Approved:
Date 2-24-03

MINUTES OF THE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE

The meeting was called to order by Chairperson Senator Ruth Teichman at 9:30 a.m. on February 13, 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: Eric Rosenberg, Government Relations Liaison
Brad Smoot, Legislative Counsel, American Ins. Assoc.

Others attending: See attached list

Senator Teichman introduced Eric Rosenberg, Government Relations Liaison (See attachment 1)
Mr. Rosenberg testified in opposition to certain provisions of **SB 144**. He is with Trans Union, one of the leading providers of consumer credit reporting services in Kansas. The concerns with this bill are (1) The definition of credit information sets an adverse precedent for the State of Kansas as it contradicts existing federal law. (2) The restriction of specific model criteria such as medical and inquiry information will result in lower predictive performance of all models. (3) Smaller companies, both insurers and financial institutions, will suffer a disproportionate impact of the decreased predictive performance. Larger institutions with their own customized scoring models will better be able to react. (4) The sought after fairness are not based on any analysis of the many models actual performance, and is likely to produce other unfair consequences on other groups. (5) Singling our consumer reporting agencies so that they cannot sell data based upon credit inquiries in a consumer report.
In conclusion, this imbalance and contradiction with existing federal standards can be corrected by adding a provision from the legal benchmark, Missouri law, which states:

> The provisions of this subsection shall not preclude the exchange of information permitted by the federal Fair Credit Reporting Act, 15 U.S.C. Section 1681, et seq., the Gramm-Leach-Bliley Act 15 U.S.C. Sections 6809 and other applicable federal law.

Brad Smoot, American Insurance Assoc. (See attachment 2 and 2a)
AIA Supports **SB 144** with the technical amendments that the insurance department is going to offer. There are several issues that deserve your attention.
(1) We should want insurers to use the most effective and accurate rating techniques they can find.
(2) Millions of insurance customers are currently benefitting from use of their credit information. It is faulty to assume that credit information only hurts. In fact, credit information helps hundreds of thousands of Kansans. At least half have average or better credit-based insurance scores. Those people are getting better rates than they might otherwise.
(3) We are concerned with proposals to ban the use of credit-based scoring on renewals. This does not accomplish the intended goal.
(4) We are concerned with substituting the word "primarily" in place of the word "solely". Of the eight states that have acted on this issue, only two have opted for the term "primarily." Regulation of credit-based scoring is new and for those carriers operating on a national scene, a uniform and straight forward law is greatly preferred.
(5) Credit information on commercial lines has not been included.
AIA believes that credit-based insurance scoring should be regulated by the states and that model language should be used whenever possible to improve efficiency and compliance.

Meeting Adjourned.

Additional Attachments: # 5 - Ernest Kutzley, AARP; #6 & #7 - Chris Wilson, Kansas Building Industry Association.

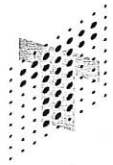
SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST
DATE: 2/13/03

NAME	REPRESENTING
BILL YANEK	Ks Assn of REALTORS
Barb Conant	KTCA
Michael D. Davis	KFB
JOHN SHEOSTAK	KFB
Frank Van Fleet	KFB
Mary Jo Vanfleet	KFB
Tim HOLVERSON	Kansas City Regional Association of Realtors.
Jennifer Schwartz	ASSISTIVE TECHNOLOGY FOR KANSANS
Barb Conklin	KS Assistive Technology Cooperative
Amber Kjellin	Sen. Brungardt
Ann Murphy	TG
Lisa Stewart	TG
Ron Gaches	CDIA
CHRIS STEROHAM	INTERN
Chuck Stones	KBA
Kevin Davis	Am Family Ins
Lee Wright	Farmers Ins.
James C Johnson	Intern Sen. Corbin
LARRY MAGILL	KAIA

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST

DATE: ______________________________

NAME	REPRESENTING
Bill Henry	KCUA
Lynne Ann Rower	Alliance of Am. Insurers
Brad Smoot	AIA
Jenn Bunten	KID
Jerry [illegible]	KID



TransUnion

Eric Rosenberg
Government Relations Liaison

Law Department
555 West Adams Street
Chicago, Illinois 60661
Tel (312) 466-6323
Fax (312) 466-7986

February 13, 2003

Re: Opposition to Kansas Senate Bill 144, which seeks to restrict the use of credit in insurance underwriting and rating

TransUnion Background

TransUnion, with 3600 employees worldwide and 17 employees in our Overland Park and Wichita, Kansas offices, is one of the leading providers of consumer credit reporting services in Kansas and throughout the nation. TransUnion maintains consumer credit information and provides this information to banks, credit card companies, lenders, insurance companies, or others when consumers apply for credit or when creditworthiness needs to be established. We do not determine whether consumers will be granted credit or at what interest rate; we merely provide the information necessary to enable credit or insurance decisions.

Basis of Opposition

Section 3 (h) defines credit information as "any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Credit information shall not include any information which is not credit-related, regardless of whether such information is contained in a credit report or in an application or is used to calculate an insurance score."

We oppose the inclusion of this definition because it sets a precedent for the state of Kansas that contradicts existing federal law. The federal Fair Credit Reporting Act (FCRA), 15 U.S.C. § 1681 et seq., which was first enacted in 1970 and modernized in 1997, is a national legal standard for regulation of the consumer reporting industry. The FCRA is a sweeping, effective, and comprehensive law used as a model at the state level. There is neither a "credit information" definition in the FCRA, nor is there one in any state credit reporting law. There is no need for a definition of credit information because the bill proposes to regulate "credit reports" or "insurance scores." The FCRA frequently refers to information from a consumer report without defining that term.

Section 4 (h)(3) would prevent an insurer from considering "information that has been identified by the consumer reporting agency as related to medical accounts with a medical code."

We oppose this provision because it unnecessarily contradicts current law. As the federal keystone for credit based transactions, the FCRA already prohibits creditors, employers, or insurers to receive a consumer report that contains medical information without the express consent of that consumer. § 604 (g), 15 U.S.C. § 1681b, of the FCRA states that "a consumer reporting agency shall not furnish…in connection with a credit or insurance transaction, a consumer report that contains medical information about a consumer, unless the consumer consents to the furnishing of the report." Thus, consumers already have the right to opt-out of the sharing of medical information. The FCRA recognizes that there are circumstances that may lead to unfulfilled medical account obligations and provides remedy to a consumer whose consumer report contains this information. The FCRA provides for consumers to include a 100-word statement on their consumer reports explaining their unpaid medical account information.

