COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
FRANKFORT, KENTUCKY

IN THE MATTER OF:

GUARANTEED ISSUANCE OF INDIVIDUAL HEALTH INSURANCE COVERAGE FOR CHILDREN UNDER THE AGE OF 19 AND PROHIBITION AGAINST IMPOSING PRE-EXISITING CONDITIONS

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WHEREAS, for the purposes of this Order, a "child-only" policy refers to a health benefit plan delivered or issued for delivery to an individual who is the primary subscriber on the policy and under the age of 19 years. A "child-only" policy does not include a health benefit plan that is delivered or issued for delivery to a primary subscriber who is 19 years of age and older but that insures persons under the age of 19 years.

WHEREAS, for the purposes of this Order, "Insurers" refers to all health insurers or health maintenance organizations (Insurers) that deliver or issue for delivery individual health benefit plans in the State of Kentucky.

WHEREAS, on March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA).

WHEREAS, PPACA included several insurance market reforms and consumer protection provisions, some of which became effective on September 23, 2010.

WHEREAS, prior to September 23, 2010, insurers issuing individual policies to children under the age of 19 in Kentucky were permitted to medically underwrite and approve or deny applications for coverage.

WHEREAS, after September 23, 2010, pursuant to PPACA and related federal regulations, Insurers were prohibited from imposing pre-existing condition exclusions on insured members up to the age of 19, such exclusions being defined to include denial of coverage.

WHEREAS, the effect of the PPACA market reform and the interim final rule was to require Insurers to guarantee issue coverage to an individual under the age of 19, thereby eliminating the insurers' ability to deny applications for coverage.

WHEREAS, Insurers in the individual health insurance market in Kentucky have made the business decision to cease the issuance of individual health benefit plans to children under the age of 19 on and after September 23, 2010.

WHEREAS, the decision by Insurers to cease the issuance of individual insurance coverage to children under the age of 19 has drastically impeded accessibility and limited insurance coverage options available for children under the age of 19.

WHEREAS, the impediment to accessibility and limitations on insurance coverage options for children under the age of 19 affects healthy children as well as unhealthy children.

WHEREAS, the influx of new child-only members into the state's high-risk pool, Kentucky Access, may detrimentally harm the pool and its current members.

WHEREAS, the lack of availability of individual insurance coverage for children under the age of 19 in the Kentucky insurance market is a matter of strong public interest.

WHEREAS, the decision of the Insurers to cease the issuance of individual insurance coverage to children under the age of 19 is an act or practice that is not in the public interest.

WHEREAS, KRS 304.12-130 authorizes the Commissioner to hold a hearing if a proceeding by the Commissioner regarding an act or practice would be in the public interest.

WHEREAS, the Commissioner held a fact-finding hearing on October 13, 2010, to receive testimony from insurers that made the decision to cease the issuance of individual insurance coverage to children under the age of 19.

WHEREAS, during the hearing the Commissioner heard testimony regarding the reasons Insurers decided not to participate in the child-only market and circumstances that would influence Insurers to reverse their decision to discontinue writing child-only policies.

WHEREAS, all Insurers testifying at the hearing indicated that they would continue to offer dependent coverage to children under the age of 19 if the primary subscriber is age 19 and older.

WHEREAS, all insurers testifying at the hearing indicated that they would continue to renew current child-only policies that were effective prior to September 23, 2010.

WHEREAS, the current individual health insurance market provides access to coverage of healthy and unhealthy children under the age of 19 where the child is not the primary policyholder.

WHEREAS, the current individual health insurance market provides renewable coverage to healthy and unhealthy children under the age of 19 who secured health coverage prior to September 23, 2010.

WHEREAS, the Commissioner has determined that some children under the age of 19 do not have access to individual health insurance coverage after September 23, 2010, while others do. This results in disparate treatment in the insurance market for individuals of the same class involving essentially the same hazards and is in violation of KRS 304.12-080(3).

NOW THEREFORE, in accordance with KRS 304.12-080, KRS 304.12-130, and all other applicable law, for the protection of the public, particularly children under the age of 19, and for the protection of Insurers required to guarantee the issuance of individual health benefit plans to children under the age of 19 without imposing any pre-existing conditions, the Commissioner hereby ORDERS the following:

1. This Order shall apply to all Insurers that deliver or issue for delivery individual health benefit plans in the State of Kentucky;

2. Insurers shall offer coverage to primary subscribers under the age of 19 during the open enrollment period established by this Order. There shall be an annual open enrollment period during which Insurers shall accept applications for child-only coverage. The first open enrollment period for child-only applicants shall commence on January 1, 2011, and end on January 31, 2011. Insurers shall provide for subsequent open enrollment periods for child-only applicants during the entire month of January of 2012 and 2013.

3. Insurers shall advertise the open enrollment period for children under the age of 19 on the Insurers' website and through any other media desired by the insurer. The advertisement shall be conspicuous and in a manner reasonably calculated to give timely and informative notice to potential applicants regarding the annual open enrollment period and the special open enrollment period defined herein.

4. For applications received during the open enrollment period, individual health insurance coverage shall be offered on a guaranteed issue basis to individuals up to the age of 19. Nothing in this order shall prohibit an insurer from setting a premium rate for individuals based upon medical underwriting so long as such rate is in compliance with the applicable product's rate filing on record with the Department of Insurance. Insurers may establish the health benefit plans available to children under the age of 19 provided the plans are in compliance with PPACA, KRS Chapter 304, and have been filed in accordance with KRS Chapter 304, Subtitle 14 and applicable administrative regulations.

5. Insurers shall not offer child-only policies outside the open enrollment periods established by this Order except Insurers shall permit a child under the age of 19 to apply and enroll for coverage during a special enrollment period under the terms of the health benefit plan if the child has experienced a qualifying event as set forth under KRS 304.17A-220(10)(a). A health benefit plan issued during a special enrollment period after a qualifying event to a child under the age of 19 shall be issued on a guaranteed basis and shall not impose any pre-existing condition provision.

6. Coverage under individual policies applied for during the open enrollment period shall be effective by March 1 following the end of the open enrollment period. Insurers may provide for a future effective date, after March 1, only upon agreement by the Insurer and the applicant.

7. Individuals applying for coverage during the open enrollment period or during a special enrollment period shall not be eligible for guaranteed issue coverage if the individual has other coverage or other coverage available at the time of the effective date of coverage.

Other coverage shall not include coverage through Kentucky Access or the Federal Pre-Existing Condition Insurance Plan.

8. In the event that an individual under the age of 19 is a dependent on a policy with a primary subscriber who is over the age of 19 and such primary subscriber drops the policy, all dependents shall lose coverage as a result of the termination of coverage of the primary subscriber. Such individuals under the age of 19 may re-enroll with the insurer during the open enrollment period or, in the case of a qualifying event, during a special enrollment period.

9. Insurers currently covering subscribers or dependents under the age of 19 on individual policies shall continue to renew such policies in accordance with KRS 304.17A-240.

10. The Commissioner reserves the right to clarify any questions or issues that arise out of this Order through the issuance of a Bulletin, Advisory Opinion, or subsequent Order.

11. Insurers shall report, on or before April 30, to the Department of Insurance, the following information:

a. The number of child-only applicants received during the annual open enrollment period;

b. The number of child-only applicants who were enrolled during the annual open enrollment period; and

c. The number of child-only applicants who were denied coverage after applying during the annual open enrollment period and the reasons for the denials.

12. Policies issued during the open enrollment or special enrollment periods shall be in conformity with all applicable insurance statutes and regulations. Insurers shall comply with

KRS 304.17A-150(1) which provides that it is an unfair trade practice for an insurer, agent, broker, or any other person in the business of marketing and selling health plans, to commit or perform any of the following acts:

a. Encourage individuals or groups to refrain from filing an application for coverage with the insurer because of the individual's or group's health status, claims experience, industry, occupation, or geographic location; or

b. Encourage or direct individuals or groups to seek coverage from another insurer because of the individual's or group's health status, claims experience, industry, occupation, or geographic location; or

c. Encourage an employer to exclude an employee from coverage.

13. Insurers who fail to comply with the provisions of this Order shall be subject to administrative action authorized by KRS 304.2-140 and KRS 304.3-200 which may include suspension, revocation, the imposition of civil penalties, or any combination of these actions.

It is further ORDERED that the Report on Child-Only Coverage in Kentucky by the Commissioner of the Kentucky Department of Insurance is attached to this Order as Exhibit A for reference purposes only.

Done and effective this 18th day of November, 2010.

Sharon P. Clark

Sharon P. Clark, Commissioner
Kentucky Department of Insurance

APPEAL RIGHTS

Pursuant to KRS 304.2-310, please take notice that any person aggrieved by and desiring to appeal an order of the commissioner shall make application for a hearing with DOI within sixty (60) days after the aggrieved party knew, or reasonably should have known, of the order. The application for a hearing shall briefly state the respects in which the applicant is so aggrieved, together with the grounds to be relied upon as a basis for the relief to be sought at the hearing.

