Millard
PUBLIC SCHOOLS

COMMITTEE OF THE WHOLE MEETING

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NOVEMBER 10,2003

MILLARD PUBLIC SCHOOLS

BOARD MEETING NOTICE

The Board of Education will meet on Monday, November 10, 2003, at 7:00 p.m. at the Don Stroh Administration Center, 5606 South 147th Street.

Public Comments on agenda items - This is the proper time for public auestions and comments on agenda items only. Please make sure a request form is given to the Board Vice-President before the meeting begins.

AGENDA

1. Millard Public Schools Employee Health Plan Update

2. Board Legislative Resolutions

The members of the Board of Education met for a Committee Meeting on Monday, November 10,2003 at 7 p.m. at the Don Stroh Administration Center, 5606 South 147th Street. The topics that were discussed included an update on the District's health care plan and a review of the board's legislative resolutions.

PRESENT: Jean Stothert, Mike Pate, Linda Poole, and Mike Kennedy.

ABSENT: Brad Burwell and Julie Johnson

Others in attendance were Keith Lutz, Angelo Passarelli, Steve Moore, Bill Mueller, district lobbyist, and other administrators.

Mike Pate called the meeting to order. Mr. Pate announced that Brad Burwell and Julie Johnson would be absent from the meeting.

COMMENTS FROM THE PUBLIC: A community member commented on the resolutions that board members would be reviewing.

Steve Moore briefly gave the historical background on the health plan from the early 1970's to the present. In the 1997-98 school year the district changes insurance carrier to United Healthcare. In the 1999-2000 school year the district opted to go with a self-funded program with United Healthcare being the third party administrator. Except for the first year the district had the self-funded program, the receipts have exceeded the expenditures.

The district continues to review the plan benefits and the concept of fully insured versus the self-funded program. The district must stay competitive with other school districts and the district needs to have benefits that are comparable with EHA.

The district could consider, at some point in time, to bid out the health plan for another third party administrator.

Bill Mueller, the district's lobbyist, and Angelo Passarelli reviewed with the board some of their legislative resolutions they have had for a few years to see if some could be eliminated.

The board kept resolutions that asks for funding that is should reflect an equitable distribution of state revenue, spending and levy restrictions should be removed from the building fund, state and federal governments should never impose un-funded mandates, local boards are accountable to their community for making decisions regarding the education program, and are in the best position to make decisions on curriculum, management and funding, financial decisions on lids on spending or levies are best made at a local level where elected officials are most accountable to the community, state appropriations should increase in order to offset the reductions in revenue at a local level caused by student fees legislation, school finance studies should focus on adequacy of funding, additional state funding should follow any new requirements for new or revised assessments, a legislative solution is the most effective way to resolve the issues that are represented in the current finance litigation, and a separate ESU system should be established to serve students in the Millard Public Schools.

Board members asked for a resolution be drafted that would address the issue of reorganization/consolidation of school districts.

Mike Pate adjourned the meeting.

