Status of the Health Insurance Market in Kentucky, 1998

Prepared by:

Mike Clark, Ph.D.
Staff Economist

Research Report No. 290

Legislative Research Commission

January, 2000

This report was prepared by the Legislative Research Commission and printed with state funds.
This report is available in alternative forms on request.

FOREWORD

Each year the Legislative Research Commission sponsors the Kentucky Health Insurance Survey. This survey provides data on the insurance status and characteristics of Kentuckians. The purpose of this report is to present the results of the 1998 Kentucky Health Insurance Survey and data from other sources. It is hoped that this information will provide policymakers with up-to-date information on the status of Kentucky's health insurance market.

This report was prepared by Mike Clark of the Legislative Research Commission. The Legislative Research Commission appreciates the assistance of Mark Berger, Steve Allen, and Eric Thompson with the University of Kentucky's Center for Business and Economic Research in developing some of the methodology used in this report.

ROBERT SHERMAN
Director

The Capitol
Frankfort, Kentucky
January, 2000

TABLE OF CONTENTS

LIST OF TABLES

EXECUTIVE SUMMARY

Health insurance continues to be a topic that produces a great deal of interest with the Kentucky General Assembly. From 1994 through 1998 the General Assembly passed several pieces of legislation focusing on the individual and small-group health insurance market. This legislation was aimed at making health insurance more accessible and affordable for those with high-risk conditions. In 1998 more focus was placed on providing health insurance for uninsured children. It is expected that health insurance will continue to attract a great deal of legislative attention in the future.

This report is intended to provide policy-makers with up-to-date information on the status of Kentucky's health insurance market. The data for this report comes primary from the Legislative Research Commission's Kentucky Health Insurance Survey and the U.S. Census Bureau's Current Population Survey. It is hoped that this data helps policy-makers make more informed decisions.

The data presented focuses on several segments of the health insurance market.

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

Information is also reported on the newly uninsured, those with government provided health insurance, and the insurance status of children in Kentucky.

The data shows that there has been relatively little change in Kentucky's health insurance market. The most recent estimates show that approximately 545,000 people are without health insurance in Kentucky. Although this is a decrease from the year before, the change is not statistically significant. In fact, there has been no evidence to suggest that the number of uninsured people in Kentucky has changed in recent years. There was also little change in their characteristics from 1997 to 1998. The uninsured tend to be younger and poorer than the rest of the population. Fewer of the uninsured adults indicated that they were in excellent health. However, there was no difference in the percent that indicated they were in fair or poor health. Smoking rates were higher among the uninsured. Utilization of health care appeared to be lower among the uninsured.

Over all, the number of people with group coverage increased. This increase came from the small-group market. The number of people with large-group coverage decreased. There was virtually no change in the characteristics of both those with large-group coverage and those with small-group coverage. There was a slight decrease in the number of people classified as individually insured.

Those who were newly uninsured (within the past year) accounted for approximately 18% of the uninsured. The newly uninsured tend to be in better health than the other uninsured and are more likely to have utilized health care in the past year.

Most children obtain their insurance through a group plan. Over one-quarter of children receive their insurance through government programs such as Medicaid. Approximately 14% of children (139,000) are uninsured. It is estimated that nearly 80% of these children (110,000) are eligible for health insurance through Medicaid or KCHIP. One major reason eligible children are not enrolled in these programs appears to be parents' belief that the children are not eligible.

The data also showed that the characteristics of health insurance policies are continuing to change. Within all private market segments, movement toward managed care continues. There was also continued movement away from deductibles and toward co-payments.

Estimates of the Kentucky Population by Insurance Status

Insurance Status	Population			Percent		
	1999	1998	1997	1999	1998	1997
Uninsured	545,000	587,000	601,000	14%	15%	15%
Government Insured	1,081,000	1,164,000	1,187,000	28%	30%	30%
Employer Insured	2,131,000	2,040,000	1,976,000	55%	52%	51%
Individually Insured	107,000	132,000	132,000	3%	3%	3%
Total	3,864,000	3,923,000	3,896,000	100%	100%	100%

Note: The changes in the population distribution across insurance status from 1997 to 1998 are not statistically significant. Of the changes from 1998 to 1999, only the increase in employer insured is statistically significant.
Source: 1997-1999 March Current Population Survey, U.S. Census

1998
Demographic Characteristics of Non-Elderly Adults by Market Segment

Characteristics		All Non-Elderly Adults		Uninsured		Government Insured		Employer Insured		Individually Insured
Gender										
	Male		48%		52%		40%		49%	40%
	Female		52%		48%		60%		51%	60%
Age										
	19 to 29		24%		35%		21%		22%	* 20%
	30 to 39	*	24%		24%		23%		25%	20%
	40 to 49	*	24%		24%		22%		29%	24%
	50 to 54		9%		6%		10%		10%	12%
	55 to 59	*	9%		7%		12%	*	9%	10%
	60 to 64		7%		4%		12%		6%	14%
Annual Household Income										
	Less than $10,000		12%		24%		33%	*	3%	10%
	$10,000-$15,000		7%		16%		13%	*	3%	8%
	$15,000-$25,000		14%		24%		19%		10%	* 13%
	$25,000-$40,000		14%	*	14%		8%		16%	15%
	$40,000-$45,000		12%		7%		8%		15%	9%
	$45,000-$55,000		12%		5%		6%		16%	11%
	More than $55,000	*	29%	*	11%		13%		38%	* 35%
Work Status										
	Employed		67%		58%	*	28%		81%	68%
	If employed, part time		15%		21%		33%		11%	24%
Health in General										
	Excellent	*	28%		24%		12%		34%	* 33%
	Very Good	*	30%		29%		19%		34%	34%
	Good		25%		29%		20%		25%	23%
	Fair		10%		10%		24%		6%	8%
	Poor		7%		8%		26%		2%	3%
Dr. Visits in Last Year										
	0		19%		30%		7%		19%	22%
	1-2		40%		42%		27%		43%	45%
	3-4		17%		11%		16%		18%	18%
	5-6		8%		7%		11%		8%	7%
	More than 6	*	16%		10%		39%		13%	9%
Amount Spent Out-of-Pocket for Health Care During Past Year										
	$0	*	28%		34%	*	43%		23%	25%
	$1 - $249		46%		34%		32%		52%	39%
	$250 - $499		10%		11%		8%		10%	13%
	$500 - $999		8%	*	5%		11%		8%	10%
	$1000 - $4999	*	7%		10%	*	7%	*	6%	11%
	$5000 - $9999		1%		1%		0%		1%	1%
	$10,000 or more		1%	*	3%		0%		0%	2%

* Indicates that changes from 1997 to 1998 are statistically significant at the 5% level.
Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey.

1997
Demographic Characteristics of Non-Elderly Adults by Market Segment

Characteristics	All Non-Elderly Adults	Uninsured	Government Insured	Employer Insured	Individually Insured
Gender					
Male	47%	49%	41%	48%	43%
Female	53%	51%	59%	52%	57%
Age					
19 to 29	24%	35%	19%	22%	29%
30 to 39	26%	28%	25%	26%	23%
40 to 49	27%	21%	25%	30%	21%
50 to 54	9%	6%	11%	9%	9%
55 to 59	7%	5%	11%	7%	8%
60 to 64	6%	4%	9%	6%	10%
Annual Household Income					
Less than $10,000	13%	27%	40%	2%	10%
$10,000-$15,000	8%	19%	13%	4%	5%
$15,000-$25,000	14%	25%	18%	9%	23%
$25,000-$40,000	13%	10%	8%	16%	15%
$40,000-$45,000	12%	6%	6%	16%	10%
$45,000-$55,000	12%	5%	7%	16%	13%
More than $55,000	27%	7%	9%	37%	24%
Work Status					
Employed	67%	58%	21%	82%	67%
If employed, part time	15%	23%	29%	12%	27%
Health in General					
Excellent	31%	27%	14%	35%	43%
Very Good	28%	25%	17%	31%	32%
Good	24%	28%	20%	25%	17%
Fair	10%	13%	21%	7%	6%
Poor	7%	7%	29%	2%	2%
Dr. Visits in Last Year					
0	18%	32%	8%	16%	18%
1-2	41%	38%	25%	44%	49%
3-4	18%	12%	20%	20%	16%
5-6	9%	7%	14%	8%	7%
More than 6	14%	11%	33%	11%	10%
Amount Spent Out-of-Pocket for Health Care During Past Year					
$0	23%	31%	27%	21%	21%
$1 - $249	47%	38%	36%	51%	43%
$250 - $499	10%	9%	9%	11%	11%
$500 - $999	8%	10%	9%	8%	10%
$1000 - $4999	10%	10%	16%	8%	13%
$5000 - $9999	1%	2%	2%	1%	1%
$10,000 or more	1%	1%	2%	1%	1%

Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey.

CHAPTER I
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. 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.

Recognizing this need, the Kentucky General Assembly sponsored the 1996 Kentucky Health Insurance Survey (KHIS). This survey was aimed at providing the first detailed description of the number and characteristics of people in the markets affected by changes in legislation. The survey was subsequently replicated in the summer of 1997 and has become an annual survey. By comparing data collected over time, 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 have 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.

While the initial focus of the survey was to estimate the characteristics of the individual and small-group markets, the focus of the survey has changed to reflect current policy interest. Currently, more policy interest is being focused on the uninsured population. For example, the KHIS has been used to refine estimates of the number of children eligible for the Kentucky Children's Health Insurance Program and to make estimates of the cost of providing health insurance benefits for certain uninsured adults. It is expected that the KHIS will continue to evolve as legislative focus shifts.

This report presents the results of the 1998 Kentucky Health Insurance Survey, combined with other data, to show the status of the health insurance market in Kentucky. 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 expected effects this might have on Kentucky's health insurance market. Second is a description of the data sources used. This description is followed by an analysis of the various segments of the health insurance market.

CHAPTER II
HEALTH INSURANCE LEGISLATION IN KENTUCKY

There have been a number of legislative changes that have affected the health insurance market in Kentucky. The majority of the changes dealt with the private market for health insurance. Some legislation, however, was aimed at public health insurance.

1994 Legislation

In 1994, the Kentucky General Assembly passed legislation aimed to provide Kentuckians greater access to private health insurance at affordable rates, no matter what their health status. HB 250 primarily affected health insurance policies sold directly to individuals and small groups (at the time "small groups" were defined as 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 buying 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 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

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

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 pricing control should have lowered the premium for older people, while increasing the premium for the younger people, all else held equal. This process is referred to as modified community rating (MRC). MRC is less restrictive than pure community rating, which requires that companies charge everyone the same premium regardless of variations in any demographic or health characteristics.

Under MCR, healthy people within a rating group tend to subsidize unhealthy people in the rating group. Health insurance premiums for the healthy are greater than their expected health care costs, while premiums for the unhealthy decrease below their expected costs. This subsidy was expected to allow people with high cost medical conditions to obtain health insurance at affordable rates and allow some people who had been priced out of the market to purchase insurance. Lower prices for those with expensive medical conditions provide an incentive for people who had been priced out of the market to purchase new coverage. Access to health insurance, however, does not come without costs. Because those with high health care expenses pay less under MCR, the healthy must pay more. The higher rates faced by the young and healthy may have discouraged them from purchasing insurance and may have induced some of them 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 could identify and deny coverage to those who had health care costs that were higher than the premium they paid, companies could have lowered 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 prevented 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 intended to make coverage comparable across all companies, to allow easier price comparisons. Each of the eight standard plans specified the levels of coverage and cost-sharing provisions, such as co-payments and deductibles. For example, in addition to its other provisions, an enhanced high standard plan through an HMO had maximum out-of-pocket expenses of $1,000, required no deductible, and required various co-payments (depending on the service). The provisions of this policy were the same for all companies offering it. There were eight standard plans, with each of the eight offering various levels of cost-sharing. 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 enrollment by high-cost policyholders 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, was that customers may not have been able to purchase the exact set of benefits they preferred.

HB 250 did not affect everyone insured under an individual or small-group policy. On January 29, 1996, the Governor issued an executive order that 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 had 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, were to 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.

1996 Legislation

During the 1996 regular session, the General Assembly again addressed the issue of health insurance and made 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." Policies sold to these groups were no longer subject to guaranteed issue or the 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 gender. Also, the rating spread for age was increased. The most substantial change to the reforms, however, was the exemption from the rating restrictions of insurance policies sold through associations.

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 somewhat 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 younger people. Increasing the age spread reduces the subsidy of older people by

[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 allowed people with pre-reform plans to maintain their existing benefit levels.

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 was still capped and premiums still could not be based on health status.

The most significant market change was the exemption of policies sold by 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 eligible association could again be rated on health status, with no limits on the spread for age. Therefore, premiums through the associations could be 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 were no subsidies; those with low expected health care costs were charged low premiums, and those with higher expected health care costs were charged high premiums. Individuals and groups with lower than average expected costs had an incentive to purchase health insurance through associations because their premiums would have been lower. Those with high expected costs would prefer to purchase health insurance through the non-association market, where the healthier people in the market subsidized the unhealthy. Over time, this was expected to cause the market to move back to pure experience rating, as the healthiest people in the non-association market would always have been able to find lower premiums through an association. As these people move to associations, those remaining would have had to pay higher premiums to reflect the higher average costs of the remaining group.