Certificate of Service

This is to certify that the original of the foregoing Order was mailed, by certified mail, to the following:

Ronald A. Williams, President
Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Michael E. Abbott, President
American Republic Insurance Company
P.O. Box 1
Des Moines, IA 50301

Deb Moessner, President
Anthem Health Plans of Kentucky, Inc.
13550 Triton Park Boulevard
Louisville, KY 40223

Donald George Hamm, Jr. , President
Assurant Health/Time Insurance Company
P.O. Box 3050
Milwaukee, WI 53201

Steven Louis Pollack, President
Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, IN 462781719

Michael B. McCallister, President
Humana Health Plan, Inc.
P.O. Box 740036
Louisville, KY 402017436

Donald George Hamm, Jr. , President
John Alden Life Insurance Company
P.O. Box 3050
Milwaukee, WI 53203

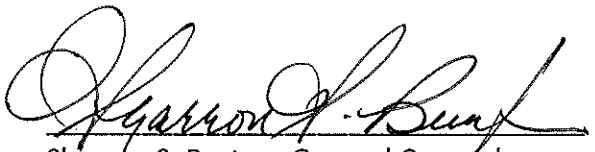
Phillip John Hildebrand, President
MEGA Life and Health Insurance Company
9151 North Grapevine Highway
North Richland Hills, TX 76180

Robert A. Reed, President
Physicians Mutual Insurance Company
2600 Dodge Street
Omaha, NE 68131-2671

and by e-mail to persons attending or submitting comments after the hearing as follows:

Joseph Stevens	Steve DeRaleau	Andrea Welker	Kelli Rodman
Tony Felts	Jimmy Lee	Lacey McNary	Larry Kissner
Lawrence Ford	Paul Herrington	Carl Breeding	Carl Felix
Melodie Shrader	Elena Butkus	Sheila Schuster	Mike Helton
Miriam Fordham	Mike Corne	Marie Cull	Michael Medley
Dustin Miller	Sarah Dilger	Jessica Kearney	B. Cantor
Jodi Mitchell			

On this 18th day of November, 2010.



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COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
FRANKFORT, KENTUCKY

REPORT ON CHILD-ONLY COVERAGE IN KENTUCKY BY THE COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE

November 18, 2010

COMMISSIONER'S REPORT ON CHILD-ONLY COVERAGE IN KENTUCKY

I. HISTORY

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA). The new law included numerous provisions related to health insurance that would be implemented over a period of four years. PPACA contains several insurance market reforms and consumer protection provisions, some of which became effective on September 23, 2010. Some of these consumer protection provisions include:

- A prohibition against insurers imposing lifetime dollar limits on essential benefits;
- Dependent children are permitted to remain on their parents' insurance plan until their 26th birthday;
- A prohibition against imposing pre-existing medical conditions on children under the age of 19;
- A prohibition against arbitrary rescissions of health insurance policies;
- Restrictions and a phase-out of annual dollar limits on claim payouts;
- Freedom to choose a primary care provider; and
- Removal of barriers related to using emergency services;

On June 21, 2010, the U.S. Department for Health and Human Services (HHS) issued an interim final rule related to the coverage for children under the age of 19. The rule clarified that plans may not impose any pre-existing condition exclusion, including a denial of coverage, for an individual under age 19. In essence, this means that an insurer must guarantee issue coverage to an individual under the age of 19.

In response to the new consumer protections afforded by PPACA, several insurance carriers chose to implement the protections prior to the required implementation date of September 23, 2010. However, on and around September 22, 2010, the Kentucky Department of Insurance (Department) surveyed insurance carriers writing individual health plans in Kentucky to determine whether individual coverage for children under the age of 19 would be available in the Kentucky insurance market. All insurers indicated that they would no longer issue individual health benefit plans to children under the age of 19 (child-only policy)[1] after September 23, 2010.

The lack of insurance coverage options for children under the age of 19 quickly became a national concern as insurance carriers throughout the United States made the choice to decline to issue child-only policies.

HHS issued guidance related to child-only policies in the form of a "Questions and Answers" document regarding the "Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions" (HHS Guidance). (Exhibit 1). Through this guidance, HHS clarified that child-only insurance plans that existed on or prior to March 23, 2010, and that do not significantly

[1] Throughout this report, the Department will refer to a "child-only" policy defined, for the purposes of this report, as a health benefit plan delivered or issued for delivery to an individual that is the primary subscriber on the policy and under the age of 19 years. A "child-only" policy does not include a health benefit plan that is delivered or issued for delivery to a primary subscriber that is 19 years of age and older but that insures persons under the age of 19 years.

change their benefits, cost sharing, or other features, will be "grandfathered" and not subject to the pre-existing condition, guaranteed issue requirement. The guidance further clarified that the following actions are not precluded:

- Adjusting rates for health status only as permitted by State law (note: PPACA prohibits health status rating for all new insurance plans starting in 2014);
- Permitting child-only rates to be different from rates for dependent children, consistent with State law;
- Imposing a surcharge for dropping coverage and subsequently reapplying if permitted by State law;
- Instituting rules to help prevent dumping by employers to the extent permitted by State law;
- Closing the block of business for current child-only policies if permitted by State law;
- Selling child-only policies that are self-sustaining and separate from closed child-only books of business if permitted by State law;
- States could choose to use open enrollment periods consistent with existing regulations; and
- States may consider legislation that would require individual-market issuers that offer family coverage to also offer child-only policies.

Despite the guidance provided by HHS, insurers continued to decline to issue any new individual child-only policies in the State of Kentucky.

II. THE KENTUCKY RESPONSE

Pursuant to KRS 304.17A-200, insurers are required to issue coverage to small groups regardless of health status. However, in the individual market, private insurers are currently allowed to deny coverage to an individual based on his or her health status. Individuals who are denied coverage have the option to seek coverage through Kentucky Access, the state high-risk pool, or, if eligible, through the Pre-Existing Condition Insurance Plan (PCIP), the federal high-risk pool. As an alternative, a private insurer could issue coverage, but exclude coverage for a pre-existing condition (known as an exclusionary rider[2]).

The Department recognized that the decision by insurers to decline to issue child-only policies will obstruct accessibility to insurance coverage leaving healthy children, as well as sick children, with limited coverage options. In response, the Commissioner of the Department (Commissioner) issued a directive to Kentucky Access requiring the pool to accept her Memorandum in lieu of a denial letter from an insurer in order to comply with the eligibility rule in KRS 304.17B-015(2)(a) requiring an individual to have been rejected by at least one insurer for coverage. This action by the Commissioner eliminated an impediment to gaining membership and procuring child-only health coverage through Kentucky Access. (See, Exhibit 2 – Memorandum from Commissioner to Kentucky Access).

The insurers surveyed indicated that they will allow children under the age of 19 to continue as dependents on policies where the primary subscriber is over the age of 19. Also, insurers have indicated that they are willing to renew current child-only policies. In addition, the PCIP is another option

[2] Some insurers utilize exclusionary riders in the individual market. After September 23, 2010, exclusionary riders to avoid covering certain pre-existing conditions for children under the age of 19 are prohibited.

available to children under age 19, provided the child meets the eligibility rules for participation in PCIP. Lastly, the Kentucky Children's Health Insurance Program (KCHIP) provides another coverage option for children under the age of 19 provided the child's family income is below 200 percent of the federal poverty level.

Because the decision of the insurance carriers resulted in limited availability of coverage options for children under the age of 19, the Commissioner issued subpoenas to nine insurers that write individual health benefit plans in Kentucky. In addition, the Commissioner issued a subpoena to Kentucky Access.

The purpose of the subpoena was to require the insurers and Kentucky Access to provide specified documents, information, and materials to the Commissioner. Further, the subpoena ordered the insurers and Kentucky Access to appear at the Department for a "Fact-Finding Hearing Related to Child-Only Coverage." The purpose of the hearing was to gather information from the insurers and Kentucky Access regarding individual health insurance coverage for children under the age of 19 years. (Exhibit 3 – Sample Subpoena and Letter from the Commissioner).