Sections 4 (h) (1,2,4) would prevent the use of inquiry information in insurance scoring models.

Senate F I & I Committee
Meeting Date: 2-13-03
Attachment No.: 1

We oppose this provision, as inquiry information is actuarially sound data. The predictive performance of the model will suffer with each of these adjustments, and the execution of the various models may vary greatly as hard-to-define restrictions will not be interpreted uniformly by different developers or regulators. Even with eroded performance, the predictive power that such models derive from our database of consumer credit information is great, and will most likely continue to out-perform other criteria such as driving history drawn from state records.

Section 10 would "prohibit a consumer reporting agency from providing or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about an individual's credit information or a request for a consumer report or an insurance credit score…" although "Nothing in this subsection shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report."

We oppose this section because it is anti-competitive; it is designed to restrict one insurer from enticing a consumer of a competitor. This provision would allow other consumer reporting agencies as defined by the FCRA (such as those furnishing an accident history report or claims history report), to include "expiration date" information in lists they provide.

This provision would have the unintended effect of creating a virtual monopoly for one marketing list provider, ChoicePoint, to sell data or lists based upon its Vehicle Owner Verification (MVR) and Claims History (CLUE) Reports. Notwithstanding the anti-competitive nature of the section, consumer reporting agencies strictly adhere to the requirements of data sharing established in the FCRA and the Gramm-Leach-Bliley Act. This section also potentially interferes with data collection by consumer reporting agencies under the FCRA. This imbalance and contradiction with existing federal standards can be corrected by adding a provision from the legal benchmark, Missouri law, which states:

> The provisions of this subsection shall not preclude the exchange of information permitted by the federal Fair Credit Reporting Act, 15 U.S.C. Section 1681, et seq., the Gramm-Leach-Bliley Act, 15 U.S.C. Sections 6801 to 6809 and other applicable federal law.

1-2

BRAD SMOOT
ATTORNEY AT LAW

800 SW JACKSON, SUITE 808
TOPEKA, KANSAS 66612
(785) 233-0016
(785) 234-3687 (fax)

10200 STATE LINE ROAD
SUITE 230
LEAWOOD, KANSAS 66206
(913) 649-6836

Statement of Brad Smoot
Legislative Counsel
The American Insurance Association
Senate Financial Institutions & Insurance Committee
Regarding 2003 Senate Bill 144
February 13, 2003

Madam Chair and Members:

The American Insurance Association is a trade group of 413 property & casualty insurers who provide auto, home, workers compensation and general liability coverage for thousands of Kansans and their business. We appreciate this opportunity to comment on SB 144, a bill regulating the use of credit-based insurance scoring.

We thank the Kansas Legislature for establishing the Task Force on Credit Scoring to study this issue in depth. It is a new topic for most lawmakers and consumers and deserves the time and attention that the Task Force was able to provide. After several days of meetings, hours of expert testimony and review of written information, the Task Force agreed on several basic concepts which the Kansas Insurance Department has attempted to incorporate in SB 144. With one or two exceptions, AIA agrees with the Task Force conclusions and recommendations and therefore, we support SB 144 with the technical amendments to be offered by the Kansas Insurance Department.

Attached to our statement are two documents. The first is a Consumer Alert from the National Association of Insurance Commissioners explaining insurance scoring, how it's used and what credit factors may affect an insurance score. The one page Alert also recommends that consumers know their credit history, take charge of their credit history and get more information about how their credit information is being used. The second attachment is one of our publications that describes credit-based insurance scoring, including how to find out about your credit history and how to improve it. Both are short and easy to read.

Before my appointment to the Credit Scoring Task Force, I knew nothing about the issue. But, I did attend all the meetings and reviewed much of the material provided by the experts and the Insurance Department. And, like many of you, I was skeptical about the use of credit information in the underwriting and pricing of insurance. Part of my reaction was due in part to concern about credit information being available for any purpose. But, the fact is personal credit history is readily available for a variety of purposes from purchasing phone service to credit applications and now insurance. It's collection and distribution are highly regulated by federal law. As consumers, we had better get to know our credit history and take responsibility for ensuring that our credit record is as good as possible and maintained accurately.

Once over that hurdle, I too, wondered why my credit history would be a predictor of future insurance losses. As I thought about it and visited with people, I realized that careful and responsible behavior is a trait of risk adverse individuals, whether they are managing their money and credit or driving their cars or maintaining their homes. The expert testimony we heard in Task Force meetings and the studies establishing the statistical correlation reaffirmed that notion. For years, insurers have rated risks based on similar statistical correlations that to some may not seem "intuitive" either. Why should smokers have higher auto insurance rates and women have lower rates than men? We're just used to these factors and, in time, we can get used to credit history as an underwriting and rating tool.

There are several issues that deserve your attention. First, and foremost, we should want insurers to use the most effective and accurate rating techniques they can find. As consumers, we deserve to be rated on our risk of loss. We want that assessment to be as objective as possible and not based on our ethnicity, address, marital status, income or other discriminatory factors. We want our insurers to give us the best deal we can get. We want carriers to compete for our business. Use of credit information in insurance underwriting and rating is one of the most cost-effective and objective tools available. AIA believes use of credit information in rating personal lines of insurance increases competition and benefits consumers.

Second, lost in the discussion so far are those millions of insurance customers who are currently benefiting from use of their credit information. It is faulty logic to assume that credit information only hurts. In fact, credit information helps hundreds of thousands of Kansans. At least half have average or better credit-based insurance scores. Those people are getting better rates than they might otherwise. Many insurance consumers with less than great driving records can get coverage or better rates because of their better than average credit-based insurance score. Those whose rates may go up because of poor credit history will complain. Those who get preferred rates because of their good credit record will not call to thank anyone. But, we must not forget those who benefit just because they are not vocal. If you were to ban or substantially restrict the use of credit-based insurance scoring, you most certainly would here from large numbers of these consumers.

