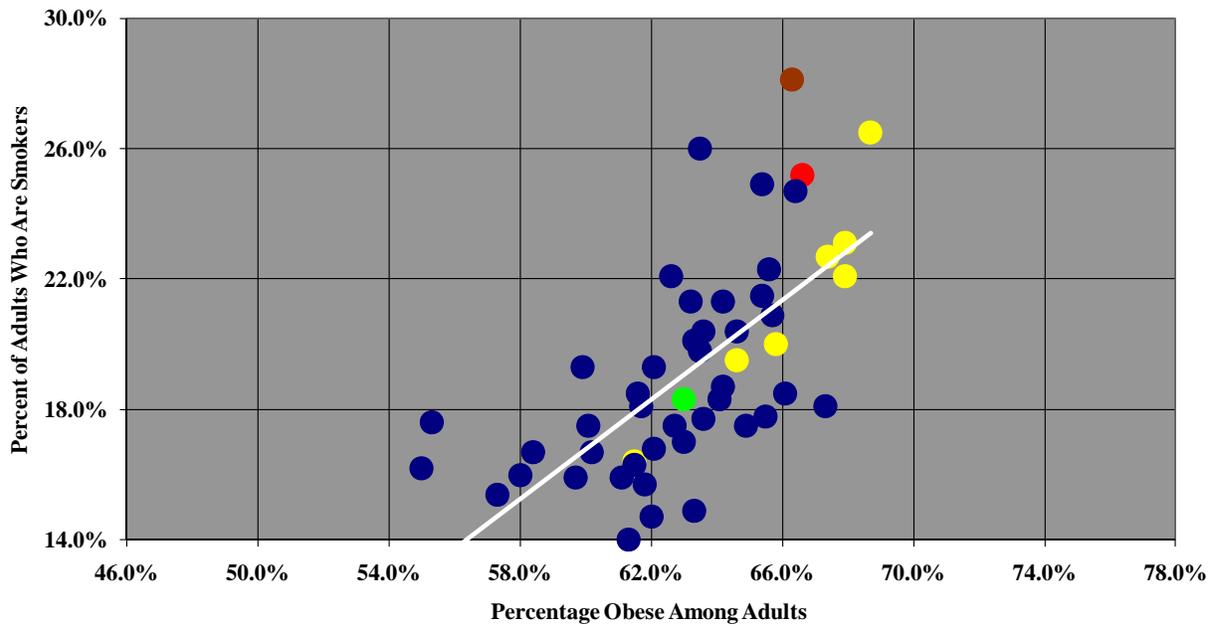


	Prevalence of Obesity Among Adults	Prevalence of Diagnosed Diabetes Among Adults
Kentucky (Current Survey)	66.6%	9.8%
Kentucky (Prior Survey)	66.3%	9.9%
Alabama	67.9%	11.2%
Georgia	64.6%	9.8%
Mississippi	67.4%	11.3%
North Carolina	65.7%	9.3%
South Carolina	65.8%	10.1%
Tennessee	67.9%	10.3%
Virginia	61.5%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

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

**Exhibit XXXV**

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

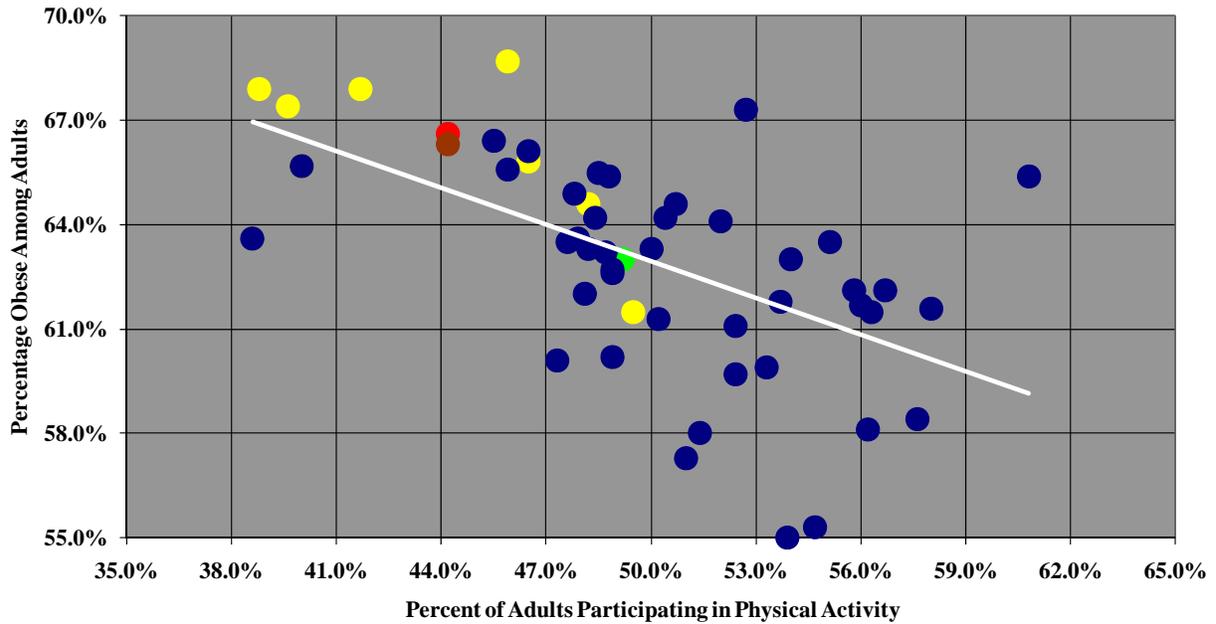


	Prevalence of Obesity Among Adults	Percent of Adults Who Are Smokers
Kentucky (Current Survey)	66.6%	25.2%
Kentucky (Prior Survey)	66.3%	28.1%
Alabama	67.9%	22.1%
Georgia	64.6%	19.5%
Mississippi	67.4%	22.7%
North Carolina	65.7%	20.9%
South Carolina	65.8%	20.0%
Tennessee	67.9%	23.1%
Virginia	61.5%	16.4%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

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

**Exhibit XXXVI**

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

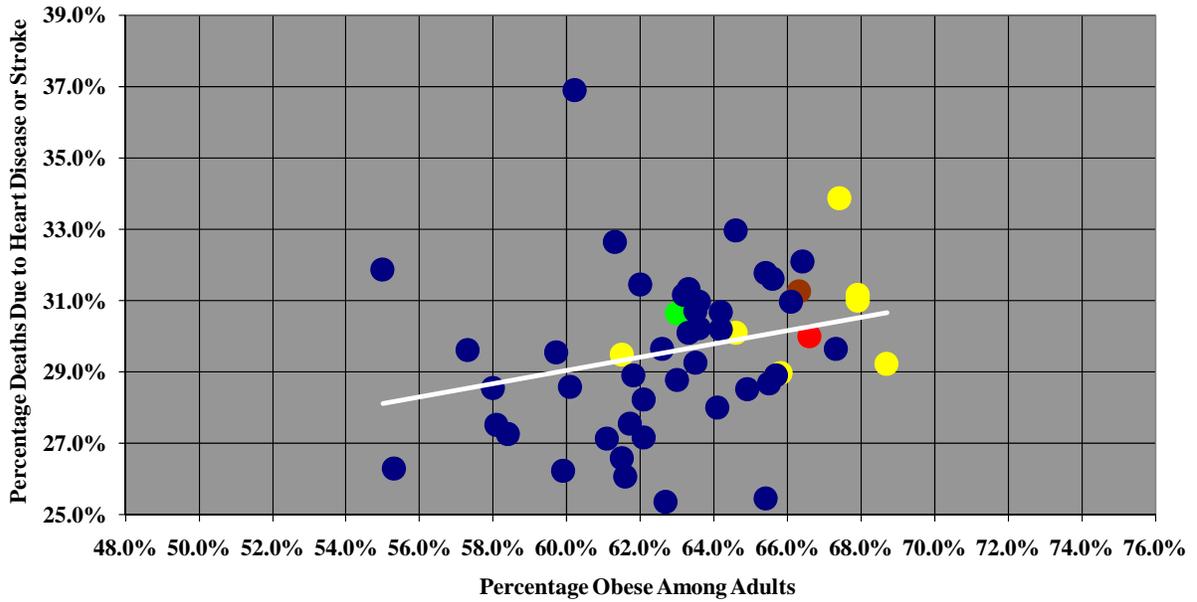


	Percent of Adults Who Are Participating In Physical Activity	Prevalence of Obesity Among Adults
Kentucky (Current Survey)	44.2%	66.6%
Kentucky (Prior Survey)	44.2%	66.3%
Alabama	41.7%	67.9%
Georgia	48.2%	64.6%
Mississippi	39.6%	67.4%
North Carolina	40.0%	65.7%
South Carolina	46.5%	65.8%
Tennessee	38.8%	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	2008

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

**Exhibit XXXVII**

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

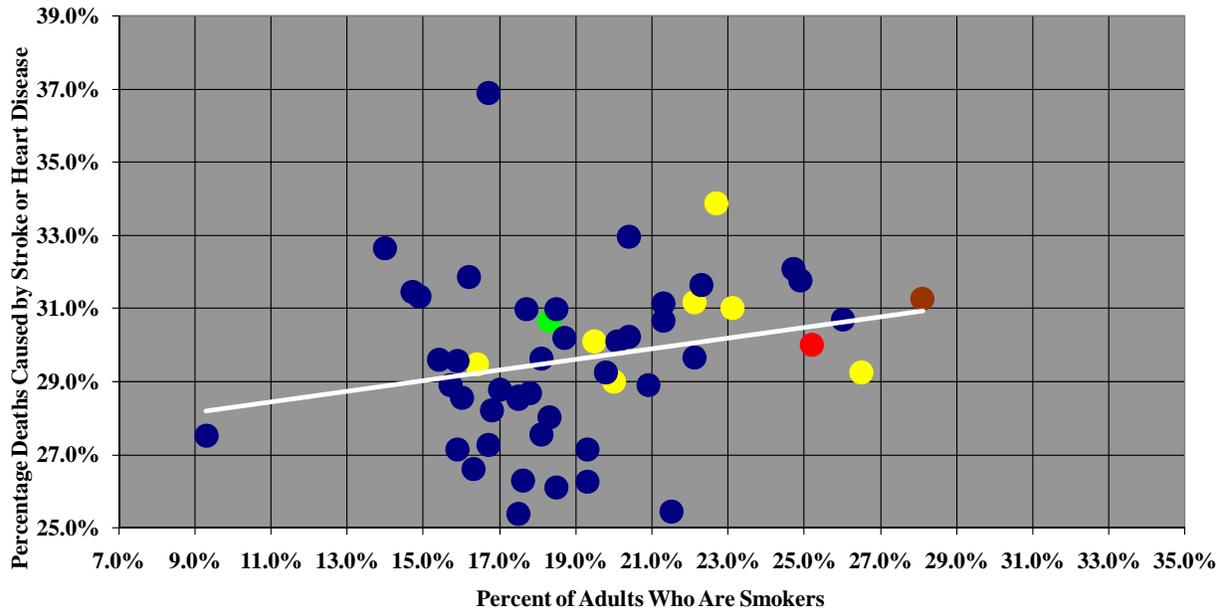


	Prevalence of Obesity Among Adults	Percent of Deaths Due to Heart Disease or Stroke
Kentucky (Current Survey)	66.6%	30.0%
Kentucky (Prior Survey)	66.3%	31.3%
Alabama	67.9%	31.2%
Georgia	64.6%	30.1%
Mississippi	67.4%	33.9%
North Carolina	65.7%	28.9%
South Carolina	65.8%	29.0%
Tennessee	67.9%	31.0%
Virginia	61.5%	29.5%
West Virginia	68.7%	29.2%
United States	63.0%	30.7%
Current Survey Year	2008	2007
Prior Survey Year	2008	2006
		1 Year Update

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

**Exhibit XXXVIII**

**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%	30.0%
Kentucky (Prior Survey)	28.1%	31.3%
Alabama	22.1%	31.2%
Georgia	19.5%	30.1%
Mississippi	22.7%	33.9%
North Carolina	20.9%	28.9%
South Carolina	20.0%	29.0%
Tennessee	23.1%	31.0%
Virginia	16.4%	29.5%
West Virginia	26.5%	29.2%
United States	18.3%	30.7%
Current Survey Year	2008	2007
Prior Survey Year	2008	2006
		1 Year Update

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

## KEHP Pharmacy Benefits Detailed Experience

### Key Findings & Considerations

- Allowed charges for prescription drugs increased 10.8% from 2007 to 2008 and 8.8% from 2008 to 2009. The 2009 trend rate for the KEHP's portion of the cost in total is 6.7% due to member cost sharing increasing by 15.7%. The new plan designs effective in 2009, which included increases in pharmacy co-pays, were a contributing factor to the increase in member cost sharing.
- Scripts per member per year declined slightly by 1.0%, after a slight increase of 0.7% in 2008, though this decrease is split between a 1.1% PMPY decrease in retail scripts and a 4.4% PMPY increase in mail order scripts. The 2009 average number of scripts per member per year was 20.2.
- 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 XXXIX and XL.