In addition to Kentucky Access, the insurers that received subpoenas were:

- Aetna Life Insurance Company
- American Republic Insurance Company
- Anthem Health Plans of Kentucky, Inc.
- Time Insurance Company
- Golden Rule Insurance Company
- Humana Health Plan, Inc.
- John Alden Life Insurance Company
- MEGA Life and Health Insurance Company
- Physicians Mutual Insurance Company

III. DATA AND INFORMATION COLLECTION

As noted above, the Commissioner issued subpoenas to several insurers and Kentucky Access ordering that certain documents, information, and materials be submitted to the Department on or before October 8, 2010. The documents, information, and materials ordered to be submitted were as follows:

- The number of "child-only" applicants, by month, during the time period beginning July 1, 2009, and ending June 30, 2010;
- The number of "child-only" enrollees, by month, during the time period beginning July 1, 2009, and ending June 30, 2010;
- The medical loss ratio (pure premium to claims) for "child-only" enrollees;
- Details regarding any changes made to the company's underwriting practices, criteria, or guidelines for any policies, which changes are attributable in any manner to the

requirement in the Patient Protection and Affordable Care Act to cover children under the age of 19 years with no pre-existing condition exclusions; and

- Factors that led to the company's decision to either not write or cease writing "child-only" policies.

All insurers, as well as Kentucky Access, complied with the subpoena and provided the Commissioner with the requested data.

The Department compiled the data received from the insurers and Kentucky Access and the results are reported below. The Department requested certain data based on a twelve-month period beginning July 1, 2009, and ending June 30, 2010. The results reported below represent a monthly average.

A. The Number of Child-Only Applicants

American Republic	MEGA	Anthem	Kentucky Access	Aetna	Golden Rule	Time	John Alden	Physicians Mutual	Humana
0	.1	351	8	5.5	17	6	1	0	128

B. The Number of Child-Only Enrollees[3]

American Republic	MEGA	Anthem	Kentucky Access	Aetna	Golden Rule	Time	John Alden	Physicians Mutual	Humana
0	.1	215	-1.75	4	12	3	.25	0	63

[3] The reason for the difference between the number of applicants versus the number of enrollees is not reflected in the data collected. Further, children under the age of 19 may have applied with several different carriers for coverage, thereby inflating the applicant numbers. Consequently, no valid conclusions may be reached as to the number of incidents where an insurer declined coverage for children under the age of 19.

C. Medical Loss Ratio for Child-Only Enrollees

The medical loss ratio calculation was based on a pure premium-to-claims ratio.

American Republic	MEGA	Anthem	Kentucky Access	Aetna	Golden Rule	Time	John Alden	Physicians Mutual	Humana
0%	N/A	75.8%	1516%[4]	36%	58.8%	65%	9%	0%	76.6%

The medical loss ratio is intended to provide a general idea regarding the amount of claims paid on child-only policies in relation to the amount of premiums received from these policies. When submitting the data, several insurers included disclaimers regarding the credibility of the data. Those disclaimers are noted herein as a footnote. [5]

D. Changes to Underwriting Practices Regarding Child-Only Policies

Below are excerpts from the insurers in response to the Commissioner's request for details regarding any changes made to the company's underwriting practices, criteria, or guidelines for any policies, which changes are attributable in any manner to the requirement in the Patient Protection and Affordable Care Act to cover children under the age of 19 years with no pre-existing condition exclusions.

1. Aetna

For October 1, 2010, and later effective dates, Aetna discontinued new business sales of the company's child-only policies to applicants under the age of 19. Effective August 18, 2010, any

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[4] Data was unavailable to calculate a twelve-month average medical loss ratio. As such, the impact of unusually high claims is reflected in this ratio as opposed to the smoothing that would occur if a twelve-month average could be calculated.

[5] **MEGA** – A valid medical loss ratio is not available due to the low number of "child only" plans for the limited length of coverage duration.
Kentucky Access – This medical loss ratio for child only enrollees was calculated purely as incurred claims compared to premiums. However, it should be noted that, as a high risk pool, Kentucky Access guarantees coverage to all eligible applicants and does not consider health status for rating purposes. Of the total child only enrollees, 3% of the enrollees account for 93% of the claims.
Aetna – The medical loss ratio is not credible given the limited number of policies and the very short average policy duration.
Time - The medical loss ratio for Kentucky is not credible due to the small size of the block of business. Pricing determinations are based on national experience in order to achieve actuarial sound price points. MLR is for Ky in 2009. Nationwide MLR for 2009 is 78%.
John Alden - The medical loss ratio for Kentucky is not credible due to the small size of the block of business. Pricing determinations are based on national experience in order to achieve actuarial sound price points. MLR is for Ky in 2009. Nationwide MLR for 2009 is 44%.
Humana – Loss ratio at December, 2009 which is a 12-month average.

applications received which request a child-only policy with an October 1, 2010 effective date (or later) will be closed. Underwriting will notify applicants by mail of their ineligibility.

Existing members will not be impacted by this action and may continue their current coverage. These policies are renewable.

Aetna continues to receive, underwrite and accept children under age 19 for coverage on individual plans when applying for coverage as dependents with their parents/legal guardian, or when applying to be added to an existing parent policy.

2. American Republic

On July 13, 2010, the company stopped accepting child only applications. Existing child-only policies remain in effect.

3. Anthem

Anthem recently revised policies for child-only applicants. The company is no longer accepting child-only applications for effective dates of September 23, 2010, or later.

Anthem has revised underwriting guidelines for dependents under the age of 19 who are applying as part of a parent/legal guardian's application. The dependents will not be denied coverage because of a pre-existing condition when requesting an effective date of September 23, 2010, or after. A parent must be approved for coverage on the same application with a child under the age of 19 in order for a child to be eligible for coverage. As of September 23, 2010, dependent applicants under age 19 will not be subject to a pre-existing condition waiting period. This provision does not apply to individual grandfathered plans.

4. Golden Rule

On September 23, 2010, the company revised internal guidelines to indicate that for children under the age of 19 with a non-grandfathered plan, those children cannot be declined due to a pre-existing medical condition, nor can the company issue such a plan with a medical rider that excludes a pre-existing medical condition. On September 21, 2010, the company changed its eligibility requirements to limit coverage to require that all applications for coverage include at least one applicant age 19 or older.

5. Humana

To comply with PPACA, Humana eliminated the practice of applying condition-specific exclusion riders for all dependents under the age of 19. Humana does not currently decline any dependents under age 19 during open enrollment periods (except for dependents applying to be part of a grandfathered plan). Some states define open enrollment periods. In states that don't, Humana has established its own open enrollment period for the month of July.

While not specifically an underwriting change, the company has discontinued the sale of child-only policies, effective September 22, 2010.

6. John Alden

On July 17, 2010, the company amended its eligibility standards and ceased accepting applications for submissions in which the primary applicant was under the age of 19.

7. Kentucky Access

Kentucky Access has not made any changes in underwriting practices etc. other than accepting a directive Memorandum from the Commissioner directing Kentucky Access to use the same Memorandum in the place of the rejection letter from the insurer regarding child-only policies.

8. MEGA

The company is currently not marketing any health benefit plans in Kentucky.

9. Physicians Mutual

The company's underwriting practices have not changed since the company is not in the market.

10. Time

On July 17, 2010, the company amended its eligibility standards and ceased accepting applications for submissions in which the primary applicant was under the age of 19.

E. Factors Impacting Insurance Company Decision Regarding Child-Only Policies

Below are excerpts from the insurers in response to the Commissioner's request for factors that led to the insurers' decision to cease writing "child-only" policies.

1. Aetna

After PPACA, the child-only market is essentially a guarantee issue environment for policy years beginning on or after September 23, 2010, with respect to individuals under age 19. [HHS] has issued two clarifying question and answer documents allowing for a limited open enrollment period for policies issued under the new law, as well as other actions such as the ability to adjust rates for health status prior to 2014. While the company believes these are positive steps, further regulatory action is necessary to discourage people from only buying insurance when they need it, which could significantly increase premiums.

The company would like to stress that it will continue to administer these policies for their current 15,000 nationwide members in this market and are committed to working with the KDOI to create a regulatory environment where affordable child-only policies can exist.

2. American Republic

The premium rates for child-only coverage did not appropriately reflect the actual costs. Several carriers made announcements they would no longer be accepting child-only applications. There would

be a disproportionate amount of risk if the company did not adopt the same practice. If these and other concerns are addressed with regard to child-only coverage, the company may consider offering this option again at some point in the future.

3. Anthem

Many of [Anthem's] competitors have chosen to discontinue new business sales of their child-only policies. Most have cited the lack of an effective mandate for individuals to obtain coverage, as well as ongoing market uncertainty. In order for Anthem to ensure they operate on a level playing field, the company has chosen to suspend child-only policies. Unless all carriers are required to offer child-only coverage, the ones that do will be at a disadvantage because of the additional risk they are assuming by covering children with no medical underwriting.

4. Golden Rule

In an environment where children are guaranteed issue year round, we believe there is great potential for adverse selection.

5. Humana

Guaranteed issue without a common open enrollment period is likely to fuel a destructive spiral that will drive premiums higher for current and future plan members. Most major insurers have announced they will no longer offer child-only coverage, substantially increasing adverse selection risk for the few insurers who continue to write such policies.

