

# **Kentucky Employees' Health Plan**

## **Eleventh Annual Report**

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

**December 15, 2011**

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## EXECUTIVE SUMMARY

This Eleventh 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 2010 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 2011, historical information on plan designs, legislative mandates, and commentary on the KGHIB's focus in a post-federal healthcare reform world.

### Highlights of KEHP Experience in 2010 and the First Half of 2011

KEHP 2011 costs continue to trend upward, but at a lower rate than the previous year.

- In 2010 KEHP's paid claims cost for medical and pharmacy benefits was nearly \$1.440 billion in total. This is 7.9% higher than the plan cost in 2009. Part of this increase was due to a 2.6% growth in average annual membership. The first 6 months of 2011 show a more modest increase of 3.0% over the total plan cost for the first 6 months of 2010.
- On a per member per month (PMPM) basis, which adjusts for the increased enrollment, KEHP paid claims cost increased 5.2% from 2009 to 2010 and 3.5% from the first 6 months to 2010 to 2011. In 2010, this is comprised of a 4.8% increase in medical claims PMPM and a 6.5% increase for pharmacy claims PMPM. In 2011 this is made up of a 3.5% medical claims PMPM increase and a 4.3% decrease in pharmacy claims PMPM. The 2010 increases are slightly higher than the increases seen from 2008 to 2009, and are lower than in prior years, largely due to the introduction of new plan designs in 2009 and increased member cost sharing.
- Overall, however, KEHP's allowed cost trends continued to be 1 to 2% lower than industry averages.

KEHP's cost-sharing percentages continue to move toward the national averages. KEHP pays a greater percentage of the cost for employees and a lesser percentage for members in employee plus dependent(s) tiers than national averages.

- The KEHP's average monthly subsidy (or portion of the total cost paid by the plan) for each employee's health insurance coverage has increased, on average, from \$462 per month in 2006 to \$692 in 2010 and to an estimated \$693 in 2011, a 50% increase over 2006. The employee's portion of the cost has risen from \$73 in 2006 to \$117 in 2010 and an estimated \$144 in 2011, a 97% increase over 2006.
- Compared to national averages, KEHP pays a greater percentage of the cost for employees and a lesser percentage for members in employee plus dependent(s) tiers. These subsidy levels continue to move toward the national averages.

KEHP membership continues to grow as does the portion of members who are children, while the number of employees waiving coverage under KEHP continues to decline.

- Membership in KEHP grew 2.6% from 2009 to 2010 and is estimated to grow by around 1.4% from 2010 to 2011. This growth is larger than the increase in employee headcounts, which mean the plan is covering more dependents. In fact, the percentage of members who are children has increased from 27% in 2008 to 28.1% in 2010 and projected to be 29.1% in 2011, likely due, in part, to Healthcare Reform.
- The number of employees who elect to waive coverage continues to decline from 25,690 in 2009 to 24,032 in 2010 and 23,549 for the first 6 months of 2011, likely due, in part, to the economy.

KEHP spends the largest portion of its total claims cost for hospital outpatient care and this service component's cost continues to increase at a higher rate than other service types.

- KEHP's claims distribution across inpatient hospital, outpatient hospital, physician, other medical, and pharmacy goods and services remained relatively consistent from 2009 to 2011.
- KEHP's outpatient PMPM claims, the largest component of cost, increased at a rate of 7.8%. Inpatient services increased 7.6%, and pharmacy costs grew 6.5%.

Clinical conditions related to heart disease, arthritis, and respiratory conditions, such as asthma, continue to be prevalent in KEHP's population.

- A significant portion of plan cost has been attributable to largely the same clinical conditions since 2004.
- Musculoskeletal conditions such as arthritis, circulatory conditions and digestive conditions top the list.
- Members with these three clinical conditions are responsible for 40% of the plan's 2010 medical claims cost.
- Given that KEHP 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

- Allowed prescription drug charges, defined as total discounted charges less charges for non-covered drugs, increased by 7.5% from 2009 to 2010, less than the 8.8% increase experienced in 2009. However, due to fixed copayment plan design structure, this 7.5% increase in total cost for prescription drugs caused an increase of 9.3% in plan cost in 2010, up from 6.7% in 2009.
- The allowed cost increase for the first 6 months of 2011 has only been 2.1%. Due to the introduction of new plan designs in 2011, KEHP's portion of the costs actually decreased by 3% over this same period.

## Benchmark Results

Thomson Reuters benchmarked several statistics for KEHP's active population. This data shows that the total allowed cost PMPY for KEHP population is 19.4% higher than that of other clients in the public sector. This is not a recent development, as evidenced by the single digit trends for the last several years. It is more the product of the overall health of the membership and the population of the State in general. Additionally, KEHP's membership includes more females than the average, leading to higher costs. Females have higher average claim costs due to maternity.

Disease frequencies for KEHP were found to be much higher than other clients of Thomson Reuters. The results were driven mainly by the Hypertension and Diabetes rates, while KEHP shows a much lower incidence rate of Breast Disease than both the public and private sectors. Cancer prevalence was found to be lower in the KEHP active population than the public sector for breast and prostate cancer, the most common forms in these groups, though for other types of cancers, KEHP's rates were average.

## Healthcare Reform

Health Care Reform was signed into law in March 2010. The first wave of employer-based compliance has passed with many changes having been executed in 2011. In 2012 and 2013, the focus will be on reporting compliance and operational issues such as providing Uniform Summary of Benefits to participants, defining W-2 reporting of the value of health coverage for members, providing notices of options in the exchange and preparing for automatic enrollments. However, there are many rules and guidance still outstanding on these provisions that are required to move forward. The next substantial change will take place in 2014, when individual mandates and

the state exchanges go into effect. In the meantime, the U.S. Supreme Court has stated they will hear the case for constitutionality of the law starting in March 2012 and expect a decision in June 2012.

## Board Recommendations

For this year's report, Board member's were surveyed and ranked the importance of its Guiding Principles. The Board recommends that the KEHP continue to follow the guiding principles stated below, presented in ranked order importance:

1. Provide uniform coverage across the Commonwealth
2. Encourage wellness and healthy lifestyles
3. Provide preventive care at little or no cost
4. Strive to hold down costs for family and dependent coverage
5. Improve chronic disease care
6. Educate members about plans that are more appropriate for their health needs
7. Provide members with quality PPO and Consumer Directed options
8. Provide plan alternatives that are accessible for retirees

Previous years' lists included a Guiding Principle on providing a plan with an unlimited lifetime maximum. However, under Federal Health Reform all plans providing minimum substantive coverage will be required to provide unlimited benefits. Therefore, this Principle has been removed.

Based on the results of the survey of Board members, the Board continues to support many of the recommendations made in last year's Tenth Annual Report. These recommendations are listed below.

1. Continuing to explore alternative methods for controlling plan costs of the plans and improving the health of members.
2. Evaluating programs and options for improving the clinical and administrative quality of programs and services.
3. Improving communication to members
4. Developing a long-term policy for funding strategies to ensure that adequate funds are budgeted each year towards the self-insured plans.
5. Evaluating the impact of federal healthcare reform measures.

## 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 eleventh 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 2010 KEHP experience
- A look at plan experience for the first six months of 2011
- A perspective on sustainability in a post-reform world

The appendix to this report contains the following information:

- A review of the history and development of the KEHP program
- A list of historical Employee Contribution rates
- A summary of legislated health insurance benefit mandates and other mandates passed by recent General Assemblies that affect KEHP
- A glossary of terms
- An index of the exhibits found in this report

Research was jointly conducted by the Department of Employee Insurance (DEI) and Aon Hewitt 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.

### 2010 KEHP Experience

This section of the Annual Report provides a summary of cost and usage trends experienced by KEHP in 2010. The 2009-2011 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. Any data from a prior year was taken directly from the tenth Annual Report, prepared by Price Waterhouse Cooper, as data prior to 2009 was no longer available in the Thomson Reuters database at the time of this writing.

### A Note about 2011 Claims Experience

At the time that this report was written, incurred 2011 claims data was available through June 2011, with three months of run-out (paid through September 2011).

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.

# KENTUCKY EMPLOYEES' HEALTH PLAN EXPERIENCE

## Summary of KEHP Program Costs

### Key Findings

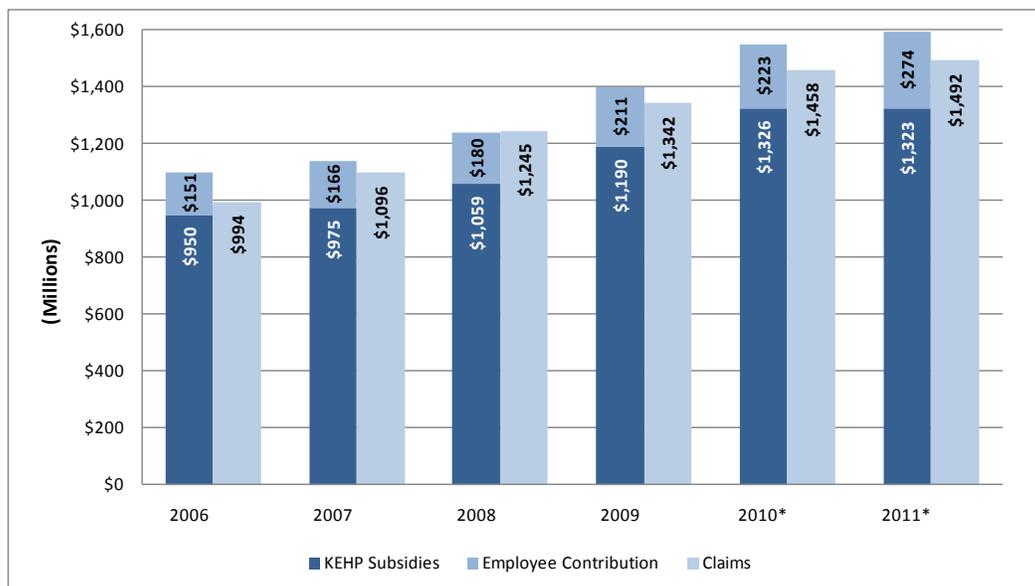
- Over the past several years, KEHP claims and expenses have been fairly close to the budgeted costs.
- KEHP subsidy levels have moved closer to the benchmark norms for both employee and dependent coverage from 2007 to 2011.

### Summary of Total Costs

KEHP's total incurred claims, KEHP's subsidy (the amount paid by the plan, excluding the amount paid by the participant), and employee contributions are shown in Exhibit 1 (The total incurred claims paid by KEHP's self-funded program are identified as "Claims"). Administrative fees are not included in these figures. For 2011, only the first 6 months of incurred data was available at the time of the writing of this report.

Exhibit 1 identifies the total subsidy amounts KEHP paid in 2006 through 2010, as well as the first 6 months of 2011 for all members of KEHP, the total annual employee contributions and the aggregate claims costs incurred. The figures included in this exhibit represent millions of dollars.

**Exhibit 1 - Aggregate KEHP Paid Claim Costs versus KEHP Subsidies and Employee Contribution (\$Millions)**



Source: Tenth Annual Report, KEHP's claims data aggregated by Thomson Reuters, Aon Hewitt Projections of Trust Balances

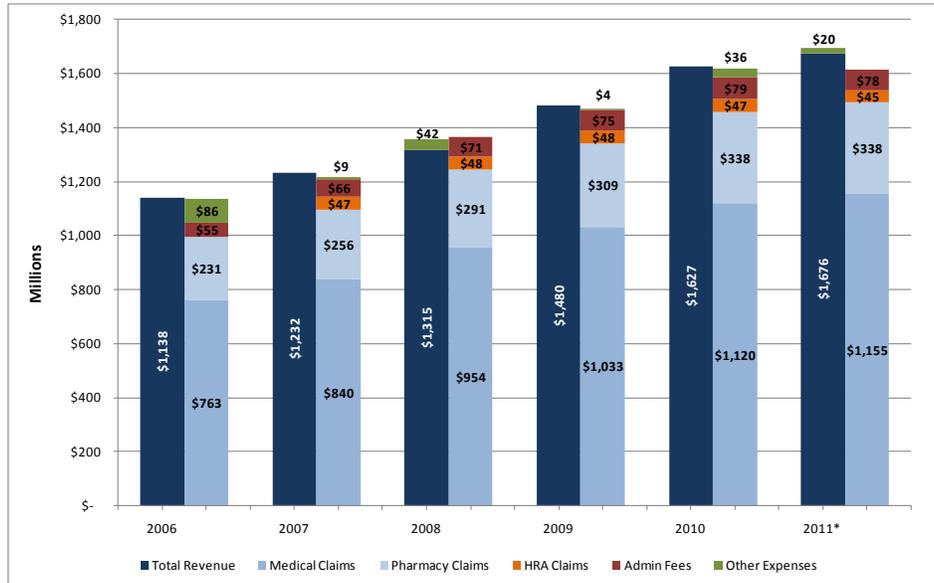
\*2010 and 2011 claims are based on Aon Hewitt's projections for KEHP; 2011 contributions and subsidies estimated by applying the claims seasonality observed in 2010 to the six months of claims experience available in 2011

Since KEHP changed the funding from fully insured to self insured in 2006, the actual KEHP claims and expenses have been fairly close to the budgeted costs, with all but one year (2008) showing costs less than budgeted. A look at the first six months of available data for 2011 shows this trend continuing, though this observation may change as the 2011 plan year progresses.

### Year by Year Trust Fund Balances

Exhibit 2 shows the KEHP Plan Year Balances from 2006 to 2011. Note that 2009 through 2011 uses Aon Hewitt’s projections incorporating the Trust Fund Report as of September 2011.

**Exhibit 2 - Plan Year Balances as of September 30, 2011**



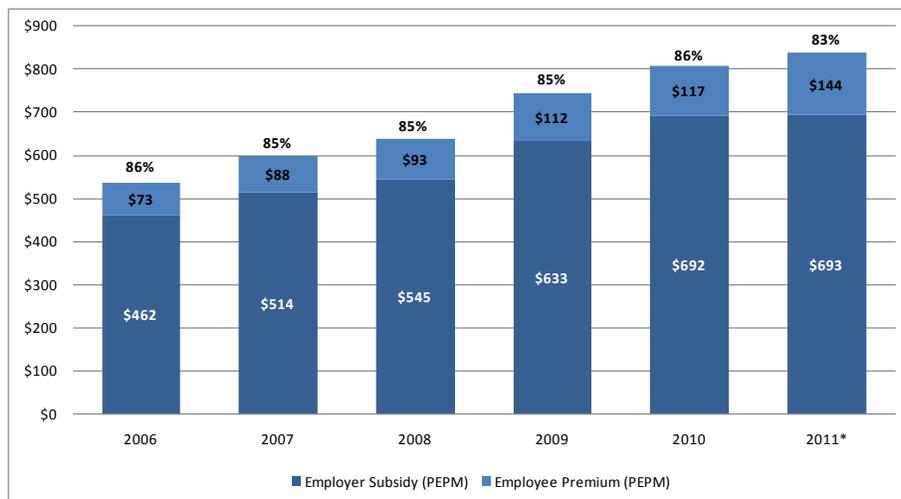
Source: KEHP Trust Cash Transactions from September 2011, Aon Hewitt Projections

With the exception of 2008, KEHP has had modest surpluses each year from 2006 to 2010. Note that in 2008 and 2011, the category ‘Other Expenses’ was negative, as this field includes balance transfers between years.

### Historical Per Employee KEHP Subsidies

KEHP’s per employee per month (PEPM) subsidy, Employee PEPM Premium, and KEHP’s subsidy percentage (% of total contributions from KEHP) from 2006 through 2011 are illustrated in Exhibit 3.

**Exhibit 3 - Historical KEHP (PEPM) Health Benefit Subsidy Paid For Those Electing Coverage**



Source: Tenth Annual Report and KEHP’s claims and enrollment data aggregated by Thomson Reuters  
 \*2011 figures reflect estimates based on six months of 2011 claims experience

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 \$692 in 2010, and is projected to increase slightly to \$693 per month for 2011. Above each year's bar is the % of KEHP's subsidy. In 2011, the members are beginning to pay a slightly larger percentage of the total premiums, with the KEHP subsidy projected to drop to 83% from 85% from 2010 to 2011.

### KEHP Subsidy Benchmarks

Exhibit 4 compares the KEHP subsidies to national averages for government employers.

#### **Exhibit 4 - KEHP Subsidies Compared to Government Sector Benchmarks**

	2007		2008		2009		2010		2011	
	Kaiser	KEHP								
<b>Employee Only</b>	87.0%	97.2%	88.0%	97.3%	90.0%	96.3%	91.0%	96.1%	89.0%	91.7%
<b>Employee + Dependents</b>	78.0%	71.5%	79.0%	71.6%	79.0%	75.4%	75.0%	76.2%	77.0%	75.2%
<b>Overall</b>	<b>82.7%</b>	<b>85.0%</b>	<b>83.7%</b>	<b>84.9%</b>	<b>84.2%</b>	<b>85.3%</b>	<b>82.8%</b>	<b>85.9%</b>	<b>82.8%</b>	<b>83.2%</b>

Source: Tenth Annual Report, Benchmarks from 2010 Kaiser Family Foundation Employer Health Benefits survey

In 2011, KEHP is projected to cover 83.2% of total costs (91.7% for single coverage and 75.2% blended for the employee + dependent coverage tiers). 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, with the exception of 2010, when the national average dipped lower than before. However, the KEHP subsidy has moved closer to the benchmark norms for both employee and dependent coverage from 2007 to 2011. KEHP's subsidy was 5.1 percentage points higher than the national average for single coverage in 2010, but only 2.7 percentage points in 2011. The subsidy difference for employee plus dependent coverage was 3.6% lower than the national average in 2009, but projected to be only 1.8% lower in 2011.

## Enrollment / Demographics Analysis

### Key Findings

- KEHP membership has exhibited moderate growth over the last several years.
- Headcounts, the average age of employees and the number of children covered by the plan have all gradually increased.
- The number of covered employees dropped slightly in 2011, but membership continues to grow for younger ages.
- The Optimum PPO plan continues to be the most popular plan, due to employee perception of it being the richest plan, offering lower deductible and cost-sharing features.
- The number of employees who have waived coverage under KEHP continues to decline slightly.

