Approved March 30, 1988
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by SENATOR AUGUST "GUS" BOGINA at
Chairperson

11:00 a.m./~~p.m.~~ on March 14, 1988 in room 123-S of the Capitol.

All members were present except:
Senator Doyen was excused

Committee staff present:
Research Department: Scott Rothe, Russ Mills
Revisor's Office: Norman Furse
Committee Office: Judy Bromich, Pam Parker

Conferees appearing before the committee: * ATTACHMENT #

INTRODUCTION OF BILLS

Senator Gannon moved, Senator Gaines seconded, the introduction of the following bills:

7 RS 2643 - An act concerning acquisition of historic property; relating to review by state historic sites board of review.

7 RS 2672 - An act authorizing the exchange and conveyance of certain real property between Emporia state university and the Emporia state university endowment association.

7 RS 2698 - An act concerning the swine industry in the state of Kansas; establishing a swine technology center; making and concerning appropriations for the fiscal year ending June 30, 1989.

7 RS 2688 - An act relating to local seed capital pools.

7 RS 2680 - An act relating to the Kansas statewide risk capital system; concerning investments of the pooled money investment board in Kansas Venture Capital, Inc.

7 RS 2664 - An act concerning controlled substances; relating to presumptive mandatory sentencing.

The motion carried on a voice vote.

Senator Feleciano moved, Senator Werts seconded, the introduction of a bill which will clarify the Kansas Employment Security Law relating to the "cafeteria" plan and what would be determined to be salaries for unemployment compensation tax, after it is drafted. The motion carried on a voice vote.

SB 561 - State health care benefits program, benefits self-funding, commission expanded.

Senator Jack Steineger, as the primary sponsor of SB 561, was the first conferee to speak before the Committee. (Attachment 1)

The second conferee was Mr. Lynn Baker, Utah Public Employees' Health Program. (Attachment 2 is an outline of a presentation he made last fall which addresses most of the considerations needed with an in-house self-administered health insurance program. Also included is brief history of the state of Utah's program.) In regard to the cost effectiveness of the Utah program, Mr. Baker stated that they have paid in claims 99.1 percent of the premium they collected. During that time they accumulated a reserve in the health program of $9.4 million. Their administrative costs are approximately 3.85 percent

compared to the average carrier in Utah of 11 percent. The interest earnings they have realized from their reserve account have been inserted into the program and have almost funded their administrative overhead costs.

In answer to questions, Mr. Baker stated that Utah has 20,000 active employees, about 5,000 people on a Medicare supplement plan, another 3,000 on an early retirement program. There are 23,000 in the long term disability program and about 15,000 in the dental program. The population of Utah is approximately 1.6 million. They offer an option, beyond COBRA, for early retirement and charge a little higher premium. The total cost for the group of early retirees runs about 25 to 30 percent higher than the active group.

Mr. Ron Meyer, Associate Executive Director, Medical Plans, Missouri State Employees' Retirement System, was the third conferee. He stated that the program in Missouri was formed in 1973 and it consists of three programs: (1) the long term disability, (2) group term life insurance, and (3) the self insured health insurance program. They have a comprehensive policy with a $150 deductible and 20 percent co-pay. The maximum out-of-pocket expense for the employee annually is $1,150 and they have $.5 million limitation per employee for liability for the medical care plan. In the traditional health care program, they have 30,000 active members enrolled in their program, 5,000 retirees and 1,000 early retirees under age 65. They have an additional 6,000 members in contracted HMO's and about 11,000 dependents of the active members and retirees. He pointed out that a self insurance program allows for more immediate responses to problems in the program and gives a freer option on how to deal with benefits. In regard to cash flow, he stated that they have a reserve of over $11 million and have been able to maintain that through an investment program monitored by the Board of Trustees and various associated staff members. Their overhead runs about five percent which includes both operations and their ASO contract. He stated the only item they reinsure is organ transplants.

Mr. Tom Wands, Former Administrator, Boilermakers National Health and Welfare Fund, was the next conferee. He stated that he came onto the KPERS Board in 1967. He stated that the Boilermakers' program is completely self funded and they process all of their own claims. Last year they processed 370,000 claims amounting to about $52 million. Their administration costs last year amounted to about six percent. They have never participated in HMO's or PPO's.

The meeting was recessed at 12:00 noon, for Session, and reconvened at 12:30 p.m.

John P. Mackin, Senior Vice President, Martin E. Segal Company, Inc., presented his testimony following the recess. He stated that the individual circumstances of each health benefit plan vary. He noted that before SB 561 is seriously considered the present provisions of the law may need to be reviewed as they seem much more flexible. He stressed the need for flexibility in a self insured program. He stated that before a law is enacted to mandate self funding as provided in SB 561 there needs to be further analysis and study to consider what net savings, if any, may be expected and the long term cost implications of self funding.

He recommends the buildup of a catastrophic reserve rather quickly or to buy some stop loss coverage in the early years of a self insure program. Consideration should be given to conversion privileges and the establishment of a PPO network in Kansas.

In answer to a question, Dr. Mackin stated that self funded plans offer

more flexibility to deal with some of the areas of rising health care costs. The basis used to finance the program does not change the claims experience. Whether the program is insured or self funded the claims experience will be the same, in theory, unless certain kinds of cost management provisions are implemented. The mandate of self funding by itself will not affect the claims experience.

Charles Dodson, KAPE, presented his testimony. (Attachment 3)

Dr. Charles Wheeler, M.D., former Mayor of Kansas City, Missouri, stated that he feels the escalation of health care costs are due to increased technology and the aging population. Having served as an elected official for 14 years he was impacted by those escalating costs. He stressed the importance of a good data base.

Ed Flentje, Secretary of Administration, introduced Robert Malloy, the new Benefits Manager for the Health Care Commission, and told the Committee of activities of the Commission in regard to study of the self insuring issue in Kansas. He urged not to mandate at this time. In answer to a question, he stated that, at this point in time, he does not have any strong feelings about the proposed expansion of the HCC.

INTRODUCTION OF BILLS

Senator Werts moved for the introduction of the following bills:

7 RS 2670 - gaming revenues and EDIF

7 RS 2671 - change the fund and develop a natural resource fund.

The motion failed for the lack of a second.

The meeting was adjourned.

GUEST LIST

COMMITTEE: SENATE WAYS AND MEANS DATE: 3/14/88

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Bob Malloy	Health Benefits Admin	State of Kansas
Michael Revell	419 W 29th	BC/BS
Cindy Hocker	Topeka	Judicial
John Peterson	"	Kaiser Permanente
Cheryl Dillard	Kansas City	Kaiser Permanente
Charles Dodson	Topeka	KAPE
RON Meyer	Jefferson City	Mo. State Retirement Sys.
LINN BAKER	S.L.C., UTAH	UTAH P.E.H.P.
CHARLES WHEELER	KC Mo.	M.D.
Tom Wands	KCK	SRS
Jack Hamm	Topeka	KPERS
Marshall Crowther	Lawrence	KPERS
John Mackin	New York	Segals
Cliff Doel	Topeka	KDOR
Marlow Rein	Lawrence	KU
[illegible]	[illegible]	[illegible]
[illegible]	Topeka	Budget
[illegible]	[illegible]	[illegible]
Jan Johnson	Topeka	Budget Division

SWAM 3-14-88

ATTACHMENT 1
SWAM 3-14-88

JACK STEINEGER
SENATOR, SIXTH DISTRICT
STATE CAPITOL BLDG., ROOM 136-NORTH
TOPEKA, KANSAS 66612
(913) 296-7375

STATE OF KANSAS

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
MEMBER: INTERSTATE COOPERATION
JUDICIARY
LABOR, INDUSTRY, AND SMALL BUSINESS
LEGISLATIVE AND CONGRESSIONAL APPORTIONMENT
LOCAL GOVERNMENT

Testimony of Senator Jack Steineger on March 14, 1988, before the Senate Ways and Means Committee in support of

SENATE BILL NO. 561

I am before you today to address a problem that the State of Kansas has been facing for over a decade now. That problem is the runaway costs associated with the State Employees Health Insurance program. Kansas currently has the most expensive employee health plan in the nation, and that plan this year is telling State employees that they can expect fewer benefits, shoulder more expenses and to submit to new cost controls that not only limit health care options, but which have not been proven effective.