PPACA requires carriers to meet a minimum 80% loss ratio on their individual insurance block for each legal entity in each state, or carriers must rebate premiums to achieve that ratio. This leaves less than 20% of premium for [other costs]. Lower application placement ratios and lower persistency on child-only policies create additional actuarial challenges.

6. John Alden

The company's decision is consistent with the industry's reaction to the increased risk of anti-selection resulting from changes in federal requirements. Any actions by state or federal regulatory authorities to mitigate that risk would be cause for our company to re-evaluate anti-selection risks associated with this segment of the individual market.

7. Kentucky Access

Kentucky Access continues to write child-only policies.

8. MEGA

The company is currently not marketing any health benefit plans in Kentucky.

9. Physicians Mutual

There are no factors that have led the company to specifically not write child only policies.

10. Time

The company's decision is consistent with the industry's reaction to the increased risk of anti-selection resulting from changes in federal requirements. Any actions by state or federal regulatory authorities to mitigate that risk would be cause for our company to re-evaluate anti-selection risks associated with this segment of the individual market.

IV. FACT-FINDING HEARING

Kentucky Revised Statute 304.12-130 authorizes the Commissioner to hold a hearing if:

1. The Commissioner believes that any person in the business of insurance is engaging, in the state of Kentucky, in any method of competition or in any act or practice in the conduct of such business;
2. The act or practice is not defined in KRS Chapter 304, Subtitle 12;
3. The act or practice is unfair, deceptive, or not in the public interest; and
4. A proceeding by the Commissioner regarding the act or practice would be in the public interest.

The Commissioner exercised her powers and authority granted by KRS 304.12-130 after having determined that:

1. Insurers have made the business decision to cease the issuance of individual health benefit plans to children under the age of 19;
2. The decision by insurers to cease issuing individual insurance coverage to children under the age of 19 has drastically impeded accessibility and limited insurance coverage options available for children under the age of 19;
3. The impediment to accessibility and limitations on insurance coverage options for children under the age of 19 affects healthy children as well as unhealthy children;
4. The influx of new child-only members into the state's high-risk pool, Kentucky Access, may detrimentally harm the pool and its current members;
5. The lack of availability of individual insurance coverage in the Kentucky insurance market is a matter of strong public interest; and
6. The decision of the insurers to decline to issue individual insurance coverage to children under the age of 19 is an act or practice that is not in the public interest,

In accordance with KRS 304.12-130, the Commissioner held a "fact-finding hearing" for the purposes of gathering information from insurers, Kentucky Access, and other interested parties, regarding individual health insurance coverage for children under the age of 19 years.

Prior to the scheduled hearing date, the Commissioner advised the subpoenaed parties to be prepared to comment as follows:

- Provide general comments about your insurer's coverage of children under age 19 prior to September 23, 2010.
- Provide a general statement regarding applicants under age 19 who were denied coverage prior to the insurer's decision to discontinue issuing policies.
- Under what circumstances would an insurer be willing to reverse its decision to discontinue writing child-only policies?
- Is the insurer continuing to offer coverage for children under age 19 as a dependent where the primary insured is over the age of 19?
- Is the insurer's decision to discontinue offering child-only policies a national decision? Has this decision been reversed in any state? What circumstances led to the reversal?
- Provide comments on the suggestions tendered by HHS. Which solutions will work? Which will not? (See HHS Guidance).

The Commissioner's fact-finding hearing, pursuant to KRS 304.12-130, was held at the Department on October 13, 2010, beginning at 1:30 p.m. A representative for Kentucky Access was in attendance. All, except for three, insurers subject to the subpoena were in attendance. The three insurers that did not attend are Physicians Mutual Insurance Company, MEGA Life and Health Insurance Company, and American Republic Insurance Company.

- **Physicians Mutual Insurance Company** – Physicians Mutual requested to be excused from attendance at the hearing. The reason given for the request was that the company was not marketing individual health benefit plans in Kentucky and had only one individual health benefit plan in force in Kentucky. The Department agreed to excuse Physicians Mutual from the hearing on this basis and requested notice, in accordance with KRS 304.17A-240, from the company. Physicians Mutual delivered the requested notice in the form of a "Certification" to the Department under cover of a letter dated October 13, 2010. (Exhibit 4).
- **MEGA Life and Health Insurance Company** – MEGA requested to be excused from attendance at the hearing. The reason given for the request was that the company had ceased sales of all new individual health benefit plans in the State of Kentucky. The Department agreed to excuse MEGA from the hearing on this basis and requested notice, in accordance with KRS 304.17A-240, from the company. MEGA delivered the requested notice in the form of an "affidavit" to the Department under cover of a letter dated October 12, 2010. (Exhibit 5).
- **American Republic Insurance Company** – American Republic did not appear at the hearing and did not request to be excused from the hearing. The company phoned after the hearing and indicated that the failure to appear was a mistake caused by misreading the subpoena. It was believed that the production of the requested information was in lieu of appearance at the hearing. The Department communicated to the company that any outcome from the hearing would be applicable to American Republic. The company agreed.

Testimony was received from insurer and Kentucky Access representatives. Interested parties were given an opportunity to submit questions. The hearing was overseen by a facilitator, Vicky Horn, counsel for the Department. The Department of Insurance was represented by the following individuals:

- Sharon P. Clark, Commissioner
- William Nold, Director, Health and Life Division
- DJ Wasson, Legislative Liaison and Assistant to the Commissioner
- Ronda Sloan, Communications
- Ray Perry, Deputy Commissioner
- Sharron S. Burton, General Counsel

The hearing testimony revealed the following:

A. General Comments about Child-Only Coverage Prior to September 23, 2010

1. Aetna

Aetna did not enter back into the individual market in Kentucky until September 1, 2009. The company began selling child-only policies after re-entry into the Kentucky market. The company has only a small book of business in the state with approximately 117,000 total covered lives.

2. Anthem

Prior to September 23, 2010, Anthem offered coverage to children under the age of 19 both as dependents under their parents' plans and as subscribers, provided the child-only applicant met the company's eligibility requirements.

Leading up to September 23, 2010, Anthem was one of a few insurance carriers offering child-only products in the Kentucky market.

The lack of an effective mandate that would ensure that all carriers operated on a level playing field led Anthem to suspend sales in the child-only market.

3. Golden Rule

Golden Rule wrote child-only policies prior to September 23, 2010, and has done so for many years. The company ceased offering child-only policies around September 21, 2010.

4. Humana

Through September 22, 2010, Humana offered coverage under all the company's individual health insurance plans to primary applicants under the age of 19. Regulations in place prior to September 23, 2010, permitted the company to medically underwrite each applicant and to take the applicant's health history into consideration prior to insuring them.

Effective September 23, 2010, the provisions of PPACA that prohibit the application of pre-existing conditions took effect. Further, HHS's interim final regulations further defined this provision and required insurers to guarantee coverage to all children under age 19. Effective January 1, 2011, insurers writing individual coverage must also meet an 80% medical loss ratio. Humana ceased writing child-only policies 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.

5. John Alden/Time

Assurant Health writes individual and small group medical insurance through two legal entities, Time Insurance Company and John Alden Life Insurance Company.

With regard to child-only policies, Assurant Health made the decision to amend the companies' eligibility standards and cease accepting applications from primary applicants under the age of 19.

B. General Statements Regarding Child-Only Coverage Denials Prior to September 23, 2010

1. Aetna

Prior to the insurer's decision to discontinue to issue child-only policies, individuals who were denied coverage were denied after going through the company's health underwriting process.

2. Anthem

Prior to the insurer's decision to discontinue to issue child-only policies, all applicants were subject to the company's eligibility requirement and 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 the company's underwriting guidelines.

3. Golden Rule

Prior to the insurer's decision to discontinue to issue child-only policies, the company's issue rate was approximately 80%. Approximately 20% of the child-only applicants were denied coverage.

4. Humana

Prior to the insurer's decision to discontinue to issue child-only policies, the company could medically underwrite each applicant and take the applicant's health history into account. Humana, through regulations in effect, was able to balance the risk of the plan's member pool and offer affordable coverage to applicants, except those with serious health conditions that didn't meet the company's underwriting guidelines.

5. John Alden/Time

Prior to September 23, 2010, Assurant Health offered coverage to persons19 years of age or younger, if the application for coverage conformed to the company's underwriting guidelines and the premium to be charged was paid by the applicant.

C. Under What Circumstances Would the Insurer be Willing to Reverse its Decision to Discontinue Writing Child-Only Policies?

1. Aetna

In order for the company to reverse its decision to discontinue writing child-only policies:

- States would need to mandate carriers to provide child-only plans in the individual market;
- States should implement a standardized open enrollment period for child-only coverage;
- There should be no caps on rate-ups or health status;
- Carriers would need to be able to get actuarially justified rate adjustments;
- Surcharges should be implemented when coverage lapses; and
- The carrier should be able to achieve actuarially sound premium increases and allowed to exit the market if the increases cannot be obtained.

