COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
FRANKFORT, KENTUCKY

IN THE MATTER OF:

Fact-Finding Hearing Related to
"Child-Only" Coverage

TRANSCRIPT OF HEARING

OCTOBER 13, 2010

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The foregoing hearing was taken, pursuant to subpoena duces tecum, request for information, and order, on Wednesday, October 13, 2010, beginning at the hour of 1:30 p.m., at the offices the Kentucky Department of Insurance, 2nd Floor Hearing Room, 215 West Main Street, Frankfort, Franklin County, Kentucky, pursuant to KRS 304.2-100, KRS 304.2-340, KRS 304.12-130, and 806 KAR 2:070 and all other applicable law.

MS. CLARK: We will go be ahead and get started.

I want to welcome everyone to the department. I am Sharon Clark, the commissioner. I think you can see the name tags of my colleagues at the table. And we appreciate everyone's attendance today. I would like to go over and just make some general comments. And then I will turn it over to the facilitator.

Obviously the purpose of the meeting was after we learned that there were -- the insurers in the state had declined to write child-only policies. We thought that it was in the public interest to hold a hearing about the matter and try to get some fact finding measures, if you would, to try to get some additional information.

The -- we hope to have a deliberative process. And it would be wonderful if we could come to a consensus regarding solutions for the coverage availability by the end of the hearing.

We encourage the insurer to come up with any solutions, come up with any ideas. Everything is on the table here. And the other purpose of the hearing is, as I said, for fact finding. The purpose of the hearing is not to debate federal

health care law. We're -- and also the purpose is not to scold the insurance companies for their decision.

So with that in mind, I would like to introduce Vicky Horn, who is an attorney here with the department. And she will be facilitating the meeting today.

Thank you.

MS. HORN: I am going to stand up. Can you hear me in the back? Well, you shook your head no so you must have heard something.

We began this process by sending everyone the same questions, give you a chance to look over them. And today you will be asked to present your answers to those questions one at a time as I call you forward.

You will come and sit at this table so the court reporter can hear you and we can hear you and present answers to those 5 questions. We had requested information pursuant to our subpoena that might have been supplied in addition to the answers to those questions.

And all of this information will be made available in the commissioner's final report, which should be forthcoming about 30 days after

the end of this hearing.

The way we are going to proceed is the insurers will make their opening remarks and answer the 5 questions. At 3 o'clock, we will take a break and collect the interested party questions and let everybody have a break while we look through those and eliminate duplicative questions and questions that might not be quite on point.

Then we will return. And those questions will be asked to the insurers.

We are going to be out of here by 5. There will not be an opportunity for questions from the floor. There will be no open mic.

Are there any questions about the procedure?

For those of you who might be listening in the overflow area in the law library, there is a box of question cards at the head of the table if you are looking around for those. All right, then. Let's begin.

Can I have the representative from Anthem? If you would just introduce yourself so the court reporter can get your name.

MR. LEE: Sure. Good afternoon. And thank you for inviting us today.

Commissioner Clark and representatives of the Department of Insurance, thank you for convening this important public forum to discuss issues regarding the recent federal law changes and their impact on the child-only business here in Kentucky.

MS. CLARK: Did we get the name of both parties?

MR. LEE: Yeah. My name is Jimmy Lee. And I am the senior vice-president for WellPoint. And the president of Anthem's individual market. And I am responsible for our 14 Anthem Blue Cross states with regards to managing the individual business in those states, including Kentucky.

So we appreciate the outreach to Anthem to, you know, assist you in seeking solutions that's become an issue not only in Kentucky but across the country as we speak. And that issue is really how to best address the market for stand alone insurance products for children.

The department did request, as we heard, specific information about, you know, the number of the child-only policies that we have and what our experience has been with those policies. And we provided that information in the past week.

You also submitted in advance the specific areas and questions that you asked me to address today. And I am very happy to do so and have that open dialogue.

Before I do, I wanted to take the opportunity to really reiterate Anthem's commitment to the Kentucky marketplace as well as our past and current roles in Kentucky. Much of what the rest of the country is experiencing now with regards to health care reform, or PPACA as we sometimes call it, is really nothing new to Kentucky. If we remember in the 1990's kind of what the roller coaster ride for Kentucky's health insurance market was. And then Anthem was there, along with many of you, during that period. Sometimes holding on for our dear life.

You know, when the 60 or so companies that left the marketplace following the reforms of the '90s, Anthem Blue Cross stayed. We have since remained committed to Kentucky through various programs such as the Purchasing Alliance, the GAP Program, Eye Care, Mandate Light, and Kentucky Access.

And we are very much hopeful to continue that great partnership with the Kentucky department,

the Governor, and General Assembly, as we work to keep our commitment to you and to our customers in the future.

I think we all know these are turbulent times in our industry. In a similar environment that Kentucky health care reform experienced in the 1990's. But this time, it is on a much larger, grander scale, on a national scale.

So, you know, in preparation for today's hearing, we did kind of went back and reviewed the Department's publication that kind of chronicled those health care reforms in Kentucky in the '90s. And there are a lot of, you know, similarities there in what we are trying to tackle in the environment then and in the environment today.

I think the real interesting point that I gleaned from, you know, the well-intentioned Kentucky reform efforts in the '90s is that it is that balancing act that occurs between guarantee issue of coverage and affordability.

Guaranteed health insurance is a great consumer benefit. But it is expensive, particularly when there is no requirement for people to maintain insurance through that process. So, you know, after all, if one knows that one

will be issued coverage without any limitations or any pre-existing conditions, the question becomes why purchase the coverage until I need it.

You know, it's a similar concept, you know, I was talking earlier to Lawrence that I would try to explain to my wife people trying to understand what this guarantee issue means. I said it would be similar to us not having to pay homeowner's insurance which would be kind of nice. But then there is this nice law that says, you know, when we smell smoke, we can go on-line and pick out which private company is going to build our house.

So there is really not a lot of difference between that when you don't have a mandate and you have guarantee issue.

And in Kentucky I think, you know, we chased this same game back in the '90s, guaranteed issue requirements without a mandate that people carry, which led basically all the companies to leave the Kentucky market.

So if you think about the problem we are faced with today in regards to child-only policies, the Kentucky experience is again relevant.

The regulations for implementing children's

coverage provisions of PPACA effectively created guarantee issue requirement with no limits on pre-existing conditions. And as we were one of the few, if not the only, private carrier issuing child-only policies leading up to 9/23, it led to an unlevel competitive playing field for Anthem in Kentucky.

And because of this, we did make the decision just prior to 9/23, as permitted under Kentucky and federal law, to really suspend our sales of the child-only market until such times as rules, you know, are in place that would insure that all carriers compete on a level playing field when providing coverage in the child-only market.

And really the rules to help develop and insure a sustainable market there.

Anthem remains committed to offering a broad range of policies and products and services that meet our customer's needs in the changing health insurance market. We're also committed to implementing the new health care reform legislation in a way that benefits our customers and our members.

The absence of a policy that insures all children are in the system really kind of

undermines the goal of establishing a balanced risk pool that includes a broad mix of enrollees and helps keep child-only policies, and for that matter all individual policies, more affordable and sustainable.

So with that, I will go ahead and if it is all right get into the 5 questions and topics.

The first one was to provide general comments about Anthem's coverage of children under age 19 prior to September 23. So prior to September 23rd at Anthem, we did offer coverage both as dependents under their parents plans and as subscribers as long as the child-only applicant, you know, met eligibility requirements.

Many of our competitors chose to discontinue the sale of child-only policies and most cited, you know, the lack of an effective mandate that I described earlier as well as just ongoing market uncertainly.