Third, we are concerned with proposals to ban the use of credit-based scoring on renewals. It seems to us that if the goal is to rate the risk of loss as accurately as possible, arbitrarily ignoring the risk just because a customer has been with one company for six months or six years does not accomplish the intended goal. The true risk of those established customers is not being evaluated and the renewing customer gets an unfair advantage over the new customer. A similar problem arises with the agents' proposed amendment to allow consumers to request review of their credit-based score annually and get a lower rate if indicated but not a higher one if that is indicated. This may generate a lot of business for the credit bureaus (who wouldn't request a review every year under

those circumstances?) but it would quickly distort the pool of risk, shifting the burden to those who did not request a review or did not qualify for a lower rate. We agree with proponents of this amendment that "things are not always fair." We think, however, that we should strive for fairness when ever possible.

Fourth, we are very concerned with the proposal to substitute the word "primarily" in place of the word "solely," where the provisions of the bill limiting the use of credit in insurance scoring. See Section 4(b) and (c). The national agents association negotiated with several national insurance trade groups during the drafting of the NCOIL model. All parties involved with the NCOIL model agreed on the use of the word "solely." Of the eight states that have acted on this issue, only two have opted for the term "primarily," and in those states our carriers are reporting great difficulty in applying that standard. Regulation of credit-based scoring is new and for those carriers operating on a national scene, a uniform and straight forward law is greatly preferred.

Fifth, the Task Force received information only on personal lines of insurance (auto and home). But for anecdotal information on the use of credit-based scoring in farm policies, it did not receive any evidence that the state needs to regulate the use of credit information in commercial lines. Moreover, no state has chosen to do so. We think this is an area where the Insurance Department can gather more information on this subject and come forth with a proposal if a problem in the farming sector is identified.

In summary, use of credit information is widespread in the insurance business and elsewhere. When used in conjunction with other recognized rating factors it can be a valuable tool for underwriting and rating a person's risk of loss or claim. Because it relies on a strict formula that evaluates empirically derived data, subjectivity is minimized, allowing for a more objective and impartial underwriting and pricing decision. Credit-based insurance scoring allows consumers to pay premiums more in line with their own risk. Millions of Americans are benefiting from its use and will be harmed if it is removed or overly restricted. The Task Force recommendations are based on volumes of information, reflect a good balance of competing interests and should generally be given great weight. SB 144 reflects that balanced approach while creating several valuable consumer protections. AIA believes that credit-based insurance scoring should be regulated by the states and that model language should be used whenever possible to improve efficiency and compliance.

Thank you for this opportunity to comment.

NAIC

Consumer Alert from the NAIC

Credit Scoring: How Does it Affect You?

If you are shopping for auto or homeowners insurance, or if your current policy is up for renewal, your insurance company may be looking at your credit history. Here are some tips from the National Association of Insurance Commissioners (NAIC) to help you understand how your credit information may be used and how it may affect your insurance premiums.

1. What is Credit Scoring?

A credit score is a snapshot of your credit at one point in time. The credit information from your credit report is put through a mathematical formula (credit scoring model) that assigns weights to the various factors and summarizes your credit information into a three-digit number ranging from zero to 999. Generally, the higher the number, the more financially responsible the consumer.

2. How is Credit Scoring Used?

If your insurance company relies on credit scoring, they may use it in two ways:

- Underwriting — Deciding whether to issue you a new policy or to renew your existing policy.
- Rating — Deciding what price to charge you for your insurance by placing you into a specific rating "tier" or level.

Some insurers use credit information along with other more traditional rating factors, such as motor vehicle records and claims history. Other insurers may use credit alone to determine your rate.

3. What Affects a Credit Score?

There are several factors that determine credit scores. Each factor is assigned a weighted number that, when applied to your specific credit information and added together, equals your final three-digit score. Following is a list of common factors:

- *Major negative items* — Bankruptcy, collections, foreclosures, liens, charge-offs, etc.
- *Past payment history* — Number and frequency of late payments.
- *Length of credit history* — Amount of time you've been in the credit system.
- *Homeownership* — Whether you own or rent.
- *Inquiries for credit* — Number of times you've recently applied for new accounts, including mortgage loans, utility accounts, credit card accounts, etc.
- *Number of open credit lines* — Number of major credit cards, department store credit cards, etc., that you've actually opened.
- *Type of credit in use* — Major credit cards, store credit cards, finance company loans, etc.
- *Outstanding debt* — How much you owe compared to how much credit is available to you.

4. Know Your Credit History

There is a good chance your current or prospective insurance company is looking at your credit. Therefore it is a good idea to review your credit history to make sure it's accurate. Request a copy of your credit history from Equifax www.credit.equifax.com, Experian www.experian.com or Trans Union www.transunion.com. You can also contact the Federal Trade Commission for consumer brochures on credit at www.ftc.gov.

The Fair Credit Reporting Act requires an insurance company to tell you if they have taken an "adverse action" against you, in whole or in part, because of your credit report information. If your company tells you that you have been adversely affected, they must also tell you the name of the national credit bureau that supplied the information so that you can get a free copy of your credit report and correct any errors.

5. Take Charge of Your Credit History

If your insurance company is using your credit score to evaluate your rates, you can take steps to improve your premiums.

- Get a copy of your credit report and correct any errors. Notify your insurance agent and company of any errors.
- Improve your credit history if you've had past credit problems. If your credit score is causing you to pay higher premiums, ask your insurer if they will re-evaluate you when your credit improves.