CHAIRMAN

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REPORT ON

MILLARD PUBLIC SCHOOLS EMPLOYEE HEALTH PLAN

NOVEMBER 10,2003

History

✓	1970's	Millard Public School's health insurance is with Mutual of Omaha.
✓	1980's	Millard's health carrier is Blue Cross & Blue Shield of Nebraska, a large group plan covering most public school employees in Nebraska.
✓	1996-97	The Board contracts with Scott Blackard of Arthur Anderson to evaluate the health insurance plan. Medical utilization data is not available for Millard employees, since it is a subgroup of the statewide educator's plan. Blackard recommends placing the plan for bids. Plan benefits remain unchanged.
✓	1997-98	United Healthcare of the Midlands is the successful bidder. First year premium savings to the district is approximately $600,000. To establish a fiscally sound plan, cash-option (salary in-lieu of insurance) is no longer offered to new employees; the cash value is frozen at $325/mo with no insurance and $157/mo with single insurance. The percentage of full-time employees taking cash-option has dropped from 29% in 1997-98 to 15% in 2003-04.
✓	1998-99	The drug co-pay increases from $5 to $10.
✓	1999-00	Benefit consultant Bob Moyle of Blackstone recommends the Board self-insure. The Health Plan is changed from a fully insured plan to a self-funded plan. Two-thirds of US workers with health benefits are covered by self-funded plans. United Healthcare of the Midlands provides a seamless conversion. UHC continues to process claims as the TPA (third party administrator) and also provides stop-loss insurance (specific and aggregate) to protect the district from large claims. The plan design (coverage) remains unchanged except for drug co-pays. Three tiered drug formulary co-pay implemented ($10 generic, $12 preferred brand, $15 brand). Employee benefit fund established. Expenditures greater than receipts by $272,907. $1,885,000 is moved from the general fund to the employee benefit fund as prepaid salaries to establish a fund reserve.
✓	2000-01	Plan design changes: drug co-pay increased to $10, $20, $25. $713,469 repaid to the general fund from the benefits fund. District pays full-family premium for full-time employees in their first two years of employment. Receipts exceed expenditures by $488,871.
✓	2001-02	No change in plan design. Receipts exceed expenditures by $1,358,151.
✓	2002-03	Board contracts with new consultant, Holmes/Murphy. Plan changes to a true PPO network with increased benefits for preferred providers. Co-pay for preferred providers is 10%, co-pay for non-preferred providers is 20%. With the conversion to a true PPO network, UHC experiences some deductive and maximum out-of-pocket claims processing errors which take approximately 3 months to rectify. Receipts exceed expenditures by $1,193,561.
✓	2003-04	Effective September 1, 2003, UHC changes computer platforms used to process claims. Effective January 1,2004, the plan is modified to provide co-insurance of 80120 in-network and 70130 out-of-network. The maximum out-of-pocket is increased to $1,250 individual, $2,500 family in-network and $2,500 individual, $5,000 family out-of-network. The Supplemental Accident Benefit of $300 is eliminated. Benefit consultant Mary Kramer of Holmes

		Murphy recommends increasing the specific stop-loss protection from $75,000 to $100,000. Open enrollment is moved to January 1,2004 (instead of September 1,2003). We discover a drug co-pay claims processing error for 2002-03 and UHC refunds $58,000 to the plan. UHC is re-negotiating contracts with Nebraska Health Systems, Methodist Health Systems, and Children's Hospital.
✓	Future	Effective January 1, 2005 the Plan will be modified to provide a deductible of $250 individual, $500 family in-network, and $500 individual, $1000 family out-of-network. We continually review the plan benefits and the concept of fully insured vs. self-insured. Being self-insured seems to be cost effective at this point. In order to remain competitive with other school districts, we must have benefits comparable to the EHA plan, which is used by most school districts in Nebraska. Such comparability may be in the form of a self-insured plan, a fully insured plan or a return to the EHA plan. As long as our plan is substantially different from the EHA plan however, we cannot return to the EHA plan even if we wanted to. One of the positives about having our own plan, is the freedom to have the kind of health benefits we want and need. The resulting negative is the annual necessity to collective bargain the coverage with the employee group representatives. When we participated in the EHA plan we accepted the benefits they had to offer and the corresponding premiums.

2.

Millard Public Schools
Employee Benefit Fund Balance
For Period 09/01/99 Through 08/31/03

Fiscal Year	Premium Receipts	Interest	Claims	Reinsurance Premium	Other Expenses	Fiscal Year Balance	Fund Balance
813111999							**$**
9/1/1999 - 8/31/2000	$ 5,334,018.60	$ 12,249.55	$ (4,929,974.76)	$ (689,200.61)	$ -	*$ (272,907.22)*	**$ (272,907.22)**
9/1/2000 - 8/31/2001	$ 7,536,568.78	$ 116,784.47	$ (6,208,198.05)	$ (951,379.93)	$ (4,904.00)	*$ 488,871.27*	**$ 215,964.05**
9/1/2001 - 8/31/2002	$ 9,601,325.91	$ 32,055.46	$ (7,033,088.38)	$ (1,242,141.83)	$ -	*$ 1,358,151.16*	**$ 1,574,115.21**
9/1/2002 - 8/31/2003	$ 11,807,020.54	$ 33,400.54	$ (9,017,332.85)	$ (1,629,527.09)	$ -	*$ 1,193,561.14*	**$ 2,767,676.35**