2. Anthem

In order for the company to reverse its decision to discontinue writing child-only policies:

- Rules and regulations need to be in place to ensure that all carriers compete on a level playing field when providing coverage in the child-only market;
- All insurers must be mandated to sell child-only coverage. Otherwise, a limited number of carriers will be forced to absorb the additional risk of covering children with no medical underwriting;
- There should be standard, annual open enrollment periods for child-only policies;
- There should be rules to encourage continuous coverage and discourage subscribers of child-only policies from enrolling only when medical services are needed;
- Carriers should be allowed to medically underwrite children outside of open enrollment periods;
- Carriers should be allowed to medically underwrite during the open enrollment period for the purposes of setting the appropriate surcharge for the policy; and
- Criteria should be established that would help mitigate "dumping" into the guarantee issue market – if the applicant is eligible for other coverage either through a public or private program

3. Golden Rule

In order for the company to reverse its decision to discontinue writing child-only policies:

- There should exist a properly structured open enrollment period;
- All carriers should be required to participate in the child-only market;
- There should be a specified 30-day open enrollment period and it should be the same for all carriers;
- There should be an open enrollment period annually for new applicants or for coverage changes;
- There should be a provision for qualifying events to keep children in the system;
- There should be provisions in place to prevent "dumping;" and
- There should be provisions to prohibit "gaming" – or choosing to seek coverage when medical services are needed.

4. Humana

In order for the company to reverse its decision to discontinue writing child-only policies:

- Mandate that all insurers serving the individual market also provide child-only coverage;
- Mandate 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 who have other options such as access to public programs or employer-sponsored coverage;
- Permit a premium surcharge for applicants who have previously and voluntarily allowed their coverage to lapse;
- Prohibit the sale of child-only plans outside of the uniform open enrollment period; and
- 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.

5. John Alden/Time

In order for the company to reverse its decision to discontinue writing child-only policies:

- Consideration must be given to the number of carriers providing such coverage in order to spread the risk;
- There should be a state defined open enrollment period that is the same for all carriers; and
- Carriers must have the ability to price appropriately for the anticipated impact on business.

D. Is the Insurer Continuing to Offer Coverage to Children Under the Age of 19 as Dependents?

1. Aetna

Aetna continues to offer coverage to children under the age of 19 as dependents where the primary insured is over age 19.

2. Anthem

Anthem continues to offer coverage for children under 19 as a dependent where the primary insured is over the age of 19. Anthem is offering this coverage on a guaranteed issue basis after September 23, 2010.

3. Golden Rule

The company continues to offer dependent coverage for children under age 19 where the primary insured is over age 19.

4. Humana

The company will continue to offer dependent coverage and will continue to insure all of the children who are under child-only policies.

5. John Alden/Time

Assurant continues to offer coverage for children under age 19 as a dependent where the primary insured is over the age of 19.

E. Is the Insurer's Decision a National Decision?

1. Aetna

For Aetna, getting out of the child-only market was a national decision effective on October 1, 2010, for most of the company's markets. This decision was extended in two markets, Connecticut and Maryland, because of filing issues. The company will not be issuing child-only policies in those two states as of December 15 and December 1, 2010. In addition, California has recently passed a guaranteed issue statute if a company plays in the individual market.

2. Anthem

Anthem's suspension of offering child-only is a national decision. However, there are some states and some products that preclude suspension, including states such as New York, Maine, and New Hampshire. Also, California enacted legislation that required offering of child-only policies effective January 1, 2011. Lastly, the company has some sales of child-only that will continue under some of the HIPAA guarantee issue products and eligible individuals in the states of Ohio and Virginia.

3. Golden Rule

The insurer's decision to discontinue offering child-only policies is a national decision.

4. Humana

Although there are a few states that require insurers to offer child-only coverage under limited circumstances, the company has not resumed offering child-only coverage under the current rules. The company's decision is a national decision.

5. John Alden/Time

Assurant's decision was on a national basis subject to state statutory and regulatory requirements.

F. Provide Comments on the Suggestions Tendered HHS (HHS Guidance)

1. Aetna

The FAQs that were issued by HHS, while they would allow for some relief, do not go far enough.

2. Anthem

The company appreciates the clarification that insurers can utilize open enrollment periods. It is still unclear on things like whether open enrollment period applies to both dependent child and child-only policies.

3. Golden Rule

The company believes flexibility is helpful when trying to find solutions for difficult issues. The company is committed to finding a solution and would recommend leaving all of the suggested options on the table.

4. Humana

While the recent guidance issued by HHS makes it clear that insurers can increase premiums for those children with health conditions, the company believes 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 the market viable again is to create a regulatory structure that will help attract the balance of healthy and unhealthy individuals to enroll in the plans. The company believes that creating a viable child-only market requires going beyond the solutions tendered by HHS.

5. John Alden/Time

With regard to the suggestions tendered by HHS's FAQ, those suggestions can be very helpful. The company would assess all of those issues as they would arise. For the Assurant companies, the solution requires going further than the HHS guidance.

G. Kentucky Access Testimony

Because Kentucky Access is Kentucky's high-risk pool, the issues addressed by the representatives of the insurers at the fact-finding hearing are not relevant to the pool. Kentucky Access continues to issue child-only policies. The testimony on behalf of Kentucky Access at the hearing

centered around responding to how the insurers' decision to discontinue offering individual child-only plans may impact Kentucky Access. Kentucky Access raised concerns as follows:

- The financial effect on Kentucky Access will be immediate and harsh. Kentucky Access pays a third party administrator (TPA) on a per member per month basis. As Kentucky Access enrolls children who cannot obtain coverage in the private market, membership will swell as will the basic cost to Kentucky Access.
- Kentucky Access will recognize increased costs by insuring additional healthy and unhealthy children.
- Claims costs for unhealthy children will increase, likely beyond the premium intake.
- The added membership will require Kentucky Access to design new health plans to accommodate the child-only policies.
- Kentucky Access has a maximum membership for effective service of no more than 5,000 persons. Kentucky Access currently has over 4,800 members. Kentucky Access has little room for more members without a diminution of service.

H. Comments on a 60-Day Waiting Period

At the close of the hearing, all interested parties were afforded an opportunity to submit additional written comments to the Department within five working days of the close of the hearing. Further, the Commissioner requested that insurers submit written comments regarding the possible use of a "waiting period," in lieu of a traditional 30-day open enrollment, to resolve the concerns that the insurers expressed at the hearing regarding issuing coverage to children under the age of 19. Below are the comments received regarding the proposed "waiting period."

1. Aetna

The [waiting period] solution in and of itself is not workable for Aetna due to the issues outlined during the hearing and submitted to the Department in the company's written testimony.

2. Anthem

Anthem certainly believes that a delayed effective date in a guaranteed issue individual market is a critical element to mitigate the adverse selection that can occur in an environment where individuals can wait until services are immediately needed to get coverage. Thus, a 60-day delayed effective date would go a long way towards ensuring a more functional guaranteed issue, child-only market. A delayed effective date of at least thirty days is one of several conditions that must exist for a functional child-only market to exist with carrier participation.

3. Golden Rule

The company does not believe a 60-day waiting period addresses all of the situations where adverse selection will occur.

4. Humana

After thoroughly reviewing the 60-day waiting period proposal compared to an open enrollment, Humana does not believe a 60-day waiting period provides sufficient protection against adverse selection to create a viable child-only marketplace. We continue to believe an open enrollment period is the best public policy option.

5. John Alden/Time

The 60-day waiting period for children who purchase a child-only plan is in lieu of an open enrollment period and attempts to guard against individuals seeking coverage after a health condition begins and terminating coverage once healthy again. Assurant does not believe this will solve the problem. Instead, there is a need to:

- Have many carriers actively involved in the market thereby spreading the risk among carriers;
- A state defined open enrollment period and;
- An ability to appropriately price products.

I. Other Comments Received After Adjournment of the Hearing

In addition to the comments received from the insurers after the adjournment of the hearing, the Department also received comments as follows:

1. Kentucky Voices for Health

Kentucky Voices for Health (KVH) is concerned that the lack of child-only policies will be a barrier to accessing coverage for the most vulnerable Kentuckians. KVH feels that the actions of insurers to stop issuing child-only policies are detrimental to the health of Kentucky's children and families.

KVH is interested in gathering additional information/data regarding the number of children currently covered on child-only plans in Kentucky, the number of applications received per month for child-only coverage, the number of children denied coverage due to medical conditions, and the denial rate/issue rate for child-only plans.