6. Get More Information

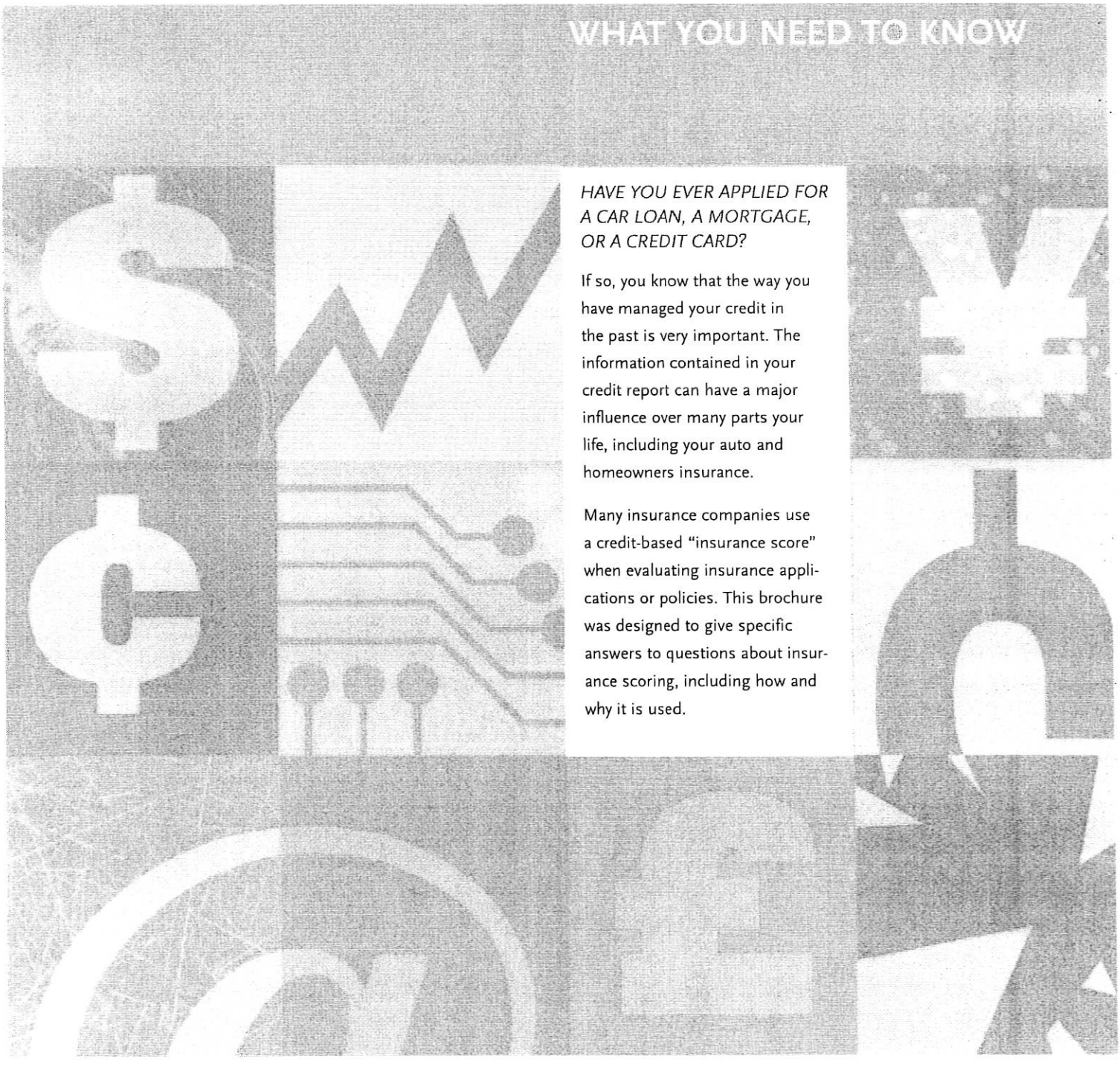
Insurance rates based on credit information can vary from company to company, so if you feel your premiums are too high, shop around. Some states have regulations in place for how — and if — insurance companies may use credit scores. If you have questions about credit scoring in your state, contact your state insurance department. You can link to your insurance department's Web site by visiting *www.naic.org*. Click on "State Insurance Regulators — Web Sites," then click on your state.

The National Association of Insurance Commissioners is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia and four U.S. territories. The overriding objectives of state regulators are to protect consumers and help maintain the financial stability of the insurance industry. If you would like to be removed from the "Consumer Alert" media list, please contact Michele Compton at (816) 783-8003 or mcompton@naic.org.

American Insurance Association

CREDIT-BASED INSURANCE SCORES

WHAT YOU NEED TO KNOW



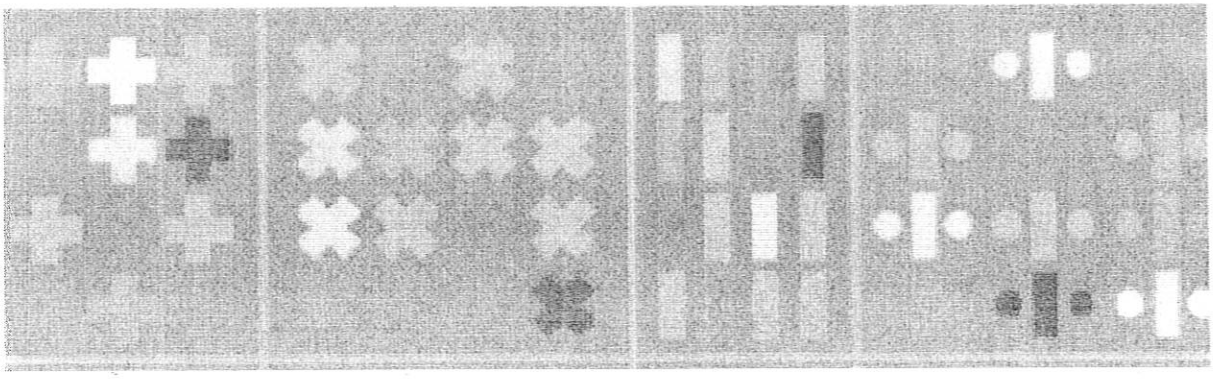
HAVE YOU EVER APPLIED FOR A CAR LOAN, A MORTGAGE, OR A CREDIT CARD?

If so, you know that the way you have managed your credit in the past is very important. The information contained in your credit report can have a major influence over many parts your life, including your auto and homeowners insurance.

Many insurance companies use a credit-based "insurance score" when evaluating insurance applications or policies. This brochure was designed to give specific answers to questions about insurance scoring, including how and why it is used.

What is a credit-based insurance score? Why do insurance companies use them?

An insurance score uses information from your credit report to predict how often you are likely to file claims, and/or how expensive those claims will be. The way you handle your credit says a lot about how responsible you are. Insurance companies want to reward responsible people by offering them better insurance products and by charging them lower rates. That's why insurance scores are so useful.



It is important to understand that an insurance score is not the same thing as a credit score. Both are derived from the information found in your credit report, but they predict very different things. A credit score predicts how likely you are to repay a loan or other credit obligation. When you are applying for a loan or some other form of credit, the bank will consider your credit history as well as other factors in determining whether you are likely to repay your debt. **While banks and other lenders will look at your income when making decisions, insurers *do not*.**

When you apply for insurance, the insurance company orders credit information from one or more of the three major U.S. credit bureaus. This information is entered into a computer program that generates an insurance score. Most of these programs, or "models," look at things like payment history, collections, credit utilization and bankruptcies. For example, if you have never been late paying your mortgage, you will probably have a better score than a person who pays late. If you have "maxed out" credit cards, that will negatively affect your score. When you apply for coverage and your insurance company orders your score, the credit bureau will make a note in your file that the insurance company looked at the record.

