Approved:
Date 2-5-03

MINUTES OF THE FINANCIAL INSTITUTIONS & INSURANCE.

The meeting was called to order by Chairperson Senator Ruth Teichman at 9:30 a.m. on January 29, 2003 in Room 234-N of the Capitol.

All members were present except:

Committee staff present: Ken Wilke, Office of the Revisor of Statutes
Dr. Bill Wolff, Kansas Legislative Research Department
Marlene Putnam, Committee Secretary

Conferees appearing before the committee: Sandy Praeger, Insurance Commissioner
Tom Tunnel, KS Grain & Feed
Larrie Ann Lower, Executive Director, KAHP
Brad Smoot, Legislative Counsel, BC-BS of KS

Others attending: See attached list

Senator Teichman introduced Sandy Praeger, Commissioner of Insurance.
She requested a bill for an act concerning insurance; relating to the use of credit information in personal lines. (See attachment 1)
Senator Brungard made a motion that the committee introduce the proposed legislation
Seconded by Senator Barnett.
Motion Carried.

Senator Teichman Introduced Tom Tunnel, Kansas Grain & Feed Association
He requested a bill for an act concerning accident and health insurance. (See attachment 2)

Larrie Ann Lower, executive Director, KAHP
She presented information on Health Care Costs (See attachment 3)

Brad Smoot, Legislative Counsel, BC-BS of KS presented information regarding current trends in health care costs. (See attachment 4).
Mr. Smoot gave a very informative presentation explaining why our health costs are increasing. Due to time restraints, no question period was initiated.

Meeting adjourned

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

GUEST LIST

DATE: 1-29-03

NAME	REPRESENTING
Glenn Bunten	KID
Commissioner Praeger	KID
Jarrod Forbes	KID
Jerry Wells	KID
TOM TUNNELL	KANSAS GRAIN & FEED ASSN.
R Williams	Ks Pharmacists Assoc.
GARY Robbins	Ks Optometric Assn
Chip Wheelen	Assn of Osteopathic Med
Rich Guthrie	Health Midwest
Phil Harness	KDHR-Workers Comp.
TERRY TRACY	KDHR - DWC
Brenda Kuder	SRS
Tanya Dorf	SRS
Bernie Koch	Wichita Area Chamber
Larrie Ann Lower	KAHP
Bob Alderson	KPSC
Bill Sneed	NIAA
Linda DeCoursey	Dept of Adm. Health Benefits
Christina Collins	KaMMCO
Julie Hein	Hein Law Firm
Barb Conant	Ks Trial Lawyers Assoc
Brad Burke	Issues Mgmt. / Anthem
Brad Smoot	BCBS

Proger proposed bill

Proposed Bill No._____

Section 1. Short Title

An Act concerning insurance; relating to the use of credit information in personal lines

Section 2. Definitions

For the purposes of this Act, these defined words have the following meaning:

A. Adverse Action—A denial or cancellation of, any change in the charge for anything other than the best possible rate an individual(s) would be eligible for prior to any specific credit information with regards to underwriting or rating is considered, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with the underwriting of personal insurance.

B. Affiliate—Any company that controls, is controlled by, or is under common control with another company.

C. Applicant—An individual who has applied to be covered by a personal insurance policy with an insurer, or prior to formal application has had an insurance score computed by the insurance company.

D. Consumer—An insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy.

E. Consumer Reporting Agency—Any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

F. Credit Information—Any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related shall not be considered "credit information," regardless of whether it is contained in a credit report or in an application.

G. Credit Report—Any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

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H. Insurance Score—A number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

I. Personal Insurance—any private passenger automobile, homeowners, motorcycle, mobile-homeowners and non-commercial dwelling fire insurance policies and boat, personal watercraft, snowmobile and recreational vehicle polices. Such policies must be individually underwritten for personal, family or household use.

Section 3. Use of Credit Information

An insurer authorized to do business in Kansas that uses credit information to underwrite or rate risks, shall not:

A. Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor.

B. Deny, cancel or nonrenew a policy of personal insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by Section 5(A).

C. Base an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information.

D. Take an adverse action against a consumer because he or she does not have a credit card account or has an inadequate credit history, without other justifiable rating and/or underwriting reasons independent of credit information.

E. Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

   1. Treat the consumer as if the applicant or insured had neutral credit information, as defined by the insurer.

   2. Exclude the use of credit information as a factor and use only other underwriting criteria.

F. Take an allowed adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score

calculated within 90 days from the date the policy is first written or notice of renewal is issued.

G. Use credit information unless not later than every 36 Months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Regardless of the requirements of this subsection:

1. At annual renewal, the insurer shall appropriately re-underwrite and re-rate the policy based upon a current credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a twelve-month period.

2. The insurer shall have the discretion to obtain current credit information upon any renewal before the 36 months, if consistent with its underwriting guidelines.

3. No insurer need obtain current credit information for an insured, despite the requirements of subsection (G)(1), if one of the following applies:

(a) The insured is in the most favorably-priced tier of the insurer, within a group of affiliated insurers. However, the insurer shall have the discretion to order such report, if consistent with its underwriting guidelines.

(b) Credit was not used for underwriting or rating such insured when the policy was initially written. However, the insurer shall have the discretion to use credit for underwriting or rating such insured upon renewal, if consistent with its underwriting guidelines.

(c) The insurer re-evaluates the insured beginning no later than 36 months after inception and thereafter based upon other underwriting or rating factors, excluding credit information.

H. Use the following as a negative factor against a consumer(s) in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

1. Credit inquiries not initiated by the consumer or inquiries requested by the consumer for his or her own credit information.

2. Inquiries relating to insurance coverage, if so identified on a consumer's credit report.

3. Collection accounts with a medical industry code, if so identified on the consumer's credit report.

4. Additional lender inquiries beyond the first related to the same loan purpose, if coded by the consumer reporting agency on the consumer's credit report as being from the given loan industry and made within 30 days of one another.

Section 4. Dispute Resolution and Error Correction

If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i(a)(5), that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall re-underwrite and re-rate the consumer within 30 days of receiving the notice. After re-underwriting or re-rating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

Section 5. Initial Notification

A. If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with such application. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance.

Section 6. Adverse Action Notification

If an insurer takes an adverse action based upon credit information, the insurer must meet the notice requirements of both (A) and (B) of this subsection. Such insurer shall:

A. Provide written notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, 15 USC 1681m(a).

B. Provide written notification to the consumer explaining the reason for the adverse action. The reasons must be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action. Such notification shall include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms such

as "poor credit history," "poor credit rating," or "poor insurance score" does not meet the explanation requirements of this subsection.

Section 7. Filing

A. Insurers that use credit-based insurance scores to underwrite and rate risks must file their scoring models (or other scoring processes) with the Department of Insurance. A third party may file scoring models on behalf of insurers. A filing that includes insurance scoring may include loss experience justifying the use of credit information. The filing of such information will be held confidentially and considered trade secret and not subject to the open records act.

Section 8. Education Authority

The Commissioner of Insurance may conduct research, hold public hearings, make inquiries and publish studies relating to the purposes of this act.

Section 9. Indemnification

An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of an agent who obtains or uses credit information and/or insurance scores for an insurer, provided the agent follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

Section 10. Sale of Policy Term Information by Consumer Reporting Agency

A. No consumer reporting agency shall provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. Such information includes, but is not limited to, the expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

B. The restrictions provided in subsection (A) of this section do not apply to data or lists the consumer reporting agency supplies to the insurance agent from whom information was received, the insurer on who's behalf such agent acted, or such insurer's affiliates or holding companies.

C. Nothing in this section shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

Section 11. Severability

If any section, paragraph, sentence, clause, phrase, or any part of this Act passed is declared invalid due to an interpretation of or a future change in the federal Fair Credit Reporting Act, the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected thereby but shall remain in full force and effect.

Section 12. Effective Date

This Act shall take effect upon publication in the statute book, applying to personal insurance policies either written to be effective or renewed on or after 9 months from the effective date of the bill.

SENATE BILL NO. (?)

tunnel

By Committee on Financial Institutions and Insurance

AN ACT concerning accident and health insurance; exceptions to jurisdiction of commissioner of insurance, amending K.S.A. 40-2222 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1, K.S.A. 40-2222 is hereby amended to read as follows: 40-2222. Any person or other entity which provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the commissioner of insurance unless the person or other entity:

(a) conclusively shows by submission of an appropriate certificate, license, letter or other document issued by the United State department of labor that such person or entity is not subject to Kansas law; or

(b) conclusively shows that it is subject to the jurisdiction of an agency of this state or the federal government. For purposes of this act, tax exempt status under section 501(c) of the federal internal revenue code of 1986 shall not be deemed to be jurisdiction of the federal government.