### Key Statistics

Exhibit 5 shows some key demographic statistics for the KEHP population.

**Exhibit 5 - Population Demographics—Key Statistics**

	KEHP Membership (Actives, Non-Medicare Eligible Retirees and COBRAs Participants)						
	2008	2009	2010	2010 vs. 2009	Jan - Jun, 2010	Jan - Jun, 2011	2011 vs. 2010
<b>Total Enrollment:</b>							
Employees	153,005	156,753	159,547	1.8%	159,837	159,754	-0.1%
Members	251,024	259,196	265,876	2.6%	266,740	270,580	1.4%
<b>Average Age:</b>							
Employees	47.7	47.9	48.0	0.3%	48.0	48.2	0.5%
Members	38.0	37.9	37.9	0.0%	37.8	37.8	0.0%
<b>Demographic Splits:</b>							
Employee Percentage Male	34.9%	34.7%	34.5%	-0.2%	34.4%	34.4%	0.0%
Member to Employee Ratio	1.64	1.65	1.67	1.3%	1.67	1.69	1.5%
<b>% of Covered Members Who Are:</b>							
Adult Male	26.8%	26.6%	26.4%	-0.2%	26.4%	26.0%	-0.3%
Adult Female	46.2%	45.8%	45.5%	-0.2%	45.5%	44.9%	-0.6%
Children	27.0%	27.7%	28.1%	0.4%	28.2%	29.1%	0.9%

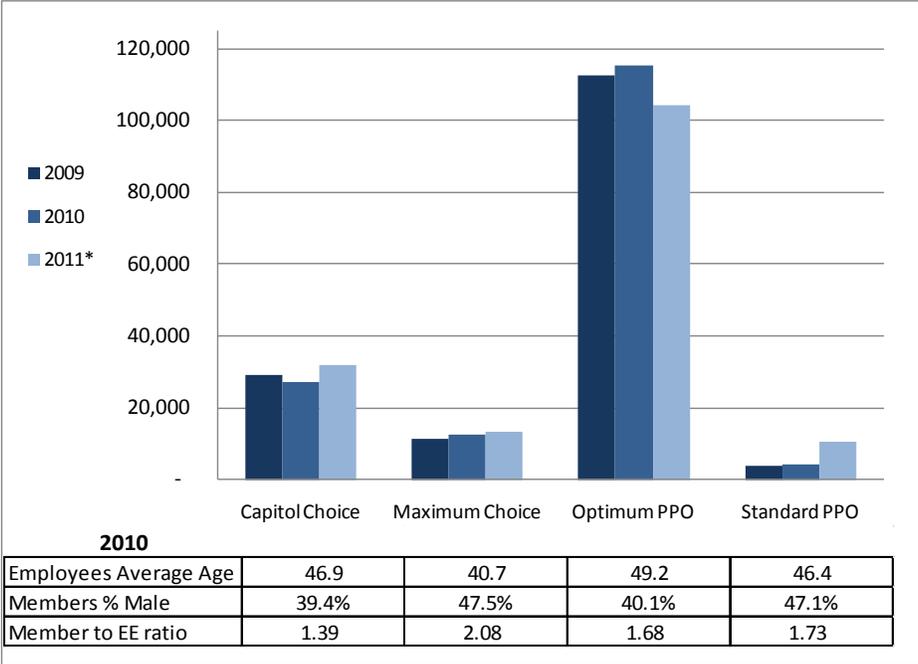
Source: Tenth Annual Report and KEHP's enrollment data aggregated by Thomson Reuters

Total enrollment for KEHP's plans increased by 2.6% from 2009 to 2010, and the first 6 months of 2011 show an increase of 1.4% over the prior year. The average member to employee ratio increased slightly from 1.65 in 2009 to 1.67 in 2010. The first 6 months of 2011 has seen another slight increase, to 1.69 years. The percentage of children covered by the Plan has grown from 2008 to 2011.

Enrollment by Plan

Exhibit 6 shows KEHP enrollment by plan option from 2009 through the first six months of 2011.

**Exhibit 6 - Employee Enrollment by Plan**

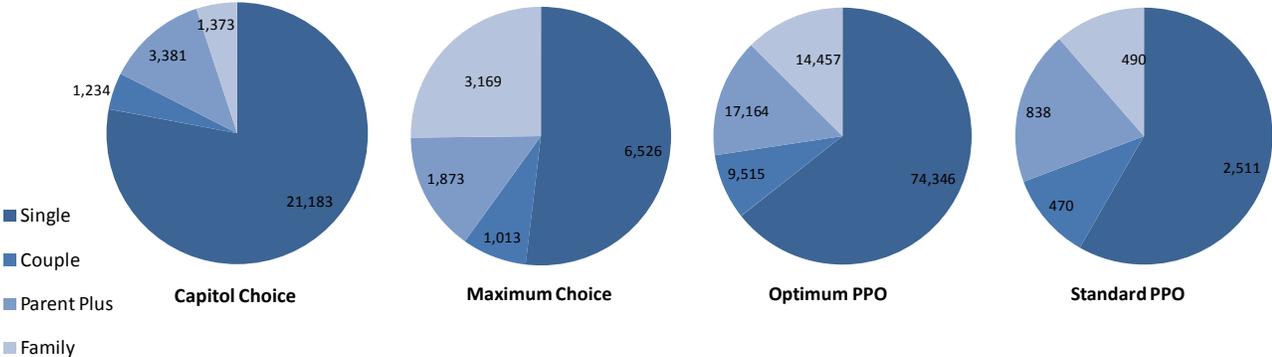


Source: KEHP's enrollment aggregated by Thomson Reuters  
 \* 2011 figures include January through June 2011 data only

The employee-directed Maximum Choice Plan remained fairly level from 2009 to 2011, though the Capitol Choice Plan and Standard PPO Plan experienced significant increases in 2011. These shifts appear to be coming from the Optimum PPO Plan: in 2009 and 2010, 70% of employees elected the Optimum Plan, though in 2011 this has decreased to 65%. This plan is seen by employees as the richest plan, as it offers the lowest deductible and cost-sharing provisions, even though it requires the highest monthly employee premiums. In reality, the Capitol Choice Plan provides the highest level of benefits. Premium adjustments can result in enrollment shifts between plan options.

Exhibit 7 shows the plan compositions by tier.

**Exhibit 7 – Employee Enrollment by Coverage Tier and Plan, 2010**



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

Singles comprise a larger portion of the Capital Choice Plan than on average, and the same is true of families in the Maximum Choice Plan.

### Group Composition

Exhibit 8 shows some key statistics for KEHP's groups, for 2009 to 2011.

**Exhibit 8 - Key Statistics by Group**

Group	Number of Employees					2010 Key Statistics			2011 Key Statistics		
	2009	2010	2011 (6 Months)	2011 % of Total	2011 vs. 2010	Employee Ave. Age	Member to EE ratio	Members % Male	Employee Ave. Age	Member to EE ratio	Members % Male
<b>Actives</b>	<b>110,989</b>	<b>114,088</b>	<b>114,762</b>	<b>71.8%</b>	<b>0.6%</b>	<b>44.1</b>	<b>1.78</b>	<b>40.9%</b>	<b>44.3</b>	<b>1.81</b>	<b>41.1%</b>
School Boards	71,414	73,291	74,251	46.5%	1.3%	44.5	1.80	37.6%	44.6	1.83	38.1%
State Employees	30,361	31,206	30,916	19.4%	-0.9%	43.1	1.74	48.5%	43.3	1.77	48.0%
Quasi/Local Govt	3,503	3,634	3,562	2.2%	-2.0%	43.5	1.76	47.0%	43.7	1.77	46.6%
KCTCS	3,077	3,217	3,366	2.1%	4.6%	47.3	1.79	44.8%	47.4	1.83	44.6%
Health Departments	2,634	2,739	2,666	1.7%	-2.7%	44.0	1.74	29.0%	44.6	1.81	31.2%
<b>Retirees</b>	<b>45,466</b>	<b>45,063</b>	<b>44,725</b>	<b>28.0%</b>	<b>-0.7%</b>	<b>57.9</b>	<b>1.37</b>	<b>41.1%</b>	<b>58.2</b>	<b>1.39</b>	<b>40.9%</b>
KERS	29,508	29,170	29,112	18.2%	-0.2%	57.1	1.43	45.1%	57.4	1.45	45.1%
KTRS	15,959	15,893	15,614	9.8%	-1.8%	59.5	1.27	33.9%	59.8	1.27	33.4%
<b>COBRA</b>	<b>268</b>	<b>358</b>	<b>214</b>	<b>0.1%</b>	<b>-40.2%</b>	<b>45.8</b>	<b>1.75</b>	<b>36.9%</b>	<b>48.0</b>	<b>1.66</b>	<b>35.5%</b>
<b>Unknown</b>	<b>29</b>	<b>38</b>	<b>47</b>	<b>0.0%</b>	<b>21.3%</b>	<b>59.6</b>	<b>1.28</b>	<b>35.0%</b>	<b>60.1</b>	<b>1.31</b>	<b>38.2%</b>
<b>Total</b>	<b>156,753</b>	<b>159,547</b>	<b>159,754</b>	<b>100.0%</b>	<b>0.1%</b>	<b>48.0</b>	<b>1.67</b>	<b>40.9%</b>	<b>48.2</b>	<b>1.69</b>	<b>41.1%</b>

Source: KEHP's enrollment data aggregated by Thomson Reuters

The participating groups' composition changed very little over the last several years, with small increases in the overall member to employee ratio for nearly every group, except for COBRAs.

### 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, where it has remained through 2011.

Exhibit 9 shows the annual waiver participation for 2009 through June 2011.

**Exhibit 9 - 2009 through June 2011 Monthly Coverage Waiver Participation**

	2009	2010	2011*
<b>Average # Employees</b>	<b>25,690</b>	<b>24,032</b>	<b>23,549</b>
% Change	N/A	-6.5%	-2.0%
HRA Waiver Contributions	\$55,664,486	\$52,205,724	\$49,452,375
HRA Waiver Claims	\$48,452,881	\$46,927,843	\$44,507,138
HRA Waiver Claims PEPM	\$157.17	\$162.73	\$157.50
% Change in PEPM	N/A	3.5%	-3.2%

Source: KEHP Trust Fund Summaries, 2011 contributions and claims are projected

With the \$175 waiver per month remaining constant since 2007, the value of the waiver incentive has continued to decline as inflation erodes the incentive purchasing price. The incentive reduction and the rise in healthcare costs were the primary factors resulting in few people waiving coverage. Additionally, KEHP spouses who were provided healthcare coverage through their employers may have seen their situations change and need coverage under the program. These factors may have all contributed to the steady decline in waiver participation, resulting in lower waiver contributions and claim costs.

## Medical & Pharmacy Trends

### Key Findings

- KEHP's annual trends are 1 - 2% less than the market.
- Recently, KEHP has shown modest increases in medical and pharmacy costs on a per member per month basis. Aon Hewitt predicts these trends to increase over the next several years.
- Overall, on a PMPM basis, most costs are increasing at a moderate rate.

### Medical and Pharmacy Claims Cost Increases

Exhibit 10 shows some key statistics for medical and pharmacy claims, split between allowed cost and plan cost. Note that allowed claim cost is not available for 2007 or 2008 as it was not included in the Tenth Annual Report and is no longer available in the data warehouse.

**Exhibit 10 - 2007 – 2011 Claims Experience**

	2007	2008	2009	2010	2010 vs. 2009	Jan - Jun, 2010	Jan - Jun, 2011	2011 vs. 2010
Allowed Cost - Medical	N/A	N/A	\$1,145,734,178	\$1,230,556,889	7.4%	\$588,674,150	\$628,670,435	6.8%
Allowed Cost - Rx	N/A	N/A	\$376,804,254	\$405,116,263	7.5%	\$199,783,338	\$203,893,820	2.1%
<b>Total Allowed Cost</b>	<b>N/A</b>	<b>N/A</b>	<b>\$1,522,538,432</b>	<b>\$1,635,673,152</b>	<b>7.4%</b>	<b>\$788,457,488</b>	<b>\$832,564,255</b>	<b>5.6%</b>
Plan Paid - Medical	\$850,061,028	\$946,785,361	\$1,018,422,840	\$1,094,926,860	7.5%	\$517,125,663	\$542,722,383	4.9%
Plan Paid - Rx	\$263,411,276	\$298,709,346	\$315,768,145	\$344,994,118	9.3%	\$168,047,259	\$163,181,316	-2.9%
<b>Total Plan Paid</b>	<b>\$1,113,472,304</b>	<b>\$1,245,494,707</b>	<b>\$1,334,190,985</b>	<b>\$1,439,920,978</b>	<b>7.9%</b>	<b>\$685,172,922</b>	<b>\$705,903,699</b>	<b>3.0%</b>
<b>Covered Members</b>	<b>244,581</b>	<b>251,024</b>	<b>259,196</b>	<b>265,876</b>	<b>2.6%</b>	<b>266,740</b>	<b>270,580</b>	<b>1.4%</b>
Allowed Cost PMPM - Medical	N/A	N/A	\$368	\$386	4.7%	\$368	\$387	5.3%
Allowed Cost PMPM - Rx	N/A	N/A	\$121	\$127	4.8%	\$125	\$126	0.6%
<b>Total Allowed Cost PMPM</b>	<b>N/A</b>	<b>N/A</b>	<b>\$490</b>	<b>\$513</b>	<b>4.7%</b>	<b>\$493</b>	<b>\$513</b>	<b>4.1%</b>
Plan Paid PMPM - Medical	\$290	\$314	\$327	\$343	4.8%	\$323	\$334	3.5%
Plan Paid PMPM - Rx	\$90	\$99	\$102	\$108	6.5%	\$105	\$101	-4.3%
<b>Total Plan Paid PMPM</b>	<b>\$379</b>	<b>\$413</b>	<b>\$429</b>	<b>\$451</b>	<b>5.2%</b>	<b>\$428</b>	<b>\$435</b>	<b>1.6%</b>

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

Overall, the total allowed costs incurred by members of KEHP increased 7.4% from 2009 to 2010 and 5.6% from 2010 to 2011. KEHP's annual paid claims costs increased by 7.9% in 2010 and 3% in 2011. Since membership increased by 2.6% in 2010 and 1.4% in 2011, on a per member per month basis (PMPM), the total claims costs increased by only 4.7% in 2010 and 4.1% in 2011. The KEHP's portion of the total Medical and Rx claims increased by 5.2% in 2010 and 1.6% in 2011.

Allowed cost includes the total cost of the service, both plan and employee cost share. The trend for allowed cost represents the true increase of the cost of the services. However, as the employee portion of the cost was not made to increase at the same rate as the allowed cost for 2009 to 2010, KEHP's portion of the cost was made to carry this extra cost burden, resulting in higher trend for the plan costs. However, for 2011, due to plan design changes, more of the allowed cost increase was shifted to employees, resulting in lower plan paid cost trend than for the allowed cost, resulting in the -4.3% projected decrease for pharmacy claims in 2011.

Additionally, Rx claims comprise roughly 24% of the total cost of KEHP and these claims have a tendency to increase at a slightly higher rate than medical claims.

Exhibit 11 contains KEHP’s medical and pharmacy claim trends for 2006 to 2010 as well as the projected claim trends for 2011.

**Exhibit 11 – Historical Claims Trends for KEHP**

Historical trend	2008	2009	2010	2011
Plan Paid PMPM - Medical	8.5%	4.2%	4.8%	3.5%
Plan Paid PMPM - Rx	10.5%	2.4%	6.5%	-4.3%
<b>Total Plan Paid PMPM</b>	<b>9.0%</b>	<b>3.7%</b>	<b>5.2%</b>	<b>1.6%</b>

Source: Tenth Annual Report, KEHP’s claims and enrollment data aggregated by Thomson Reuters

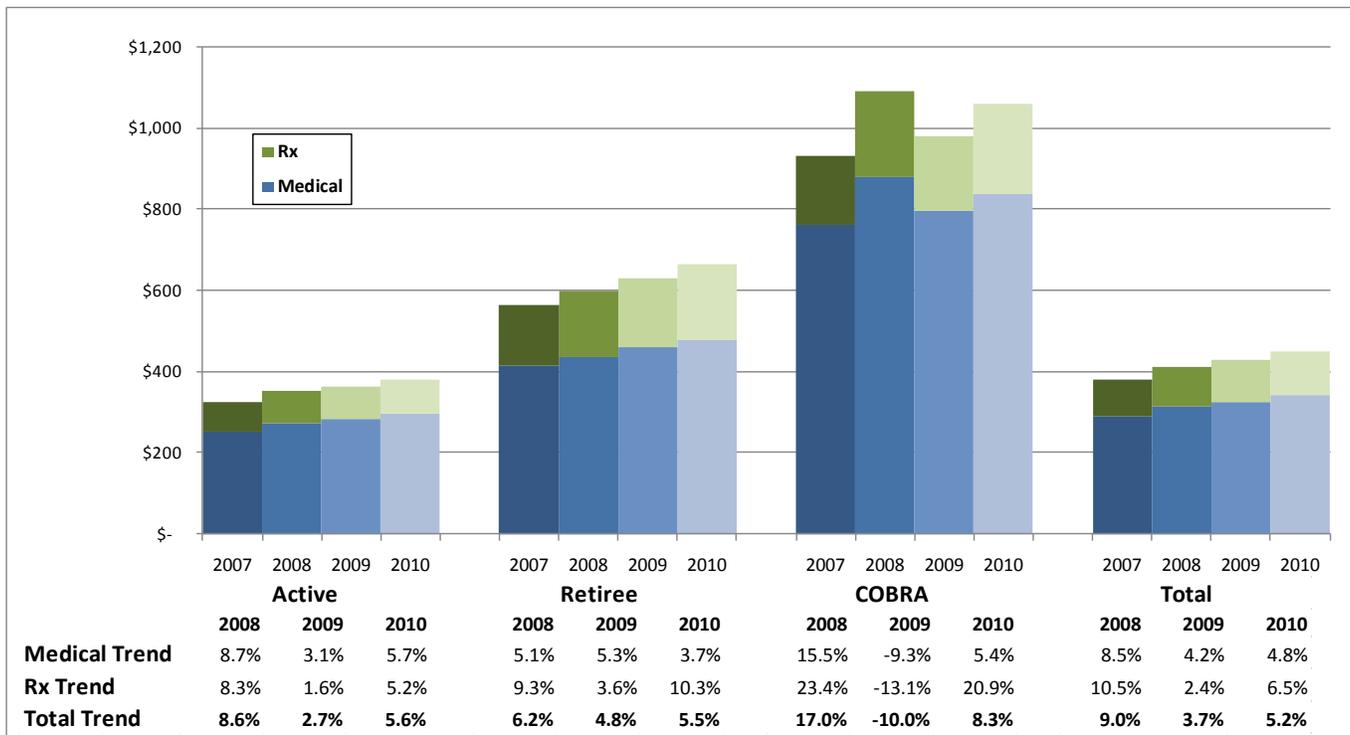
Aon Hewitt used trend survey data to develop a trend expectation for 2012 of 8.5% for KEHP.