A review of the Annual Report of the Kansas State Employees Health Care Commission indicates that last year:

1. Hospital bills for the state employees group were 23% higher than similar groups statewide;
2. Hospital admissions were 8% higher than groups similarly situated;
3. Hospital charges were 28% higher; and
4. Outpatient charges were 32% higher.

ATTACHMENT 1
SWAM 3-14-88

From this, one of two conclusions can be reached. Either the Employees of the State of Kansas are, on the average, in worse physical condition than the rest of the nation, or, more likely, they are being victimized by a health care system which provides no incentive to keep the cost of health care at a minimum.

The Kansas Health benefits program has reached the magnitude of over 42,000 participants with a financial obligation estimated at over $75 million for 1989. The State is currently responsible for 60% of those costs. In 1988, the state will contribute $41 million dollars and projections for 1989 indicate the State will contribute nearly $46 million, which is an increase of 18.5%. Under the present health care system, relief does not appear to be in sight.

Senate Bill No. 561 would provide the State of Kansas with a mechanism to deal with constantly-increasing health related costs. Specifically, it would allow the state to take control of its own destiny by setting up a self-funded, direct pay insurance plan for state employees and upgrade the public's oversight of the multi-million dollar annual insurance plan.

In 1982, the State of Kansas studied the feasibility of initiating a direct pay health care insurance program. Many of the people testifying today testified at that time as well. Although the testimony was favorable, a direct-pay system was not adopted. The results of that decision, as I

have already indicated, have been a spiraling of health care costs, which continue to rise unimpeded. It is interesting to note that 23 states currently have some form of self-funded insurance for their employees. It is even more interesting to note that not one of the states which have implemented a self-funded insurance program have reverted to a carrier form of insurance. All reports indicate that their experience with self-funded insurance has been positive.

We have with us today, representatives from the State of Utah and the State of Missouri. Both states have instituted their own insurance plans which are state funded and state operated, and their representatives are here to testify to the favorable results those plans have yielded. But before we hear from them, I would like to explain generally the concepts behind self-insurance.

Self-funding allows the employer to manage reserves and pay health care claims from its own funds. It is not a cost containment technique in the tradition of generic drugs, preferred providers or mandatory second opinions; rather, self-funding is a means for improving the cash flow supporting an employee benefits system. It provides a number of unique advantages:

First, it provides investment returns to the state. Under a standard insured coverage, the employer deposits a predetermined amount with the carrier from which claims are

paid and reserves maintained. Under self-funding the premium pool and reserves are held and managed by the state. Return on investment of these reserves accrues directly to the state.

Second, it eliminates risk premiums. Carriers include a retention charge for the coverage they provide. This fee includes a risk premium which compensates the carrier for the liabilities it has assumed. Self-funding places the risk with the state, which eliminates the payment of risk premiums to insurance carriers.

Third, it allows direct control over the program by the State. The administrator of the program is better able to provide flexible plans which more adequately meet the needs of State employees. The State is also better able to oversee expenditures directly, and to limit over utilization.

I hope that the 1988 legislature heeds the tesimony delivered by this group today. It is the same message that was delivered in 1982, and its validity has withstood the passage of time. It is time the state took control of rising health care costs and implemented a program designed to combat them; not one which simply accepts their inevitability and adds them into the next fiscal budget.

ATTACHMENT 2
SWAM 188

In-House Benefits Administration

I. State of Utah's Self-Administered Benefit Plans

A. Health Program

1. In-house 10 years
2. Pioneered cost containment programs
    (1) Low utilizer
    (2) Wise consumer
        (a) Out-patient surgery
        (b) Short Hospital stays
        (c) Second surgical opinion
    (3) Healthy lifestyles
3. Implemented statewide Pharmacy Card System
4. Implemented statewide Preferred Provider Network
    (1) Medical claim draft system
    (2) Physician profiling
    (3) Global fee system

B. Medicare Supplement Plan

C. Dental Program

D. Long Term Disability Program

II. Advantages of Self-Administration

A. Financial

1. Eliminate retention charges from carrier
    (1) Premium Tax
    (2) Risk charges
    (3) Profits
    (4) Unnecessary administrative costs
        (a) advertising
        (b) Sales commissions
        (c) Agents commissions
2. Earnings on reserves and cash flow

B. Flexibility to develop and implement new programs

C. More sensitive to employee's needs and problems

D. More capable of recognizing and eliminating hidden costs

1. Alternative delivery system costs
2. Funding costs
3. Lifestyle costs

ATTACHMENT 2
SWAM 3-14-88

III. Disadvantages of Self-Administration

A. Risk assumption

1. Funding annual claims cycle
2. Large claims
3. Adverse selection

B. Competition

1. Rate negotiation
2. Utilization control
3. Alternative systems

C. Group size

1. Cost effective administration

D. Insulation

1. Lose the buffer between employer and employee

E. Loss of outside expertise

IV. Factors to Address When Considering Self-Administration of Employees Benefits

A. Risk Factors

1. Is the group large enough ?
2. Is present risk pool healthy ?
3. Penetration by alternative systems
4. Claims experience
5. Group demographics

B. Competitive Factors

1. Able to negotiate favorable rates
    (a) From hospitals
    (b) From physicians
    (c) From pharmacies
2. Cost controls
    (a) Utilization controls
    (b) Case management

C. Cost of Self-Administration

1. Prepare Pro-Forma budget
    (a) Personnel services
    (b) Data Processing
2. Start up costs
3. Annual administrative costs
4. Comparison with industry standards

D. Management Committment

1. Financial
    - (a) Keep plan actuarially sound
        - (1) Reserving
        - (2) Funding claims
    - (b) Assume risks
        - (1) New technology
        - (2) Epidemics
        - (3) New deseases
2. Administrative
    - (a) Hire industry professionals
3. Plan performance
    - (a) Claims service level
    - (b) Benefit package

V. Implementing Self-Administration

A. Staffing key people

1. Director
2. Claims manager
3. Consultants
    - (a) Actuary
    - (b) Medical director
    - (c) Data Processing
    - (d) C.P.A.
4. 6 to 10 claims processors per 10,000 employees

B. Data Processing

1. Analyze hardware and software configurations
2. Seek high levels of performance that will optimize operations
3. Refer to addendum A for an overview on expected DP costs

History and Analysis of The Public Employees Health Program

HISTORY

In 1977, the Utah State Legislature passed a bill that established Utah's self-insured health program. At that time, the state was using Prudential Insurance Company as the carrier. A great deal of input was received from the Office of the Legislative Fiscal Analyst in drafting the legislation. The bill provided that the state must use the self-insured program and that other public entities covered under the Utah State Retirement System could use the program if they desired. The program was made available to political subdivisions of the State because there were already several entities participating in the program prior to self-insurance. They were included to achieve the savings that can be procured by a large group. Provisions were implemented, making it mandatory for the program to be kept actuarily sound, and for the State Insurance Department to perform an annual audit and report the results of the audit to the Governor and the Legislature.

Utah was the first state in the nation to implement a self-insurance program entitled Public Employees Health Program. Since that time, Louisiana has set up a self-insurance program that requires all public employees in that state to participate, including educators and local governments. They insure approximately 120,000 employees.

More recently, Washington and Alaska have strongly considered implementing self-insurance as an alternative to either increased spending or cuts in benefits to their employees. Exhibit "A" explains the recent developments in Washington and Alaska.

In 1977, the primary force behind the new Utah legislation was to save money in the State's insurance program. Since that time, there have been several studies made to determine what savings have been achieved. The savings were more dramatic than anticipated. Because of the savings achieved through self-insurance, the dental program and long-term disability program were established on a self-administered basis.