All trade association plans which provide coverage for the payment of expenses described herein to or for the members of the association or their dependents in this state are subject to the jurisdiction of the commissioner of insurance. A non-profit professional trade association under Section 501(c) of the federal internal revenue code, incorporated in Kansas, is permitted to provide coverage for the payment of expenses described herein to or for the members of the association or their dependents through a trust which complies with K.S.A. 40-2222a and amendments, thereto; under the following conditions:

(a) such trade association has maintained either a self-funded plan or fully insured plan of coverage for the payment of expenses described herein to or for the members of the association and/or their dependents for a period of 10 or more consecutive years, and which coverage is provided to at least 500 covered participants, provided:

i) state premium tax is paid by the plan at the same level as if such coverage was provided by an In-State (domestic) insurance carrier, and

ii) KID would have financial surveillance authority over such plans and require a reporting package as determined by KID to be provided at least once each year within a pre-determined time period for KID review.

(b) The final decision as to whether or not a trade association can offer and/or continue a self-funded health plan for its members is subject to the jurisdiction of the commissioner of insurance, as stated in writing each year.

Sec. 2. K.S.A. 40-2222 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

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In an effort to address past KID concerns, and to be more consistent and fair to all trade associations, we believe K.S.A. 40-2222 should be amended to allow a non-profit professional trade association under Section 501(c) of the federal internal revenue code, incorporated in Kansas, which has maintained either a self-funded plan or fully insured plan of coverage for the payment of expenses described herein to or for the members of the association and/or their dependents for a period of 10 or more consecutive years, and which coverage is provided to at least 500 covered participants, to establish and maintain a self-funded health plan for the benefit of its members, provided:

i) state premium tax is paid by the plan at the same level as if such coverage was provided by an In-State (domestic) insurance carrier, and

ii) KID would have financial surveillance authority over such plans and require a reporting package as determined by KID to be provided at least once each year within a pre-determined time period for KID review.

The final decision as to whether or not a trade association can offer and/or continue a self-funded health plan for its members is subject to the jurisdiction of the commissioner of insurance, as stated in writing each year.

Kansas Association of Health Plans

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Topeka, KS 66604

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Testimony before the
Senate Financial Institutions and Insurance Committee
Presentation on Health Care Costs
January 29, 2003

Madam Chairman and members of the Committee. Thank you for allowing me to appear before you today. I am Larrie Ann Lower, Executive Director of the Kansas Association of Health Plans (KAHP).

The KAHP is a nonprofit association dedicated to providing the public information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and other entities that are connected to managed care. KAHP members serve most all of the Kansans enrolled in a Kansas licensed HMO. KAHP members also serve the Kansans enrolled in HealthWave and medicaid managed care and also many of the Kansans enrolled in PPO's and self insured plans. We appreciate the opportunity to provide comment on the rising costs of health care.

As you are aware, health care premiums are rising. You hear this from both large and small group employers and their employees, the state health plan and their employees, other insureds and in your case probably from many constituents. I will attempt to explain the various reasons these premiums are increasing nationwide for the larger groups and then Brad Smoot will present more specific reasons and statistics generated by BCBS-Kansas on the issue of small group increases in Kansas.

Attached to my testimony is a report generated by PriceWaterhouseCoopers. The report is very informative and may also help you answer questions presented to you by constituents on this issue. I will try to highlight several of the key findings of the report.

According to the study, large employers are seeing an average of 13.7 percent increase in health care costs. Why is that? A number of reasons help explain this increase. As you may recall during the 1990's, health care costs rose at a slower rate than in the 80's. Health Plans and the managed care industry emerged as a dominant leader in health care during the 90's. These plans, most commonly known as Health Maintenance Organizations (HMO's), helped restrain the growth of health care costs. However, as one leader in the managed care world stated "we have come through a period of low health care inflation, during which everyone loved to hate us, but everyone wanted us to be there to be hated." Gellert, Jay; Lawrence, David M.D. Health Care at a Critical Juncture. *Healthplan*, vol. 43/No.3 May/June 2002. As doctors, patients and the general public became less satisfied with the role of managed care, the trend shifted away from the true HMO model to a more loosely managed health care system which then contributed to the increase in costs we started seeing in the last few years.

Please see page 3 of study.

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Drugs, Medical Devices and Other Medical Advances: The study estimates that medical advances including drugs, devices, treatments and testing constitute 3 percent of the 13.7 percent increase or 22 percent of the overall increase. ($15 billion of the $67 billion increase spent in 2001) Please keep in mind this number does not take into consideration the savings potential in years to come due to reduced hospitalizations and consumption of other health care services. On a positive note, health plans have helped keep some medical advances more affordable by using techniques such as multi-tiered formularies for prescription drugs. However, both the Senate and House versions of the Patients' Bill of Rights Legislation in the United States Congress include a provision that could place restrictions on health plans use of multi-tiered formularies. The passage of this restrictive legislation could cause prescription drug costs to rise even more in the future. This may cause employers to utilize higher co-pays and deductible or simply eliminate prescription drug coverage.

Rising Provider Expenses: In the past few years, major hospital systems have merged or purchased smaller hospitals which has increased their negotiating leverage. In some markets this increased negotiating leverage has resulted in higher hospital reimbursement rates. Hospitals are also facing increasing costs associated with nursing and other personnel and consumers are also asking their employers to offer insurance with a broader network of hospitals. To meet consumer demand health plans have widened their networks to include more hospitals, causing costs to increase. The study estimates that rising provider expenses constitute 2.5 percent of the 13.7 percent increase in health care spending.

General Inflation: General inflation is measured by the consumer price index in this study which has been increasing at an annual rate of 2.5 percent. This general inflation rate for medical services accounts for 2.5 percent of the 13.7 percent increase.

Government Mandates and Regulation: Healthcare for many reasons is a heavily regulated industry. In the recent years over 1500 mandated benefits have been enacted at the state and federal level, with many more being proposed. Two have already been introduced this session in Kansas. In addition, states also have enacted numerous process and provider mandates. These mandates, which require coverage for certain types of providers and require plans to have certain processes in place have contributed to the overall cost impact of mandates on premiums. Separately each mandate adds its own costs and collectively they have significantly increased health care costs. On the federal level some of you may recall legislation passed titled The Health Insurance Portability and Accountability Act (HIPAA). This act contains numerous requirements on health plans and providers to institute a variety of new data systems to insure privacy and standardize electronic transactions. The US government has estimated the cost of compliance with the privacy regulation alone to be $3.8 billion, while a private association within the industry has estimated the cost of compliance to be $43 billion. It should also be noted again, the two passed versions of the Patients' Bill of Rights Legislation include numerous process mandates. The study estimates that government mandates and regulations constitute 2.0 percent of the 13.7 percent increase in health care spending.

Increased Demand: As Americans age they use more medical resources. Baby boomers who used few health care services for two decades are now turning to physicians for prescriptions and hospitals and other providers with increasing regularity. Increasing demand is estimated to constitute 2.0 percent of the 13.7 percent increase in health care spending.

Litigation: A hot issue around the nation right now is litigation in the health care system. This litigation has lead to large jury awards, high malpractice premiums and defensive-but unnecessary medicine. We are seeing more and more class action lawsuits and the health care industry incurs high legal costs associated with defending even the most frivolous claims. Should a health plan liability provision be enacted, the result could be cost increases by as much as 8.6 percent nationally. (Barents Group) Litigation is estimated to constitute 1.0 percent of the 13.7 percent increase in health care spending.

Fraud and Abuse and Other Cost Drivers: A 1999 Health and Human Service office of the inspector general report stated that the annual amount of improper payments due to coding errors is $2-3 billion per year over the last four years and that is the cost of errors associated with only a small component in one federal program. Fraud, abuse and other cost drivers are estimated to constitute 0.7 percent of the 13.7 percent increase in health care spending.

Summary: The drivers and their portion of overall increase for years 2001-2002 are:

General Inflation	2.5%	$12 billion
Drugs, Medical Devices and Other Medical Advances	3.0%	$15 Billion
Rising Provider Expenses	2.5%	$12 billion
Government Mandates and Regulation	2.0%	$10 billion
Increased Demand	2.0%	$10 billion
Impact of Litigation	1.0%	$5 billion
Fraud and Abuse and Other Cost Drivers	0.7%	$3 billion
Total Increase	13.7%	$67 billion

Other than general inflation (about 2.5 percent) about half of the increase in health care costs are attributed to increased consumer demand, drugs, medical devices and other medical advances. The other half is a result of mostly litigation, mandates and rising provider expenses.

Also please remember the private health insurance market is moving away from a tightly managed care environment. What happens over the next few years will depend to some extent what happens to the ability to continue with some sort of managed care. See chart 3. With some managed care in place, premium spending is expected to increase from $537 billion 2002 to $767 billion in 2007, without managed care that increase is expected to be $833 billion.

Again thank you for allowing us to appear before you. I'll be happy to try to answer any questions you may have.

THE FACTORS FUELING RISING HEALTHCARE COSTS

By

PRICEWATERHOUSECOOPERS

April 2002

Prepared for the American Association of Health Plans

Washington, DC (202) 778-3200

3-4

I. Introduction

The following report is a unique attempt to examine rising healthcare costs in the context of the factors that are driving them higher. In the past, most research of rising costs has focused on where the dollar is being spent. This report instead examines why the dollar is being spent. We believe this approach allows the industry to take a deeper look at the issue of rising healthcare costs, and it may give policymakers a better roadmap to use in their efforts to make healthcare more affordable.