An important contributing factor to the decrease in both the medical and pharmacy trend in 2009 is the change in plan designs - four new plans were introduced in 2009, and members were actively required to select plan options during active 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, but requires the highest employee monthly premium.

**Claims Payments by Employee Status**

As noted in Exhibit 10, combined medical and pharmacy paid claims increased by 5.2% on a PMPM basis from 2009 to 2010. Exhibit 12 provides KEHP’s PMPM costs and trends for both Medical and Pharmacy claims by member status (active employees, non-Medicare eligible retirees, and COBRA participants).

**Exhibit 12 - Medical and Pharmacy Paid Claims Per Member Per Month (PMPM) by Member Status**

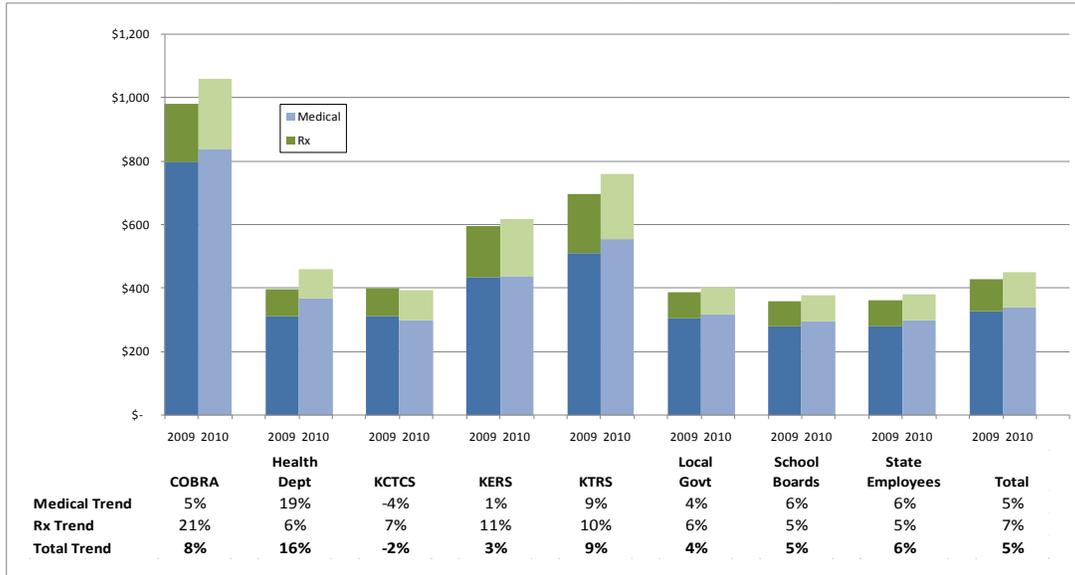


Source: KEHP’s claims and enrollment data aggregated by Thomson Reuters

The Active group trend increases moderately in 2010 after a dip in 2009, whereas the Retirees remained fairly stable over the past few years, despite a relatively high increase in the Pharmacy claim costs in 2008 and 2010. The COBRA participants are in general more costly than the members in the older groups, as only those who know they need medical coverage are likely continue coverage. This group shows more volatility over the last several years, though no conclusions should be drawn regarding future trend using the figures here, as this is a relatively small group, representing 0.22% of the total covered member population in 2010.

Exhibit 13 further breaks out the medical and pharmacy costs for KEHP’s groups, again on a PMPM basis.

**Exhibit 13 – Medical and Rx Claims PMPM by Employee Group, 2009-2010**

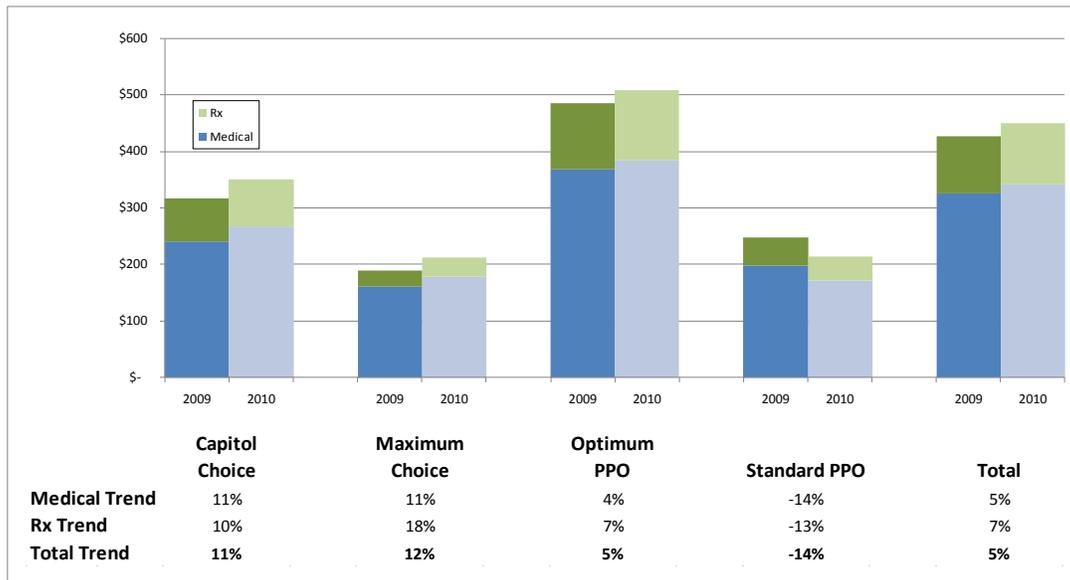


Source: KEHP’s claims and enrollment data aggregated by Thomson Reuters

As noted above, the COBRA members are by far the most expensive, followed by KTRS and KERS, the two groups of retirees. In general, the health department and KTRS groups experienced higher medical trend than average, while the KERS and KTRS experienced higher pharmacy trend than average. Due to the small size of the health department group (less than 3,000 employees), a few large claims (greater than \$400,000) cause the 19% medical trend from 2009 to 2010. The age of the groups also significantly impact how the PMPM cost results vary.

Exhibit 14 shows the medical and pharmacy costs for KEHP’s four plans, also on a PMPM basis.

**Exhibit 14 – Medical and Rx Claims PMPM by Plan, 2009-2010**

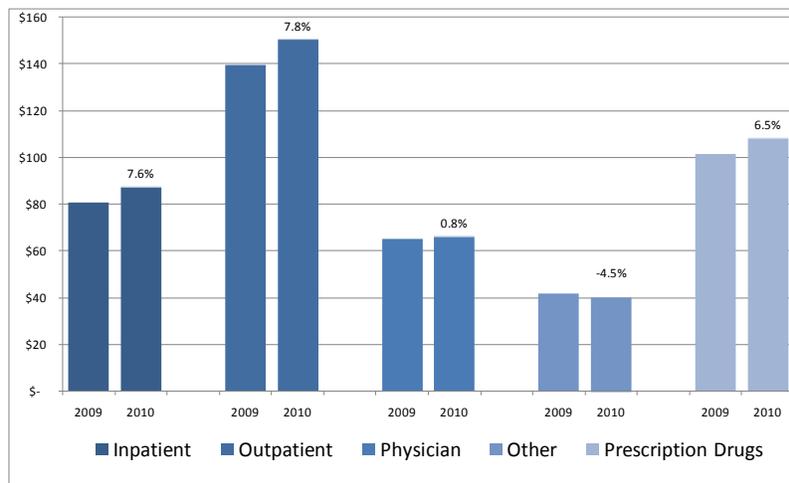


Source: KEHP’s claims and enrollment data aggregated by Thomson Reuters

The Optimum PPO is the most popular plan and is also the most costly plan to KEHP. Additionally, the Optimum plan costs increased at a lower rate than most of the other plans. The Capitol Choice and Maximum plans experienced double digit trend from 2009 to 2010, while the Standard PPO plan experienced negative trend during the same period. Trends are influenced by employee migration between plans, with higher cost members migrating from the Optimum PPO to the Capitol and Maximum Choice plans, and lower cost members migrating to the Standard PPO. Selection plays a large role in these results.

Exhibit 15 shows the increase in cost, on a per member per month basis, for different service types.

**Exhibit 15 – Medical and Rx Allowed Costs PMPM by Service Type, 2009-2010**



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

Facility based costs have increased at a much higher rate than Physician claims.

# Review of KEHP Cost & Utilization

## Summary of Medical and Rx

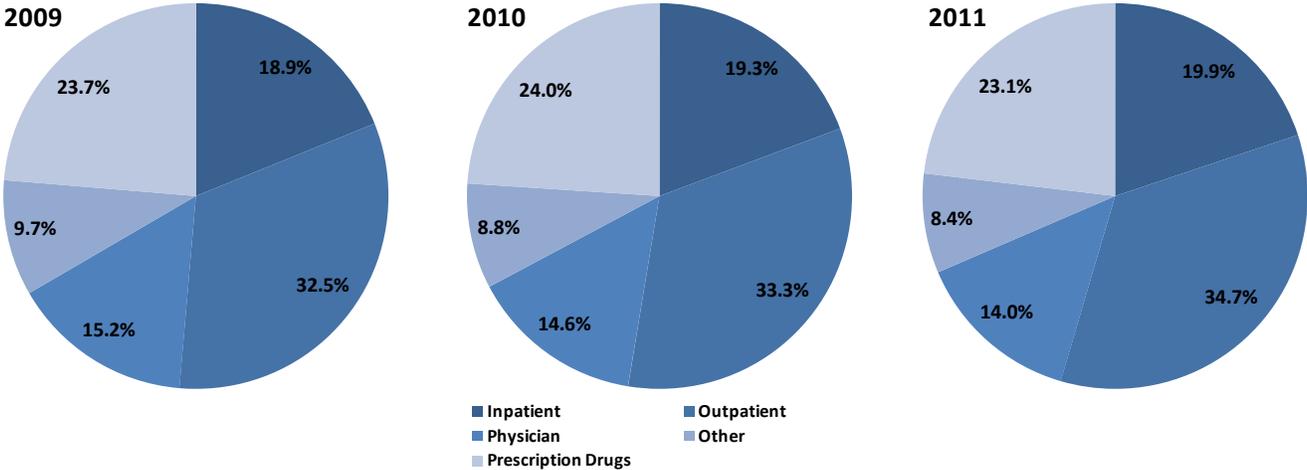
### Key Findings

- KEHP’s distribution of claims by service remains fairly consistent, with outpatient claims comprising the largest portion.
- The KEHP paid claim structure has remained stable in recent years. Approximately 23% of claimants accounted for about 80% of claims costs.
- Inpatient utilization decreased from 2009 to 2010, but the average cost of inpatient service increased at a higher rate, resulting in an upward overall cost trend that was still below industry norms. Both utilization and average cost for outpatient claims increased, making it the highest trend driver. Both utilization and average cost for professional claims decreased resulting in a decrease in professional per capita costs.
- The top ten Major Diagnostic Categories account for almost 80% of claim costs.
- Children cost less than adults, but their costs are increasing at a higher rate, around 11%.

### Distribution of Paid Claims by Service Type

Exhibit 16 shows the KEHP paid claims distribution by Service Type for 2009 to 2011.

**Exhibit 16 - Paid Claims Distribution by Service Type and Year**



Source: KEHP’s claims data aggregated by Thomson Reuters

KEHP’s distribution of claims by Service Type (Inpatient, Outpatient, Physician, Prescription Drugs, and Other Claims) remains fairly consistent, with Outpatient claims comprising the largest portion (approx. 33%), and contributing the highest trend.

## KEHP Medical Benefits Detailed Experience

### Paid Claims by User-Type

The proportion of KEHP’s patients and their costs, separated by User Type, is shown in Exhibit 17.

**Exhibit 17 - Paid Claims by User Type**

	Low Users \$0 - \$1,000	Medium Users \$1,000 - \$5,000	High Users \$5,000 - \$100,000	Very High Users \$100,000+
<b>2009</b>				
<b>Patient %</b>	39.8%	37.2%	22.6%	0.4%
<b>Claim Amount %</b>	3.0%	18.0%	65.4%	13.6%
<b>2010</b>				
<b>Patient %</b>	40.0%	36.5%	23.1%	0.4%
<b>Claim Amount %</b>	2.9%	17.2%	65.1%	14.7%

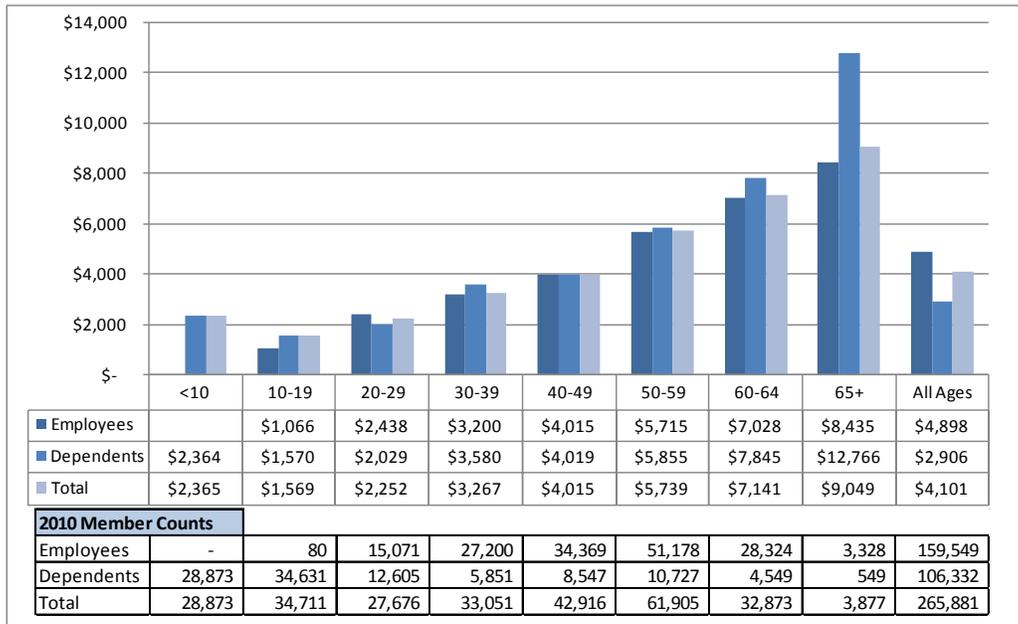
Source: Tenth Annual Report and KEHP’s claims and enrollment data aggregated by Thomson Reuters

The KEHP paid claims distribution in 2010 is very similar to the prior year. Roughly 40% of members had net paid claims of less than \$1,000, whereas 23.5% of claimants in 2010 accounted for 79.8% of claims costs.

### Paid Claims Cost Detail by Age Band

Exhibit 18 shows KEHP’s 2010 Medical Claims per member per year (PMPY) by age band.

**Exhibit 18 – 2010 Employee and Dependent Medical Claims PMPY by Age Band**



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

As expected, paid claims per member increases with age. Dependents under age 30 represent 71.6% of total dependents enrolled in the plan but only 48% of dependent costs. In comparison, dependents over 50 are only 14.9% of the dependent population, but their costs represent 34% of the total dependent paid claims. Aging typically results in 1-2% higher cost per year of age. In the exhibit above, members over 65 are active employees

(or dependents of active employees). The combination of the smaller size and higher demographic risk of this cohort leads to a greater likelihood of fluctuations in per capita costs.

### Paid Claims Cost Details by Service Type

Exhibit 19 shows applicable utilization statistics for the Major Medical service types.

#### **Exhibit 19 - Utilization by Service Type on an Allowed Charges Basis**

<b>Inpatient Hospital Claim Utilization Statistics</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2010 vs. 2009</b>	<b>Jan - Jun, 2010</b>	<b>Jan - Jun, 2011</b>	<b>2011 vs. 2010</b>
Admits Per 1,000 Lives	79.0	88.5	85.9	-2.9%	88.0	81.9	-6.9%
Days Per 1,000 Lives	304.3	351.0	336.6	-4.1%	343.0	325.1	-5.2%
Average Length of Stay (Days)	3.9	4.0	3.9	-1.3%	3.9	4.0	1.8%
Average Cost per Admit	\$12,422	\$13,707	\$14,808	8.0%	\$14,288	\$15,380	7.6%
Average Cost per Day	\$3,225	\$3,454	\$3,780	9.4%	\$3,690	\$3,877	5.1%
Allowed Charges PMPM	\$82	\$101	\$106	4.9%	\$103	\$105	2.0%

<b>Outpatient Hospital Claim Utilization Statistics</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2010 vs. 2009</b>	<b>Jan - Jun, 2010</b>	<b>Jan - Jun, 2011</b>	<b>2011 vs. 2010</b>
Visit Per 1,000 Lives	1,741.3	1,878.0	1,859.0	-1.0%	1,805.6	1,812.0	0.4%
Services Per 1,000 Lives	9,903.5	10,070.8	10,309.8	2.4%	10,927.4	11,043.5	1.1%
Services Per Visit	5.7	5.4	5.5	3.4%	6.1	6.1	0.7%
Average Cost per Visit	\$805	\$838	\$920	9.8%	\$1,013	\$1,091	7.7%
Average Cost per Service	\$142	\$156	\$166	6.2%	\$167	\$179	6.9%
Allowed Charges PMPM	\$117	\$133	\$144	8.7%	\$137	\$149	8.9%

<b>Professional Service Claim Utilization Statistics</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2010 vs. 2009</b>	<b>Jan - Jun, 2010</b>	<b>Jan - Jun, 2011</b>	<b>2011 vs. 2010</b>
Visit Per 1,000 Lives	8,530.9	8,982.5	8,633.7	-3.9%	8,599.6	8,322.7	-3.2%
Services Per 1,000 Lives	18,140.0	18,460.9	17,674.2	-4.3%	17,533.4	16,960.3	-3.3%
Services Per Visit	2.1	2.1	2.0	-0.4%	2.0	2.0	-0.1%
Average Cost per Visit	\$120	\$111	\$109	-1.7%	\$121	\$125	3.1%
Average Cost per Service	\$57	\$54	\$53	-1.3%	\$60	\$61	3.2%
Allowed Charges PMPM	\$86	\$84	\$80	-5.5%	\$79	\$79	-0.2%

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

2010 Inpatient utilization decreased from 2009, but the average cost of service increased at a higher rate from 2009, which results in an allowed cost trend of 4.9%. Outpatient claims experienced a higher trend (8.7%) than inpatient claims due to high average cost trend. For professional claims, both claims utilization and average cost decreased from 2009, resulting in a negative cost trend of 5.5%.