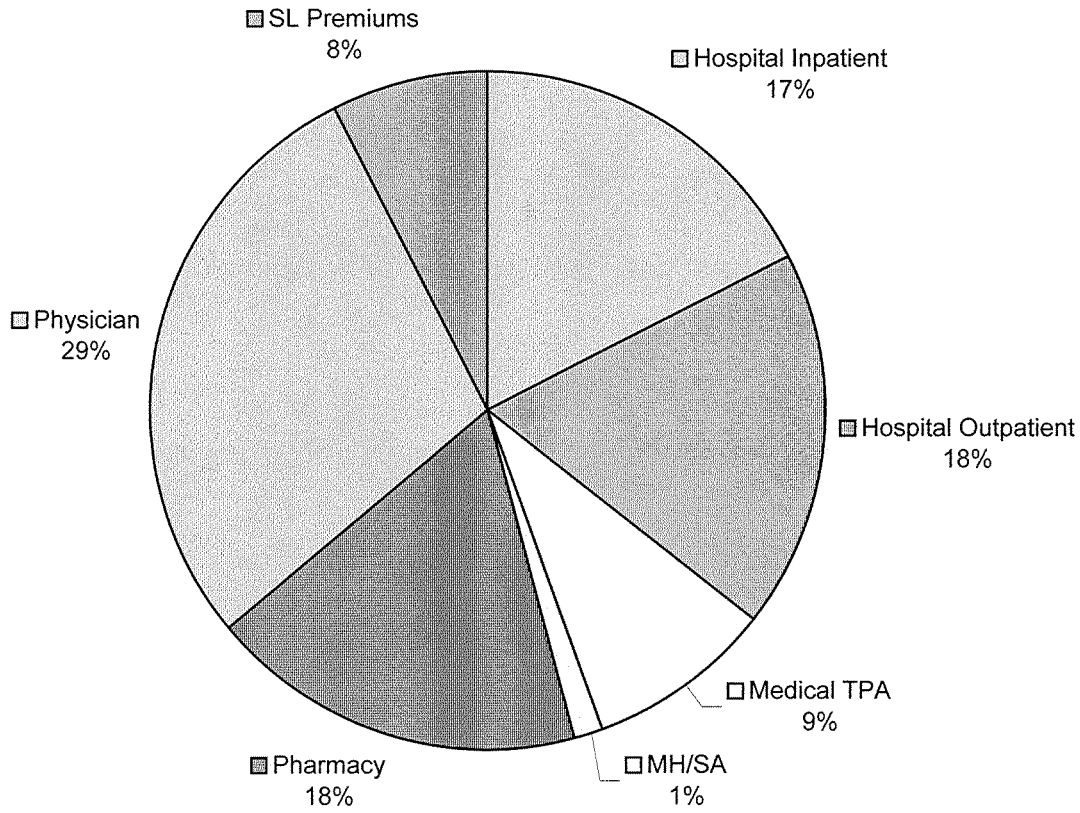
813112003	Reconciliation to Fund Balance		**$ 3,939,206.90**
	FY00 Prepaid Salaries	1,885,000.00	
	FY01 Claims Recoded to General Fund	786,530.55	**Runout reserve = 5 months**
	FY01 Prepaid Salaries Expense	(1,500,000.00)	
		1,171,530.55	

	Average Subscribers per month	Average Members per month	Average Expenses per Sub per mo	Average Expenses per Mem per mo	% change er Sub per mo	% change per Mem per mo
9/1/1999 - 8/31/2000	1460	3160	$ 320.73	$ 148.19		
9/1/2000 - 8/31/2001	1526	3573	$ 390.98	$ 166.98	21.9%	12.7%
9/1/2001 - 8/31/2002	1635	3947	$ 421.78	$ 174.72	7.9%	4.6%
9/1/2002 - 8/31/2003	1732	4281	$ 512.26	$ 207.25	21.5%	18.6%
9/1/2003 - 8/31/2004	1756					

