Status of the Health Insurance Market in Kentucky

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MEMORANDUM

TO: Don Cetrulo, Director
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FROM: Mike Clark, Ph.D.
LRC Staff Economist

SUBJECT: Report of Data on the Number and Characteristics of the Individually Insured, Small-Group Insured, Large-Group Insured, and Uninsured

DATE: January 22, 1998

The purpose of this memo is to report staff analysis of newly available data on four segments of the Kentucky population - those who reported that they obtain health insurance policies in the individual segment of the health insurance market, those who report that they obtain health insurance policies in the small-group segment of the health insurance market, those who report that they obtain health insurance policies in the large-group segment of the health insurance market, and those who reported that they have no insurance, with particular attention given to those who reported being newly uninsured and to uninsured children.

EXECUTIVE SUMMARY

Since the initial health care legislation was passed in 1994, the health insurance market in Kentucky has been constantly changing. House Bill 250, passed in 1994, and Senate Bill 343, passed in 1996, both significantly changed how the health insurance market operated. After the passage of each of these bills, the market responded to these new sets of rules. While there was no doubt that the market was changing, previously there was little information available to show how or how much. However, in 1996 and 1997, the Legislative Research Commission sponsored the Kentucky Health Insurance Surveys. These surveys were aimed at providing detailed information on the status of Kentucky's health insurance market over time. By comparing the market in 1996 and 1997 it is possible to see how the market has changed over time. These changes reflect the impacts of legislation, but are, in part, market reactions to other economic forces.

The Kentucky Health Insurance Surveys focused on four segments of the health insurance market:

- The Individually Insured - those who purchase health insurance directly from an insurance company;
- The Small-Group Insured - those who obtain health coverage through an employer who has fewer than 50 employees;
- The Large-Group Insured - those who obtain health coverage through an employer who has 50 or more employees (surveyed in 1997 only); and
- The Uninsured - those who have no health insurance.

The results of the Kentucky Health Insurance Survey and other data sources were used to estimate the number and characteristics of Kentuckians in these groups.

The data shows that there were substantial changes in the individual market from 1996 to 1997. The number of individually insured decreased from 210,000 to 165,000. In addition, the overall characteristics of the individually insured changed. Females represented a greater share of the market in 1997 than they did in 1996. Household incomes were generally higher in 1997 than in 1996. Also, the health status of the individually insured was better in 1997 than in 1996. These changes are a result of several factors, including changes to legislation and improvements in the economy.

The small-group segment of the market showed significant growth in 1997. The number of Kentuckians with small-group coverage increased to 465,000 from 360,000 (in 1996). Although the small-group market increased by 105,000 people, there was little change in the overall characteristics of this market segment.

The uninsured market segment showed little growth. The percentage of the population that was uninsured in 1997 was not statistically different than the percentage in 1996. The estimate of the uninsured was 560,000 in 1996 and 570,000 in 1997. This difference reflects the change in the population. Comparing the data from 1996 to 1997 appears to

show that there were changes in the characteristics of the uninsured. However, these changes were generally not statistically significant. The uninsured indicated that the cost of health insurance was the reason they do not have coverage, as opposed to access. Half of those who did have insurance at one time lost their coverage because they left their job.

Those who were newly uninsured (within the past year) were generally younger and in better health than all uninsured. The newly uninsured were also more likely to be male. Many of the newly uninsured were adult children living with their parents.

It is estimated that there are approximately 181,000 uninsured children in Kentucky. Eighty percent of the uninsured children have incomes below 200% of the federal poverty level. Approximately 30% qualify for Medicaid.

There were also changes in the health insurance policies sold in Kentucky. Premiums for individual, small-group, and large-group policies generally increased. The data also showed that managed care plans became more common in 1997. In both the individual and small-group markets, policies were less likely to have a deductible in 1997 than in 1996. Those policies with a deductible generally had lower deductibles in 1997 than 1996.

INTRODUCTION

Starting with the initial passage of health insurance legislation (HB 250) by the 1994 Kentucky General Assembly, the Kentucky health insurance market has been in a constant state of change. There has been a great deal of speculation about how these changes have affected Kentuckians. Unfortunately, during the policy debates there was little reliable data to show how many people would be affected or how they would be affected by the provisions contained in the legislation.

To fill this gap, the LRC sponsored the 1996 Kentucky Health Insurance Survey. This survey was aimed at providing the first detailed description of the number and characteristics of people in the markets effected by changes in legislation. The survey was subsequently replicated in the summer of 1997. By comparing the 1997 survey to the 1996 survey it is possible to see not only the current status of the market, but also how the market has changed as people and insurance companies adjusted to legislation and market changes. Unfortunately, because data prior to the enactment of HB 250 is limited and the first survey was conducted after the passage of SB 343, it is not possible to compare the health insurance markets after 1996 to the markets before that time.

This report presents the results of the 1997 Kentucky Health Insurance Survey, combined with other data, to show how the market has changed since 1996. It should be noted that the changes discussed below are not necessarily caused by changes in health insurance laws. Other factors, such as the general state of the economy, can cause changes in the health insurance market. Also, some of the estimates presented in this report have been released as preliminary estimates in previous memos. Where there are differences, the estimates presented in this report should supersede any preliminary results. The report is organized as follows. First is a brief discussion of legislative changes and the likely effects they had on Kentucky's health insurance market. Second is a description of the data sources used. This is followed by an analysis of the various segments of the health insurance market.

HEALTH INSURANCE LEGISLATION IN KENTUCKY

In 1994, the Kentucky General Assembly passed legislation aimed at providing Kentuckians with greater access to health insurance at affordable rates. HB 250 primarily affected health insurance policies sold directly to individuals and small groups (employer groups with fewer than 100 employees). The most significant health insurance provisions of HB 250 required insurers to sell a policy to anyone who applied for coverage (guaranteed issue) and restricted how premiums could be rated (or priced), mandated standard benefit plans, and created a state health purchasing alliance to expand buyer power.

These provisions in HB 250 substantially changed the individual and small-group markets. Prior to HB 250, health insurance premiums were based on the expected costs over a given period of time (typically one year) for the individual or group purchasing the policy.

Those individuals (or groups) with higher expected costs were charged higher premiums. Insurance companies were able to determine which people were more likely to have high future medical costs based on each person's characteristics. For example, younger people generally have lower health care costs than older people and young men generally have lower health care costs than young women. Insurance companies were also able to use medical histories or health status to determine the likelihood of future claims. These, and other, characteristics were used to estimate the costs of future claims during the policy period. Premiums were then set on this basis. This process is typically referred to as experience rating. A criticism of experience rating was that those with serious medical conditions were sometimes charged prices that were not affordable, or were denied coverage altogether.

Under HB 250, rating on health status and gender was prohibited. While premiums could be rated based on age, the premium charged for the oldest policy holder could not be more than three times the premium charged for the youngest policyholder. Under these rating rules, companies were required to charge the same premium to people of the same age regardless of gender or health status. With HB 250, companies set premiums by looking at the expected health care costs of an entire group (for example, all 18-year-olds). Each person insured would pay the average expected costs.[1] People in groups that were in poorer health, on average, would have paid higher premiums than those in groups that were healthier, on average. So while all 18 year olds paid the same rate, their rate was lower than the 60 year olds, because 60 year olds were more likely to have higher costs. HB 250 also restricted the extent to which age could be used to set premiums. The premium charged for the oldest policy holder could be no more than three times the premium charged for the youngest policyholder. This should have lowered the premium for older people, while increasing the premium for the younger people. This process is referred to as modified community rating (MRC). MRC is less restrictive than pure community rating, which requires that companies charge the same premium regardless of variations in any demographic or health characteristics.

Under MCR, the healthy people within a rating group tend to subsidize unhealthy people in the rating group. Health insurance premiums for the healthy increase over their expected health care costs, while premiums for the unhealthy decrease below their expected costs. This was expected to allow people with high cost medical conditions to obtain health insurance at lower costs and allow some people who had been priced out of the market to purchase insurance. Lower prices for those with medical conditions provides an incentive for people who had been priced out of the market to purchase new coverage. However, access to health insurance does not come without costs. Because those with high health care expenses pay less under MCR, the healthy most pay more. Higher rates also discourage the healthy from purchasing insurance and could induce some healthy people to drop coverage.

Given the rating restrictions placed on the individual and small-group markets, insurance companies had an incentive to deny coverage for the unhealthy. If an insurance company

[1] Premiums will actually be higher to cover administrative costs and provide a profit for the company.

could identify and deny coverage to those who had health care costs that were higher than the premium they paid, companies could lower their costs per covered life. In an attempt to prevent this, HB 250 also required guaranteed issue in the individual and small group markets. Guaranteed issue prevents insurers from denying coverage for all but a few reasons, such as fraud. It was intended to reduce insurance companies' ability to select only low-cost, healthy people.

Insurance companies were also required to offer only standard benefit plans. Standard plans were a way of making coverage comparable across all companies, to allow easier price comparisons. Each of the eight standard plans specifies the levels of coverage provided and other policy provisions, such as co-payments and deductibles. For example, in addition to its other provisions, an enhanced high standard plan through an HMO has maximum out-of-pocket expenses of $1,000, requires no deductible, and requires various co-payments depending on the service. The provisions of this policy are the same for all companies offering it. The standard plans consist of eight plans, with each of the eight plans offering various levels of benefits. This requirement forced each company to provide the same benefits for a given standard plan. Standard plans across all companies providing individual coverage was further expected to reduced the ability of companies to discourage high cost customers while attracting low cost customers. Without standard plans, policies could be constructed to discourage high cost people. For example, if an insurance company did not want to insure young females, it could exclude maternity benefits. With each company offering the same benefits it was hoped that companies would compete on price and quality of services. The cost of this, however, is that customers may not be able to purchase the exact set of benefits they prefer.

HB 250 did not affect everyone insured under an individual or small-group policy. An executive order from Governor Paul Patton temporarily allowed holders of any individual or small-group policy prior to July 1995 the right to renew their existing benefit plan at the existing price. Therefore, these policies did not come under the reforms of HB 250. Initially, the freeze was to last until July of 1996. At that time, the policies would have to conform to the provisions of HB 250. However, additional orders were issued that extended the freeze until December 1, 1997. Pre-reform policies that renew after December 1, 1997 must conform to current legislation.[2] It is most likely that the people who took advantage of the freeze were those who expected their premiums to increase under reforms.

During the 1996 regular session, the General Assembly again addressed the issue of health insurance and made additional changes to the initial reforms of HB 250. SB 343 redefined small groups so that employers with 50 to 99 employers were no longer considered small groups. Policies sold to these groups were no longer subject to guaranteed issue or restrictions on rating. SB 343 also changed the rating restrictions imposed by the initial reforms. Companies providing individual and small group policies could now rate on

[2] The Executive Order extending the freeze until December 1, 1997 also gave insurance companies the option to file their pre-reform plans as "standard" plans. This allows people with pre-reform plans to maintain their benefit levels.

gender. Also, the rating spread for age was increased. However, the most substantial change to the reforms was the exclusion of insurance policies sold through associations from the rating restrictions.

The changes to rating restrictions moved the individual and small-group market closer to setting premiums based on the expected costs of the individual people rather than the expected costs of the group. Lifting the restriction on gender rating allowed companies to charge different rates for males and females. Because males and females for any given age have different health care costs on average, gender rating permits companies to reflect those different costs in their premiums. Under the rating restrictions of HB 250, young males were subsidizing young females, because young females generally have higher health care costs. Similarly, older females were subsidizing older men. Increasing the rating spread for age also allowed companies to reflect differences in expected costs for age in their rates. Older people generally have more and higher claims than the young. Increasing the age spread reduces the subsidy of older people by younger people. Overall, allowing gender rating and increasing the age spread had an effect opposite to that of HB 250; those with low expected costs should have seen their premiums decrease, while those with high expected costs should have seen their premiums increase. However, these effects from SB 343 would have only partially offset the effects of HB 250, because the age spread is limited and premiums still could not be based on health status.