Overall trend is driven by average cost per service increases and changes in utilization. However, utilization is lower than anticipated, resulting in plan experience being better than anticipated.

## Paid Claims Cost by Top Ten Major Diagnostic Categories

The top ten Major Diagnostic Categories (MDCs), with expenditures and number of patients covered, are shown in Exhibit 20. Note that Thomson Reuters' categorization of "Health Status", included in this list is a "catch-all" category (e.g., Preventive/Administrative Health Encounters, Signs/Symptoms/Others).

**Exhibit 20 - Utilization by Major Diagnostic Categories**

Major Diagnostic Category	Total Plan Cost				Patients			
	2009	2010	Jan - Jun, 2010	Jan - Jun, 2011	2009	2010	Jan - Jun, 2010	Jan - Jun, 2011
Musculoskeletal	\$171,871,543	\$189,998,492	\$89,437,080	\$90,264,795	103,265	106,352	72,887	72,682
Circulatory	\$134,149,055	\$143,900,861	\$73,570,084	\$71,585,958	77,049	77,291	53,196	51,788
Digestive	\$96,650,044	\$104,046,149	\$49,067,495	\$53,681,579	58,776	59,544	35,608	34,680
Health Status	\$78,090,135	\$85,355,184	\$38,064,061	\$42,335,399	172,850	175,468	100,397	103,005
Kidney	\$46,063,264	\$57,764,216	\$25,046,186	\$29,023,497	33,935	34,653	20,091	20,554
Skin, Breast	\$58,747,150	\$56,654,224	\$27,079,012	\$27,375,137	92,074	93,794	56,654	55,749
Ear, Nose, Mouth & Throat	\$55,360,126	\$56,041,782	\$26,570,755	\$27,050,230	138,691	134,012	91,949	99,283
Nervous	\$50,426,946	\$52,709,012	\$24,446,997	\$25,843,869	35,804	35,552	22,110	21,879
Myeloproliferative Diseases	\$40,599,655	\$50,174,110	\$22,907,344	\$27,746,473	6,638	6,876	4,296	4,655
Respiratory	\$50,441,281	\$48,012,708	\$23,562,049	\$29,422,558	63,061	56,790	34,721	36,417
<b>Top Three as % of Total Spend</b>	<b>39.5%</b>	<b>40.0%</b>	<b>41.0%</b>	<b>39.7%</b>				
<b>Top Ten as % of Total Spend</b>	<b>76.8%</b>	<b>77.1%</b>	<b>77.3%</b>	<b>78.2%</b>				

Source: KEHP's claims data aggregated by Thomson Reuters

Nearly 80% of claim costs are for treatment of members whose diagnoses are contained in the top ten Major Diagnostic Categories (MDCs). The high relative cost of Musculoskeletal, Circulatory, and Digestive MDCs, in particular, 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.

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 the top ten MDCs, please note that many patients have multiple conditions falling within more than one MDC or clinical condition.

Exhibit 21 shows the total plan costs for several common chronic conditions.

**Exhibit 21 - Utilization by Chronic Conditions**

	2009 Plan Cost	2010 Plan Cost	2011 Plan Cost
Cancer	\$70,616,362	\$70,551,991	\$40,344,869
Chronic Back/Neck Pain	\$48,197,656	\$50,151,386	\$22,321,938
Osteoarthritis	\$42,507,732	\$47,915,729	\$23,516,259
Coronary Artery Disease	\$43,514,496	\$44,950,455	\$20,331,853
Diabetes	\$12,065,381	\$13,477,734	\$6,356,163
Hypertension	\$11,516,744	\$11,919,638	\$5,383,206
Weight Management	\$10,817,882	\$9,409,963	\$3,437,628
Heart Failure	\$4,588,734	\$4,653,095	\$2,885,003
COPD	\$3,786,088	\$3,483,900	\$2,162,180
Asthma	\$4,014,793	\$3,369,469	\$1,928,663

Source: KEHP's claims data aggregated by Thomson Reuters

Several Chronic Conditions, such as Chronic Back/Neck Pain, Coronary Heart Disease, and Osteoarthritis, each cost KEHP around \$40 to \$50 million in 2010. For comparison, all types of cancer combined cost \$70 million.

The costs associated with these ten chronic conditions represent approximately 24% of KEHP's medical costs. Members with these conditions should be targeted for disease management programs.

Exhibit 22 shows KEHP's medical costs separated by family status.

**Exhibit 22 - Paid Claims by Member Type**

Relationship	Total Plan Cost					
	2009	2010	2010 vs. 2009	Jan - Jun, 2010	Jan - Jun, 2011	2011 vs. 2010
Employee/Retiree	\$731,074,099	\$781,423,524	6.9%	\$371,505,947	\$384,488,151	3.5%
Spouse	\$160,414,219	\$166,152,469	3.6%	\$78,682,780	\$79,494,972	1.0%
Child	\$123,598,123	\$142,863,646	15.6%	\$65,124,983	\$77,007,109	18.2%
<b>Total</b>	<b>\$1,018,422,840</b>	<b>\$1,094,926,860</b>	<b>7.5%</b>	<b>\$517,125,663</b>	<b>\$542,722,383</b>	<b>4.9%</b>

Relationship	Total Plan Cost PMPM					
	2009	2010	2010 vs. 2009	Jan - Jun, 2010	Jan - Jun, 2011	2011 vs. 2010
Employee/Retiree	\$388.65	\$408.14	5.0%	\$387.38	\$401.13	3.5%
Spouse	\$435.55	\$437.20	0.4%	\$412.30	\$411.26	-0.3%
Child	\$143.55	\$159.46	11.1%	\$144.54	\$163.27	13.0%
<b>Total</b>	<b>\$327.43</b>	<b>\$343.18</b>	<b>4.8%</b>	<b>\$323.12</b>	<b>\$334.30</b>	<b>3.5%</b>

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

KEHP's costs for adults are trending at a modest rate, and total costs for dependent children have risen from 2009 to 2010, at 15.6%. On a per member per month basis, the trend is 11.1%, well above industry norms.

We expect much of the trend is driven by adult dependents that were newly enrolled in 2011 due to the expanded dependent eligibility mandated by Healthcare Reform.

Exhibit 23 shows KEHP's medical costs separated by Active / Retiree Status.

**Exhibit 23 - Paid Claims by Active / Retiree Status**

Status	Total Plan Cost					
	2009	2010	2010 vs. 2009	Jan - Jun, 2010	Jan - Jun, 2011	2011 vs. 2010
Active Employees	\$673,922,555	\$741,489,310	10.0%	\$350,335,041	\$362,906,358	3.6%
Retirees	\$344,500,285	\$353,437,550	2.6%	\$166,790,622	\$179,816,025	7.8%
<b>Total</b>	<b>\$1,018,422,840</b>	<b>\$1,094,926,860</b>	<b>7.5%</b>	<b>\$517,125,663</b>	<b>\$542,722,383</b>	<b>4.9%</b>

Status	Total Plan Cost PMPM					
	2009	2010	2010 vs. 2009	Jan - Jun, 2010	Jan - Jun, 2011	2011 vs. 2010
Active Employees	\$285.56	\$302.89	6.1%	\$284.79	\$290.18	1.9%
Retirees	\$459.14	\$476.04	3.7%	\$439.64	\$482.25	9.7%
<b>Total</b>	<b>\$327.43</b>	<b>\$343.18</b>	<b>4.8%</b>	<b>\$323.12</b>	<b>\$334.30</b>	<b>3.5%</b>

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

Active employees experienced a 10% increase in total medical claims from 2009 to 2010, though on a PMPM basis, this is lowered to 6.1%. The 2011 increase for actives is projected to be much lower, at 1.9% on a PMPM basis, but the Retirees are projected to increase 9.7%.

## KEHP Pharmacy Benefits Detailed Experience

### Key Findings

- Pharmacy costs have increased modestly over the last several years, with trends significantly lower than industry norms.
- Significant cost shifting in 2011 has resulted in a 4.3% drop in pharmacy claims.
- Both the generic dispensing rate and mail order utilization have increased since 2007, helping to slow down the drug cost growth.
- Some of the top drugs utilized by KEHP are scheduled for patent expiration over the next several years, meaning a potential significant saving to KEHP for these drugs.

### Pharmacy Cost Statistics

A summary of year over year trends for KEHP's total pharmacy claims experience is illustrated in Exhibit 24.

**Exhibit 24 - Key Statistics - Aggregate Pharmacy Benefits Costs**

	2007	2008	2009	2010	2010 vs. 2009	Jan - Jun, 2010	Jan - Jun, 2011	2011 vs. 2010
<b>Total Eligible Members</b>	244,581	251,024	259,196	265,876	2.6%	266,740	270,580	1.4%
<b>Total Number of Scripts</b>	4,967,740	5,135,122	5,216,242	5,369,295	2.9%	2,652,894	2,640,397	-0.5%
<b>Scripts Per Member</b>	20.31	20.46	20.12	20.19	0.3%	9.95	9.76	-1.9%
Total Plan Paid	\$263,411,276	\$298,709,346	\$315,768,145	\$344,994,118	9.3%	\$168,047,259	\$163,181,316	-2.9%
Total Member Paid	\$36,592,240	\$33,758,217	\$61,036,109	\$60,122,145	-1.5%	\$31,736,079	\$40,712,504	28.3%
<b>Total Allowed Cost</b>	<b>\$300,003,516</b>	<b>\$332,467,563</b>	<b>\$376,804,254</b>	<b>\$405,116,263</b>	<b>7.5%</b>	<b>\$199,783,338</b>	<b>\$203,893,820</b>	<b>2.1%</b>
Plan Paid PMPM	\$89.75	\$99.16	\$101.52	\$108.13	6.5%	\$105.00	\$100.51	-4.3%
Member Paid PMPM	\$12.47	\$11.21	\$19.62	\$18.84	-4.0%	\$19.83	\$25.08	26.5%
<b>Total Allowed Cost PMPM</b>	<b>\$102.22</b>	<b>\$110.37</b>	<b>\$121.15</b>	<b>\$126.98</b>	<b>4.8%</b>	<b>\$124.83</b>	<b>\$125.59</b>	<b>0.6%</b>

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

The total allowed cost for prescription drugs increased 7.5% from 2009 to 2010, but only 2.1% from the first 6 months of 2010 to the first 6 of 2011. However, since enrollment increased 2.6% and 1.4% over these two periods, respectively, this only amounts to a 4.8% and .6% increase in overall cost on a per member per month basis.

The observed 2010 trend rate for KEHP's portion of the pharmacy cost in total is 9.3% versus the overall 2010 trend on pharmacy allowed cost of 7.5%. The increase in employer cost share occurs because member copayments are kept level, leaving the total cost increase to shift to the employer.

The observed first 6 months of 2011 trend rate for KEHP's portion of the pharmacy cost in total is -2.9% versus the overall trend in pharmacy allowed cost of 2.1%. The increase in employee cost share is due to the new plan designs offered in 2011 and increased member copayments of 27%, on a PMPM basis.

Exhibit 25 shows key utilization and cost share statistics for KEHP’s pharmacy claims.

**Exhibit 25 - Key Pharmacy Cost Share Statistics**

	2007	2008	2009	2010	2010 vs. 2009	Jan - Jun, 2010	Jan - Jun, 2011	2011 vs. 2010
<b>Total Copayment per Claim</b>	<b>\$9.11</b>	<b>\$8.36</b>	<b>\$10.44</b>	<b>\$9.83</b>	<b>-5.8%</b>	<b>\$10.16</b>	<b>\$12.90</b>	<b>27.0%</b>
Retail Copayment per Claim	\$8.82	\$8.05	\$10.08	\$9.47	-6.1%	\$9.79	\$12.54	28.0%
Mail Copayment per Claim	\$22.57	\$20.75	\$24.56	\$23.15	-5.7%	\$23.75	\$26.11	9.9%
<b>Total Member Cost Share</b>	<b>14.6%</b>	<b>12.6%</b>	<b>16.2%</b>	<b>14.8%</b>	<b>-1.4%</b>	<b>15.9%</b>	<b>20.0%</b>	<b>4.1%</b>
Retail Member Cost Share	14.7%	12.6%	16.5%	15.0%	-1.5%	16.1%	20.3%	4.3%
Mail Member Cost Share	13.8%	12.1%	12.4%	12.9%	0.5%	13.6%	15.4%	1.8%
<b>Generic Utilization</b>								
Generic Dispensing Rate	59.9%	63.7%	66.3%	69.7%	3.3%	68.6%	71.3%	2.7%
Generic Substitution Rate	89.6%	88.9%	92.7%	94.2%	1.5%	94.1%	94.4%	0.3%
<b>Mail Order Utilization</b>	<b>2.1%</b>	<b>2.4%</b>	<b>2.5%</b>	<b>2.6%</b>	<b>0.2%</b>	<b>2.6%</b>	<b>2.6%</b>	<b>0.1%</b>

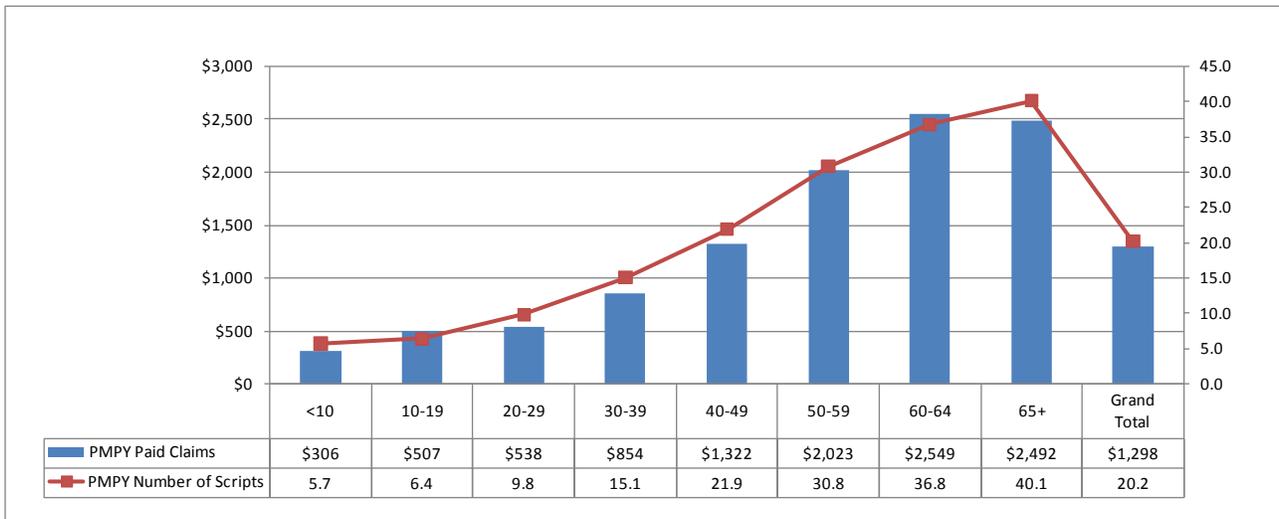
Source: Tenth Annual Report and KEHP’s enrollment and claims data aggregated by Thomson Reuters

The generic dispensing rate continued to increase steadily from 59.9% in 2007 to 69.7% in 2010 and 71.3% in 2011. Mail order utilization has increased more slowly over this same time period due to minimal incentives. The member cost share has been stable from 2007 to 2010, but has increased to 20% in 2011 due to plan design changes implemented in 2011 that increased member co-pays.

**Demographic Impact on Pharmacy Experience**

Exhibit 26 illustrates the increase in medication usage with each increasing age band.

**Exhibit 26 - 2010 Distribution of Pharmacy Claims and Number of Prescriptions, PMPY by Age Band**

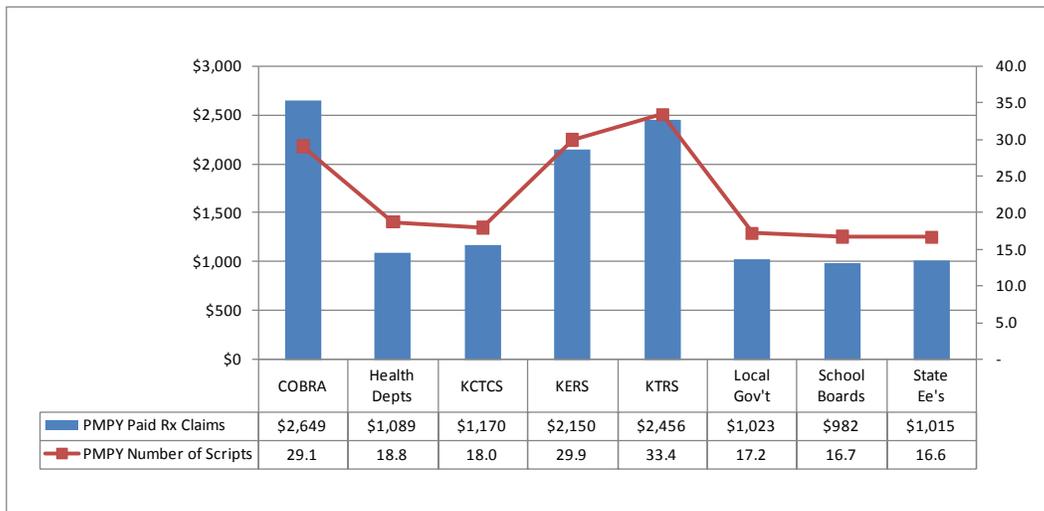


Source: KEHP’s enrollment and claims data aggregated by Thomson Reuters

This increase in utilization and cost is due to the natural progression of the membership’s health status with age. The number of scripts, on a PMPY basis, increases throughout the age bands.