As shown in Exhibit XXXIX, the total allowed charges for prescription drugs increased 10.8% in 2008 and 8.8% in 2009. Member cost sharing increased from 12.6% in 2008 to 14.6% in 2009.

The observed 2009 trend rate for the KEHP's portion of the pharmacy cost in total is 6.7% versus the overall 2009 trend on pharmacy allowed charges of 8.8%. The increase in employee cost share is due to the new plan designs offered in 2009 and increased co-payments for members.

### *Exhibit XXXIX*

#### Key Pharmacy Benefits Aggregate Cost Statistics

	2007	2008	2009	2008 vs. 2007	2009 vs. 2008
<b>Total Eligible Members</b>	244,581	251,024	257,400	2.6%	2.5%
<b>Total Allowed Charges</b>	\$300,003,516	\$332,467,563	\$361,769,113	10.8%	8.8%
<b>Total Net Paid Claims</b>	\$263,411,276	\$298,709,346	\$318,753,656	13.4%	6.7%

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

**Exhibit XL****Key Pharmacy Benefits Cost Per Claim and Cost Share Statistics**

	2007	2008	2009	2008 vs. 2007	2009 vs. 2008
<b>Total Copayment per Claim</b>	<b>\$9.11</b>	<b>\$8.36</b>	<b>\$10.31</b>	<b>(8.2%)</b>	<b>23.4%</b>
Retail Copayment per Claim	\$8.82	\$8.05	\$9.88	(8.7%)	22.7%
Mail Copayment per Claim	\$22.57	\$20.75	\$26.88	(8.1%)	29.5%
<b>Total Member Cost Share</b>	<b>14.6%</b>	<b>12.6%</b>	<b>14.6%</b>	<b>(14.0%)</b>	<b>15.7%</b>
Retail Member Cost Share	14.7%	12.6%	14.7%	(14.1%)	16.9%
Mail Member Cost Share	13.8%	12.1%	12.4%	(12.1%)	1.8%
<b>Plan Cost:</b>					
Per Member Per Year (PMPY)	\$1,076.99	\$1,189.96	\$1,238.36	10.5%	4.1%
PMPM	\$89.75	\$99.16	\$103.20	10.5%	4.1%
Per Claim	\$53.02	\$58.17	\$61.16	9.7%	5.1%

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

The number of scripts per member per year was 20.3 in 2007, 20.5 in 2008, and 20.2 in 2009. The generic dispensing rate continued to increase from 59.9% in 2007 to 63.7% in 2008 to 66.3% in 2009, consistent with the total number of generic scripts increasing and brand scripts decreasing.

**Exhibit XLI****Key Pharmacy Utilization Statistics**

	2007	2008	2009	2008 vs. 2007	2009 vs. 2008
<b>Scripts PMPY</b>	<b>20.3</b>	<b>20.5</b>	<b>20.2</b>	<b>0.7%</b>	<b>(1.0%)</b>
<b>Total Scripts</b>	<b>4,967,740</b>	<b>5,135,122</b>	<b>5,212,034</b>	<b>3.4%</b>	<b>1.5%</b>
Retail Scripts	4,864,480	5,012,818	5,081,104	3.0%	1.4%
Mail Order Scripts	103,260	122,304	130,930	18.4%	7.1%
Brand Scripts	1,992,613	1,862,939	1,755,795	(6.5%)	(5.8%)
Generic Scripts	2,975,127	3,272,183	3,456,239	10.0%	5.6%
<b>Generic Utilization:</b>					
Generic Dispensing Rate	59.9%	63.7%	66.3%	6.4%	4.1%
Generic Substitution Rate	89.6%	88.9%	90.8%	(0.8%)	2.2%
<b>Mail Order Utilization</b>	<b>2.1%</b>	<b>2.4%</b>	<b>2.5%</b>	<b>14.6%</b>	<b>5.5%</b>
<b>Days Supply:</b>					
Days Supply Total	141,607,810	148,122,322	152,691,137	4.6%	3.1%
Days Supply per Claim	28.5	28.8	29.3	1.2%	1.6%

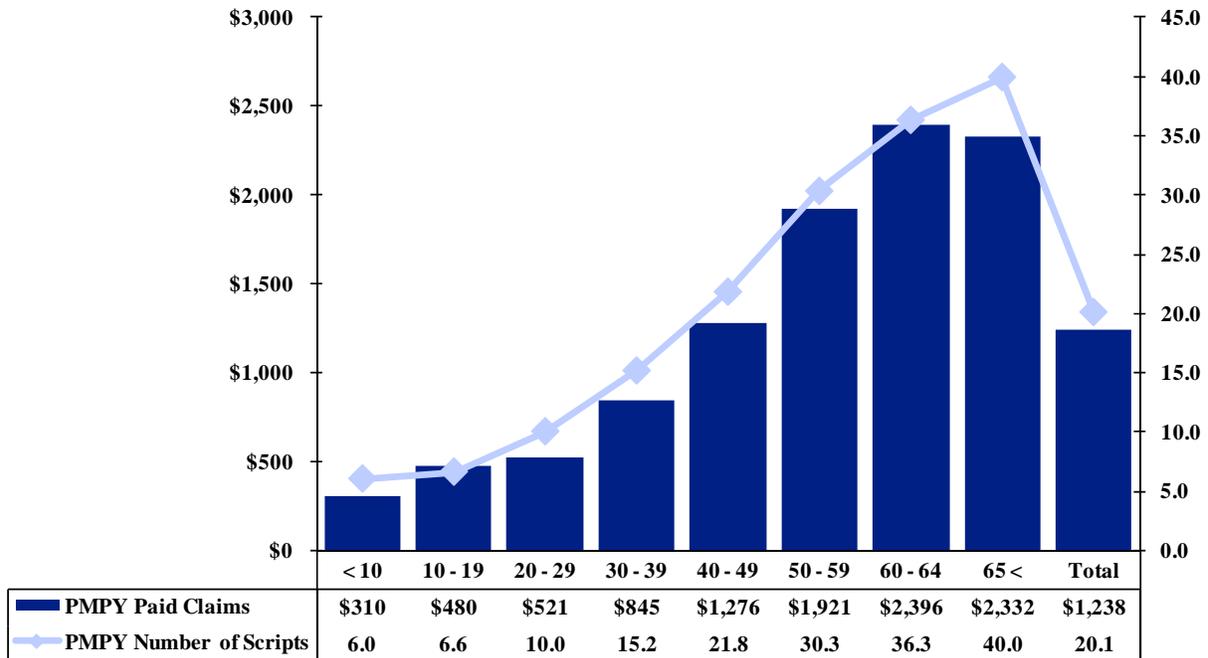
Source: KEHP's enrollment and claims data aggregated by Thomson Reuters.

## Demographic Impact on Pharmacy Experience

In 2009, the KEHP average member age was 37.9. For that age, there was an average of 15.2 scripts and \$845 in prescription claims paid during the year. These are relatively consistent with the prior year. Exhibit XLII illustrates the increase in medication usage with each increasing age band. This increase is due to the natural progression of people's health status as they age.

### Exhibit XLII

#### 2009 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.

While the employee cost share per drug increased from 2008 to 2009 due to increased co-payments for members, pharmacy costs have continued to escalate, demonstrating that both KEHP and its members are sharing in the growth of prescription drug costs.

**Exhibit XLIII**  
**Top 10 Drugs**

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
Crestor	Cholesterol	5	\$4,807,897	54,221	\$88.67	\$15.62
Singulair	Asthma/Allergies	2	\$6,264,901	65,809	\$95.20	\$15.21
Enbrel	Rheumatoid Arthritis	3	\$5,094,825	2,610	\$1,952.04	\$16.23
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
Effexor-XR	Depression/Anxiety	6	\$4,743,696	33,987	\$139.57	\$15.14
Actos	Diabetes	9	\$3,535,646	20,201	\$175.02	\$15.31
Pantoprazole Sodium	GERD	N/A	N/A	N/A	N/A	N/A

2008						
Product Name	Category	Rank	Net Pay (Total)	Scripts Rx	Net Pay (Per Script)	Employee Cost Share
Nexium	GERD	1	\$9,103,657	49,461	\$184.06	\$15.69
Crestor	Cholesterol	3	\$5,775,251	56,961	\$101.39	\$15.82
Singulair	Asthma/Allergies	2	\$6,739,265	64,987	\$103.70	\$15.36
Enbrel	Rheumatoid Arthritis	4	\$5,545,068	2,742	\$2,022.27	\$16.18
Plavix	Cirulatory	8	\$4,667,057	32,708	\$142.69	\$15.31
Humira	Rheumatoid Arthritis	9	\$4,458,923	2,115	\$2,108.24	\$16.61
Cymbalta	Depression/Anxiety	10	\$4,454,723	30,077	\$148.11	\$14.84
Effexor-XR	Depression/Anxiety	5	\$5,463,622	34,796	\$157.02	\$15.35
Actos	Diabetes	11	\$4,168,513	21,536	\$193.56	\$15.57
Pantoprazole Sodium	GERD	13	\$3,628,049	32,171	\$112.77	\$5.28

2009						
Product Name	Category	Rank	Net Pay (Total)	Scripts Rx	Net Pay (Per Script)	Employee Cost Share
Nexium	GERD	1	\$10,532,030	54,222	\$194.24	\$20.76
Crestor	Cholesterol	2	\$7,017,382	62,947	\$111.48	\$21.00
Singulair	Asthma/Allergies	3	\$6,817,076	62,764	\$108.61	\$20.06
Enbrel	Rheumatoid Arthritis	4	\$5,869,089	2,679	\$2,190.78	\$21.02
Plavix	Cirulatory	5	\$5,132,983	33,783	\$151.94	\$20.30
Humira	Rheumatoid Arthritis	6	\$5,127,691	2,345	\$2,186.65	\$21.18
Cymbalta	Depression/Anxiety	7	\$5,066,311	31,859	\$159.02	\$19.46
Effexor-XR	Depression/Anxiety	8	\$4,976,032	29,541	\$168.44	\$20.17
Actos	Diabetes	9	\$4,567,064	21,316	\$214.26	\$20.80
Pantoprazole Sodium	GERD	10	\$3,977,329	33,000	\$120.53	\$5.27

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

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

**Exhibit XLIV**

**Prescription Drug Utilization Detail by Drug Classification**

	Average Scripts Per Member Per Year		
	2008	2009	% Change
<b>Retail and Mail Order</b>			
Brand Single Source	5.8	5.5	(5.7%)
Brand Multi Source	1.6	1.4	(16.5%)
Total Brand	7.4	6.8	(8.1%)
Generic	13.0	13.4	3.0%
<b>Total All</b>	<b>20.5</b>	<b>20.2</b>	<b>(1.0%)</b>
<b>Retail</b>			
Brand Single Source	5.6	5.3	(6.2%)
Brand Multi Source	1.6	1.3	(16.8%)
Total Brand	7.2	6.6	(8.6%)
Generic	12.8	13.2	3.0%
<b>Total Retail</b>	<b>20.0</b>	<b>19.7</b>	<b>(1.1%)</b>
<b>Mail Order</b>			
Brand Single Source	0.2	0.2	9.9%
Brand Multi Source	0.0	0.0	(4.0%)
Total Brand	0.2	0.2	7.4%
Generic	0.3	0.3	2.0%
<b>Total Mail Order</b>	<b>0.5</b>	<b>0.5</b>	<b>4.4%</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.