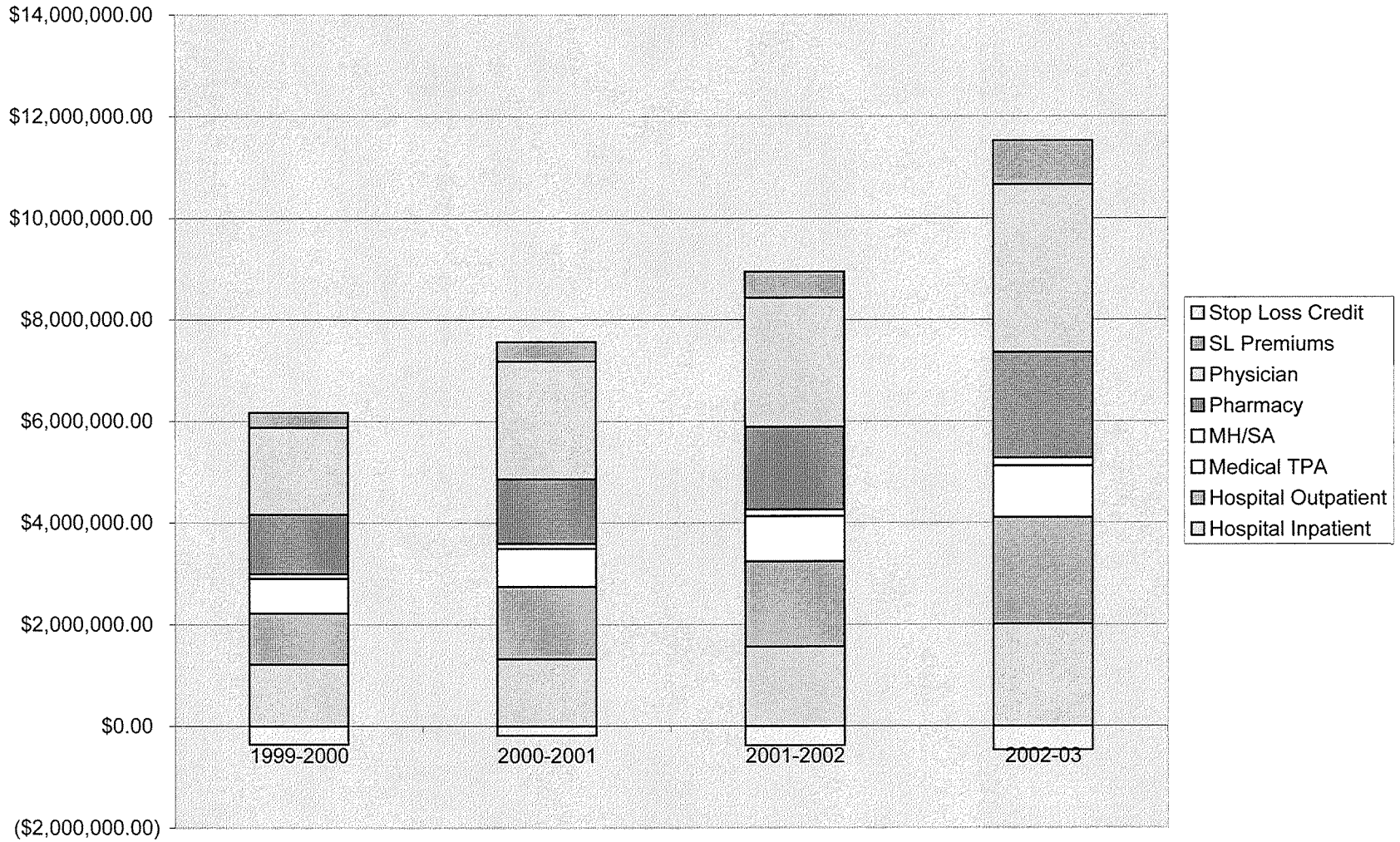
	Annual Premium Single	Family	% increase Single	Family
9/1/1999 - 8/31/2000	$ 2,119	$ 5,784		
9/1/2000 - 8/31/2001	$ 2,596	$ 7,086	22.5%	22.5%
9/1/2001 - 8/31/2002	$ 3,000	$ 8,220	15.6%	16.0%
9/1/2002 - 8/31/2003	$ 3,450	$ 9,453	15.0%	15.0%
9/1/2003 - 8/31/2004	$ 3,672	$ 10,056	6.4%	6.4%

3.