In 1981, Public Employees Health Program developed a statewide drug card program which resulted in substantial savings over the Pharmaceutical Cards Systems, Inc., the program previously offered to State employees. This also accomplished bringing the pharmacy business in-state where the local economy could benefit.

Approximately five years ago, Public Employees Health Program started a health promotion program in conjunction with the Utah State Health Department. It began with distributing the book **Take Care of Yourself** to all state employees to begin their educational program, along with sponsoring the Healthy Utah workshops. The program, still in force, also involves paying incentives to employees who adopt healthy lifestyles. Payments in the form of credit are made to employees who stop smoking, lose weight, or begin and maintain a regular exercise program.

More recently, Public Employees Health Program has implemented a unique incentive program called **FLEXPLAN**. FLEXPLAN encourages employees to become wise consumers of health care services, to minimize their utilization of the health insurance program, and to adopt healthy lifestyles. **Hope**, a newsletter, is also distributed on a regular basis to encourage healthy lifestyles.

The Public Employees Health Program pioneered two new concepts nationally; the first is the **global fee** concept which is now being published and explained in a college textbook, **Health Care Administration**, and the **medical claims draft** concept used to reimburse hospitals and physicians. Public Employees Health Program has received national attention from both the public and private sectors, and many of the concepts currently used are being adopted by other organizations.

In 1983, Public Employees Health Program began the first statewide preferred provider organization called Preferred Care. This program resulted in much lower costs from the medical community for all health care services including hospitalization, out-patient surgery, and physician services.

Where it has been determined that private carriers can provide the benefits in a more economically efficient manner, the bid process has been used to identify the most cost-effective carriers to provide the benefits. This process has been used for the **alternative health carriers, universal life insurance products, accidental death and dismemberment**

benefits, **term-life** coverage, and to replace the death benefit that was previously provided through the Retirement System. Exhibit "B" describes this process.

SELF-INSURANCE

Employers in the state of Utah have been pioneers in implementing self-insurance concepts. Two national carriers, Alta Health Care Strategies and Smith Administrators, were leaders using these concepts. Employers, such as the LDS Church and Utah Power and Light, started their own health insurance program because they understood the savings that could be achieved.

With Utah leading the way, other state and local governments are now beginning this process in order to save money in providing their health care benefits. Self-insurance allows them to be leaders in their states by developing cost containment programs, health promotion plans, and other innovative cost-reduction strategies.

COST-EFFECTIVENESS (Saving Tax Payers' Dollars)

Exhibit "C" contains the formulas used by the Utah State Insurance Department to analyze the financial status of the various carriers they audit. The carriers used in the example insure over half the state's population. You will note that Public Employees Health Program's administrative overhead is substantially lower than the private insurance carriers.

Exhibit "D" shows the administrative expenses contained in a report from the office of OHMO in Washington of Utah's HMO's. The Public Employees Health Program is substantially lower in administrative overhead than other carriers.

Exhibit "E" takes the average administrative expenses of the largest indemnity carriers and shows what the financial impact would have been if their average expenses were used on last year's Public Employees Health Program premiums and claims experience.

During the past 10 years of operation, the average claims paid to premiums received has been 99.1 percent. From those same premiums, the administrative costs of running the program have been subtracted, and a reserve of $9 million has been generated. Public Employees Health Program has also paid back $2.5 million to the State's General Fund. This has been achieved through a very successful investment program that has generated an additional 3 percent of premiums from investing reserves and cash flow.

Exhibit "F" is the cover letter that was distributed with the Insurance Department's audit as well as information from the report showing the program's financial experience.

Exhibit "G" shows three large Utah carriers compared to Public Employees Health Program on administrative expenses and total income ratios.

COST-EFFECTIVE GOVERNMENT

When it can be documented that government is saving tax payers' dollars, does it make sense to privatize a government program when tax payers have to pick up the additional costs? If Public Employees Health Program saves the State money, why shouldn't local governments be able to take advantage of these savings? In the past, local governments have been allowed to take advantage of these savings achieved in both Public Employees Health Program and the Utah State Retirement System. The Retirement Board has recently established a pooling system that eliminates the possibility of a subsidy between state and local governments in the Public Employees Health Program.

TAXES

The Utah State Legislature eliminated the tax on health insurance premiums some time ago. Many of the health insurance plans in Utah are non-profit operations and are not subject to income tax.

Several years ago, Public Employees Health Program agreed to pay sales tax on durable medical equipment. Taxes are not a valid issue in analyzing self-insurance.

LOCAL ECONOMY

Public Employees Health Program has made it a policy to use Utah providers. Many large insurance carriers have their claims operations outside Utah and many carriers use an out-of-state corporation to provide drug benefits. By excluding out-of-state providers, Public Employees Health Program aids Utah's economy in all of its relationships including providers and banking institutions.

COMPETITION

It has been Utah's policy to be a leader in developing competition among medical providers in an effort to control medical costs.

Preferred Care encourages competition among providers because of the way it was designed. Hospitals and physicians are selected based on utilization and efficiency criteria. By limiting who belongs to its preferred provider organization and keeping the panel as small as possible, Public Employees Health Program is placed in a strong position in negotiating rates.

Since Public Employees Health Program believes competition must be encouraged to help control costs in the medical community, it has negotiated contracts with outside carriers which have been offered to public employees for approximately nine years. Two years ago, because there were so many alternative delivery systems in Utah, the program asked for bids. Ten bids were received and two carriers were selected to be offered in addition to Traditional Care and Preferred Care. The two carriers are Healthwise, sponsored by Blue Cross-Blue Shield, and FHP. This provides a mechanism where carriers in the private sector may compete with Utah's self-insured program on an ongoing basis.

GROWTH IN THE MARKET PLACE

Recently, competitive forces in the market place have encouraged many public agencies to enter Public Employees Health Program. At the present time, Public Employees Health Program is experiencing tremendous growth with the entry of Salt Lake City, Salt Lake County, and the Utah Local Governments Trust. This growth has been quite surprising since Public Employees Health Program does not market its program.

ECONOMY OF SIZE

Exhibit "H" shows the state and local government enrollment totals in Public Employees Health Program. At the present time, approximately 40 percent of the total enrollment is from political subdivisions. This also includes early retirees and retirees enrolled in the Medicare Supplement program.

This enrollment allows the political subdivisions to participate not only in the savings achieved by Public Employees Health Program but also places Public Employees Health Program in a stronger position when negotiating discounts from physicians and hospitals. Hospitals give bigger discounts for volume. If the smaller political subdivisions were not allowed to associate themselves with a larger group, they would be unable to take advantage of these larger discounts.

If employees of political subdivisions were forced to leave Public Employees Health Program, it would place a large burden on them to duplicate the coverage at anywhere near the cost they are presently paying. It would be especially difficult for the retirees.

LIST OF EXHIBITS

SPORTS, Page D1

UW faces a challenge from rights movement
LIVING, Page C1

BUSINESS, Page B4

Seattle Post-Intelligencer

A HEARST NEWSPAPER

TUESDAY MORNING DECEMBER 29, 1987 25 CENT

Exhibit A

Blue Cross in red on state plan

Insurer seeks to raise premium by 54 percent

By Tom Paulson
P-I Reporter

Blue Cross of Washington and Alaska says it wi lose $43 million on its current two-year contract t provide medical insurance for many state employees And it's blaming the loss on patients and doctors who Blue Cross says are overusing the coverage.

The insurer wants more money to pay the bills and has requested an increase in premiums tha could cost taxpayers $91 million. One alternativ would be to put some of this financial burden on the state workers.

Blue Cross, primary health insurer for state workers, wants to raise the monthly premium 54 percent in its next contract. That's an increase per employee from about $147 per month to about $226 per month — $60 million over two years.

If similar benefits are provided to all state-insured employees, the total cost could jump to $91 million, the state Office of Financial Management estimates.