In addition, other events relating to health insurance were occurring. In June and July of 1995, just 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 57 companies had left the Kentucky market. 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. In the individual market only Anthem and Kentucky Kare, the plan created to be a self-insured plan for state government employees, continued to offer policies.

1998 Legislation

To address the loss of carriers in the individual market, the 1998 General Assembly passed HB 315. HB 315 was designed to encourage insurance companies to reenter the Kentucky market. Carriers that left Kentucky may now reenter with no penalty. In addition, HB 315 attempted to make the Kentucky market more appealing to companies. This legislation essentially returned the market to experience rating, with a few exceptions. HB 315 stipulated that, for any demographic characteristics except health status, the

highest rate charged can be no more than five times the lowest rate. For individuals with the same demographic characteristics, those with higher expected claims because of a health condition can be charged an additional 135 percent of the index rate (125% for small group policies). The index rate is the median rate a company charges to a group of customers with similar demographic characteristics.

The 1998 legislation maintained the provision that guaranteed renewal of all existing policies. Premium for existing policies could not increase by more than 25% in the first two years after passage of HB 315. After two years, premiums could increase further, but only up to 35% of the premium prior to HB 315.

HB 315 also contained provisions to ensure that people with high-risk conditions have access to private health insurance through the creation of the Guaranteed Acceptance Program (GAP). Anyone who suffers from any of a list of designated health conditions,[3] such as juvenile diabetes or leukemia, and is not eligible for health insurance coverage in the primary market can obtain health insurance through the GAP. Because people diagnosed with these high-cost conditions are likely to have higher claims, insurance companies are permitted to charge new applicants with these conditions up to 150 percent of the index rate. All companies selling health insurance in Kentucky must either provide insurance to GAP eligible people or be assessed a portion of the losses that result from GAP policies. For most people in the individual market, these rules essentially returned the market to the rate spread that existed in 1994, where the highest non-GAP premium can be 11 times the lowest. One difference, however, is that although premiums are not restricted, people are now guaranteed access to health insurance. That is, those who would have been denied coverage prior to 1994 can purchase coverage at these rates, if they can afford the premium. Once issued, all policies are guaranteed renewable.

Although HB 315 largely returned the Kentucky health insurance market to pre-reform rules, many of the people who benefited from the reforms continue to benefit. During the period of reforms, those with high-risk conditions had an opportunity to purchase coverage at relatively low premiums. Any high-risk people who took advantage of this opportunity and maintained their coverage now have policies that are guaranteed renewable, with limits on how much premium can be increased. This limit is lower than what they might face if purchasing new coverage through the Guaranteed Acceptance Program.

Other Changes in the Kentucky Health Insurance Market

[3] The bill lists the following as high cost conditions: acquired immune deficiency syndrome (AIDS), angina pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, huntington chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, open heart surgery, Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease.

Not all changes dealt with the private market. The1998 General Assembly also established the Kentucky Children Health Insurance Program (KCHIP) and expanded Medicaid to cover more children. KCHIP is part of a federal program designed to provide health insurance to children in families with low income, but not low enough to qualify for Medicaid. The eligibility guidelines required that children be under the age of 14 and that their family income be under 200% of the Federal Poverty Guidelines. To cover children from age 14 through 18 with family incomes under 200% of Federal Poverty Guidelines, Kentucky expanded the Medicaid program.

CHAPTER III
DATA SOURCES

Data on insurance status and demographic characteristics was collected in two separate random surveys of Kentucky households: the Current Population Surveys (CPS) and the Kentucky Health Insurance Surveys (KHIS). These surveys were conducted at different times, asked different questions, and have different strengths and limitations for the analysis. The data from both sources are therefore combined in a way that maximizes their usefulness.

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. The March Supplement to the CPS also includes questions designed to obtain information on the source of health insurance coverage.

The March CPS samples 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, but can be used for state level estimates as well. The March 1999 CPS sample includes 659 Kentucky households, with 1,652 individuals.

1998 Kentucky Health Insurance Survey

Data for the 1998 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: the uninsured, large-group insured, small-group insured, and the individually insured. The main 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 in August 11, 1998, and was completed September 15, 1998. The Urban Studies Institute interviewed 1326 households to provide a picture of the overall health insurance market. To generate the 1326 completed surveys, 7562 phone numbers were contacted. Of those, 3073 were determined to be ineligible for various reasons, such as language barriers or no answer after repeated attempts. In addition, 1563 refused to participate or terminated the interview before completion. This yielded an overall response rate of 47%. The overall margin of error for estimates on the first phase of the survey is plus or minus 2.7%.

The second phase of the survey involved interviewing additional households in certain segments of the health insurance market: Uninsured, small group insured, and individually insured. Previous surveys showed that the size of these markets are 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 January 20, 1999. Table 1 shows the number of people sampled for each market segment.

Table 1
1998 Kentucky Health Insurance Survey
Sample Sizes

Market Segment	Number of People Sampled
Uninsured	739
Government Insured	597
Large-Group Insured	965
Small-Group Insured	687
Group Insured (no data on group size)	477
Individually Insured	278
Total	3743

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 all persons 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. 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 asked if household members suffered from any serious medical conditions (such as heart disease, diabetes, and cancer). If they

had suffered from a serious health condition, they were provided with the high cost condition list from HB 315 and asked if they suffered from any conditions listed and if so, which ones. Respondents were also asked if anyone in the household had been newly uninsured in the past 12 months. For anyone who had been uninsured in the past 12 months, respondents were asked why they were uninsured. Finally, 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.

Differences in Methodology from the 1997 Kentucky Health Insurance Survey

Although the 1998 Kentucky Health Insurance Survey is largely a replication of the surveys conducted in 1997 and 1996, there are several changes worth noting.[4] These changes are aimed at addressing limitations identified in previous surveys and at improving the content of the survey.

Research Memorandum 480, which reported the results of the 1997 survey, identified several limitations of the previous surveys. One limitation of the 1997 and 1996 surveys were that detailed data on health insurance policies was only collected for policies that covered the main respondent (typically the head of household). If there was an adult child in the household with a policy that did not cover the head of household, the survey would not likely collect information about this policy. Because these policies are not represented, results from the 1997 and 1996 surveys may not accurately represent all policies. That is, the estimates on policy characteristics may be biased. It was argued that any bias that existed was likely to be fairly small because the missing policies were not expected to differ substantially from the ones observed. However, without data on these missing policies, this could not be verified.

To address this limitation, the main respondents (head of households) were asked if anyone in the household had their own coverage. Those that did have their own health coverage were then interviewed to provide data on the missing policies. Analysis of these policies showed that these policies were generally similar to those policies covering the head of households. However, there were a few differences that were statistically significant. These differences have been accounted for in the estimates.

A second limitation of the 1997 survey was that a number of questions regarding health status were deemed unusable. The questions provided respondents with a statement, such as "I expect my health to get worse." Respondents were then asked if they strongly agreed, agreed, did not know, disagreed or strongly disagreed with the statement. A large percentage of the respondents answered "don't know," making the results questionable. This appeared to be the result of the wording of the health questions, which included "don't know" as an option. The 1998 survey removed "don't know" from the wording of these questions. Respondents could still respond "don't know," but they were not read this as one of the possible answers. This change appears to have had a

[4] For a detailed description of the 1997 Kentucky Health Insurance Survey, see Research Memorandum No. 480: Status of the Health Insurance Market in Kentucky.

substantial impact on responses. The 1998 data had a much more reasonable percentage of people responding "don't know."

The final limitation listed in the 1997 survey dealt with phone bias. Phone bias occurs in the KHIS because phones are used to contact respondents. Households that do not have phones cannot be contacted and are not represented in the KHIS. Estimates from the 1999 Current Population Survey show that approximately 5.6% of the Kentucky population is without a phone. 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 that of 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.

To address the phone bias, the LRC Staff Economist Office worked with economists from the Center for Business and Economic Research to develop a methodology that would combine the CPS and the KHIS. Combining data from these sources was judged to be the preferred methodology because each data source offers both advantages and disadvantages. Because the KHIS is conducted by telephone, it does not capture information on Kentucky residents without phones; however, the reduced cost of the telephone method allowed collection of information about a relatively large sample. In contrast, the CPS is conducted with in-person interviews, so it does include those without phones, but has a relatively small sample size. While the sample size on the CPS is sufficient to provide a reliable estimate of insurance status, it is not sufficient to estimate the income and age distribution of people with a particular type of coverage. The methodology basically creates weights for each person represented in both surveys. Those without phones from the CPS were given their full weight. Those with phones from the KHIS and CPS were given weights that would allow them to total to the state population with phones.

An additional change dealt with the definition of insurance status. This change was not intended to address a limitation of the data but rather to improve the usefulness of the results. Insurance status is generally defined somewhat differently in this report than in previous reports released by the LRC. The estimates presented in this report assign each person to one category of insurance status. It is possible, however, for people to have two or more types of insurance. For example, a person may have an employer-provided policy and an individually purchased policy. Rather than assigning people to multiple categories, individuals were assigned to one category only. This prevents double counting if multiple categories are later combined. Assignment to the categories was done in the following manner. Persons not covered by any form of insurance were considered uninsured. Of those remaining, those with government coverage, such as Medicaid or Medicare, were classified as having Government coverage regardless if they had other

coverage. After identifying the uninsured and those with government coverage, those remaining who were covered by an employer-provided plan were classified as group coverage, regardless of any other coverage they may have. Finally, those not already classified and covered by a policy they purchased directly from an insurance company were classified as individually covered.

While this classification prevents double counting, depending on the policy options under discussion, it may not always be the most appropriate way to present the data. For example, a policy discussion focusing on the individually insured may need to address all people with individual insurance regardless of other coverage they may have. However, the individually insured as defined above would not reflect those with both individual and employer provided coverage. Because both definitions are useful, this report does present estimates made both ways. However, the primary discussion focuses on estimates made by assigning each person to only one market segment. Some caution therefore should be used in applying these estimates to policy decisions.

A final change was the addition of a follow-up survey. The KHIS surveys a new set of households each year and provides data on the current status of Kentucky's health insurance market. Although the main portion of the survey provides some information about how people move from being insured to uninsured and from being uninsured to insured, it does not provide information about movement between other market segments. To understand how people are moving between these segments, households interviewed in 1997 were contacted again in 1998 to see how their insurance status had changed. The follow-up survey was separate from the main 1998 KHIS survey.

A major issue regarding a follow-up survey is that it is possible to contact the same people that were contacted in the first survey. To improve the chances of contacting the 1997 respondents, each respondent interviewed in 1997 was asked to provide their first name in case additional information was needed. In case respondents moved, they were also asked to provide the name and phone number of a person who would know how to reach them.

Slightly more than 50% of the original respondents from 1997 were interviewed again in 1998. Although a response rate of 50% may appear high compared to many response rates, in this survey it was a signal of non-response bias. Non-response bias occurs when the people interviewed are somehow different than those that are not interviewed. In the follow-up survey, non-response bias was expected to some extent because of migration. It was recognized prior to the survey that some people surveyed in 1997 would move and, in spite of attempts to track these people down, it would not be possible to contact some of them. It was also expected that those moving might be different than the rest of the sample. For example, younger adults tend to be more mobile than older adults. Therefore, the follow-up survey might be biased toward older, more stable adults. It was hoped that few people would be unreachable and the bias would be fairly small.

Because data from the 1997 survey was available about all individuals that the follow-up was attempting to contact, it was possible to compare the demographics and insurance status of those who were re-interviewed in 1998 and those who were not. These results showed that there were substantial differences between these two groups. Those not contacted in the follow-up survey were much younger, earned substantially less, and were more likely to be uninsured in 1997 than those who were re-interviewed in 1998. Given that nearly half of the 1997 sample could not be contacted in 1998 and that there were large differences between those who could be re-contacted and those who could not, any estimates of movement between market segments are likely to be biased. As the less mobile, or more stable, individuals were contacted in the follow-up survey, it is expected that estimates of movement between market segments based on the follow-up survey would show more stability in the market than what actually exists.

Because the estimates do not appear to accurately represent movement in the Kentucky health insurance market, they are not included in this report. This data will continue to be analyzed to determine if it is possible to adjust the results to account for the non-response bias.

Limitations

Adjustments were made to address the phone bias, a phone bias, but may remain for some of the estimates. Because much of the data collected in the KHIS is not collected in the CPS. For example, the CPS does not collect information about people's health insurance policies. The CPS also does not ask people why they are uninsured. For questions that are asked in the KHIS only, a phone bias may exist. Generally, it is believed that the remaining phone bias is fairly small. The phone bias is primarily a concern for any estimates of low-income or uninsured populations that rely solely on the KHIS.

A second concern is the method used to collect income data in the KHIS. To obtain income information, the KHIS asks respondents to indicate their total household income. This includes the total income of all people living in the households. Programs, such as Medicaid, typically use family income as an eligibility guideline. A family unit does not always include all people in the household. Therefore, in some cases, family income can be substantially different than household income. Consider a traditional household of a married couple with young children. The household income includes the incomes of both adults. In this case, the family income is equal to the household income. Now consider a household of a married couple with an adult child and young grandchildren. Household income is the total of all household members' income. However, frequently when determining Medicaid eligibility only the income of the adult child would be considered. Because the KHIS collects household income and does not break this down by family members, household income is used as a proxy for family income. For the majority of the households sampled in the KHIS household and family income are equal. However, for some families household income is larger than family income. This becomes a concern when estimating the number of people who would be eligible for a program for which eligibility is based on family income. Essentially, income

may be over-estimated, therefore, the number of people who could be eligible is under-estimated.