Formulary utilization for KEHP members has increased slightly from 2008 to 2009. The compliance rate in 2009 was 94.2%. A continued increase in formulary compliance will also be a contributing factor in efforts to manage costs for both the plan and its members.

**Exhibit XLV**

**Prescription Drug Formulary Compliance**

	2008	2009	% Change
<b>Formulary</b>			
Formulary Compliance Rate	93.4%	94.2%	0.9%

Source: Express Scripts, Inc.

While patent expiration does not equal generic availability, several highly utilized drugs are scheduled for patent expiration over the next several years. 14 of KEHP's top 50 utilized drugs are scheduled to lose patent protection through 2013 (Exhibit XLVI).

***Exhibit XLVI***

**Schedule of Top Prescription Drugs Losing Patent Protection**

<b>Year</b>	<b>Brand Name</b>	<b>Manufacturer</b>	<b>Use</b>
2010	Effexor	Wyeth Pharmaceuticals	Depression
2011	Lipitor®	Pfizer	Cholesterol Lowering
	Levaquin	Ortho-McNeil	Pneumonia/Bronchitis
2012	Singulair	Merck	Asthma
	Plavix®	Bristol-Myers Squibb/ Sanofi Pharmaceuticals	Platelet Inhibitors
	Actos	Takeda Pharmaceuticals	Type 2 diabetes
	Lexapro	Pfizer	Schizophrenia
	Diovan HCT	Novartis	High blood pressure
	Seroquel	AstraZeneca	Dementia
	Provigil®	Cephalon	Sleep Disorders
	Diovan	Novartis	High blood pressure
2013	Cymbalta	Eli, Lilly and Company	Depression
	Niaspan	Kos Pharmaceuticals	Cholesterol Lowering
	OxyContin	Purdue Pharma	Painkiller

*Source: Express Scripts, 2010*

## A LOOK AHEAD: FIRST SIX (6) MONTHS OF 2010

### Key Findings & Considerations

- The KEHP claims cost increase per member per month is 5.6% from 2009 to 2010 (six months 2009 versus six months 2010).
- Enrollment increased by 3.5%.
- Non-Medicare eligible retiree costs are increasing at a slightly higher rate than costs for active full-time employees, driven by pharmacy differences. The medical increase is 6.0% for actives and 4.7% for retirees. However, retirees' pharmacy trend of 16.2% is higher than actives' pharmacy trend of 5.7%.
- The cost of services, by place of service, from 2009 to 2010 remains consistent. Outpatient hospital claims continue to be the largest component. The growth rate in costs for physician services dropped 8.0% from 2009 to 2010.
- The number of mail order scripts increased by 8.8%, while retail scripts increased by 3.0%.
- Employee cost sharing per script for pharmacy decreased by 3.8%, from an average of \$11.00 per script in 2009 to an average of \$10.58 per script in 2010.

In order to identify the emerging trends in 2010, we analyzed the claims experience for January through June of 2009, compared to the same period in 2010. However, using 6 months of data may not show the same results as a full year of experience, due to the effect of seasonality.

### Exhibit XLVII

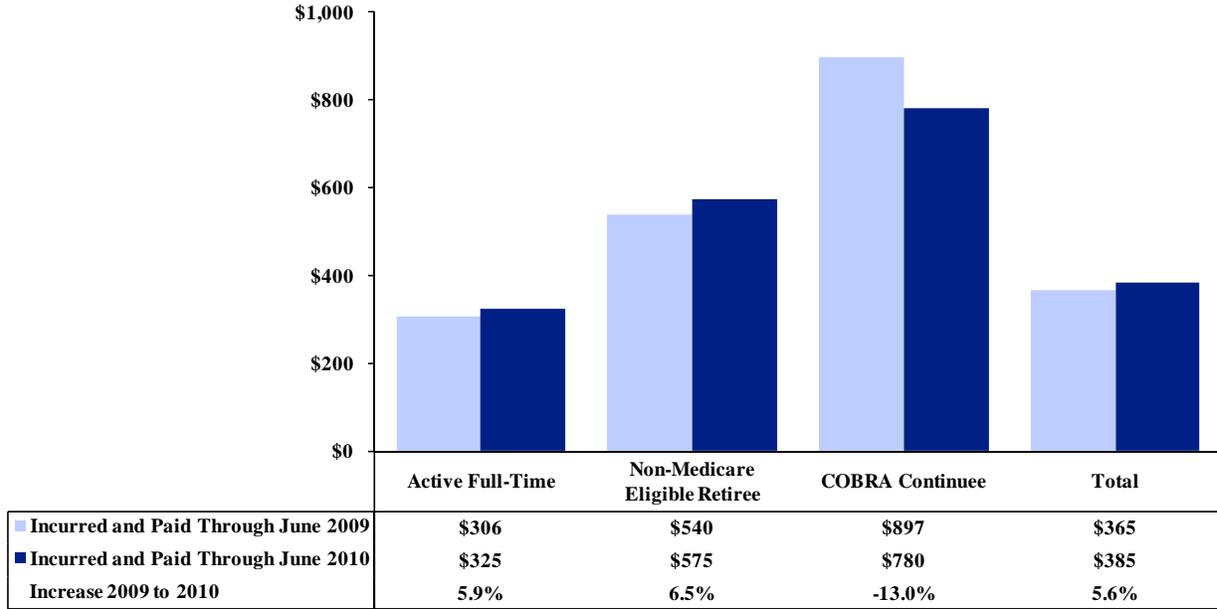
#### 2009 - 2010 Six Months Aggregate Paid Claims Experience

	Incurred and Paid through June 2009	Incurred and Paid through June 2010	% Change
<b>Aggregate</b>			
Medical Claims	\$414,880,214	\$451,871,652	8.9%
Rx Claims	\$149,347,171	\$164,831,383	10.4%
Total Claims	\$564,227,385	\$616,703,035	9.3%
Covered Lives	257,756	266,740	3.5%
<b>Per Member Per Month</b>			
Medical Claims	\$268	\$282	5.2%
Rx Claims	\$97	\$103	6.7%
Total Claims	\$365	\$385	5.6%

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

**Exhibit XLVIII**

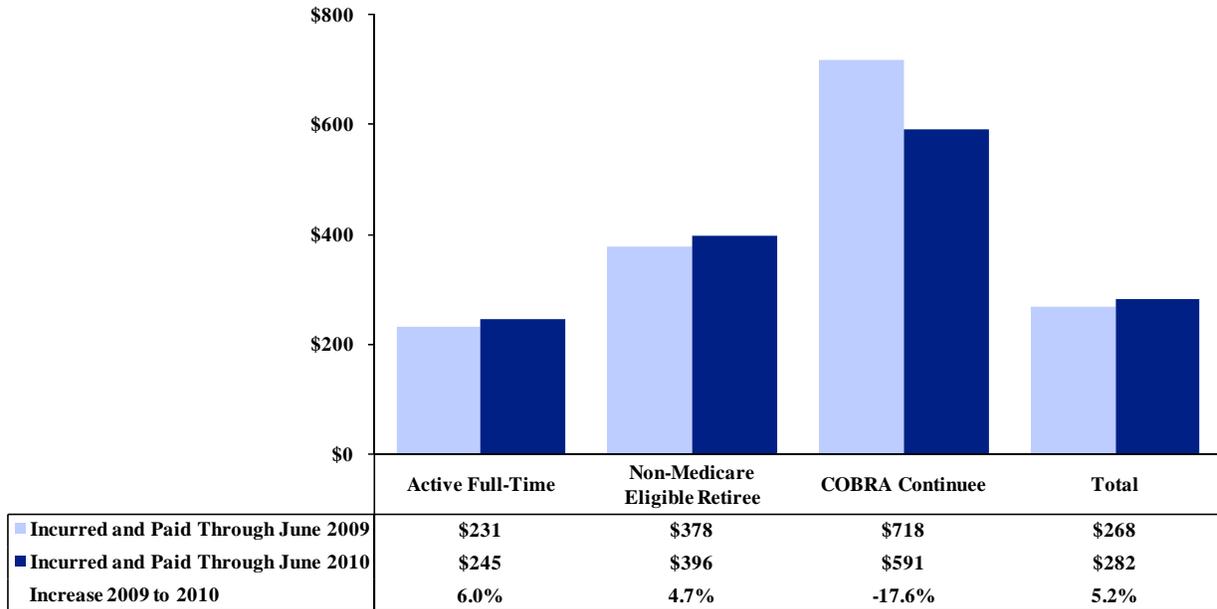
**2009 - 2010 Six Months Medical and Pharmacy Paid Claims Per Member Per Month (PMPM)**



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

**Exhibit XLIX**

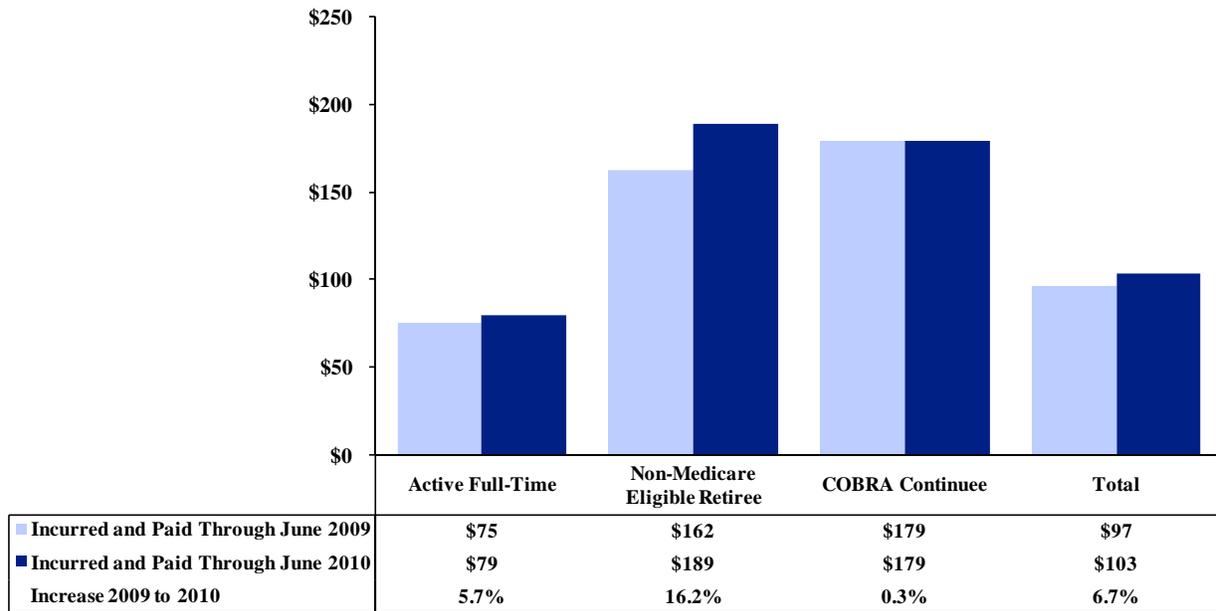
**2009 - 2010 Six Months Medical Paid Claims Per Member Per Month (PMPM)**