Exhibit 27 shows the pharmacy claim and script PMPMs by Group.

**Exhibit 27 - 2010 Distribution of Pharmacy Claims and Number of Prescriptions, PMPY by Group**



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

As expected, KERS and KTRS, the retiree groups, are the highest users of pharmacy benefits due to increased ages. The other groups, other than COBRA members, are fairly level. The COBRA levels appear high due to the fact that higher users of medical and pharmacy benefits are more likely to continue their coverage through COBRA.

### Prescription Drug Utilization and Disease States

Exhibit 28 shows the drugs that KEHP paid most for in 2010, along with their costs and number of scripts for 2007 through the first 6 months of 2011.

**Exhibit 28 - Top 10 Drugs for KEHP**

Drug	2010 Rank	Total Plan Cost					Number of Scripts				
		2007	2008	2009	2010	Jan - Jun, 2011	2007	2008	2009	2010	Jan - Jun, 2011
NEXIUM	1	\$7,958,521	\$9,103,657	\$10,545,713	\$10,915,139	\$5,211,163	47,791	49,461	54,315	51,894	23,685
CRESTOR	2	\$4,807,897	\$5,775,251	\$7,019,628	\$9,041,563	\$4,898,439	54,221	56,961	62,971	71,399	35,544
SINGULAIR	3	\$6,264,901	\$6,739,265	\$6,835,600	\$7,887,573	\$3,925,512	65,809	64,987	62,951	64,437	30,331
ENBREL	4	\$5,094,825	\$5,545,068	\$5,869,089	\$6,576,469	\$3,265,804	2,610	2,742	2,679	2,865	1,354
CYMBALTA	5	\$3,237,154	\$4,454,723	\$5,066,659	\$5,963,632	\$3,033,426	24,721	30,077	31,867	33,108	16,789
PLAVIX	6	\$3,512,932	\$4,667,057	\$5,132,983	\$5,942,182	\$3,042,744	27,456	32,708	33,783	34,393	15,858
HUMIRA	7	\$3,251,915	\$4,458,923	\$5,127,691	\$5,930,464	\$3,192,120	1,687	2,115	2,345	2,566	1,283
ACTOS	8	\$3,535,646	\$4,168,513	\$4,567,393	\$4,907,283	\$2,395,777	20,201	21,536	21,318	20,611	9,425
COPAXONE	9	N/A	N/A	\$3,455,620	\$4,474,031	\$2,678,560	N/A	N/A	1,106	1,214	599
ABILIFY	10	N/A	N/A	\$2,944,940	\$3,851,001	\$2,239,130	N/A	N/A	6,498	7,760	4,128

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

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, such as reduced copays for maintenance drugs prescribed to treat chronic conditions. In 2010 these ten drugs represented 19% of the KEHP total pharmacy costs.

Several of KEHP's highly utilized drugs, including all several of the top 10 listed above, are scheduled for patent expiration over the next several years, as shown in exhibit 29.

**Exhibit 29 - Schedule of Top Prescription Drugs Losing Patent Protection**

Year	Drug	Manufacturer	Use	KEHP Cost - 2010
2011	Lipitor	Pfizer	Cholesterol Lowering	\$3,788,094
2011	Zyprexa	Eli Lilly and Company	Antipsychotic	\$975,907
2011	Levaquin	Ortho-McNeil	Pneumonia/Bronchitis	\$2,547,276
2012	Actos	Takeda Pharmaceuticals	Type 2 diabetes	\$4,907,283
2012	Diovan HCT	Novartis	High blood pressure	\$4,046,658
2012	Lexapro	Pfizer	Schizophrenia	\$3,358,564
2012	Plavix	Bristol-Myers Squibb / Sanofi Pharmaceuticals	Platelet Inhibitors	\$5,942,182
2012	Seroquel	AstraZeneca	Dementia	\$2,713,381
2012	Singulair	Merck	Asthma	\$7,887,573
2012	Tricor	Abbott	Cholesterol Lowering	\$1,531,646
2013	AcipHex	Ortho-McNeil	Acid Reflux	\$1,362,492
2013	Cymbalta	Eli Lilly and Company	Depression	\$5,963,632
2013	Niaspan	KOS Pharmaceuticals	Cholesterol Lowering	\$1,867,736
2013	Oxycontin	Purdue Pharmaceuticals	Painkiller	\$1,760,187

These highly utilized drugs in Exhibit 29 represent a significant portion of KEHP's total pharmacy costs. Over \$8.5 million of KEHP's 2010 pharmacy cost come from drugs that expire in 2011, over \$30.3 million in 2012 and nearly \$13 million in 2013. Together, these drugs account for over \$51.8 million, or 15% of KEHP's total pharmacy cost.

However, it is important to note that, while these drugs represent a significant portion of KEHP's drug spend, they may not necessarily result in significant savings to the plan. Drugs coming off patent may have high cost generic alternatives or new, more expensive therapeutic equivalent brands.

# Population Health Issues

## Key Findings

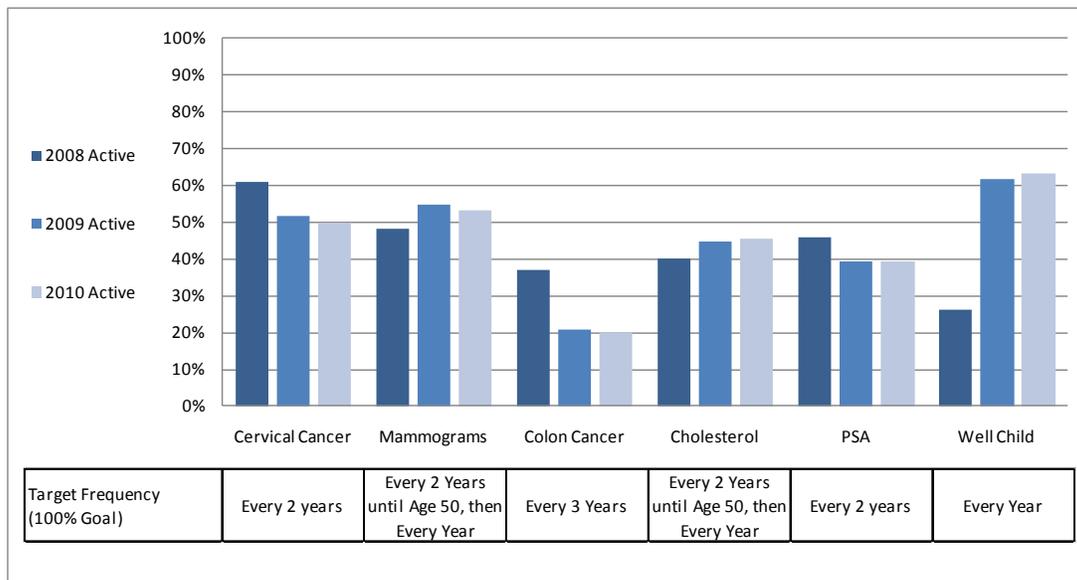
- Members of KEHP are not utilizing preventive care screenings as often as recommended.
- Of the members who are engaged in the ICM program, some improvement is being made to manage specific clinical indicators, though in total the percentage of members who opt out of the program is growing.
- The Kaiser Family Foundation Survey in 2011 reveals that the Commonwealth of Kentucky, as a whole, have less healthy behaviors and outcomes than the United States as a whole, as well as other states in the South Region.

## Preventive Care Screenings

"Healthy People 2010" and "Healthy People 2020" are sets of national health objectives for the U.S. to achieve by their respective target years - 2010 and 2020. Created by health experts, these objectives identify a wide range of public health priorities and specific, measurable objectives. These 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.

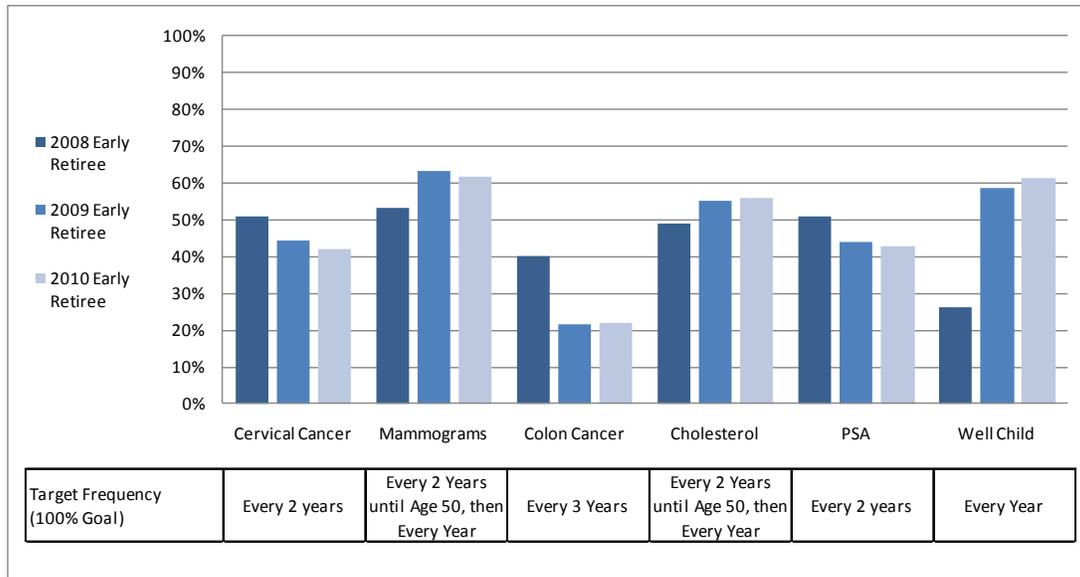
In Exhibits 30 and 31, the preventive care screening rates for KEHP members in 2008-2010 are shown for active members and for non-Medicare eligible retirees, respectively.

**Exhibit 30 - Preventive Care Screening Utilization (Actives)**



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

**Exhibit 31 - Preventive Care Screening Utilization (Early Retirees)**



Source: Tenth Annual Report and 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".

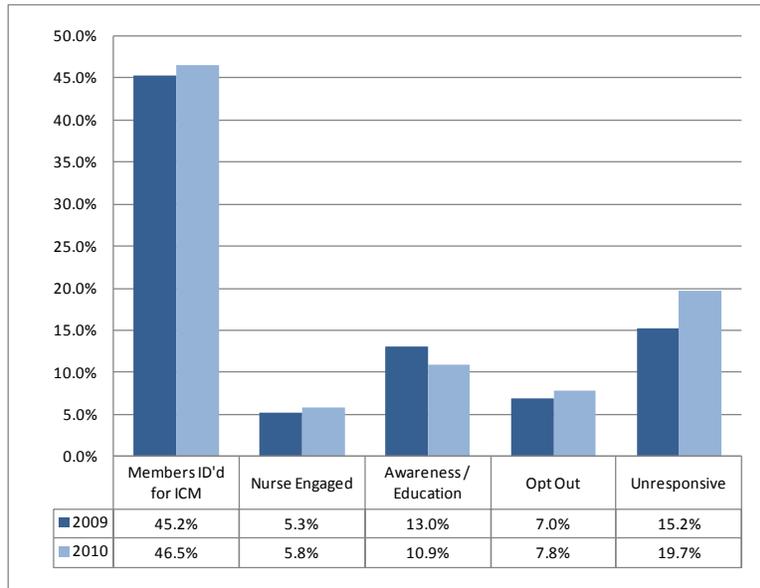
For all three years, KEHP non-Medicare eligible retiree population achieved higher screening rates for all adult preventive measures, with the exception of cervical cancer screens, when compared to actives. For early retirees, the screening rates averaged 42-51% for all adult screens besides colon cancer. The targeted active population range was slightly lower, at 39-48% for all adult screenings other than colon cancer. Levels for both member groups are well under goals and expectations.

Preventive care screening rates remained mostly level from 2009 to 2010. Mammograms and cervical cancer screenings are down from 2009 for both groups, whereas cholesterol screenings and well child visits increased. Improvements in preventive care screenings are needed in several categories, including cholesterol and prostate cancer screenings, but especially for colon cancer.

## Disease Management and Care Management

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 2010, 126,249 KEHP members (46.5% of all members) had at least one of the identified conditions and were targeted for outreach. Exhibit 32 indicates the percentage of KEHP members in the following categories:

**Exhibit 32 – ICM Outreach Results (% of KEHP Population)**



Source: ActiveHealth Management's Annual Review Report for KEHP, 2010

In 2010, 16.7% of the total KEHP population was engaged in the program, either working with a nurse or in an awareness / education program, compared to 18.3% in 2009 and 15% in 2008. However, the percentage of members who participated in awareness or education programs fell sharply, from 13% to 10.9%. Additionally, the percentage of members who were unresponsive to outreach efforts rose dramatically from 15.2% of the total KEHP member population in 2009 to 19.7% in 2010. KEHP should continue to investigate ways to increase participation and engagement.

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 2010 (similar in size to 2009), resulting in slightly less than \$13 PMPM in savings for the whole program 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 2010, with 5.8% of KEHP's population being actively engaged with a nurse, up from 5.3% in 2009 and 4.0% in 2008.

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 2010, and found that primarily a member opts-out based on the member's sense that they are managing their condition with their doctor.

Exhibit 33 compares the pre-nurse engagement compliance to results after program engagement for some key clinical indicators.

**Exhibit 33 – ICM Clinical Indicators**

Condition Cluster	Clinical Indicator	Measured Population	Baseline	Current	Goal
<b>Vascular Conditions</b>	LDL Cholesterol Monitoring	11,222	78%	81%	75%
	Appropriate use of lipid-lowering agents	39,274	43%	54%	75%
	Met LDL Cholesterol Target for vascular condition	2,570	75%	80%	60%
	Use of beta-blockers after heart attack	754	74%	75%	75%
	Met blood pressure target	954	47%	51%	60%
<b>Diabetes</b>	HbA1c monitoring	9,193	85%	88%	75%
	Eye Exam appropriate for type 1 and 2	8,805	34%	43%	75%
	Nephropathy screening	2,201	35%	42%	75%
	Foot Exam	305	83%	88%	75%

*Source: ActiveHealth Management's Annual Review Report for KEHP, 2010*

The compliance rates increased for all clinical indicators after program engagement. However, further improvement can be made in several areas to meet the compliance targets, such as: the appropriate use of lipid-lowering agents, meeting blood pressure targets, eye exams, and nephropathy screenings.

Among the top conditions being addressed by the ICM program are hypertension, diabetes, chronic back / neck pain, GERD, and obesity, similar to the top conditions in 2009. The largest percentage of Severity 1 Care Considerations sent to members in 2010 was related to movement disorders. This is consistent with KEHP's most prevalent conditions and diseases as shown in exhibits 20 and 21.

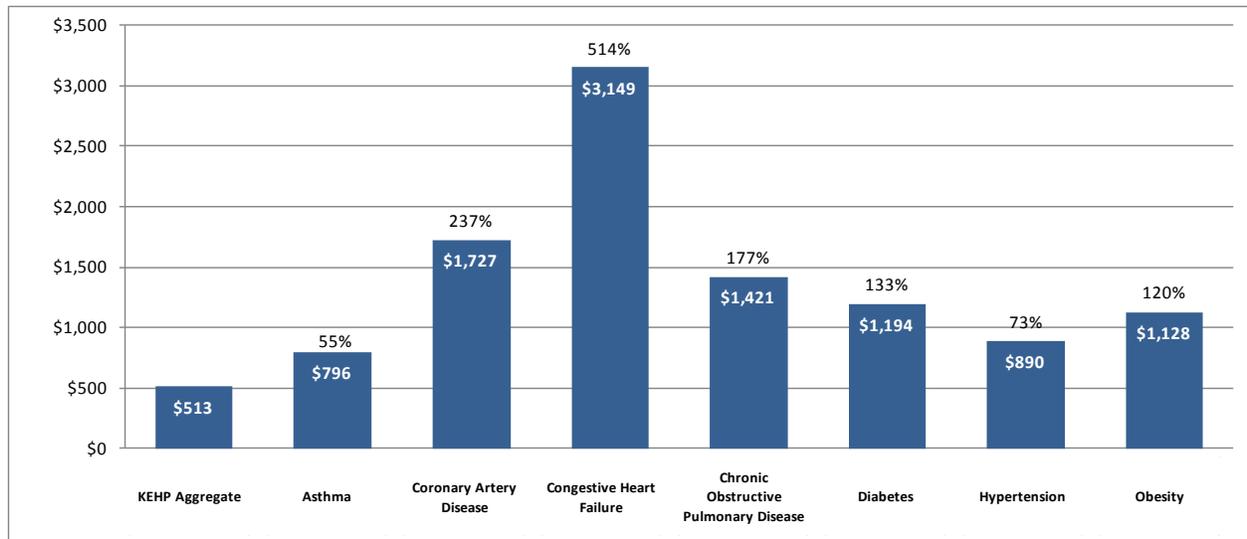
In addition, members continue to enroll in the Why Weight Kentucky program, also managed through Active Health. There were 863 new enrollees in 2010, bringing the total number of members enrolled to 3,128 since the program was introduced in August 2006. This number is fairly low given the number of overweight and obese plan members.

The program coordinates with Express Scripts to make weight loss medication coverage available to all members working with a nurse in the ActiveHealth weight management ICM program. In 2010, there were 1,902 standard case management participants, an increase from 1,604 in 2009. ICM also conducted 3,204 case management utilization reviews, increasing total case management utilization to 5,106.

## Costs by Disease State

Exhibit 34 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 34 - 2010 Chronic Disease States PMPM versus KEHP Aggregate PMPM**



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

Members with Congestive Heart Failure, for example, are 514% more expensive than the average member. 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.