A number of tests were performed to determine the extent of this bias. First, it was determined that, when stated as a percent of federal poverty guidelines, family income is different than household income for 7.7% of the total population. However, the primary concern is with the low income population, because the programs that this report deals with target those with low incomes. Fewer than 4% of the total population have family incomes that are not equal to their household income and have family incomes below 150% of the federal poverty guidelines. Many of these are already covered by Medicare or Medicaid. This fact suggests that the bias of concern affects a fairly small segment of the population. Finally, to determine the impact this proxy has on estimates, estimates of income as a percent of poverty by insurance status were calculated using the weighted methodology that combines the CPS and the KHIS, and a second set of estimates were made using only the CPS. The estimates show that there was little difference between the two sets of estimates when considering the entire population, partly because the bias exists for only a small portion of the population. A second factor that may have kept the difference from being large is that self-reported income in the KHIS appears to be somewhat lower than in the CPS. Based on these tests, it appears that the difference in household income and family income does not create a substantial bias in the estimates.

A final limitation that should be noted is that because of the substantial changes to the methodology, it is generally not possible to compare the results that appear in this report to the results published in previous reports. There may appear to be several differences between the 1997 report and this report. Many of those differences, however, are the result of the improvements made in the estimation process. It should not be assumed that these differences represent actual changes. To assess changes over time we have applied the new methodology to data from previous years.

CHAPTER IV
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 have no health insurance coverage. Since there is nearly universal coverage of those 65 and older by Medicare, estimates of the characteristics are presented primarily for the non-elderly adult population.

The second segment consists of those who obtain coverage for medical services through a government program, such as Medicare or Medicaid. The remaining segments are the large-group insured, the small-group insured, the individually insured. Collectively, these segments make up the private health insurance market. The large-group and small-group segments of the market are comprised of those who obtain health insurance as part of an employee group. In these segments of the market, the employer negotiates with an insurer for plans to offer to 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 those of the individual. Past legislation defined small-groups as those with fewer than 50 employees and large-groups as those with 50 or more employees. Therefore, the small-group and large-group segments of the market are discussed separately in this report. Finally, 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 on an individual basis.

Table 2 shows the distribution of Kentuckians across the market segments. These estimates are obtained from the March Current Population Survey. There have been no substantial changes in the percentage of Kentucky's population in each market segment during the period reviewed.

Table 2
Estimates of the Kentucky Population by Insurance Status

Insurance Status	Population			Percent		
	1999	1998	1997	1999	1998	1997
Uninsured	545,000	587,000	601,000	14%	15%	15%
Government Insured	1,081,000	1,164,000	1,187,000	28%	30%	30%
Employer Insured	2,131,000	2,040,000	1,976,000	55%	52%	51%
Individually Insured	107,000	132,000	132,000	3%	3%	3%
Total	3,864,000	3,923,000	3,896,000	100%	100%	100%

Note: The changes in the population distribution across insurance status from 1997 to 1998 are not statistically significant. Of the changes from 1998 to 1999, only the increase in employer insured is statistically significant.
Source: 1997-1999 March Current Population Survey, U.S. Census

Entire Market

To provide a basis of comparison, results for non-elderly adults in all segments of the market are provided in Table 3. Nearly half of the non-elderly adult respondents were below the age of 40. Sixteen percent lived in households with family incomes below the federal poverty level, while 56% lived in households with family incomes of 250% or more of the federal poverty level. The median household income category reported was $40,000 to $45,000. Sixty-seven percent of those surveyed were employed, with 85% of the employed working over 35 hours per week.

Fifty-eight percent of the sample had a reported health status of very good or excellent. Only 7% reported a health status of poor. Thirty-four percent indicated that they had smoked in the past two years. Nineteen percent had not seen a doctor in the past year. On average the respondents visited a doctor four times in the past year.

Table 3
Demographic Characteristics of All Non-Elderly Adults

Characteristic		Percent 1998	Percent 1997
Gender			
Male		48%	47%
Female		52%	53%
Age			
19 to 29		24%	24%
30 to 39	*	24%	26%
40 to 49		26%	27%
50 to 54		9%	9%
55 to 59	*	9%	7%
60 to 64		7%	6%
Annual Household Income			
Less than $10,000		12%	13%
$10,000-$15,000		7%	8%
$15,000-$25,000		14%	14%
$25,000-$35,000		14%	13%
$35,000-$45,000		12%	12%
$45,000-$55,000		12%	12%
More than $55,000	*	29%	27%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%		16%	16%
100% to 149%	*	9%	11%
150% to 199%		9%	7%
200% to 249%		11%	10%
250% to 299%		9%	9%
300% and Above		47%	45%
Work Status			
Employed		67%	67%
If employed, part time		15%	15%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent	*	28%	31%
Very Good	*	30%	28%
Good		25%	24%
Fair		10%	10%
Poor		7%	7%
Smoked Regularly in Past 2 Years			
		34%	35%
Serious Health Condition Past 10 Years			
		15%	-
HB 315 High Cost Condition List			
		6%	-
Number of Dr. Visits in Last Year			
0		19%	18%
1-2		40%	41%
3-4		17%	18%
5-6		8%	9%
More than 6	*	16%	14%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0	*	28%	23%
$1 - $249		46%	47%
$250 - $499		10%	10%
$500 - $999		8%	8%
$1000 - $4999	*	7%	10%
$5000 - $9999		1%	1%
$10,000 or more		1%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey.

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 uninsured children, which are discussed later in this report.

Number of Uninsured

The most recent estimate of the uninsured comes from the 1999 March Current Population Survey. Based on this data, it is estimated that approximately 14.1% of the Kentucky population is uninsured. Thus, about 545,000 people in Kentucky are without any form of health insurance. The margin of error for this estimate is +/- 1.68%. This means that there is a 95% probability that the actual number of the uninsured is between 480,000 and 610,000.

Kentucky's rate of uninsured compares well with the entire nation. Approximately, 15% of the entire nation is uninsured. Although Kentucky's estimate is slightly lower than the national rate, the difference is not statistically significant. One reason that Kentucky is not above the national rate is that Kentucky has a larger share of its population covered by Medicaid.

There is a great deal of confusion regarding changes in the uninsured. Some reports have discussed the growing problem of the uninsured. Others have pointed out that the rate of uninsured in Kentucky has decreased. Both of these statements are somewhat misleading. Typically there are two figures which show the magnitude of the uninsured, both of which were used above. The first is the actual number of uninsured. The second is the percentage of the population that is uninsured (the rate of uninsured). The rate of uninsured is usually calculated by dividing the number of uninsured people in the non-institutionalized population by the total non-institutionalized population. Expressing the uninsured as a percentage of the total population allows for comparison of the uninsured population relative to the total population. It also provides a better comparison across states. It is possible for these two estimates of the uninsured to move in different directions or for one to change while the other remains constant. For example, while there has been an increase in the number of people uninsured nationally, there has been no statistically significant change in the percentage of the nation's population that is uninsured. So, although there may be more people without insurance, the uninsured population is growing at the same rate as the general population. That is, the uninsured population is not increasing relative to the total population.

In Kentucky, there is no evidence that the uninsured population has grown, either in terms of the actual number or in terms of the percentage of the population that is uninsured. In addition, there is no evidence to suggest that the uninsured have decreased. Although the 1999 estimate of the rate of uninsured and the number of uninsured in Kentucky are lower than the estimates for 1998 and 1997, these decreases are not statistically significant. This means that the data shows no evidence that the uninsured

population has changed in recent years. Differences between years are within the margin of error on the sample estimates.

There has also been an increased interest in estimates of the uninsured for each county. Unfortunately, no data currently exists that is sufficient for estimating county level uninsured rates with any accuracy. The problem with existing data is that the number of people sampled within each county is not sufficient to make accurate estimates. Even after combining the Current Population Survey and the Kentucky Health Insurance Survey the sample sizes are not sufficient. There have been attempts to estimate the number of people uninsured at the county level using alternative methods. These attempts, however, appear biased or yield estimates with large margins of error. These problems make these estimates meaningless for policy analysis.

Characteristics of Uninsured Non-Elderly Adults

Table 4 shows the characteristics of the non-elderly adult respondents without any form of health insurance coverage from the Kentucky Health Insurance Surveys and the March Current Population Surveys for 1997 and 1998. The uninsured non-elderly adults are generally younger than other non-elderly adults. Nearly sixty percent are under the age of forty. The uninsured are also poorer. Thirty-three percent of the uninsured non-elderly adults had household incomes below 100% of the federal poverty level. This is somewhat lower than non-elderly adults with government insurance, but much higher than those with private insurance. The uninsured were also less likely to be employed.[5]

The uninsured had nearly the same percentage of people responding that their health status was fair or poor. Approximately 18% of the non-elderly adult uninsured fell into these categories. However, fewer uninsured responded that their health was excellent. From 1997 to 1998 the health status of uninsured adults did not change significantly. Only 3% indicated that they suffered from at least one of the high cost conditions listed in HB 315. This is statistically different from adults with government provided insurance, 24% of whom reported having one of the conditions, but is the same as privately insured adults.

Smoking rates were much higher for the uninsured. Almost half of uninsured 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 percent of the uninsured had not been to a doctor in the past year. 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 have some of the cost absorbed by the insurance carrier, depending on deductibles or copayments. The incentive

[5] The percentage of people employed presented in this report cannot be compared to the official estimates of the unemployment rate. Unemployment rates generally consider people unemployed only if they are not working but are actively seeking work. A person who does not work and 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.

Demographic Characteristics of Uninsured Non-elderly Adults

Characteristic		Percent 1998	Percent 1997
Gender			
Male		52%	49%
Female		48%	51%
Age			
19 to 29		35%	35%
30 to 39		24%	28%
40 to 49		24%	21%
50 to 54		6%	6%
55 to 59		7%	5%
60 to 64		4%	4%
Annual Household Income			
Less than $10,000		24%	27%
$10,000-$15,000		16%	19%
$15,000-$25,000		24%	25%
$25,000-$35,000	*	14%	10%
$35,000-$45,000		7%	6%
$45,000-$55,000		5%	5%
More than $55,000	*	11%	7%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%		33%	35%
100% to 149%		18%	22%
150% to 199%		11%	12%
200% to 249%		12%	11%
250% to 299%		6%	5%
300% and Above	*	20%	16%
Work Status			
Employed		58%	58%
If employed, part time		21%	23%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent		24%	27%
Very Good		29%	25%
Good		29%	28%
Fair		10%	13%
Poor		8%	7%
Smoked Regularly in Past 2 Years			
		45%	50%
Serious Health Condition Past 10 Years			
		10%	-
HB 315 High Cost Condition List			
		3%	-
Number of Dr. Visits in Last Year			
0		30%	32%
1-2		42%	38%
3-4		11%	12%
5-6		7%	7%
More than 6		10%	11%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0		34%	31%
$1 - $249		34%	38%
$250 - $499		11%	9%
$500 - $999	*	5%	10%
$1000 - $4999		10%	10%
$5000 - $9999		1%	2%
$10,000 or more	*	3%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.

Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey.

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 1998 Kentucky Health Insurance Survey asked those who had been uninsured at any time in the past year why they were uninsured. The results are reported in Table 5. While similar questions were asked in the 1997 KHIS, the results of the 1998 KHIS are not comparable. The reason for this is that the 1997 KHIS asked this question only of head of households while the 1998 KHIS asks this question for all household members. The reasons for head of households being uninsured can vary from those of other household members.

Table 5
Reasons for Being Without Health Insurance

Reason Uninsured are Without Health Insurance	Non-Elderly Adults
Left Job Where Health Insurance was Offered	23%
No Longer Eligible for Coverage on a Relative's Policy	9%
No Longer Eligible for Student Coverage	2%
Could No Longer Afford Because of Premium Increase	9%
Could No Longer Afford Because of Other Expenses	25%
Policy Cancelled Because of Health Conditions	2%
Other Reasons	31%
Why Health Insurance Coverage Ended	Households Only
Left Job Where Health Insurance was Offered	51%
No Longer Eligible	18%
Could No Longer Afford	13%
Canceled Because of Health Condition	3%
Other	15%

Source: 1998 Kentucky Health Insurance Survey.

Respondents were asked why they were uninsured and were provided with a list of possible options. If none of the list reasons fit their situation they could answer "other." Other reasons was the most common response, at 31%. Although 34% of the non-elderly adults were uninsured because they could no longer afford health insurance, only 9% attributed this to premium increases. The remaining 25% indicated they could not afford health insurance because of other expenses. This may reflect those who must make a choice between health insurance and other necessities, such as food and shelter. It may also reflect the young uninsured who are generally healthy and have low incomes and, therefore, do not place a priority on health insurance. Twenty-three percent indicated that coverage was lost because of a change in employment. Two percent indicated that their health insurance was cancelled due to health conditions. While this number appears low, it should be considered in the context of the reforms in the individual market.