And, as a result, Anthem again leading up to 9/23 was one of few if not the only carrier that at that time was offering child-only products in the Kentucky market.

So in order to insure, you know, and operate on a level playing field and that our

policyholders in the individual market were not adversely impacted, we reluctantly did choose to suspend the sale of child-only products.

Again, unless all insurers are required to offer child-only, the ones that will be at a disadvantage. And their policyholders that have to subsidize that will be at a disadvantage.

Okay.

Number 2. Provide a general statement regarding applicants under age 19 who were denied coverage prior to the insurer's decision to discontinue issuing policies. All applicants are subject to the eligibility requirement. An example of that might be the residency requirement within our service area.

So prior to September 23rd, an applicant was also medically underwritten. A child under age 19 could have been denied coverage based on pre-existing conditions that presented a material risk according to our underwriting guidelines. And also, you know, in some cases, you know, there could have been a declination based on several or numerous conditions that an underwriter would review.

Okay. So basically there was medical

underwriting. It was not guaranteed issue.

Okay. Number 3. Under what circumstances would an insurer be willing to reverse its decision to continue writing child-only policies? In our opinion, in order to begin writing child-only policies again without disproportionately disrupting, you know, the impact on the whole individual market, we think again that all insurers must sell child-only policies, not some.

So unless all insurers offer child-only, the ones that do, again, will be forced to absorb that additional risk of covering these children with no medical underwriting.

Secondary, we think there should be standard, annual open enrollment periods for child-only policies. With standardized effective dates, also, as far as -- such as 30 days after the close of the open enrollment period. Again the standardization is important.

Thirdly, rules to encourage continuous coverage and discourage subscribers of child-only policies from enrolling only when services are needed. And then we also think to keep the market viable and to allow children to enroll and the

concept of insurance to remain outside of open enrollment periods, that we should be allowed to medically underwrite those children outside of open enrollment periods. And also during the open enrollment period be able to underwrite those -- the children and apply the appropriate surcharge, if you will, or rate-up that would be allowed.

So actually there were 2 things there that I mentioned. One was medical underwriting kind of during the open enrollment period, not for purposes of the declining coverage but for purposes of setting the appropriate surcharge for that policy.

And then, secondly, that enrollment outside of open enrollment periods for the 11 or so months the rest of the year, that that enrollment be allowed for those that could pass underwriting at that point.

And then also lastly, that there should be some criteria established that would help mitigate what we would call dumping into a guarantee issue market. An example might be prohibiting someone from obtaining a guarantee issue no pre-ex product if they are already eligible for other coverage either through a public or private program.

So the child-only platform would guarantee issue. And no pre-existing conditions allows for a very easy process to reduce costs, for example, on the employer's side and send all of those children -- because it is very easy. The parents can just stay on their employer plan and let's reduce employer costs by sending them into this nice, easy, child-only guaranteed issue, no pre-ex, claims paid on day one process.

And, of course, that will come at the expense of all of the individual policyholders who must pay for that activity.

Okay. On to number 4. Is Anthem continuing to offer coverage for children under 19 as a dependent where the primary insured is over the age of 19? And the answer to that is yes. So we are, as we speak, offering that coverage on a guarantee issue basis after 9/23. So that children for the first time have access through guarantee issue as we speak. Okay?

Number 5, is the insurer's decision to discontinue offering child-only policies a national decision? Has this decision been referenced in any state and what circumstances led to the reversal? Our suspension of offering

child-only is a national decision. However, there are some states and some products that preclude the suspension of child-only sales, including states such as New York, Maine, and New Hampshire. There may be more. I am talking about the 14 states that WellPoint does business in.

In addition, California recently enacted legislation that required the offering of child-only policies effective January 1 of 2011. Also, we have some sales of child-only that will continue under some of our HIPAA guarantee issue products and eligible individuals in the states of Ohio and Virginia. So besides those, it is a -- the national policy is the same. Okay?

MS. HORN: We can go ahead and finish this.

MR. LEE: Provide comments on the suggestions tendered by HHS. Which solutions will work, which will not.

We do appreciate the clarification that insurers can utilize open enrollment periods. But it is still unclear on things like whether open enrollment period applies to both dependent child and child-only policies. So whether, you know, your open enrollment period is also for those that are guaranteed issue under their parent's plan.

So that still remains an open question.

And insurers should be allowed to underwrite and accept children outside of open enrollment. I have already addressed that. And in absence of a standard, annual open enrollment period, there is a strong incentive for some carriers to delay the open enrollment period until as long as possible into the year 2011, for example. Because the first carriers that come in are going to be the first that are going to attract all of the pent up demand, all of those that need those that need big claims paid immediately.

So with this open-ended, you can have your open enrollment period whenever you want, it causes a fair amount of confusion.

So we would advocate for a standard open enrollment period. A defined amount of the surcharge that would facilitate a level playing field for all insurers. So the amount you are kind of rating for the risk that being standardized.

Then also insurers need a clear definition on when a surcharge can be applied. So, for example, if a child has not been continuously covered for 63 days, for example, leading up to the

application date, there might be a standard say 25 percent or whatever surcharge applied. Okay?

I had just a couple of closing remarks. But I know our time is up. And I think I have pretty much covered most of our positions. So thank you for the opportunity.

UNIDENTIFIED SPEAKER: So just for clarification, then, questions be will be addressed after 3 o'clock?

MS. CLARK: Yes.

MS. HORN: Questions submitted in writing.

UNIDENTIFIED SPEAKER: Okay.

MR. FORD: Any questions that we need to answer now?

MS. HORN: No.

MR. LEE: Thank you.

MS. HORN: If I could have the representative from Kentucky Access.

MR. PERKINS: Commissioner Clark, for the record, my name is Al Perkins. I am the director of the division of Kentucky Access within the Kentucky Department of Insurance. The General Assembly created Kentucky Access for Kentucky qualifying residents who otherwise have no recourse to acquire health insurance coverage.

I appreciate the opportunity to address the effect on Kentucky Access of private health insurance cessation of offering child-only policies. The financial effect on Kentucky Access will be immediate and harsh. The health insurance offered through Kentucky Access is serviced by a private administrator due to the lack of staffing and resources for administration by the division itself.

Kentucky Access pays the administrator on a per member per month basis. Clearly, as Kentucky Access enrolls those children who cannot obtain coverage in the private market, the Kentucky membership will swell as will the basic cost to Kentucky Access. This would be true even if, as we all would wish, every child was healthy.

Very many of the new members, these children, though will not be healthy. Already as a high risk pool, Kentucky Access guarantees coverage to all eligible applicants and does not consider health status for rating purposes. In the last fiscal year from total premiums of just over $652,000 for child-only enrollees, incurred claims for that group reached over $9,800,000.

As more children enter the program, and sadly

as the pool of seriously ill children grows, the math is evident. The division's expenditures will further outrun its receipts from premiums. Additionally, Kentucky Access will incur a certain loss of efficiencies in both cost and operation. Existing health plans will not be adaptable to child-only use. The added membership will require Kentucky Access to design new health plans to accommodate the child-only policies.

The development of the new plans will bring extra expense to Kentucky Access.

Finally, Kentucky Access as a high risk pool has a maximum membership for effective service of no more than 5,000 persons. Standing at this point at over 4,800 members, Kentucky Access has small room for more members without a diminution of service. Make no mistake, Kentucky Access will strive for excellence always. The division always will have as its first job the service the state citizens expect and deserve.

But the facts and numbers attributable to the loss of child-only policies from private insurers are as sure and hard fast as is the adverse effect they will have on Kentucky Access.

Thank you.

MS. HORN: Any questions?

MS. BURTON: No.

The questions posed to the other insurers really are not applicable to Kentucky Access. So we asked them to address certain issues which he has addressed in his testimony.