What does my credit history have to do with how I drive my car?

Having a good insurance score does not necessarily mean you are a good driver or a more responsible homeowner. However, research has shown that consumers with better insurance scores generally file fewer claims and have lower insurance losses. That is not to say that all people with low insurance scores are higher risks.

For instance, if you add a 16- or 17-year-old driver to your auto insurance policy, your premiums will very likely increase. This is because, as a group, younger drivers have more claims and losses than those with more experience. That does not mean that all 17-year-olds are bad drivers. Research shows, though, that drivers in that age group are more likely to have losses, so they pay more in premiums. It's the same thing with insurance scores– research shows that people with certain patterns of behavior in their credit history are more likely to result in losses for the insurance company. As a result, they pay higher premiums, or, in extreme cases, they might have trouble getting insurance from some companies.

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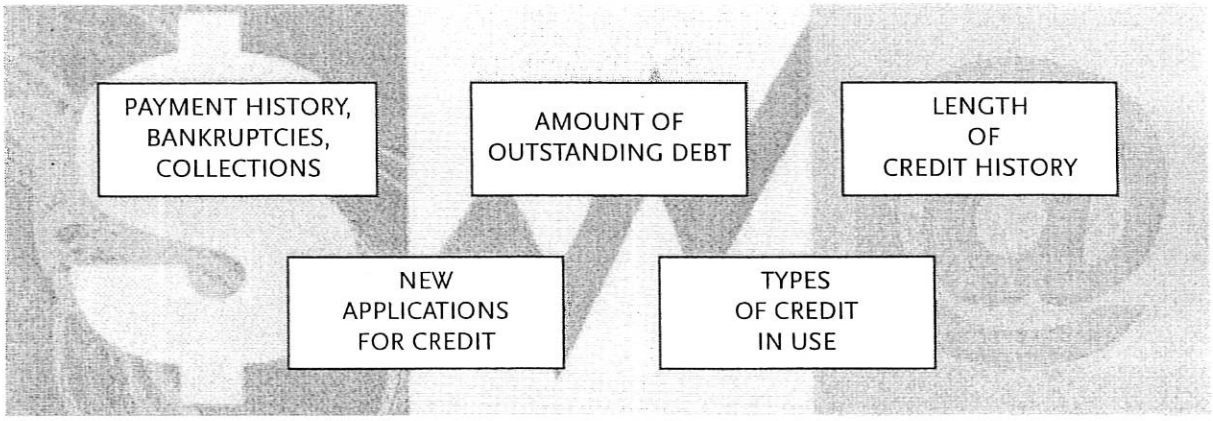
What kinds of things affect my insurance score?

Insurance scores are based on information like payment history, bankruptcies, collections, outstanding debt and length of credit history. For example, regular, on-time credit card and house payments affect a score positively, while late payments affect a score negatively.

CREDIT REPORT INFORMATION USED IN INSURANCE SCORES



Any time someone looks at your credit report, the credit bureaus record this activity – they refer to it as an "inquiry." The number of inquiries on your record can also affect your insurance score. There are several types of inquiries, but under the models used by most insurance companies, the only inquiries that affect your insurance score are those you initiate. Every time you apply for credit, whether a department store charge card, a new car loan, or "easy financing" on new bedroom furniture, an inquiry is noted on your record. Applying for a lot of credit in a short time shows that you might be taking on more than you can handle. ▼

Credit-based insurance scores look at patterns of financial management. Applying for one credit card is unlikely to have much effect on an individual's score. But applying for several lines of credit in a short period probably will have an impact.

One way to improve your insurance score is to limit the number of self-initiated inquiries in your credit report. This can be done by only applying for credit when you really need it. For example, an unsolicited "pre-approved" credit card notice in the mail would not affect your score, because you did not initiate the offer. If you fill out the form and send it back, though, you are applying for new credit. An inquiry will then be posted in your credit history, which may have an effect on your score. ▼

If you are shopping for a car or a house, you may fill out lots of applications within a short period to find the best deal. This shows that you are a responsible consumer. Under most of the models used by insurance companies, applying for several car or mortgage loans over a certain amount of time will only count as one inquiry. Also, most models do NOT consider inquiries you initiate when you are shopping for insurance.

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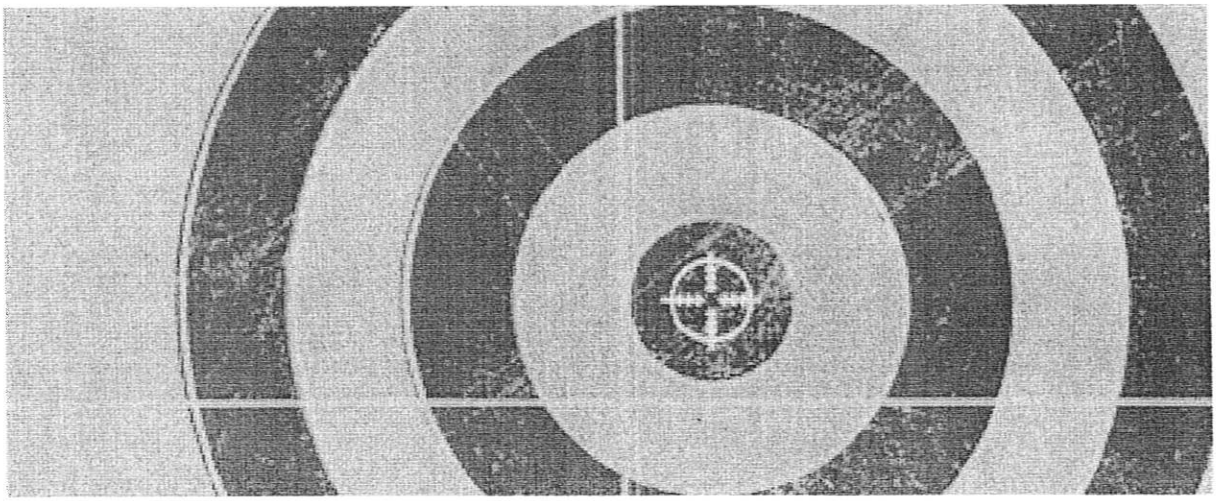
Do credit-based insurance scores discriminate against certain ethnic or income groups?