Prior to the 1994 reforms, insurance companies could cancel coverage for any reason. After the 1994 reforms, insurance companies were not permitted to rate premiums based on health conditions, and because policies were guaranteed renewable, they were not allowed to cancel coverage. The legislative change in 1996 kept these provisions in place for most companies. Certain employer associations were exempted, however, from these restrictions. It is possible that some people could have seen their policies canceled by associations, but this is likely to be a small number. The passage of HB 315 in 1998, made all policies guaranteed renewable and limited the premium increases. Many of the people who had serious health conditions purchased coverage under the 1994 reforms and now are locked in. That is, insurance companies cannot cancel their coverage and are limited in the extent that they can get policyholders to drop coverage through premium increases. Those who are insured and later develop serious health conditions are likewise protected. Because of guaranteed renewal, insurance companies cannot cancel their coverage for health reasons.

Characteristics of the Newly Uninsured

For the purposes of the Kentucky Health Insurance Survey, the newly uninsured consisted of anyone who became uninsured within the past 12 months. The Current Population Survey does not allow us to determine how long respondents have been uninsured; therefore, the following analysis is based entirely on the Kentucky Health Insurance Survey. Accordingly, the usual caveats regarding phone survey bias apply to these estimates.[6]

The newly uninsured represent approximately 18% of the uninsured. This rate is higher than in 1997 when 14% of the uninsured were newly uninsured. This increase could have been caused by a number of factors. For example, it may be that more people are dropping or losing their health insurance coverage. This result could also occur if people who have been uninsured for some time are obtaining health insurance coverage, perhaps because they are getting coverage through employers or new government programs.

The newly uninsured, non-elderly adults are somewhat different than other uninsured adults (Table 6). Although they do not differ substantially with respect to age and gender, they do differ with respect to income and health. The newly uninsured non-elderly generally have higher incomes. Only 9% of the newly uninsured non-elderly have incomes below $10,000. This is lower than the other uninsured.

Income as a percent of the Federal Poverty Guidelines (FPG) are also different. Comparing income as a percent of the FPG, however, shows that within the non-elderly demographic there are more newly uninsured than the total insured below the poverty level. Approximately 35% of newly uninsured non-elderly adults reported that their health was excellent, compared to 24% of other uninsured non-elderly adults. Only 8% of newly

[6] These caveats are discussed in the data limitations section.

uninsured non-elderly adults reported a health status of fair or poor. This figure is low even when compared to the entire non-elderly adult population.

Newly uninsured non-elderly adults are similar to other uninsured non-elderly adults with respect to smoking rates, serious medical conditions, and the high cost conditions listed in HB 315. Newly uninsured non-elderly adults have seen the doctor more frequently than other uninsured non-elderly adults and have generally spent more on health care. Substantially fewer of the newly uninsured non-elderly adults have had no health care expenses in the past year than other uninsured adults. However, more of the newly uninsured non-elderly adults spent between $250-$499. The $250 to $499 range is a fairly common range for deductibles. It is likely that the newly uninsured attempt to time their use of health care to periods when they are covered. A person with employer provided health insurance may regularly utilize health care because the expense is paid for by the insurance company. If this person losses his health insurance benefits because of a lost job, he or she may postpone health care until he or she has a new job and new insurance, rather than pay the expenses out-of-pocket. These people show up as newly uninsured, but have higher utilization due to the periods of time when they were covered.

Table 6
Demographic Characteristics of the Uninsured Non-Elderly Adults

Characteristic		Percent 1998	Percent 1997
Gender			
Male		56%	57%
Female		44%	43%
Age			
19 to 29		33%	38%
30 to 39		31%	22%
40 to 49		22%	24%
50 to 54		6%	8%
55 to 59		3%	6%
60 to 64		5%	2%
Annual Household Income			
Less than $10,000		9%	9%
$10,000-$15,000		10%	12%
$15,000-$25,000		25%	23%
$25,000-$35,000		21%	21%
$35,000-$45,000		9%	8%
$45,000-$55,000		9%	12%
More than $55,000		18%	14%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%		36%	25%
100% to 149%		13%	16%
150% to 199%		15%	8%
200% to 249%	*	7%	16%
250% to 299%		9%	11%
300% and Above		20%	25%
Work Status			
Employed		63%	71%
If employed, part time		31%	22%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent		35%	35%
Very Good		28%	33%
Good		30%	22%
Fair	*	3%	9%
Poor		5%	2%
Smoked Regularly in Past 2 Years			
		47%	45%
Serious Health Condition Past 10 Years			
		8%	-
HB 315 High Cost Condition List			
		3%	-
Number of Dr. Visits in Last Year			
0		12%	23%
1-2		44%	47%
3-4		18%	9%
5-6		12%	11%
More than 6		15%	9%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0		18%	31%
$1 - $249		32%	32%
$250 - $499		26%	11%
$500 - $999		9%	16%
$1000 - $4999		9%	8%
$5000 - $9999		3%	2%
$10,000 or more		3%	0%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Kentucky Health Insurance Survey.

Government-Provided Health Insurance

Government-provided health insurance, or public health insurance, generally covers people who receive Medicaid or Medicare. Medicaid provides health insurance coverage for certain groups of low-income and medically needy people. Medicare provides health insurance benefits to people of the age of 65 and people with certain disabilities. It may also include other forms of insurance, such as Champus. This segment of the health insurance market is primarily included for comparison purposes. Little discussion of the data is provided because much more reliable data on these groups can be obtained from the government departments that administer these programs. Still, it is useful to include comparable results for the government insured to see how they differ from people insured through other segments of the health insurance market.

Survey results show that approximately 28% (+/-2.16%) of the Kentucky population are insured through some form of government-provided health plan. The number of people with public insurance ranges from 998,000 to 1,165,000, with a point estimate of 1,081,000. Table 7 show the characteristics of those with government provided health insurance.

Table 7
Demographic Characteristics of Non-Elderly Adults with Government-Provided Insurance

Characteristic		Percent 1998	Percent 1997
Gender			
Male		40%	41%
Female		60%	59%
Age			
19 to 29		21%	19%
30 to 39		23%	25%
40 to 49		22%	25%
50 to 54		10%	11%
55 to 59		12%	11%
60 to 64		12%	9%
Annual Household Income			
Less than $10,000		33%	40%
$10,000-$15,000		13%	13%
$15,000-$25,000		19%	18%
$25,000-$35,000		8%	8%
$35,000-$45,000		8%	6%
$45,000-$55,000		6%	7%
More than $55,000		13%	9%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%		42%	46%
100% to 149%		14%	18%
150% to 199%		8%	7%
200% to 249%	*	11%	6%
250% to 299%		3%	5%
300% and Above		22%	19%
Work Status			
Employed	*	28%	21%
If employed, part time		33%	29%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent		12%	14%
Very Good		19%	17%
Good		20%	20%
Fair		24%	21%
Poor		26%	29%
Smoked Regularly in Past 2 Years			
		53%	47%
Serious Health Condition Past 10 Years			
		42%	-
HB 315 High Cost Condition List			
		24%	-
Number of Dr. Visits in Last Year			
0		7%	8%
1-2		27%	25%
3-4		16%	20%
5-6		11%	14%
More than 6		39%	33%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0	*	43%	27%
$1 - $249		32%	36%
$250 - $499		8%	9%
$500 - $999		11%	9%
$1000 - $4999	*	7%	16%
$5000 - $9999		0%	2%
$10,000 or more		0%	2%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey.

Private Health Insurance Market

The private market consist of health insurance obtained through an employer (group insured) or directly from an insurance company (individually insured). Table 8 shows the characteristics of all people with private health insurance. 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 disabled. Those who are uninsured are often unemployed or are employed in lower-paying jobs that either do not provide insurance or do not pay enough to make health insurance affordable. Rather than discuss the entire private market in detail, each segment within the private market is discussed below.

Table 8
Demographic Characteristics of Privately Insured Non-Elderly Adults

Characteristic		Percent 1998	Percent 1997
Gender			
Male		49%	48%
Female		51%	52%
Age			
19 to 29		22%	23%
30 to 39		24%	26%
40 to 49		28%	29%
50 to 54		10%	9%
55 to 59	*	9%	7%
60 to 64		7%	6%
Annual Household Income			
Less than $10,000		3%	2%
$10,000-$15,000		3%	4%
$15,000-$25,000		10%	10%
$25,000-$35,000		16%	16%
$35,000-$45,000		14%	15%
$45,000-$55,000		15%	16%
More than $55,000		38%	36%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%		4%	4%
100% to 149%	*	5%	7%
150% to 199%	*	8%	6%
200% to 249%		11%	12%
250% to 299%		11%	12%
300% and Above		61%	60%
Work Status			
Employed		80%	81%
If employed, part time		12%	13%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent		34%	36%
Very Good	*	34%	31%
Good		25%	24%
Fair		6%	7%
Poor		2%	2%
Smoked Regularly in Past 2 Years		28%	30%
Serious Health Condition Past 10 Years		10%	-
HB 315 High Cost Condition List		3%	-
Number of Dr. Visits in Last Year			
0		19%	17%
1-2		43%	45%
3-4		18%	19%
5-6		8%	8%
More than 6		12%	11%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0		23%	21%
$1 - $249		51%	50%
$250 - $499		10%	11%
$500 - $999		8%	8%
$1000 - $4999	*	6%	9%
$5000 - $9999		1%	1%
$10,000 or more		0%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey.

Group Market

The group market consists of people who obtain their health insurance through employers. Health insurance is typically offered as a benefit where the employer arranges for employees to purchase health insurance as part of a 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 premium for the policies generally reflects the average health characteristics of the group rather than the individual.

In Kentucky, group insured are separated into two categories: small-group and large-group. The classification is based on past legislation which defined small groups as those with fewer than 50 employees and large groups as those with 50 or more employees. It should be noted that how a group is classified is based on the number of employees, not on the size of the group. The size of the group could differ from the number of employees if dependents are covered. Therefore, a group policy that covers 60 people could be classified as small-group for legislative purposes if there are fewer than 50 employees. The small-group and the large-group markets are discussed separately below.

Number Covered Under Group Policies

Two estimates for those with group coverage are presented. The first estimate is of all people who are covered by an employer-provided policy. This estimate is useful when considering the impact of legislation specifically dealing with this market segment as it shows the number of people that would be affected by the legislation. However, some of the group insured have additional coverage through government programs.

In 1999, approximately 58.7% of the population was insured through an insurance policy provided by an employer. The margin of error is +/-2.37%. This means it is estimated that 2,268,000 people in Kentucky were covered by a group policy, and we are 95% confident that the actual number falls between 2,176,000 and 2,360,000. This was an increase from 1998, when 54.3% of the state's population was covered through an employer-provided policy. Excluding those who reported having public health issurance, it is estimated that approximately 55.1% of the Kentucky population, or 2,131,000 people have group insurance. The margin of error on this estimate is +/-2.4%. This means that the actual number of group insured, excluding those with public health insurance, is likely to fall between 2,039,000 and 2,224,000.

Characteristics of Non-Elderly Adults Covered Under Group Policies

Table 9 shows the characteristics of the non-elderly adults with group coverage, excluding those with public health insurance. This table includes both large-group and small-group policies. There has been very little change in the group market from 1997 to 1998. Even the changes that are statistically significant are actually fairly minor changes.

The non-elderly adult group insured generally have higher incomes than non-elderly adults in other markets. Eighty-three percent of the group market have incomes above 200% of the federal poverty guidelines. Sixty-seven percent of all non-elderly adults have incomes above 200% of FPG. This is expected, as the other markets are primarily the uninsured and those with government insurance. People in these markets are in these categories largely because of their low-income status.

The group insured tend to be more heavily concentrated between the ages of 40 and 50 than those in other markets. Those with group policies are also healthier in general. Approximately 68% of non-elderly adult group insured reported that their health was excellent or very good. This compares favorable to all non-elderly adults, of whom 58% reported excellent or very good health. Smoking rates are also lower for those covered under group plans. The percentage of group insured who reported having a serious health condition was lower than the entire non-elderly adult population. There were also significantly fewer people suffering from any of the high cost conditions listed in HB 315.

There was little difference between the group insured and the entire population in terms of the number of doctor visits in the past year. More of the group insured paid some amount out of pocket than all non-elderly adults.

Table 9
Demographic Characteristics of Employer Insured Non-Elderly Adults

Characteristic		Percent 1998	Percent 1997
Gender			
Male		49%	48%
Female		51%	52%
Age			
19 to 29		22%	22%
30 to 39		25%	26%
40 to 49		29%	30%
50 to 54		10%	9%
55 to 59	*	9%	7%
60 to 64		6%	6%
Annual Household Income			
Less than $10,000	*	3%	2%
$10,000-$15,000	*	3%	4%
$15,000-$25,000		10%	9%
$25,000-$35,000		16%	16%
$35,000-$45,000		15%	16%
$45,000-$55,000		16%	16%
More than $55,000		38%	37%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%		4%	3%
100% to 149%	*	4%	6%
150% to 199%	*	8%	6%
200% to 249%		11%	12%
250% to 299%		11%	12%
300% and Above		61%	61%
Work Status			
Employed		81%	82%
If employed, part time		11%	12%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent		34%	35%
Very Good		34%	31%
Good		25%	25%
Fair		6%	7%
Poor		2%	2%
Smoked Regularly in Past 2 Years			
		28%	31%
Serious Health Condition Past 10 Years			
		9%	-
HB 315 High Cost Condition List			
		2%	-
Number of Dr. Visits in Last Year			
0		19%	16%
1-2		43%	44%
3-4		18%	20%
5-6		8%	8%
More than 6		13%	11%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0		23%	21%
$1 - $249		52%	51%
$250 - $499		10%	11%
$500 - $999		8%	8%
$1000 - $4999	*	5%	8%
$5000 - $9999		1%	1%
$10,000 or more		0%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey.