KVH outlined a range of options for stabilizing the health insurance market for children and ensuring that families can secure the care that they need. Those options include:

- Requiring insurers to continue offering child-only plans;
- Establishing open enrollment periods;
- Consideration of the Department's proposal for a 60-day waiting period;
- Ability of insurers to increase the cost of child-only policies. The Department is urged to use caution in allowing additional costs or premium increases for child-only policies;
- Utilizing other available coverage options so that families with sick children can obtain the coverage they need such as "buy in" to Medicaid and KCHIP;

- Making sure that the new federal and state Pre-Existing Condition Insurance Plans work for families;

KVH expressed its disappointment with insurers in Kentucky that are not offering any new child-only policies. KVH will work with other advocates to recommend that families who are currently benefiting from child-only insurance coverage maintain their policies to avoid difficulty in obtaining future coverage.

2. Kentucky Youth Advocates

Kentucky Youth Advocates (KYA) expressed their concern with children going without health coverage as this leads to poor health and educational outcomes. Not having health coverage also places undue financial burdens on families.

KYA believes that insurers who made available child-only policies before September 23rd should continue offering the product. This coverage should be reasonably priced so families who need the coverage can afford it.

Like KVH, KYA requested similar data regarding child-only plans.

In terms of the 60-day waiting period, KYA states that the Department may want to consider what exemptions it would allow for children with pre-existing conditions, such as involuntary loss of coverage.

Lastly, KYA comments that it is disheartened to see the insurers in Kentucky pulling out of offering child-only coverage. KYA hopes the Department can remedy this situation swiftly.

V. FINDINGS OF FACT

The Commissioner's findings of fact, are being made in accordance with KRS 304.12-130(1).

After consideration of:

- All documents, materials, data, and information received by the Commissioner prior to the fact-finding hearing;
- All testimony received during the fact-finding hearing;
- All comments submitted by insurers, Kentucky Access, and interested parties after the adjournment of the fact-finding hearing;
- The guidance issued by HHS; and
- All other relevant information,

the Commissioner makes the following findings of fact:

a. On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act.

b. PPACA included several insurance market reforms and consumer protection provisions, some of which became effective on September 23, 2010.

c. One insurance market reform effective September 23, 2010, was a prohibition against imposing pre-existing medical conditions on children under the age of 19.

d. Prior to September 23, 2010, insurers issuing individual policies to children under the age of 19 in Kentucky were permitted to medically underwrite and approve or deny applications for coverage.

e. On June 21, 2010, HHS issued an interim final rule related to the coverage for children under the age of 19.

f. The interim final rule clarified that plans may not impose any pre-existing condition exclusion, including a denial of coverage, for an individual under age 19.

g. The effect of the PPACA market reform and the interim final rule was to require insurers to guarantee issue coverage to an individual under the age of 19, thereby eliminating the insurers' ability to deny applications for coverage.

h. All insurers in the individual health insurance market in Kentucky have made the business decision to cease the issuance of individual health benefit plans to children under the age of 19.

i. The decision by insurers to decline to issue individual insurance coverage to children under the age of 19 has drastically impeded accessibility and limited insurance coverage options available for children under the age of 19.

j. The impediment to accessibility and limitations on insurance coverage options for children under the age of 19 affects healthy children as well as unhealthy children.

k. HHS issued guidance related to child-only policies in the form of a "Questions and Answers" document regarding the "Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions."

l. Despite the guidance provided by HHS, insurers continued to decline to issue any new individual child-only policies in the State of Kentucky.

m. The influx of new child-only members into the state's high-risk pool, Kentucky Access, may detrimentally harm the pool and its current members.

n. The lack of availability of individual insurance coverage in the Kentucky insurance market is a matter of strong public interest.

o. The decision of the insurers to decline to issue individual insurance coverage to children under the age of 19 is an act or practice that is not in the public interest.

p. KRS 304.12-130 authorizes the Commissioner to hold a hearing if a proceeding by the Commissioner regarding an act or practice would be in the public interest.

q. The Commissioner held a fact-finding hearing on October 13, 2010, to receive testimony from insurers that made a decision to cease issuing individual insurance coverage to children under the age of 19.

r. The insurers testifying at the hearing provided reasons for not participating in the child-only market, including:

    1. The lack of a clear mandate to issue child-only policies;

2. Rules are needed to discourage or prohibit individuals from only buying insurance when medical services are needed;
3. The lack of a uniform open enrollment period; and
4. Insurers are at a disadvantage in the market unless all insurers participate to spread the risk.

s. The insurers testifying at the hearing provided circumstances that would influence an insurer to reverse its decision to cease issuing child-only policies, including:

1. The existence of an effective mandate for all insurers participating in the individual market to issue child-only policies;
2. The existence of a standardized, annual open enrollment period for child-only coverage;
3. The ability to appropriately rate based on the health status of the applicant;
4. The ability of the insurers to receive actuarially justified rate adjustments;
5. The existence of rules to encourage continuous coverage and discourage subscribers of child-only policies from enrolling only when medical services are needed, otherwise referred to as "gaming;"
6. The ability to impose a surcharge for persons who cancel or allow their coverage to lapse;
7. The existence of rules to eliminate "dumping" into the guarantee issue market when the applicant is eligible for other coverage either through a public or private program;
8. The ability of individuals under 19 to obtain coverage after certain specified qualifying events;
9. The ability to medically underwrite children under 19 outside of open enrollment;
10. The ability of insurers to limit the plans available for children under the age of 19;
11. Prohibit the sale of child-only plans outside of the uniform open enrollment period; and
12. 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.

t. All insurers testifying at the hearing indicated that they would continue to offer dependent coverage to children under the age of 19 if the primary subscriber is over the age of 19.

u. All insurers testifying at the hearing indicated that they would continue to renew current child-only policies that were effective prior to September 23, 2010.

v. The current individual health insurance market provides access to coverage of healthy and unhealthy children under the age of 19 where the child is not the primary policyholder.

w. The current individual health insurance market provides renewable coverage to healthy and unhealthy children under the age of 19 who were fortunate enough to have secured health coverage prior to September 23, 2010.

x. The fact that children under the age of 19 do not have access to individual health insurance coverage after September 23, 2010, results in disparate treatment in the insurance market of individuals of the same class involving essentially the same hazards in violation of KRS 304.12-080(3).

VI. CONCLUSION

The Commissioner, after conducting a fact-finding hearing, believes that the insurers in the individual health insurance market in the State of Kentucky, by discontinuing to make child-only policies available in the market, have engaged in an act or practice that is not in the public interest, results in disparate and unequal treatment among persons in the same class, and is in violation of KRS 304.12-080(3) which provides as follows:

> No insurer shall make or permit any unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatsoever, except that in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business or any other relevant factor.

KRS 304.12-080(3) allows consideration to be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, and any other relevant factor. In order to protect against potential abuses that might result from a requirement that insurers guarantee coverage to children under the age of 19 without regard to any pre-existing condition, the Commissioner, by Order, will:

a. Establish an effective mandate that requires all insurers in the individual health insurance market to issue child-only policies;
b. Establish a standardized, annual open enrollment period for child-only coverage through January 2013;
c. Clarify that child-only policies may be appropriately rated based on the health status of the applicant;
d. Clarify that insurers may received actuarially justified rate adjustments that are appropriately filed and otherwise in compliance with KRS Chapter 304, Subtitle 17A;
e. Establish rules that will encourage continuous coverage and discourage subscribers of child-only policies from enrolling only when medical services are needed;
f. Establish rules to prevent "dumping" into the guaranteed issue market when the applicant is eligible for other coverage either through a public or private program;
g. Enable individuals under 19 to obtain coverage outside of the open enrollment period after certain specified qualifying events;
h. Permit insurers to limit the plans available for children under the age of 19; and

i. Prohibit the sale of child-only plans outside of the uniform open enrollment period.

The Commissioner's Order will not permit insurers to impose a surcharge for individuals who cancel or allow their coverage to lapse. Rather, in order to prevent gaming the system, coverage for children under the age of 19 will only be available during the open enrollment period. The Commissioner's Order will not authorize insurers to medically underwrite children under the age of 19 outside of an annual or special open enrollment period defined by the Order. Insurers may medically underwrite in order to properly rate the coverage during the open and special enrollment periods specified in the Order. Lastly, the Commissioner's Order will not address the medical loss ratio (MLR). Rather, MLR is being addressed at the federal level through the National Association of Insurance Commissioners.

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: October 13, 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?

A: If a State requires continuous open enrollment or requires issuers to maintain an open enrollment period of a particular length or open enrollment periods of a particular frequency, then the State requirement will apply. The State law is not preempted by any current federal requirements.

Question #5: "Premium assistance" programs allow States to provide payments to help people eligible for Medicaid and Children's Health Insurance Programs (CHIP) enroll in private coverage. Won't the policy to ban pre-existing condition exclusions in new plans for children lead cash-strapped States to steer high-cost children into individual market policies for children as a way to limit their own liability?