## 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 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. A summary of these key statistics for Kentucky (KY), compared against other states in the South Region and the United States in total, is provided below in Exhibit 35 (statistics for which Kentucky is worse than either the South Region or the United States are marked in yellow, statistics where it is worse than both are marked in red).

**Exhibit 35 – Comparison of Selected Population Health Statistics**

Statistic	KY (Current)	South Region	US Total
Life Expectancy at Birth	76.2	77.5	78.7
Percent of Adults Who are Overweight or Obese	67.5%	66.0%	64.1%
Percent of Children (10-17) who are Overweight or Obese	37.1%	33.9%	31.6%
Percent of Adults who Participate in Moderate or Vigorous Physical Activities	45.6%	46.1%	49.5%
Percent of Adults Who Smoke	24.8%	18.8%	17.1%
Percent of Smokers who Attempt to Quit Smoking	56.2%	59.3%	59.0%
Percent of Adults Who Have Ever Been Told by a Doctor that They Have Diabetes	10.0%	10.2%	9.2%
Adult Self-Reported Current Asthma Prevalence Percentage	10.2%	7.5%	8.4%
Percent of Adults Reporting Poor Mental Health	36.7%	32.3%	34.1%
Percent of Adults Aged 50+ Who Have Ever Had a Sigmoidoscopy or Colonoscopy	63.7%	65.1%	65.9%
Number of Cancer Deaths (per 100,000)	214	183	178
Number of Deaths due to Colorectal Cancer (per 100,000)	20	17	17
Number of Deaths Due to Diseases of the Heart (per 100,000)	221	199	191
Invasive Cancer Incidence Rate (per 100,000)	518	462	460
Number of Deaths Caused by Stroke and other Cerebrovascular Diseases (per 100,000)	48	47	43

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

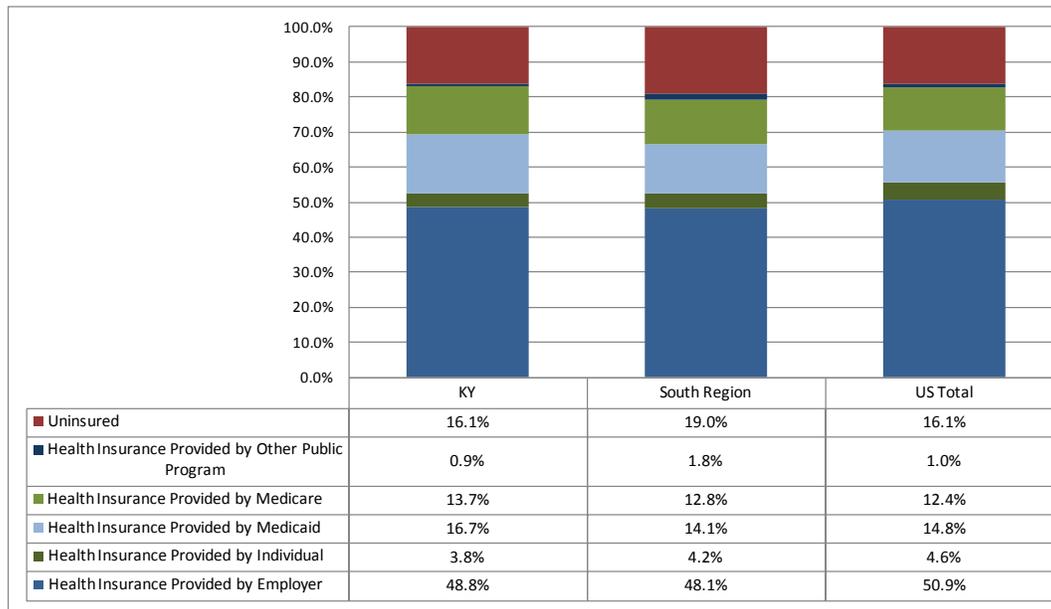
While some of Kentucky's statistics (diabetes and physical activity) are no worse than the average for the South Region, the population statistics suggest that Kentucky residents, on average, have a less healthy lifestyle than both the South Region and the United States as a whole, and can expect both a higher prevalence of health issues and a lower life expectancy.

Kentucky's population has demonstrated improvements in some areas. However, consistent with the health issues affecting KEHP members, the Commonwealth still lags behind national averages for metrics such as obesity, diabetes, and smoking. Progress towards reaching and exceeding the 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.

## Health Insurance Coverage for the Commonwealth of Kentucky

In addition to the Health Risk Statistics Comparison, the Kaiser Family Foundation has aggregated data regarding the health insurance coverage of each state’s residents. In Exhibit 36, Kentucky is again compared against the South Region as well as the United States as a whole.

**Exhibit 36 – Source of Insurance Coverage Comparison**



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

In contrast to the disparity in their health risk statistics, the residents of Kentucky are insured in roughly the same proportions as the rest of the United States, with an uninsured rate as low as the National Average and significantly lower than the other Southern States.

## BENCHMARK RESULTS

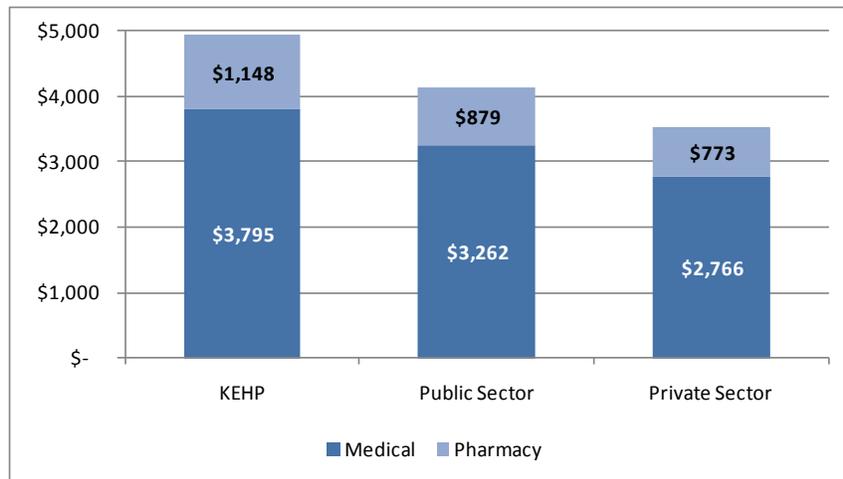
### Key Findings

- Consistent with poor risk profiles, KEHP’s total allowed per member per year cost is 19.4% higher than other clients in the public sector (16.3% higher for medical costs and 30.6% higher for pharmacy costs), and much higher than clients in the private sector.
- KEHP’s plans cover a younger population with smaller family size and more females than other Thomson Reuters clients in the public sector.

### Total Allowed Costs

Thomson Reuters has compiled several benchmarks, comparing KEHP’s 2009 allowed costs for active employee population against the active populations for other Thomson Reuters clients, separated by public and private sectors. Exhibit 37 shows the difference in total costs PMPY for both KEHP and the public and private sectors.

**Exhibit 37 –2009 KEHP Active Population PMPY Allowed Costs vs. Public and Private Sector**



Source: Thomson Reuters

KEHP’s total allowed per member per year cost is 19.4% higher than other clients in the public sector (16.3% higher for medical costs and 30.6% higher for pharmacy costs), and much higher than clients in the private sector. Much of this is due to the poor risk status throughout the state.

### Demographics

Exhibit 38 compares some key demographic statistics for the KEHP against the public and private sectors.

**Exhibit 38 –2009 key Demographic Statistics**

	KEHP	Public Sector	Private Sector
Average Member Age	33	35	32
Member to Employee Ratio	1.8	1.9	2.3
Employee % male	41%	44%	50%

Source: Thomson Reuters

In general, KEHP’s plans cover a younger population with smaller family size and more females than other Thomson Reuters clients in the public sector. At younger ages, females have higher average claim costs than males, due to maternity. KEHP’s higher percentage of females accounts for 5-10% of the 19.4% cost differential.

Disease Prevalence in KEHP active population

Exhibit 39 compares the prevalence of several chronic diseases for the KEHP active population against other states and US population in general.

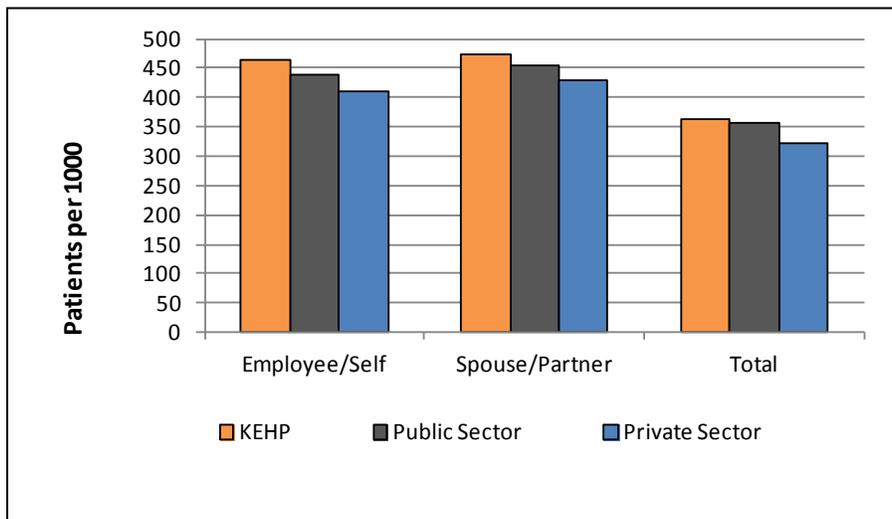
**Exhibit 39 –2010 Disease Prevalence for Actives**

Disease Prevalence (Patients per 1000)	KEHP	State and Local Benchmark	US Total Benchmark
Anxiety Disorder	27.1	19.3	18.8
Asthma	34.9	31.4	29.8
Bipolar Disorder	6.0	6.7	6.0
Coronary Heart Disease	20.8	15.2	14.1
CHF	3.2	2.8	2.4
COPD	12.3	7.6	7.0
Depression	45.3	41.9	40.6
Diabetes	64.3	54.5	47.0
HIV Infection	0.4	1.0	1.0
Hypertension	139.5	118.0	93.5
Osteoarthritis	62.2	47.2	43.4
Rheumatoid Arthritis	4.8	4.4	4.2

Source: Thomson Reuters

Exhibit 40 compares the prevalence of chronic conditions, separated by relationship.

**Exhibit 40 –2009 Chronic Condition Prevalence by Relationship for Actives**

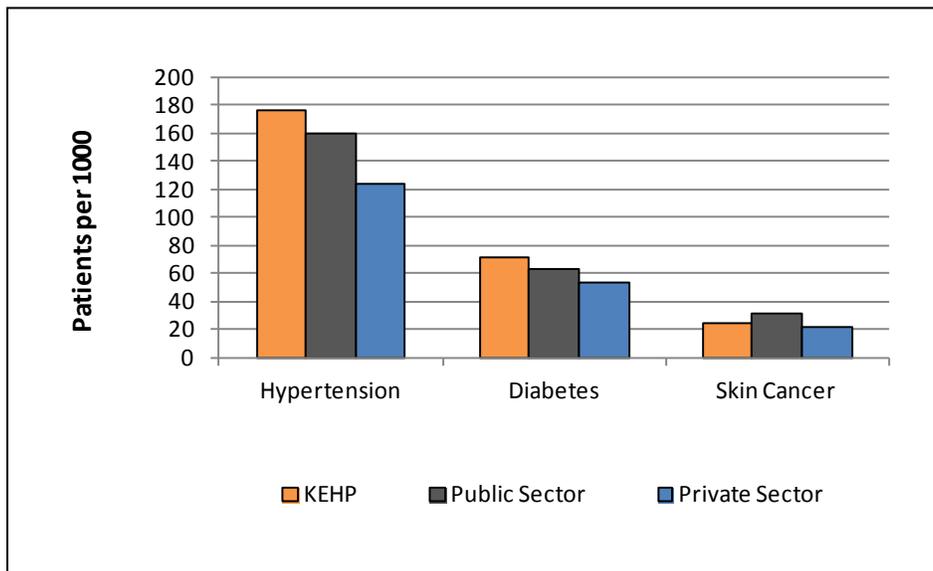


Source: Thomson Reuters

Except for Bipolar disorder and HIV infection, KEHP active population has significantly higher chronic disease prevalence rates than the benchmarks. When grouping the conditions together, as shown in Exhibit 40, this same trend applies to employees, spouses, and in total (which includes children).

Exhibit 41 shows select disease prevalence figures for KEHP.

**Exhibit 41 – 2009 Select Disease Frequency for Active Employees**

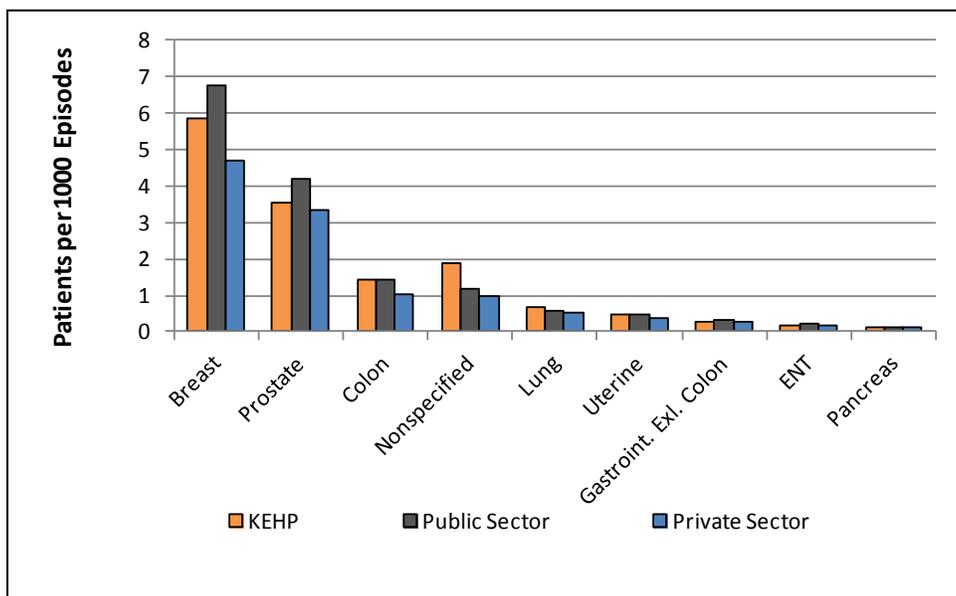


Source: Thomson Reuters

Hypertension and Diabetes are much more prevalent in KEHP’s active population than in the active population for both public and private sector. These two conditions, in particular, drive the overall chronic disease burden.

Exhibit 42 compares the frequency of specific cancers in the active population of KEHP against those in the public and private sectors.

**Exhibit 42 – 2009 Cancer Prevalence for Actives**

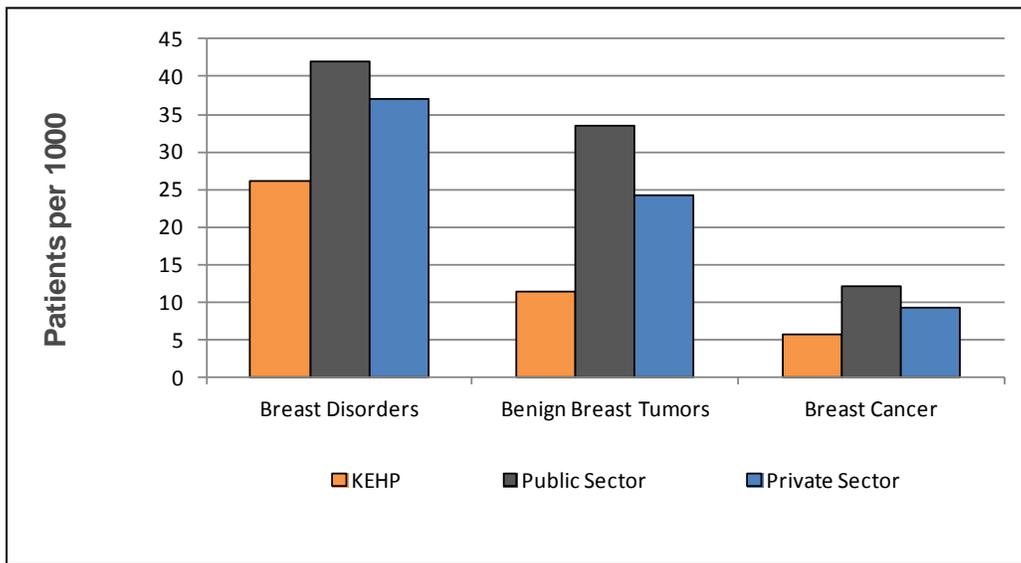


Source: Thomson Reuters

KEHP’s active population exhibits lower cancer rates, compared to both the public and private sectors, the two most common cancers, breast and prostate, are significantly lower than the public sector average.

Exhibit 43 shows the 2009 prevalence of breast disease in KEHP’s active population.

**Exhibit 43 – 2009 Breast Disease Prevalence for Actives**

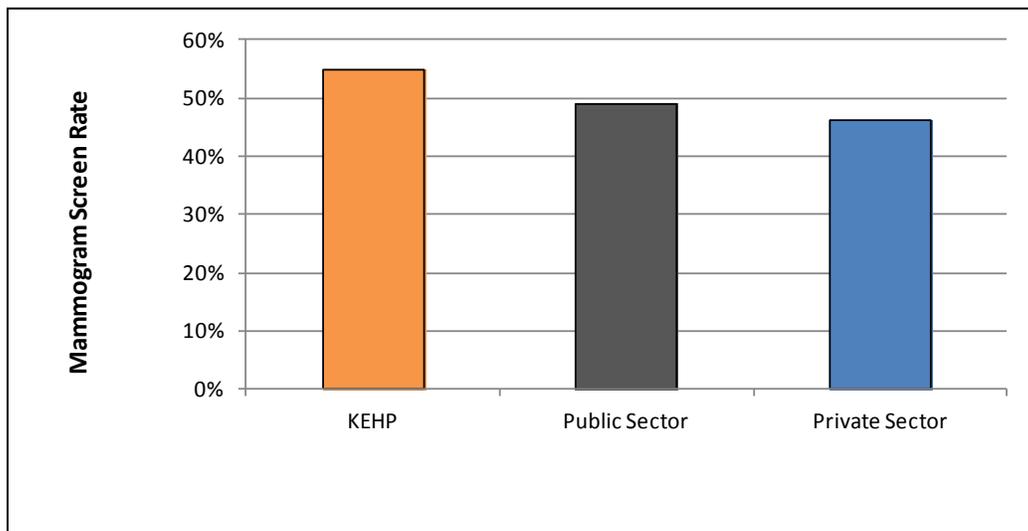


Source: Thomson Reuters

In contrast to the higher than average disease prevalence rates shown in Exhibits 39 and 40, KEHP shows a significantly lower incidence of breast disease.