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 reflect the average health characteristics of the group rather than an 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.

Changes in legislation had little effect on large-group health insurance. The primary change for this segment was that insurance companies providing large-group policies had to support the GAP fund, which reimbursed other insurance companies for GAP related losses. This may have increased premiums in this segment as insurance companies passed the higher costs on to their policyholders. Self-insured health benefit plans covering employees of institutions of higher education and self-insured plans covering elected and salaried employees of cities, counties, urban-counties, charter counties, or special districts were not subject to the assessment to support the Guaranteed Acceptance Program.

Number Covered Under Large-Group Policies

It is estimated that 39.2% of the Kentucky population obtained health insurance through a large employer. This represents approximately 1,537,000 people.[7]

Characteristics of Non-elderly Adults Covered Under Large-Group Policies[8]

The average age of the large-group insured adults was 41 years. The large-group insured were only slightly older than all privately insured adult respondents (Table 10). It is expected that the ages would be fairly similar, as the large-group insured make up nearly three-fourths of the privately insured. Over half of the large-group insured adults reported household incomes over $45,000. Sixty-seven percent were in excellent or very good health. Twenty-one percent indicated that, not including health insurance premiums, they had no out-of-pocket health care expenditures in the past 12 months. Of those that did spend out-of-pocket for health care, the large-group insured generally spent less, on average, than all privately insured.

[7] Firm size data, in the Current Population Survey, does not permit us to determine if there are fewer than 50 employees. Therefore, estimates of the large-group and the small-group are calculated from the KHIS only.

[8] Estimates of all people with large-group insurance are provided in Appendix A.

Table 10
Demographic Characteristics of Large Employer Insured Non-Elderly Adults

Characteristic		Percent 1998	Percent 1997
Gender			
Male		48%	47%
Female		52%	53%
Age			
19 to 29		20%	21%
30 to 39		28%	27%
40 to 49		29%	30%
50 to 54		10%	9%
55 to 59		9%	7%
60 to 64		6%	6%
Annual Household Income			
Less than $10,000		3%	2%
$10,000-$15,000		3%	5%
$15,000-$25,000		11%	10%
$25,000-$35,000		17%	16%
$35,000-$45,000	*	14%	18%
$45,000-$55,000		17%	17%
More than $55,000		34%	32%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%		5%	4%
100% to 149%		5%	7%
150% to 199%	*	9%	5%
200% to 249%	*	10%	13%
250% to 299%	*	10%	14%
300% and Above		61%	57%
Work Status			
Employed		86%	86%
If employed, part time		10%	12%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent		34%	36%
Very Good		33%	32%
Good		26%	23%
Fair		7%	8%
Poor		1%	1%
Smoked Regularly in Past 2 Years			
		29%	30%
Serious Health Condition Past 10 Years			
		9%	-
HB 315 High Cost Condition List			
		1%	-
Number of Dr. Visits in Last Year			
0		17%	15%
1-2		44%	45%
3-4		20%	20%
5-6		7%	8%
More than 6		13%	11%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0		21%	19%
$1 - $249		54%	53%
$250 - $499		11%	10%
$500 - $999		7%	8%
$1000 - $4999	*	6%	9%
$5000 - $9999		1%	0%
$10,000 or more		0%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Kentucky Health Insurance Survey.

Characteristics of Large-Group Policies

Table 11 shows various characteristics of the large-group policies for 1998 and 1997. The CPS does not collect information on policies; therefore, the results in Table 11 are entirely from the KHIS.

A major change in the national health insurance market has been the shift to 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 rendered by a participating provider. Services from providers not on the list of network providers are either not covered or are covered at a reduced rate. The KHIS asked respondents to indicate the level of choice they had in choosing physicians. Respondents were given three possible answers and asked which one best described their policy. The first answer was that the policy "only paid physicians on the plan list." This is most representative of managed care plans. The second choice was that their plan paid a small amount for physicians not on the plans list. This most likely represents policies that merge managed care and traditional indemnity plans, such as point-of-service or preferred provider plans. With these plans, the insured can go to physicians outside the network but may have to pay a higher deductible or co-payment. The final response that could be given was that the policy paid the same amount for all physicians, which represents the traditional indemnity plan.

Approximately 27% 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. Forty-three percent paid only for physicians on the plan's list. This represents a significant move toward managed care from indemnity plans for the large-group market, which mirrors the national trend.

The percentage of plans that included a deductible decreased from 64% in 1997 to 57% in 1998. This was offset by an increase in the number of plans including a co-payment from 1997 to 1998. The dollar amount of the co-payments also changed somewhat. There were more plans with co-payments of $10 in 1998 than 1997. Co-payments were almost always $15 or less. There was little change in the percentage of medical costs that large-group plans paid. Ninety-eight percent pay 80% or more of medical costs. There was virtually no change in the services covered by large group policies. Covered services 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.

Table 11
Characteristics of Large-Group Policies

Characteristic		Percent	
		1998	1997
Physician Choice			
Same Amount Paid All Physicians	*	27%	35%
Smaller Amount Paid Physicians not on Plan List		30%	30%
Only Paid Physicians on Plan List	*	43%	35%
Annual Deductible Included in Plan			
Yes	*	57%	64%
If Deductible Assessed: Amount of Deductible			
Less than $200		50%	46%
$200-$400	*	25%	31%
$401-$800		17%	18%
$801-$1,000		4%	2%
$1,001-$2,500		4%	3%
More than $2,500		0%	1%
Percent of Medical Costs Paid by Plan			
Less than 80%		2%	2%
80%		63%	63%
More than 80%		35%	35%
Copayment for Doctor Visits			
Yes	*	69%	55%
If Copayment Assessed: Amount of Copayment			
$5 to $9		32%	35%
$10	*	55%	50%
$15		11%	12%
More than $15		2%	3%
Services Covered by Plan			
Hospital Stay		98%	99%
Outpatient Doctor Visits		98%	98%
Prescriptions		94%	94%
Mental Health		92%	94%
Vision		48%	49%
Dental		43%	46%

* Indicates that differences in estimates from one year to the next are statistically significant at the 5% level .
Source: 1996-1998 Kentucky Health Insurance Survey.

In addition to comparing 1998 data to 1997 data, the 1998 respondents were asked to compare their coverage to the coverage they had one year ago. The comparison could be against the same policy, if it was a renewal, or against a previous policy, if the

coverage is new. These results are presented in Table 12. Ten percent indicated that their benefits increased from the previous year, while 11% said benefits decreased. Seven percent reported that there were more restrictions on choice of physician. Only 4% indicated that there were fewer restrictions. Finally, 20% indicated that their premiums increased in the past year. However, some people reported a decrease in premiums. Of those with higher premiums, 37% also saw benefits increase. Only 11% had greater choice of physicians (or fewer restrictions). One factor that might account for increases in premium can be the number of people covered by the plan. However, only 6% of those policies for which premiums increased had an increase in the number of people covered. 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 12
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	10%	7%	2%	20%
No Change	79%	89%	96%	75%
Decrease	11%	4%	2%	5%
Large-Group Insured Non-Elderly Adults Whose Premium Increased				
Increase	37%	26%	6%	
No Change	36%	64%	91%	
Decrease	27%	11%	2%	

Source: 1998 Kentucky Health Insurance Survey.

The average monthly premium paid by the household for large-group policies was $42 and the median was $0.[9] 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 employees' 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. Approximately 38% were covered by at least one policy that was fully funded by the employer. Fifty-eight percent were covered by a policy that was partially funded by the employer. The remaining 4% received no employer contribution. The share of household

[9] 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.

income allocated to premiums for large-group policies was less than 2%. Neither the Current Population Survey nor the Kentucky Health Insurance Survey provide accurate data on employer costs for employee health insurance. The U.S. Bureau of Labor Statistics collects data on employee benefits costs. The Bureau of Labor Statistics reported that, nationally, employers were paying approximately $1.03 in health insurance benefits for each hour worked in March of 1999.[10] Note that this is a national estimate and Kentucky firms may pay more or less than this amount. This estimate applies to firms of all sizes. The report does not break out firms of 50 employees or more. The cost for firms with 100 employees or more was $1.30 per hour. This means that a firm with 100 or more employees pays on average $2,700 per year in health insurance benefits for an employee who works 40 hours per week for a full year and receives this benefit.

Small-Group Market

The small-group market consists of those who obtain a health insurance policy through an employer with fewer than 50 employees. As with the large-group market, the pricing of the policy reflects the average health characteristics of the group. Premiums in the small-group market, however, can be more sensitive to the health conditions of the members, because there are typically fewer people to spread the costs over.

Number Covered Under Small-Group Policies

Based on the 1998 Kentucky Health Insurance Survey, it is estimated that 12.8% of the Kentucky population, or 502,000 people, were classified as small-group insured. This is an increase from the 1997 estimate of 10.4% of the population. One explanation for this increase is the tight labor market. Higher wages and benefits may have induced some self-employed workers to find employment with a firm offering group coverage, or may have induced more small firms to offer health insurance as a way to attract or retain employees.

Approximately 6% of those with small-group coverage in 1998 indicated that they were uninsured two years prior to the survey. Seventy percent of these indicated that they chose to purchase insurance because an employer offered the coverage. Twelve percent listed premium becoming affordable as the reason for purchasing coverage. The remaining 18% said other reasons caused them to acquire health insurance.

[10] U.S. Department of Labor, Bureau of Labor Statistics, News Release, "Employer Costs for Employer Compensation – March 1999," June 24, 1999.

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 13). The average age of the adult small-group insured (41 years) is essentially the same as the average age of large-group insured adults. However, the distribution of the small-group insured across age categories is more concentrated. The small-group insured had a greater percentage of people between the ages of 30 and 49 than those with other types of private health insurance. There was a lower percentage of small-group insured below 30 and above 54 than for large-group insured. Household income was generally lower for the small-group market than for all privately insured.

From 1997 to 1998 there was relatively little change in the distribution of small-group insured. The primary change was a redistribution of income. There were more small-group insured earning under $10,000 in 1998 than in 1997. Comparing income to the poverty guidelines showed that there was also an increase in the number of small-group insured below the poverty level.

The respondents with small-group policies were somewhat healthier than large-group insured respondents in the 1998 survey. Forty-one percent were reported as being in excellent health. Health status was virtually unchanged from 1996. Twenty-nine percent of the small-group insured had smoked in the past two years. Twenty-four percent had not seen a doctor in the last year. This number is higher than large-group privately insured adult respondents, of which only 17% had not seen a doctor. Twenty-seven 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.

Table 13
Demographic Characteristics of Small Employer Insured Non-Elderly Adults

Characteristic		Percent 1998	Percent 1997
Gender			
Male		49%	50%
Female		51%	50%
Age			
19 to 29		18%	20%
30 to 39		29%	29%
40 to 49		31%	28%
50 to 54		11%	11%
55 to 59		7%	8%
60 to 64		3%	5%
Annual Household Income			
Less than $10,000	*	6%	1%
$10,000-$15,000	*	1%	4%
$15,000-$25,000		14%	14%
$25,000-$35,000		21%	21%
$35,000-$45,000		16%	15%
$45,000-$55,000		11%	13%
More than $55,000		31%	32%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%	*	6%	3%
100% to 149%	*	5%	9%
150% to 199%	*	13%	7%
200% to 249%		11%	14%
250% to 299%		13%	12%
300% and Above		52%	57%
Work Status			
Employed		84%	85%
If employed, part time		15%	16%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent		41%	40%
Very Good		30%	32%
Good		22%	21%
Fair		6%	6%
Poor		1%	2%
Smoked Regularly in Past 2 Years			
		29%	32%
Serious Health Condition Past 10 Years			
		8%	-
HB 315 High Cost Condition List			
		2%	-
Number of Dr. Visits in Last Year			
0		24%	20%
1-2		42%	44%
3-4		14%	17%
5-6		7%	9%
More than 6		12%	11%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0		27%	23%
$1 - $249		46%	47%
$250 - $499	*	10%	13%
$500 - $999	*	11%	7%
$1000 - $4999	*	4%	8%
$5000 - $9999		1%	1%
$10,000 or more		1%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Kentucky Health Insurance Survey.

Characteristics of Small-Group Policies

The small-group policies surveyed in 1998 showed some differences from those surveyed in 1997 and 1996. The characteristics of small-group policies are shown in Table 14. From 1996 to 1997 there was a substantial shift toward managed care policies. At the time, it was thought that this shift might be a reflection of the national move toward managed care. The 1998 results, however, show that this may not be the case. Although the percentage of plans that were managed care increased in 1998, the change was not statistically significant. It is possible that the movement toward managed care is not as fast in the small-group market. There was a decrease in plans that pay a smaller amount for physicians not on the plan's list. These policies that pay a smaller amount for physicians not on the plan's list are a mix of managed care and indemnity policies. In 1997, 30% of the policies paid for physicians not on the plan's physician list, but paid a smaller amount. In 1998 this decreased to 24%.

There appears to be a movement away from deductibles in the small-group market. Each year that data has been collected has seen a decrease in policies with a deductible. In 1996, 81% of policies sampled had some deductible. In 1998, only 58% of small-group policies had deductibles. Co-payments, however, have increased each year. Services covered changed substantially from 1996 to 1997. There were increases in coverage of outpatient services, prescription drugs, and vision care. From 1997 to 1998 the only change was an increase in mental health coverage.