The most significant market change was the exemption of associations from the rating restrictions placed on the individual and small-group markets. Because of the exemption, individual and small-group policies sold through an approved association may be rated on health status, with no limits on the spread for age. Therefore, premiums through the associations are based on the expected cost of the individual or of the small-group, as they were for the entire market prior to HB 250. For those insured under an association there are no subsidies; those with low expected health care costs are charged low premiums and those with high expected health care costs are charged high premiums. Individuals and groups with lower than average expected costs have an incentive to purchase health insurance through associations because their premiums will be lower. Those with high expected costs will prefer to purchase health insurance through the non-association market, where the healthier people in the market subsidize the unhealthy. Over time, this is expected to cause the market to move back to pure experience rating, as the healthiest people in the non-association market will always be able to find lower premiums through an association. As these people move to associations, those remaining will have to pay higher premiums to reflect the higher average costs.

The health insurance legislation had additional effects on the market beyond rates. In June and July of 1995, prior to the implementation of HB 250, several insurance companies chose to stop selling individual policies in Kentucky. This turned into a trend, and most of the health insurance carriers stopped selling individual policies in Kentucky. According to the Department of Insurance, over 40 companies have left the market. Currently in Kentucky, individual coverage is only available through Kentucky Kare[3] and Blue Cross /

[3] Kentucky Kare was originally established as the self-insured plan to cover state employees.

Blue Shield. Although most of the insurance companies left the individual market, they accounted for a relatively small share of the covered lives in the individual market. The most common explanation for why companies left the market is that companies were not making a profit in the individual market. Low profits may be have been caused by the rating restrictions limiting premiums or the regulatory constraints increasing costs.

In the near future there are several possible sources for additional change in the health insurance market. First, people with pre-reform policies that were frozen by the executive order will have to find new coverage that conforms to current legislation. Because both premiums and coverage have been frozen since 1995, there may be large increases in premiums and changes in coverage for those affected by the freeze. The second source of change may be legislative. Several proposals were discussed during the 1997 Special Session on Health Insurance, such as high-risk pools and "pay or play" proposals. While no legislation was passed during the special session, discussion of health insurance is likely to continue during the 1998 Regular Session. Passage of any of these proposals would have substantial impacts on the health insurance market.

DATA SOURCES

Data on insurance status and demographic characteristics was collected in two separate random surveys of Kentucky households: the 1997 Kentucky Health Insurance Survey and the Current Population Survey for various years (CPS). These surveys were conducted at different times, asked different questions and have different strengths and limitations for the analysis. Therefore, the decision was made to draw on each data source as it was judged to provide a more reliable estimate of the characteristics of the population of interest. Results from the two sources are not always strictly comparable, and may even provide substantially different estimates because of their differences in timing, methodology, and content.

1997 KENTUCKY HEALTH INSURANCE SURVEY

Data for the 1997 Kentucky Health Insurance Survey was collected through a telephone survey administered by the Urban Studies Institute at the University of Louisville. The purpose of the survey was to provide information regarding the characteristics and insurance status of all people in Kentucky. However, four market segments were of primary interest: Individually insured, small-group insured, large-group insured, and the uninsured. The survey was conducted in two phases. The initial phase consisted of randomly interviewing households regarding their health insurance. The second phase consisted of oversampling certain segments of the health insurance market.

The initial phase of the survey began on May 17, 1997. The Urban Studies Institute interviewed 1,259 households to provide a picture of the overall health insurance market. To generate the 1,259 completed surveys, 3,497 households were contacted. Of those, 1,567 were determined to be ineligible for various reasons, such as language barriers or no

answer after repeated attempts. In addition, 783 refused to participate or terminated the interview before completion. This yielded an overall response rate of 62%. The overall margin of error for estimates on the first phase of the survey is plus or minus 2.8%.

The second phase of the survey involved interviewing additional households in certain segments of the health insurance market: Individually insured, small group insured, and uninsured. Previous surveys showed that the size of these markets were small relative to the whole market. Therefore, the number of respondents from phase one that fell into each segment was expected to be too small a sample to provide meaningful analysis within each segment. Larger sample sizes were needed in these segments to be able to determine their characteristics and provide meaningful comparisons. This phase of the survey was completed on September 15, 1997. Table 1 shows the final sample sizes, along with margins of error for each segment.

Table 1
1997 Kentucky Health Insurance Survey

Market Segment	Number of Households Sampled	Margin of Error
Individual	373	5.1%
Small-Group	463	4.6%
Large-Group	614	4.0%
Uninsured	646	3.9%

Content

So as to interview the person most knowledgeable of the household's characteristics and health insurance coverage, the survey was directed to the head of the household. The respondents were asked questions regarding each person in the household and their insurance status. The survey was tailored so that the questions asked were determined by the insurance status of the individuals.

If the respondents had insurance through an individually purchased plan or through an employer provided plan, they were asked questions regarding each of the policies covering them. The information collected included the level of benefits, amount of co-payments or deductibles, and the premiums paid for the policy. In the case of coverage provided by an employer, the respondents were also asked how much they paid for premium and how much the employer paid. In addition, respondents were asked if the policy was one of the standard plans and if the policy was purchased through the Kentucky Health Purchasing Alliance. Finally, they were asked if there had been any changes to the policies in the past year, and if so, what those changes were.

Respondents were asked several questions about each member of the household. In addition to insurance status, information was collected on age, gender, education, employment, and health status. Respondents were also asked if household members had been previously refused health insurance, suffered from one of a list of serious medical

conditions generally considered uninsurable (such as heart disease, diabetes, and cancer), or had been newly insured in the past 12 months. Those household members covered by the policies referenced above were asked questions about utilization of medical care, such as how many times they had been to a doctor in the past year.

Finally, if the household heads were uninsured, they were asked why they did not have health insurance. Because responses to these questions were asked only to the head of the household, they are not necessarily generalizable to the population.

Differences in Methodology from the 1996 Kentucky Health Insurance Survey

Although the 1997 Kentucky Health Insurance Survey is largely a replication of the survey conducted in 1996, there are several changes worth noting.[4] The most substantial difference is that the 1997 survey was expanded in scope to include the large-group insured. The 1996 survey limited its focus to the individual and small-group markets and the uninsured. The reason for this was that the primary policy issues focused on these groups. While this is still the case, it was deemed important to have information on all segments of the population to provide comparisons between groups.

A second difference is that the 1997 survey obtained the total number of people in the household. Because federal poverty thresholds are based on the household size and household size was not obtained in the 1996 survey, analysis for different poverty levels was previously not possible.

Also, in the 1996 survey, market shares were based on the number of policies each company provided rather than the number of people covered under those policies. The 1997 survey allows for the calculation of market shares based on the number of covered lives.

Finally, due to differences in the way occupation data was collected, direct comparisons between occupations in the 1996 survey and the 1997 survey are not possible.

Limitations

With any data collection method there are strengths and weaknesses. The strengths of a telephone survey are the short time period needed to collect data and the relatively low cost. The weakness, however, is that a portion of the population is not represented in a telephone survey. Therefore, households without phones are not represented in the Kentucky Health Insurance Survey.

A Statistical Brief from the Bureau of the Census, *Phoneless in America*, estimated that, in 1990, approximately 10% of Kentucky households were without a phone. More recent

[4] For a detailed description of the 1996 Kentucky Health Insurance Survey, see Research Memorandum No. 474: Numbers and Characteristics of the Individually Insured, Small-Group Insured, and Uninsured in Kentucky.

estimates from the 1996 Current Population Survey show that approximately 8.8% of the Kentucky population are without a phone. The statistical brief also found that, for the nation, those without phones tended to be young and male. While this is generally not a problem in most applications of the survey data, by not accurately representing this portion of the population the phone survey could potentially bias certain estimates. Bias results when an estimate does not accurately reflect the number being estimated. For example, the education level of the state cannot accurately be measured by sampling only people at a university. The level of education at a university will likely be higher than the state. Similarly surveying only people with phones can potentially bias estimates of the health insurance market if those without phones exhibit different characteristics than those with phones. This has the most potential to be a problem for estimating numbers and characteristics of the uninsured and the poor. Reasonable alternatives were used where possible. Where alternatives were not available, it is believed that the bias does not substantially change the results. Based on the Statistical Brief, for estimates that cannot be substituted, young males will be over-represented.

A second limitation of the data was the measures of health status. Several questions regarding health were asked with the intention of creating a health index by combining the five questions. However, in four questions a large portion of the sample responded with "don't know". Because a large share of the sample was unable to answer the health questions, the health index would not be very useful and therefore was not calculated. Instead, health status is measured by the responses to the question regarding the individual's general health.

The final limitation of the data is that detailed information was collected only for policies covering the head of household interviewed. However, policy characteristics are not expected to be substantially different for the policies for which detailed information was not collected.

MARCH SUPPLEMENT TO THE CURRENT POPULATION SURVEY

In March of every year, the Census Bureau supplements the monthly current population survey (CPS) with an extensive set of questions regarding household income and benefits for the prior year. In some years, the Census will add or modify certain questions to better collect information on a particular policy issue of interest. The March 1996 Supplement to the CPS included questions designed to obtain more complete information on the source of health insurance coverage. The CPS is used, where possible, to address the limitations of the 1997 Kentucky Health Insurance Survey.

The March 1996 CPS sample was about 50,000 households nationwide. Since information was collected for each member of the household, the sample includes over 150,000 individuals. The sample was designed to be nationally representative of the civilian non-institutional population of the United States. The March 1996 CPS sample includes 767 Kentucky households, with 1,524 individuals. Results from other years of CPS data are reported as noted.

DESCRIPTION OF INSURANCE MARKET SEGMENTS

The market for health insurance in Kentucky can be separated into several distinct segments for the purposes of analysis. The first segment is comprised of those who obtain coverage for medical services through a government program, such as Medicare or Medicaid. Because this group was not affected by changes in the Kentucky law, it is not considered here. Also, since there is nearly universal coverage of those 65 and older under Medicare, estimates for relevant categories of the privately insured and uninsured are presented both as a percent of the total population and as a percent of the non-elderly population.

The remaining segments are the individually insured, the small-group insured, the large-group insured, and the uninsured. The individual segment of the market is composed of policyholders who do not obtain health insurance as a member of an employee group, but who purchase it directly from an insurance carrier. Next is the segment of the market comprised of those who obtain health insurance as part of an employee group. In this segment of the market, the employer negotiates with an insurer for plans to offer eligible employees. Employers may or may not contribute to the employees' premiums, but the pricing of the policy is such that the premiums for the policies usually reflect the average characteristics of the group, rather than the individual. SB 343 restricted the limits on the factors which can be used to price health insurance policies to employers with fewer than 50 employees, so the small-employer and large-employer segments of the market are discussed separately in this report. The final segment is the uninsured, those who do not have coverage in either the private market or through a government plan.

Table 2 shows the distribution of Kentuckians across the market segments. Estimates are obtained primarily from applying the results of the 1997 KHIS to the Bureau of Census estimate of the Kentucky population in 1996.