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

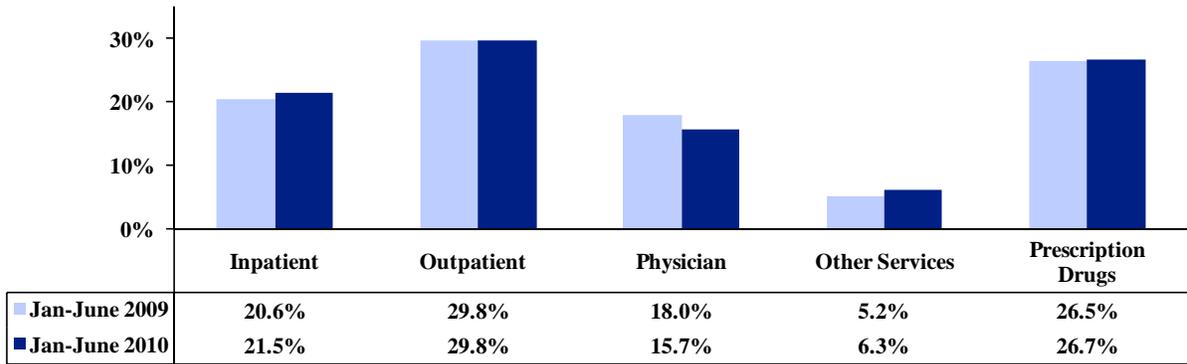
**Exhibit L**

**2009 - 2010 Six Months Pharmacy Paid Claims Per Member Per Month (PMPM)**



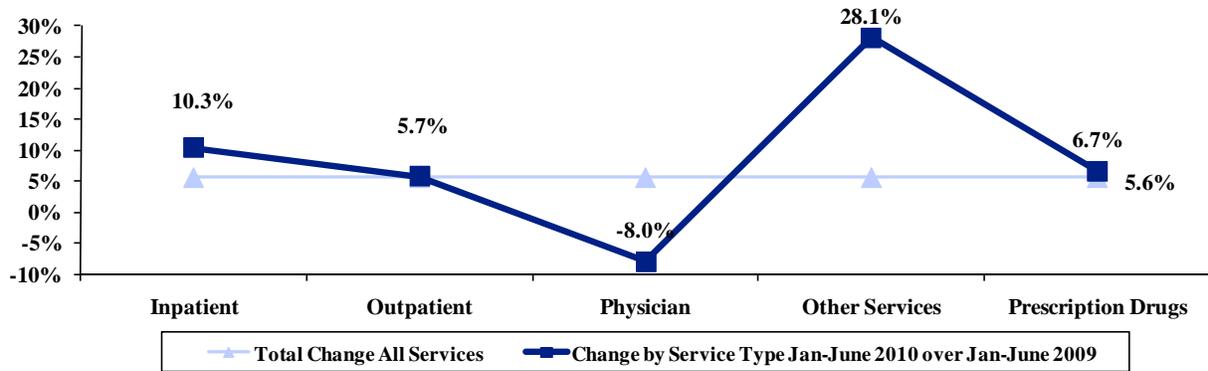
Source: KEHP's enrollment and claims data aggregated by Thomson Reuters

**Exhibit LI**  
**2009 - 2010 Paid Claims Distribution by Place of Service**



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

**Exhibit LII**  
**2009 - 2010 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 LIII****2009 - 2010 Key Pharmacy Benefits Aggregate Cost Statistics**

	Incurred and Paid Through June		
	2009	2010	2010 vs. 2009
Total Eligible Members	257,756	266,740	3.5%
Total Allowed Charges	\$173,516,226	\$189,128,688	9.0%
Total Net Paid Claims	\$149,347,171	\$164,831,383	10.4%

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

**Exhibit LIV****2009 - 2010 Key Pharmacy Benefits Cost Per Claim and Cost Share Statistics**

	Incurred and Paid Through June		
	2009	2010	2010 vs. 2009
Total Copayment per Claim	\$11.00	\$10.58	(3.8%)
Retail Copayment per Claim	\$10.57	\$10.15	(4.0%)
Mail Copayment per Claim	\$28.25	\$27.12	(4.0%)
Total Member Cost Share	15.7%	14.4%	(8.6%)
Retail Member Cost Share	15.8%	14.4%	(8.6%)
Mail Member Cost Share	14.9%	13.6%	(9.0%)
<b>Plan Cost:</b>			
Per Member Per Year (PMPY)	\$579.41	\$617.95	6.7%
PMPM	\$48.28	\$51.50	6.7%
Per Claim	\$58.83	\$62.97	7.0%

**Exhibit LV****2009 - 2010 Key Pharmacy Utilization Statistics**

	Incurred and Paid Through June		
	2009	2010	2010 vs. 2009
Scripts Per Member Per 6 Mos	9.8	9.8	(0.4%)
Total Scripts	2,538,591	2,617,724	3.1%
Retail Scripts	2,477,535	2,551,321	3.0%
Mail Order Scripts	61,056	66,403	8.8%
Brand Scripts	862,902	821,036	(4.9%)
Generic Scripts	1,675,689	1,796,688	7.2%
<b>Generic Utilization:</b>			
Generic Dispensing Rate	66.0%	68.6%	4.0%
Generic Substitution Rate	89.8%	92.2%	2.6%
Mail Order Utilization	2.4%	2.5%	5.5%
<b>Days Supply:</b>			
Days Supply Total	74,000,814	77,744,815	5.1%
Days Supply per Claim	29.2	29.7	1.9%

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

*Exhibit LVI*

**2009 - 2010 Prescription Drug Utilization Detail by Drug Classification**

	<b>Average Scripts Per Person (6 Months)</b>		
	<b>Incurred and Paid Through</b>		<b>2010 vs. 2009</b>
	<b>June 2009</b>	<b>June 2010</b>	
<b>Retail and Mail Order</b>			
Brand Single Source	2.6	2.5	(4.0%)
Brand Multi Source	0.7	0.6	(22.5%)
Total Brand	3.3	3.1	(8.1%)
Generic	6.5	6.7	3.6%
<b>Total All</b>	<b>9.8</b>	<b>9.8</b>	<b>(0.4%)</b>
<b>Retail</b>			
Brand Single Source	2.5	2.4	(4.3%)
Brand Multi Source	0.7	0.6	(22.8%)
Total Brand	3.2	3.0	(8.4%)
Generic	6.4	6.6	3.6%
<b>Total Retail</b>	<b>9.6</b>	<b>9.6</b>	<b>(0.5%)</b>
<b>Mail Order</b>			
Brand Single Source	0.1	0.1	6.9%
Brand Multi Source	0.0	0.0	(12.4%)
Total Brand	0.1	0.1	3.4%
Generic	0.1	0.1	6.5%
<b>Total Mail Order</b>	<b>0.2</b>	<b>0.2</b>	<b>5.1%</b>

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

## **MAINTAINING A SUSTAINABLE KENTUCKY EMPLOYEES' HEALTH PLAN IN THE FACE OF KENTUCKY'S BUDGET CHALLENGES AND IN A POST-FEDERAL HEALTHCARE REFORM WORLD**

*To continue to provide valuable health benefits and maintain financial solvency in the coming years, the Kentucky Employees' Health Plan (KEHP) will need to continue to reassess current strategies and approaches related to its health benefits and programs. Emerging healthcare system and market dynamics driven by health reform in the US and the Commonwealth's continuing budget constraints have, and will create, a challenge to the financial sustainability of the Plan. A new healthcare equilibrium will evolve, shaped by demographic and employment dynamics, US tax policy, budget constraints and new challenges and opportunities in the healthcare system.*

*KEHP's assessment of the most sustainable balance of programs and cost post reform will reflect its unique government plan dynamics, financial challenges, and participating employers' talent management and rewards strategies. While, in some ways, KEHP's approaches will build on the lessons learned and successes of the past few decades, they will also leverage the new opportunities presented in a post-reform world.*

For the past half century, American employers, both public and private, have been the primary source of healthcare security for working people and their families. Forged by favorable tax policy for employer provided benefits and a lack of universal access in the private markets, most employers (particularly larger employers) have not only provided affordable coverage but also leadership in driving incremental changes to the health system related to cost containment, health improvement, and driving improved value and performance. Yet, in spite of those efforts, our health system costs continue to escalate, our people's health behaviors have deteriorated and generally our health system remains behind other developed countries in its connectedness and delivery of world class quality healthcare. The convergence of these challenges led to the enactment of Federal health reform.

### **An Overview of the Patient Protection and Affordable Care Act (PPACA)**

*On Sunday, March 21, 2010, the House of Representatives passed the Patient Protection and Affordable Care Act (PPACA), by a vote of 219 to 212. This bill had passed the Senate on Christmas Eve 2009. The House then immediately passed H. R. 4872, the Healthcare and Education Reconciliation Act (the "reconciliation bill"), which would amend the PPACA in many respects. PPACA was signed on Tuesday, March 23 by President Obama, and the Senate began debate on the reconciliation bill to amend PPACA shortly thereafter.*

PPACA will create unprecedented change in the US healthcare system, phased in over the next nine years. It impacts all stakeholders in healthcare, including employers, government, payers, providers and pharmaceutical companies. It impacts virtually all aspects of employment-based health benefits, including:

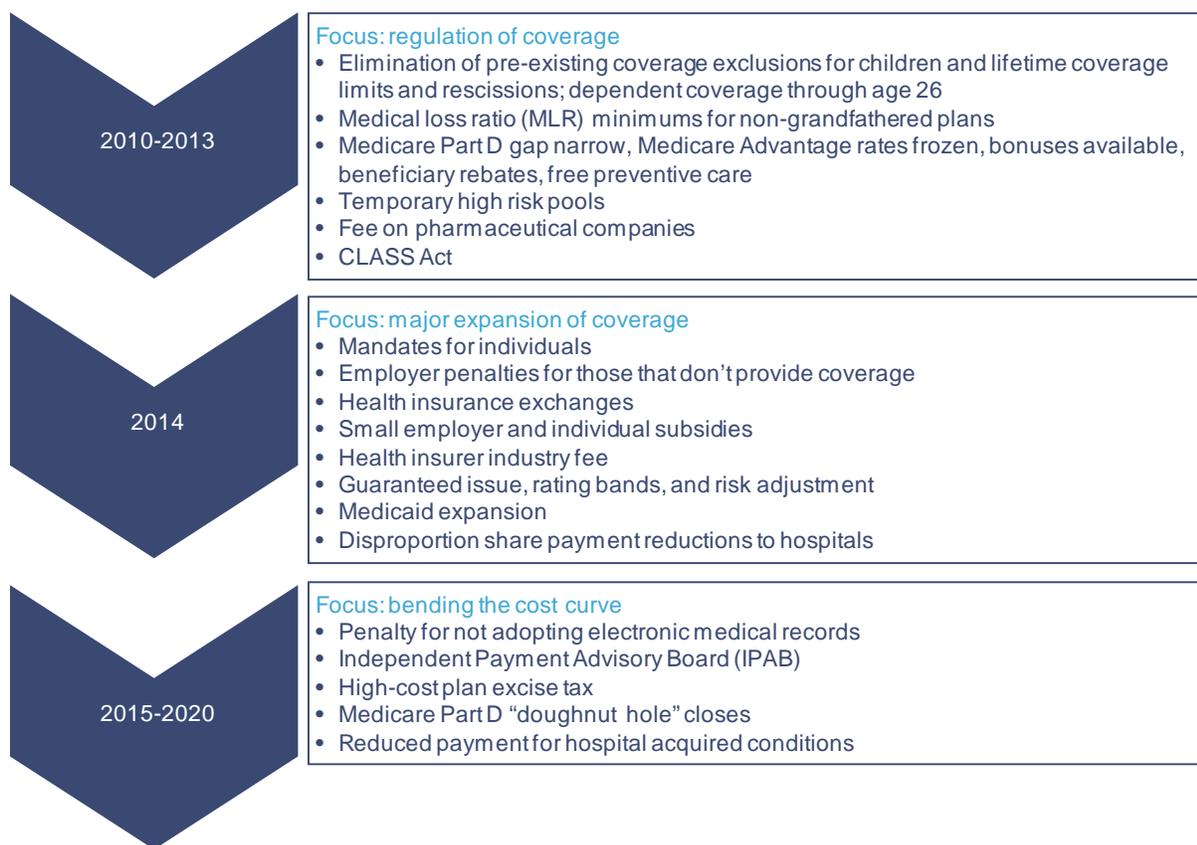
- Eligibility for coverage
- Benefit plan design

- Underwriting rules
- Regulatory compliance
- Funding
- Taxes

It impacts fully-insured and self-insured plans for active employees and retirees.