Table 14
Characteristics of Small-Group Policies

Characteristic		Percent		
	1998		1997	1996
Physician Choice				
Same Amount Paid All Physicians	35%	*	33%	42%
Smaller Amount Paid Physicians not on Plan List *	24%		30%	31%
Only Paid Physicians on Plan List	41%	*	37%	27%
Annual Deductible Included in Plan				
Yes *	58%	*	68%	81%
If Deductible Assessed: Amount of Deductible				
Less than $200	37%	*	36%	26%
$200-$400	27%	*	27%	33%
$401-$800	23%	*	22%	27%
$801-$1,000	5%		5%	5%
$1,001-$2,500	5%		9%	8%
More than $2,500	2%		1%	1%
Percent of Medical Costs Paid by Plan				
Less than 80%	2%		2%	2%
80%	70%	*	68%	80%
More than 80%	28%	*	30%	19%
Copayment for Doctor Visits				
Yes *	79%	*	70%	56%
If Copayment Assessed:				
Amount of Copayment				
Less than $10	27%		27%	24%
$10	53%		59%	54%
$15 *	14%	*	8%	13%
More than $15	6%		6%	9%
Services Covered by Plan				
Hospital Stay	99%	*	99%	100%
Outpatient Doctor Visits	98%	*	98%	96%
Prescriptions	95%	*	94%	88%
Mental Health *	92%		87%	84%
Vision	38%	*	37%	31%
Dental	28%		26%	28%

* Indicates that differences in estimates from one year to the next are statistically significant at the 5% level .

Source: 1996-1998 Kentucky Health Insurance Survey.

Table 15 shows how those with small-group coverage in 1998 responded to questions about how their current coverage compared to the coverage they had last year. Thirteen percent indicated their benefits increased, while 7% reported a decrease in benefits. Eight percent reported more restrictions on choice of physician, with only 6% reporting fewer restrictions. Twenty-four percent responded that their premiums had increased. However, as in the large-group market, premiums did not increase for the entire small-group market. Eight 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 36% 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	13%	8%	2%	24%
No Change	81%	86%	97%	68%
Decrease	7%	6%	1%	8%
Small-Group Insured Non-Elderly Adults Whose Premium Increased				
Increase	28%	16%	4%	
No Change	60%	69%	93%	
Decrease	12%	14%	3%	

Source: 1998 Kentucky Health Insurance Survey.

The average monthly premium paid by the household for small-group policies was $60. The median was $0. As with large-group policies, small employers often paid a portion of the health insurance premiums. Half of the respondents were covered by at least one plan that was fully funded by the employer. Another 43% were covered by a plan that was partially funded by an employer. The remaining 6% 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 2%. According to the Bureau of Labor Statistics,

nationally firms with fewer than 100 employees pay $0.77 per hour worked in health insurance benefits for their employees.[11] This figure does not match the definition of small firms as defined in Kentucky, which is firms with fewer than 50 employees. It does, however, provide some sense of what small employers contribute to health insurance benefits. Annually, firms with fewer than 100 employees pay approximately $1,600, on average, for health insurance benefits for an employee who works 40 hours per week, 52 weeks per year, for those employees who receive this benefit.

Individual Market

The individual health insurance market is comprised of those who purchase health insurance directly from an insurance carrier 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 affected by reforms, this market segment has experienced the most substantial change.

Number Covered Under Individual Policies

Two estimates for those with individual coverage are presented. The first estimate is of all people who are covered by an individually purchased policy. This estimate is useful when considering the impact of legislation specifically dealing with the individual market, as it shows the number of people affected by the legislation. However, many of the individually insured have additional coverage purchased in other markets. For example, some people in the surveys indicated that they purchased their own individual coverage and also had coverage through another source, such as through a relative's policy. It is also useful to know the number of people who rely solely on individual coverage for their health care.

Based on data from the 1999 March CPS, it is estimated that approximately 4.6% of the Kentucky population is covered by a policy purchased directly from an insurer.[12] The margin of error on the estimate is +/- 1.0%, so there is a 95% probability that the actual percentage is between 3.6% and 5.6%. This percentage represents 139,000 to 218,000 people, with a point estimate of 177,000. Based on estimates from the 1997 and 1998 CPS, there was an increase in the number of people and the percentage of the population purchasing individual coverage. From 1998 to 1999, there was a decline to the 1997 levels.

It is estimated that 2.8% (+/-0.8%) of the population (107,000 people) have health insurance coverage solely through an individually purchased policy. There has been no statistically significant change in the number of people with only individual insurance.

---

[11] U.S. Department of Labor, Bureau of Labor Statistics, News Release, "Employer Costs for Employer Compensation – March 1999," June 24, 1999.

[12] There were a number of people surveyed by the CPS who were covered by Medicare and who indicated they also had private coverage. It is likely that these policies are Medicare Supplemental policies, and they are excluded from the estimates of individual coverage.

It is not clear why the number of individually insured increased from 1997 to 1998, but decreased from 1998 to 1999. The legislative changes contained in HB 315 should have lowered the premiums for the healthy; therefore, we would expect more healthy people to purchase individual coverage. Similarly, HB 315 should have caused premiums to increase for the unhealthy. Although premium increases were limited, some people may have chosen to drop their coverage in response to the increasing premiums. In addition, there were a number of high-risk people who were able to take advantage of the premiums under modified community rating through the Kentucky Health Purchasing Alliance. These policies were cancelled when the Alliance was abolished by HB 315. Some of these people may have chosen to go uninsured rather than face the higher premiums, which reflected their high-risk health status.

Even in the absence of legislative changes, 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 obtain government insurance.[13] The tight labor market may have provided the individually insured with greater access to group coverage by providing more employment opportunities. As people move to traditional employment they often obtain coverage under group policies offered by the employer. Another factor that contributes to the changes is general premium increases. As premiums for individual policies increase, people may choose to go uninsured or find insurance through an employer rather than paying the higher rates. The limited choice of insurance companies may also have discouraged people from obtaining individual coverage.

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 from all other market segments, the percentage of the individually insured that were previously uninsured can be estimated. The 1998 KHIS asked respondents who were covered by an insurance policy if they were insured two years ago. Approximately 9% of the individually insured were uninsured two years ago. Of these, 46% indicated they obtained individual

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

coverage because the premiums became affordable (either premiums decreased or their incomes increased); the remaining 54% stated other reasons.[14]

Characteristics of Adults Covered Under Individual Policies

The following analysis is of adults who are covered only by an individually purchased policy. Those who have coverage either through an employer or a government program are excluded. As discussed earlier, some situations may arise where the characteristics of all people covered by individually purchased insurance is of interest. Therefore, the characteristics of all individually covered non-elderly adults are presented in Appendix A. Because the data on characteristics comes from surveys conducted before HB 315 was fully implemented, we would not yet expect to see large changes as a result of this legislation.

Characteristics of adults covered solely by individual health insurance policies in Kentucky are shown in Table 16. Approximately 60% of the individually insured were female. This is a slight increase from 1997, but the change is not statistically significant. There was, however, a statistically significant change in the age distribution. There were fewer people between the ages of 19 and 29 in 1998 than in 1997. Income also changed from 1997 to 1998. The percentage of people with household incomes over $55,000 increased from 24% to 35%. The percentage of individually insured with incomes 300% of Federal Poverty Guidelines and above increased from 45% to 56%.

The average health status of the individual insured declined. In 1998, only 33% indicated they were in excellent health compared to 43% in 1997. There was no change in the smoking rate.

One of the major provisions of HB 315 was the creation of the Guaranteed Acceptance Program (GAP). People seeking to purchase individual insurance who suffered from one of the high cost conditions listed in HB 315 were guaranteed coverage through the GAP. Approximately 6% of those with individual coverage suffered from at least one of the high cost conditions that would make them eligible for GAP. Although these people would be eligible for the GAP, there is little reason for them to obtain coverage through this program. As discussed earlier, HB 315 required that current policies be guaranteed renewable. Therefore, insurance companies could not cancel coverage because of health status. While insurance companies could raise the premiums of those with high cost health conditions, they could only increase premiums up to 135% of the base rate. Premiums in the Guaranteed Acceptance Program could be rated up to 150% of the base rate. Finally, any premium increases had to be phased in. That is, premiums could not be immediately increased to the full 135%. Because of these provisions in HB 315, there is no reason for anyone to voluntarily move from the regular market into the Guaranteed Acceptance Program.

[14] Because the sample size of the number of people individually insured in 1998 and uninsured in 1996 is small, the estimates of why they obtained insurance have large margins of errors and should only be used as rough approximations.

The frequency of doctor visits did not change significantly from 1997 to 1998. Approximately 22% of the individually insured adults had not been to a doctor in the past 12 months. Approximately 25% had no out-of-pocket health care expenses except for health insurance premiums. This fact does not indicate that their health insurance paid for all of their expenses. It is more likely that these people did not utilize any health care services in the previous 12 months.

Table 16
Demographic Characteristics of Individually Insured Non-Elderly Adults

Characteristic		Percent 1998	Percent 1997
Gender			
Male		40%	43%
Female		60%	57%
Age			
19 to 29	*	20%	29%
30 to 39		20%	23%
40 to 49		24%	21%
50 to 54		12%	9%
55 to 59		10%	8%
60 to 64		14%	10%
Annual Household Income			
Less than $10,000		10%	10%
$10,000-$15,000		8%	5%
$15,000-$25,000	*	13%	23%
$25,000-$35,000		15%	15%
$35,000-$45,000		9%	10%
$45,000-$55,000		11%	13%
More than $55,000	*	35%	24%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%		12%	11%
100% to 149%		10%	15%
150% to 199%		8%	7%
200% to 249%		8%	11%
250% to 299%	*	6%	12%
300% and Above	*	56%	45%
Work Status			
Employed		68%	67%
If employed, part time		24%	27%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent	*	33%	43%
Very Good		34%	32%
Good		23%	17%
Fair		8%	6%
Poor		3%	2%
Smoked Regularly in Past 2 Years		26%	26%
Serious Health Condition Past 10 Years		11%	-
HB 315 High Cost Condition List		6%	-
Number of Dr. Visits in Last Year			
0		22%	18%
1-2		45%	49%
3-4		18%	16%
5-6		7%	7%
More than 6		9%	10%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0		25%	21%
$1 - $249		39%	43%
$250 - $499		13%	11%
$500 - $999		10%	10%
$1000 - $4999		11%	13%
$5000 - $9999		1%	1%
$10,000 or more		2%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey.

Many of the provisions of the reforms dealt with restricting insurance companies' ability to vary premiums based upon demographic characteristics. For example, the reforms prohibited insurance companies from charging higher premiums to people with poor health. As discussed earlier, this restriction shifts the burden of health care costs from one group of people to another. The idea is that there are relatively few people with

very high health care expenses and that their high costs can be spread over a larger number of people. The healthy people pay higher premiums, but if the costs are spread over enough people, the increase in premiums per person will be low. Because of this, it is important to know how many people fall into each of these groups so that it can be determined if there are a sufficient number of people to bear the costs. Table 17 shows the percentage of the total sample of individually insured adults that fell into the various age, gender, and health status categories. Note that for this type of analysis it is necessary to consider all of the individually covered. Therefore, Table 17 includes those who have additional coverage through another source. 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.

When considering rating restrictions, however, the current distribution is merely a starting point. The data in Table 17 shows the age, gender, and health distribution of the individual market as it was in 1998. This distribution reflects the insurance premiums as they were in 1998. It is expected that changes from HB 315 will change the age, gender, and health distribution of the individually insured. As rating restrictions are placed on or removed from the market, premiums must change. For example, with the initial reforms, premiums were decreased for older and high risk individuals, but were increased for the young and healthy. As premiums change, people react to these changes. People who were once priced out of the market can now afford to buy health insurance. Others who are very healthy may find the premiums to be too high and choose to forego health insurance. There has been evidence of people reacting to changes in premiums.[15] Therefore, the distribution presented in Table 17 is a starting point, but this distribution would likely change as premiums change. In fact, data collected in 1999 and 2000 will most likely show that there has been a shift in the distribution as people react to the changes adopted in HB 315.

[15] Michael Clark and Ginny Wilson, "Market Responses to Kentucky's Health Insurance Reforms," *Kentucky Annual Economic Report*, , Center for Business and Economic Research: University of Kentucky, 1999.