Exhibit 44 shows the 2009 mammogram screening rate for KEHP’s active population, again compared against the public and private sectors.

**Exhibit 44 –2009 Mammogram Screening Rate**

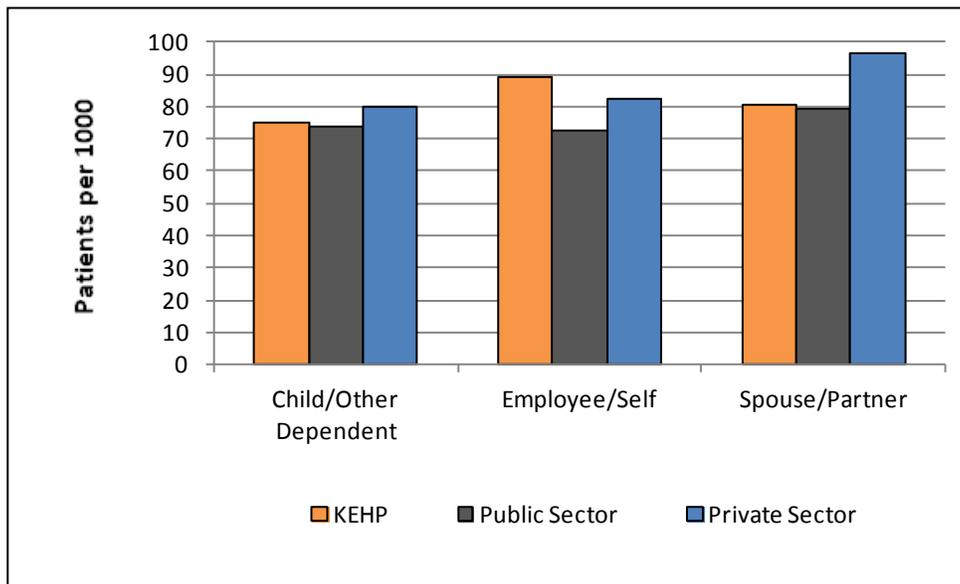


Source: Thomson Reuters

KEHP’s active population has a higher than average rate of Mammogram Screening, which could explain the lower incidence of breast diseases, as seen in Exhibit 43.

Exhibit 45 shows the prevalence of Mental Health and substance abuse.

**Exhibit 45 –2009 Mental Health / Substance Abuse Episode Prevalence for Actives**



Source: Thomson Reuters

The private sector exhibits a higher prevalence of mental health / substance abuse episodes than public sector. The episode prevalence for KEHP employee dependents is very similar to that of the public sector employee dependents, while the episode prevalence for KEHP employees is much higher than that of the public sector employees.

## FEDERAL HEALTHCARE REFORM

### The Patient Protection and Affordable Care Act (PPACA)

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010, and the related Health Care and Education Reconciliation Act of 2010 (HCER), which modifies certain provisions of PPACA, was signed into law on March 30, 2010. These two statutes made sweeping changes to existing law governing employer-sponsored group health plans, individual health coverage, and governmental health programs. The provisions affect insured and self-insured employer health plans.

The provisions provided by these two statutes generally are added to the Public Health Service Act (PHSA) and are incorporated by reference into the Employee Retirement Income Security Act of 1974, as amended (ERISA). Certain changes are also made to the Internal Revenue Code of 1986, as amended (Code), and the Fair Labor Standards Act (FLSA). Since the law implicates a number of different statutes, various governmental agencies have authority to issue guidance. Much guidance has been released since the law went into effect, with much more still to come. 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.

The Congressional Budget Office (CBO) originally estimated the cost of PPACA to be \$938 billion. Savings and revenues were projected to provide \$1.08 trillion, for a net reduction to the federal deficit of \$143 billion. Savings and revenues were based on:

- Savings from Medicare Advantage cuts
- Savings from a reduction in the Medicare growth rate
- Savings from the CLASS program (a national Long Term Care program)
- Excise taxes on high cost insurance
- New Medicare taxes on high income individuals
- Penalty payments from Employers not providing coverage for employees
- Penalty payments from Individuals not maintaining minimum coverage for themselves and dependents
- A cap on annual contributions to flexible spending accounts
- Elimination of the Retiree Drug Subsidy tax exclusion
- Fees on insurance companies, pharmaceutical companies and medical devices companies
- Other net savings and net revenues

However, the CLASS program was repealed in October 2011. By law, implementation of this program was contingent on certification by the Secretary of Health and Human Services that the program was financially sound. The secretary, Kathleen Sebelius, reported to congress in October that the program, as designed, was not financially sound. Savings from this program were projected to have been \$70 Billion.

### The U.S. Supreme Court will decide the fate of the Patient Protection and Affordable Care Act (PPACA)

Multiple lawsuits were filed in 2010 challenging the constitutionality of PPACA including the requirement that individuals must purchase health insurance, the fine for not purchasing health insurance, the federal authority to force states to implement health policy, financial disclosure rules for doctors, and various changes made to the Medicare and Medicaid systems. While many cases are still pending, final rulings have been decided on some cases with decisions that PPACA does violate the constitution and decisions that PPACA does not violate the constitution.

On November 14, 2011, the U.S. Supreme Court announced it will take up the issue. The court said it will consider several arguments including:

- 1) Whether the individual mandate is constitutional, and if not, whether that affects the feasibility of other provisions in the law;
- 2) Whether the challengers have standing to contest the law under the Anti-Injunction Act; and
- 3) Whether the expansion of the Medicaid program is constitutional.

The court is expected to hear arguments in March, with a decision expected in June 2012.

## Some Key Provisions of PPACA that Impact KEHP

### Changes to Health Plans

PPACA creates unprecedented change in the US healthcare system. It impacts all stakeholders in healthcare, including employers, government, payers, providers and pharmaceutical companies. It will have a significant impact on employers, their health plans, and related administration for years to come. Some provisions were effective immediately, while some are deferred until 2013, 2014, and as late as 2018, with many provisions gradually phased-in. For KEHP, many provisions became effective January 1, 2011.

PPACA changes a number of requirements for individual and group health plans.

- 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 maximums (\$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.

### 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. Families with income up to 400% of the federal poverty

level may receive premium tax credits and cost-sharing subsidies for their coverage. PPACA also expands Medicaid eligibility to those with income up to 133% of the federal poverty level.

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 employee contribution towards the cost of the coverage compared to 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 is enrolled 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 (at least 60% actuarial value), but where at least one full-time employee of the employer has enrolled in an Exchange and qualified for a premium tax credit (where employee income is less than 400% of the federal poverty level and the employee share of the premium exceeds 9.5% of income), is \$3,000 for each such employee, but not more than \$2,000 times the number of full-time employees.
- The penalty amounts will be indexed for inflation beginning in 2015.

In light of the Individual Mandate, special consideration will need to be made regarding the benefit provided to employees that waive coverage in KEHP. Currently, these employees are provided \$175 per month to cover healthcare expenses via a Health Reimbursement Arrangement (HRA). This benefit does not satisfy the requirements for minimum essential coverage and is likely to result in assessment of one of the employer penalties listed above. Further, this "standalone" HRA does not satisfy the requirements for coverage needed for the employee to meet the Individual Mandate provisions in the law.

### 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 out-of-pocket maximums equal to the HSA current law, as well as a Catastrophic plan for individuals up to age 30:

- Bronze Plan (the standard for "minimum creditable coverage") covers 60% of the benefit costs
- Silver Plan covers 70% the benefit costs
- Gold Plan covers 80% of benefit costs
- Platinum Plan covers 90% 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, based on current law HSA levels, 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% of the federal poverty level. Premiums in the exchange may not vary by more than 3 to 1 based on age.

### Free-choice Vouchers

Employers that offer coverage to their employees would have been required to 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 chose to enroll in a plan in the Exchange. **This provision has since been repealed.**

### Early Retiree Reinsurance Program (ERRP)

Congress appropriated \$5 billion for a temporary program to reimburse retiree health plans for certain costs of benefits provided to pre-Medicare eligible retirees and their dependents. 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), or when the \$5 billion appropriation has been exhausted.

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.

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% of the portion of the costs attributable to the early retiree's claims that exceed \$15,000 and are not greater than \$90,000. Payments are not taxable to the plan sponsor.

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.

The KEHP application was submitted on the first day that applications were being accepted 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 are 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.

Plan sponsors who use proceeds from ERRP to reduce their own premiums or costs are required to maintain the level of effort in contributing to support their plans.

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.

As of November 3, 2011, total ERRP payments made to plan sponsors totaled \$4.1 billion. The Commonwealth of Kentucky has received \$95 million to date.

### "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 2012.

KEHP will address future PPACA challenges and opportunities according to the following timeline.

<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2017+</b>
<ul style="list-style-type: none"> <li>▪ <i>Employer Distribution of Uniform Summary of Benefits to Participants</i></li> <li>▪ <i>Comparative Effectiveness Fee</i></li> <li>▪ <i>Employer Quality of Care Report*</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>W-2 Reporting of the Value of Health Coverage</i></li> <li>▪ <i>Notice to Inform Employees of Coverage Options in Exchange</i></li> <li>▪ <i>Limit of Health Care FSA Contributions to \$2,500 (Indexed)</i></li> <li>▪ <i>Elimination of Deduction for Expenses Allocable to Retiree Drug Subsidy (RDS)</i></li> <li>▪ <i>Medicare Tax on High Income</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Individual Mandate to Purchase Insurance or Pay Penalty</i></li> <li>▪ <i>State Insurance Exchanges</i></li> <li>▪ <i>Employer Responsibility to Provide Affordable Minimum Essential Health Coverage</i></li> <li>▪ <i>Free Choice Vouchers REPEALED</i></li> <li>▪ <i>Preexisting Conditions Exclusions Prohibited</i></li> <li>▪ <i>Annual Limits Prohibited</i></li> <li>▪ <i>Automatic Enrollment</i></li> <li>▪ <i>Limit of 90-Day Waiting Period for Coverage in Plan</i></li> <li>▪ <i>Employer Reporting of Health Insurance Information to Government and Participants</i></li> <li>▪ <i>Increased Cap on Rewards for Participation in Wellness Program</i></li> </ul>	<ul style="list-style-type: none"> <li>▪ <i>Large employers can join state exchanges without penalty</i></li> <li>▪ <i>High cost plan excise tax (2018)</i></li> </ul>

\* **Denotes group/insurance market reforms not applicable to grandfathered health plans**

## Some Key Considerations

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. While PPACA reforms are mainly focused on regulation and expansion of coverage, employer-based plans still face the challenges associated with rising health care costs and deteriorating population health. After short term efforts to comply with immediate requirements, employers are recalibrating their longer term strategies based on a new set of underlying dynamics. What has been unthinkable in how employers approach benefits in the past will change in the very near future.

Going forward, employer costs are expected to rise 60% on a "stand still" basis with the following upward pressures:

- Demographics
- Obesity-related chronic illness—including children
- New therapies and technologies
- Cost shift from Medicare / Medicaid
- Industry fee pass-throughs
- New coverage provisions
- Individual mandate

These upward pressures may be mitigated with the following downward pressures:

- Plan design value
- Discretionary purchasing
- Uncompensated care
- Brand drug patent expirations
- Focused care management
- Investments in health

Employers will have to decide whether they want to be involved in aggressive health management or whether they want to provide subsidies to employees to receive coverage on an exchange. Down either path, employers have a persistent need to have a workforce that is healthy, present, and productive. This is imperative for all businesses.

Aggressive Health Management involves:

- Heavy emphasis on health risk improvement and cost management
- Sophisticated use of data analytics to drive design, program management, vendor accountability
- Migration from incentives to penalties and "requirement gates" to access better benefits
- Alignment with pay for performance business culture

Managed Defined Contribution involves:

- Subsidy fixed with company-driven increase
- Coverage via individual market (private or public Exchanges)
- Worksite health shifts to focus on return to work, absence reduction, productivity gains

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 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 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.

## BOARD RECOMMENDATIONS

For this year's report, Board member's were surveyed and ranked the importance of its Guiding Principles. The Board recommends that the KEHP continue to follow the guiding principles stated below, presented in ranked order importance:

1. Provide uniform coverage across the Commonwealth
2. Encourage wellness and healthy lifestyles
3. Provide preventive care at little or no cost
4. Strive to hold down costs for family and dependent coverage
5. Improve chronic disease care
6. Educate members about plans that are more appropriate for their health needs
7. Provide members with quality PPO and Consumer Directed options
8. Provide plan alternatives that are accessible for retirees

Previous years' lists included a Guiding Principle on providing a plan with an unlimited lifetime maximum. However, under Federal Health Reform all plans providing minimum substantive coverage will be required to provide unlimited benefits. Therefore, this Principle has been removed.

Based on the results of the survey of Board members, the Board continues to support many of the recommendations made in last year's Tenth 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 align 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.

*For 2012, DEI has engaged Humana Vitality (HV) to provide a robust wellness program. The HV program assists members to identify their health/lifestyle risks, set goals/identify activities for improving their risks and earn rewards for meeting goals and engaging in healthy behaviors. The program then provides a customized pathway for each member that will engage them to take action to improve their health, regardless of their risk level. The program is highly data-driven and provides sufficient incentives and options to encourage and continuously stimulate member engagement.*

*DEI will continue 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 the continued expansion of wellness and prevention programs will continue to be evaluated and implemented as opportunities arise.*

- 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. DEI negotiated pricing concessions and performance guarantee enhancements for 2012 with both Humana and ESI. The performance of the Humana and ESI clinical programs will continue to be monitored and evaluated by DEI.*

- 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.

*Beginning in 2009, DEI increased communications outreach to KEHP members. This has continued through 2011 and is planned to expand in 2012. This includes an extensive campaign (in conjunction with Humana Vitality) to promote the new wellness program and encourage engagement and participation. 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, including Social Media, will continue over the course of this next year.*

- 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 the actuary 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.

*DEI has worked with the actuary to develop a funding strategy for 2012 that will ensure that KEHP obligations will be covered by 2012 revenue. DEI is working with Aon Hewitt to determine a more formal and long-term policy.*

- KEHP should continue to study to evaluate the impact of any federal healthcare reform measures as the scope and detail of reform programs continue to develop and regulations and guidance emerge.

*DEI has evaluated the impact of federal healthcare reform law and regulations as information became available during the course of 2011. DEI will continue to evaluate the emerging impact of the law as regulations are finalized and market impact information becomes available.*

## APPENDIX

### KEHP Program Changes & Plan Design Provisions by Year

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

## Appendix – KEHP Program Changes and Plan Design Provisions

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.

Appendix – KEHP Program Changes and Plan Design Provisions

2002 Public Employee Health Insurance Program Benefit Provisions (continued)

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

Appendix – KEHP Program Changes and Plan Design Provisions

2002 Public Employee Health Insurance Program Benefit Provisions (continued)

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Annual Deductible</b>		Single: \$250 Family: \$500	Single: \$500 Family: \$1,000	Single: \$500 Family: \$1,000	Single: \$1,000 Family: \$2,000
<b>Maximum out-of-pocket for Covered Expenses (including deductible)</b>	Co-payments for office visits, hospital emergency room visits, urgent care center visits and coinsurance amounts for dental, vision, audiometric and autism respite services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: \$1,250 Family: \$2,500	Single: \$2,500 Family: \$5,000	Single: \$2,000 Family: \$4,000	Single: \$4,000 Family: \$8,000
<b>Lifetime Maximum Benefit</b>		Unlimited	Unlimited	Unlimited	Unlimited
<b>In Hospital Care</b>	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
<b>Outpatient Services</b>	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
		\$400 maximum benefit per year		\$300 maximum benefit per year	
	Diagnostic Testing (per visit) - laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
<b>Emergency Services</b>	Hospital Emergency Room—\$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay plus 20% co-ins	\$50 co-pay plus 40% co-ins	\$50 co-pay plus 25% co-ins	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
<b>Maternity Care</b>	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	\$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
<b>Prescription Drugs</b>	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$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 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*

Appendix – KEHP Program Changes and Plan Design Provisions

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:

## Appendix – KEHP Program Changes and Plan Design Provisions

- 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).

Appendix – KEHP Program Changes and Plan Design Provisions

2003 Public Employee Health Insurance Program Benefit Provisions

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

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

Appendix – KEHP Program Changes and Plan Design Provisions

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 child care, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit)-outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$50 co-pay (per visit)	40% co-ins*	\$125 co-pay (per visit)	50% co-ins*
<b>Emergency Services</b>	Hospital Emergency Room--\$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay (per visit)	\$50 co-pay plus 40% co-ins	\$50 co-pay (per visit)	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
<b>Maternity Care</b>	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	\$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	\$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
<b>Prescription Drugs Retail</b>	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
<b>Mail Order</b>	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary		\$20 generic \$30 brand \$60 non-formulary	
<b>Dental</b>		Not Covered		Not covered	
<b>Vision</b>		Not Covered		Not covered	
<b>Other Services</b>	Audiometric--Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit)--No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services-\$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	\$10 co-pay 50% co-insurance	40% co-ins* 50% co-insurance*	\$20 co-pay 50% co-insurance	50% co-ins* 50% co-insurance*
	Hospice - Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit		Covered same as Medicare benefit	
	Physical Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Occupational Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Speech Therapy (per visit)-Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission)-Limit 30 days per year.	\$100 co-pay	40% co-ins*	\$250 co-pay	50% co-ins*

\* Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.  
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.  
Referrals and/or prior approval may be required for some services. Please contact your Carrier

Appendix – KEHP Program Changes and Plan Design Provisions

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 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	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.