A: Federal law prohibits Medicaid and CHIP from denying children coverage based on their health status. Moreover, it limits the extent to which these programs can provide payment to support coverage in individual market policies. "Premium assistance" programs in CHIP allow States to provide payment to private policies to cover children if doing so both protects children and is cost effective to the Federal and State governments. Premium assistance is not designed as a strategy to transfer vulnerable children to individual market coverage. The Administration will enforce its current policies on premium assistance and consider new ones if evidence emerges that children with pre-existing conditions are being diverted inappropriately from Medicaid or CHIP to private insurance plans that newly offer guaranteed issue to children regardless of their health status.

HHS will not enforce these rules against issuers of stand-alone retiree-only plans in the private health insurance market.

Question #6: Some issuers have expressed concerns about adverse selection from newly offering child-only health insurance on a guarantee issue basis, and have asked for clarifications of what they could do, consistent with the current regulations, to mitigate this concern?

A: A number of actions have been suggested by insurance commissioners and insurers to address adverse selection in child-only policies. The following actions are not precluded by existing regulations:

- Adjusting rates for health status only as permitted by State law (note: the Affordable Care Act prohibits health status rating for all new insurance plans starting in 2014);
- Permitting child-only rates to be different from rates for dependent children, consistent with State law;
- Imposing a surcharge for dropping coverage and subsequently reapplying if permitted by State law;
- Instituting rules to help prevent dumping by employers to the extent permitted by State law;
- Closing the block of business for current child-only policies if permitted by State law; and
- Selling child-only policies that are self-sustaining and separate from closed child-only books of business if permitted by State law.

In addition, some States are considering legislation that would require individual-market issuers that offer family coverage to also offer child-only policies. This approach could increase the options for families with healthy as well as sick children, and would lower the risk of adverse selection. The Administration would welcome this and other State actions that ensure access to health plans by families with children and prevent adverse selection in the market.

Question #7: In some States with guarantee issue, to limit adverse selection, open enrollment periods are set for a particular time of the year, required to be used by all issuers, and, in some cases, are the only time when issuers can sell policies. Would the Administration consider adopting such a policy?

A: As clarified earlier, issuers and States can already choose to use open enrollment periods consistent with existing regulations. To require a uniform open enrollment period for child-only

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.

Question #8: May carriers cancel or non-renew children currently insured under child-only coverage due to a pre-existing condition, while continuing to renew coverage only for healthy children?

A. No. Under federal and state laws – pre-dating the Affordable Care Act – all policies in the individual health insurance market are guaranteed renewable. In addition, the Affordable Care Act (by adding section 2712 of the Public Health Service Act) expressly prohibits carriers from rescinding coverage except in cases of fraud or intentional misrepresentation of material fact. Children under age 19 with pre-existing conditions who have child-only coverage may therefore maintain their coverage so long as that coverage is offered.

Question #9: May either a state or HHS establish a uniform open enrollment period during which all insurers would be required to accept a child who applies, regardless of any pre-existing condition?

A. HHS does not have the authority to establish a uniform open enrollment period without adopting a regulation that would expressly establish such a period. The Administration would consider making such a regulatory change if it would result in issuers selling new child-only plans, as explained in Q7 posted on September 24, 2010. States typically have the authority to promulgate bulletins or emergency regulations establishing uniform open enrollment periods relatively quickly. Some states, including California, Colorado, Ohio, Oregon, South Dakota, and Washington, have already established such periods, and others are considering doing so. HHS welcomes the state-based establishment of such periods to the extent that they expand options for families. If HHS were to establish a uniform open enrollment period in the future, it would anticipate accommodating states that have enacted their own uniform open enrollment periods.

Question #10: In states that have established uniform open enrollment periods, under what, if any, circumstances may families purchase child-only coverage for their children during the remainder of the year?

A. If a child has had at least 18 months of prior creditable coverage (or has had continuous creditable coverage since a date within 30 days of birth) and loses group health coverage, he/she is a HIPAA-eligible individual and is guaranteed access to individual coverage without regard to a pre-existing health condition. The child must be allowed to apply for HIPAA-mandated coverage within 63 days after losing coverage. In many states, this coverage would be provided by a state high risk pool. Additional circumstances like the birth of a child or adoption may also be circumstances in which families may purchase child-only coverage for their children outside of open enrollment periods, depending on state law. These policies pre-date the Affordable Care Act.

Question #11: May an issuer that has an open enrollment period during which it enrolls children under age 19 with pre-existing conditions, medically underwrite during the rest of the year and decline to enroll children under age 19 with pre-existing conditions outside of the open enrollment period?

A: No. Issuers that have an open enrollment period may not decline to enroll children under age 19 with pre-existing conditions outside of the open enrollment period while enrolling children under age 19 without such conditions. Depending on state policies regarding open enrollment periods, issuers must either (i) enroll all children under age 19, regardless of pre-existing conditions, at all times, including outside the open enrollment period; or (ii) enroll all children under age 19, regardless of pre-existing conditions, during the open enrollment period, but decline to enroll all children under age 19 outside the open enrollment period, with exceptions described in Q10. Even for children who qualify for exceptions to enrollment during open enrollment periods, issuers may not decline enrollment due to a pre-existing condition. States may set one or more open enrollment periods for coverage for children under age 19, but cannot

allow insurers to selectively deny enrollment for children with a pre-existing condition while accepting enrollment from other children outside of the open enrollment period(s).

Question #12: Does the pre-existing condition policy for children under age 19, and the clarifications in these "frequently asked questions," apply to the family policies as well as child-only policies?

A: Yes.

Letter from Secretary Sebelius to Jane L. Cline Regarding Child-Only Policies (Oct. 13, 2010)

Letter from Secretary Sebelius to America's Health Insurance Plans Regarding Children's Access to Health Insurance

Letter from Secretary Sebelius to Blue Cross and Blue Shield Association Regarding Children's Access to Health Insurance

PUBLIC PROTECTION CABINET

Steven L. Beshear
Governor

Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517
1-800-595-6053
http://insurance.ky.gov

Robert D. Vance
Secretary

Sharon P. Clark
Commissioner

Memo

To: Al Perkins, Director
Kentucky Access Division

From: Sharon P. Clark, Commissioner

Date: 10/6/2010

Re: Eligibility for Kentucky Access – Insurer Rejection for Children under age 19

The Patient Protection and Affordable Care Act ("PPACA") contains numerous insurance market reforms. One of the reforms prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to such plan or coverage. This provision is effective for policies issued and and renewed on or after September 23, 2010 for individuals up to the age of 19. An interim final rule was issued on June 21 related to this provision and clarified that plans may not impose any exclusion of benefits, including a denial of coverage, based upon a pre-existing condition, for an individual under age 19.

After contacting the insurers offering individual coverage in Kentucky, the Department of Insurance has learned that, as of September 23, 2010, there are no private insurers offering new individual policies to children under the age of 19 as the named insured (commonly referred to as "child-only plans".) This business decision leaves Kentucky Access or, if eligible, PCIP, as the only options for children under the age of 19 to purchase health insurance through the individual market as the named insured.

KRS 304.17B-015(2)(a) states that an individual is eligible for Kentucky Access if the individual has been rejected by at least one (1) insurer for coverage of a health benefit plan that is substantially similar to Kentucky Access coverage. As documentation for this eligibility category, 806 KAR 17:320 section 4(1)(b)1. requires the applicant to provide a copy of a notice of rejection from one (1) insurer for individual health

care coverage substantially similar to the Kentucky Access coverage for which the individual is applying, dated within the ninety (90) day period prior to the effective date of Kentucky Access coverage or the approval date of the application, whichever is later. In that a child under the age of 19 cannot currently purchase a child-only health benefit plan in the private insurance market in Kentucky, this memorandum will serve as the rejection letter for a child under the age of 19 applying for Kentucky Access as the named insured under the rejection category.

The Department of Insurance has requested that private insurers attend a fact-finding hearing to discuss their business decision to cease writing child-only policies. Should insurers begin offering child-only plans in Kentucky again, the Department will provide a subsequent notice to Kentucky Access regarding the documentation needed for this eligibility category.

PUBLIC PROTECTION CABINET

Steven L. Beshear
Governor

Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517
1-800-595-6053
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Robert D. Vance
Secretary

Sharon P. Clark
Commissioner

September 27, 2010

Donald George Hamm, Jr., President
Assurant Health/Time Insurance Company
P.O. Box 3050
Milwaukee, WI 53201

Re: Child-only coverage in Kentucky

Dear Mr. Hamm:

On September 23, 2010, several insurance market reforms required by the Patient Protection and Affordable Care Act (PPACA) became effective. These reforms include consumer protections prohibiting the imposition of a pre-existing condition exclusion for children under the age of 19 and the requirement that insurers permit parents to maintain coverage for their adult children until age 26.

Kentucky Department of Insurance (KDOI) records indicate that your company is currently approved to offer health benefit plans in the individual market, which includes approval to issue and deliver individual policies to children under the age of 19 (child-only). Information received from various insurers, news reports, informal surveys conducted by KDOI in recent weeks, and consumer inquiries indicates that some, if not all, insurers approved in the individual market will not write child-only coverage due to the requirements of PPACA.