Table 2			
Insurance Status of Kentuckians			
1997			
	Number	**Percent**	
Population: 7/1/96 (a)	**3,880,000**	**100.0%**	
Less: Uninsured (b)	570,000	14.6%	
Total Insured	**3,310,000**	**85.3%**	
Less: Government Insured (c)	880,000	22.7%	
Privately Insured	**2,430,000**	**62.6%**	
Insurance Companies (d)	1,630,000	42.0%	
Individually Insured	165,000	4.3%	
Small-Group Insured	465,000	12.0%	
Large-Group Insured	1,000,000	25.8%	
Self-Insured (mostly large groups) (e)	800,000	20.6%	
Source: LRC staff estimates based on notes below			
Notes:			
a. U.S. Census Bureau.			
b. Estimate from the 1996 Current Population Survey (CPS), published by the Census Bureau.			
c. Rounded estimates of Medicare, Medicaid net of Medicare, and other government coverage (such as CHAMPUS & VA) net of all other coverage, from 1997 Health Insurance Survey.			
d. Rounded estimates from the 1997 Health Insurance Survey except for the estimate of associations which was taken from the Department of Insurance, Market Report on Health Insurance.			
e. Estimated by applying national percentages, published by the Bureau of Labor statistics, to the distribution of KY firms by size, and updated from the 1993 base.			

Entire Market

To provide a basis of comparison, survey results for non-elderly adults in all segments of the market are provided in Table 3. Respondents were fairly young; nearly half were below the age of 40. Fifteen percent lived in households with family incomes below the federal poverty level, while 57% lived in households with family incomes of 250% or more of the federal poverty level. The median household income category reported was $35,000 to $45,000. Seventy percent of those surveyed were employed, with 83% of the employed working over 35 hours per week.

Table 3

Demographic Characteristics of All Non-elderly Adults

Characteristic	Percent 1997	Characteristic	Percent 1997
Gender		**Health in General**	
Male	46%	Excellent	33%
Female	54%	Very Good	29%
		Good	22%
Age		Fair	10%
Less than 30	23%	Poor	6%
30 to 39	24%		
40 to 49	27%		
50 to 59	19%	**Smoked Regularly in Past 2 Years**	33%
60 to 64	7%		
Annual Household Income			
Less than $10,000	11%	**Number of Dr. Visits in Last Year**	
$10,000-$15,000	9%	0	17%
$15,000-$25,000	14%	1-2	42%
$25,000-$35,000	15%	3-4	20%
$35,000-$45,000	13%	5-6	9%
$45,000-$55,000	12%	More than 6	13%
More than $55,000	26%		
Household Income as a Percent of the Federal Poverty Level (FPL)		**Amount Spent Out-of-Pocket for Health Care During Past Year**	
Less than 100% of FPL	15%	$0	22%
100% to 149% of FPL	12%	$1 - $249	49%
150% to 249% of FPL	16%	$250 - $499	9%
250% or more of FPL	57%	$500 - $999	8%
		$1000 - $4999	10%
Work Status		$5000 - $9999	1%
Employed	70%	$10,000 or more	1%
If employed, part time	17%		
		Sample Size	1929

* Indicates that changes from 1996 to 1997 are statistically significant at the 5% level.

Source: 1997 Kentucky Health Insurance Survey.

Sixty-two percent of the sample had a reported health status of very good or excellent. Only 6% reported a health status of poor. Thirty-three percent indicated that they had smoked in the past two years. Seventeen percent had not seen a doctor in the past year. On average the respondents visited a doctor four times in the past year.

Table 4

Demographic Characteristics of All Privately Insured Non-elderly Adults

Characteristic	Percent 1997	Characteristic	Percent 1997
Gender		**Health in General**	
Male	46%	Excellent	37%
Female	54%	Very Good	30%
		Good	22%
Age		Fair	9%
Less than 30	21%	Poor	3%
30 to 39	23%		
40 to 49	29%		
50 to 59	19%	**Smoked Regularly in Past 2 Years**	29%
60 to 64	8%		
Annual Household Income			
Less than $10,000	2%	**Number of Dr. Visits in Last Year**	
$10,000-$15,000	6%	0	15%
$15,000-$25,000	12%	1-2	44%
$25,000-$35,000	16%	3-4	21%
$35,000-$45,000	16%	5-6	9%
$45,000-$55,000	15%	More than 6	11%
More than $55,000	33%		
Household Income as a Percent of the Federal Poverty Level (FPL)		**Amount Spent Out-of-Pocket for Health Care During Past Year**	
Less than 100% of FPL	4%	$0	21%
100% to 149% of FPL	9%	$1 - $249	51%
150% to 249% of FPL	17%	$250 - $499	10%
250% or more of FPL	71%	$500 - $999	8%
		$1000 - $4999	9%
Work Status		$5000 - $9999	1%
Employed	80%	$10,000 or more	1%
If employed, part time	14%		
		Sample Size	1400

* Indicates that changes from 1996 to 1997 are statistically significant at the 5% level.

Source: 1997 Kentucky Health Insurance Survey.

Table 4 shows the survey results for all privately insured, non-elderly adults in Kentucky. The privately insured consists of only those who purchase insurance through the individual or group market. The uninsured and those with government health insurance are excluded. The privately insured differ primarily from the uninsured and government insured in terms of household income. Those purchasing private insurance generally have higher incomes. This result is fairly intuitive, since those with government insurance typically qualify for the programs because they have low incomes or are retired. Those who are uninsured are often unemployed or employed in lower-paying jobs that do not provide insurance or do not pay enough to make health insurance affordable.

Individual Market

The individual health insurance market is comprised of those who purchase health insurance directly from an insurer rather than purchasing it as a member of an employee group. This segment of the health insurance market has particularly been at the center of the policy debate. While the individually insured were not the only ones effected by reforms, this market segment has experienced the most substantial change.

Number Covered Under Individual Policies

It is estimated that, in the summer of 1997, approximately 4.3% of the Kentucky population (4.1% of the Kentucky non-elderly population) was covered by a policy purchased directly from an insurer. The margin of error on the estimate is +/- 0.7%, so that there is a 95% probability that the actual percentage is between 3.5% and 5.0%. When these percentages are applied to the Bureau of Census estimate of the 1996 Kentucky population, the estimate of the number of individually insured is between 150,000 and 180,000, with a point estimate of 165,000.

The estimate for 1997 shows a statistically significant decrease in the number of individually insured from the 1996 estimate of 210,000. While the net change was a decrease, it should be noted that the pool of people with individual insurance is dynamic over time. That is, people are constantly moving in and out of the individual market.

People will move out of the individual market as they find employment that provides coverage, as premiums become unaffordable, or as they get government insurance.[5] The tight labor market may have provided the individually insured with greater access to group coverage, by providing more employment opportunities. According to the Bureau of Labor Statistics, the national unemployment rate is the lowest it has been for many years. In this tight labor market, employers are finding it increasingly difficult to find workers and are recruiting the self-employed. The self-employed are common purchasers of individual policies. As they move to traditional employment they often obtain coverage under group policies offered by the employer. Additional support for this hypothesis is found in the next section, where it is shown that the number of people covered by small-group policies has increased since 1996. This is consistent with people finding employment. Increasing premiums may also have been a factor that contributed to the decrease in the individual market. Although no proof has been provided that overall premiums have increased in the individual market relative to the other market segments, there have been stories of people receiving large rate increases. Certainly, there have been events that could have caused premiums for some people to increase. The rating changes in SB 343 likely caused rates to increase for some groups. In addition, the loss of most companies selling individual policies may have put upward pressure on prices. If premiums for individual policies have been increasing, then people may choose to go uninsured or find insurance through an employer rather than paying the higher rates. The

[5] Premiums can become unaffordable as rates increase or as a person's income decreases.

limited choice of insurance companies may also have discouraged people from seeking individual coverage.

Although there was a large number of people leaving the individual market, there were people entering the individual market, also. People may decide to purchase individual coverage for several reasons. For example, a person may lose a job that provided group coverage, or a college student may no longer qualify for coverage under a parent's policy. In these situations, an individual policy is purchased to replace the lost coverage. Another source of people entering the individual market is the uninsured. The uninsured react to several factors when deciding to purchase individual coverage. The first factor is the need for health insurance coverage. A change in one's health status could make health insurance more valuable and provide the incentive to purchase individual coverage. The second factor is the uninsured's ability to afford individual coverage. Either lower premiums or higher incomes will induce the uninsured to purchase an individual policy. Regardless of whether there are changes in premiums or incomes there will always be new entrants into the individual market. While it is not possible to determine how many people are entering the individual market, the percentage of the individually insured that were previously uninsured can be estimated. The 1997 KHIS asked respondents who were covered by an insurance policy if they were insured 2 years ago. Two years was used because the reforms in HB 250 did not go into effect until the summer of 1995, two years before the survey was conducted. Approximately, 13% of the individually insured were uninsured two years ago. This is twice the percentage in the group (small and large) market. Of these, 23% indicated they obtained individual coverage because the premiums became affordable (either premiums decreased or their incomes increased); the remaining 77% stated other reasons.[6]

Characteristics of Adults Covered Under Individual Policies

Characteristics of the non-elderly adults covered under individual health insurance policies in Kentucky are shown in Table 5. Approximately 56% of the individually insured were female. This represents a substantial change from the 1996 survey. In 1996, females represented less than half of the non-elderly individually insured adults. The change in gender distribution likely reflects changes in the rating provisions from HB 250 to SB 343 and other changes in the economy.

[6] Unfortunately, because the sample size of the number of people individually insured in 1997 and uninsured in 1995 is small, the estimates of why they obtained insurance have large margins of errors and should only be used as rough approximations.

Table 5

Demographic Characteristics of Individually Insured Non-elderly Adults

Characteristic		Percent		Characteristic		Percent	
		1997	1996			1997	1996
Gender				**Health in General**			
Male	*	44%	53%	Excellent	*	42%	33%
Female	*	56%	47%	Very Good		33%	30%
				Good	*	16%	21%
Age				Fair	*	6%	10%
Less than 30		20%	23%	Poor	*	3%	6%
30 to 39		22%	20%				
40 to 49		24%	23%				
50 to 59		22%	22%	**Smoked Regularly in Past 2 Years**		27%	27%
60 to 64		13%	11%				
Annual Household Income							
Less than $10,000	*	5%	8%	**Number of Dr. Visits in Last Year**			
$10,000-$15,000		5%	6%	0		20%	20%
$15,000-$25,000		17%	19%	1-2	*	47%	40%
$25,000-$35,000	*	15%	24%	3-4	*	16%	21%
$35,000-$45,000		12%	13%	5-6		8%	7%
$45,000-$55,000	*	14%	9%	More than 6		9%	12%
More than $55,000	*	31%	21%				
Household Income as a Percent of the Federal Poverty Level (FPL)				**Amount Spent Out-of-Pocket for Health Care During Past Year**			
Less than 100% of FPL		4%	-	$0		23%	-
100% to 149% of FPL		12%	-	$1 - $249		42%	-
150% to 249% of FPL		19%	-	$250 - $499		12%	-
250% or more of FPL		65%	-	$500 - $999		9%	-
				$1000 - $4999		11%	-
Work Status				$5000 - $9999		1%	-
Employed		67%	-	$10,000 or more		0.4%	-
If employed, part time		27%	-				
				Sample Size		528	609

* Indicates that changes from 1996 to 1997 are statistically significant at the 5% level.

Source: 1997 & 1996 Kentucky Health Insurance Surveys.

With the passage of HB 250, insurance companies in the individual market could no longer set premiums based on gender and were limited on how much premiums could vary based on age. Although the rating provisions did not effect those with pre-reform policies, they likely had a significant effect on the distribution of the individually insured. Because average costs for males and females of the same age are generally not equal, prohibiting gender rating created cross-gender subsidies. Similarly, because average costs are different across age groups, there was potential for subsidies across age, as well. Claims data from Kentucky Kare illustrates the differences between the average cost for females and males for various age groups (Table 6). On average females between the ages

of 21 and 50 have much higher health care costs than males of similar age. However, males between the ages of 51 and 64 have higher average costs than females of the same age. For both males and females, health care costs increase as age increases. Prior to HB 250, premiums would have reflected these differences in average costs. However, the rating restrictions of HB 250 forced prices to be equal for males and females of the same age and caused the average premiums for each age group to change.[7] The legislation likely caused premiums for young males to increase above their expected costs. The effect on young females is not as clear. Rating females with males should have lowered premiums for young females. However, the rating restrictions put on age should have caused the premiums for young females to increase. The net effect of these changes is uncertain. If the increase from the age restriction was larger than the decrease from rating females and males together, then the premiums for young females would have increased. The premiums for older males should have decreased because they were being rated with the older females, who have lower health costs, and the age restrictions lowered premiums for older people in general. As with the younger women, the change in premium for older women is uncertain. As premiums adjusted to the rating restrictions of HB 250, consumers likewise adjusted. Older males would be attracted to the individual market because of the decrease in premiums. Younger males would be more likely to leave the individual market because of the higher premiums. Females would enter or exit the market depending on how their premiums changed. The 1996 KHIS data largely reflects the individual market under HB 250.