MPS Health Plan Expenses 2002-03



MPS Health Plan Expenditures



Appendix G

MPS Health Plan for 2003-05

Benefit Overview	MPS PPO Plan 2003-04 Changes effective 1/1/2004	MPS PPO Plan 2004-05 Changes effective 1/1/2005
Annual Deductible		
In-network		
Individual	$100	~~$100~~ $250
Family	$200	~~$200~~ $500
Out-of-network		
Individual	$200	~~$200~~ $500
Family	$400	~~$400~~ $1,000
Co-insurance %		
In-network	~~90%~~ 80%	80%
Out-of-network	~~80%~~ 70%	70%
Out-of Pocket Max, NOT including deductible		
In-network		
Individual	~~$625~~ $1,250	$1,250
Family	~~$1,250~~ $2,500	$2,500
Out-of-network		
Individual	~~$1,250~~ $2,500	$2,500
Family	~~$2,500~~ $5,000	$5,000
~~**Supplemental Accident Benefit**~~	~~First $300 covered at 100%~~	
Office Visit Exam Copay		
In-network	Deductible & Co-insurance	Deductible & Co-insurance
Out-of-network	Deductible & Co-insurance	Deductible & Co-insurance
Prescription Drug Copay	Generic $5 Preferred Brand $20 Non-Preferred Brand $25 Mail Order: **3** copays for 90 day supply	Generic ~~$5~~ $10 Preferred Brand ~~$20~~ $25 Non-Preferred Brand ~~$25~~ $40 Mail Order: **3** copays for 90 day supply
Lifetime Maximum	$5,000,000	$5,000,000
Cardiac Rehab	~~18~~ 36 visits per year maximum	36 visits per year maximum

6.

MPS Health Plan Revisions for 2002-03

	MPS Indemnity Plan 2001-02	MPS $100 Deductible PPO Plan 2002-03
Annual Deductible		
In-network		
Individual	$100	$100
Family	$200	$200
Out-of-network		
Individual	n/a	$200
Family	n/a	$400
Co-insurance %		
In-network	80%	90%
Out-of-network	n/a	80%
Stop-Loss Point		
In-network		
Individual	$2500	$6250
Family	$5000	$12500
Out-of-network		
Individual	n/a	$6250
Family	n/a	$12500
Out-of Pocket Max, incl deductible		
In-network		
Individual		
Family	$500+$100=$600	$625+$100=$725
Out-of-network	$1000+$200=$1200	$1250+$200=$1450
Individual		
Fatnily	n/a	$1250+$200=$1450
	n/a	$2500+$400=$2900
Supplemental Accident Benefit	First $300 covered at 100%	First $300 covered at 100%
Office Visit Exam Copay	Deductible & Co-insurance	Deductible & Co-insurance
Prescription Drug Copay	Generic $10 Preferred Brand $20 Non-Preferred Brand $25	Generic $5 Preferred Brand $20 Non-Preferred Brand $25
Lifetime Maximum	$5,000,000	$5,000,000

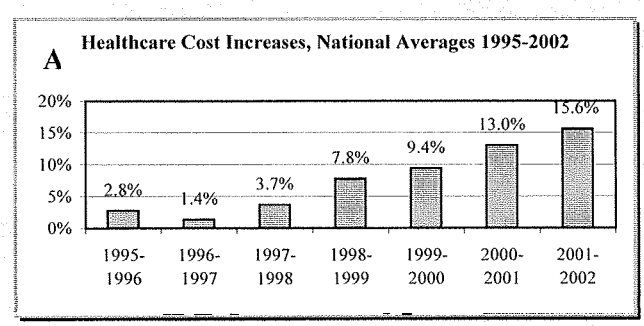
HOLMES MURPHY

PERSPECTIVES

PROVIDING INSIGHT INTO TODAY'S EMPLOYEE BENEFITS ISSUES

Increasing Healthcare Costs and Your Employee Health Plan

Third Edition



Source: tlewitt Health Value Initiative™ 2002.

HEALTHCARE costs, and consequently health insurance premiums, have been increasing at an alarming rate for the past four years. Can you avoid it? Probably not. But, you can learn about why it is happening, and what you can do to decrease its impact on your organization and your employees.