No. Insurance companies do not consider the following information in the calculation of your insurance score:

- ▸ Income
- ▸ Ethnic group
- ▸ Religion
- ▸ Gender
- ▸ Marital status
- ▸ Nationality
- ▸ Disability
- ▸ Address
- ▸ Public assistance sources of income



Can my insurance score help me save money on insurance?

Yes. Credit-based insurance scores allow companies to charge lower premiums to customers who are better risks. For most people, a better insurance score, combined with a good driving record, helps them qualify for a better rate.

In recent years, some states have enacted legislation dealing with insurance scores. This information is available from each state's Insurance Department.

Do I have any rights if I am denied insurance based on my credit history?

Absolutely. If an insurance company takes an "adverse action" against you (such as denying you coverage) as the result of information contained in your credit report, you may obtain a copy of your credit report free of charge from the bureau that provided the information. Again, if you believe there are errors in the report, you should immediately notify the credit bureau – the credit bureau must promptly correct errors.

Can I get a copy of my credit report before I apply for insurance?

For a small fee, each of the three major credit bureaus will send you an updated copy of your credit report.* If you believe there are errors in the report, you should immediately notify the credit bureau. If the information is incorrect, the bureau is required to promptly correct any errors.

Contact information for the three major credit bureaus is listed at the end of this brochure.

* *Some states have laws which permit consumers to receive one free copy of their credit report each year. As of Jan. 1, 2002, those states were: CO, GA (allows two per year), MA, MD, NJ and VT.*

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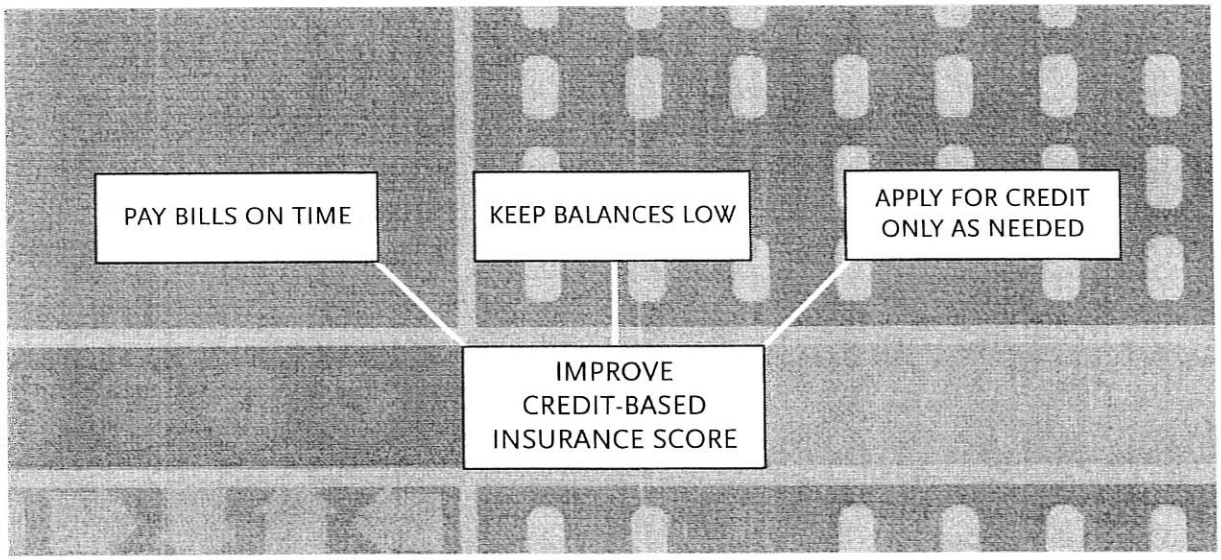
How do credit-based insurance scores benefit consumers?

- Credit-based insurance scores can help you qualify for lower premiums, because insurance companies charge lower premiums to customers who are considered more responsible.
- The use of credit-based insurance scores has allowed more companies to offer more products to more people. Since insurance scores have been used, competition in the auto insurance market has increased significantly - and competition quite often leads to more choices and lower costs.
- The Federal Fair Credit Reporting Act (FCRA) provides numerous consumer protections. These include:
  - *The right to obtain a free copy of your credit report if you are adversely affected (for example, denied coverage) based on information in your credit report*
  - *The right to contest any inaccuracies in your credit report and have inaccurate information removed*
- Insurance scores can be improved. By using credit wisely – paying bills on time and exercising responsibility in other financial activities – you can usually qualify for lower rates.**

***Insurance companies have different policies with regard to how often they will recheck your insurance score. Check with your insurer to find out their policy.*



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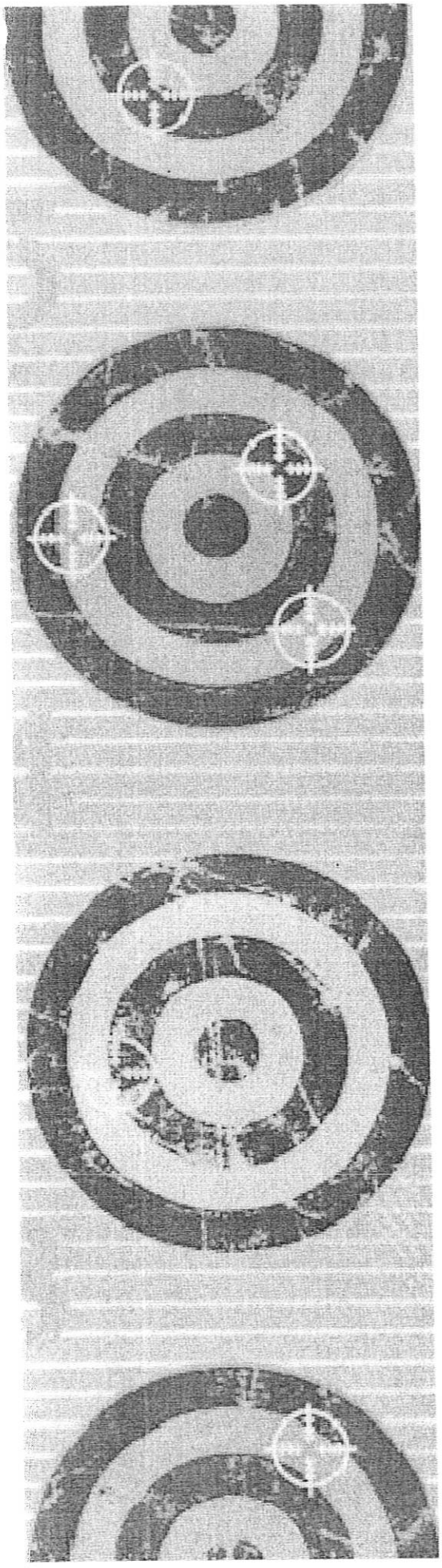

American Insurance Association

Contacts and other resources:

Consumer Data Industry Association (CDIA)
(www.cdiaonline.org)

Contact CDIA for information on the credit report dispute resolution process.
Phone 202-408-8011

Federal Trade Commission (FTC)
(www.ftc.gov)

Visit the FTC's website for information on credit and your rights under the Fair Credit Reporting Act (FCRA).