Table 6
Gender and Age Ratios
Kentucky Kare
Claims Incurred in 1996

	Females				Males				Female to Male
Age	Covered Lives	Total Claims	Claims per Covered Life (A)		Covered Lives	Total Claims	Claims per Covered Life (B)		Gender Ratio (A/B)
21-30	4,065	$ 4,924,887	$ 1,212	(C)	3,004	$ 1,576,999	$ 525	(E)	2.3
31-40	6,210	$ 9,104,510	$ 1,466		3,628	$ 3,362,796	$ 927		1.6
41-40	10,412	$ 19,655,735	$ 1,888		6,376	$ 9,510,861	$ 1,492		1.3
51-60	7,710	$ 19,428,310	$ 2,520		5,094	$ 13,762,906	$ 2,702		0.9
61-64	2,497	$ 7,840,572	$ 3,140	(D)	1,667	$ 5,863,697	$ 3,518	(F)	0.9
Total	30,894	$ 60,954,014	$ 1,973		19,769	$ 34,077,259	$ 1,724		1.1
	Age Ratio	---------->	2.6 (D/C)				6.7 (F/E)		

Source: LRC staff analysis of data supplied by Humana, Inc., the claims administrator for Kentucky Kare and by PlanSource, former data administrator for the Kentucky Health Purchasing Alliance.

[7] Rates could still vary based on occupation and location.

SB 343 again allowed for premiums to reflect gender differences and reduced the constraints on age. As premiums adjusted to SB 343, premiums for older men should have increased, providing them less incentive to purchase insurance in the individual market. However, premiums for young men should have decreased, providing a greater incentive for them to purchase insurance in the individual market. Again the change in premium for females is uncertain.

The 1997 data shows that there was a decrease in the number of young males, young females, and older males. Older females, however, actually increased in number. This is the only segment of the market that increased from 1996 to 1997. The higher exit rate of men from the individual market may be related to the tight labor market, rather than changes in legislation. As the labor market improves, both men and women have a greater probability of finding employment. However, fewer women in the individual market may be looking for employment than men. Overall, a greater percentage of men participate in the labor force than women. A person is considered participating in the labor force if employed or actively seeking employment. The U.S. Bureau of Labor Statistics estimated that in 1996 the participation rate of males in Kentucky was 70%, while the participation rate of females in Kentucky was only 56%. If this difference carries over to the men and women in the individual market, then men would be more likely to obtain employment, which may provide access to group insurance. In addition, men who do find employment may be more likely than the women who find employment to find jobs that offer group coverage. According to an article from the U.S. Department of Labor,[8] women generally work fewer hours than men. This could effect their eligibility for group coverage, because many group plans require a minimum number of hours worked to participate. However, the extent to which changes in legislation or the economy has effected the individual market is not known. In addition, numerous other factors may have caused the gender distribution of the individual market to change.

Respondents were fairly evenly distributed across most age categories. Compared to all privately insured (individual, small-group, and large-group) non-elderly adults, the individually insured respondents were generally older. However, this does not represent a statistically significant change from the individually insured in the 1996 survey. That is, the age distribution of the individually insured has been fairly stable over the past year.

The median household income for this market segment fell within the range of $35,000 and $45,000. Household incomes were somewhat lower for the individually insured than all privately insured non-elderly adults. Although the difference is small, it is statistically significant. Incomes for the individually insured were generally greater in the 1997 survey than they were for the individually insured in the 1996 survey.

Health status was better for the non-elderly, individually insured adults than all privately insured non-elderly adult respondents. Seventy-five percent of the individually insured had a health status of excellent or very good, compared to 67% of all privately insured

[8] "How Long is the Workweek," Issues in Labor Statistics, U.S. Department of Labor, Bureau of Labor Statistics, February 1997.

respondents. This also represents a change in health status from the individually insured in 1996. In the 1996 survey only 63% of the individually insured indicated their health was excellent or very good. One factor that may have contributed to the improved health of the individual market is the association's exemption from MCR that was passed in SB 343. The exemption allowed associations selling individual health insurance to rate their policies based on health status. Compared to MCR, this encourages healthy people to purchase individual coverage through associations, but discourages unhealthy people.

Twenty-seven percent of the individually insured smoked regularly in the past 2 years. Perhaps due to their better health status, the individually insured were less likely to have been to a doctor in the past year than all privately insured non-elderly adult respondents. On average, the individually insured visited a doctor three times in the past year. Approximately 23% of the individually insured non-elderly adults indicated that they did not have any out-of-pocket medical expenses beyond premiums. Of those who had out-of- pocket expenses, 55% indicated that their expenses for the past year were below $250. Approximately 2% of those who had out-of-pocket expenses paid over $5,000 out-of-pocket in the past year. It should be noted that these expenses do not include insurance premiums the respondents paid and do not include expenses paid by the insurance companies.

Table 7 shows the percentage of the total sample of individually insured adults that fell into the various age, gender, and health status categories. While the percentage for any particular cell may have substantial error, the overall distribution of percentages should be a fairly accurate depiction of the distribution of adults covered under individual policies by age, gender, and health status.

Table 7 Distribution of Individually Insured Adults Age, Gender, and Health Status						
Males	**Health Status Category**					
Age	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**	**Total**
Less than 30	6%	2%	1%	0%	0%	9%
30 to 39	5%	3%	3%	0%	1%	11%
40 to 49	5%	4%	2%	1%	0%	11%
50 to 59	3%	3%	2%	1%	1%	10%
60 to 64	1%	2%	1%	1%	0%	4%
Male Totals	**19%**	**14%**	**7%**	**3%**	**2%**	**44%**
Females						
Age						
Less than 30	5%	4%	1%	0%	0%	11%
30 to 39	6%	4%	1%	0%	0%	12%
40 to 49	6%	4%	2%	1%	0%	13%
50 to 59	3%	4%	3%	2%	0%	12%
60 to 64	3%	3%	2%	1%	0%	9%
Female Totals	**22%**	**20%**	**9%**	**4%**	**1%**	**56%**
Overall Totals	**42%**	**33%**	**16%**	**7%**	**3%**	**100%**
Note: Zeros may represent numbers that are less than 0.5%.						
Source: 1997 Kentucky Health Insurance Survey.						

Table 8 shows companies' market share for people with individual policies.[9] Blue Cross / Blue Shield accounted for nearly 60% of the individually insured non-elderly adults. Kentucky Kare and Humana each covered approximately 3%. For 3% of the people surveyed, the respondents were not able to provide the name of the company issuing the policy. Various other companies with small shares of the market covered the remaining 32%. Although Blue Cross / Blue Shield and Kentucky Kare are the only companies currently writing new policies in the individual market, several companies, including Humana, continue to renew old policies.

[9] The market shares presented in Tables 5 and 10 are different than those presented in Research Memorandum No. 474. Research Memorandum No. 474 presented companies' share of policies. Tables 5 and 10 present market shares of covered lives. Market shares of policies for 1996 and 1997 are presented in Appendix A.

Table 8

Market Share of Companies Offering Individual Coverage

Company	Percent of Covered Lives	Percent of Respondents Reporting that an Insured: Had a Serious Health Problem	Had Previously Been Refused Health Insurance	Was Newly Insured within Past 12 Months
All Companies	100%	13%	5%	23%
Blue Cross-Blue Shield	59%	54%	64%	66%
Ky Kare	3%	7%	0%	4%
Humana	3%	0%	5%	1%
Other	32%	35%	31%	27%
Unknown	3%	4%	0%	2%
Ky Health Purchasing Alliance	8%	10%	0%	15%
Sample Size	464	56	22	113

Source: 1997 Kentucky Health Insurance Survey.

The Kentucky Health Purchasing Alliance allows people to purchase individual and small-group coverage through the Alliance with the expectation that participants could obtain lower rates through the Alliance than they could obtain outside of the Alliance. The Alliance acts as an intermediary by negotiating premiums from insurance companies for its customers. Policies purchased through the Alliance are actually issued by insurance companies, such as Blue Cross / Blue Shield. Eight percent of all non-elderly adults with individual coverage obtained their coverage through the Kentucky Health Purchasing Alliance.

Table 8 also shows the percentage of individually insured, non-elderly adults who reported having a serious medical condition, being refused health insurance, and being newly insured in the past 12 months and their distribution across companies.[10] Thirteen percent had suffered from a serious medical condition (such as heart disease, diabetes, or cancer) in the past 10 years. Blue Cross / Blue Shield covered approximately 54% of those with a serious health problem. Compared to their market share, Blue Cross / Blue Shield was not covering a disproportionate share of those with a serious condition. Although it appears that Kentucky Kare covered more than their share of those with serious health problems and Humana covered less, the differences in market share and share of those with health problems is not statistically significant for either company.

Very few of those surveyed had been refused health insurance. This is not too surprising, given that Kentucky law has required guarantee issue since 1995. Those that indicated they had been refused insurance may have been referring to refusals prior to 1995. Twenty-three percent had indicated that they were newly insured in the past 12 months.

[10] Due to the low number of people sampled that had been refused insurance, the distribution across companies has large standard errors and may not accurately reflect the true distribution.

As mentioned earlier, not all people with individual coverage are covered by the reforms. An executive order permitted those with policies in effect prior to July 1995 to continue renewing those policies without changes to the coverage or premium. These policies did not have to conform to the standard plans required by legislation. According to the 1997 Kentucky Health Insurance Survey, approximately 53% (87,000 people) of the individually insured are covered by non-standard plans.

Characteristics of Individual Policies

Table 9 shows the characteristics of individual policies, such as level of choice and benefits. Although there are some differences between the characteristics of individual policies sampled in 1996 and those sampled in 1997, in general, individual policies did not appear to change substantially. However, one change that did occur was an increase in the share of policies under managed care. Under managed care, an insured's health care is managed through a network of participating providers. Typically, services are only fully covered if a participating provider renders them. Services from providers not on the list of network providers are either not covered or are covered at a reduced rate. Policies that paid only for physicians on the plan's approved list accounted for 27% of the individual policies. In 1996 they accounted for only 21%. Twenty percent paid a smaller amount for physicians not on the plan's list of providers. This percentage is down from 1996. Over half of the policies allowed the insured to go to any doctor without a decrease in the amount the insurance company would pay. This suggests that, although managed care is increasing, non-managed care plans still comprise a slight majority of policies in the individual health insurance market. The change may reflect the national trend toward managed care. However, it is too early to determine if this will be a trend for the individual market in Kentucky or if this is simply a one-time increase.

Fewer individually purchased policies were reported as having deductibles in 1997 than in 1996. Of those that did, the amounts of the deductibles were lower in 1997. Thirty percent of individual policies had deductibles under $200 in 1997, compared to 21% in 1996. There was no statistically significant change in the percentage of a claim that a plan paid once all deductibles and co-payments were made. Nearly all individual plans covered 80% or more of medical costs. Nearly half of the individual policies required a co-payment for doctor visits. Although this is not a statistically significant change from 1996, the distribution of the co-payment amount did change. Co-payments below $10 and co-payments over $15 were more common in 1997 than in 1996, while $10 co-payments were less common.