Beyond general inflation, other forces are driving recent healthcare cost increases. Our study finds that increased consumer demand, drugs, medical devices, and other medical advances are behind nearly half of the increase. The other half is driven largely by litigation, mandates, and rising provider expenses. For some of the drivers, such as drugs and medical advances, current spending may be offset by future savings in eliminating or reducing other medical services.

A Historical Overview of Rising Costs

For much of the 1990s, healthcare costs rose at a slower rate than had been the case during the previous decade. Health plans were a contributing factor in restraining the growth of healthcare costs. Following a period in the late eighties and early 1990s, in which rising healthcare costs were seemingly out of control, the managed care industry emerged as a dominant leader in the healthcare system.

That costs were held in check during this period is all the more remarkable given the unprecedented strength of the economy. The combination of rapidly growing incomes and labor shortages should have acted as an upward pressure on healthcare prices, due to increased demand and ability to pay. Instead, premium increases fell during the early- to mid-1990s and were at a record low during the period of 1994-1998. In 2000, the share of GDP devoted to healthcare was 13.2 percent (up from 8.8 percent in 1980) and, based on official government forecasts, that share will continue to rise and reach 16 percent of GDP during the next five years.[i]

Consumers pay the greatest price, but rising healthcare costs have an impact on other sectors as well. Employers are increasingly facing difficult choices, as they are forced to pass costs along to their employees, reduce salaries, or reduce benefits. These higher costs constitute a significant upward pressure on other goods and services, and government programs such as Medicare and Medicaid see their funding crises grow worse.

In the following study, we seek to define the extent of the rising cost problem, and attempt to gauge how serious it is likely to become in future years. In this effort, we identify and isolate the specific drivers of rising costs, and we explore each cost driver in depth, looking at the various ways they respectively contribute to the overall cost.

Methodology

For this report, PricewaterhouseCoopers (PwC) has calculated the size of the overall increase between 2001 and 2002 at 13.7 percent. We believe this number represents the average increase in health insurance premiums for large employers. In this report, we will segment the drivers that make up that 13.7 percent.[ii]

While administrative costs are included in health insurance premiums, the lion's share of the increase stems from benefit costs exclusive of administrative expenses. We recognize that benefit costs in this context are not the same as medical costs. As measured by the federal government, overall medical costs are growing at a lower rate of increase. The premiums charged to employers must be a forecast of medical costs for the year ahead, as well as a consideration of costs already incurred. Health insurance actuaries must work backwards when they price future premiums, taking into account past claims experience and factoring in medical cost trends.

II. Major Cost Drivers

Our determination of what trends are driving healthcare premium cost increases is described below. To arrive at the following percentages, we reviewed the literature, published and unpublished, including journal articles and internal memos from health plan actuaries. Internally, we discussed cost trends and their sources with PwC benefit consultants who advise employers and health plans. Externally, we discussed these issues with actuaries and benefit specialists in health plans and company benefits departments.

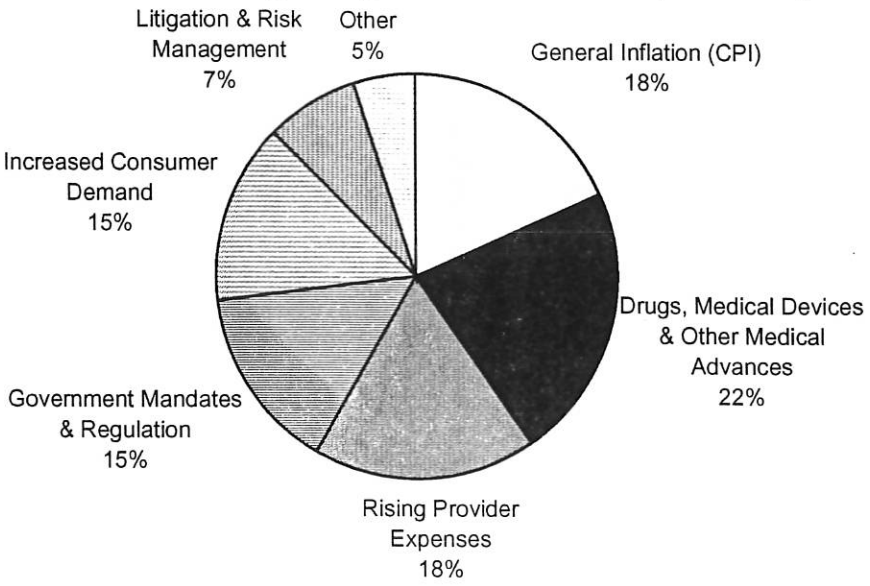
What follows is our best estimate of the various drivers and their contribution to the 13.7 percent trend growth. The relative absolute contribution is shown in Table 1 and the relative shares are shown in Charts 1 and 2.

Table 1
The Factors Driving Rising Costs in Healthcare Premiums (2001-2002)

Trend Factors	Percentage Points	Percent of Total Increase
Medical Trend	**13.7%**	**100%**
General Inflation (CPI)	**2.5%**	**18%**
Drugs, Medical Devices and Medical Advances*	**3.0%**	**22%**
Prescription drugs		
Other advances in diagnostics and treatment		
Rising Provider Expenses	**2.5%**	**18%**
Hospitals (consolidated, in particular) negotiating higher payments		
Government Mandates and Regulation	**2.0%**	**15%**
Over 1,500 existing mandates at state and federal level		
New mandated benefits		
Elimination of cost-control tools or limiting flexibility to use them		
Regulatory requirements (red tape, duplication of federal and state requirements)		
Increased Consumer Demand	**2.0%**	**15%**
Aging population		
"Front page" treatments (i.e., media coverage drives demand for expensive treatment)		
Increased preventive and diagnostic activity		
Consumers moving away from less expensive managed care products		
Litigation and Risk Management	**1.0%**	**7%**
Class action lawsuits		
Outsized awards and legal costs		
Defensive medicine		
Malpractice premiums		
Reinsurance/risk management		
Other Categories	**0.7%**	**5%**
Fraud and Abuse		
Miscellaneous		

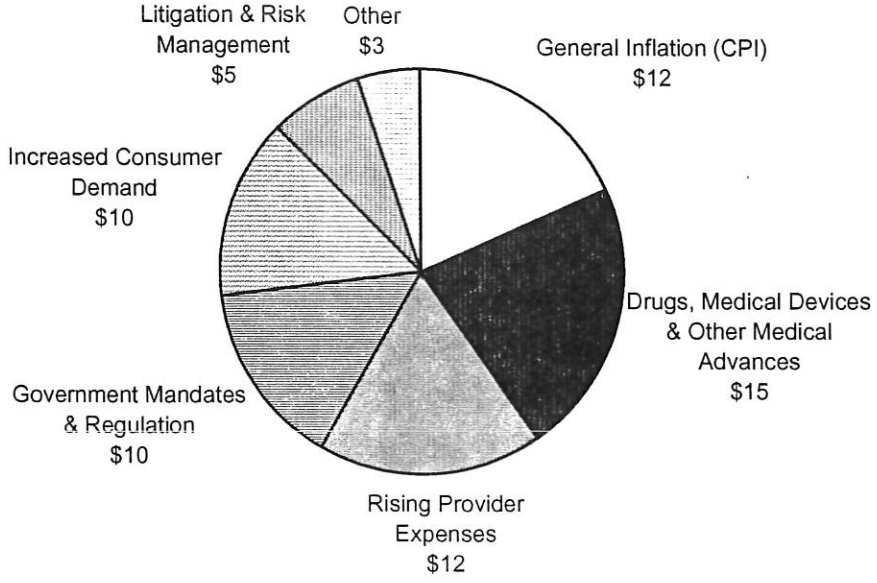
Source: PricewaterhouseCoopers analysis, April 2002.
* This percentage does not reflect potential future savings from drugs, medical devices and other medical advances. For example, savings in future years may include reduced hospitalizations and consumption of other healthcare services.

Chart 1
The Factors Driving Rising Costs in Healthcare (2001-2002)



Source: PricewaterhouseCoopers, April 2002.

Chart 2
The Factors Driving Rising Costs in Healthcare (2001-2002, in $ billions)



Source: PricewaterhouseCoopers, April 2002.

Drugs, Medical Devices and Other Medical Advances

We estimate that medical advances, which includes drugs, devices, treatments, and testing, contributed 3 percent to healthcare costs between 2001 and 2002, or 22 percent of the overall increase as shown in Chart 1. However, this increase does not reflect savings in future years from these advances today. Future-year savings likely include reduced hospitalizations and consumption of other healthcare services.

Medical advances often have inflationary effects. For example, one of the fastest growing areas among hospitals and outpatient centers is radiology. The number of imaging procedures is growing at 8 percent to 9 percent a year, and much of the increase is in more expensive modalities, such as MRI and PET. In addition, some clinicians are combining PET and CT for even more precise diagnoses at ever-higher expense.