PPACA is financed in part by savings from Medicare and Medicaid as well as new taxes and fees, including an excise tax on high cost insurance, new Medicare taxes on high income individuals, the elimination of the tax deduction for employers for the Medicare Part D retiree drug subsidy, a cap on annual contributions to flexible spending accounts, and fees on insurance companies, pharmaceutical companies and medical devices companies. Some provisions are effective immediately, while some are deferred until 2013, 2014, and as late as 2018, with many provisions gradually phased-in. For group health plans, many provisions will become effective with the first plan year beginning six months after March 23, 2010. For KEHP this will be January 1, 2011.

The PPACA reforms are focused on three areas of change. The earliest reforms, having already begun in 2010, are focused on regulating coverage. The second, beginning in 2014, focus on expansion of coverage. Later reforms focus on significant changes in the health system itself, sometimes called "bending the cost curve" for healthcare in the US. The timeline for reform spans to 2020 with more than 60 major regulatory deadlines that have and continue to be addressed by the Federal government. Below is an abbreviated implementation timeline of the law.



In considering health reform, certain mega trends will impact each sector of the healthcare system.

- Providers are being encouraged to deliver system-wide, coordinated care through performance-based payment methodologies that cross traditional silos of care. Two such emerging models are accountable care organizations (ACOs) and medical homes. Providers will see a 40% increase in Medicaid recipients, whose care is paid at lower rates. Quality metrics will be evaluated on a relative basis resulting in continual pressure to improve quality.
- Payers will face increased pressure to ensure that the proportion of spending on medical services meets the new medical loss ratio (MLR) requirements. At the same time, we estimate the group market will decline by 25% and the individual market will quadruple by 2019. Insurance reforms and exchanges will force payers to compete based on a new value proposition.
- Pharmaceutical and life sciences organizations will face an accelerated movement toward outcomes- and quality-based reimbursement and a new standard of comparative effectiveness. The creation of new biologic products will dramatically alter the portfolio design process and the economics of treatment and discovery.

After short term efforts to comply with immediate requirements, employers will recalibrate their longer term strategy based on a new set of underlying dynamics. What today is unthinkable in how employers approach benefits, could be real in the very near future. The initial decision will

be “pay or play”. Tax policies integral to recent reforms will help to drive a new equilibrium in employer provided health benefits. The transition will be complex and staged over multiple years.

Employers and plan sponsors should also prepare for higher scrutiny as the regulatory environment related to health benefits will likely become even more demanding than in the past. Existing federal agencies will take on complex new responsibilities, while new regulators are also being created. Employers will want to evaluate their internal processes and those of their vendors to improve compliance, sustain high performance and mitigate financial and reputational risk.

## **Some Key Provisions of PPACA that will Impact KEHP**

### **Changes to Health Plans**

PPACA changes a number of requirements for individual and group health plans. Many of these are effective for the first plan year beginning after September 23, 2010. For KEHP, the applicable changes will begin January 1, 2011.

- Plans must offer coverage for the children of covered individuals until age 26, and may opt to continue to do so through the end of the plan year during which they attain age 26.
- Plans may not place lifetime limits on the dollar value of coverage.
- Beginning in 2014, plans may not impose any annual limits on coverage; prior to 2014, only "reasonable" annual limits, as determined by the Secretary, may be imposed.
- Plans may not have waiting periods longer than 90 days.
- Plans must eliminate pre-existing condition exclusions, effective for children under 19 in 2011; effective for adults in 2014.
- Plans may not rescind coverage except in the case of fraud or intentional misrepresentation.
- Out-of-pocket limits may be no greater than current year's health savings account (HSA) out-of-pocket maximum (\$5,950 individual, \$11,900 family).
- Employer plans must have an HHS-approved binding external review process.
- Employers will be required to report the aggregate value of health benefits on employees' W-2 Forms beginning with the 2012 tax year.
- Changes to flexible spending accounts (FSAs):
  - The cost of over-the-counter drugs not prescribed by a doctor may not be reimbursed through a health reimbursement account (HRA) or health FSA beginning January 1, 2011.

- Increased penalty for nonqualified HSA or Archer medical savings account (MSA) purchases or distributions increased from 10 to 20 percent, effective for distributions in 2011.
- The maximum contribution to an FSA will be limited to \$2,500 annually, beginning in 2013.
- Discrimination in insured group health plans based on the employee's salary is prohibited, effective for plan years beginning after September 23, 2010.
- PPACA includes the CLASS Act provisions, which requires employers to automatically enroll employees in a salary reduction program to provide benefits for long-term care, effective in 2011. Employees may opt out of this program.

### **Mandated Health Insurance Coverage**

PPACA requires that most U.S. citizens and legal immigrants have health insurance starting in 2014. This individual mandate provision is enforced by a tax penalty based on income level. Insurance will be offered through state-based Exchanges to be available in 2014. Low income families may receive premium tax credits and cost-sharing subsidies for their coverage. PPACA also expands Medicaid eligibility to those with income up to 133 percent of the federal poverty level, and makes major changes to rules for private insurance, Medicare, Medicaid, quality metrics, prevention and wellness standards, and long-term care.

PPACA imposes penalties on group health plans that do not provide coverage for full-time employees, as well as on plans that have coverage that is inadequate or unaffordable for low-paid employees, beginning in 2014. A full-time employee is defined as an employee working at least 30 hours per week. The penalties vary based on whether or not the employer offers minimum essential coverage and, if so, the employer contribution towards the cost of the coverage and the employees' income.

- The penalty for employers who do not offer minimum essential coverage under an eligible employer-sponsored health plan, if at least one full-time employee enrolls in a qualified health plan under an Exchange and receives a premium tax credit, is \$2,000 times the number of full-time employees, excluding the first 30 full-time employees.
- The penalty for employers who do offer minimum essential health insurance coverage, but where at least one full-time employee of the employer has enrolled in an Exchange and qualified for a premium tax credit, is \$3,000 for each such employee, but not more than \$2,000 times the number of full-time employees.

If the actuarial value of the employer's portion of the plan cost is at least 60 percent, this penalty will not apply except with respect to any employee who cannot afford the employee share of the premium (because it exceeds 9.5 percent of his income) and who enrolls in an Exchange and receives the premium credit.

- The dollar amounts will be indexed for inflation beginning in 2015.

*Free-choice Vouchers.* Employers that offer coverage to their employees must provide a free-choice voucher to employees with incomes less than 400 percent of the federal poverty level whose share of the premium exceeds 8 percent, but is less than 9.8 percent of their income and who choose to enroll in a plan in the Exchange. The voucher must be the amount the employer would have paid to provide coverage for the employee under its plan, and will be used to pay the premium for the plan in which the employee is enrolled. Employers will not be assessed the penalty on employees enrolled in the Exchange who receive a free-choice voucher.

### **Early Retiree Reinsurance Program (ERRP)**

Congress has appropriated \$5 billion for a temporary program to reimburse retiree health plans for certain costs of benefits provided to pre-Medicare eligible retirees. PPACA provided that the program be established by June 21, 2010, and end no later than January 1, 2014, the effective date for the new state insurance exchanges.

The objective of ERRP is to reduce the decline in the number of employers providing health coverage to early retirees, and to provide a bridge to Medicare for early retirees until the state-based exchanges are established. According to White House officials, in 1988 66 percent of employers provided retiree health insurance; today retiree health insurance is offered by fewer than 31 percent of employers.

ERRP provides reimbursement to participating employment-based plans for a portion of the cost of providing health coverage to early retirees and their eligible spouse or surviving spouse and dependents. PPACA provides that a participating employment-based plan that meets the requirements of the Act may submit claims for reimbursement based on the amount spent by the plan for the health benefits provided to an early retiree or the spouse, surviving spouse, or dependent of such retiree. The government will reimburse the plan for 80 percent of the portion of the costs attributable to the early retiree's claims that exceed \$15,000 and are not greater than \$90,000. Amounts received by the plan are to be used to lower costs for the plan. Payments may be used to reduce premium contributions, co-payments, deductibles, co-insurance or other out-of-pocket costs for plan participants, or to reduce premium costs for the plan sponsor. Payments may not be used as general revenues for the plan sponsor. Payments are not taxable to the plan sponsor. The Program will end no later than January 1, 2014, or when the \$5 billion appropriation has been exhausted.

The ERRP defines an "early retiree" as a plan participant who is age 55 and older who is enrolled for health benefits in a certified employment-based plan, who is not eligible for coverage under Medicare and is not an active employee of an employer maintaining or currently contributing to the plan, or of any employer that has made substantial contributions to fund such plan. Early retiree also includes the spouse, surviving spouse, and dependents of these individuals who are enrolled in the plan, regardless of their age or Medicare eligibility status.

In order to participate in ERRP, the plan sponsor must:

- Submit an application to the Secretary of HHS;
- Ensure that policies and procedures are in place to protect against fraud, waste and abuse under the Program, and must substantiate their implementation and effectiveness as well;

- Make available required information to the Secretary of HHS.

The KEHP application was submitted on the first day that applications were being accepted, was approved without incident, and was in the first group of 2,000 such approved applications as reported by HHS on September 1, 2010. The regulations state that claims reimbursement requests will be processed on a "first-come, first-served" basis in the order received from plan sponsors with accepted applications.

A plan sponsor may not use proceeds under ERRP as general revenue for the sponsor, but must use the proceeds:

- To reduce increases in the sponsor's health benefit premiums or health benefit costs,
- To reduce health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs, or any combination of these costs, for plan participants, or
- Any combination of these.

The regulations provide that the term "plan participants" for whom costs may be reduced includes all plan participants, including early retirees and active employees, retirees, and their spouses and dependents who participate in the plan. Under the regulations, the plan sponsor may determine how to use the reimbursement; for example, whether to use it to reduce costs immediately or for the next plan year.

A Fact Sheet released earlier this year by the White House, discussed the ability of plan sponsors to use proceeds from ERRP to reduce their own premiums or costs. The regulations confirm that sponsors have the ability to lower their own plan costs using these funds, but the preamble reiterates that HHS will require plan sponsors to maintain the level of effort in contributing to support their plans. According to the preamble, they expect sponsors "will use the reimbursement to pay for increases in, for example, the sponsor's premium, or increases in other health benefit costs." The preamble indicates that HHS encourages sponsors to use the reimbursements to reduce costs for plan participants as well as the plan sponsor. As noted above, the sponsor's summary of how it will use the Program's reimbursement, which is required to be included in the application, must "explain how the reimbursement will be applied to maintain the sponsor's level of effort in contributing to support the applicable plan".

ERRP applications continue to be approved by HHS, and the number of certified employers continues to increase. There is much speculation as to when the \$5 billion dollar funding will be exhausted.