There was some change in the services covered by individual plans. The number of plans covering outpatient doctor visits, prescription drugs, and mental health increased to 93%, 77%, and 74%, respectively. As in 1996, nearly all individual plans covered hospital stays. The number of plans covering vision care and dental care did not change significantly.

Table 9
Characteristics of Individual Policies

Characteristic		Percent	
		1997	1996
Physician Choice			
Same Amount Paid All Physicians		53%	54%
Smaller Amount Paid Physicians not on Plan List	*	20%	25%
Only Paid Physicians on Plan List	*	27%	21%
Annual Deductible Included in Plan			
Yes	*	72%	79%
If Deductible Assessed: Amount of Deductible			
Less than $200	*	30%	21%
$200-$400		19%	23%
$401-$800	*	29%	22%
$801-$1,000	*	4%	8%
$1,001-$2,500	*	11%	19%
More than $2,500		8%	6%
Percent of medical Costs Paid by Plan			
Less than 80%		5%	4%
80%		75%	79%
More than 80%		20%	17%
Copayment for Doctor Visits			
Yes		48%	44%
If Copayment Assessed: Amount of Copayment			
$3 to $9	*	24%	18%
$10	*	42%	52%
$15		14%	15%
More than $15	*	20%	15%
Services Covered by Plan			
Hospital Stay		98%	98%
Outpatient Doctor Visits	*	93%	89%
Prescriptions	*	77%	70%
Mental Health	*	74%	66%
Vision		21%	20%
Dental		13%	14%
Sample Size		376	439

* Indicates that changes from 1996 to 1997 are statistically significant at the 5% level.

Source: 1997 & 1996 Kentucky Health Insurance Surveys.

In addition to asking about the characteristics of the policies, the survey asked how the respondents' current health insurance coverage compared to the coverage they had last year. The comparison could be against the same policy, if it was a renewal, or against a previous policy, if the coverage is new. Table 10 shows the percent of non-elderly adults effected by various changes in their individually purchased policies. Benefits were greater for ten percent of the individually insured non-elderly adults and were lower for eleven percent. Seven percent reported that their current coverage had more restrictions on choice of physicians compared to their old coverage. Slightly less reported fewer restrictions. Nearly the same number reported having more people on the plan as having fewer people on the plan. Approximately 35% of the individually insured non-elderly adults reported an increase in premium. Only 4% reported a decrease in premium.

Table 10
Changes in Individual Policies
Percent of Non-Elderly Adults with Change

	Benefits	Restrictions on Choice of Physician	Number of People Covered	Premium
All Individually Insured Non-Elderly Adults				
Increase	10%	7%	3%	35%
No Change	79%	89%	93%	61%
Decrease	11%	4%	4%	4%
Individually Insured Non-Elderly Adults Whose Premium Increased				
Increase	21%	13%	6%	
No Change	65%	80%	86%	
Decrease	15%	7%	8%	
Sample Size = 528				
Source: 1997 Kentucky Health Insurance Survey				

The average premium in the individual market increased approximately 8% overall. Some respondents indicated their premiums increased by over 300%. Those experiencing lower premiums indicated their premiums decreased by as much as 66%. These estimates are based on premiums provided by the respondents before and after the increase. Their reliability is dependent on respondents' ability to recall premiums from last year. There are numerous factors that could have caused premiums to increase, such as the changes noted above (increased benefits, fewer restrictions, and increased number of people covered), or perhaps the changing characteristics of the policyholders. However, the extent to which these factors actually contributed to the overall increase appears to be minor. Of those experiencing an increase in premiums, only 23% indicated that they had one of the changes listed that might have caused premiums to rise (greater benefits, fewer restrictions on choice of physician, or more people covered). The changes in characteristics of the individually insured should not have contributed to increasing

premiums either. As discussed, the individually insured are generally healthier than they were in 1996 and are not significantly older. Other factors that may have caused changes in premiums were the changes to the rating restrictions, people moving to individual coverage from group coverage, and increased utilization of health care services. Finally one additional factor, which would contribute to higher premiums, was inflation for medical services. From July 1996 to July 1997, the Consumer Price Index for Medical Services increased by 2.7%.

The average monthly premium for all of the individual policies in the sample was $229, with a standard error of $127. The median monthly premium was $205.[11] Although these amounts appear to be substantially higher than what was reported from the 1996 survey, the standard errors on the estimates of premium are relatively large.[12] Large standard errors for an estimate, such as an average, indicate that the true average could fall within a relatively large range. That is, the estimates are not precise. Therefore, even though there appears to be a large increase in premium since 1996, the difference is not statistically significant. The large standard errors on the estimates of premium are caused by the complexity of factors that determine the premium for any single policy. Even for a single policy-holder in a stable insurance market, the premium charged for any particular policy is affected by the age, gender, location, occupation, and (when allowed) health status of the individual covered under the policy. The premium also reflects the scope of the medical services covered, the amount of co-insurance paid by the insured, and the size of the deductible. In the individual insurance market in Kentucky in 1997, premiums were also likely affected by whether the policy was a standard or non-standard plan, whether purchased inside or outside the Kentucky Health Purchasing Alliance, and whether it was a new policy or a renewal. Increase this complexity by the business strategy particular to each insurer, and the fact that the overall market was experiencing considerable uncertainty, and the limited usefulness of a measure of the "average" premium should become apparent.

Even with the relatively large sample size obtained in the 1997 Kentucky Health Insurance Survey, it was not possible to control for all of the factors that affect the amount of premium charged for a particular policy. For example, this sample did not contain enough higher-deductible, basic-coverage, non-standard policies covering single males under age 30 who scored in the best half of the health index, to reliably estimate what the average premium for that group might actually be in the overall individual market. Because the sample would have to be divided into so many small pieces to estimate the average premium for any particular group of policies, none of the groups was large enough to allow reliable estimation of the average premium. The implication is that collection of survey data, while valuable for describing and tracking many aspects of the health insurance market, is unlikely to be a reliable method for gauging and monitoring market

[11] The median premium amount is that amount at which half of the premiums in the sample are above that amount, and half are below. The median is a useful measure because it is not affected by a few very high or very low amounts, as is the average premium.

[12] The average monthly premium for all individual polices in the 1996 Kentucky Health Insurance Survey was $173 and the median was $142.

premiums, unless the sample size is significantly increased, the same households are surveyed repeatedly, or the number of factors used to set premiums on individual policies is reduced.

Keeping in mind the limitations caused by the substantial variation in premiums, it is informative to examine the percentage of household income allocated to pay the premiums of individual policies. It is estimated that premiums for individual policies range from a high of 37% of the midpoint of the household's income range, for households reporting an income under $10,000, to a low of 5%, for households reporting an income over $55,000.[13] The weighted average percentage for all households with individual policies was approximately 12%.[14] Two points should be made about this estimate. First, 12% is not an estimate of what percentage of income households spend for all insurance coverage, but only for coverage obtained under individual policies. Many households with some members covered under individual policies also had other members covered under an employment-based policy from either a large or small employer. Also, it may seem inconceivable that households with less than $10,000 in gross income dedicate approximately 37% of that amount to health insurance premiums. It should be remembered that measures of income do not capture the amount of wealth available to the household. Many of the individually insured are likely to be early retirees who have lower-than-average incomes but who are drawing on accumulated wealth to pay for on-going living expenses. This is not to say that there are no poor households who are dedicating a significant share of their incomes to insurance premiums, but that not all households with low incomes are without financial resources.

SMALL-GROUP MARKET

The small-group market consists of those who obtain a health insurance policy through an employer with fewer than 50 employees. In this segment of the market, the employer negotiates with an insurer for plans to offer eligible employees. Employers may or may not contribute to the employees' premiums, but the pricing of the policy is such that the premium for the policies generally reflects the average health characteristics of the group, rather than the individual.

Number Covered Under Small-Group Policies

Based on the 1997 Kentucky Health Insurance Survey, it is estimated that 12% of the Kentucky population (and 13.1% of the Kentucky non-elderly population) were covered

[13] To increase willingness to respond to the question, respondents were not asked for their exact household income, but whether the household income falls within some range, such as $25,000 to $55,000. In order to estimate premium as a percent of household income, the midpoint of the household's income range was used. For households reporting incomes above $55,000, the figure $75,000 was arbitrarily selected to represent the midpoint.

[14] The weighted average share of household income allocated to pay for individual policies was estimated at 8% from the 1996 Kentucky Health Insurance Survey. While the 1997 estimate is higher than the 1996 estimate, because of the large variation in premiums these estimates are not believed to be statistically significant.

by health insurance policies obtained through a small employer. Applying these estimates to the Bureau of the Census estimate of the 1996 Kentucky population shows that approximately 465,000 residents were covered in the small-group market at the time the survey was conducted. The margin of error for this estimate is +/- 1.2%.

The estimate for 1997 is significantly higher than the 1996 estimate of 360,000 Kentucky residents with small-group policies. As discussed earlier, one explanation for this increase is the tight labor market. Higher wages and benefits may have induced many self-employed workers to find employment with a firm offering group coverage.

Approximately 9% of those with small-group coverage in 1997 were uninsured in 1995. Sixty-nine percent of these indicated that they chose to purchase insurance because an employer offered the coverage. Nine percent listed premium becoming affordable as the reason for purchasing coverage. The remaining 22% said other reasons caused them to acquire health insurance.

Characteristics of Non-elderly Adults Covered Under Small-Group Policies

Non-elderly adults covered by small-group policies were evenly distributed across males and females (Table 11). Seventy-six percent were below the age of 50. The small-group insured were relatively old compared to those with small-group policies in 1996. Generally, household incomes were also different than in 1996. In 1997, 45% of the small-group, non-elderly adults reported household incomes above $45,000, compared to only 38% in 1996. The median household income for the small-group insured in 1997 fell within $35,000 and $45,000.

The respondents with small-group policies were somewhat healthier than all other privately insured respondents in the 1997 survey. Seventy-two percent were reported as being in either excellent or very good health. This was virtually unchanged from 1996. Thirty-two percent of the small-group insured had smoked in the past two years. Twenty percent had not seen a doctor in the last year. This is higher than all non-elderly privately insured adult respondents of which only 15% had not seen a doctor. Twenty-three percent of the small-group insured had not spent any of their own money on health care in the past year. This does not include money paid for premiums or money paid by an insurance company.

As with the individual market, not all of the small-group insured were covered by the changes in legislation. Approximately 62% (288,000 people) were not covered under standard plans.

Table 11

Demographic Characteristics of the Small-Group Insured, Non-elderly Adults

Characteristic		Percent		Characteristic		Percent	
		1997	1996			1997	1996
Gender				**Health in General**			
Male		49%	50%	Excellent		40%	39%
Female		51%	50%	Very Good		32%	32%
				Good		22%	21%
Age				Fair		5%	6%
Less than 30		20%	23%	Poor		2%	2%
30 to 39		28%	32%				
40 to 49		28%	26%				
50 to 59	*	18%	14%	**Smoked Regularly in Past 2 Years**		32%	29%
60 to 64		5%	4%				
Annual Household Income							
Less than $10,000		1%	2%	**Number of Dr. Visits in Last Year**			
$10,000-$15,000	*	4%	6%	0		20%	21%
$15,000-$25,000		14%	15%	1-2		44%	46%
$25,000-$35,000		21%	22%	3-4		18%	17%
$35,000-$45,000		15%	18%	5-6		9%	8%
$45,000-$55,000		13%	12%	More than 6		10%	9%
More than $55,000	*	32%	26%				
Household Income as a Percent of the Federal Poverty Level (FPL)				**Amount Spent Out-of-Pocket for Health Care During Past Year**			
Less than 100% of FPL		3%	-	$0		23%	-
100% to 149% of FPL		9%	-	$1 - $249		47%	-
150% to 249% of FPL		18%	-	$250 - $499		12%	-
250% or more of FPL		71%	-	$500 - $999		8%	-
				$1000 - $4999		8%	-
Work Status				$5000 - $9999		1%	-
Employed	*	85%	62%	$10,000 or more		0.4%	-
If employed, part time		15%	15%				
				Sample Size		791	1231

* Indicates that changes from 1996 to 1997 are statistically significant at the 5% level.