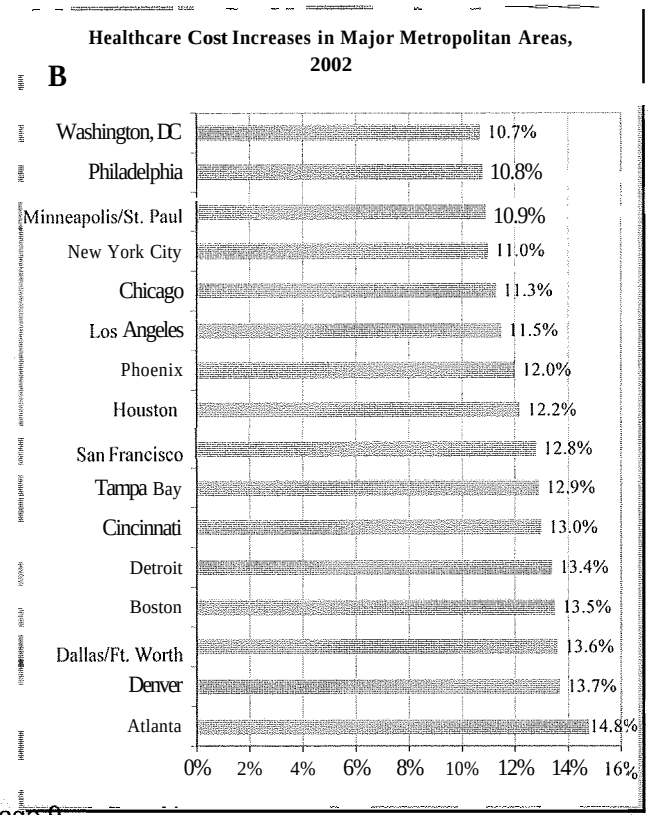
The next few pages will discuss factors leading to the greatest increases in healthcare costs since the early 1990s, and some solutions that firms around the U.S. are undertaking to help soften the blow.

National Healthcare Cost and Renewal Rate Projections

Health benefits remain one of the most valuable components of any employee compensation package. Nonetheless, unpredictable and uncontrollable rate increases every year make it difficult for employers to balance employee needs with their own capabilities and bottom lines.

To understand why rates are rising so dramatically, one must understand that overall national healthcare costs are skyrocketing — reflecting the biggest surge in medical inflation since the early 1990s. From 1994 to 1998, average annual healthcare cost increases hovered around 2%. From 1999 to 2000, however, costs leapt 9.4%, and the annual percent change has entered and stayed in the double digits since. **Exhibit 1A**, right, depicts the percent change in average annual healthcare cost increases from 1995 to 2002.

Healthcare cost increases have varied across the country over the last several years, with some metropolitan areas hit much harder than others. **Exhibit 1B**, right, illustrates healthcare cost increases in sorne major metropolitan areas in the U.S.



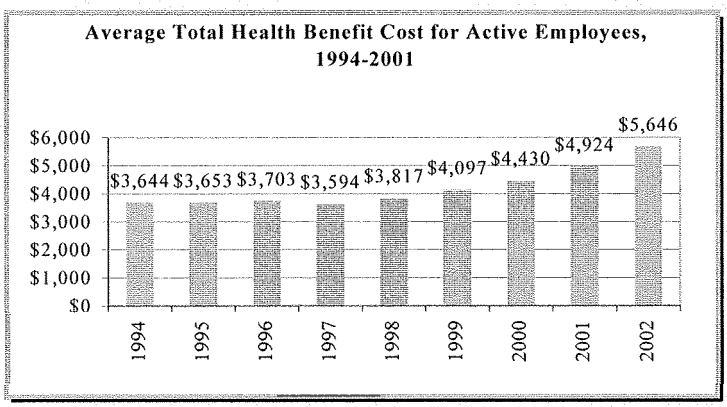
Source: Hewitt Health Value Initiative™ 2002.

8.

Many ernployers have been faced with double-digit rate hikes over the last several years, reflecting the upward trend in overall healthcare costs across the nation. 2002 was the fifth year in a row that health benefit costs rose faster than the rate of inflation, and the trend is expected to continue indefinitely. According to the *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans,* the average cost of healthcare benefits for active employees rose 14.7% in 2002 — from $4,924 per employee in 2001, to $5,646 per ernployee in 2002. **Exhibit 2A,** below, shows the average total health benefit cost for active employees for the years 1994 to 2002. **Exhibit 2B** depicts how health benefit costs have changed from 1987 through 2002. Note especially, the trend since 1998.