"There's no way to do it for one employee group and not for another," said Sen. Dan McDonald, R-Bellevue and chairman of the Senate Ways and Means Committee. The $91 million appropriation "is not going to happen. . . . The sock is empty."

To cut the cost, the State Employees Insurance Board is suggesting state workers in the program be required to pay part of the cost of their health care, as are employees in other plans.

As a result, Gov. Booth Gardner has asked for $2[illegible] million in his supplemental budget to explore self-insurance as an alternative to increased spending or cuts in benefits.

The problem, some critics say, is with the health insurer's plan providing 100 percent coverage at no patient cost.

"Blue Cross made a mistake," McDonald said yesterday. "When you have zero costs, people buy more."

A Blue Cross spokesman suggested that because the insurance is free, patients are making more claims and that doctors may even be encouraging patients to make more trips to see their physicians.

Added George Masten, chairman of the State

See HEALTH PLAN, Page A4

Health plan: Blue Cross in the red on state contract

From Page A1

Employees Insurance Board: "There's no question in my mind that Blue Cross will experience a substantial loss this year . . . but their losses are their losses."

The insurance board contracts with insurers to provide benefits for state employees (other than those employed in K-12 education). Masten said it is still unclear whether Blue Cross' Prudent Buyer plan has been the main culprit for cost overruns.

"But that's a concern," Masten said. "For some reason, starting in January '86, the rates (of usage) have been going up substantially."

A San Francisco-based CPA firm, Coopers & Lybrand, has been hired by the House and Senate Ways and Means committees to identify the problem at Blue Cross and recommend how to solve it.

Blue Cross spokesman Denny Fleenor said the problem is that state employees are "over-utilizing" services. The insurer signed its contract with the state based on a predicted 6 percent annual cost increase.

"Right now, it's running at 18 percent," Fleenor said. "The program is spending more than it's bringing in.

"The costs have gone up because state employees are using services more than we expected. Doctors' office rates have gone up and we're seeing more billing. Because there's no patient cost (in the Prudent Buyer plan), I'm sure some doctors are encouraging people to come in more."

Fleenor said the requested increase "is not a bailout."

"When we talk about the 54 percent increase, this won't account for any of the program's losses," he said. "This is simply the amount of money needed to put the program on an even keel."

The State Employees Insurance Board recognizes the problem of inflating medical costs is a national phenomenon and not solely a problem with Blue Cross, Masten said. For that reason, the board supports Blue Cross' request for more money — although not as much as the insurer is seeking.

The board has, however, suggested that state employees pay part of the cost of health care. Masten said one proposal is to have employees pay 15 percent co-insurance with a $75 deductible for individuals ($225 for families) in the Prudent Buyer plan just as they do for the standard plan.

Scott Sigmon, spokesman for the Washington Federation of State Employees, said his organization could support some modifi-

[illegible] to the Prudent Buyer p[illegible] but that the union intends [illegible] lobby for continuing the curre[illegible] benefits.

Masten said the board a[illegible] suggested the state look into se[illegible] insuring after this year's turmo[illegible] The state would provide the fu[illegible] and contract out the business [illegible] paying claims.

Bruce Bullock, a spokesman [illegible] the governor's office, said [illegible] concept of self-insurance has be[illegible] promoted [illegible] the proble[illegible] with Blue [illegible] not whol[illegible] The [illegible] industry [illegible] generally [illegible] cost [illegible]

"The reports we get are n[illegible] good," Bullock sa[illegible]

"We [illegible] examining this [illegible] an financial [illegible] he said. "It [illegible] an option. The governor wants t[illegible] set up a task [illegible] to examin[illegible] what's responsible for the increas[illegible] in costs."

Exhibit B

Bid Results

Alternative Health Carriers

Bids Received 1985

Bids

Family Health Plan (FHP)
HealthWise
Holy Cross Care (HCC)
Hospital Corporation of America (HCA)
Humana Care Plus
Intermountain Health Care (IHC)
Maxicare
Physicians Health Plan (PHP)
Valuecare

Successful Bids

HealthWise
Family Health Plan (FHP)

Universal Life Insurance

Bids Received 1986

Bids

Amoco Life
Beneficial Life
Connecticut
Diversified
E.F. Hutton
Equitable
Midwestern United
Northwestern National Life
West Coast Life

Successful Bids

Beneficial Life
Northwestern National Life

Accidental Death and Dismemberment

Bids Received in 1986

Bids

AIG Life Insurance Co
American Claims Administration
Bankers Life and Casualty
Beneficial Life
Colonial Life and Accident
Combined Insurance Company of America
Mutual of Omaha
State Mutual International Accident
The Hartford Group
Transamerica Life

Successful Bid

State Mutual International Accident

Term Life Insurance

Bids Received 1986

Bids

Beneficial Life
Educators Mutual
Gem State Mutual
Guaranteed Mutual Life Co.
Hartford Life
Security Life of Denver
Transamerica Occidental Life
Washington National

Successful Bid

Transamerica Occidental Life

Exhibit C

	Average Utah Carrier	PEHP
Claims Ratio	88.87%	99.27%
Administrative Expenses Ratio	11.20%	4.14%
Claims to Total Income	85.68%	92.00%
Administrative Exp. to Premiums	11.20%	4.14%
Administrative Exp. to Total Income	10.89%	3.84%