Equifax *(www.equifax.com)*

For a copy of your report, call 1-800-685-1111.

To dispute information in your report, write to:
P.O. Box 740241, Atlanta, GA 30374

Experian *(www.experian.com)*

For a copy of your report, call 1-888-397-3742.

Trans Union *(www.tuc.com)*

For a copy of your report, call 1-800-888-1213.

If you have a copy of your report and wish to discuss it, call 1-800-916-8800.

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THE FACTORS FUELING RISING HEALTHCARE COSTS

By

PRICEWATERHOUSECOOPERS

April 2002

Prepared for the American Association of Health Plans

Washington, DC (202) 778-3200

Attachment 2a.

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)

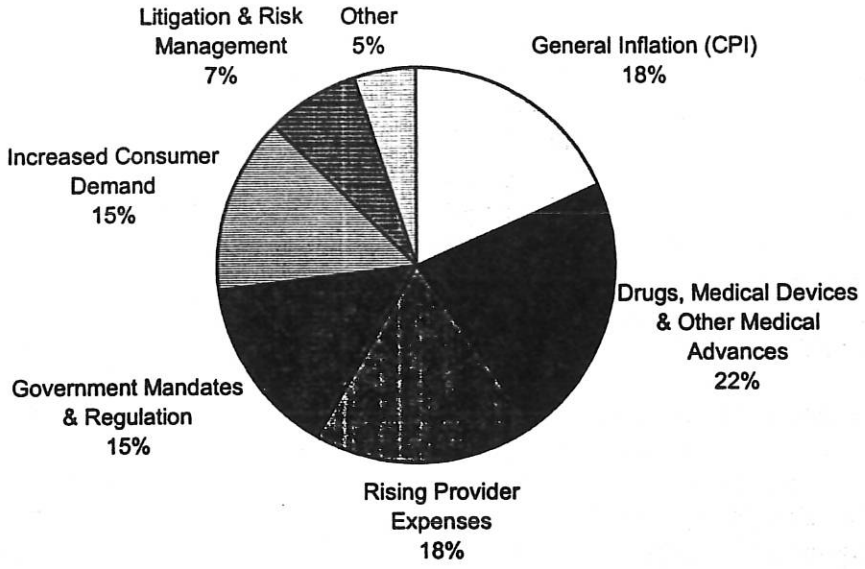
Trend Factors	Percentage Points	Percent of Total Increase
Medical Trend	**13.7%**	**100%**
General Inflation (CPI)	**2.5%**	**18%**
Drugs, Medical Devices and Medical Advances*	**3.0%**	**22%**
Prescription drugs		
Other advances in diagnostics and treatment		
Rising Provider Expenses	**2.5%**	**18%**
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.

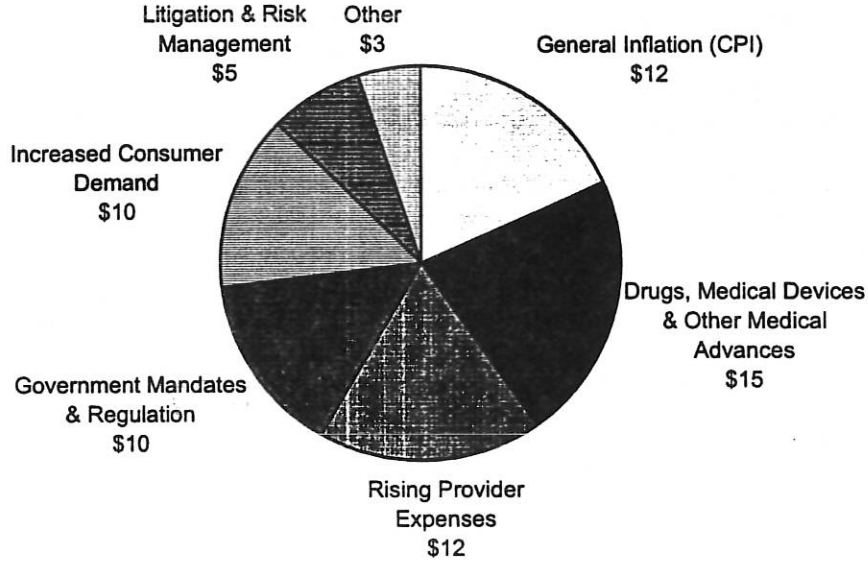
2a-4

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

12-10

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.