And if anyone has questions that you want us to expound upon that, we'll just ask for the questions to be on the question cards. And we will present those this afternoon a little later.

MS. HORN: Thank you, Mr. Perkins.

MR. PERKINS: Thank you, Ms. Horn.

MS. HORN: If I could have the representative from Aetna.

MS. BUTKUS: Good afternoon. My name is Elena Butkus. And I am the director of government affairs for the Mid-America Region which is about 20 states.

I am pleased to be here. And just as an opening comment, we generally didn't get back into the individual market in Kentucky until September 1 of 2009. So we have a small book of business here as you know. And during that time, we did begin to sell child-only policies. And that is a subset, the numbers you have is a subset

of a total of -- we had 117,000 total lives in the state of Kentucky.

Before I get to the questions at hand, I just wanted to open up with a general statement. And we want to make clear that Aetna absolutely supports health care reform, including the individual coverage requirement with the financial help or subsidies for those who will need it. And that will allow us to move into the guarantee issue area on 1/1/2014 to make sure that everybody is covered.

We absolutely believe in comprehensive coverage. And we demonstrated that commitment with what we believed in being able in that we applied dependent coverage up to age 26 early in all of our markets.

We appreciate the attention to the child-only issue under PPACA. And would reiterate that the FAQs that were issued by HHS, while they would allow for some relief, we absolutely don't believe that they go far enough. And have our suggestions for the state on what we would recommend.

For Aetna, getting out of the child-only market was a national decision effective on October 1 of this year for most of our markets.

We have extended that in 2 markets, in particular Connecticut and Maryland, because of filing issues. And so we will not be issuing child-only policies in those 2 states as of 12/15 and 12/1 of the end of the year.

In addition, as the gentleman from WellPoint pointed out, California has recently passed a state statute. And, in particular, that state statute is the guaranteed issue statute if you play in the individual market. And it is effective on 1/1 of '11. And so while we have pulled out of many markets, we will be re-evaluating the entire California situation very shortly because of the authorities that were passed there.

I would like to take this time just to generally -- and I know these are a little jumbled in the order. And if you prefer I go in order, I can.

MS. CLARK: No. We are good note-takers.

MS. BUTKUS: Okay. Okay. With respect to how we believe that the states can accomplish getting at least Aetna back into this particular market, the company sat down and has 5 very specific recommendations, most of which are not

addressed in the FAQs.

Initially, we would have to have that states would mandate carriers to provide child-only plans in the individual market, be that under regulatory authority or statutory authority. We believe that that provides a level playing field for everybody to be consistent much like what's happening in California.

Second, we believe that the states should implement a standardized open enrollment period for child-only coverage. We understand under many states they are operating under a 30 or 45 or 60 day time frame. Some states have split up those open enrollment time frames. We are okay with considering that it be on the birth date of the child, just that there be an open enrollment period established that is consistent for the entire state.

Third, we believe that there should be no caps on rate-ups or health status. And that is consistent with the federal guidelines. We believe that there should be no caps on rate-ups for health status only during that open enrollment period. Carriers would also need to be able to get actuarially justified rate adjustments for the

base rate to reflect guarantee issue.

Fourth, we believe that surcharges should be implemented where coverage lapses. And this is regardless of and in addition to any rate-up for health status.

We believe that just generally if, for example, a child doesn't have health coverage for 63 days very much like HIPAA, that they should be subject to an additional permanent rate-up because of that lapse of coverage. This would apply either for child-only coverage or for coverage where the child was a dependent as the goal is to encourage continuous coverage across the board for all products.

And then lastly, we believe that carrier should be able to achieve actuarially sound premium increases and allowed to exit the market if we can't obtain them. And just to explain that particular comment, in order for carriers to participate and remain in this market, rate filings have to be allowed to accurately reflect the impact of the guarantee issue requirement. In this way, and I know this doesn't happen in Kentucky, but politically driven rate review processes do not in this way interfere with a

insurer's ability to set rates accurately to reflect the experience of this particular group.

And now going back to the other questions.

We were asked to provide a general statement regarding applicants under age 19 who were denied coverage prior to the insurer's decision to discontinue issuing the policies. As the gentleman from WellPoint said, for Aetna, individuals do go through a health underwriting process for those policies under our eligibility requirements. And individuals who are denied, are denied under that underwriting process.

And then the following question it asks under what circumstances would we be willing to reverse a decision to discontinue policies. I would just go back to stressing either the California solution in that the California law specifically addressed guarantee issue. Or if you would consider in rule-making, the 5 points that we went through.

The following question is whether the insurer is continuing to offer coverage for children under age 19 as a dependent where the primary insured is over age 19. Yes, we are absolutely.

And then the last question, is the insurer's

decision to discontinue offering a national decision. Again, as I said earlier, it is a national decision. It is only been reversed so far outside of looking at some of the filing issues that I spoke about in Kentucky or, so sorry, in California because of the statute. And I think I went through the solutions that we believe are workable within the HHS guidelines.

In conclusion, we absolutely believe that every state can come up with a sensible, practical approach whether it be in rule-making is preferable for our company. And we believe that adjustments can be made for carriers to come back into the market.

And with that, I will be happy to take any questions at the appropriate time. And thank you very much.

MS. BURTON: I have do have a question.

You had indicated earlier that because of a California legislation, that Aetna was re-evaluating whether you would stay in the market there. Yet part of your recommendations is legislation to that effect, to make it an even playing field. And, granted, I have not looked at the California legislation so I really can't

comment on what it contains.

But if it has these pieces of your recommendations, is that -- I am assuming the California legislation maybe doesn't have all of those pieces and that's why you are re-evaluating.

Is that the case?

MS. BUTKUS: It does not have all of those pieces. It has extra pieces in addition. So what we did was take the HHS guidelines, and specifically the California legislation and some of the rules from the other states, and try and come up with a structure that could be done either by rule-making or legislation.

Did I answer your question?

MS. BURTON: Yes.

Although my question was poorly stated. But, yes, you did answer my question.

MR. NOLD: I had a question. And maybe I just didn't hear it when WellPoint was giving their presentation. But to be clear, I know you all clarified the issue about dependent coverage.

But policies that you all currently have in effect that were issued prior to September 23, you will continue to renew those policies into the future?

MS. BUTKUS: Yes.

MR. NOLD: Those are guaranteed renewable and you all are obligated and will continue in that market in that sense, is that correct?

MS. BUTKUS: Yes, sir. Absolutely. We are suspending -- I am so sorry.

The right words to have used is, we are suspending applications for new applicants. Our applicants that are currently enrolled under child-only policies in the state of Kentucky and every state in the nation, we have 15,000 enrollees, they will all continue to be renewable.

MR. NOLD: And, Mr. Lee, that would be the same answer on behalf of WellPoint? Is that --

MR. LEE: That's correct. Same answer.

MS. HORN: Anything further? Any other questions? Thank you.

MS. BUTKUS: Thank you very much.

MS. HORN: If I could have American Republic. Someone here for American Republic? No?

How about Humana?

MR. DERALEAU: Good afternoon, Commissioner Clark, and members of the department. My name is Steve DeRaleau. I am the second vice-president for Humana. I lead all of the Humana's individual

market operations nationally, including the Humana One line of individual health insurance plans which we currently offer in Kentucky and 25 additional states.

Humana believes that all Americans deserve affordable quality health care. And we have long supported efforts to expand satisfaction and extend health care coverage so that no one need go uninsured. The Patient Protection and Affordable Care Act includes many important provisions which will help cover millions of people who they cannot afford or cannot obtain health insurance.