It may be that health plans played a positive role in keeping certain medical advances more affordable: for example, spending increases for prescription drugs tempered slightly in 2001 as health plans and employers increasingly moved towards multi-tiered prescription drug formularies. Future forecasts indicate that multi-tiered formularies and other drug benefit management techniques could hold this contribution steady at 3 percent.

However, new laws could result in additional increases in prescription drug costs in the future. Both the Senate-passed and House-passed patients' bill of rights legislation include a provision that could place restrictions on plans' use of multi-tiered formularies –a tool that many plans utilize to limit the out-of-pocket costs of prescription drugs to consumers. If provisions restricting the use of multi-tiered formularies were signed into law, prescription drug costs could rise even more in the future. Some of these increases may be tempered by higher co-pays and deductibles adopted by employers.

Drugs, medical devices, and other medical advances are a significant factor in healthcare premium increases. PwC estimates that this factor added 3 percent to the trend for 2002, or about 22 percent of the overall increase. This represents $15 billion of the increase in health premiums.

Rising Provider Expenses

Rising provider expenses were a factor that precipitated the current trend of rising healthcare costs. PwC estimates that this factor added 2.5 percent to the trend for 2002, or about 18 percent of the overall increase. This represents $12 billion of the increase in health premiums.

Hospital Systems Successfully Negotiating Higher Rates

Record consolidation took place among hospitals during the mid- to late-1990s. As a result, fewer hospital systems dominate many major metropolitan areas. In the past few years, mergers and rising admission levels have shifted negotiating leverage to major hospital systems, which in some markets has resulted in higher hospital rates. In

addition, hospitals' costs, particularly nursing and other personnel costs, have increased faster than revenues. Finally, after under-investing in their physical plants during the mid- to late-1990s, hospitals are once again addressing their physical infrastructures. This has prompted hospitals to ask for larger price increases from payers. As hospitals' negotiating leverage increased, consumers asked their employers to offer insurance products with broader networks of hospitals. To make their products more appealing to consumers, health plans have widened their networks to include more hospitals. However, when plans try to include all providers, costs inevitably increase.

During the height of managed care, providers were willing to share risk with health plans. However, that trend has largely reversed itself. In numerous cases, providers lost money or went bankrupt because they inappropriately allocated the cost of the risk they assumed. Now, most hospitals are refusing risk contracts, instead opting for per-diems or variations of fee-for-service. This shifts most, if not all, of the risk back to health plans or self-insured employers, requiring them to price premiums with the understanding that they're accepting higher levels of risk.

General Inflation

Prices of almost everything inch up over time. The most commonly accepted measure is known as the consumer price index (CPI)—which has been increasing at an annual rate of about 2.5 percent in recent years and accounts for about 18 percent of the overall increase in healthcare costs. Because of this, the measure of spending, the U.S. dollar, becomes worth less each year. Spending on healthcare is expected to increase this much "just to keep up with inflation." Alternatively, we say that healthcare premium costs rose by 11.2 percent in "real" terms (2.5 percent CPI subtracted from 13.7 percent premium increase).

Government Mandates and Regulation

Healthcare is heavily regulated in almost every aspect. Two areas, in particular, appear to be increasing the scope of government regulation and the costs associated with it. First, the spread of state and federal mandates has continued without abatement for the past three decades. Mandates increased 25-fold over the period, 1970-1996, an average annual growth rate of more than 15 percent.[iii] Second, regulations in the healthcare system have increased significantly, and they often duplicate or conflict with rules and regulations at the state level. The Health Insurance Portability and Accountability Act (HIPAA) alone will add billions of dollars in new compliance costs to the healthcare system.

1,500 Mandated Benefits Drive Consumer Costs Higher

Over 1,500 mandated benefits exist at the state and federal level, with many more on the horizon. Each mandate adds its own cost, and collectively they have significantly increased healthcare costs. For instance, research has shown that mandated chemical dependency treatment coverage increased costs by 9 percent in those states that adopted

this type of mandate.[iv] Mandated benefits for routine dental services increased costs by 15 percent. These estimates suggest that mandates have a huge overall impact on healthcare costs. Similarly, a few years ago, the General Accounting Office reported that mandates accounted for up to 22 percent of Maryland's healthcare costs.[v]

In addition to mandated benefit requirements, states have also enacted numerous process and provider mandates. These mandates, which require coverage for specific types of providers and require plans to have specified processes in place, have contributed to the overall cost impact of mandates on health insurance premiums.

New Mandates on the Horizon?
Additionally, both the Senate-passed and House-passed patients' bill of rights legislation include numerous process mandates that would apply simultaneously to state requirements in some instances. Research indicates that this could increase healthcare costs, although studies conflict on whether the increase will be minor or major. One expert's analysis tallied over 700 legal requirements that health plans would be required to follow if a patients' bill of rights were enacted.[vi]

Duplicative and Confusing Regulations Add Billions In Compliance Costs
The second major growth area for government regulation is the Health Insurance Portability and Accountability Act, which requires health plans and providers to institute a variety of new data systems to insure privacy and standardize electronic transactions. The estimated cost of compliance with the HIPAA privacy regulation alone ranges from $3.8 billion (U.S. Department of Health and Human Services) to $43 billion (BlueCross/BlueShield Association).

The contribution of mandates and government regulation is estimated to be about 2 percent, or 15 percent of the overall increase, representing $10 billion of the overall increase in health premiums.

Increased Demand

As Americans age into their 40s, 50s and beyond, they consume more medical resources. The biggest surge of Baby Boomers is currently between the ages of 55 and 59. This group will grow 24 percent between 2001 and 2005 and 41 percent between 2001 and 2010, according to the Census Bureau. On average, a U.S. male's healthcare spending doubles in the 45 to 54 age group, as compared to the 35 to 44 age group. Upon entering the 55 to 64 age group, his spending rises another 50 percent. Baby boomers who used few healthcare services for two decades are turning to physicians, hospitals, and other providers with increasing regularity.

At the same time, consumers are demanding more than ever before from the healthcare system. The Baby Boomers who have driven almost every major trend of the last five decades are very interested in getting the very best medical care no matter how high the costs. Increased advertising for certain brand-name drugs has driven consumers' demand for them. This could impact other areas. Increases in drug spending could pull physician

spending higher as more patients need to see their physicians to access drugs that they see heavily marketed.

Demand for new technologies impacts overall spending as consumers demand that previously uncovered services be paid for by their health insurance. This type of demand leads to government mandates, primarily within the states. One burgeoning area that could increase spending today and could spur demand in the near future is a healthy, asymptomatic individual paying out-of-pocket for whole-body imaging and virtual colonoscopies. Less than 100 whole-body imaging centers are now operating, but that is estimated to soar in the next few years as consumers worry about their chances of cancer and heart attack.

PwC estimates that increased demand is a very powerful force and will continue to be so for the next decade. We estimate that increased demand is adding about 2 percent annually to healthcare costs, or about 15 percent of the overall trend, representing $10 billion of the increased health premiums.

Impact of Litigation

Litigation in the healthcare system has grown dramatically over the past 20 years, resulting in large awards, skyrocketing malpractice insurance premiums, and defensive–but unnecessary–medicine. Meanwhile, a new round of class action lawsuits have targeted major players in the healthcare industry for high-dollar awards, and the legal costs associated with defending even the most frivolous claims have spiraled out of control.

Legal Awards

Damages awarded in malpractice suits are skyrocketing. For example, the median malpractice award increased 43 percent in 2000 to $1 million, according to Jury Verdict Research. A few claims even ran as high as $40 million. Awards are only part of the picture, since the majority of cases never result in a judgment, but cost millions of dollars to defend.

Malpractice Insurance Premiums

In December 2001, St. Paul Companies, one of the nation's largest physician insurers, decided to quit its medical malpractice business nation-wide. As a result, some physicians, medical schools, and hospitals have seen their malpractice premiums increase from 20 percent to 100 percent. Such premiums already run more than $100,000 annually for some specialists, eclipsing what they spend on rent and utilities. The crisis has grown so acute that some states face a severe shortage of key specialties, such as obstetrician-gynecologists, who have been literally unable to afford the price of practicing medicine.

Defensive Medicine

The threat of litigation is a significant driver in the unnecessary use of treatments and medicine, which not only add to the cost of healthcare, but may actually dilute its quality.

Doctors have been outspoken about how the fear of litigation not only causes them to order tests and treatments that are not needed, but also inhibits efforts to report and track incidents relating to medical safety.

Class Action Lawsuits
Over the last few years, health plans have been faced with a growing number of lawsuits brought by physicians and individuals under ERISA, RICO, and state law. Some of these cases include the massive class actions, such as those consolidated in Miami, Florida, which claim to represent all physicians and all health plan subscribers in the United States.