Managed care plans, including HMOs, have not managed to keep costs down. The average costs of closed-panel HMOs rose just as significantly as PPO plans in 2002, despite the greater cost control measures embedded in HMOs. For all employers, HMO costs increased an average of 15.3% in 2002. Large employers made strides to keep HMO cost increases down compared to recent years (15% in 2001, 8.1% in 2002). However, smaller employers saw a 25.9% increase in average HMO cost per employee. **Exhibit 2C,** below, indicates the average increases by plan type for large and small employers combined.

A



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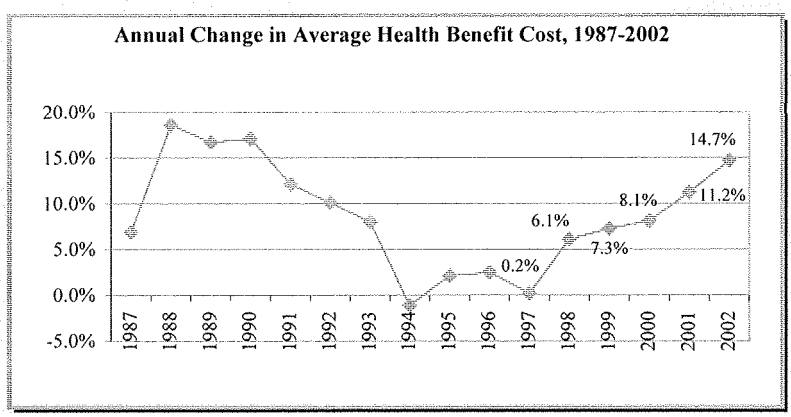

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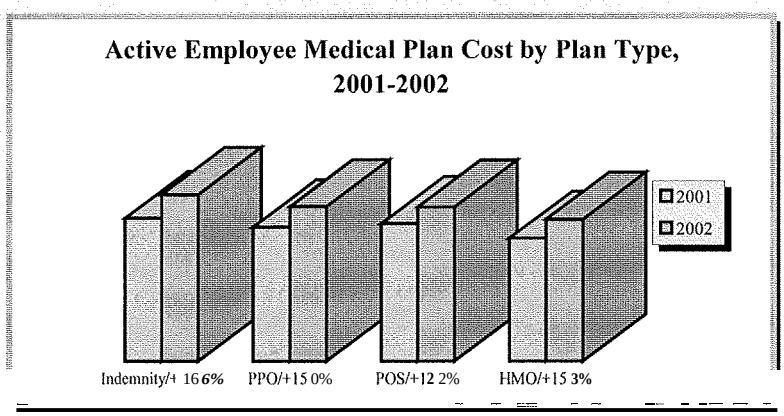


Source: Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2002.

Factors Leading to Increased Healthcare Costs

Why are U.S. hcalthcare costs skyrocketing? Several market conditions working in tandem have led to the current onslaught of steep increases. Understanding why your annual health plan renewal rates may be significantly higher than the previous year is the key to formulating alternatives and solutions to your particular plan's challenges. It is also the key to educating your employees about the reasons behind any plan or contribution changes you may decide to introduce.

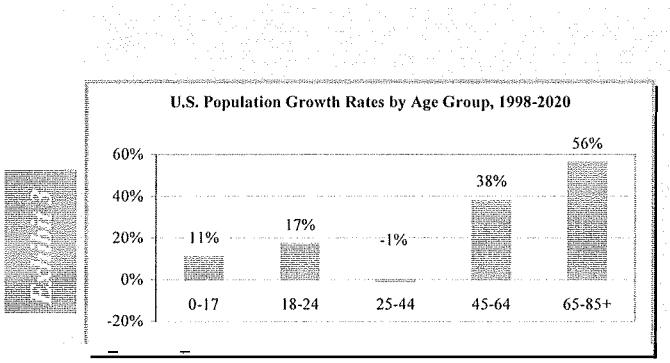
A discussion of the key factors leading to recent hikes in medical costs and health insurance premiums follows.