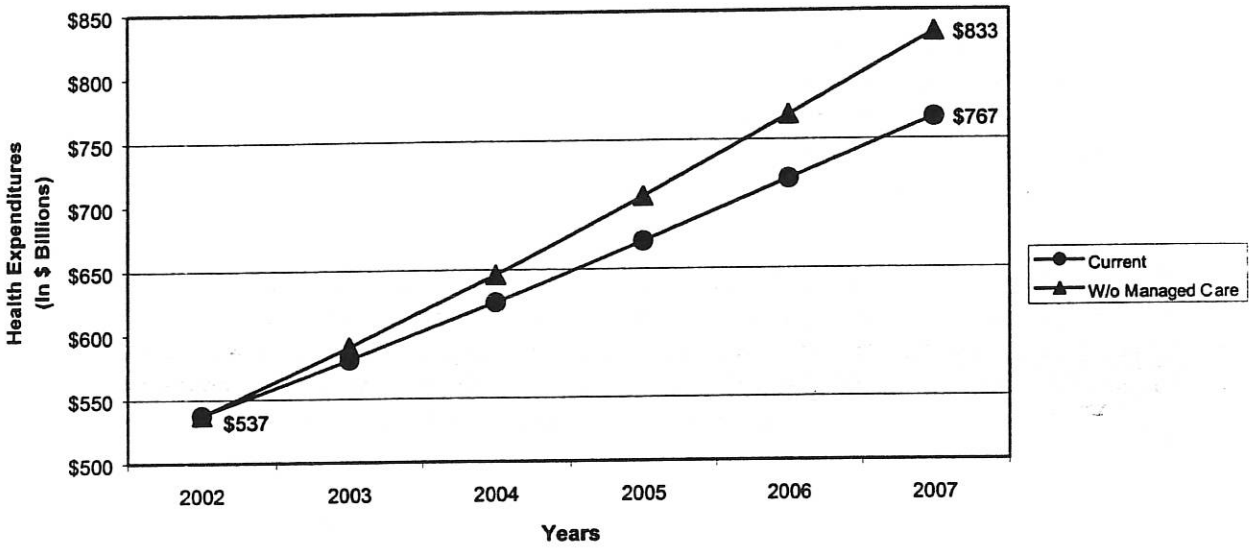
To what degree the major cost drivers in 2002 will influence future cost increases depends on the response to those drivers by payers, providers, patients, and policy makers. However, we believe it is useful to mention that the private health insurance market is moving away from tightly managed health 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.

For more information, contact Lee Launer, Partner, PricewaterhouseCoopers

1-646-394-2406

[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.

AARP Kansas

Written

February 13, 2003

Good morning Senator Teichman and members of the Senate Financial Institutions and Insurance Committee. My name is Ernest Kutzley and I am the Associate State Director of Advocacy for AARP Kansas. AARP Kansas represents the views of our more than 348,000 members in the state of Kansas. Thank you for this opportunity to express our comments on Senate Bill 144.

A recent industry study found that more than 90 percent of insurance carriers use credit data for insurance scoring purposes. Credit scores are based extensively on information contained in consumers 'credit reports; thus the accuracy of the reports is key to the accuracy of risk. Because not all creditors report credit information to credit-reporting agencies, positive credit information may not be included in the reports thereby lowering the consumer's score.

AARP believes that the use of credit scores has not been sufficiently analyzed to show that they are a reliable predictor of risk. We believe that the use should be analyzed by an uninterested third party with review by the Insurance Commissioner. Therefore at a minimum this needs to be done before credit scoring is considered.

AARP believes that a moratorium of 1 to 2 years be set on this issue allowing adequate time for the completion of studies and public hearings.

We believe that access to insurance at a fair and reasonable rate is a critical concern to all Kansans. Thank you for this opportunity to express our comments on credit scoring and SB 144.

Ernest Kutzley
AARP Kansas

Senate F I & I Committee
Meeting Date: 2-13-03
Attachment No.: 5

555 S. Kansas Avenue, Suite 201 | Topeka, KS 66603 | 785-232-4070 | 785-2328-8259 fax
Jim Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org

Written

STATEMENT OF KANSAS BUILDING INDUSTRY ASSOCIATION

TO THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

SENATOR RUTH TEICHMAN, CHAIR

REGARDING S.B. 144

FEBRUARY 13, 2003

Chairman Teichman and Members of the Committee, I am Chris Wilson, Director of Government Affairs for the Kansas Building Industry Association. KBIA is the statewide professional trade organization of the home building industry, with approximately 1800 members. At our recent annual meeting, KBIA adopted a position regarding credit scoring. Our policy is that the Association opposes the practice of credit scoring and believes it should be prohibited. If it is not prohibited, KBIA believes that companies should make all information about the credit scoring process available to the consumer.

This practice adversely, and we believe unfairly, affects our members as small businesses as well as our homebuyer customers. Small businesses often have personal insurance policies and business debt in the name of the business owner. Many, many people have experiences to relate about errors in their credit information. We continually hear from our credit card companies that everyone should routinely obtain copies of their credit reports, because they are so fraught with error, and work to correct those errors. We are told that we need to repeat this effort every few months to keep our report accurate. Those who have attempted to correct errors have found that it is difficult or impossible to do so, and that years later, long closed credit card accounts remain on their reports. To learn that this frequently erroneous information is being used to calculate insurance premiums is shocking to consumers.

If this practice is going to be used by insurance companies, then surely the companies should make the practice known to the consumer and provide any negative information to the consumer so that it can be corrected if it is in error. In the past, the mortgage lending industry used credit scoring, without informing the consumer. But in the past couple of years, that industry has openly provided the information to the consumer. That openness has greatly helped consumers to know and correct erroneous information and helped lenders make better, more accurate decisions. This should also be the case with insurance.

We believe there's a whole lot here that consumers are just becoming aware of, and that the whole issue of credit scoring merits more study and attention, with the full participation of consumers and their representative organizations. Thank you for your consideration of this issue. We would urge you to further study credit scoring practices and to prohibit them or at least place further requirements on their use.

Senate F I & I Committee
Meeting Date: 2-13-03
Attachment No.: 6

Written

TO: Members of the Senate Financial Institutions and Insurance Committee

RE: S.B. 144

February 13, 2003

Kansas Dairy Association, Kansas Agricultural Aviation Association and Kansas Seed Industry Association are in opposition to the practice of insurance credit scoring. Our 1050 plus members are family farms and agribusinesses.

By the nature of our businesses, we often have a significant amount of debt compared to average Americans. Farmers often have operating and land loans. Operating loans are large due to the capital intensive nature of planting a crop, but those loans are then paid when the crop is harvested. These loans are tied to our members as individuals, so this kind of debt would be reflected in credit scoring, as we understand it. Our members need to know what information is being used. We need to bring a human element to a computer determination.

One KAAA member recently told me his insurance premiums for his pickup trucks had been credit scored. He keeps two older trucks at the airport for use on the airport grounds. The book value of those trucks is no more than the insurance premium he is paying for them. He is an outstanding farmer and aerial applicator, with no credit problems or loss history. With the human element involved, the agent who insures ag pilots is happy to have this individual. He knows his insureds and their businesses well. But for a computer credit scoring determination, this individual has a lot of potential debt compared with other individuals.

We think this is a practice that deserves more study and attention. Consumers don't know a lot about it because it's done in secrecy. We need to cast more light on this practice and have the opportunity for informed consumers to have greater input.

Thank you for your consideration.

Sincerely,

Chris Wilson

Chris Wilson

SEN. FI + I
2-13-03
ATTACHMENT 67