Employer-Based Healthcare
Recent health plan lawsuits have involved claims relating to coverage denials, as well as claims–such as those relating to payment–that traditionally were resolved through negotiations between the parties. Lawsuits against health plans also have involved claims that relate to activities that occur as a matter of course in the managed care business. These claims, if successful, could undermine the very basis of managed care. In many of these cases, numerous parties, including the plan, its administrators and providers, have been named defendants. As with medical malpractice cases, many lack merit, yet resources must still be expended to defend the cases regardless of outcome.

PricewaterhouseCoopers estimates that the cost of litigation and malpractice adds about 1 percent to the cost of healthcare premiums. This makes up 7 percent of the overall increase, representing $5 billion of increased premium costs.

Our forecast is that without significant tort reform this could increase even more in the next few years as consumers become more aware of medical errors and patient safety issues. In addition, as new diagnostic testing, particularly in the area of genetics, becomes more prevalent, the standard of care for early diagnosis of disease will change.

Patients' Bill of Rights
If a federal patients' bill of rights passes that significantly expands health plan liability, healthcare costs could increase even more in the future. As discussed earlier, studies conflict on whether the increase will be minor or major. In an analysis prepared for AAHP, the Barents Group estimated that an expansion of health plan liability similar to that included in the pending patients' bill of rights legislation would result in cost increases of as much as 8.6 percent nationally.[vii] Similarly, according to a fiscal note submitted by the Minnesota Department of Employee Relations, health plan liability requirements would increase premiums by 5 percent.[viii]

Fraud and Abuse and Other Cost Drivers

Large-scale fraud and abuse investigations were launched against nearly every segment of the healthcare industry during the last decade. The absolute level of fraud and abuse may be a significant share of healthcare costs. For example, a 1999 HHS Office of the Inspector General report stated that the annual amount of improper payments due to

coding errors is $2 to $3 billion per year over the last four years. If this level of costs for only a small component in one federal program is typical, the overall impact of fraud and abuse must be large on private health spending as well.

III. Key Findings and Conclusions

In this paper, PricewaterhouseCoopers has quantified the drivers behind the 2002 increase in healthcare premiums. The drivers and their portion of the overall increase are:

- Drugs, medical devices and other medical advances (22 percent)
- Rising provider expenses (18 percent)
- General inflation (18 percent)
- Increased demand (15 percent)
- Government mandates and regulation (15 percent)
- Impact of litigation (7 percent)
- Fraud and abuse and other cost drivers (5 percent)

This report by PricewaterhouseCoopers is unique in that we have attempted to attribute increases in healthcare costs to specific "drivers" that have been defined in new ways. These drivers are the gasoline that fuels new spending on doctors, hospitals, drug companies, and other medical supplies and services. Further, some sectors contend that drivers, such as drugs and medical advances, will reduce future healthcare spending, such as reducing hospital admissions.

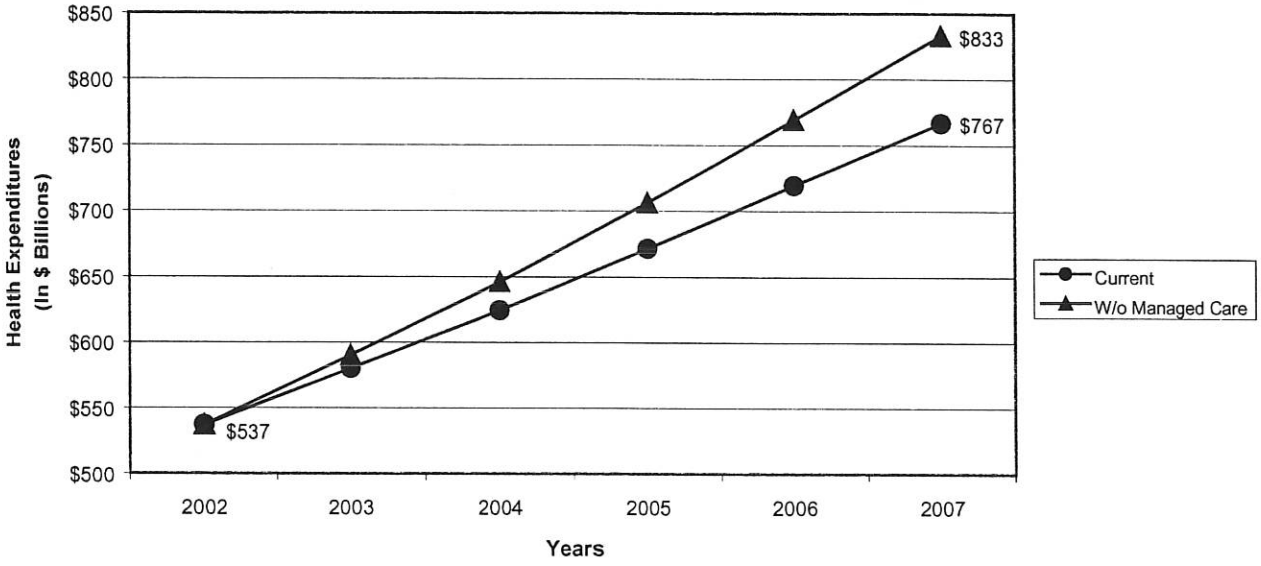
To what degree the major cost drivers in 2002 will influence future cost increases depends on the response to those drivers by payers, providers, patients, and policy makers. However, we believe it is useful to mention that the private health insurance market is moving away from tightly managed health benefit products, and that this, in itself, could inflate premiums with a return to more indemnity-style products.

As discussed previously, the slowdown in rate increases that took place in the early- to mid-1990s is widely thought to have been influenced by the spread of managed care. Likewise, what happens over the next five years will depend to some extent on developments in managed care. For example, Chart 3 below shows that, according to official US government statistics, total spending by private health insurance is expected to increase from $537 billion in 2002 to $767 billion in 2007, an annual growth rate of 7.4 percent.

To show how managed care might affect this growth rate, we adjusted the official forecasts to reflect the rapid disappearance of all but conventional plans between 2002 and 2007. The adjustment was based on data from the Kaiser Family Foundation/HRET Employer Health Benefits 2001 Annual Survey which shows that conventional plans have premiums that are 8.6 percent higher, on average, compared with other plans (HMOs, PPOs, and POSs). Although the data from Kaiser Family Foundation are not adjusted to reflect benefit design and demographics between types of plans, Chart 3 does

illustrate the principle that shifts from lower cost plans to higher cost conventional coverage would increase the trend significantly. Chart 3 shows that without managed care private health insurance is expected to increase from $537 billion in 2002 to $833 billion in 2007, an annual growth rate of 9.2 percent. The difference in spending is $182 billion over the five-year period, or about $1,600 per policyholder over the same five-year period.[ix]

Chart 3
Next Five Years With and Without Managed Care



Source: PricewaterhouseCoopers, April 2002.

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[i] The share could be even higher if the current recession is the beginning of a period of relatively stagnant economic growth. That forecast also assumes that the Congress does not pass any major new programs that reduce the effectiveness of managed care or increase administrative costs to plans and providers.

[ii] This number is based on interviews with PricewaterhouseCoopers consultants as well as discussion with health insurance industry actuaries and a review of reports in the media. Because of the methods used, this estimate is probably more indicative of the increases for large, private-sector employers but the same general forces probably apply to the employees in small firms, public organizations, and to individuals who purchase insurance. If anything, the estimate would be higher for small firms and individual purchasers. It is higher than national averages for cost increases because it reflects private health insurance figures only and does not include data on government programs, which would result in a lower average cost increase. Additionally, it should be noted that government statistics on private health insurance costs suggest that premiums rose about 9 percent in 2000 and are likely to rise about 10 percent in 2001.

[iii] Gail A. Jensen and Michael Morrisey, "Employer-Sponsored Health Insurance and Mandated Benefit Laws," The Milbank Quarterly, Vol. 77, No. 4, 1999.

[iv] Ibid.

[v] GAO, Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance, August 1996.

[vi] William G. Schiffbauer, Beyond the Sound Bite: Implementing the Patients' Bill of Rights, BNA, February 27, 2002.

[vii] Barents Group, Impacts of Four Legislative Provisions on Managed Care Consumers, 1999-2003, April 22, 1998.

[viii] MN Department of Employee Relations, "Revised Fiscal Note for S.B. 953," April 1999.

[ix] This calculation is computed by dividing the estimated $182 billion in savings by the average number of policyholders between 2002 and 2007. The number of policyholders is estimated to be an average of 113 million during that period. Policyholders are usually families, but they also may be single workers or individuals who have purchased a health plan.

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Statement of Brad Smoot
Legislative Counsel
Blue Cross and Blue Shield of Kansas
Senate Financial Institutions & Insurance Committee
January 29, 2003

Madam Chair and Members,

Blue Cross and Blue Shield of Kansas is a mutual insurance company serving more than 700,000 Kansans in 103 counties. We are again pleased to be invited to share our information and thoughts with you regarding current trends in health care costs. We began this practice in 2001 and other committees have since asked for our input as well. From appropriations to education, legislative committees have a keen and growing interest in health care issues.