These circumstances are of great concern. If individual coverage to children under 19 is no longer available for issue in the individual market, Kentucky Access, and in some circumstances[1], the Preexisting Condition Exclusion Plan (PCIP) implemented earlier this year, will be the only options available to procure child-only coverage in Kentucky. The current budget of Kentucky Access could not sustain the entry of a substantial number of children, estimated to be hundreds per month, that were being added to the insured rolls in the individual

[1] The federal high risk pool offers coverage to individuals who have a pre-existing condition and have not had coverage for at least six months prior to enrollment. Thus, PCIP is a limited option for children under age 19.

market as subscribers. This lack of access for children and the extra demands on Kentucky Access are clearly not in the public interest.

Thus, as Commissioner, I believe that circumstances exist as referenced in KRS 304.12-130 and that a proceeding in respect thereto, would be in the best interest of the public. KRS 304.12-130 authorizes the Commissioner to proceed with a hearing and to make a written report of her findings and further determine what action may be warranted under these circumstances. Attached is a SUBPOENA DUCES TECUM AND ORDER including a request for information and documents to be provided to me on or before October 8, 2010. A fact-finding hearing will be conducted on October 13, 2010, at 1:30 pm.

Sincerely,

Sharon P. Clark

Sharon P. Clark
Commissioner

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
FRANKFORT, KENTUCKY

IN THE MATTER OF:

Time Insurance Company

Re: Fact-Finding Hearing Related to "Child-Only"[1] Coverage

SUBPOENA DUCES TECUM, REQUEST FOR INFORMATION, AND ORDER

TO: **President or Designee(s)**
Time Insurance Company
P.O. Box 3050
Milwaukee, WI 53201
DOI No. 300683

You are hereby ORDERED, pursuant to KRS 304.2-100, KRS 304.2-340, KRS 304.12-130, 806 KAR 2:070, and all other applicable law, to appear at the Kentucky Department of Insurance on the date and time specified below for the purposes of providing information to the Department regarding individual health insurance coverage for children under the age of 19 years. The location, date, and time of your appearance is ORDERED as follows:

Location: Kentucky Department of Insurance
2nd Floor Hearing Room
215 West Main Street
Frankfort, KY 40601

[1] A "child-only" policy refers to a health insurance policy delivered or issued for delivery to an individual that is the primary subscriber on the policy and under the age of 19 years. A "child-only" policy does not include a policy that is delivered or issued for delivery to a primary subscriber that is over the age of 19 years but that insures persons under the age of 19 years.

Date: October 13, 2010

Time: 1:30 p.m.

You are further ORDERED to provide to the Commissioner of the Kentucky Department of Insurance the following documents, information, and materials on or before 4:00 p.m. on October 8, 2010:

1.) The number of "child-only" applicants, by month, during the time period beginning July 1, 2009, and ending June 30, 2010;
2.) The number of "child-only" enrollees, by month, during the time period beginning July 1, 2009, and ending June 30, 2010;
3.) The medical loss ratio (pure premium to claims) for "child-only" enrollees;
4.) Details regarding any changes made to the company's underwriting practices, criteria, or guidelines for any policies, which changes are attributable in any manner to the requirement in the Patient Protection and Affordable Care Act to cover children under the age of 19 years with no pre-existing condition exclusions; and
5.) Factors that led to the company's decision to either not write or cease writing "child-only" policies.

So Ordered this 28 day of September, 2010.

Sharon P. Clark

Sharon P. Clark, Commissioner
Kentucky Department of Insurance

Certificate of Service

This is a true copy of the original Subpoena Duces Tecum, Request for Information, and Order was mailed by certified mail to:

Donald George Hamm, Jr.; President
Time Insurance Company
P.O. Box 3050
Milwaukee, WI 53201

CSC-Lawyers Incorporating Service Co.
421 West Main St.
Frankfort, KY 40601

Sharron S. Burton 9/28/10

Sharron S. Burton, General Counsel
Office of Legal Services, Insurance Division
c/o Kentucky Department of Insurance
215 West Main Street
P.O. Box 517
Frankfort, Kentucky 40602
Phone: (502) 564-6032 x25244
Fax: (502) 564-1456

Child only

Physicians Mutual®

Insurance for all of us.™

Certification

Physicians Mutual Insurance Company does not market expense incurred health policies in Kentucky to any age.

Although we did market individual major medical policies in Kentucky for a short period of time, we have not issued an individual health benefit plan in Kentucky since 2005. We currently have only one individual health benefit plan in force in Kentucky. This policy was issued in Ohio and moved to Kentucky. The policy owner is now age 48 and the only person insured on the policy since issue in 1993. Our plan for the immediate future for this policy is for it to continue to renew at the policy owner's option.

Physicians Mutual has no intention to enter the individual health benefit market in Kentucky.

Shawn Pollock

Shawn Pollock
Vice President
Physicians Mutual Insurance Company

10/14/2010
Date

Jacqueline A Blum

GENERAL NOTARY-State of Nebraska
JACQUELINE A. BLUM
My Comm. Exp. July 28, 2014

10-15-10
mm

The MEGA Life and Health Insurance Company℠ | A HealthMarkets® Company
Health protection that fits your life.

October 12, 2010

Via E-Mail – Sharron.Burton@ky.gov
and U.S. Mail

Ms. Sharron S. Burton
General Counsel
Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

RE: Ceasing New Health Benefit Plan Sales

Dear Ms. Burton:

Please accept this letter as written notice that The MEGA Life and Health Insurance Company ("MEGA") has ceased sales of all new individual health benefit plans in the State of Kentucky. MEGA will continue to administer its existing block of individual health benefit plans and currently has no plans to non-renew or discontinue this existing block of business. MEGA has approximately 229 health benefit plans in effect in Kentucky.

We are aware of the provisions of KRS 304.17A-240(3)(b) and understood this provision to apply in cases where a carrier made a decision to discontinue offering *and* non-renew all existing health benefit plans, thereby withdrawing from the individual market. We now understand from your communications that the Kentucky Department of Insurance also anticipates that a carrier will provide written notice to the Commissioner pursuant to KRS 304.17A-240(3)(b) if a carrier makes a decision to cease offering new health benefit plans, even when the carrier will continue to renew its existing block of business.

Please let us know if you need any additional information. You can contact me at (817) 255-5516 or by e-mail at Susan.Dew@healthmarkets.com or Virginia DeTuro at (817) 255-5236 or by e-mail at Virginia.DeTuro@healthmarkets.com. We appreciate your time and assistance.

Sincerely,

Susan E Dew

'san Dew
'ice President, Associate General Counsel
'ef Compliance Officer
Compliance

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The MEGA Life and Health Insurance Company℠ | A HealthMarkets℠ Company
Health protection that fits your life.

October 12, 2010

Via E-Mail – Sharron.Burton@ky.gov
and U.S. Mail

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Kentucky Department of Insurance
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Frankfort, KY 40602-0517

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Sincerely,

Susan E Dew

Susan Dew
Sr. Vice President, Associate General Counsel
and Chief Compliance Officer
Corporate Compliance

SD/sl

RECEIVED
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The MEGA Life and Health Insurance Company℠ | A HealthMarkets® Company
Health protection that fits your life.

October 12, 2010

Via E-Mail – Sharron.Burton@ky.gov
and U.S. Mail

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Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

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Sincerely,

Susan E. Dew

Susan Dew
Sr. Vice President, Associate General Counsel
and Chief Compliance Officer
Corporate Compliance

SD/sl

RECEIVED
DEPT. OF INSURANCE
2010 OCT 15 A 8:18

AFFIDAVIT OF SUSAN E. DEW

I, Susan E. Dew, do hereby declare as follows with regard to The MEGA Life and Health Insurance Company's status in Kentucky's individual (non-employer) health insurance market:

1. I am currently Senior Vice President, Associate General Counsel and Chief Compliance Officer of The MEGA Life and Health Insurance Company ("MEGA").

2. MEGA has ceased sales of all new individual health benefit plans in the State of Kentucky.

3. MEGA will continue to administer its existing block of individual health benefit plans in the State of Kentucky and currently has no plans to non-renew or discontinue this existing block of business.

4. MEGA has approximately 229 health benefit plans in effect in Kentucky.

I declare under penalty of perjury under the laws of the State of Kentucky and the United States of America that the foregoing is true and correct.

Executed this 12th day of October, 2010, at North Richland Hills, Texas.

Susan E. Dew

Susan E. Dew

Subscribed and sworn to before me on this 12th day of October 2010.

ANALISA ROBLEDO
Notary Public, State of Texas
My Commission Expires
March 23, 2011

AnaLisa Robledo, Notary Public
In and for the State of Texas