### **State Based Health Insurance Exchanges**

Beginning in 2014, state-based Exchanges will be available to U.S. citizens and legal immigrants and employers with up to 100 employees to purchase qualified health insurance coverage. After 2017, states may permit larger employers to purchase coverage through their Exchanges. The Exchange must offer the following four categories of plans providing essential health benefits with an out-of-pocket limit equal to the HSA current limit (\$5,950 for individuals and \$11,900 for families in 2010), as well as a Catastrophic plan for individuals up to age 30:

- Bronze Plan (the standard for "minimum creditable coverage") covers 60 percent of the costs of the plan
- Silver Plan covers 70 percent of the benefit costs
- Gold Plan covers 80 percent of benefit costs
- Platinum Plan covers 90 percent of benefit costs
- Catastrophic Plan (for those up to age 30 or those who are exempt from the Individual mandate provisions of the law) provides catastrophic coverage only, with the level set at the current HSA level, except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is not available to employers.

The out-of-pocket limits are reduced for those with incomes up to 400 percent of the federal poverty level. Premiums in the exchange may not vary by more than 3 to 1 based on age.

### **"Grandfathered" Health Plans**

Under PPACA a group health plan that was in existence on March 23, 2010 and does not change plan designs or employee cost beyond certain limits identified in the regulations can be considered a "Grandfathered Health Plan". Grandfathered status permits the group health plan to be exempted from several of the PPACA requirements for as long as the plan remains grandfathered. KEHP, like most group health plans, has evaluated the advantages and disadvantages of continuing grandfathered status and concluded that grandfathered status will be maintained as long as this is a financially viable option. Because PPACA limits the amounts that a group health plan can change benefits provisions and employee contributions, most plan sponsors anticipate that they will lose grandfathered status in the next few years in order to remain financially stable.

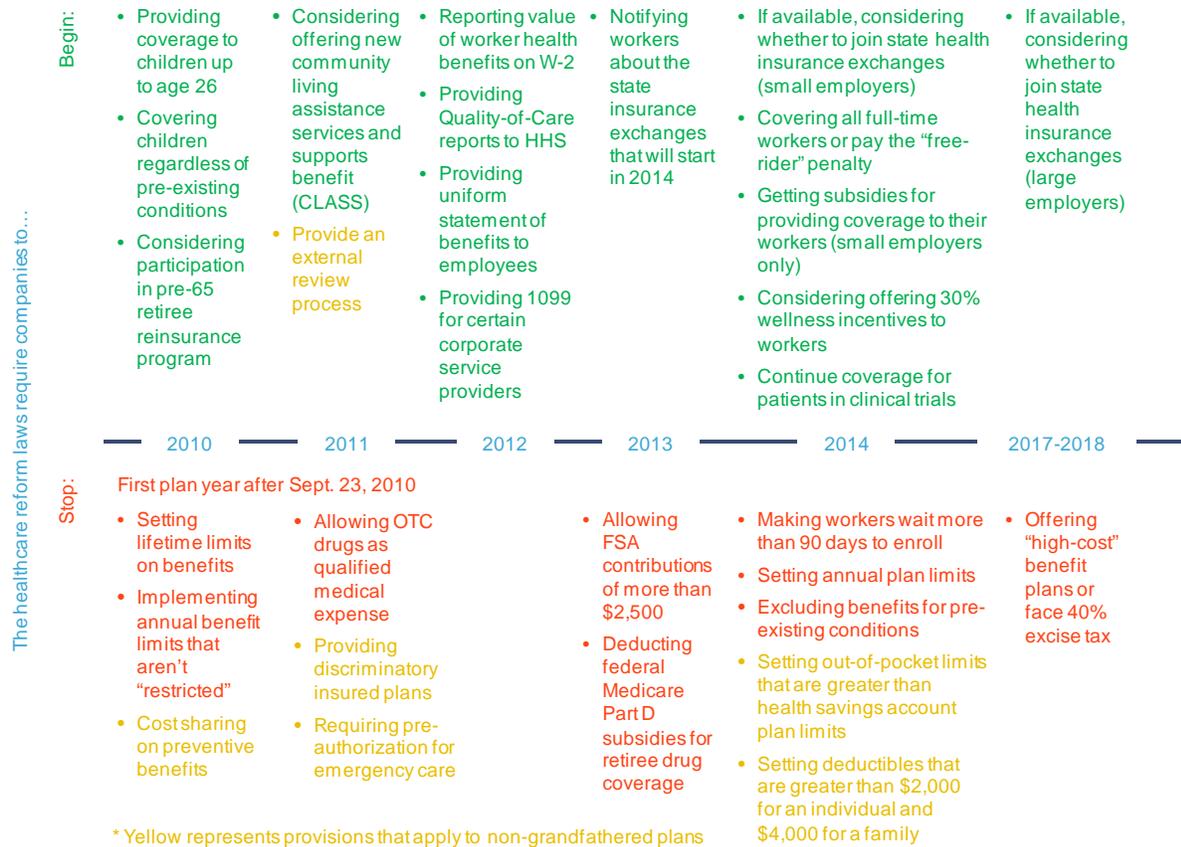
When grandfathered status is lost due to the changes mentioned above, the health plan will be required to comply with the following provisions of PPACA:

- Coverage of preventive benefits as defined by regulation with no participant cost sharing
- Implementation of the required external appeals process
- Reporting health plan information on plan costs, programs and outcomes to the federal government
- Non-discrimination requirements
- Coverage of adult children to age 26, even if they have other coverage available
- Coverage for individuals participating in approved clinical trials
- Other patient protections

KEHP will maintain grandfathered status for 2011.

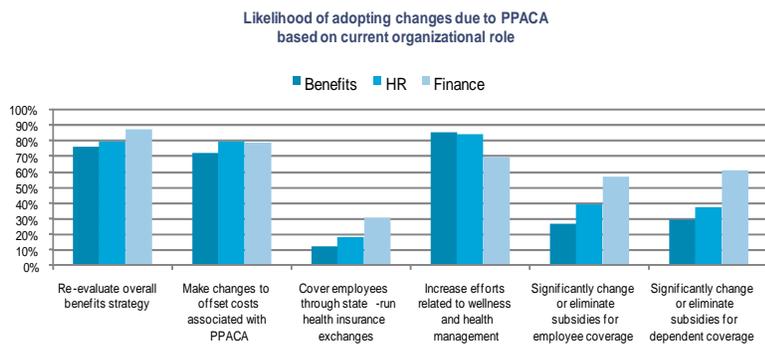
In summary, KEHP will address PPACA challenges and opportunities according to the following timeline.

### New rules for employer-sponsored benefit plans



## How Plan Sponsors across the Country are Responding To Health Reform?

On one level, PPACA does not represent radical change from the existing health system. PPACA still relies on employers, private health plans, and existing public programs to provide the fundamental foundation to health security for Americans. On another level, the rules and economics of that foundation have changed and require a "new look" at employers' benefits, rewards and health strategies. In fact, about four out of five employers report that they expect to re-evaluate their benefits strategy in light of PPACA<sup>1</sup>.



PwC Health Reform Touchstone Survey Supplement - 2010

Initial efforts to address health reform have been focused on compliance with the near term changes required by the law. The short term costs of health reform will not be great for most employers, although some employers do anticipate moderate or even significant impacts depending on their current industry practices, benefits structure and hiring practices. However, tax provisions phased in between 2012 and 2018 are key concerns and most employers believe health reform will bring significant change over time. Many employers may also relook at employment practices related to part-time and seasonal workers. The transition will be complex and staged over multiple years.

Based on PwC's Touchstone Health Reform Survey, employers have indicated the following responses to health reform:

- In light of the PPACA, employers are re-examining their health benefit plans:
  - 99% of large employers have examined their benefits, and 75% have already started to take action.
  - 95% of mid-sized employers have examined their benefits, and 51% have already started to take action.
  - 80% of smaller employers have examined their benefits, and 35% have already started to take action.
- The short term costs of health reform will not be great for most employers although some see at least a moderate impact:
  - 66% indicated elimination of "unreasonable" annual limits on benefits will have little or no financial impact.
  - 55% indicated no "pre-existing condition" exclusions for children or adults will have no financial impact.
  - In contrast, 52% indicated that extension of coverage to age 26 for adult children will have a moderate to significant impact.
  - 41% indicated that the requirement to report the value of health benefits on employees' W-2s will have a moderate to significant impact.

<sup>1</sup> Source: PwC Health Reform Touchstone Survey Supplement from July 2010

- Tax provisions phased in between 2012 and 2018 are key concerns:
  - Half of respondents indicated that the “Cadillac” plan excise tax in 2018 will have a moderate to significant impact on their company or employees.
  - Five out of ten cited the increase in Medicare tax on high-income individuals and four out of ten cited the new Medicare tax on net investment income as having a moderate to significant impact on their company or employees.
  - “Free rider” penalties were potential concerns for 20-25% of the companies.
- Most employers believe health reform will bring significant change:
  - 94% of employers expect to have to make changes to their benefits to comply with PPACA while 74% expect to make additional changes to offset the costs of complying.
  - 79% expect to re-evaluate their benefits strategy with the most common focus being to increase efforts related to health and wellness and with a substantial minority focusing on significant changes to company subsidies for employees or dependents, or considering coverage of employees through the state exchanges.
  - 83% anticipate an increase in efforts related to wellness and health management.
- Some employers may decide to relook at why and how they provide coverage:
  - While most employers will continue to offer health coverage even when access is guaranteed in the open market, 16% of employers are looking to eliminate company plans and subsidize health exchange programs in the future.
  - If employers do provide subsidies to a health exchange in the future, most envision subsidies not varying by age or area but potentially varying based on other factors such as income.
  - About half of employers are looking to significantly change or eliminate retiree medical benefits due to PPACA.
- Almost all employers anticipate health reform creating additional compliance and administrative burdens:
  - 49% feel the additional compliance and administrative burden will be significant.
  - 88% of employers exhibited at least moderate concern with the impact on administration and compliance efforts.
  - Only 1% indicated that health reform would have no impact on compliance and their administrative burden.
- Many employers may relook at employment practices related to part-time workers:
  - To avoid PPACA “Free Rider” penalties, employers need to provide coverage to all “full time employees” where “full time” is defined as a minimum of 30 hours per week worked (not scheduled).
  - Approximately 64% of employers define a full-time as over 30 hours a week.
  - Over half of employers define work hours based on hours scheduled rather than average hours worked.

After addressing short term efforts to comply, employers will recalibrate their longer term strategy based on a new set of underlying dynamics. The initial consideration will be to “pay or play”.

## **To "Pay or Play" - The Initial Question**

With the advent of minimum benefit mandates, guaranteed issue coverage and federal subsidies for lower income households, many employers will relook at why and how they provide coverage. While most employers will continue to offer health coverage, even when access is guaranteed in the open market, 16% of employers are looking to eliminate company plans and potentially subsidize health exchange programs in the future. If employers do provide subsidies to a health exchange in the future, most envision subsidies not varying by age or area but potentially varying based on other factors such as income. About half of employers are looking to significantly change or eliminate retiree medical benefits due to PPACA.

Some industries with high turnover, major labor costs and relatively low paid workers will be most open to such strategies. These companies will reassess current benefit eligibility and plan options. Today, many employees in these industries are uninsured, on Medicaid, or get individual insurance or insurance through a spouse or parent. For the next three years, these employers will have to change their plans to comply with regulations; likely resulting in increased eligibility and benefit costs.