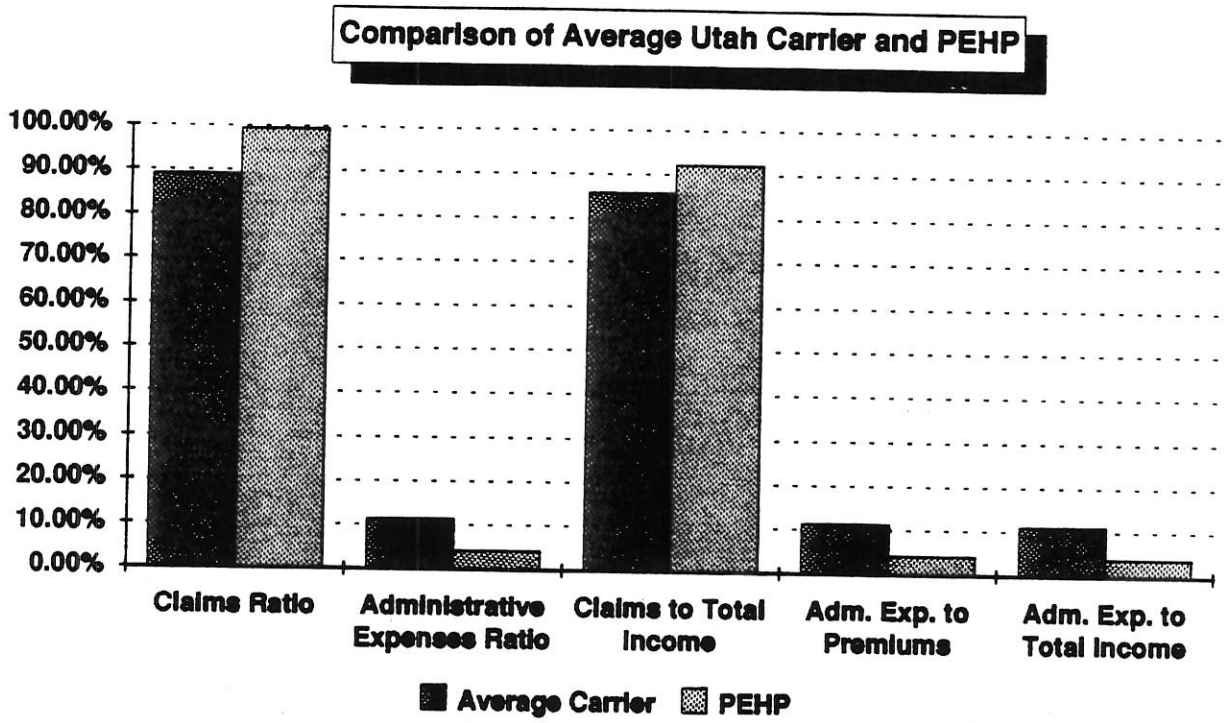
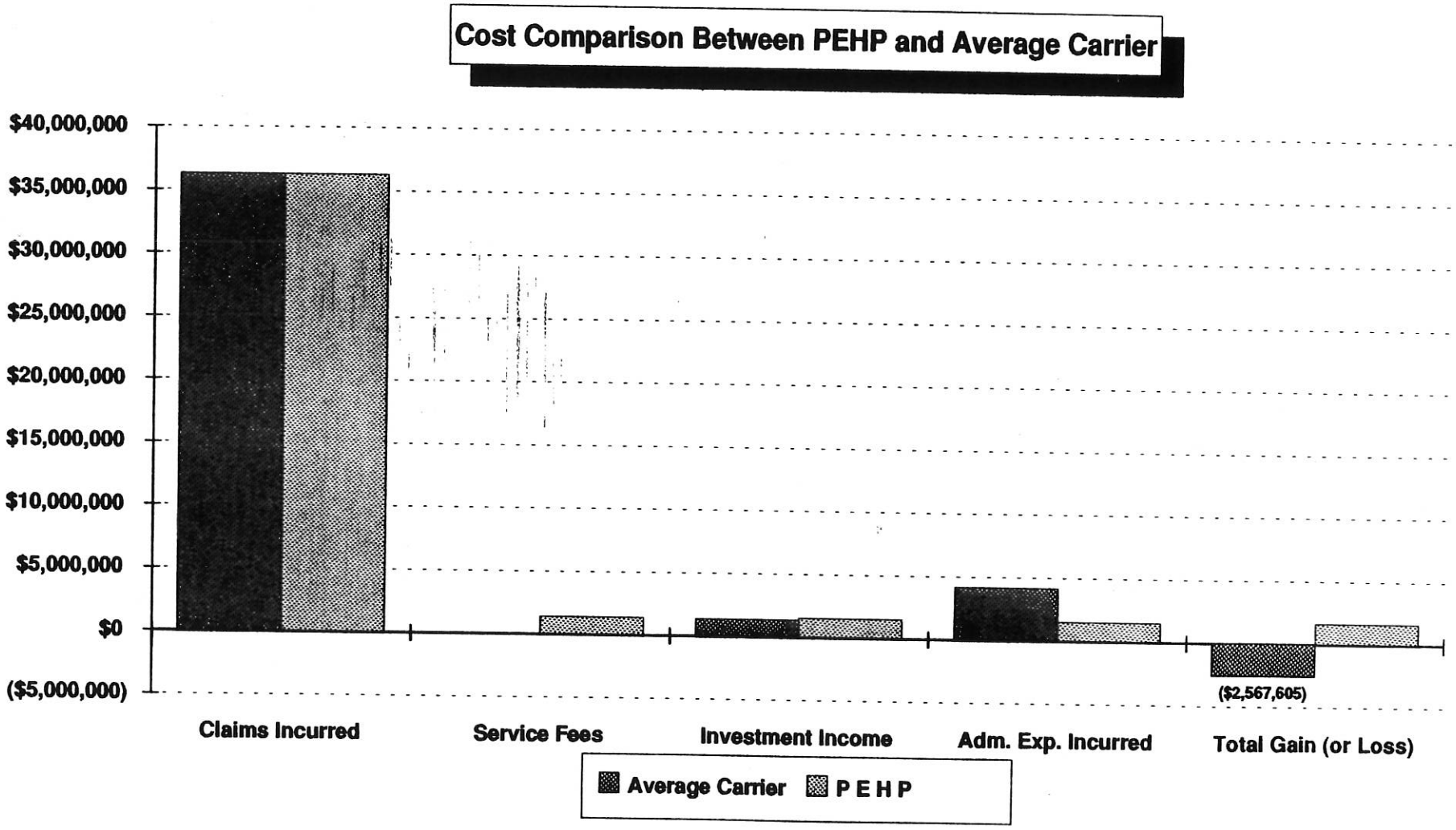


Exhibit D

H.M.O. Carrier	Health Plan Administrative Expenses As a Percentage of Total Expenses
A	9.50
B	9.20
C	11.30
D	16.50
PEHP	3.84

Administrative Expenses ratios contained in a report from the office of OHMO in Washington.

Exhibit E



This chart assumes PEHP's Premiums and Claims Incurred, projecting a loss of $ 2,567,605 by the average carrier, against a gain of $ 1,642,620 by PEHP.

Exhibit F

Insurance Department's Audit

PUBLIC EMPLOYEES GROUP INSURANCE
UTAH STATE RETIREMENT BOARD
540 East 200 South
Salt Lake City, UT 84102
(801) 355-3885

BERT D. HUNSAKER
EXECUTIVE DIRECTOR

January 15, 1988

Gentlemen:

In conformance with the provisions in Section 49-8-101 of the Utah Code, enclosed is the annual audit by the Insurance Department of the Public Employees Health Program.

We are very pleased that once again this year the audit reflects a healthy program that continues to provide substantial savings for the participants. These savings can be identified by reviewing page 5 which summarizes the last ten years.

The program has the remarkable record of paying out claims that represent 99.1 percent of the premiums collected. At the same time, the program has accumulated reserves of $9.4 million, reimbursed the State General Fund approximately $2.5 million, and also paid the cost of operations.

This savings has been achieved because of an extremely low overhead and an excellent investment record. This is an enviable record when compared to other health insurance programs in the state. Similar success has been achieved in providing health, long-term disability, and life insurance benefits to public employees.

If you have any questions regarding the audit report, please feel free to contact us or the State Insurance Department.

Sincerely,

Bert D. Hunsaker
Executive Director

Group personal accident insurance is available to public employees through the Public Employees Health Program office.

This coverage is provided by the State Mutual Life Assurance Company of America. It is available at the employee's cost; the employer does not participate in the cost of this insurance. The coverage provided is accidental death, dismemberment, and loss of sight due to an accident. An accident weekly indemnity benefit may also be added as a benefit for an additional premium.

The Plan began offering Preferred Provider Care on July 12, 1986. This program offers the same benefits as the Traditional hospital and sickness coverage. It requires the insured to receive their health care from health care providers who have contracted with the Plan to provide these services at a negotiated fee. An insured can receive care from non-preferred providers with pre-authorization or in an emergency situation. This service is provided at a reduced medical fee and, consequently, at a reduced premium.

ADJUDICATION PROCESS

The Plan uses an automated system for the claims adjudication process. The computer program is designed to recognize the various criteria important to settlement of claims. It recognizes eligibility; applies usual, customary and reasonable maximums; recognizes procedures eligible for full benefits; applies appropriate percentages to cases where benefits are limited to a percentage of eligible charges, etc.

Following the entry and verification of this basic data, the computer, with the adjudicators approval, generates a check to the person indicated as the entitled recipient of the payment.

RATING

The Program's consulting actuary makes his recommendations to the Insurance Committee of the Board of Directors of the State of Utah Retirement Office. Final responsibility for establishing rates rests with the board.

The total rate thus adopted, reduced by the portion the Legislature has determined to be the State's share, if the amount of the employee's share.