Table 17
Distribution of Individually Insured Non-Elderly Adults
by Age, Gender, and Health Status

Males	Health Status Category					
Age	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**	**Total**
Less than 30	4%	1%	2%	0%	0%	8%
30 to 39	3%	4%	1%	1%	0%	9%
40 to 49	4%	4%	3%	0%	0%	11%
50 to 54	1%	1%	2%	0%	0%	4%
55 to 59	1%	1%	2%	1%	0%	5%
60 to 64	1%	2%	1%	0%	0%	6%
Male Totals	**14%**	**14%**	**12%**	**3%**	**1%**	**43%**
Females						
Age						
Less than 30	3%	3%	1%	0%	0%	8%
30 to 39	4%	6%	4%	1%	0%	16%
40 to 49	5%	4%	3%	1%	1%	14%
50 to 54	1%	3%	2%	1%	0%	8%
55 to 59	1%	1%	1%	1%	0%	5%
60 to 64	1%	2%	3%	2%	0%	7%
Female Totals	**16%**	**20%**	**14%**	**6%**	**1%**	**57%**
Overall Totals	**30%**	**34%**	**26%**	**9%**	**2%**	**100%**

Note: Zeros may represent numbers that are less than 0.5%.
Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey

Characteristics of Individual Policies

Table 18 shows the characteristics of individual policies, such as level of choice and benefits. As with the other private market segments, there has been a major shift toward managed care in the individual market. Each year since data has been collected there has been an increase in the percentage of policies that only pay for services performed by physicians on the plan's list. In 1996, 21% of the individual policies were managed care. By 1998, 37% of the policies surveyed were managed care. The growth of managed care has come primarily at the expense of policies that merge characteristics of managed care and indemnity plans. This segment of the individual market decreased from 25% in 1996 to 13% in 1998. The percent individual plans that were indemnity plans has decreased, but the change was fairly small and not statistically significant. This may change soon because Kentucky Kare is no longer in the market. In July 1998, Kentucky Kare could no longer provide individual coverage and any current plans could not be renewed. Because of this, a number of people had to find new health insurance. Many of these people may have chosen to switch to managed care as they find new coverage.

There was a move away from deductibles from 1996 to 1997. Although the percentage of individual policies with deductibles also decreased from 1997 to 1998, this decrease was not statistically significant. Co-payments, however, have been increasing each year. There has been virtually no change in the percent of medical costs that policies pay.

From 1996 to 1997, individual policies increasingly provided coverage for outpatient doctor visits, prescription drugs, and mental health services. The increases in coverage of these services from 1997 to 1998 were not statistically significant, but they also did not decrease. The changes between 1997 to 1998 came in the form of increased coverage for vision and dental care.

Table 18
Characteristics of Individual Policies

Characteristic		Percent		
	1998		1997	1996
Physician Choice				
Same Amount Paid All Physicians	50%		53%	54%
Smaller Amount Paid Physicians not on Plan List *	13%	*	20%	25%
Only Paid Physicians on Plan List *	37%	*	27%	21%
Annual Deductible Included in Plan				
Yes	67%	*	72%	79%
If Deductible Assessed: Amount of Deductible				
Less than $200 *	22%	*	30%	21%
$200-$400	23%		19%	23%
$401-$800	23%	*	29%	22%
$801-$1,000 *	12%	*	4%	8%
$1,001-$2,500	12%	*	11%	19%
More than $2,500	7%		7%	6%
Percent of Medical Costs Paid by Plan				
Less than 80%	6%		5%	4%
80%	72%		75%	79%
More than 80%	21%		20%	17%
Copayment for Doctor Visits				
Yes *	66%	*	52%	44%
If Copayment Assessed: Amount of Copayment				
Less than $10 *	12%	*	24%	18%
$10 *	56%	*	42%	52%
$15	16%		14%	15%
More than $15	17%	*	20%	15%
Services Covered by Plan				
Hospital Stay	97%		98%	98%
Outpatient Doctor Visits	93%	*	93%	89%
Prescriptions	80%	*	77%	70%
Mental Health	76%	*	74%	66%
Vision *	30%		21%	20%
Dental *	19%		13%	14%

* Indicates that differences in estimates from one year to the next are statistically significant at the 5% level .
Source: 1996-1998 Kentucky Health Insurance Survey.

Table 19 shows the percent of non-elderly adults affected by various changes in their individually purchased policies. Benefits were greater for five percent of individually insured adults and were lower for thirteen percent. Eight percent reported that their

current coverage had more restrictions on choice of physicians compared to their old coverage. Three percent reported fewer restrictions. No one surveyed reported having more people on the plan. Only 2% reported having fewer people. Approximately 40% of individually insured adults reported an increase in premium. Only 4% reported a decrease in premium.

Table 19
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	5%	8%	0%	40%
No Change	82%	89%	98%	57%
Decrease	13%	3%	2%	4%
Individually Insured Non-Elderly Adults Whose Premium Increased				
Increase	12%	16%	0%	
No Change	66%	77%	96%	
Decrease	22%	7%	4%	

Source: 1998 Kentucky Health Insurance Survey.

The average premium increase in the individual market was approximately 8% overall. Some respondents indicated their premiums increased by over 150%. Some people indicated that their premiums decreased slightly. 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 17% 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). Some of the increases may have been the result of changes allowed under HB 315. Under HB 315, insurance companies could once again charge those with chronic health conditions higher premiums. This only partially explains the increase as most of the people surveyed likely had not yet been affected by HB 315. It might be argued that the healthy should have seen a corresponding decrease in premiums; however, this is not necessarily true. Because there is little competition in the individual market, there is little incentive for insurance companies to compete on price. Other factors that may have caused changes in premiums were 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 1997 to 1998, the Consumer Price Index for Medical Care increased by 3.2%.

The average monthly premium for all of the individual policies in the sample was $229, with a standard error of $152. The median monthly premium was $200. These figures are virtually unchanged from the 1997 data. 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 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 any deductible. Increase this complexity by the business strategy particular to each insurer and by 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 1998 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 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 36% of the midpoint of the household's income range for households reporting an income under $10,000, to a low of 6% for households reporting an income over $55,000.[16] The weighted average percentage for all households with individual

[16] 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.

policies was approximately 13%. These estimates are almost exactly equal to the 1997 estimates.

Two points should be made about these estimates. First, the 13% is not an estimate of what percentage of income households spend for all insurance coverage, but only for coverage obtained under individual policies. Also, it may seem inconceivable that households with less than $10,000 in gross income dedicate approximately 36% 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.

CHAPTER V
THE HEALTH INSURANCE OF KENTUCKY'S CHILDREN

Because the sample size of children is fairly small for any one year, data for 1997 through 1999 were combined to increase the sample size. The advantage of this is that it is possible to look at very narrowly defined segments of the child population, which is necessary when estimating the number of children eligible for KCHIP. The disadvantage of combining multiple years of data is that it is not possible to track changes over time.

The insurance status of Kentucky's children mirrors the insurance status of the entire state (Table 20). Approximately 13.7% of Kentucky's children (18 and under) are without insurance. This estimate has a margin of error of 1.1%. This means that approximately 139,000 children are without health insurance, with a confidence level of 95% that the true number of uninsured children falls between 127,000 and 150,000. This is a decrease from previous estimates of the uninsured children, but the decrease is not statistically significant.

Table 20
Insurance Status of Kentucky Children

Insurance Status	Population	Percent
Uninsured	139,000	14%
Government Insured	257,000	28%
Employer Insured	593,000	55%
Individually Insured	23,000	3%
Total	1,012,000	100%

Source: 1997-1999 Current Population Survey & 1997-1998 Kentucky Health Insurance Survey, Weighted Methodology.

It is estimated that one quarter of children receive public health insurance.[17] Public health insurance is provided through Medicaid and the Kentucky Children's Health Insurance Program (KCHIP). KCHIP is probably the most significant factor currently affecting the number of uninsured children. The program was created as a way to provide health insurance to children whose household incomes are low, but too high to qualify for Medicaid. According to a recent news release from the Cabinet for Health Services, nearly 30,000 children have signed up for health insurance through KCHIP.[18] KCHIP is

[17] As with the public insurance for the entire state, more accurate estimates for children with public health insurance may be obtained from the departments that administer these programs.
[18] Smith, Barbara Hensley, "KCHIP enrolls more than 29,000 Children" Kentucky Cabinet for Health Services, Statewide News Release, Frankfort, KY, Dec 21, 1999.

likely having an effect on the number of uninsured children. However, it should not be assumed that all 30,000 children enrolled in KCHIP would be uninsured if KCHIP did not exist. By providing free health insurance for children, the state has created an incentive for parents who would normally purchase insurance for their children to drop self-funded coverage. It is not clear how many of those enrolled in KCHIP would normally be insured in the private sector or how many would actually be uninsured.

Nearly 60% of Kentucky's children are insured through an employer-provided policy. Two percent are insured in the individual market.

Table 21 shows the characteristics of children by insurance status. The data shows that there is little difference in age, except for those with public health insurance. Prior to KCHIP, public health insurance did not cover older children. Therefore, those with public insurance tend to be younger. With respect to health status, children covered by public health insurance tend to have worse health. Only 35% of publicly insured children were in excellent health, which is substantially lower than other groups. Ten percent of the publicly insured were in fair or poor health, while less than 4% of all children were in fair or poor health. Even compared to the uninsured, the publicly insured children are in much poorer health. The publicly insured children also tend to have a greater occurrence of serious health conditions. The reason for this is likely to be that the need for medical services among unhealthy children means they cannot afford to go without insurance. Unhealthy children receive greater benefits from the insurance. The healthier children will tend to use insurance less, so their parents place a lower value on health insurance and have less incentive to obtain coverage for their children.

Table 21
Characteristics of Kentucky Children (Age 18 & Under)
by Insurance Status

Characteristic	Uninsured	Government Insured	Employer Insured	Individually Insured
Age				
Under 1	4%	5%	3%	3%
1 to 5	19%	32%	24%	23%
6 to 15	56%	52%	55%	52%
16 to 18	22%	11%	18%	22%
	100%	100%	100%	100%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)				
Less than 100%	45%	58%	7%	10%
101% to 133%	17%	14%	5%	16%
134% to 150%	7%	4%	3%	3%
151% to 185%	7%	7%	7%	5%
186% to 200%	4%	1%	4%	2%
Over 200%	21%	16%	74%	64%
	100%	100%	100%	100%
Health in General				
Excellent	44%	35%	61%	68%
Very Good	30%	26%	27%	19%
Good	22%	29%	11%	11%
Fair	3%	7%	1%	2%
Poor	1%	3%	0%	0%
	100%	100%	100%	100%

Source: 1997-1999 Current Population Survey & 1997-1998 Kentucky Health Insurance Survey, Weighted Methodology.

Uninsured Children

Table 22 shows information specifically on uninsured children. Thirty-four percent of uninsured children have at least one adult member of their family who does have health insurance. The remaining 66% of uninsured children live in households where no adults are insured. There are several reasons why an adult member of a household would be insured while the child was uninsured. First, the adult members with insurance may not be the parents of the children. This occurs when multiple generations live in the same house or with non-traditional households. Second, some employers will provide insurance coverage for the employer as a benefit but charge for dependent coverage.

The KHIS asks respondents with uninsured children present how much they would be willing to pay per month to provide basic health insurance for one child. Seventy-eight percent of households with uninsured children indicated that they would be willing to pay some amount. The average amount that households were willing to pay was $64 per month. The median amount was $50 per month. That is, half indicated they would pay an amount over $50 per month and half indicated they would pay an amount below $50. Twenty-five percent of respondents indicated that they would be willing to pay $100 or more.

Table 22
Demographic Characteristics of Uninsured Children

Characteristic	
Number of Uninsured Children in Kentucky	139,000
Percent of Children Uninsured in Kentucky	14%
Insurance Status of Adults with Uninsured Children	
No Adult Family Members Insured	66%
One or More Family Members Insured	34%
Family Income as a Percent of Poverty Guidelines (b)	
Less than 100%	45%
101% to 133%	17%
134% to 150%	7%
151% to 185%	7%
186% to 200%	4%
Over 200%	21%
Amount Adult Respondent with Uninsured Children would be Willing to Pay per Month for a Basic Health Insurance Policy for One Child	
Number of Respondents Answering Question	444
Mean Amount (Affected by a Few Very large Responses)	$64
Median Amount (Half would Pay More and Half would Pay Less)	$50
Amount Greater than 75% of Responses	$100
Percent of Responses Who Would (or Could) Not Pay Any Amount	22%

Source: 1997-1998 Current Population Survey & 1997-1998 Kentucky Health Insurance Survey.

Children make up a disproportionate share of the newly uninsured. While approximately 26% of the total population are children, approximately 37% of the newly uninsured population are children. This was the case in both the 1998 and the 1997 data and probably does not represent a new trend.

In a report published in 1995, the Governmental Accounting Office (GAO) estimated that, in the U.S. as a whole, 30% of the uninsured children are actually Medicaid

eligible.[19] The 30% represents children who were eligible for Medicaid but not insured through Medicaid or any other health insurance program. In Kentucky, children can qualify for Medicaid based on numerous factors such as household situation, age, financial resources, and family income. Although information on the household status, such as physical disabilities and financial resources, were not collected in the KHIS, the survey does allow for the estimation of children's Medicaid eligibility based on age and income.

It is expected that currently more than 30% of the uninsured children in Kentucky would be eligible for public health insurance. There are two main reasons for this. First, Kentucky's population tends to be poorer than the rest of the nation, so more people would qualify for Medicaid. Second, the GAO estimate was made prior to the creation of KCHIP and the expansion of Medicaid. KCHIP and the Medicaid expansion extend coverage to all children under 200% of the federal poverty guidelines. Estimates from the KHIS and the CPS show that approximately 38% of the uninsured children in Kentucky are Medicaid eligible, based on age and income only, and an additional 40% are eligible for KCHIP. In total, nearly 80% of uninsured children in Kentucky, or 110,000 children, are eligible for public health insurance. The margin of error for this estimate is +/-3.13 %, meaning that we are reasonably confident that between 105,000 and 114,000 of the uninsured children are eligible for public health insurance. Although this estimate is lower than previous estimates, the change is not statistically significant. While it might be argued that KCHIP is causing the number of uninsured children in Kentucky to decrease, it should also be noted that this estimate was largely obtained from data collected before the implementation of KCHIP and the expansion of Medicaid. Therefore, the effects of KCHIP have not yet shown up in the data. Table 23 shows the distribution of uninsured children by age and income as a percent of the Federal Poverty Guidelines. It should be noted that because the sample size for this table is fairly small, these estimates are rough approximations and are subject to large margins of error.