In the past, Kansas lawmakers have considered a variety of health insurance issues, including benefit and provider mandates; additional administrative responsibilities for health insurance carriers (privacy, prompt pay, prescription drug cards); new types of insurance mechanisms; the uninsured; and admitting municipalities into the state employees health program. Some of these issues may return and you will undoubtedly also have interest in the growth of Medicaid, corrections and state employees health care budgets. These government programs, while not part of the private insurance market, certainly reflect many of the cost trends in health care.

Two years ago, we estimated health care expenses were 14% of the U.S. gross domestic product (GDP) and estimated growth by 2008 to 16.2% and 25% of GDP by 2030. The latest predictions are only slightly higher (14.1% today and 17% in six years). A recent Wall Street Journal article (citing a Mercer report) observed that the rise in health care costs was greater than expected (about 15% or 7 times the rate of ordinary inflation) and the largest increase since 1990. Already a huge part of the economy, such dramatic increases continue to strain the ability of employers, families and taxpayers to fund services and insurance coverage.

The problem is universal. It affects all states, the group and non-group insurance markets, state and local governments, employers (insured and self-insured), Medicare and Medicaid and those without coverage. Even with recent allotments, cutbacks in services and reduction of provider reimbursements, Kansas is on track to fund a Medicaid budget which has grown from $544 million in 1999 to $919 million in FY 2003 and expected to be more than $1 billion in FY 2004. Workers Compensation coverage, a mandatory employee benefit under Kansas law, now pays more (approximately $214 million in 2001) for hospital and medical costs than it does for lost wages or functional disabilities (58% to 42%). Ultimately, neither government nor employers will shoulder all these increases. Instead, an ever growing share of the cost of care and coverage will be borne

by workers and their families. Last year, for example, the state employees health care plan increased co-pays and deductibles, shifting cost to employees, as a way to stay within the state budget. The legislature may be forced this year to make more tough decisions regarding health insurance for 90,000 state employees, retirees and their families. These options may include an even greater employee share of premium, a likely trend for private employers as well.

Where is all this money going? It is going to provide health care services, for which we Americans seem to have a nearly insatiable need. From allergy medicine to infant heart surgery, it all costs money. Note a few examples of our average costs:

$ 118,789	–	heart surgery for infant
$ 226,106	–	liver transplant surgery
$ 86,723	–	major brain trauma with surgery
$ 73,669	–	heart bypass surgery
$ 6,130	–	allowed charge per hospital admission
$ 1,539	–	allowed charge per hospital room per day
$ 392	–	allowed emergency room services per visit
$ 59	–	per prescription

Normal delivery of a child is one of the most common procedures we experience, with an average cost for hospital and medical care of $4,636.

With only a modest growth in overall inflation and a relative stagnant population in our 103 county service area, provider charges to BCBSKS have doubled in five years from $940 million to $1.86 billion. Like most insurers, BCBSKS works hard to control costs by contracting with doctors and hospitals and limiting the amount we pay for services. We negotiated provider "write offs" in excess of $470 million in 2001, 6.5 times the total cost of our administrative expense. Such cost containment efforts, however, often put real strain on physicians and hospitals who must deal with inflationary trends in medical malpractice insurance, indigent care costs, under reimbursement of government programs, nursing shortages, expensive technologies and other ordinary business expenses.

The total cost of care is a combination of charge increases and increases in use of services, and utilization of services is exploding. To illustrate: BCBSKS paid for 201,000 more physician office visits in 2001 than in 2000. With an average cost of $200 per visit (including lab, radiology, etc.) this is an additional annual cost of $40 million. While BCBSKS granted an allowable charge increase to hospitals of 3.5% in 2001, the actual payout increase from the previous year was 20.6% or $57.7 million. The same is true for physicians and professional health care providers. We gave an aggregate rate increase of 3.2% in 2001, yet, payouts to providers were much larger: Radiology (19.5%); Diagnostic imaging (25.3%); Clinical lab (29.2%); Family and General Practice (26.6%); Anesthesiology (19.9%); Chiropractors (22.7%) and Speech, physical and

occupational therapists (26.9%). In short, more Kansans were receiving more services at a much higher total cost, even though the cost per service increased only slightly.

In the aggregate, BCBSKS paid out $862,352,000 for health care services in 2001 and $939,385,000 million in 2002. For a broad view of where our premium dollar is going, see the attached pie chart. Another way to look at this is to consider how much is paid out per covered person per month. The attached chart tracks the increases in allowed charges per member per month since 1997 through 2002. As you can see, hospital and medical claims, which represent the allowed charges, will have increased 51% over this period while pharmacy claims nearly doubled. Combined, claims are expected to be up 63% over this six year period.

There is no single cause for the increases in health care costs and the corresponding insurance premium costs. And while these cost-driving forces are not readily subject to state government control, several are worthy of mention:

Our aging population. Americans are getting older. Kansas' average age increased six years from 1960 to 1990, from 26.9 to 32.9 years. Life expectancy in general has increased seven years from 1960 to 1998, from 69.7 to 76.7. KU's Policy Research Institute projects that the number of Kansans over age 65 will increase by 200,000 in thirty years. With the aches and pains of old age come the increased costs of treating chronic conditions. So while quality and longevity of life have improved, these improvements are, and will remain, very expensive.

Lifestyle choices. It is a fact: It is less expensive to insure a group of 100 who exercise regularly, eat healthy, don't smoke and limit alcohol consumption than to insure a similar group which does not practice good health habits. The Healthy Kansans 2000 initiative estimates that overweight adults in Kansas increased from 26% of the population in 1992 to 32% in 1998. A Boston researcher estimates that Americans could save $24 billion annually if those who don't exercise merely added 30 minutes of moderate exercise to their daily routines.

Prescription drugs. In 2000, Kansas ranked ninth in the per capita use of prescription drugs reporting an average of 10.62 scripts per year. BCBSKS processes millions of claims, paying out more than $96 million per year. New pharmaceuticals extend life and improve life quality. With the new genetic research underway, our reliance on medications for treatment of illnesses, both mental and physical, will only increase. Add to this the increase in direct to consumer advertising, patient awareness, patent issues and the explosion in generic drug costs, and the upward push in pharmacy costs is likely to continue.

Government regulation. New federal privacy legislation, patient protections, health plan liability exposure, administrative simplification requirements and mandated coverages will add billions to the costs of health insurance. While many features of these

laws are desirable, the costs are phenomenal. BCBSKS has already spent $15 million to comply with HIPAA. Nationally, carriers and providers will spend billions over the next few years. Obviously, these costs will be passed on to consumers in the form of higher provider charges and insurer administrative costs.

Cost-shifting and the uninsured. An estimated 43 million Americans lack health insurance. In Kansas, a recent comprehensive survey suggests 10.5% of the under 65 population is uninsured. Yet, the uninsured do receive health care, the costs of which are absorbed by doctors and hospitals and passed along as higher costs to those who can pay the bills. Kansas hospital experts estimate the mark-ups to be 20 to 25%.

Many of you have taken a special interest in the issue of the uninsured and are working to stimulate greater insurance coverage. We commend you for the effort. And to give you an idea of the magnitude of the problem, we have made some rough calculations on what it might cost to insure Kansas' uninsureds. At a premium of $292 per member per month (similar to the state employees health care plan), it would take $858 million dollars annually to cover the estimated 244,880 Kansans who lack coverage today.

While lack of insurance is a huge problem, under-reimbursements by government programs also cause costs to be shifted to the private sector. Medicare and Medicaid generally pay much less for services than private insurers or private pay patients. Attached, please find a graph prepared by the Minnesota Hospital Association showing how under reimbursement by government programs and the uninsured transfer costs to the private insurance market, which includes state and local government health programs.

Expansion of services. When hospitals and clinics compete for patients, they often feel compelled to acquire new and expensive facilities, equipment and the staff to operate them. Unfortunately, this competition does not translate into cheaper care, but more care and more expense. "Hospital spending was the key driver of overall cost growth, accounting for more than half of the total increases." Stunk, B.C., Ginsburg, P.B., and Gabel, J.R., Tracking Health Care Costs: Growth Accelerates Again in 2001, *Health Affairs*, January 24, 2003. The costs associated with excess capacity (the number of hospital beds in Kansas is 45% higher than the national average) and inefficiencies, even for services that enhance diagnostic accuracy, are passed along to patients and insurers.

Use of new medical technologies. Like new and life sustaining drugs, non-medicinal devices and procedures have revolutionized health care delivery. Disease state management will reduce hospitalizations and emergency room visits but it requires up front costs for physician visits, monitoring, drugs, etc. An insulin pump may save a diabetic's life or improve life quality. It costs $7,500. A portable implantable defibrillator, like the Vice President's, costs $10,000. And the biggest cost driver of all may be the technological advances in the area of disease diagnosis. CAT (computed

axial tomography), MRI (magnetic resonance imaging), PET (positron emission tomography) and other devices are widely available and are rapidly becoming standards of care or demanded by patients. See attached map showing location of this equipment in Kansas. Generally, our allowed charge for CAT scans is $600; for MRI's $700 and PET imaging is $2000. In Kansas, we may have too much technology at our finger tips. The national average for MRI's is 7.6 per million population. By this standard Kansas should have 19. We have 47, nearly the same as Michigan (48) which has four times the population.