EXPERIENCE

The program has 10 years operations from which to collect statistical data relative to health insurance operation claims experience and 9 years for life insurance. Some of this data is summarized as follows:

Fiscal Year Ended	Health Program	Term Life Program	Medicare Supplement	Dental Program	Long Term Disability Program
6-30-78	92.77%				
6-30-79	92.25%	67.36%			
6-30-80	99.66%	61.55%			
6-30-81	107.42%	100.62%	86.15%		
6-30-82	110.38%	99.45%	115.76%		
6-30-83	104.77%	108.26%	119.63%		
6-30-84	96.40%	74.73%	107.37%	129.44%	50.88%
6-30-85	91.74%	107.63%	93.92%	112.38%	84.87&
6-30-86	95.22%	74.66%	98.48%	101.26%	99.34%
6-30-87	100.33%	100.28%	104.23%	76.30%	45.91%

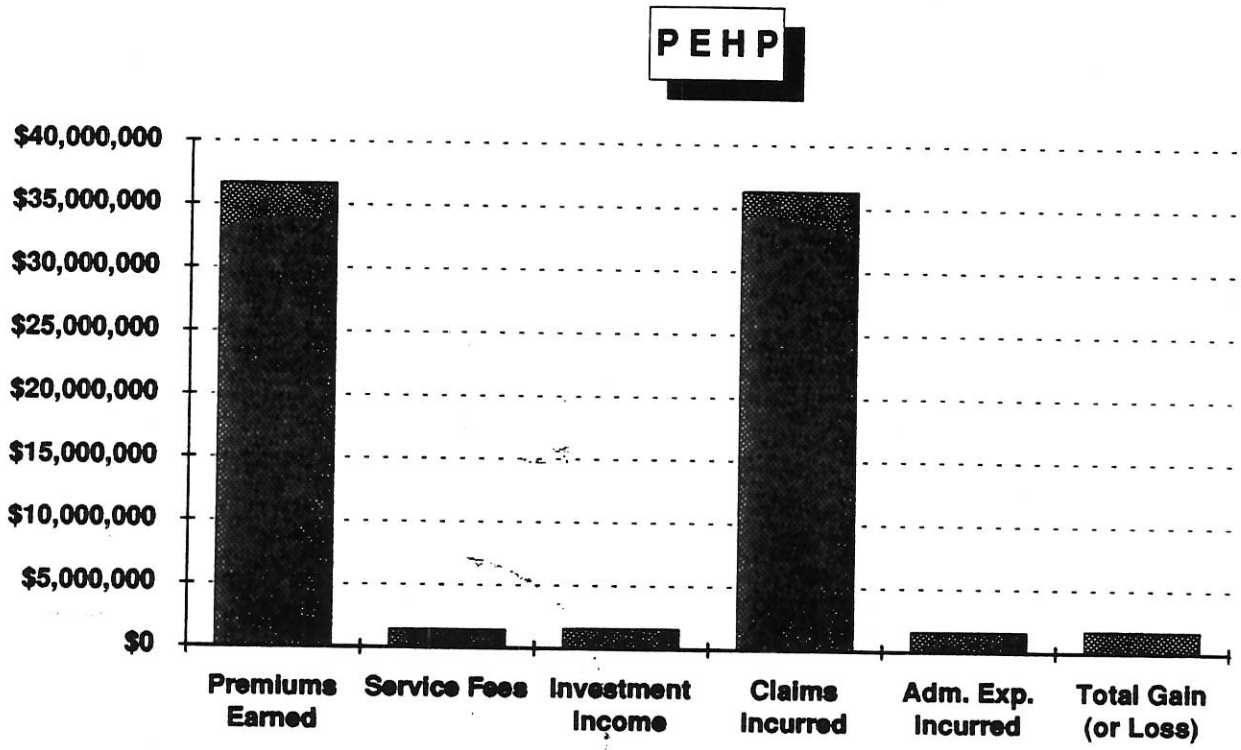
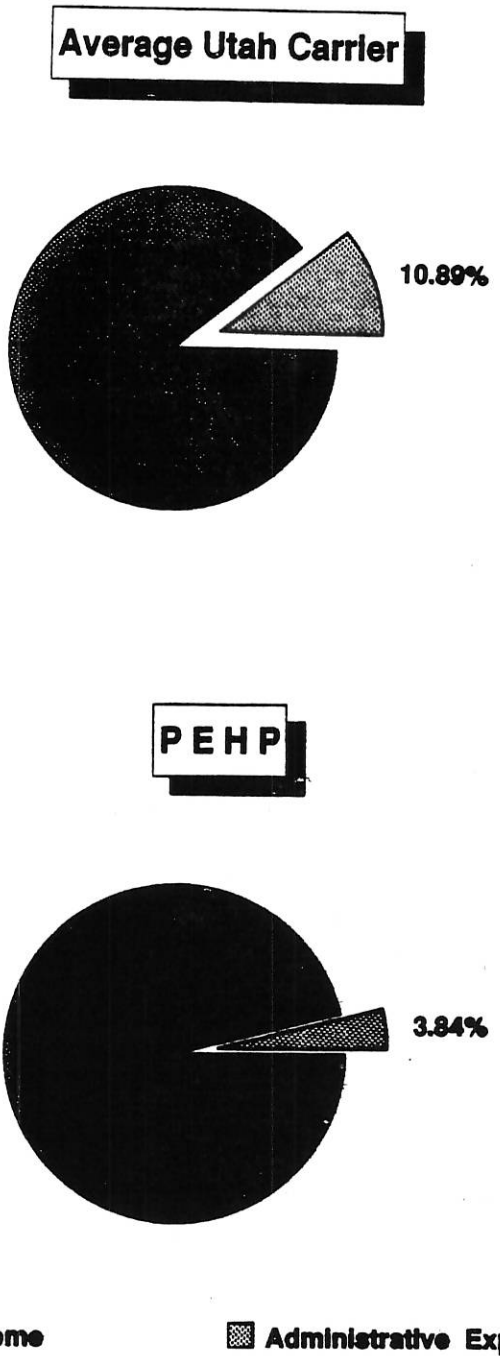
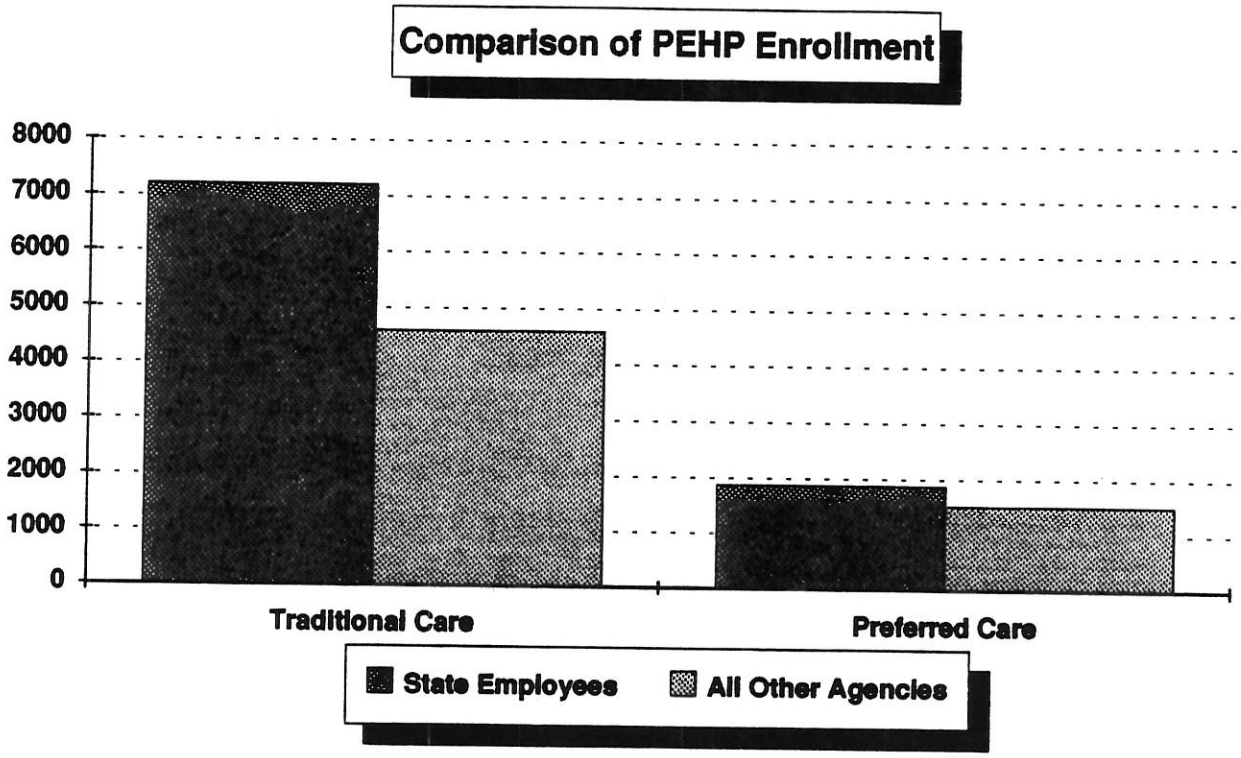

PEHP
$40,000,000
$35,000,000
$30,000,000
$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$0
Premiums Earned
Service Fees
Investment Income
Claims Incurred
Adm. Exp. Incurred
Total Gain (or Loss)

Exhibit G



Administrative Expenses ratios range from 6.44 % to 14.48 % for other carriers, compared to PEHP's ratio of 3.84 %.