But as we open access, it is paramount that we keep premiums affordable for everyone by insuring the ongoing stability in the long term viability of the health insurance marketplace. Otherwise, we jeopardize the gains made by the new law and we risk putting coverage out of reach once again.

When health plan attracts more people with immediate health care needs without a sufficient number of healthier individuals to balance the pool and offset medical claims, the result is higher premiums. If this imbalance continues, it creates a downward spiral that can have dire

consequences, a phenomenon we have seen play out in any number of other health insurance markets.

Encouraging the enrollment of healthy individuals to support those in need of care is essential to hold down premiums for current plan members as well as those that are seeking coverage.

Through September 22nd of this year, Humana offered coverage under all its individual health insurance plans to primary applicants under the age of 19. We based our decision to offer this coverage on the regulations that were in place at that time. Those regulations allowed us to medically underwrite each applicant and to take into account their health history.

And through this process, we were able to balance the risk of our plan's member pool and offer affordable coverage to applicants, except those with serious health conditions that didn't meet our underwriting guidelines.

Effective September 23, 2010, the provisions of the Affordable Care Act that prohibit the application of pre-existing conditions took effect. The department of health and human services, or HHS, has also issued interim final

regulations that further define this provision and that effectively require insurers to guarantee coverage to all dependents under age 19.

In addition, effective January 1 of 2011, insurers writing individual coverage must also meet an 80 percent medical loss ratio.

Humana's decision to end writing child-only policies in all states where previously we were offering that coverage was, in our eyes, regrettable but unavoidable. That's because the current law and regulations limit the mechanisms that can be used to account for and balance the risk in the child-only market.

Writing child-only policies in this environment is even more difficult when there are only a few insurers willing to do the same. Without that kind of active marketplace, any plan writing child-only will attract more than its fair share of high risk children with no ability to adequately cover that risk and cover the cost.

In addition, the cost of administering child-only policies makes it exceedingly difficult to meet the new standards that require at least 80 percent of the premium to be spent on medical care. While the details that underlie these

standards are still the subject of debate, the fact is that child-only policies typically bring in much lower premiums. But the cost of administering such policies is really not very different than that of any other individual plan.

So the ratio of administrative costs compared to premiums is greater than the new law requires.

With no other family members to contribute additional premium that might help offset administrative costs and improve that ratio, the 80 percent medical loss ratio required included in the ACA, remains another barrier to offering child-only coverage. While Humana is not currently offering individual coverage when the primary policyholder is under age 19, we are actively examining alternative approaches that could allow us to begin serving the child-only market again.

Although there are a few states that require insurers to offer child-only coverage under limited circumstances, we have not resumed offering child-only coverage in any state under the current rules. And our decision to withdraw was a national decision.

To create a viable marketplace for child-only

coverage with guaranteed access, but without a coverage mandate, we need a different approach. We need a regulatory structure that gives all parents a strong incentive to cover their children and to maintain that coverage.

Humana advocates that federal regulators establish a common and uniform open enrollment period for all carriers. Children with health conditions would have access during the open enrollment period while insurers could continue to enroll healthy children throughout the year.

Families whose children have health conditions are understandably eager to obtain coverage. The same is not necessarily true for families with healthy children. Faced with the financial burden of paying premiums with after-tax dollars and unable to rely upon employer or government assistance, many parents simply forego covering their healthy children.

To keep premiums affordable, we must attract healthy children to support the risk of the children that need care. Unfortunately, that is not possible under the current HHS regulations. The HHS rules require insurers offering coverage outside an open enrollment period to accept all

applicants. That means coverage is always available and there is no incentive to obtain coverage today because you know you can get it tomorrow or whenever you are in need of care.

While the recent guidance issued by HHS makes it clear that insurers can increase premiums for those children with health conditions, we believe this attacks the adverse selection problem in the wrong way.

The primary focus must be on attracting healthy children to coverage, not just increasing the rates for children with health conditions.

The key to making this market viable again is to create a regulatory structure that will help attract the balance of healthy and unhealthy individuals to enroll in these plans. We believe that creating a viable child-only market requires the following.

First, mandate that all insures serving the individual market also provide child-only coverage. Second, mandate that a uniform 30-day open enrollment period when all insurers will offer child-only coverage.

Allow insurers to limit the plans available to child-only applicants. Allow eligibility

standards that do not require insurers to offer coverage to children that have other options such as access to public programs or employer-sponsored coverage. Permit a premium surcharge for applicants that have previously and voluntarily allowed their coverage to lapse. Prohibit the sale of child-only plans outside of the uniform open enrollment period.

And, finally, provide a phase-in or a transition period for the individual market minimum loss ratio requirements to account for the lower premiums and the administrative expenses on child-only policies.

So in closing, we need to solve this important issue, not just here in Kentucky, but all across the nation. Ultimately, it is up to us, the insurers, who provide coverage and the regulators who oversee our industry. Children and their families are depending on us to work together and to get this right. And we look forward to working with you in that aim.

So thank you for your time and consideration.

Any questions?

MS. CLARK: Yes, sir.

You mentioned limit plans. Are you talking

about the plan design? Or are we talking about -- could you elaborate on that at this point, please?

MR. DERALEAU: Sure. Be happy to.

We think one way to limit adverse selection and to address the issue of the administrative expense is, on the lower premium policies, is to limit the amount of plan selection that would be available in the child-only market.

So rather than our full array of plans that we offer to the broad general market, have a narrow set of plans available for child-only.

MS. CLARK: Are we talking multiple or different cost sharing? Or what? You said a narrower. Are we talking one or are we talking a few with different cost sharing?

MR. DERALEAU: We would just look probably for a choice but a much narrower choice than general. We haven't a specific number in mind.

MS. CLARK: Thank you, sir.

MR. DERALEAU: Any other questions?

MR. NOLD: I was somewhat unclear about dependent coverage. Any decision that Humana has made with regard to continuing to offer dependent coverage? Can you explain that?

MR. DERALEAU: Yes. We will continue to

offer dependent coverage. And we will continue to, as you asked earlier, we will continue to insure all of the children that are under child-only.

MR. NOLD: Continue to renew them? Guarantee renewable?

MR. DERALEAU: Yes.

MR. NOLD: That's all I have for right now.

MS. HORN: Thank you.

MR. DERALEAU: Thank you.

MS. HORN: Do we have a representative from Golden Rule?

MR. CORNE: Yes. My name is Mike Corne. I am with Golden Rule. We are a subsidiary of United Health Care. And we have been offering health insurance coverage to individuals and families for about 60 years now.

And what I would like to do is just track down through your questions if that is okay with you.

MS. HORN: That's fine.

MR. CORNE: Question number one was provide general comments about your insurer's coverage of children under age 19 prior to September 23. We did write child-only policies prior to

September 23. And we have done that for many years. We have done that in all states.

We did cease that offering around September 21st of this year.

Two, provide a general statement regarding applicants under age 19 who were denied coverage prior to the insurer's decision to discontinue issuing policies.

We provided some data to the department. And our issue rate was approximately 80 percent for these applicants. So about 20 percent were declined.

Number 3, under what circumstances would an insurer be willing to reverse its decision to continue writing child-only policies.

We think there is a solution for this. And we are interested in obtaining and finding a solution. We are interested in continuing to write child-only policies. We are an insurance business and we think everyone should be included. There has been discussion in several states about child-only coverage open enrollment periods. We believe a properly structured open enrollment period can work. And, at a high level, we think there are really 7 things that would provide a

properly structured open enrollment period.

The first, which has already been mentioned by others, is that we believe all carriers should participate in this market. We think there should be a specified 30-day open enrollment period. We think that period should be the same for all carriers. We think there should be an initial open enrollment period to get these children in the system. And then we think there should be an open enrollment period annually to bring others into the system or to allow those that are in the system to change coverage should they decide to do so.