Source: 1997 & 1996 Kentucky Health Insurance Surveys.

Table 12
Distribution of Small-Group Insured Adults
Age, Gender, and Health Status

Males	Health Status Category					
Age	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**	**Total**
Less than 30	6%	3%	1%	0%	0%	11%
30 to 39	6%	4%	4%	1%	0%	14%
40 to 49	4%	4%	3%	1%	0%	13%
50 to 59	2%	4%	3%	0%	0%	9%
60 to 64	1%	1%	1%	0%	0%	2%
Male Totals	**20%**	**15%**	**12%**	**2%**	**1%**	**49%**
Females						
Age						
Less than 30	5%	3%	2%	0%	0%	9%
30 to 39	7%	4%	2%	0%	0%	14%
40 to 49	6%	6%	3%	1%	0%	16%
50 to 59	2%	4%	2%	1%	0%	9%
60 to 64	1%	1%	1%	0%	0%	3%
Female Totals	**20%**	**17%**	**10%**	**3%**	**1%**	**51%**
Overall Totals	**40%**	**32%**	**22%**	**5%**	**2%**	**100%**

Note: Zeros may represent numbers that are less than 0.5%.
Source: 1997 Kentucky Health Insurance Survey.

Table 13 shows the distribution of non-elderly adults across the insurance companies providing small-group policies. As in the individual market, Blue Cross / Blue Shield had the largest market share of all companies, with 51%. Alternative Health, a subsidiary of Blue Cross / Blue Shield, had 4% of the small-group market. Humana had 8%. Approximately 12% obtained their small-group plan through the Kentucky Health Purchasing Alliance.

Comparing company market shares with the share of people with serious health problems shows that no company was over- or under-represented among those with health problems. Also there was no statistically significant evidence to suggest that any company was over- or under-represented in new business. These results are not surprising, given that companies doing business in the small-group market are subject to guaranteed issue and cannot set premiums based on health status. These provisions make it difficult for companies to select against certain segments of the population, such as those with health problems.

Table 13

Market Share of Companies Offering Small-Group Policies

Company	Percent of Covered Lives	Percent of Respondents Reporting that an Insured: Had a Serious Health Problem	Had Previously Been Refused Health Insurance	Was Newly Insured within Past 12 Months
All Companies	100%	17%	2%	22%
Blue Cross-Blue Shield	51%	51%	54%	56%
Humana	8%	12%	0%	6%
Alternative Health	4%	3%	0%	3%
Aetna	3%	2%	0%	3%
CHA	2%	1%	8%	4%
Other	29%	26%	30%	24%
Unknown	3%	5%	8%	4%
Ky Health Purchasing Alliance	12%	10%	10%	15%
Sample Size	848	140	13	190

Source: 1997 Kentucky Health Insurance Survey.

Characteristics of Small-Group Policies

The small-group policies surveyed in 1997 showed substantial differences from those surveyed in 1996. The characteristics of small-group policies are shown in Table 14. The first major difference is in choice of providers. Thirty-three percent of small-group plans paid the same amount for all providers. Thirty percent paid a smaller amount if the provider was not on the plan's list. Finally, thirty-seven percent only paid for providers on the plan's list. Policies that paid only for listed providers represent managed care. The estimates show a large increase in the number of managed care plans from the 1996 survey to the 1997 survey. As with the individual market, this change may reflect the national trend toward managed care, but it is too early to draw conclusions. Another difference in small-group plans in 1997 and 1996 is that policies with deductibles were less common. In 1996, 81% of the small-group policies included a deductible. In 1997, however, only 68% of small-group policies were reported as having a deductible. Small-group plans were also covering a greater percentage of medical costs in 1997 than 1996. Thirty percent covered more than 80% of medical costs in 1997, compared to only 19% in 1996. The number of policies requiring a co-payment also decreased. Finally, small-group policies were more likely to cover outpatient doctor visits, prescriptions, and vision care in 1997 than in 1996.

Table 14 Characteristics of Small-Group Policies			
Characteristic		**Percent**	
		1997	1996
Physician Choice			
Same Amount Paid All Physicians	*	33%	42%
Smaller Amount Paid Physicians not on Plan List		30%	31%
Only Paid Physicians on Plan List	*	37%	27%
Annual Deductible Included in Plan			
Yes	*	68%	81%
If Deductible Assessed: Amount of Deductible			
Less than $200	*	36%	26%
$200-$400	*	27%	33%
$401-$800	*	22%	27%
$801-$1,000		5%	5%
$1,001-$2,500		9%	8%
More than $2,500		1%	1%
Percent of medical Costs Paid by Plan			
Less than 80%		2%	2%
80%	*	68%	80%
More than 80%	*	30%	19%
Copayment for Doctor Visits			
Yes	*	30%	56%
If Copayment Assessed:			
Amount of Copayment			
$5 to $9		27%	24%
$10	*	59%	54%
$15	*	8%	13%
More than $15	*	6%	9%
Services Covered by Plan			
Hospital Stay	*	99%	100%
Outpatient Doctor Visits	*	98%	96%
Prescriptions	*	94%	88%
Mental Health		87%	84%
Vision	*	37%	31%
Dental		26%	28%
Sample Size		462	835
* Indicates that changes from 1996 to 1997 are statistically significant at the 5% level.			
Source: 1997 & 1996 Kentucky Health Insurance Surveys.			

Table 15 shows how those with small-group coverage in 1997 responded to questions about how their current coverage compared to the coverage they had last year. Fifteen percent indicated their benefits increased, while 10 percent reported a decrease in benefits.

Twelve percent reported more restrictions on choice of physician, with only 5% reporting fewer restrictions. This provides additional evidence that small-group plans have moved toward managed care. Twenty-three percent responded that their premiums had increased. However, as in the individual market, premiums did not increase for the entire market segment. Ten percent reported a decrease in premium. While changes in benefits, choice of physician, or the number of people covered may have contributed to increasing premiums, these changes cannot account for all of the increases. Only 23% of those with higher premiums also had at least one of these changes. It is not possible to determine from the health survey the extent to which premiums in the small-group market have increased. Because employers frequently contribute to the purchase of health insurance, respondents may not be well informed about the total premiums charged. Therefore, it is not possible to determine if premiums in the small-group market are increasing faster than inflation.

Table 15
Changes in Small-Group Policies
Percent of Non-Elderly Adults with Change

	Benefits	Restrictions on Choice of Physician	Number of People Covered	Premium
All Small-Group Insured Non-Elderly Adults				
Increase	15%	12%	1%	23%
No Change	75%	83%	97%	67%
Decrease	10%	5%	2%	10%
Small-Group Insured Non-Elderly Adults Whose Premium Increased				
Increase	19%	30%	3%	
No Change	56%	62%	97%	
Decrease	25%	8%	0%	
Sample Size = 791				

Source: 1997 Kentucky Health Insurance Survey

The average monthly premium paid by the household for small-group policies was $65. The median was $0. It should be noted that these figures do not represent the full cost of the insurance policy, as many employers pay for all or part of their employee's premium. Often the employees are not well informed about the amount of premium the employer pays and therefore can only accurately report the portion their families pay. Nearly half of the respondents were covered by at least one plan that was fully paid for by the employer. Another 44% were covered by a plan that was partially paid for by an employer. The remaining 8% received no contribution towards health insurance from an employer. Because so many small-group insureds received an employer contribution, the share of household income allocated to small-group policies was fairly low, at 1%.

LARGE-GROUP MARKET

The large-group market consists of people who obtain health insurance through an employer with 50 or more employees. As in the small-group market, the employer may negotiate with an insurer for plans to offer eligible employees. The pricing of the policy is such that the premium for the policies generally reflects the average health characteristics of the group, rather than the individual. Alternatively, the employer may choose to self-insure. Self-insured companies pay for their employees' medical claims rather than purchasing a group plan from an insurance company. In either case, the employer may or may not contribute to the employees' premiums.

The effects of the reforms in the large-group market were not nearly as extensive as in the small-group and individual markets. As in the other markets, large-group policies were required to be one of the standard plans. However, there were no rating restrictions placed on the large-group market, such as prohibiting rating on health status. Because the costs of health care are already spread over a large number of people for a large group in which all participants pay the same premium, any increased access from MCR for the unhealthy would be small. Therefore, rating provisions would have had little direct impact on the large-group market. The only other change to the large-group market dealt with the definition of large-groups. Initial reforms defined any employer with 100 or more employees as a large-group. SB 343 subsequently redefined large-group employers as those with 50 or more employees. Because of this, employers with 50 to 99 employees were temporarily defined as small-groups and covered by reforms. Any group insurance purchased by these employers between July 15, 1995 and July 15, 1996 had to be an MCR. After July 15, 1996, however, policies sold to these employers could be rated on each group's experience.

Because the large-group market was not surveyed in the 1996 Kentucky Health Insurance Survey, it is not possible to show how this market segment has changed.

Number Covered Under Large-Group Policies

It is estimated that 46.4% of the Kentucky population (and 50.5% of the non-elderly Kentucky population) obtained health insurance through a large employer. The margin of error for the estimate is 1.8%. This means that there is a 95% probability that the true percentage is between 44.6% and 48.2%. When these estimates are applied to the Bureau of Census estimate of the 1996 Kentucky population, it is estimated that between 1,730,000 and 1,870,000 Kentuckians were covered in the large-group market. The point estimate is 1,800,000.

Five percent of those with large-group insurance were uninsured in 1995. Most of these indicated they obtained health insurance because an employer offered coverage.

Characteristics of Non-elderly Adults covered Under Large-Group Policies

The average age of the large-group insured, non-elderly adults was 40. The age distribution (Table 16) was not largely different than for all privately insured adult respondents. This is to be expected, as the large-group insured make up nearly three-fourths of the privately insured. Nearly half of the large-group insured, non-elderly adults reported household incomes over $45,000. Sixty-eight percent were in excellent or very good health. Eighty-one percent indicated that they spent their own money for health care. This is in addition to any money allocated to health insurance premiums or money paid out by an insurance company. Of those that did spend out-of-pocket money for health care, the large-group insured generally spent less than all privately insured.

Employers that self-insure will sometimes contract the administration of their health insurance plan out to other companies. This may have caused some confusion for respondents in answering what insurance company their policy was with. Because of this, it is not possible to accurately determine companies' market shares in the large-group market.

Table 16

Demographic Characteristics of the Large-Group Insured, Non-elderly Adults

Characteristic	Percent 1997	Characteristic	Percent 1997
Gender		**Health in General**	
Male	47%	Excellent	37%
Female	53%	Very Good	31%
		Good	23%
Age		Fair	8%
Less than 30	22%	Poor	2%
30 to 39	26%		
40 to 49	30%		
50 to 59	17%	**Smoked Regularly in Past 2 Years**	30%
60 to 64	6%		
Annual Household Income			
Less than $10,000	2%	**Number of Dr. Visits in Last Year**	
$10,000-$15,000	5%	0	15%
$15,000-$25,000	11%	1-2	44%
$25,000-$35,000	16%	3-4	22%
$35,000-$45,000	18%	5-6	8%
$45,000-$55,000	17%	More than 6	11%
More than $55,000	32%		
Household Income as a Percent of the Federal Poverty Level (FPL)		**Amount Spent Out-of-Pocket for Health Care During Past Year**	
Less than 100% of FPL	4%	$0	19%
100% to 149% of FPL	7%	$1 - $249	52%
150% to 249% of FPL	17%	$250 - $499	11%
250% or more of FPL	72%	$500 - $999	8%
		$1000 - $4999	9%
Work Status		$5000 - $9999	1%
Employed	85%	$10,000 or more	1%
If employed, part time	12%		
		Sample Size	1137

* Indicates that changes from 1996 to 1997 are statistically significant at the 5% level.