However, 2014 will introduce an entirely new dynamic as employees will be guaranteed coverage in the open marketplace and those who are not provided coverage through their employer may be eligible for federal subsidies to make such coverage affordable. Consequently, companies will want to examine whether their current benefits subsidies could be better spent elsewhere. The new market alternatives available in 2014 will give companies the opportunity to rebalance their approaches to benefits, rewards and health programs, forming a new equilibrium that will support financial objectives. By evaluating the tradeoffs of the anticipated cost of coverage against the free rider penalties and forgone federal subsidies, employers can consider the potential for state-run health exchanges and federal subsidies to replace all or some of employer provided subsidized health benefits.

## **"Optimizing Play" Under a New Set of Tax Rules**

Changing the tax treatment of employer-provided health benefits will transform healthcare economics. Tax provisions phased in between 2012 and 2018 will be key drivers toward the new equilibrium in health benefits. "Free rider" penalties are expected to have at least moderate impact on 20-25% of the companies. Half of employers indicate that the "Cadillac" plan excise tax will have a moderate to significant impact on their company or employees. The change in tax

### **"Pay or Play" Strategic Considerations**

Employers will explore the financial, tax, and employee relations implications associated with:

- continuing to offer medical benefits,
- discontinuing or limiting those benefits
- encouraging/subsidizing employees (and/or dependents) to purchase coverage through the state exchanges

#### **Key Considerations**

- Expanded Medicaid coverage for low income households
- New federal subsidies for middle income households
- Free rider assessments and excise taxes if provide "no coverage" or "unaffordable coverage" to full-time workers
- Mandated subsidies in the form of Free Choice Vouchers
- Costs of near term and longer term mandated benefit plan provisions
- Opportunities to participate in state-sponsored or privately developed health exchanges
- Impact on recruiting, retention and total rewards
- Transition strategies for potential exit

status of retiree drug subsidies has already had a major financial impact on companies providing retiree health benefits. Employers may reconsider eligibility rules, benefits and employment practices to mitigate the impact of these new tax rules. Some examples include:

- *Definition of part-time employment* - Approximately 64% of employers define a full-time as over 30 hours a week. Over half of employers define work hours based on hours scheduled rather than average hours worked. To avoid PPACA "Free Rider" penalties, employers may choose to provide coverage to all "full-time employees" where full-time is defined as a minimum of 30 hours per week worked (not scheduled).
- *High turnover and seasonal workers* - Companies may want to implement a 90 day waiting period which would mitigate the financial impact of providing coverage for seasonal and short term employees as well as mitigate the cost and administrative burdens associated with automatic enrollment under PPACA.
- *Low paid workers* - With the expansion of Medicaid, many of the lower paid employees covered under the plan may become Medicaid eligible and no longer participate in the employer sponsored plan. Employers may want to explore how to facilitate such access.
- *Optimizing subsidies* - Even where employers elect not to provide subsidized coverage for certain workers, they can avoid the "sledgehammer effect" of the free rider penalties (i.e. \$2,000 times every full-time employee) by offering coverage to all full-time employees.
- *Minimum Essential Benefits vs. Employee Contributions* - Once minimum essential benefits are satisfied, the tax penalties under Free Rider are focused on the affordability of premiums, not cost at the point of care. In fact, the "Cadillac plan" excise tax encourages employers not to maintain very rich and costly plans over the long run. This should support, encourage and accelerate the movement toward consumer directed plans, and specifically high deductible plans, while constraining the degree of cost shifting in premiums.
- *Rethinking Retiree Health* - Employers that have previously offered retiree health coverage for early retirees will find less reason to do so going forward due to federal health subsidies, community rating with limits on age banding, as well as the availability of guaranteed issue coverage in the open market. Those who offer retiree health coverage post-65 may find converting drug coverage to an employer group waiver plan (EGWP) under Medicare Part D will be more economical than traditional drug plans, due to changes in the RDS tax treatment and the gradual closing of the donut hole under Part D. Medicare Advantage plans are likely to continue to be less attractive and subject to major premium increases and benefit cutbacks as government subsidies are reduced.

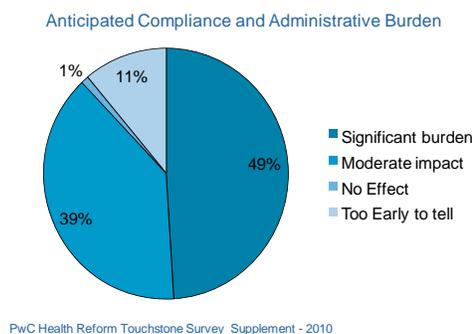
### **"Leveraging System Reforms" to Accelerate and Sustain Performance**

Many health benefits strategies that employers are executing on today can be accelerated if properly integrated and synergized with broader system reforms. By understanding the broader context of health reform, employers can help to facilitate and ensure that all stakeholders are better aligned and integrated around the universal objective of improved health and better value. All stakeholders will benefit over the long run if strategies and approaches are integrated, and elusive transformational changes may finally be possible. Some examples are provided below:

- *Wellness* - Current employer efforts can be enhanced with the availability of more universal preventive care, increased incentives as well as the opportunity to integrate with community-wide efforts focused on improving health behaviours.
- *Consumerism* - As health information technology enables more connectivity in the delivery system and provider performance becomes measurable and transparent, real data can better define value in the system and drive better and more informed consumer engagement.
- *Value Based Design* - Over time, a commitment to study the comparative effectiveness of treatments will help to ensure more thoughtful designs and utilize behavioural economics to reward more effective care and discourage care with less value.
- *Integrated Health* - Traditional approaches to disease and case management may be restructured as new approaches to integrated health emerge in the form of Accountable Care Organizations and Patient Centered Medical Homes.

Continued leadership by the employers and plan sponsors will be critical to the long term success of sustainable health system reforms. Collaboration among providers, payors and employers will be key to achieving breakthroughs in health information technology, transparency in value, coordinated care processes and improved prevention and wellness efforts. Without this collaborative approach the critical health system transformation objectives of health reform may not be achievable.

Employers and plan sponsors should also prepare for higher scrutiny as the regulatory environment related to health benefits will likely become even more demanding than in the past. Existing federal agencies will take on complex new responsibilities, while new regulators are also being created. Employers will want to evaluate their internal processes and those of their vendors to improve compliance, sustain high performance and mitigate financial and reputational risk.



### **In Summary - Federal Health Reform Presents Opportunities and Challenges for KEHP**

To successfully manage benefits programs and cost, KEHP needs to incorporate the strategic and compliance requirements of health reform into their planning and program management processes. This includes continuing to consider grandfathered status, the required plan design changes, reporting requirements to HHS, employee communications, new eligibility requirements, pay or play penalties, available subsidies, multiple tax issues and the implications of the dramatic changes which will evolve in the US healthcare system.

The short term costs of health reform will not be great for most employers, although some see at least a moderate impact. Tax provisions phased in between 2012 and 2018 are key concerns. Most employers believe health reform will bring significant change. Many employers may also relook at employment practices related to part-time and seasonal workers. Almost all employers anticipate health reform creating additional compliance and administrative burdens.

## *KEHP has Faced Additional Challenges Due to the Commonwealth's Budget Crisis*

HB1 from the Extraordinary Session of 2010, imposed funding limitations (defined employer subsidies for 2011 and 2012) that may not be sufficient based on expectations of future health care claims utilization without reductions in benefits and/or increases in required employee contributions.

### *Budget Rate/KEHP Subsidy/Employee Contribution Structure*

The LRC implemented KEHP subsidy funding caps in 2011 and 2012:

- 0% increase from 2010 to 2011, and
- 2% increase from 2011 to 2012.

These funding caps are significantly less than assumed health care inflation for the same periods:

- Health care inflation is assumed to be 9.0% per year from 2010 to 2011, and
- 9.2% from 2011 to 2012.

### *Health Care Inflation*

In general, health care inflation relates to the general level of rising costs of the total cost of health care, before employee cost-sharing elements are applied such as deductibles, copays, and coinsurance.

Health care inflation is comprised of several unique contributing cost drivers. The combined impact of these cost drivers is the above assumed 9.0% health care inflation from 2010 to 2011 (approximate split by component of health care inflation is included below):

- **Cost inflation:** The change in the unit price of medical products and services (approximately 35% of overall health inflation assumption)
- **Utilization:** Changes in the volume of services used because of health status, demographic changes, and advertising (approximately 15% of overall)
- **Technology:** Changes in the volume and types of services used because of the use of new technology (approximately 25% of overall)
- **Cost shifting:** The impact on costs resulting from the government cost-shifting away from entitlement programs, such as Medicare and Medicaid, and toward the private sector (approximately 15% of overall)
- **Litigation and risk management:** The cost impact of medical malpractice (litigation), and the cost impact of additional unnecessary services prescribed as preventive action resulting from increased litigation (risk management) (approximately 10% of overall)

Plan sponsors are able to influence some, though not all, of the above drivers of health care inflation:

- **Cost inflation:** Increases in unit prices can be somewhat mitigated by strengthening negotiated provider discounts

- Utilization: Erosion of a covered population's collective health status can be managed to a degree through the implementation of integrated care management programs such as wellness programs, disease management efforts, and preventive benefits programs.
- Technology: Advances in technology may result in cost increases because the new technology may be more costly than the technology that is replaced. Conversely the new technology may be more effective and improve quality of care.
- Cost shifting: Plan sponsors have limited ability to control the impact of cost shifting.
- Litigation and risk management: Plan sponsors have limited ability to influence the cost inflation impact of litigation and risk management.

The Commonwealth's budget constraints will continue to affect KEHP's financial sustainability over the next years. Plan design changes and changes to employee cost sharing will be implemented in 2011 to support the plan's ongoing solvency. Additional plan design changes and/or changes to employee cost sharing and required contributions will be needed in 2012 to continue to support the plan's ongoing solvency.

## 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
- Strive to hold down costs for family and dependent coverage
- Provide plans with unlimited lifetime maximums

The Board continues to support the recommendations made in last year's Ninth 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 has continued to evaluate data and information related to the plan's cost, members' use of services, and the clinical conditions prevalent in the population. Challenges and opportunities for improving both the cost to the plan and members and for improving members' health have been evaluated and implemented. Several strategic alternatives, including implementing approaches to improve and integrate disease and care management programs, strategies to increase the use of generic drugs and manage specialty drug use, and expansion of wellness and prevention programs were evaluated and implemented. DEI continues to evaluate alternatives for implementation in 2011, including evaluating additional incentive programs to improve members' participation and engagement in wellness and care management programs. 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 have been implemented and DEI continues to monitor the results. Increased active participation in wellness and disease management programs has been achieved in 2010. Care management vendors meet quarterly with DEI to discuss results and potential additional efforts to manage care.*

- KEHP should evaluate programs and options for improving the clinical and administrative quality of programs and services. This study should consider practical steps to evaluate and improve administrative services including claims payment, customer service and others. It should consider programs to measure and improve quality of care currently available in the marketplace.

*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. Further 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 implemented increased communications processes in 2009 and 2010. 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 further recommends:

- 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 healthcare 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 healthcare reform measures once the scope and detail of reform programs are known.

*DEI has evaluated the impact of federal healthcare reform law and regulations as information became available during the course of 2010. DEI will continue to evaluate*

*the emerging impact of the law as regulations are finalized and market impact information becomes available.*

## APPENDIX

### **Modifications to the KEHP Program and Plan Design Provisions by Year, 2000 - 2010**

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  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 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*
	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*	\$300 maximum benefit per year	
	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 \$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*	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	Covered same as	Covered same as	Covered same as	

	Medicare benefit	Medicare benefit	Medicare benefit	Medicare benefit
Physical Therapy (per visit)–Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Occupational Therapy (per visit)–Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Cardiac Rehabilitation Therapy (per visit)–Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Speech Therapy (per visit)–Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Skilled Nursing Facility (per visit)–Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

## 2002 Public Employee Health Insurance Program Benefit Provisions (continued)

Exclusive Provider Option		Option C
<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 child care, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	\$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit)–outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician’s office).	\$500 co-pay (per visit)
	Diagnostic Testing (per visit)–laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician’s office in conjunction with an office visit are only subject to the physician office visit co-pay; 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
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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*
	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				
	<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)	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*	\$300 maximum benefit per year	
	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*	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	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 child care, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	\$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit)—outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$500 co-pay (per visit)
	Diagnostic Testing (per visit)—laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations*—All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
<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		
	• Rehabilitative and Therapeutic care	\$10 co-pay	\$20 co-pay
	• Respite 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	

## 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>	Retail	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
	Mail Order	\$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	
	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*
	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)

<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. <b>All services performed on the same day (same site) are subject to one co-pay.</b>	\$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).