We think there should be a provision for qualifying events to keep children in the system. So if we have a specified open enrollment period at one time during the year and we don't allow for qualifying events, then we have children who are covered under employer-sponsored plans or have other coverage that might lose that coverage for one reason or another would not have the ability to stay in the system. And that's the last thing we want.

We think there should be provisions to prohibit risk dumping. So like under small group

reform, there are rules that really prohibit individual market carriers from dumping their adverse risk to the small group market. Likewise, we think there should be provisions to keep the small group carriers from dumping their risk to the individual market.

Someone mentioned eligibility criteria. So if you are eligible for other coverage. And just a little bit more detail around that. We agree with that. We think that's a workable solution.

7, we believe there should be provisions to prohibit gaming. So what do I mean by that? What I mean is that someone chooses to forego child-only coverage. And at some point they have a medical event. They decide they need coverage. So the child signs up with someone who is over age 19. And then shortly after their issue, the parent drops off, thereby gaming the system to obtain child-only coverage at times outside the open enrollment period.

Question number 4. Is the insurer continuing to offer coverage for children under age 19 as a dependent where the primary insured is over age 19?

Yes, we do continue to offer that coverage.

And, of course, under guaranteed renewable to answer your questions. Those that are currently insured under those plans are unaffected by any changes we have made to cease actively marketing child-only policies.

Number 5, is the insurer's decision to discontinue offering child-only policies a national decision? Yes, it is a national decision. And at this point, we have not changed that decision in any state where we actively market for business.

You did have a sixth question, I think, which is provide comments on suggestions tendered by HHS, which solutions will work, which will not. See responses to question 6 on the attached FAQ. I think someone talked about that.

We believe flexibility is helpful when trying to find solutions for difficult issues. And we think this is a difficult issue. But we are committed to finding a solution. We would recommend leaving all of the suggested options on the table.

We are focused on solutions and we believe, as stated earlier, that a properly structured open enrollment period would work. And we would like

the opportunity to work with you would to put that type of plan together.

MS. HORN: Any questions?

MR. NOLD: When you mentioned qualifying events, do you have any specific qualifying events other than those that are typically HIPAA based kind of qualifying events?

MR. CORNE: Not really. Those are the things I am thinking about, though. So someone is covered under a plan of insurance and they involuntarily lose that coverage. I mean that's pretty simple. That's not a very complicated thing. If you lose it involuntarily for other than fraud or something of that nature, then you should be able, within 63 days of that qualifying event, to obtain coverage outside of an open enrollment period.

MR. NOLD: And under those rules, pre-existing rules -- pre-existing rules -- under the old HIPAA rules, pre-existing conditions wouldn't apply anyway --

MR. CORNE: Well, that's correct.

MR. NOLD: -- if you had a qualifying event.

MR. CORNE: And, of course, there is a prohibition on pre-existing conditions across the

board for dependents. So that would apply here as well.

MR. NOLD: When you were talking about the open enrollment period, you mentioned an initial open enrollment period. I assume that would be the same for all of the insurers. That would start soon if we did something.

MR. CORNE: We think it should be the same for all insurers, yes.

MR. NOLD: And the same thing would be true with the annual open enrollment period that it would be the same for all insurers?

MR. CORNE: Yes. We think it is important to create a level playing field and bring everyone to the table. So, yes, we would think that those things should be the same.

MR. NOLD: One of the other insurers mentioned that open enrollment period may be keyed into the birth date. That would not be -- you would not be in favor of that?

MR. CORNE: Well, I think that would be fine. I mean the advantage to that is that rather than have this one period during the year when an insurer might receive lots and lots of applications and have to manage that new business,

that recommendation would allow business to be smoothed out throughout the year and more easily manageable in terms of issuing the policies and that sort of thing.

But even in that scenario, it would still be the same for all insurers, that particular birth month for that person. So I think that's workable as well. And, as I said, it does have some administrative advantages.

MS. HORN: Anything? Thank you very much.

MR. CORNE: Thank you. Thank you.

MS. HORN: Do we have a representative here From Time or John Alden?

MR. HILL: My name is David Hill. I am the chief state affairs officer, government relations for Assurant. Assurant Health would like to thank you for this opportunity to speak at this hearing. Assurant Health recognizes that the issue being discussed today, child-only policies, is an important issue both in Kentucky and nationally and commends the department for raising the issue and working toward a solution.

Let me provide you with a very brief background on Assurant Health. Assurant Health writes individual and small group medical

insurance through 2 underwriting legal entities, Time Insurance Company and John Alden Life Insurance Company. Assurant Health writes business in over 40 states and the District of Columbia.

With regard to child-only policies, Assurant Health made the decision after careful consideration of many factors to amend our eligibility standards and cease accepting applications in which the primary applicant was under the age of 19.

One of the factors considered was the potential for unduly selected -- to be unduly selected against resulting from the potential where other carriers withdrawal from this particular market. Prior to that time, Assurant Health offered coverage to persons 19 years of age or younger, if the application for coverage conformed to our underwriting guidelines and the premium to be charged was paid by the applicant.

Decision was made on a national basis subject to state statutory and regulatory requirements.

To date, there has been no change in that particular decision. Assurant continues to offer coverage for children under age 19 as a dependent

where the primary insured is over the age of 19. With regard to the suggestions tendered in HHS FAQ, those suggestions can be very helpful. And, obviously, we would assess all of those issues as they would arise.

However, for Assurant Health, the key I think that many people have already talked about, would have to be based on a -- the information submitted and the children who are -- I am sorry. Let me say that again.

Based on the level of business that we have in the state, one of the important things for us would have to be is consideration to the number of carriers providing such coverage in an environment in which many carriers are actively involved in the child-only market, thereby spreading the risk among carriers. And Assurant Health is not unduly selected against.

I mean I think you have pretty much heard that from all of the carriers. So that is no different.

A state defied open enrollment period that is the same for all carriers would also be important. Again, that is nothing that haven't heard from other carriers.

And, finally, the ability to price appropriately for the anticipated impact on business.

Any questions?

MS. CLARK: Thank you.

MR. HILL: Thank you.

MS. HORN: Are there any insurer's representatives here who we have not heard from?

Okay. At this time we need the question cards. And I would like to say that we will be accepting written comments for up to 5 business days. And they will be made a part of the record.

So if any of you after you go home want to make a written comment or suggestions, please feel free to do that. We need them here no later than the close of business next Wednesday to be included the record.

I guess we can go ahead and take our break now.

MS. BURTON: Can we give maybe 10 minutes to let them get the questions and submit it to us and then reconvene at 3? Is that okay?

MS. HORN: Sure.

MS. CLARK: We will see everyone back in here at 3 o'clock.

* * *

OFF THE RECORD

* * *

MS. HORN: Okay. It is a little after 3 o'clock and we are called back into session.

I believe Ms. Burton has some recordkeeping to do with the court reporter. So we will let her do that first.

MS. BURTON: Yes. There are a couple of issues that you I have.

First in relation to 2 companies that we issued subpoenas to. One was MEGA Life and Health Insurance Company. And the other was Physicians Mutual Insurance Company. Both of those companies did supply data to us pursuant to the subpoena. But they also indicated to us that they were discontinuing issuing health benefit plans, individual health benefit plans, in Kentucky. And they provided notice under our statute KRS 304.17A-240 that they were discontinuing. So we excused them from their attendance here at this hearing because they aren't in the market any more.

The other company American Republic, we did receive data from them pursuant to the subpoena.

So we are not sure why they are not here today. So I can't really respond to that.

MS. CLARK: But we will follow up with that.

MS. BURTON: We will.