Exhibit H


Comparison of PEHP Enrollment
8000
7000
6000
5000
4000
3000
2000
1000
0
Traditional Care
Preferred Care
State Employees
All Other Agencies

ATTACHMENT 3
SWAM 4/88

KANSAS
ASSOCIATION OF
PUBLIC EMPLOYEES

Presentation of Charles Dodson
Kansas Association of Public Employees
To the Committee on Ways and Means
March 14, 1988

Mr. Chairman, members of the Committee, thank you for this opportunity to speak in support of SB 561.

About 18,000 state employees earn under $1400 per month. Their costs for health insurance for family coverage takes up 17% or more of their take-home pay. If we have one more year like the last two, that cost could increase to 20% or more of their net salary.

The health insurance program for state workers has ceased being a benefit, and is rapidly becoming a burden. For some time state employees could be told that although they had salaries below those of the private sector, at least they had great benefits. Now we just have lower salaries.

Why has the insurance program gotten into such bad shape? I don't know. I don't think anyone knows. Maybe, that is our problem, no one knows anything about the program.

The Special Committee on Ways and Means heard lots of testimony this past fall about our insurance program. They heard about adverse selection, HMO's, PPO's, AIDS, reserve funds, cost-control measures, utilization rates and retainers. Most of this had very little to do with explaining the cost increases for the state employee health insurance program. Most had very little to do with explaining why our program costs are increasing at such a rapid rate. They had little to do with why our system hasn't required full accountability, or why the Government of the State of Kansas must rely entirely on the carrier for information about our program.

State employees have to ask why, with a $75 million program, we don't have a full-time, trained professional staff to administer our program? The HCC probably does all they can under the circumstances. But, that is not a satisfactory answer to the major question. Why the circumstances? Why do we only have one bidder? What can we do to change that fact? How did we get

ATTACHMENT 3
SWAM 3-14-88

400 West 8th Ave. Suite #306 Topeka, Kansas 66603 913-235-0262

ourselves into this situation, and why? What can we do to get out of this situation? How can we get a grasp on the spiraling insurance costs for state employees? These and other questions need answers.

If we had a self-funded, self administrated, or self-insured plan we would have answers to those questions. We would have answers to other questions as well.

Why, for example, have premium costs increased by 70 to 80% when the average costs of admissions per 1000 subscribers has decreased since 1984?

Why have we had an increase in premiums by 70 to 80% when the average hospital cost per day per 1000 subscribers had decreased since 1984?

Why have we had drastic increases in premium when the average monthly costs of Blue Shield for the state plan is falling.

According to the Martin Segal Company that is what is happening.

It is our belief that we must have competition. The policies of the State Employee Health Care Commission have, for several years, been to discourage competition. Now we find ourselves in a postion where we must have competition, even if we have to do it ourselves with the completed framework for a self-funded and self-administered plan.

We are now left in a position where self-funding may now be our only alternative.

We would ask you to please offer state employees some hope for relief. The bill you now have before you may be the only relief possible.

HEALTH CARE PLANS SUMMARY

The average charge per patient continues to develop at a higher level for the State Group than for BC-BS statewide or national norms. A comparison of the State Employee Group with all Blue Cross patients indicates that there is an increasing number of high cost cases occurring within the State Group. Specifically, the State Employer case mix thus far in 1987 is 12.3% above the norm compared to 8.9% in 1986.

Table 1

Comparison of Average Charges

Average Charge per Admission	State Group	Statewide	National
1-1-84/12-31-84	$2,427	$2,280	$2,878
1-1-85/12-31-85	2,798	2,568	2,732
1-1-86/12-31-86	3,392	2,755	2,979
1-1-87/05-31-87	3,473	3,007	*
Average Charge Per Patient Day			
1-1-84/12-31-84	$ 400	$ 389	$ 438
1-1-85/12-31-85	524	451	459
1-1-86/12-31-86	614	478	500
1-1-87/05-31-87	661	500	*

* Not Available

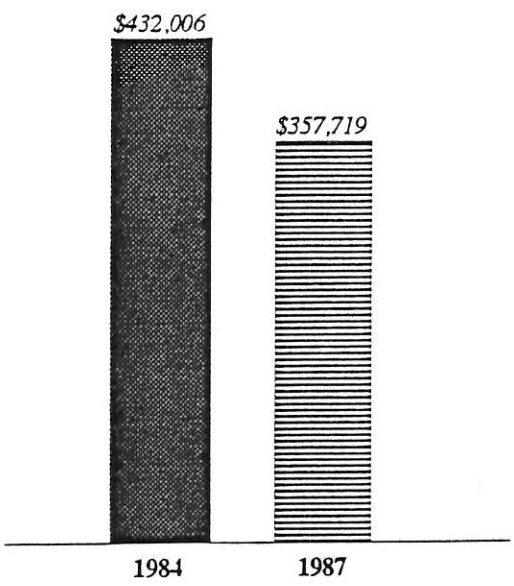
The number of admissions per 1,000 and days per 1,000 continues to decline as evidenced in Table 2. The State Group's experience for the first five months of 1987 developed at more favorable levels than BC-BS on a statewide basis. Average length of stay increased which should be expected with a lower number of admissions per 1,000. This is a result of reducing unnecessary hospital admissions and more treatment on an outpatient basis as indicated in Table 2.

Table 2

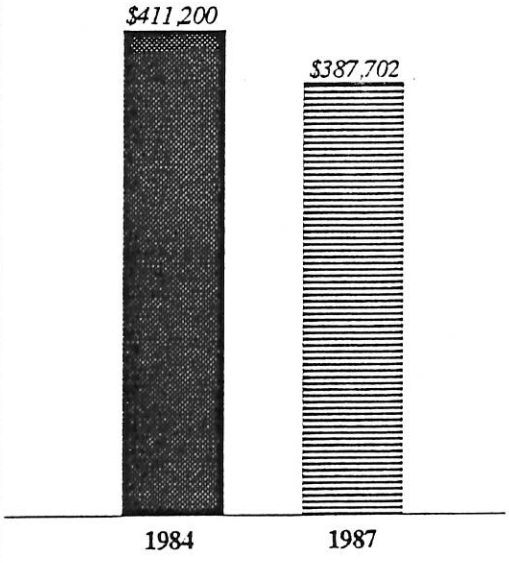
Admissions and Days per 1,000 Subscribers Annually

Admissions Per 1,000	State Group	Statewide	National
8-1-83/7-31-84	178	152	110
8-1-84/7-31-85	164	126	100
1-1-85/12-31-85	126	114	94
1-1-86/12-31-86	112	104	93
1-1-87/05-31-87	103	104	*
Days Per 1,000			
8-1-83/07-31-84	1,028	858	685
8-1-84/07-31-85	868	713	602
1-1-85/12-31-85	672	648	558
1-1-86/12-31-86	625	599	554
1-1-87/05-31/87	582	620	*
Average Length of Stay			
8-1-83/07-31-84	5.78 days	5.64 days	6.22 days
8-1-84/07-31-85	5.29 days	5.65 days	6.02 days
1-1-85/12-31-85	5.33 days	5.69 days	5.95 days
1-1-86/12-31-86	5.53 days	5.76 days	5.96 days
1-1-87/05-31/87	5.65 days	5.96 days	*
Outpatient Claims per 1,000			
8-1-83/07-31-84	550	423	381
8-1-84/07-31-85	558	337	374
1-1-85/12-31-85	576	372	403
1-1-86/12-31-86	572	433	432
1-1-87/05-31-87	590	449	*