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.

## 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 \$400 maximum benefit per covered individual per plan year	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 \$400 maximum benefit per covered individual per plan year	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 in-hospital care co-insurance applies*	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.

**In 2010:**

- The Commonwealth offered the same four benefit plans which were offered in 2009 with slight changes to benefit designs. The plans are:
  - Commonwealth Standard PPO – a \$500/\$1,500 Deductible PPO plan (changed from \$750/\$1,500 in 2009);
  - Commonwealth Capitol Choice – a \$500/\$1,500 Deductible hybrid PPO plan with an up-front benefit allowance of \$500 per member;
  - Commonwealth Optimum PPO – a \$300/\$600 Deductible PPO plan (changed from \$250/\$500 in 2009);
  - Commonwealth Maximum Choice – a \$2,000/\$3,000 Deductible consumer-directed plan with an embedded Health Reimbursement Account (HRA).
- The Commonwealth's contribution for employees who waive coverage was maintained at \$175 per month, the same amount as in 2009.

## 2010 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 - \$500 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 \$400 maximum benefit per covered individual per plan year	40%*
Emergency services				
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 in-hospital care co-insurance applies*	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.

## 2010 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 - \$300 Family - \$600	Single - \$600 Family - \$1,200	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).	\$75 co-pay plus 15%*	\$75 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	\$15 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.

## In 2011:

- KEHP evaluated the advantages and disadvantages of continuing "grandfathered health plan" status under PPACA and determined grandfathered status would be maintained for 2011.
- As PPACA regulations limit the amounts that group health plans can change benefit provisions and employee contributions to maintain grandfathered status, only slight changes were made in 2011:
  - Most plan copayments were increased by the greater of \$5 or 15%;
  - Most plan deductibles and out-of-pocket maximum amounts were increased 15% (however for the Standard PPO, deductibles and in-network out-of-pocket maximums were held constant; out-of-network out-of-pocket maximums were decreased);
  - Employee contributions were increased according to the limits allowed under PPACA while still maintaining grandfathered status (Optimum PPO, Maximum Choice, and Capitol Choice plans). Employee contributions for the Standard PPO plan were not increased.
- The Commonwealth offered the same four benefit plans which were offered in 2010 with slight changes to benefit designs, as noted above. The plans are:
  - Commonwealth Standard PPO – a \$500/\$1,500 Deductible PPO plan;
  - Commonwealth Capitol Choice – a \$575/\$1,725 Deductible hybrid PPO plan (changed from \$500/\$1,500 in 2010) with an up-front benefit allowance of \$500 per member;
  - Commonwealth Optimum PPO – a \$345/\$690 Deductible PPO plan (changed from \$300/\$600 in 2010);
  - Commonwealth Maximum Choice – a \$2,300/\$3,455 Deductible consumer-directed plan (changed from \$2,000/\$3,000 in 2010) with an embedded Health Reimbursement Account (HRA).
- Coverage was offered to dependent children up to age 26, whom do not have other equivalent coverage available.
- The Commonwealth's contribution for employees who waive coverage was maintained at \$175 per month, the same amount as in 2010.
- Legislation passed in 2010, and effective January 1, 2011, increased the amount of coverage that must be provided for autism spectrum disorders. HB 159 provides coverage for the diagnosis and treatment of autism spectrum disorders for individuals between the ages of 1 and 21, including coverage in the annual amount of \$50,000 for individuals who are 1-6 years of age, and coverage in the monthly amount of \$1,000 for individuals who are between the ages of 7 and 21.

## 2011 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 - \$500 Family - \$1,500	Single - \$1,500 Family - \$3,000	Single - \$575 Family - \$1,725	Single - \$1,150 Family - \$3,455
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 - \$5,000 Family - \$9,500	Single - \$2,300 Family - \$6,900	Single - \$3,800 Family - \$9,400
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%*	\$115 co-pay plus 0%*	40%*
Doctor's Office Visits	25%	50%*	\$20 co-pay - PCP \$25 co-pay - Spec	40%*
Allergy Serums & injections	25%	50%*	\$15 co-pay	40%*
Physician Care (Inpatient/Outpatient/Other)	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%*	\$55 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 \$400 maximum benefit per covered individual per plan year	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*	\$115 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%*	\$20 co-pay in-hospital care co-insurance applies*	40%*
Prescription drugs – Retail (30 day supply)	25%			
	Min	Max		
Generic	\$10	\$25	\$10	
Preferred Brand	\$20	\$50	\$25**	
Non-preferred Brand	\$35	\$100	\$45**	
Prescription drugs – Mail Order (90 day supply)	25%			
	Min	Max		
Generic	\$20	\$50	\$15	
Preferred Brand	\$40	\$100	\$45	
Non-preferred Brand	\$70	\$200	\$90	
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%*	\$20 co-pay	40%*
Autism Services	Ages 1 - 6 Annual Maximum of \$50,000 Ages 7 - 21 Monthly Maximum of \$1,000		Ages 1 - 6 Annual Maximum of \$50,000 Ages 7 - 21 Monthly Maximum of \$1,000	
Benefits payable based on services rendered				
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.

## 2011 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 - \$345 Family - \$690	Single - \$690 Family - \$1380	Single - \$2,300 Family - \$3,455	Single - \$2,300 Family - \$3,455
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - \$1,295 Family - \$2,590	Single - \$2,590 Family - \$5,185	Single - \$3,455 Family - \$5,185	Single - \$4,600 Family - \$6,900
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%*
Doctor's Office Visits	\$15 co-pay - PCP \$20 co-pay - Specialist	30%*	10%*	40%*
Allergy Serums & injections	\$15 co-pay	30%*	10%*	40%*
Physician Care (Inpatient/Outpatient/Other)	\$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).	\$15 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).	\$85 co-pay plus 15%*	\$75 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.	\$15 co-pay in-hospital care co-insurance applies*	30%*	10%*	40%*
Prescription drugs – Retail (30 day supply)				
Generic	\$10**	30%	10%*	40%*
Preferred Brand	\$25**	30%	10%*	40%*
Non-preferred Brand	\$45**	30%	10%*	40%*
Prescription drugs – Mail Order (90 day supply)				
Generic	\$15		10%*	
Preferred Brand	\$45		10%*	
Non-preferred Brand	\$90		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	\$15 co-pay	30%*	10%*	40%*
Autism Services	Ages 1 - 6 Annual Maximum of \$50,000 Ages 7 - 21 Monthly Maximum of \$1,000		Ages 1 - 6 Annual Maximum of \$50,000 Ages 7 - 21 Monthly Maximum of \$1,000	
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 following legislative mandates enacted by the Kentucky General Assemblies affect the Commonwealth's Public Employee Health Insurance Program.

### *Exhibit LVII*

<b>History of 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>

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

Year Enacted	Bill	Key Provisions
2002	HB 846	<p>Restricts individuals to one state subsidy for health insurance.</p> <p>Entities participating in the Public Employee Health Insurance Program must sign a contract with the Personnel Cabinet.</p> <p>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.</p> <p>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.</p> <p>Directs the LRC to study the Public Employee Health Insurance Program.</p> <p>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.</p>
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.

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

Year Enacted	Bill	Key Provisions
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.
2004	HB 1	<p>Legislation that changed the Public Employee Health Insurance Program from fully funded to self funded.</p> <p>Requires that group healthcare coverage contain three health plans named Commonwealth Essential, Commonwealth Enhanced and Commonwealth Premier.</p> <p>Permits married couples who are both eligible to participate in the state health insurance plan to be covered under one family health benefit plan and to apply each employer contribution for the single premium of the plan they select toward family coverage, not to exceed the total premium.</p> <p>Requires the state contribute \$234 per month to the employee's flexible spending account for those who waive health insurance coverage.</p> <p>Allows employees to carry forward to the succeeding plan year, any unused funds remaining in a flexible spending account at the end of the plan year to the extent permissible by the Internal Revenue Code in effect on the date the plan year ends.</p>
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 Public Employee Health Insurance Program to be in compliance with certain specifically enumerated 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.
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.

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

Year Enacted	Bill	Key Provisions
2006	HB380	Establishes a Public Employee Health Insurance Program 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.
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 Public Employee Health Insurance Program in such a manner as to provide the agencies the flexibility to lapse \$7 million in General Fund moneys in each fiscal year.
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.
2010	HB 159	Requires coverage for the diagnosis and treatment of autism spectrum disorders for individuals ages 1 to 21, limited to an annual maximum of \$50,000 for individuals ages 1 through 6, and limited to a \$1,000 monthly maximum for individuals ages 7 through 21.

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

<b>Year Enacted</b>	<b>Bill</b>	<b>Key Provisions</b>
2010	HB 1	Report of the Group Health Insurance Board: Notwithstanding KRS 18A.226(5)(b) and (c), the report of the Kentucky Group Health Insurance Board shall be submitted to the Governor, the Legislative Research Commission, and the Chief Justice of the Supreme Court by December 15th of each calendar year.

**Kentucky Insurance Code Legislative Mandates**

The Department of Insurance provided the summary in Exhibit LVII of 29 mandated health insurance benefits that currently exist in Kentucky’s statutes. These mandates are generally not applicable to the Public Employee Health Insurance Program. The Public Employee Health Insurance Program is subject to the Kentucky Insurance Code (Chapter KRS 304.17 and 17A) to the extent that code sections are specifically enumerated in the either the Insurance Code or Chapter KRS 18A. The health mandates that are applicable to the KEHP can be found in Exhibit LVIII.

***Exhibit LVIII***

<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.
Dependent Eligibility	KRS 304.17A-256. All group health benefit plans which provide dependent benefits shall offer the master policyholder the following two (2) options to purchase coverage for an unmarried dependent child: (a) Coverage until age nineteen (19) and coverage to unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are primarily dependent on the policyholder for maintenance and support; and (b) Coverage until age twenty-five (25).
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.

## Kentucky Mandated Health Insurance Benefits

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.
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*

### **Miscellaneous Other Provisions and Mandates**

#### ***Exhibit LIX***

<b>Key Provisions Enacted by 2000 General Assembly</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.

## **Glossary**

**Accountable Care Organization (ACO):** A provider organization that accepts responsibility for meeting the health needs of a specific population, including the cost and quality of care and effectiveness of services. ACO members share in the savings that result from their cooperation and coordination.

**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.

**Grandfathered Plan:** An insured or self-insured group health plan offered by an employer that was in existence on March 23, 2010, the date on which the PPACA was enacted.

**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.

**Health Savings Account (HAS):** Owned by individuals enrolled in a high deductible health plan (HDHP), as a tax-advantaged means to pay for qualified medical expenses. Funds roll over and accumulate from year to year if they are not spent.

**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.

**Patient Protection and Affordable Care Act (PPACA):** A product of the health reform agenda, signed into law on Tuesday, March 23, 2010 by President Obama. The PPACA was then amended by the Healthcare and Education Reconciliation Act in many ways. The law includes numerous provisions to be phased in over several years, including eligibility of coverage, health insurance exchanges, expanding Medicaid eligibility, and medical loss ratio regulations.

**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.

**Pre-existing Condition:** A medical condition developed prior to an individual obtaining insurance, which may result in the limitation in the contract on coverage or benefits.

**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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