Undoubtedly, there are other causes of health care cost inflation, including federal tax policy, the restraint and decline of managed care or the lack of personal financial responsibility in a third party payment system. However, the above highlighted factors are the ones we see most clearly from our claims data. As you can easily surmise, none of these issues lend themselves to quick, obvious or local solutions.

Finally, although our presentation is mostly about health care costs, lawmakers and constituents are interested in insurance and premium trends also. While much of insurance remains a mystery to me, even after ten years of exposure, there are some fundamental features that deserve your attention. First, unlike life insurance, which has only simple administrative features, accident and health insurance is very complicated, imposing a wide range of responsibilities on carriers. Consider these basic functions: Assumption of risk (including risk projections); marketing to groups and individuals; contracting with providers; coordination of benefits; cost containment; maintaining and investing reserves; claims payment; premium collection; managed care; record keeping; reporting; and privacy functions. Despite increased claims and government requirements, administrative expenses, taxes, subsidies and other costs remain a very small part of the picture (only about 10.5%). If we at BCBSKS were to perform all the above-mentioned insurance functions for free, health care costs and the insurance premiums they require would continue to rise.

Second, like any other business, insurance companies must balance their books. This is especially true for highly regulated entities like insurance companies. Inadequate reserves means claims don't get paid or, upon insolvency, others pick up the slack. Allow me to illustrate this point. In calendar year 2000, BCBSKS brought in nearly $850 million in premium and investment income. It paid out over $844 million in claims, expenses and taxes. Following a claims increase of more than $132 million and an investment decline of nearly $61 million, BCBSKS reported a loss of more than $12 million for 2001. While we have reserves for this situation, over time premiums and investments must equal or exceed claims and expenses. Premium increases during 2002 returned BCBSKS to the black although not quite recapturing all the losses from 2001.

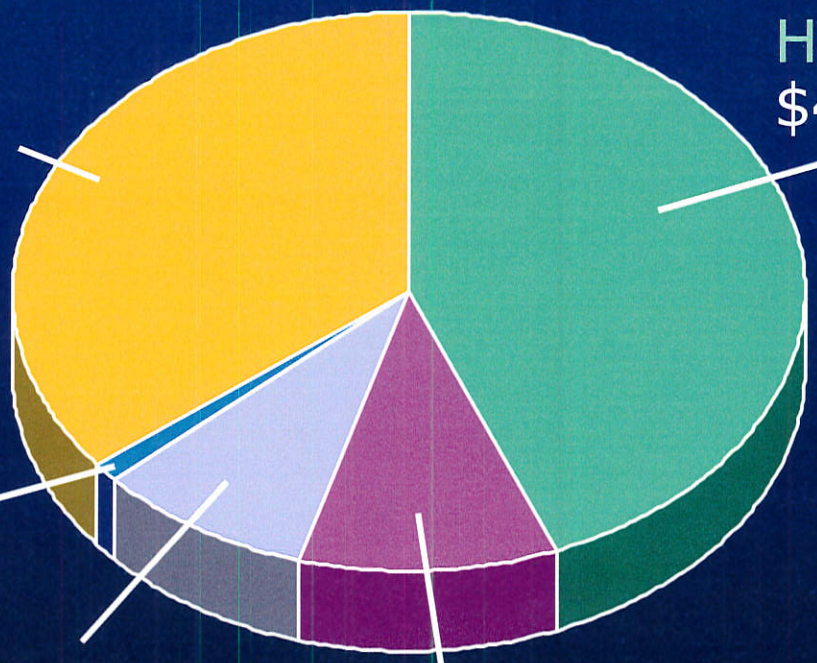
Third, insurance is, at least in part, the business of pooling and sorting risk. At BCBSKS, and under Kansas law, our health insurance customers are separated into four basic categories: Non group, small group, large group and Med Supp. Each group is

rated separately and, within each group, rates may be different depending on distinguishing characteristics of the policy holder which determine greater or lesser risk. Consequently, when rates change due to increased claims costs, premium increases may be larger in one risk category than another and different from one customer to the next. In addition, rate increases reflect, at least to some degree, the accuracy with which a carrier predicted the risk of claims for a given category or customer. In other words, if we guessed too low on a given category one year, rate increases will need to be higher the next year in order to accurately reflect the future risk within that category of business. If we guessed too high one year, the following year adjustments may reflect reductions or lesser increases. Market conditions including competition also contribute to insurance pricing. It is not a business for the faint-hearted or those without resources to manage the ups and downs of the market.

In summary, the economic strains of health care are now fully evident in Kansas. Some health insurers are no longer in business. All but two of the municipal multi-employer pools have failed. The non-group market is even more fragile. Five insurers have withdrawn from the Kansas market and two others have suspended marketing. Businesses, local governments and individuals are groaning under the weight of double digit inflation. And we at BCBSKS are growing more and more concerned about the ability of Kansans to continue to afford health insurance. In 1975, BCBSKS had 910,000 insureds. We now have about 700,000. In October 2002 alone, we lost 200 contracts and 2000 lives, indicating that families are taking the employer-paid individual coverage and dropping dependent family coverage. While there are those who believe the health insurance market will "soften" and premium increases moderate after 2004, health care cost trends will continue to burden family finances, employer benefit programs and government budgets. As you consider various proposals affecting health care and insurance, we hope you will find the above information helpful.

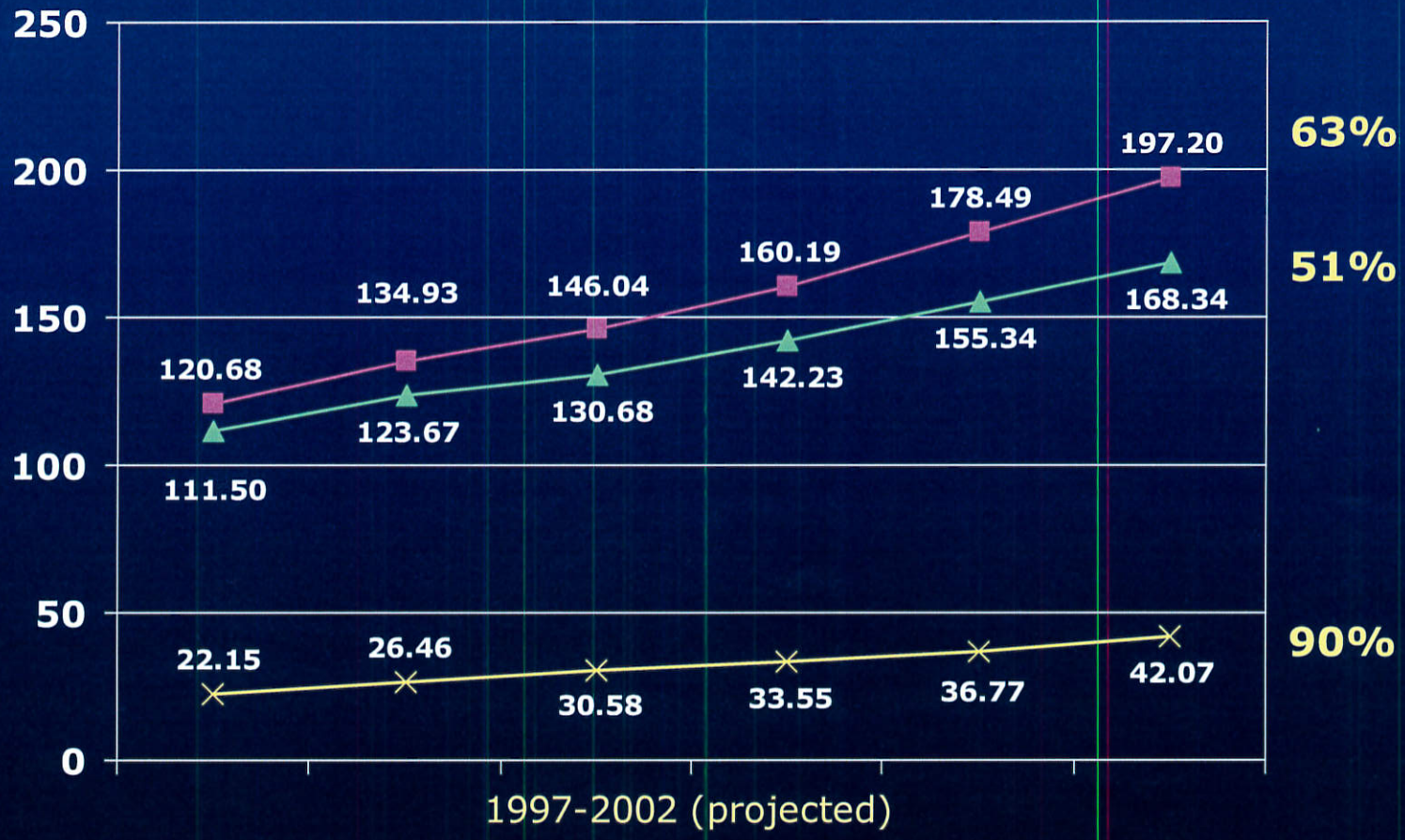
Thank you for inviting our comments.