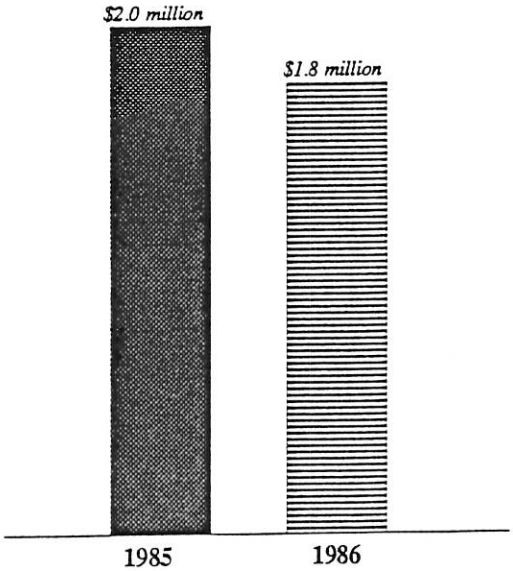
The State Group has experienced substantial decreases in hospital admissions and days per 1,000 since the 1983-84 policy year. Hospital admissions per 1,000 have decreased 42.1% since that year. The number of days has dropped 43.4% while the average length of stay increased in both 1986 and the first five months of 1987. Although the number of days has decreased, the average charge per confinement continues to increase. This also should be expected due to only sicker individuals being admitted to the hospital with less acute cases being treated on an outpatient basis.



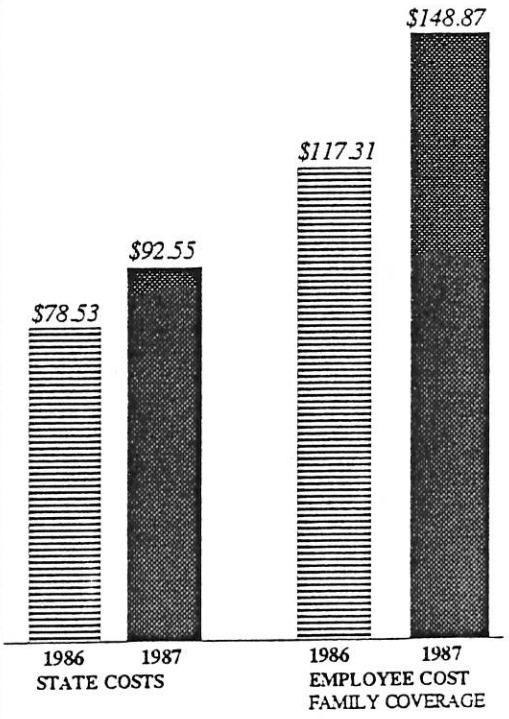
Average Admission Charge
for every 1,000 subscribers



Average Charge for Total Hospital Days
for every 1,000 subscribers



Average Monthly
Blue Shield charges



Average Monthly Premium

State health plans costs compared

A comparison of state medical plans and monthly cost to employees for individual plus family coverage is not a pretty sight for Kansas state employees. Since last year, Kansas rose from 7th to 4th in highest total cost category; from 2nd to 1st in the employee's cost rankings; but retained its position as the state which was 4th from the bottom in terms of the percentage of employee's cost paid by employer.

Total cost of state medical plan (family + individual coverage) highest to lowest		Employee's cost of coverage (family + individual) highest to lowest		Percentage of total cost (family + individual coverage) paid by the employer highest to lowest	
Michigan	$311.68	1 KANSAS	$158.12	Nebraska	100%
Connecticut	268.42	Missouri	151.75	North Dakota	100
Massachusetts	256.08	South Dakota	123.62	West Virginia	100
4 KANSAS	$250.67	Colorado	117.12	Washington	100
Rhode Island	235.66	Wyoming	115.00	Rhode Island	100
Arizona	229.94	Oklahoma	108.00	Pennsylvania	100
Wisconsin	228.09	Kentucky	97.00	Alaska	100
Ohio	226.40	Louisiana	90.96	New Hampshire	100
Maryland	225.56	Alabama	90.00	New Jersey	100
Oklahoma	223.31	Mississippi	89.70	Oregon	100
Alaska	222.60	North Carolina	89.28	Delaware	100
Missouri	220.75	Texas	88.36	California	100
Utah	218.21	Nevada	83.90	Minnesota	94.4
Wyoming	215.00	Illinois	67.18	Utah	90
Alabama	215.00	South Carolina	66.02	Massachusetts	90
Indiana	214.67	Arizona	65.30	Michigan	90
Nevada	213.10	Idaho	63.40	Wisconsin	87.4
New Hampshire	210.62	Ohio	61.13	Maryland	85
California	198.26	Iowa	59.12	Indiana	82.9
Virginia	196.54	Montana	57.60	New York	82
Delaware	189.60	Virginia	57.00	Connecticut	81.2
West Virginia	187.95	Hawaii	56.03	Vermont	80
New York	186.86	Florida	55.64	Tennessee	80
Washington	183.56	Maine	52.82	Georgia	75.4
Maine	183.12	Connecticut	50.46	New Mexico	75
Louisiana	181.92	New Mexico	42.40	Ohio	73
Florida	178.44	Georgia	39.80	Arizona	71.6
South Dakota	177.04	Indiana	36.66	Maine	71.2
Texas	175.36	Maryland	33.83	Virginia	71
Colorado	174.12	New York	33.70	Florida	68.8
Iowa	172.66	Arkansas	33.20	Arkansas	67.8
Montana	172.60	Michigan	31.16	Montana	66.6
New Mexico	169.59	Vermont	30.11	Iowa	65.8
North Dakota	168.00	Tennessee	29.22	Nevada	60.6
Kentucky	166.79	Wisconsin	28.74	Hawaii	60
Georgia	161.85	Massachusetts	25.61	Alabama	58.1
Mississippi	161.70	Utah	21.82	Illinois	55.3
New Jersey	160.56	Minnesota	8.92	Idaho	52.3
Minnesota	159.00	California	0.00	Oklahoma	51.6
North Carolina	153.10	Delaware	0.00	South Carolina	50.5
Vermont	150.56	North Dakota	0.00	Louisiana	50
Illinois	150.16	New Jersey	0.00	Texas	49.6
Nebraska	147.68	Nebraska	0.00	Wyoming	46.5
Tennessee	146.11	West Virginia	0.00	Mississippi	44.5
Oregon	141.74	Oregon	0.00	Kentucky	41.8
Pennsylvania	140.81	Pennsylvania	0.00	North Carolina	41.7
Hawaii	140.08	Rhode Island	0.00	47 KANSAS	36.9 %
South Carolina	133.29	New Hampshire	0.00	Colorado	31.7
Idaho	132.92	Washington	0.00	Missouri	31.3
Arkansas	103.20	Alaska	0.00	South Dakota	30.2

*CONFEREES
SENATE WAYS AND MEANS COMMITTEE
March ~~15~~ 14, 1988 - 1:30 p.m.

Senator Jack Steinegar
State Capitol Building

Mr. Lynn Baker
Utah Public Employees' Health Program
540 East 200 South
Salt Lake City, Utah 84102

Mr. Tom Wands
Former Administrator, Boilermakers National Health and Welfare Fund
2230 N. 70th Terrace
Kansas City KS 66109

Dr. John P. Mackin
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Mr. Charles Dodson
Kansas Association of Public Employees

Dr. Charles Wheeler, M.D.,
former Mayor of Kansas City, Missouri

Ed Flentje, Secretary of Administration

ATTACHMENT #4
SWAM 3-14-88