Appendix – KEHP Program Changes and Plan Design Provisions

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	
	<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

\* 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.

Appendix – KEHP Program Changes and Plan Design Provisions

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>	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	

Appendix – KEHP Program Changes and Plan Design Provisions

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>	<b>Retail</b>	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
	<b>Mail Order</b>	\$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>	Chiropractor (per visit)—No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
		Limit 60 visits per year.		Limit 40 visits per year.	
	Autism Services—\$500 maximum monthly benefit. For children 2 through 21 years of age				
	• Rehabilitative and Therapeutic care	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	• Respite Care	50% co-insurance	50% co-insurance*	50% co-insurance	50% co-insurance*
	Hospice – Certain limits apply. Must be pre-certified by Plan.	Covered same as Medicare benefit		Covered same as Medicare benefit	
	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*	

Appendix – KEHP Program Changes and Plan Design Provisions

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 childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
		\$400 maximum benefit per year		\$300 maximum benefit per year	
	Diagnostic Testing (per visit) - laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; 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>	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*

Appendix – KEHP Program Changes and Plan Design Provisions

2004 Public Employee Health Insurance Program Benefit Provisions (continued)

EPO Plan		
<b>Annual Deductible</b>		None
<b>Maximum out-of-pocket for Covered Expenses</b>	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$4,000 Family: \$8,000
<b>Lifetime Maximum Benefit</b>		Unlimited
<b>In Hospital Care</b>	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	\$1,500 co-pay (per admission)
<b>Outpatient Services</b>	Physician or Mental Health Provider Office (per visit)—visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well 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 <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.

Appendix – KEHP Program Changes and Plan Design Provisions

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%	
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
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

Appendix – KEHP Program Changes and Plan Design Provisions

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%*
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  in-hospital care co-insurance applies*	40%*	\$10 co-pay  in-hospital care co-insurance applies*	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	
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.

## Appendix – KEHP Program Changes and Plan Design Provisions

- 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.

Appendix – KEHP Program Changes and Plan Design Provisions

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%	
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
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

Appendix – KEHP Program Changes and Plan Design Provisions

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%*
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  in-hospital care co-insurance applies*	40%*	\$10 co-pay  in-hospital care co-insurance applies*	30%*
Prescription drugs – Retail (30 day supply) Generic Preferred Brand Non-preferred Brand	\$5** \$15** \$30**	40% 40% 40%	\$5** \$15** \$30**	30% 30% 30%
Prescription drugs – Mail Order (90 day supply) Generic Preferred Brand Non-preferred Brand	\$10 \$30 \$60		\$10 \$30 \$60	
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.

Appendix – KEHP Program Changes and Plan Design Provisions

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%		\$10 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*	\$50 co-pay plus 20%	\$50 co-pay plus 40%
Emergency room physician charges	25%*	50%*	20%	40%
Urgent care center treatment	25%*	50%*	\$20 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit co-pay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no co-pay required.	25%*	50%*	\$10 co-pay  in-hospital care co-insurance applies*	40%*
Prescription drugs – Retail (30 day supply)	25%			
	Min	Max		
Generic	\$10	\$25		
Preferred Brand	\$30	\$50	\$5 \$15**	40%
Non-preferred Brand	\$35	\$100	\$30**	40%
Prescription drugs – Mail Order (90 day supply)	25%			
	Min	Max		
Generic	\$20	\$50		
Preferred Brand	\$60	\$100	\$10 \$30 \$60	
Non-preferred Brand	\$70	\$200		
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.

Appendix – KEHP Program Changes and Plan Design Provisions

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	30%*	Plan pays 100%	
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%	
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.

Appendix – KEHP Program Changes and Plan Design Provisions

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%		\$10 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*	\$50 co-pay plus 20%	\$50 co-pay plus 40%
Emergency room physician charges	25%*	50%*	20%	40%
Urgent care center treatment	25%*	50%*	\$20 co-pay	40%*
Ambulance services	25%*	25%*	20%*	20%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit co-pay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no co-pay required.	25%*	50%*	\$10 co-pay	40%*
Prescription drugs – Retail (30 day supply)	25%			
	Min	Max		
Generic	\$10	\$25	\$5	40%
Preferred Brand	\$20	\$50	\$15**	40%
Non-preferred Brand	\$35	\$100	\$30**	40%
Prescription drugs – Mail Order (90 day supply)	25%			
	Min	Max		
Generic	\$20	\$50	\$10	
Preferred Brand	\$40	\$100	\$30	
Non-preferred Brand	\$70	\$200	\$60	
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.

Appendix – KEHP Program Changes and Plan Design Provisions

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	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 10%	\$50 co-pay plus 30%*	10%*	40%*
Emergency room physician charges	10%	30%*	10%*	40%*
Urgent care center treatment	\$20 co-pay	30%*	10%*	40%*
Ambulance services	10%*	10%*	10%*	10%*
Maternity care – prenatal care, labor, delivery, postpartum care, and one ultrasound per pregnancy. Additional ultrasounds subject to prior plan approval. Office visit co-pay is limited to the office visit in which pregnancy is diagnosed. Thereafter, no co-pay required.	\$10 co-pay	30%*	10%*	40%*
Prescription drugs – Retail (30 day supply)				
Generic	\$5**	30%	10%*	40%*
Preferred Brand	\$15**	30%	10%*	40%*
Non-preferred Brand	\$30**	30%	10%*	40%*
Prescription drugs – Mail Order (90 day supply)				
Generic	\$10		10%*	
Preferred Brand	\$30		10%*	
Non-preferred Brand	\$60		10%*	
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.

Appendix – KEHP Program Changes and Plan Design Provisions

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	
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%		\$15 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*	\$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 Preferred Brand \$20 Non-preferred Brand \$35	50% Min Max Generic \$25 Preferred Brand \$50 Non-preferred Brand \$100	\$5 \$20** \$40**	
Prescription drugs – Mail Order (90 day supply)	25% Min Max Generic \$20 Preferred Brand \$40 Non-preferred Brand \$70	50% Min Max Generic \$50 Preferred Brand \$100 Non-preferred Brand \$200	\$10 \$40 \$80	
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.

Appendix – KEHP Program Changes and Plan Design Provisions

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	30%*	Plan pays 100%	
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%*	
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.

Appendix – KEHP Program Changes and Plan Design Provisions

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%		\$15 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*	\$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	
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.

Appendix – KEHP Program Changes and Plan Design Provisions

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	30%*	Plan pays 100%	
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	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%*	
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.

Appendix – KEHP Program Changes and Plan Design Provisions

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%*	\$10 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%		\$15 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*	\$115 co-pay plus 0%*	\$115 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%			
Generic	Min \$10	Max \$25	\$10	
Preferred Brand	\$20	\$50	\$25**	
Non-preferred Brand	\$35	\$100	\$45**	
Prescription drugs – Mail Order (90 day supply)	25%			
Generic	Min \$20	Max \$50	\$15	
Preferred Brand	\$40	\$100	\$45	
Non-preferred Brand	\$70	\$200	\$90	
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	Covered the same as under the federal Medicare program		Covered the same as under the federal Medicare program	
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 \$20 preferred brand and \$35 non-preferred brand.

Appendix – KEHP Program Changes and Plan Design Provisions

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)	15%*	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	30%*	Plan pays 100%	
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$85 co-pay plus 15%*	\$85 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%*	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	\$15 co-pay	30%*	10%*	40%*
Autism Services Benefits payable based on services rendered	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 \$20 preferred brand and \$35 non-preferred brand.

**In 2012:**

- KEHP evaluated the advantages and disadvantages of continuing "grandfathered health plan" status under PPACA and determined grandfathered status would be maintained for 2012.
- 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 2012:
  - Most plan deductibles and out-of-pocket maximum amounts were increased slightly (except for Standard PPO);
  - Employee contributions were increased slightly 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 2011 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 \$600/\$1,800 Deductible hybrid PPO plan (changed from \$575/\$1,725 in 2011) with an up-front benefit allowance of \$500 per member;
  - Commonwealth Optimum PPO – a \$355/\$720 Deductible PPO plan (changed from \$345/\$690 in 2011);
  - Commonwealth Maximum Choice – a \$2,325/\$3,530 Deductible consumer-directed plan (changed from \$2,300/\$3,455 in 2011) 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 2011.
- 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.

Appendix – KEHP Program Changes and Plan Design Provisions

2012 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 - \$600 Family - \$1,800	Single - \$1,200 Family - \$3,600
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 - \$2,400 Family - \$7,000	Single - \$4,000 Family - \$9,650
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.	25%*	50%*	\$55 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 an ambulatory center.	25%*	50%*	\$55 co-pay	40%*
Preventive care – annual gynecological exam, routine physical and early detection tests, subject to age and periodicity limits.	Plan pays 100%		\$15 co-pay per visit	40%*
Emergency services				
Emergency room treatment (Emergency room co-pay waived if admitted).	\$50 co-pay plus 25%*	\$50 co-pay plus 50%*	\$115 co-pay plus 0%*	\$115 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	
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	
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 \$20 preferred brand and \$35 non-preferred brand.

Appendix – KEHP Program Changes and Plan Design Provisions

2012 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 - \$355 Family - \$720	Single - \$720 Family - \$1,430	Single - \$2,325 Family - \$3,530	Single - \$2,400 Family - \$3,600
Out-of-pocket maximum (excludes prescription drug co-pays, office visits, hospital emergency room visits and urgent care services)	Single - \$1,350 Family - \$2,700	Single - \$2,700 Family - \$5,350	Single - \$3,550 Family - \$5,280	Single - \$4,700 Family - \$7,000
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%*
Doctor's Office Visits	\$15 co-pay - PCP \$20 co-pay - Specialist	30%*	10%*	40%*
Allergy Serums & injections	\$10 co-pay	30%*	10%*	40%*
Physician Care (Inpatient/Outpatient/Other)	15%*	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	30%*	Plan pays 100%	
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%*	
Chiropractic services – limited to 26 visits per year, with no more than one visit per day	\$15 co-pay	30%*	10%*	40%*
Autism Services Benefits payable based on services rendered	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 \$20 preferred brand and \$35 non-preferred brand.

## Contribution Rates

The following are monthly employee contribution rates split by plan, year, and smoker status:

Non-Smoker					Smoker				
2009	Standard PPO	Maximum Choice	Capitol Choice	Optimum PPO	2009	Standard PPO	Maximum Choice	Capitol Choice	Optimum PPO
Single	\$ -	\$ -	\$ -	\$ 25.00	Single	\$ 21.00	\$ 21.00	\$ 21.00	\$ 46.00
Parent	\$ 64.72	\$ 103.18	\$ 134.14	\$ 167.32	Parent	\$ 106.72	\$ 145.18	\$ 176.14	\$ 209.32
Couple	\$ 305.38	\$ 317.22	\$ 420.96	\$ 445.04	Couple	\$ 347.38	\$ 359.22	\$ 462.96	\$ 487.04
Family	\$ 376.72	\$ 379.44	\$ 498.44	\$ 531.92	Family	\$ 418.72	\$ 421.44	\$ 540.44	\$ 573.92
Cross Reference	\$ -	\$ 9.16	\$ 12.20	\$ 26.86	Cross Reference	\$ 21.00	\$ 30.16	\$ 33.20	\$ 47.86

2010	Standard PPO	Maximum Choice	Capitol Choice	Optimum PPO	2010	Standard PPO	Maximum Choice	Capitol Choice	Optimum PPO
Single	\$ -	\$ -	\$ 5.00	\$ 27.50	Single	\$ 24.00	\$ 24.00	\$ 29.00	\$ 51.50
Parent	\$ 8.28	\$ 108.86	\$ 144.02	\$ 176.52	Parent	\$ 56.28	\$ 156.86	\$ 192.02	\$ 224.52
Couple	\$ 282.18	\$ 334.66	\$ 444.12	\$ 469.52	Couple	\$ 330.18	\$ 382.66	\$ 492.12	\$ 517.52
Family	\$ 288.44	\$ 398.32	\$ 525.84	\$ 561.16	Family	\$ 336.44	\$ 446.32	\$ 573.84	\$ 609.16
Cross Reference	\$ -	\$ 9.66	\$ 12.88	\$ 28.34	Cross Reference	\$ 24.00	\$ 33.66	\$ 36.88	\$ 52.34

2011	Standard PPO	Maximum Choice	Capitol Choice	Optimum PPO	2011	Standard PPO	Maximum Choice	Capitol Choice	Optimum PPO
Single	\$ -	\$ 29.98	\$ 36.54	\$ 61.52	Single	\$ 25.50	\$ 55.52	\$ 61.82	\$ 86.64
Parent	\$ 8.28	\$ 118.66	\$ 156.98	\$ 192.40	Parent	\$ 60.60	\$ 170.98	\$ 209.30	\$ 244.72
Couple	\$ 282.18	\$ 364.78	\$ 483.98	\$ 511.78	Couple	\$ 334.50	\$ 417.10	\$ 536.40	\$ 564.10
Family	\$ 288.44	\$ 434.16	\$ 573.16	\$ 611.66	Family	\$ 340.76	\$ 486.48	\$ 625.48	\$ 663.98
Cross Reference	\$ -	\$ 44.34	\$ 51.74	\$ 68.40	Cross Reference	\$ 24.72	\$ 68.98	\$ 76.50	\$ 93.12

2012	Standard PPO	Maximum Choice	Capitol Choice	Optimum PPO	2012	Standard PPO	Maximum Choice	Capitol Choice	Optimum PPO
Single	\$ -	\$ 30.74	\$ 37.24	\$ 62.74	Single	\$ 25.50	\$ 56.62	\$ 63.06	\$ 88.36
Parent	\$ 8.28	\$ 120.60	\$ 160.00	\$ 195.60	Parent	\$ 60.60	\$ 174.40	\$ 213.48	\$ 249.60
Couple	\$ 282.18	\$ 371.10	\$ 493.00	\$ 520.60	Couple	\$ 334.50	\$ 425.44	\$ 547.12	\$ 575.38
Family	\$ 288.44	\$ 442.00	\$ 584.00	\$ 622.50	Family	\$ 340.76	\$ 496.20	\$ 638.00	\$ 677.25
Cross Reference	\$ -	\$ 45.22	\$ 52.74	\$ 69.74	Cross Reference	\$ 24.72	\$ 70.36	\$ 78.02	\$ 94.98

## Legislative Mandates

The following legislative mandates enacted by the Kentucky General Assemblies may affect the Public Employee Health Insurance Program. This is intended for context and historical purposes only. 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 as such in the either the Insurance Code or Chapter KRS 18A.

History of Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	Bill	Key Provisions
2001	HB 97	The Office of Public Employee Health Insurance was established under the Personnel Cabinet.
2001	HB 138	Coverage of physician assistants assisting in surgery.
2001	HB 145	Personnel Cabinet and Cabinet for Families and Children to prepare recommendations regarding allowing foster parents to participate in the Public Employee Health Insurance Program.
2002	HB 39	Coverage of anesthesia and hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions and persons with significant behavioral problems.
2002	HB 163	Expands Kentucky Group Health Insurance Board to include: <ul style="list-style-type: none"> <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.

<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>
2003	HB 370	Required the Commonwealth’s Public Employee Health Insurance Program to include a scenario that allows regional rating in its 2004 health insurance Request for Proposal, with regions defined as the partnership regions designated by the Department for Medicaid Services.
2003	HB 430	For individuals hired on or after July 1, 2003, increased the service required of participants KRS from a minimum of 5 years to 10 years to be eligible to participate in the Commonwealth’s retiree health insurance program.
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.

<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>
2006	HB380	Provided explicit statutory authority to establish a self-insured health plan for public employees.
2006	HB380	Requires the plan to be established by administrative regulations.
2006	HB380	Provides appeal rights for formulary changes, and ensures independent review of any proposed changes in formulary.
2006	HB380	Establishes a 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.

History of Legislation Enacted by the General Assemblies that Impacts the Public Employee Health Insurance Program		
Year Enacted	Bill	Key Provisions
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.
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.
2011	HB 229	Amend KRS 78.530 to allow agencies that are established by a merger or interlocal agreement consisting of agencies who participated in the County Employees Retirement System (CERS) on or before April 9, 2002, to be exempt from the requirement of signing a contract for employee health insurance with the Personnel Cabinet as a condition of participation in CERS; apply the amendments to KRS 78.530 to existing agencies established before the effective date of the Act.

## General 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. This is intended for context and historical purposes only. 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.

<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.

<b>Kentucky Mandated Health Insurance Benefits</b>	
Temporomandibular Joint Disorder	KRS 304.17-319, KRS 304.18-0365, KRS 304.32-1585 & KRS 304.38-1937. Coverage for specific services related to TMJ and associated disorders. Also see Administrative Regulation 806 KAR 17:090.
Screening Mammography	KRS 304.17-316, KRS 304.18-098, KRS 304.32-1591 & KRS 304.38-1935. Screening mammography at specific intervals. KRS 304.17-316(2)(b) requires mammography coverage at any age for a covered person diagnosed with breast cancer.
Breast Cancer	KRS 304.17-3165, KRS 304.17A-135, KRS 304.18-0985, KRS 304.32-1595 & KRS 304.38-1936. Coverage for the treatment of breast cancer, including ABMT.
Breast reconstruction coverage, endometriosis and endometritis	KRS 304.17-3163, KRS 304.18-0983, KRS 304.38-1934, KRS 304.32-1593 & KRS 304.17A-134. Coverage for the treatment of breast reconstruction.
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.

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

Kentucky Mandated Health Insurance Benefits	
Health benefit plan wellness programs.	SB 114 (2011) creates a new section of Subtitle 17A of KRS Chapter 304 to authorize health benefit plans to offer incentives or rewards to members who participate in a voluntary wellness or health improvement program; the authorized incentives and rewards shall not be deemed a violation of the rebate prohibition contained in KRS 304.12-090 and 304.12.010; if a health plan member is unable to participate in a wellness or health improvement programs due to a medical condition, verification may be required; and, an insurer shall not be prohibited from offering incentives or rewards to members participating in a wellness or health improvement program if otherwise allowed by state or federal.

Source: Kentucky Department of Insurance

## 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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