2 more things. We have made reference in the questions to the FAQs from HHS. Everybody get all of that? And we are going to put those as exhibits into the record. And we will also supply links to those on our website.

But just for -- just so we will all have it as a part of the record. And so the first one is the Exhibit 1, the FAQ from HHS. And that's a copy of it, Georgene.

And the second one is a letter issued from Secretary Sebelius dated today to the National Association of Insurance Commissioners, President Jane Cline, regarding the subject matter of this hearing with some additional FAQs attached to that. We are going to put that as an exhibit to the record here, also. So that will be Exhibit 2.

That's all I have.

MS. HORN: Thank you.

We have just a few questions that were provided to us on these question cards. And the first question I am going to ask, I don't know if

you have stuff here that you can answer it with readily today, how many child-only policies does each company have currently, I guess, in force? And the second part of that question, how many children were deemed ineligible before September 23? And what was the issue rate for child-only policies, I guess, prior to September 23?

I think you wanted to say something about that.

MS. BURTON: Yeah. We did collect that data to a certain degree in response to the subpoenas that we will make available.

But if any company would like to talk about their numbers right now, I mean you are welcome do that. I am not sure if you have those numbers in your head is our problem. But certainly that data to a certain degree was collected in response to the subpoena. And it will be made available.

But if anybody would like to talk about your numbers, we will give you an opportunity to do that.

MR. LEE: For Anthem, first of all, in Kentucky we have about 125,000 total individual under 65 members. Of that, we have about 8500 or

6, 7 percent -- about 6.8 percent of that 125,000 are in child-only policies. And then I think the other question was what was the basically the approval rate or decline rate whatever you for child-only --

MS. HORN: Yes, yes.

MR. LEE: -- policies, I believe. I think we have our total. And I think we might have to get that to you. We have our total decline rate and approval rate total, meaning not just child-only but medical underwriting in general. And it is about 80/20. Is that it is about? 80/20.

So I don't have that broken down, though, for child-only.

MS. HORN: Okay.

MR. FORD: We did supply the department with the number of applications that we received and then also the number that we actually enrolled. But you need to take into account that many of those applicants either found coverage elsewhere, declined our offer, or perhaps went with group, or even moved out of state, or chose not to become insured.

So I am not sure that that's a true medical underwriting. And we would have to follow up with

you there.

MS. BURTON: Right. So what you are saying is the date of that we have, may not necessarily be a decision of Anthem's to not enroll them?

MR. FORD: That's not an underwriting number.

MR. LEE: Some of them may have been offered coverage and did not accept.

MS. BURTON: And I am assuming that that's true for the rest of the companies that supplied their data as well.

MS. HORN: Would that be a difficult thing to ascertain before next Wednesday?

UNIDENTIFIED SPEAKER: Would what be?

MS. HORN: The number of children declined for medical eligibilities.

MR. DERALEAU: I am not sure the difficulty we would have for the state of Kentucky.

Nationally we have statistics and it varies from period to period between 10 and 15 percent. But I don't know that I have Kentucky statistics.

MS. BURTON: Well, the data that we do have will give a general idea. And we will put certainly the caveat in there that it may not be reflective of the exact question that you were asked.

MS. HORN: Anybody else want to make a comment or try to answer the question?

UNIDENTIFIED SPEAKER: Yeah. Just in general. If you aggregate all of the data you just received from multiple carriers and then it was a medically underwritten market. So a smart person submitted multiple applications.

So one person, one child, could be counted 5 times. Right?

MS. BURTON: Could have been.

UNIDENTIFIED SPEAKER: Because it was submitted to all of the carriers.

MS. HORN: Yes.

UNIDENTIFIED SPEAKER: And then gone with one of those. So you have 1 acceptance and 4 denials.

MS. HORN: Yes.

UNIDENTIFIED SPEAKER: Because they didn't take it. Plus they could have been healthy and just don't want to pay it. I mean there is so many reasons. So I think you just need to be careful. Because one of the numbers you are trying to get at, I think the most important number is how many actually were denied that could be coming over somewhere else, right, to the Kentucky Access or somewhere else into the system.

And that's a very difficult number with what I have heard discussed here today.

MS. BURTON: You are exactly right. So any numbers out there have a few footnotes to them that it may not be exactly reflective of what you may think they are. So you are exactly right.

MR. LEE: And today those folks declined do have access.

MS. HORN: Yes.

MR. LEE: Because it is guaranteed issued after 9/23.

MS. BURTON: Right.

MS. HORN: If they can find someone to sell the policy.

MR. LEE: On their parent's policies.

MS. HORN: This is a question for Kentucky Access.

Kentucky Access mentions that they are concerned about a large influx of high risk individuals. However, won't this leave children with good medical risks also entering the pool which might help better subsidize the risk.

MR. PERKINS: Hypothetically, that could be true. But if one presenter has already spoken to, very often parents of healthy children are apt not

to enroll them in child-only health insurance.

Consequently, the subsidization supposed in the question is unlikely to be there. Also, and not hypothetically, the per member per month cost of administrative services will increase the expense to Kentucky Access regardless of the health of the children.

MS. HORN: This question for Anthem.

The representative for Anthem stated that all children must be in the market. What techniques does Anthem contemplate using or suggest could be used to insure that all children enter the health insurance market in the absence of a mandate?

MR. LEE: In the absence of a mandate?

MS. HORN: What techniques could be used to --

MR. LEE: What techniques could be used to force people to buy insurance?

MS. HORN: Well, not to force them but attract them?

MR. FORD: Can we strike that word force?

MR. LEE: Yeah, I mean --

MS. HORN: Or is a mandate the only thing that you can think of?

MR. LEE: The question is how do you actually

get everybody --

MS. HORN: Into the market.

MR. LEE: The end result is everybody without a mandate. I honestly don't know of any way to do that unless is it free.

MS. BURTON: And I am not sure. But it seems like maybe that testimony came from -- was that Humana's testimony about wanting to give and get -- Okay. Andrea is saying no.

MS. FEGLEY: It was a talking point in Anthem's introduction. I think it was Anthem. All children needed to be in the market for this to work. Which I think, you know, we understand that. If you don't have a pre-existing exclusion and you don't have an individual mandate, how would you pick up the rest?

So my question was, are you suggesting that we need an individual mandate on the child market up to 19? Or did you have another technique in mind? Like were you thinking a surcharge to get around this? Or --

MR. LEE: Yeah. I think we said that it would need to be, to get all of the children in and all of the carriers to offer child-only, that there would have to be a mandate that, first of

all, carriers offered child-only. Now, that doesn't get all children into the market.

And so absent a mandate, is the question how can you get all of the children in?

And that is a very challenging question. I don't, you know, I guess you keep lowering your premium.

MS. FEGLEY: And I am not trying to put you on the spot. I guess my question was, were you meaning simply you want all of the carriers in the market? Or that you were trying to get --

MR. LEE: Yes. I think we are saying to get back into the child-only, selling child-only policies and products, that there would have to be a level playing field in that all carriers would have to sell child-only products, you know, through standardized open enrollment periods and many of the other techniques that we have heard today.

MR. DERALEAU: I will just kind of -- you know, I think some of the mechanisms that I talked about are intended to give or some incentive to want to insure children when they are heavy -- when they are healthy -- excuse me. Or heavy.

That, you know, if we talk about having a

surcharge for people that are without coverage for a period of time, we talked about having just a limited open enrollment period so there is, in fact, some risk to the parent if they were keeping their children uninsured that they can't immediately get insurance on the date their child becomes sick.

I think there is at least some incentive for parents to want to take on that financial burden of having insurance for their children.

So without at that, if it is truly guaranteed issue, you can see where a lot of rational people would say why should I bother buying insurance now when my kids are healthy when I can always get it later when they are sick. So --

MS. HORN: Could Humana clarify why child-only policies present a problem for the 80 percent MLR requirement?