Source: 1997 Kentucky Health Insurance Survey.

Table 17
Distribution of Large-Group Insured Adults
Age, Gender, and Health Status

Males	Health Status Category					
Age	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**	**Total**
Less than 30	6%	3%	1%	0%	0%	10%
30 to 39	5%	4%	2%	0%	0%	12%
40 to 49	5%	4%	4%	1%	0%	15%
50 to 59	2%	2%	2%	1%	0%	8%
60 to 64	0%	1%	1%	1%	0%	3%
Male Totals	**19%**	**13%**	**10%**	**4%**	**1%**	**47%**
Females						
Age						
Less than 30	6%	3%	2%	0%	0%	12%
30 to 39	6%	5%	3%	0%	0%	14%
40 to 49	4%	6%	4%	1%	0%	15%
50 to 59	2%	3%	3%	1%	0%	9%
60 to 64	1%	1%	1%	1%	0%	3%
Female Totals	**18%**	**18%**	**13%**	**4%**	**1%**	**54%**
Overall Totals	**37%**	**31%**	**23%**	**8%**	**2%**	**100%**

Note: Zeros may represent numbers that are less than 0.5%.

Source: 1997 Kentucky Health Insurance Survey.

Table 18
Characteristics of Large-Group Policies

Characteristic	Percent
	1997
Physician Choice	
Same Amount Paid All Physicians	35%
Smaller Amount Paid Physicians not on Plan List	30%
Only Paid Physicians on Plan List	35%
Annual Deductible Included in Plan	
Yes	64%
If Deductible Assessed: Amount of Deductible	
Less than $200	46%
$200-$400	31%
$401-$800	18%
$801-$1,000	2%
$1,001-$2,500	3%
More than $2,500	1%
Percent of medical Costs Paid by Plan	
Less than 80%	3%
80%	63%
More than 80%	35%
Copayment for Doctor Visits	
Yes	45%
If Copayment Assessed:	
Amount of Copayment	
$5 to $9	35%
$10	50%
$15	12%
More than $15	3%
Services Covered by Plan	
Hospital Stay	99%
Outpatient Doctor Visits	98%
Prescriptions	94%
Mental Health	94%
Vision	49%
Dental	46%
Sample Size	643

Source: 1997 Kentucky Health Insurance Survey.

Characteristics of Large-Group Policies

Table 18 shows various policy characteristics for the large-group policies. Approximately 35% of large-group policies paid the same amount for all physicians. Thirty percent paid a smaller amount for physicians not on the plan's list. Thirty-five percent paid only for physicians on the plan's list. Sixty-four percent of the large-group plans required a deductible. For plans requiring a deductible, the majority, 77%, had a deductible under $400. As with individual and small group policies, large-group policies almost always covered 80% or more of medical costs. Forty-five percent of large-group policies required a co-payment. Services covered were generally greater for large-group policies than for individual or small-group policies. Almost all large-group policies covered hospital stays, outpatient doctor visits, prescriptions, and mental health services. Large-group policies were also more likely to provide vision and dental coverage than the individual or small-group policies.

While information for the large-group market was not collected in the 1996 survey, the 1997 survey did ask the large-group insured to compare the coverage they had at the time of the survey to the coverage they had last year (Table 19). Eleven percent saw benefits increase from last year. Eight percent reported that there were more restrictions this year. Finally, 19% indicated that their premiums increased in the past year. Of those with higher premiums, 30% also had either an increase in benefits, fewer restrictions of physician choice, or more people covered by the policy. While premiums are increasing for many in the large-group market, data does not exist to indicate how overall premium changes in the large-group market compare to inflation.

Table 19
Changes in Large-Group Policies
Percent of Non-Elderly Adults with Change

	Benefits	Restrictions on Choice of Physician	Number of People Covered	Premium
All Large-Group Insured Non-Elderly Adults				
Increase	11%	8%	2%	19%
No Change	82%	89%	97%	74%
Decrease	7%	3%	1%	7%
Large-Group Insured Non-Elderly Adults Whose Premium Increased				
Increase	26%	16%	5%	
No Change	61%	79%	93%	
Decrease	13%	5%	2%	
Sample Size = 1137				
Source: 1997 Kentucky Health Insurance Survey				

The average monthly premium paid by the household for large-group policies was $47 and the median was $0. As with the small-group policies, employers often paid the full cost of health insurance for their employees. Approximately 28% were covered by at least one policy that was fully paid for by the employer. Sixty-seven percent were covered by a policy that was partially paid for by the employer. The remaining 5% received no employer contribution. The share of household income allocated to large-group policies was less than 1%.

UNINSURED

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

Number of Uninsured

There are two sources for estimating the number of uninsured. Because each source has strengths and weaknesses, both are presented, to provide the most accurate possible measures of the uninsured.

The first source for estimating the number of uninsured is the 1997 Kentucky Health Insurance Survey (KHIS). The KHIS is the only source of data that provides information on people's insurance status in 1997. It also has the advantage of having a relatively large sample size, which reduces the margin of error on the estimate. However, the KHIS is somewhat lacking, in that the data was collected through a telephone survey, thereby missing the segment of the population that did not have phones. This may bias the estimate if those without phones include a disproportionate share of the uninsured. Recent estimates from the 1996 CPS show that approximately 8.8% of Kentuckians are without phones. Those without phones are more likely to be without health insurance. However, because the number of people without phones is fairly small, the bias created by not sampling this segment of the population is also expected to be fairly small (under 2 percentage points). Estimates from the 1997 Kentucky Health Insurance Survey show that approximately 14.3% of Kentucky's population was uninsured. The margin of error for this estimate is +/- 1.3%.

The second source for estimating the number of uninsured is the March 1996 Current Population Survey. Data was collected for the CPS through in-person interviews, so that there is no telephone bias as in the KHIS. However, the sample size of the CPS is small relative to the KHIS, so estimates will have larger margins of error. The main weakness of the CPS is that respondents are asked about their insurance status in 1995. Therefore, estimates from the CPS will not reflect any change in the number of uninsured since then. Using the March 1996 CPS, it is estimated that 14.6% of the Kentucky population were without insurance in 1995. The margin of error for this estimate is +/- 1.7%.

As discussed in LRC Memorandum No. 474, there have been several past estimates of the number of uninsured in Kentucky. These past estimates, compared to the estimates presented above, suggest that the percentage of the population without health insurance has increased. However, because margins of error were large on these estimates, it was not possible to determine whether there has actually been a change in the number of uninsured or whether the differences were caused by random sample variations. That is, the differences in the estimates are not statistically significant.

Characteristics of the Uninsured

Because the number of uninsured surveyed in the CPS was so small and the CPS represents 1995 information, it is not appropriate to use this data for estimating the current characteristics of the uninsured. Instead, the 1997 KHIS is used to show the characteristics of the uninsured. It should be kept in mind that the uninsured without phones are not represented in these estimates. However, it is believed that this is a fairly small fraction of the uninsured, who do not differ substantially from the uninsured with phones and, therefore, does not represent a significant bias to the estimates.[15]

Table 20 shows the characteristics of the non-elderly, adult respondents without any form of health insurance coverage from the 1997 Kentucky Health Insurance Survey and the 1996 Spring Kentucky Survey.[16] The uninsured, non-elderly adults are generally younger than all non-elderly adults. Nearly sixty percent are under the age of forty. The uninsured are also poorer. Fifty-nine percent of the uninsured, non-elderly adults had household incomes below 150% of the federal poverty level, compared to 27% of all non-elderly adults. The uninsured were also less likely to be employed.[17]

[15] If it is assumed that 40% of those without a phone are uninsured, then approximately one fifth of all uninsured are not represented by the 1997 KHIS. If the rate of uninsured among the phoneless is lower (greater) than 40%, then the bias is smaller (larger). To further ascertain the extent of the phone bias, the 1996 CPS was used to determine if evidence existed showing that the uninsured without phones were different than the uninsured with phones. Test on gender, age, and health status provided no evidence of differences. Tests on income were inconclusive. These results suggest that any bias that may exist from sampling only those with phones is fairly small.

[16] The Spring Kentucky Survey is an annual phone survey conducted by the University of Kentucky. The survey sampled 658 Kentuckians from May 21 to June 11, 1996.

[17] The percentage of people employed presented in this report cannot be compared to the official estimated of the unemployment rate. Unemployment rates generally only consider people unemployed if they are not working, but are actively seeking work. So, a person who does not work, but is not looking for employment is not considered in the calculation of official estimates of the unemployed. The percentage reported from the survey, however, does include those not looking for work in its calculation.

Table 20

Demographic Characteristics of the Uninsured, Non-elderly Adults

Characteristic		Percent		Characteristic		Percent	
		1997	1996			1997	1996
Gender				**Health in General**			
Male		48%	49%	Excellent	*	26%	19%
Female		52%	51%	Very Good		28%	22%
				Good		25%	22%
Age				Fair		14%	20%
Less than 30		29%	34%	Poor	*	8%	16%
30 to 39		28%	22%				
40 to 49		22%	24%				
50 to 64		22%	21%	**Smoked Regularly in Past 2 Years**		49%	-
Annual Household Income							
Less than $10,000		28%	44%	**Number of Dr. Visits in Last Year**			
$10,000-$15,000		18%	14%	0		31%	-
$15,000-$25,000		24%	19%	1-2		38%	-
$25,000-$40,000		19%	15%	3-4		14%	-
$40,000-$50,000		3%	4%	5-6		6%	-
More than $50,000		8%	4%	More than 6		11%	-
Household Income as a Percent of the Federal Poverty Level (FPL)				**Amount Spent Out-of-Pocket for Health Care During Past Year**			
Less than 100% of FPL		36%	-	$0		30%	-
100% to 149% of FPL		23%	-	$1 - $249		38%	-
150% to 249% of FPL		21%	-	$250 - $499		9%	-
250% or more of FPL		20%	-	$500 - $999		10%	-
				$1000 - $4999		11%	-
Work Status				$5000 - $9999		1%	-
Employed	*	58%	47%	$10,000 or more		1%	-
If employed, part time		27%	23%				
				Sample Size		1089	149

* Indicates that changes from 1996 to 1997 are statistically significant at the 5% level.

Source: 1997 Kentucky Health Insurance Survey & the 1996 Spring Kentucky Survey.

The uninsured are also in poorer health than the rest of the sample. Twenty-two percent of the uninsured, non-elderly adults fell into the fair and poor categories for general health status. Only 16% of all non-elderly adults fell into these categories. Compared to the uninsured surveyed in 1996, the uninsured in 1997 are substantially healthier.[18] There are

[18] A memorandum from the LRC to the General Assembly, dated August 12, 1997, compared the preliminary health distribution of the uninsured from the 1997 KHIS to the age distribution of the uninsured in the CPS from 1991 to 1995. This comparison also found that those uninsured in 1997 had better health than those uninsured in the past.

at least two possible explanations for this difference. First, the estimates of health status in 1997 and 1996 come from two different surveys. Because these surveys were designed and conducted differently, they may result in different estimates. The second explanation is that the difference was the result of people's reactions to the reforms. As mentioned previously, under modified community rating with guarantied issue, unhealthy people would see lower premiums while healthy people would see higher premiums. Given this change in price, some of the unhealthy people who could not previously afford insurance may have chosen to purchase insurance at the lower rate. Likewise, some of the healthy people who were covered by health insurance may have dropped coverage as premiums increased.[19]

Smoking rates were much higher for the uninsured as well. Almost half of the uninsured non-elderly adults had smoked in the past year. While the uninsured were in poorer health, they were less likely to have visited a doctor in the past year. Thirty-one percent of the uninsured had not been to a doctor in the past year, while only 17% of all non-elderly adults had not seen a doctor. One likely cause for the lower rate of doctor visits among the uninsured is the cost of the visit. Those without insurance pay the full cost of seeing a doctor. However, those with health insurance may only make a $10 co-payment. The incentive to see a doctor is reduced when the uninsured must pay the full cost out-of-pocket. A second factor in the number of visits to a doctor is age. The uninsured are often young people, who are less likely to need medical services.