[19] "Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion," Governmental Accounting Office, July 19, 1995. (GAO/HEHS-95-175, July 19, 1995).

Table 23

Uninsured Children by Age and Household Income As a Percent of the Federal Poverty Level

	Age			
Household Income	Less than 1	1 to 5	6 to 15	16 to 18
Less than 100%	2%	6%	25%	11%
101% to 133%	1%	5%	9%	2%
134% to 150%	0%	2%	4%	0%
151% to 185%	0%	2%	3%	2%
186% to 200%	0%	1%	2%	1%
Over 200%	1%	3%	11%	5%

Source: 1997-1999 Current Population Survey & 1997-1998 Kentucky Health Insurance Survey.

Note: Zeros do not imply there are no children in Kentucky who fit the cell description, simply that there were none present in the sample.

Given that so many uninsured are eligible for public insurance at no cost, the natural question is why do they not enroll. The first reason is that most of the data used in these estimates was collected prior to the implementation of the Medicaid expansion and KCHIP. While these people are now eligible, many were not eligible when the data was collected. There were, however, some people who were eligible at the time data was collected. The 1998 KHIS asked the head of household if the uninsured children were eligible for Medicaid and if so why they were not covered. By looking at age and income it is possible to determine if they were actually eligible. Approximately 34% of the uninsured children whose parents indicated they were not eligible appeared to qualify based on income and age. This suggests that a major reason why children who are eligible remain uninsured is that parents are not aware that their children are eligible. Parents who do not know if their children are eligible must weigh the benefits of health insurance versus the costs of determining eligibility and enrolling. As discussed earlier, parents of healthy children may not place a high value on health insurance. Although Medicaid and KCHIP are free for those eligible, parents may view the time needed to determine eligibility and applying for coverage as too costly. In this situation parents may chose to leave their children uninsured until medical care is needed for an emergency or illness.

A more general question is, why are children uninsured. As with the adults, the KHIS asks respondents why the children in the household are without health insurance. The results are summarized in Table 24. While the options provided may not be the most appropriate for children, they do provide insight into why they are without insurance. The reasons for children's being uninsured were different than for adults. Respondents indicated that children were less likely to be uninsured as the result of a lost job. They were more likely to be uninsured because they were no longer eligible for coverage on a relative's policy. Other reasons were more often cited for children. One reason discussed earlier but not provided on the survey may be that some parents do not place a high value on insurance for children who are generally healthy.

Table 24
Reasons Given by Adults that Children in the Household are Uninsured

Reason	Percent of Uninsured Children
(Adult) Left Job Where Health Insurance was Offered	13%
No Longer Eligible for Coverage on a Relative's Policy	19%
No Longer Eligible for Student Coverage	1%
(Adult) Could No Longer Afford Because of Premium Increase	9%
(Adult) Could No Longer Afford Because of Other Expenses	19%
Policy Cancelled Because of Health Conditions	0%
Other Reasons	39%

Source: 1998 Kentucky Health Insurance Survey.

CONCLUSION

The most notable result of this analysis was that there has been relatively little change in the Kentucky health insurance market. Data shows that there has been no change in the number of uninsured and little change in their characteristics. There was a slight increase in the number of people with employer coverage, but virtually no change in their characteristics. The number of people with individually purchased health insurance decreased slightly.

Although Kentucky's health insurance market has shown little change, this does not mean that Kentucky has achieved the market stability that many have discussed. Many of the results presented in this report reflect data collected early in the implementation of HB 315. It is likely that additional changes caused by HB 315 will be observed in future data. In addition, changes resulting from the creation of KCHIP and the expansion of Medicaid should become more visible as more data is collected.

Appendix A

The following tables show demographic characteristics of Kentucky's non-elderly adult population by insurance status. These tables differ from the ones presented in the main text in that, for these tables, people can be assigned to multiple categories of insurance coverage. For example, a person who has an employer-provided policy and also purchases an individual policy will be included in the tables for those with group coverage and the table for individual coverage. The tables in the main text assigned each person to only one insurance category.

Table A1
Demographic Characteristics of Privately Insured Non-Elderly Adults
(Includes Those Reporting Additional Coverage Through Another Source)

Characteristic		Percent 1998	Percent 1997
Gender			
Male		48%	48%
Female		52%	52%
Age			
19 to 29		21%	21%
30 to 39		25%	26%
40 to 49		28%	30%
50 to 54		10%	9%
55 to 59	*	9%	7%
60 to 64		7%	6%
Annual Household Income			
Less than $10,000	*	4%	2%
$10,000-$15,000	*	3%	4%
$15,000-$25,000		11%	10%
$25,000-$35,000		15%	16%
$35,000-$45,000		14%	16%
$45,000-$55,000		15%	16%
More than $55,000		38%	36%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%	*	5%	4%
100% to 149%	*	4%	7%
150% to 199%	*	8%	6%
200% to 249%		11%	11%
250% to 299%		10%	11%
300% and Above		62%	61%
Work Status			
Employed		79%	81%
If employed, part time		12%	13%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent		33%	35%
Very Good	*	34%	31%
Good		24%	24%
Fair		7%	7%
Poor		2%	2%
Smoked Regularly in Past 2 Years			
		29%	30%
Serious Health Condition Past 10 Years			
		10%	-
HB 315 High Cost Condition List			
		3%	-
Number of Dr. Visits in Last Year			
0		18%	16%
1-2		42%	44%
3-4		18%	20%
5-6		8%	9%
More than 6		13%	11%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0	*	24%	20%
$1 - $249		49%	51%
$250 - $499		10%	11%
$500 - $999		9%	8%
$1000 - $4999	*	6%	9%
$5000 - $9999		1%	1%
$10,000 or more		0%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey.

Table A2
Demographic Characteristics of Employer Insured Non-Elderly Adults
(Includes Those Reporting Additional Coverage Through Another Source)

Characteristic		Percent 1998	Percent 1997
Gender			
Male		49%	48%
Female		51%	52%
Age			
19 to 29		21%	21%
30 to 39		25%	26%
40 to 49		28%	31%
50 to 54		10%	9%
55 to 59	*	9%	7%
60 to 64		6%	6%
Annual Household Income			
Less than $10,000	*	3%	2%
$10,000-$15,000	*	3%	4%
$15,000-$25,000		10%	10%
$25,000-$35,000		15%	16%
$35,000-$45,000		15%	16%
$45,000-$55,000		15%	16%
More than $55,000		38%	36%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%		4%	4%
100% to 149%	*	4%	6%
150% to 199%	*	8%	6%
200% to 249%		11%	12%
250% to 299%		11%	11%
300% and Above		62%	61%
Work Status			
Employed		81%	81%
If employed, part time		11%	12%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent		33%	35%
Very Good	*	34%	31%
Good		24%	24%
Fair		6%	7%
Poor		2%	2%
Smoked Regularly in Past 2 Years			
		29%	31%
Serious Health Condition Past 10 Years			
		10%	-
HB 315 High Cost Condition List			
		3%	-
Number of Dr. Visits in Last Year			
0		18%	16%
1-2		43%	44%
3-4		19%	20%
5-6		8%	9%
More than 6		13%	11%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0	*	24%	20%
$1 - $249		51%	51%
$250 - $499		10%	11%
$500 - $999		9%	8%
$1000 - $4999	*	6%	8%
$5000 - $9999		1%	1%
$10,000 or more		0%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey.

Table A3
Demographic Characteristics of Large Employer Insured Non-Elderly Adults
(Includes Those Reporting Additional Coverage Through Another Source)

Characteristic		Percent 1998	Percent 1997
Gender			
Male		48%	46%
Female		52%	54%
Age			
19 to 29		20%	21%
30 to 39		27%	27%
40 to 49		29%	30%
50 to 54		9%	9%
55 to 59		9%	7%
60 to 64		6%	6%
Annual Household Income			
Less than $10,000	*	4%	2%
$10,000-$15,000		3%	5%
$15,000-$25,000		11%	10%
$25,000-$35,000		17%	16%
$35,000-$45,000	*	15%	18%
$45,000-$55,000		17%	17%
More than $55,000		33%	32%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%		5%	4%
100% to 149%	*	5%	7%
150% to 199%	*	8%	5%
200% to 249%	*	10%	14%
250% to 299%	*	10%	13%
300% and Above		61%	57%
Work Status			
Employed		86%	85%
If employed, part time		10%	12%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent		34%	36%
Very Good		33%	31%
Good		25%	23%
Fair		7%	8%
Poor		2%	1%
Smoked Regularly in Past 2 Years			
		29%	31%
Serious Health Condition Past 10 Years			
		9%	-
HB 315 High Cost Condition List			
		1%	-
Number of Dr. Visits in Last Year			
0		16%	15%
1-2		44%	44%
3-4		20%	21%
5-6		7%	8%
More than 6		13%	11%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0		22%	19%
$1 - $249		53%	53%
$250 - $499		11%	11%
$500 - $999		7%	8%
$1000 - $4999	*	6%	9%
$5000 - $9999		1%	1%
$10,000 or more		0%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Kentucky Health Insurance Survey.

Table A4
Demographic Characteristics of Small Employer Insured Non-Elderly Adults
(Includes Those Reporting Additional Coverage Through Another Source)

Characteristic		Percent 1998	Percent 1997
Gender			
Male		49%	49%
Female		51%	51%
Age			
19 to 29		18%	20%
30 to 39		30%	29%
40 to 49		31%	28%
50 to 54		11%	11%
55 to 59		7%	8%
60 to 64		3%	5%
Annual Household Income			
Less than $10,000	*	5%	1%
$10,000-$15,000	*	1%	4%
$15,000-$25,000		15%	13%
$25,000-$35,000		20%	21%
$35,000-$45,000		16%	15%
$45,000-$55,000		11%	13%
More than $55,000		32%	32%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%	*	6%	3%
100% to 149%		6%	8%
150% to 199%	*	12%	6%
200% to 249%		11%	13%
250% to 299%		13%	12%
300% and Above		53%	58%
Work Status			
Employed		84%	85%
If employed, part time		15%	16%

Characteristic		Percent 1998	Percent 1997
Health in General			
Excellent		40%	40%
Very Good		30%	31%
Good		23%	21%
Fair		6%	6%
Poor		1%	2%
Smoked Regularly in Past 2 Years			
		31%	32%
Serious Health Condition Past 10 Years			
		7%	-
HB 315 High Cost Condition List			
		2%	-
Number of Dr. Visits in Last Year			
0		24%	20%
1-2		43%	43%
3-4		14%	17%
5-6		8%	9%
More than 6		12%	11%
Amount Spent Out-of-Pocket for Health Care During Past Year			
$0		27%	23%
$1 - $249		46%	47%
$250 - $499		10%	13%
$500 - $999		10%	7%
$1000 - $4999	*	5%	8%
$5000 - $9999		1%	1%
$10,000 or more		1%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Kentucky Health Insurance Survey.

Table A5
Demographic Characteristics of Individually Insured Non-Elderly Adults
(Includes Those Reporting Additional Coverage Through Another Source)

Characteristic		Percent 1998	Percent 1997
Gender			
Male		43%	45%
Female		57%	55%
Age			
19 to 29		16%	21%
30 to 39		25%	25%
40 to 49		25%	23%
50 to 54		12%	9%
55 to 59		10%	10%
60 to 64		13%	11%
Annual Household Income			
Less than $10,000		8%	4%
$10,000-$15,000		7%	4%
$15,000-$25,000		13%	17%
$25,000-$35,000		16%	15%
$35,000-$45,000		15%	13%
$45,000-$55,000		11%	15%
More than $55,000		31%	32%
Household Income as a Percent of the Federal Poverty Guidelines (FPG)			
Less than 100%	*	10%	5%
100% to 149%		8%	10%
150% to 199%		6%	8%
200% to 249%		11%	8%
250% to 299%		11%	11%
300% and Above		53%	58%
Work Status			
Employed		67%	71%
If employed, part time		25%	23%

Characteristic	Percent 1998	Percent 1997
Health in General		
Excellent	30%	35%
Very Good	34%	34%
Good	26%	21%
Fair	9%	7%
Poor	2%	3%
Smoked Regularly in Past 2 Years		
	26%	28%
Serious Health Condition Past 10 Years		
	13%	-
HB 315 High Cost Condition List		
	6%	-
Number of Dr. Visits in Last Year		
0	20%	23%
1-2	41%	47%
3-4	16%	14%
5-6	12%	7%
More than 6	12%	9%
Amount Spent Out-of-Pocket for Health Care During Past Year		
$0	24%	22%
$1 - $249	35%	41%
$250 - $499	13%	15%
$500 - $999	13%	9%
$1000 - $4999	12%	11%
$5000 - $9999	1%	1%
$10,000 or more	1%	1%

* Indicates the changes from 1997 to 1998 is statistically significant at the 5% level.
Source: 1997-1998 Current Population Survey and 1997-1998 Kentucky Health Insurance Survey.