MR. DERALEAU: Sure.

Any time we have a policy, there are a certain number of standard caring costs if you will to maintain that policy. You have the building enrollment, which is standard administrative services that are provided. There is a certain level of claims activity under any

policy, regardless of the policy, the plan benefits and the premium that is being charged.

And what the new federal law requires is that $.80 out of every premium dollar goes back to the consumer in claims. Or if loss for show cause under the 80 percent, then the insurance company will rebate premiums to the insureds in order to bring the loss ratio up to 80 percent.

Now that 80 percent is the minimum.

So over a period of time, it is likely that our loss ratio is not going to run right at 80 percent. It is going to run over 80 percent because there will be, due to random fluctuations, years in which the loss ratios runs higher than 80 percent. In which case we meet the higher loss ratio in those years.

So that gives us less than $.20 out of every premium dollar to manage administrative costs.

The average premium on child-only policies is substantially lower than the premium that we have for our average policies. And so clearly applying that less than 20 percent that is available for administrative costs to the smaller premium, develops fewer dollars with which to pay the policy carrying costs. And it presents an

administrative challenge.

Our experience with child-only, prior to this time, would be that our expense ratio for those policies actually ran in excess of 20 percent. So, again, we only have that actually less than 20 percent to work with under.

MS. HORN: Okay.

MR. NOLD: But aren't those administrative expenses part of the rate filing itself? Don't you take those into account the fact that you are dealing with an individual rather than a family situation?

MR. DERALEAU: I am not sure I am following the question. So I will be --

MR. NOLD: Well, in determining the medical loss ratio, the denominator associated with that is the premium that is being charged.

MR. DERALEAU: Yes.

MR. NOLD: And so do companies do not account for the above-average administrative costs in determining and requesting that they be allowed to charge a certain premium?

MR. DERALEAU: That is exactly what we have done prior to the law. So we would have targeted a lower loss ratio, medical loss ratio, on these

policies to account for a higher percentage of premium being needed for the administrative costs.

But now that we are required to pay $.80 out of every dollar in claims costs, we can't do that. We are forced to rebate if we fall below the $.80 per dollar.

MR. NOLD: I see. Okay.

MS. HORN: Question for Aetna.

Could you clarify your statement regarding concern over rate review process or standards and the ability to exit the market?

MS. BUTKUS: Sure.

With respect to child-only policies, we want to make sure that we're able to garner appropriate, actuarially appropriate premium increases when we need to on this particular block of business.

Can you read the question one more time? I want to make sure I answered it.

MS. HORN: Okay. The rest of the question is, concern with your ability to exit the market.

MS. BUTKUS: Correct. And in given particular states, if the process is -- I am just --

MS. HORN: Does this apply to Kentucky?

MS. BUTKUS: No. It does not apply to Kentucky.

MS. HORN: Okay.

MS. BUTKUS: If the process isn't straight actuarially driven, then it may be that an insurer would have to hold down rates for this particular block. And we don't believe -- we believe, in those circumstances, that a carrier should be able to get out. Because it wouldn't make business sense to provide the product.

MS. HORN: Right. You wouldn't be able to sell your product for a high enough price to make it viable.

MS. BUTKUS: Yes.

MS. HORN: I think I understand. Okay. That's all of the questions that we have submitted to us.

Commissioner Clark?

MS. CLARK: We will close today. And, again, I want to express my appreciation for your attendance, all of the interested parties and the other stakeholders.

And I feel better after our discussion today in that I think that all of you all have indicated that, you know, some commonalties here. And that

you have indicated a willingness to look at some possible solutions.

So I am going to ask the insurers to go back with what I am about to present and to consider this with your company. And along with any comments, how this could be a workable option for your insurance company. And to please provide those comments to the department by close of business next Wednesday.

Let's consider the possibility of, in lieu of a traditional 30-day open enrollment period, that there would be an establishment of a uniform waiting period for the coverage. For example, if a policy is approved, application is approved, if there was a waiting period of let's say 60 days before coverage began. Okay. And if that would be a possible option that might be of interest to you.

I think that would help address that concept about having healthy children enrolled throughout the year. It might address that possibility that people, on their way to the hospital, you know, with a sick child trying to get coverage.

So, you know, I want you to go back. If you have some caveats, you know, that, well, this

would work, but we might need to consider this or whatever, I would like those caveats as well.

So is everybody clear on what we are talking about? Okay.

So in lieu of that open enrollment period that you will be able to take applications, you will be able to accept those. And after they are approved, that you could put a 60 day waiting period on it before the coverage would be actually in effect.

So does anybody else have any comments or questions that they would like to bring forth today?

Again, we appreciate everyone coming. And those of you who are out of state, we welcome you to stay and enjoy Keeneland while it is still running.

I always try to push for our economic development sister cabinet here. So, again, thank you for being here today. We appreciate it.

CERTIFICATE

STATE OF KENTUCKY

COUNTY OF FRANKLIN

I, Georgene R. Scrivner, a notary public in and for the state and county aforesaid, do hereby certify that the above and foregoing is a true, correct and complete transcript of the DEPARTMENT OF INSURANCE, FACT-FINDING HEARING RELATED TO CHILD-ONLY COVERAGE, taken at the time and place and for the purposes set out in the caption hereof; that said testimony was taken down by me in stenotype and afterwards transcribed by me; and that no request was made by counsel that the transcript be submitted for reading and signature.

Given under my hand as notary public aforesaid, this the 22nd day of October, 2010.

Georgene R. Scrivner
Notary Public
State of Kentucky at Large
CCR#20042109

My Commission Expires: 7/15/2011

Skip Navigation

U.S. Department of Health & Human Services

Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions

Updated: September 24, 2010

On June 28, 2010, the Administration published the interim final regulations prohibiting new group health plans and health insurance issuers in both the group and individual markets from imposing pre-existing condition exclusions on children under 19 for the first plan year (in the individual market, policy year) beginning on or after September 23, 2010. These regulations apply to grandfathered group health plans and group health insurance coverage but do not apply to grandfathered individual health insurance coverage that was in existence on March 23, 2010.

Accordingly, for non-grandfathered individual health insurance policies, children under 19 cannot be denied coverage because of a pre-existing condition for policy years beginning on or after September 23, 2010. These questions and answers will assist issuers with implementation of this requirement.

Question #1: Will children in child-only individual market health plans today be affected by the new access to these plans for children with pre-existing conditions?

A: Child-only insurance plans that existed on or prior to March 23, 2010, and that do not significantly change their benefits, cost sharing, and other features, will be "grandfathered" or exempt from these regulations. As such, children enrolled in grandfathered child-only plans today are unlikely to be affected by the new policies.

Question #2: Do these interim final rules require issuers in the individual health insurance market to offer children under 19 non-grandfathered family and individual coverage at all times during the year?

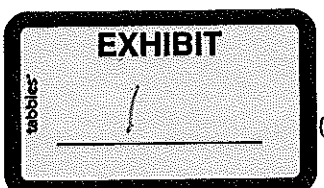
A: No. To address concerns over adverse selection, issuers in the individual market may restrict enrollment of children under 19, whether in family or individual coverage, to specific open enrollment periods if allowed under State law. This is not precluded by the new regulations.

For example, an insurance company could set the start of its policy year for January 1 and allow an annual open enrollment period from December 1 to December 31 each year. A different company could allow quarterly open enrollment periods. Both situations assume that there are no State laws that set the timing and duration of open enrollment periods.

Question #3: How often must an issuer in the individual market provide an open enrollment period for children under 19?