To fully understand the uninsured, it is important to know why they do not have health insurance coverage. To provide some insight as to the reason people go without insurance, the 1997 Kentucky Health Insurance Survey asked the main respondents without insurance why they were uninsured, if they ever had insurance, and if so, why their coverage ended. Because these questions were only asked of the head of households, the responses cannot be generalized to all uninsured. With that in mind, however, the responses do provide valuable insight for understanding why people go without insurance and why they go from being insured to uninsured. The results are reported in Table 21.

[19] If the change in health status for the uninsured was caused by people's reaction to premiums under modified community rating, then the change would likely have begun when the reforms passed. However, because it takes time for people to see the changes in premiums, it may take time for the people to change insurance status. This is why a change in health status could show up between 1996 and 1997.

Table 21		
Reasons for Being Without Health Insurance		
Uninsured Head of Households Only		
Reason Uninsured are Without Health Insurance		**Percent**
Medical Condition Made Health Insurance too Expensive or Unavailable		4%
Health Insurance too Expensive in General		81%
Other Reason		15%
Sample Size		534
Reason Health Coverage Ended for the Uninsured Who had Health Insurance at One Time		
Left Job Where Health Insurance was Offered		51%
No Longer Eligible for Coverage on a Relative's Policy		15%
Could No Longer Afford Health Insurance Because of Premium Increase		11%
Policy Canceled Because of a Health Condition		3%
Other Reason		20%
Sample Size		363
Source: 1997 Kentucky Health Insurance Survey.		

Respondents were first asked if they were without health insurance because a medical condition made insurance too expensive or unavailable, insurance was too expensive in general, or for some other reason. Only 4% of the respondents indicated that a medical condition prevented them from obtaining insurance. While this number appears low, it should be kept in mind that insurance companies in Kentucky are not allowed to restrict coverage or rate policies based on health status. Therefore, no one in Kentucky should be uninsured because a medical condition makes insurance too expensive. However, some people may have been uninsured prior to the 1994 reforms, which prevented the use of health status for underwriting health insurance. At the time they became uninsured, a medical condition could have prevented them from obtaining insurance. If they were not informed about the health insurance reforms of 1994, they would not realize that medical conditions are no longer a constraint in acquiring health insurance.

The most common reason for not purchasing insurance was that health insurance was too expensive in general. Eighty-one percent indicated that premiums were too expensive. Again, because of the restrictions preventing experience rating, it should be expected that the expense of health insurance in general should dominate medical conditions as a reason for not having insurance. However, because of the exemption of associations from the rating requirements, the market will move toward experience rating. This should cause people's reasons for being uninsured to change. Experience rating will restrict access and increase premiums for people with medical conditions. Correspondingly, premiums for the healthy will decrease. The remaining 15% responded that they were uninsured for other reasons.

Respondents who had previously been covered by a health insurance policy were asked why their coverage ended. Half of the respondents indicated that their health insurance

ended because they left the job where the coverage was provided. Fifteen percent lost their insurance because they were no longer eligible for coverage. This includes situations such as a graduating student who is no longer eligible for coverage under a parent's policy. Approximately 11% could no longer afford the premium and 3% had coverage cancelled due to a medical condition. The most interesting result is the link between employment and health insurance. It appears that, for many, health insurance coverage is present if it is available through an employer. If not, many find that coverage in the individual market is unaffordable.

Characteristics of the Newly Uninsured

For the purposes of the 1997 Kentucky Health Insurance Survey, the newly uninsured consisted of anyone becoming uninsured within the past 12 months. The newly uninsured represent approximately 14% of the uninsured. The newly uninsured, non-elderly adults are somewhat different than all uninsured non-elderly adults in many ways (Table 22). First, the newly uninsured are more likely to be male. They are also generally younger. Nearly forty percent of the newly uninsured were below the age of 30. Household incomes for the newly uninsured are more similar to those of all non-elderly adults than to those of the uninsured non-elderly adults. As mentioned above, 59% of all uninsured, non-elderly adults lived in households with incomes below 150% of the FPL. However, only 33% of the newly uninsured, non-elderly adults had incomes below 150% of the FPL. The reason for this appears to be that a number of young adults are living with their parents. Although the young adults may be uninsured, the parents often have high incomes. The parents' high incomes drive up the household income for those uninsured living with their parents. The newly uninsured were also more likely to be employed.

Comparing the 1996 results to the 1997 results suggests that there have been large changes in the characteristics of the newly uninsured; however, this is not necessarily the case. The differences from 1996 to 1997 reflect methodological changes in the survey design. The 1996 survey failed to accurately reflect uninsured adult children living in their parents' home. These people were typically young males whose parents had high incomes. The 1997 survey was improved to better reflect these uninsured. This resulted in the distribution of the newly uninsured that is more likely to be young and male, and tending to have higher household incomes. This does not mean that there were no changes to the characteristics of the newly uninsured. However, it is not possible to determine how these characteristics have changed.

Table 22

Demographic Characteristics of the Newly Uninsured, Non-elderly Adults

Characteristic		Percent		Characteristic		Percent	
		1997	1996			1997	1996
Gender				**Work Status**			
Male		58%	48%	Employed		68%	-
Female		42%	52%	If employed, part time		22%	-
Age				**Health in General**			
Less than 30		39%	30%	Excellent		35%	-
30 to 39	*	21%	33%	Very Good		33%	-
40 to 49		24%	22%	Good		21%	-
50 to 59		14%	11%	Fair		9%	-
60 to 64		2%	5%	Poor		2%	-
Annual Household Income				**Smoked Regularly in Past 2 Years**		45%	-
Less than $10,000		10%	13%				
$10,000-$15,000		12%	17%	**Number of Dr. Visits in Last Year**			
$15,000-$25,000		23%	29%	0		23%	-
$25,000-$35,000		21%	24%	1-2		47%	-
$35,000-$45,000		8%	6%	3-4		9%	-
More than $45,000	*	26%	10%	5-6		11%	-
				More than 6		9%	-
Household Income as a Percent of the Federal Poverty Level (FPL)							
Less than 100% of FPL		16%	-				
100% to 149% of FPL		17%	-				
150% to 249% of FPL		26%	-				
250% or more of FPL		41%	-	Sample Size		132	265

* Indicates that changes from 1996 to 1997 are statistically significant at the 5% level.

Source: 1997 & 1996 Kentucky Health Insurance Surveys.

1997										
Estimates of the Number of People by Market Segment & Demographic Characteristics of Non-Elderly Adults by Market Segment										
Characteristics			**Individual**		**Small-Group**		**Large-Group**		**Uninsured**	**Characteristics for Uninsured Only**
Number of People			165,000		465,000		1,800,000	(a)	570,000	
Non-Elderly Adults Only										
Gender										
	Male	*	44%		49%		47%		48%	
	Female	*	56%		51%		53%		52%	
Age										
	Less than 30		20%		20%		22%		29%	Less than 30
	30 to 39		22%		28%		26%		28%	30 to 39
	40 to 49		24%		28%		30%		22%	40 to 49
	50 to 59		22%	*	18%		17%		22%	50 to 64
	60 to 64		13%		5%		6%			
Annual Household Income										
	Less than $10,000	*	5%		1%		2%		28%	Less than $10,000
	$10,000-$15,000		5%	*	4%		5%		18%	$10,000-$15,000
	$15,000-$25,000		17%		14%		11%		24%	$15,000-$25,000
	$25,000-$35,000	*	15%		21%		16%		19%	$25,000-$40,000
	$35,000-$45,000		12%		15%		18%		3%	$40,000-$50,000
	$45,000-$55,000	*	14%		13%		17%		8%	More than $50,000
	More than $55,000	*	31%	*	32%		32%			
Work Status										
	Employed		67%	*	85%		85%	*	58%	
	If employed, part time		27%		15%		12%		27%	
Health in General										
	Excellent	*	42%		40%		37%	*	26%	
	Very Good		33%		32%		31%		28%	
	Good	*	16%		22%		23%		25%	
	Fair	*	6%		5%		8%		14%	
	Poor	*	3%		2%		2%	*	8%	
Dr. Visits in Last Year										
	0		20%		20%		15%		31%	
	1-2	*	47%		44%		44%		38%	
	3-4	*	16%		18%		22%		14%	
	5-6		8%		9%		8%		6%	
	More than 6		9%		10%		11%		11%	
Amount Spent Out-of-Pocket for Health Care During Past Year										
	$0		23%		23%		19%		30%	
	$1 - $249		42%		47%		52%		38%	
	$250 - $499		12%		12%		11%		9%	
	$500 - $999		9%		8%		8%		10%	
	$1000 - $4999		11%		8%		9%		11%	
	$5000 - $9999		1%		1%		1%		1%	
	$10,000 or more		0.4%		0.4%		1%		1%	
Sample Size			528		791		1137		1089	
* Indicates that changes from 1996 to 1997 are statistically significant at the 5% level.										
Source: 1997 Kentucky Health Insurance Survey except as noted.										
(a) 1996 March Current Population Survey.										

1996							
Estimates of the Number of People by Market Segment & Demographic Characteristics of Non-Elderly Adults by Market Segment							
Characteristics		**Individual**	**Small-Group**	**Large-Group**		**Uninsured (a)**	**Characteristics for Uninsured Only**
Number of People		210,000	360,000	-	(b)	560,000	
Gender							
	Male	53%	50%	-		49%	
	Female	47%	50%	-		51%	
Age							
	Less than 30	23%	23%	-		34%	Less than 30
	30 to 39	20%	32%	-		22%	30 to 39
	40 to 49	23%	26%	-		24%	40 to 49
	50 to 59	22%	14%	-		21%	50 to 64
	60 to 64	11%	4%	-			
Annual Household Income							
	Less than $10,000	8%	2%	-		44%	Less than $10,000
	$10,000-$15,000	6%	6%	-		14%	$10,000-$15,000
	$15,000-$25,000	19%	15%	-		19%	$15,000-$25,000
	$25,000-$35,000	24%	22%	-		15%	$25,000-$40,000
	$35,000-$45,000	13%	18%	-		4%	$40,000-$50,000
	$45,000-$55,000	9%	12%	-		4%	More than $50,000
	More than $55,000	21%	26%	-			
Work Status							
	Employed	-	62%	-		47%	
	If employed, part time	-	15%	-		23%	
Health in General							
	Excellent	33%	39%	-		19%	
	Very Good	30%	32%	-		22%	
	Good	21%	21%	-		22%	
	Fair	10%	6%	-		20%	
	Poor	6%	2%	-		16%	
Dr. Visits in Last Year							
	0	20%	21%	-		-	
	1-2	40%	46%	-		-	
	3-4	21%	17%	-		-	
	5-6	7%	8%	-		-	
	More than 6	12%	9%	-		-	
Amount Spent Out-of-Pocket for Health Care During Past Year							
	$0	-	-	-		-	
	$1 - $249	-	-	-		-	
	$250 - $499	-	-	-		-	
	$500 - $999	-	-	-		-	
	$1000 - $4999	-	-	-		-	
	$5000 - $9999	-	-	-		-	
	$10,000 or more	-	-	-		-	
Sample Size		609	1231	-		149	
Source: 1996 Kentucky Health Insurance Survey except as noted.							
(a) 1996 Spring Kentucky Survey.							
(b) 1995 March Current Population Survey.							

Appendix A:

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