How are BCBSKS Health Insurance Premiums Spent?

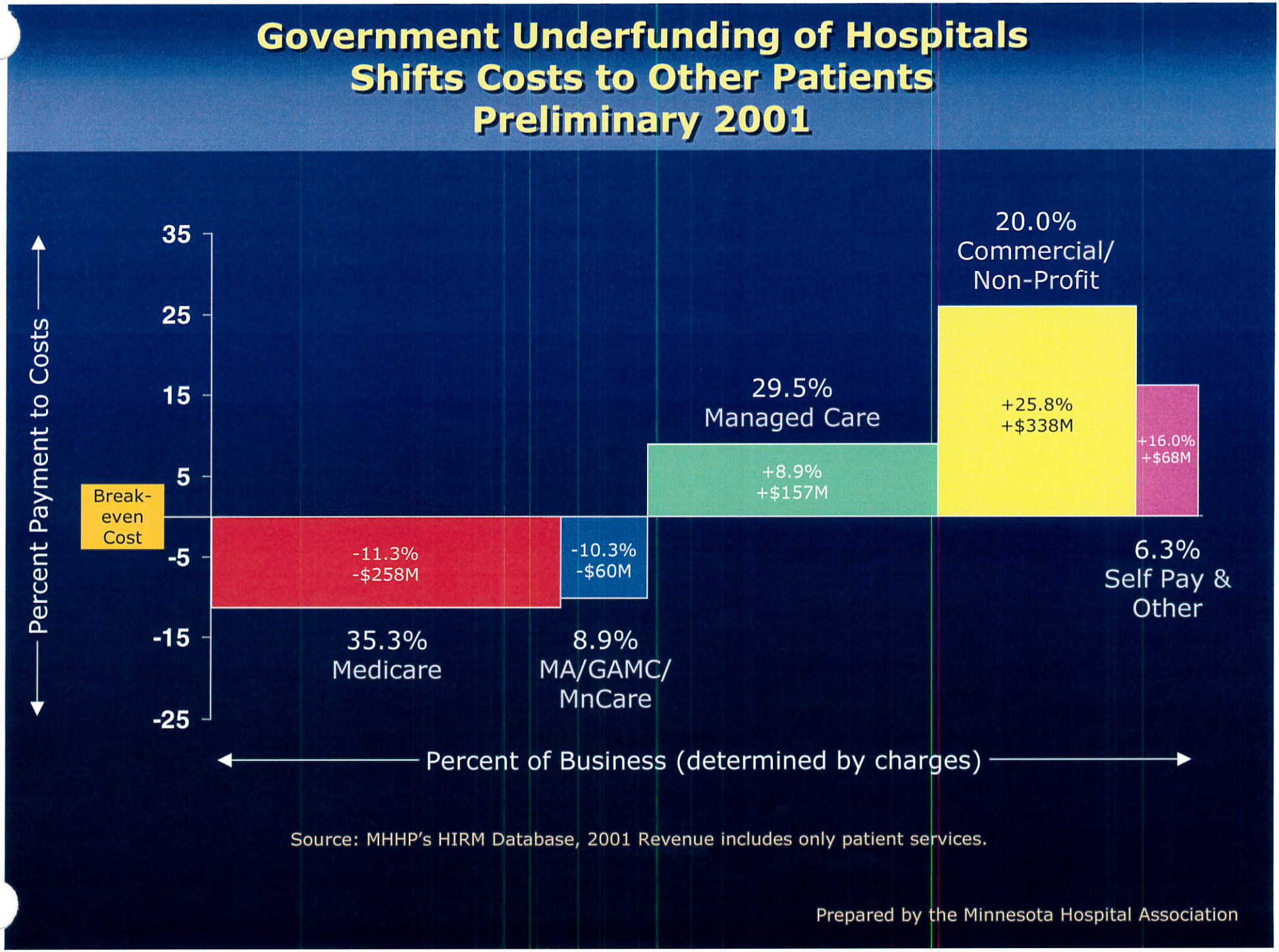


** Figures reflect health care dollar only. The chart does not include monies for dental benefits or ancillary products.*

Blue Cross and Blue Shield of Kansas, Inc.
Allowed Charge Per Member Per Month (under 65)

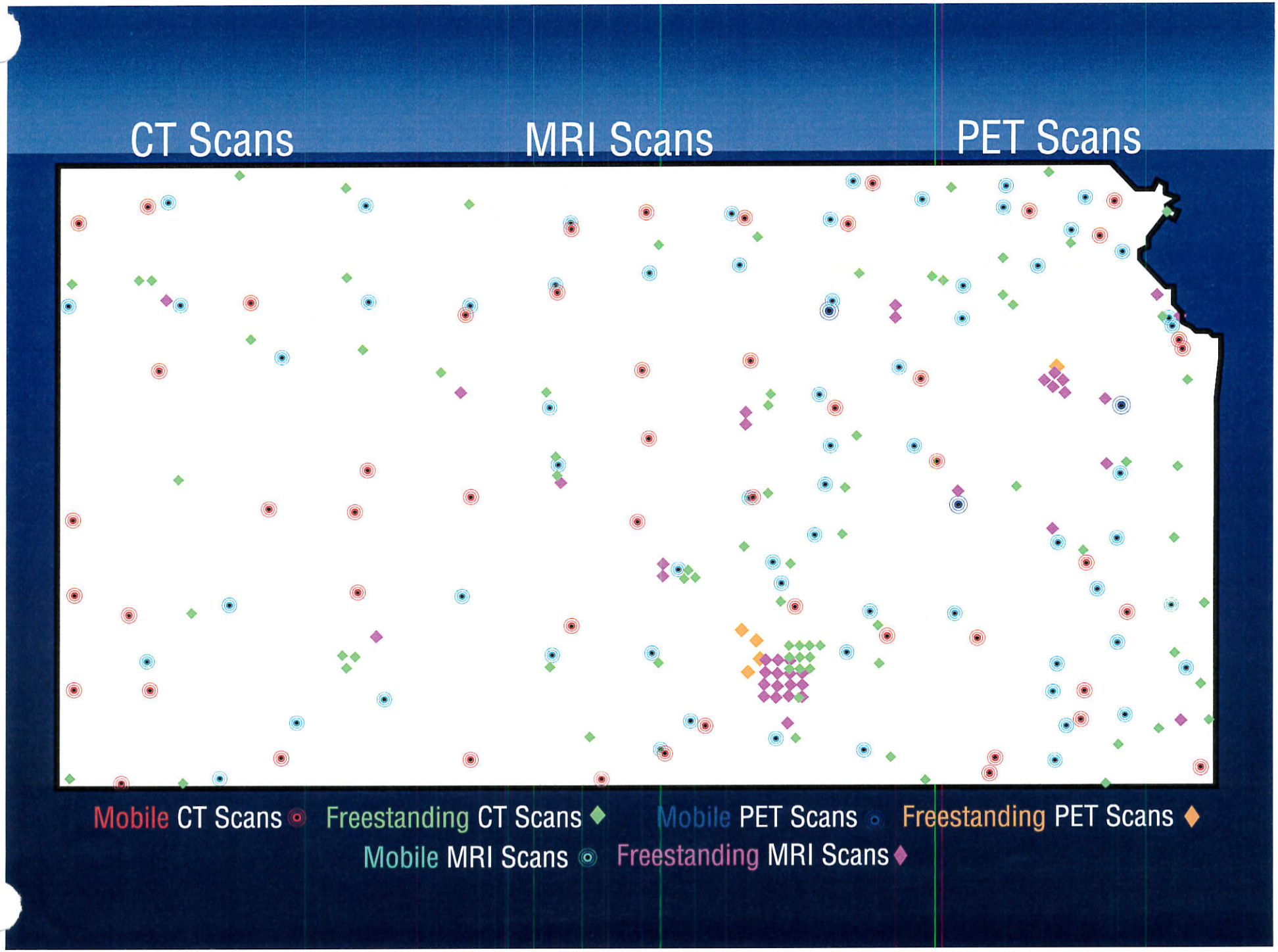


Government Underfunding of Hospitals Shifts Costs to Other Patients Preliminary 2001



Source: MHHP's HIRM Database, 2001 Revenue includes only patient services.

Prepared by the Minnesota Hospital Association


CT Scans
MRI Scans
PET Scans
Mobile CT Scans
Freestanding CT Scans
Mobile PET Scans
Freestanding PET Scans
Mobile MRI Scans
Freestanding MRI Scans

Blue Cross and Blue Shield of Kansas, Inc.
Statement of Operations
for the year ended December 2002, 2001 and 2000