A: Unless State laws provide such guidance, issuers in the individual market may determine the number and length of open enrollment periods for children under 19 (as well as those for families and adults). The Administration, in partnership with States, will monitor the implementation of the pre-existing condition exclusion policy for children and issue further guidance on open enrollment periods if it appears that their use is limiting the access intended under the law.

Question #4: How do these rules affect existing enrollment requirements in States that already require guaranteed issue of coverage for children under 19 in the individual market?



policies would require a change in the existing regulations. The Administration would consider making such a change if it would result in issuers continuing to sell child-only plans.

Letter to America's Health Insurance Plans

Letter to Blue Cross Blue Shield Association

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

October 13, 2010

Jane L. Cline
President and West Virginia Insurance Commissioner
National Association of Insurance Commissioners
1124 Smith Street
Charleston, West Virginia 25301

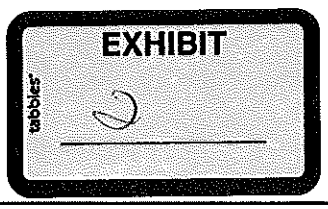
Dear Jane:

I want to thank the NAIC and its members for the productive September 22 meeting with President Obama and me on the implementation of the Affordable Care Act. It was fitting that our meeting was held so close to the six-month anniversary of the passage of the Affordable Care Act and the effective date for many of its important consumer protections. I have been gratified by our collaborative efforts and look forward to our continuing partnership as we work to make the provisions of the Affordable Care Act a reality for all Americans.

One issue we discussed at the meeting, that I know is important to both the states and to our Administration, is ensuring there are health coverage options for all children under the age of 19, regardless of their health status. One goal of the Affordable Care Act is prevent insurers from denying coverage to those who need it most – starting with children with pre-existing health conditions. Without access to insurance, many sick children will not get the care they need to lead healthy lives. The inability to obtain affordable coverage can also create significant financial challenges for the parents of these children.

Unfortunately, as we discussed, some insurers have decided to stop writing new business in the "child-only" insurance market – reneging on a previous commitment made in a March letter to "make pre-existing condition exclusions a thing of the past." Although this is a small market and children currently insured by such policies will not be affected, the decision of some health insurance companies to stop selling new polices for children is extremely disappointing. Nothing in the Affordable Care Act, or any other existing federal law, allows us to require insurance companies to offer a particular type of policy at this time.

We have been trying to work with the insurance industry to resolve this situation. Some insurers have said they would sell new child-only policies if they could accept year-round those applicants who are healthy, while restricting access for children with pre-existing conditions to a time-limited open enrollment period. We have carefully considered these insurers' legal and policy arguments, and have concluded that the approach they advocate is legally infirm, and inconsistent with the language and intent of the Affordable Care Act. Nor would it be lawful for a state to allow denials of coverage for children based on pre-existing conditions outside of an open enrollment period. We will continue to reach



out to insurers in our effort to encourage them to sell new "child-only" policies between now and 2014 – when the new health insurance exchanges will begin to offer affordable options to children and families, banning all discrimination against all Americans based on health status.

While we recognize industry concerns about adverse selection, we believe that there are options other than abandoning families who seek this coverage, as evidenced in States with similar laws already in place. In response to questions we have received, we have clarified that a range of practices related to "child-only" policies are not prohibited by the Affordable Care Act, such as allowing:

- Issuers in the individual market to determine the number and length of open enrollment periods for children under 19 (as well as those for families and adults), consistent with state law;
- Rates to be adjusted for health status as permitted by state law (note: the Affordable Care Act prohibits health status rating for all new insurance plans starting in 2014);
- The imposition of a surcharge for dropping coverage and subsequently reapplying for it if permitted by state law;
- The implementation of rules, consistent with state law, to help prevent employers from encouraging workers to enroll children in child-only policies instead of employer-sponsored insurance; and
- The sale of "child-only" policies that are self-sustaining and separate from closed "child-only" books of business if permitted by state law.

Enclosed with this letter are additional answers to frequently asked questions that address more recent inquiries.

In addition to these efforts by HHS, many states have in place existing laws to prevent discrimination against children and others with pre-existing conditions. For example, in Maine, Massachusetts, New Jersey, New York, and Vermont, all individual market insurers are required to "guarantee issue" all their policies – meaning that all children must be offered health insurance, irrespective of their health status. In addition, New Hampshire requires individual market carriers to guarantee issue all their policies to applicants under 19 years old. Parents of children with pre-existing conditions in these states therefore have a right to purchase child-only policies throughout the year. And in Michigan and Pennsylvania, so-called "insurers of last resort" are required to offer coverage on a guaranteed issue basis either periodically or continuously throughout the year to qualified applicants, including children under age 19.

The threat of insurers' no longer selling child-only policies has prompted additional state action as well. Recently, Governor Schwarzenegger signed legislation that bans insurers

in California from offering policies in the individual market for five years if they fail to offer child-only coverage. A number of states, including California, Colorado, Ohio, Oregon, and Washington, have established uniform open enrollment periods, and others, such as Minnesota, have been considering doing so. This creates a level playing field by preventing families from signing up for coverage for children only when their costs are high, and it ensures that no insurer will receive a disproportionate share of children with pre-existing conditions, since all insurers must accept such children during the same period.

States have also looked to existing programs for options for health insurance for children. Some states offer an unsubsidized buy-in to the Children's Health Insurance Program (CHIP). Roughly a dozen states now allow middle-income families to purchase child-only coverage at a full but fair premium. For example, Oregon both has required a consistent annual open enrollment period through an emergency regulation and is marketing its CHIP buy-in program to ensure that families have private and public options for insuring their children. No federal approval is required for this type of buy-in, and the Centers for Medicare and Medicaid Services stands ready to work with states interested in adopting this option.

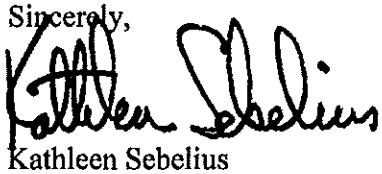
The new Pre-Existing Condition Insurance Plan (PCIP) program created by the Affordable Care Act also offers options for families to access insurance for their children with pre-existing conditions. The PCIP program is available for eligible children with pre-existing conditions who have been uninsured for at least six months. The PCIP program includes coverage of pediatric benefits, prescription drugs, and inpatient, outpatient, and mental health services. Coverage is provided at standard premium rates charged in the commercial individual market, with no pre-existing condition exclusions. PCIPs normally require an applicant to produce a denial letter from an insurer to be eligible for PCIP coverage. However, uninsured children with pre-existing conditions can qualify if they have a letter from their doctor or are charged a high rate, depending on the state program's rules. The Administration is working to ensure that PCIPs in all states offer coverage for children at a premium based on the standard rate for children.

Further, prior to the enactment of the Affordable Care Act, 34 states established high-risk pools for all residents with pre-existing conditions whom private insurers declined to insure. These pools are an additional option in those states for children with pre-existing conditions, and some states, including Mississippi, are planning to open their pools to all uninsured children. Finally, every state has coverage available to children without regard to pre-existing conditions through their Medicaid and CHIP programs; in most states, these programs are available to families with incomes below $88,000 (twice the poverty level).

I encourage all states to take whatever actions they can, whether issuing bulletins under existing law to establish uniform open enrollment periods or seeking appropriate legislation to preserve options for children to obtain coverage regardless of their health status.

I want to underscore my personal appreciation for the outstanding work of the NAIC and all state officials as we work together to implement the Affordable Care Act. I look forward to continuing to work in partnership with the NAIC and with state insurance regulators to implement the Affordable Care Act, and to maintain and strengthen state insurance regulation and the improved access and consumer protection that it yields.

Sincerely,



Kathleen Sebelius

Enclosure