Demographics: The Aging of America

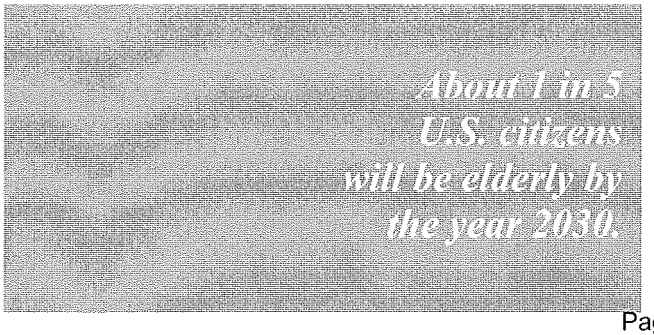
It is an inescapable fact: the U.S. population is aging. While the population of older Americans is increasing, the number of children and younger people is remaining stable and even decreasing for some age groups.

According to the U.S. Census Bureau, from 1900 to 1994 the elderly population increased 9-fold. During the same period, the number of people under the age of 65 rose only 3-fold. The growth rate of elderly persons is expected to be modest from 1990 to 2010, and is then expected to ascend dramatically from 2010 to 2030 as the Baby Boom generation enters the 65 and older category. About 1 in 5 U.S. citizens will be elderly by the year 2030.

Exhibit 3, below, shows the growth rate of persons aged 45 to 64 reaching 38% between 1998 and 2020, and the growth rate of those aged 65 to 85+ reaching 56% by 2020.



Source: Kiplinger Washington Letter, December 23, 1998.



As the American population ages, there is a subsequent rise in the occurrence of chronic diseases like asthma, heart disease, and cancer, and a resultant need for more resources to fight these diseases. This leads to elevated utilization of prescription drugs and other medical services, and an overall rise in dollar expenditures on healthcare. Essentially, the cost of caring for an elderly person is dramatically higher than for a person under the age of 65 years old. Because of this, the growth of the number of people over age 65 is beginning to and will continue to have a drastic impact on many levels, from employers funding these employees until they become eligible for Medicare, to cost shifting from Medicare to the private sector — one of the biggest factors in medical inflationary trend.

The aging of the American population will continue to be a driving factor behind increases in the costs of healthcare for many years to come.

Dramatic Rise of Prescription Drug Costs

Please turn to the attached *Special Report: Prescription Drug Costs and Your Employee Health Plan* for a discussion of why prescription drug costs are on the rise.

Consolidation of Managed Care Companies

As managed care boomed throughout the 1990s, competition among managed care giants like Aetna and Cigna — and among smaller regional players — became fierce. A desire to leverage economies of scale into bigger discounts from providers, and to gain enrollees and market share, induced many of the large organizations to consolidate and acquire smaller, weaker firms. They also kept premiums low and often did not keep them in line with the rate of medical inflation in order to gain business from rival companies and maintain their current customers.

Now, the landscape of the industry has changed. Years of under-pricing, weak underwriting, and the costly process of assimilating acquisitions has lead to serious dips in profitability and stock prices for a large number of U.S. managed care companies. Those who couldn't make the cut have either sold off their managed care operations to a bigger fish, or have completely gone out of business. Companies that haven't exited the market altogether are now faced with much less competition, and a renewed commitment to achieving healthy returns. This has ultimately resulted in increased rates.

Expansion of Providers

One of the major factors driving up the cost of healthcare is the growth of healthcare providers. Expansive healthcare systems that offer acute care hospitals, specialty facilities, clinics, labs, physician practice groups, and other services are becoming prevalent. Much of this expansion took place during the mid- to late-1990s and continues today. While these systems provide many benefits to the communities they serve, they also require a great deal of capital to fuel their growth. These capital expenditures by hospital systems and other providers place upward pressure on the costs of many medical services.

Political Environment and Government Regulation

Health insurance, and more specifically managed care, is one of the most regulated insurance sectors on both the state and

federal levels, and has also become one of the most highly debated topics in the political arena.

State and federal mandates have increased 25-fold over the last three decades. Often these mandates duplicate or conflict with each other, and almost always come with increased costs for the healthcare system. For example, the Health Care Portability and Accountability Act of 1996 (HIPAA) continues to impact the operations of many health plans seeking compliance. According to an April 2002 study by PricewaterhouseCoopers, HIPAA alone is responsible for adding billions of dollars of new compliance costs to the healthcare system.

Aside from HIPAA, there are over 1,500 mandated benefits at the state and federal level. Each of these has a cost associated with it, and together they have had a significant impact on healthcare costs.

PATIENTS' BILL OF RIGHTS

On the political front, concerns about timely access to quality healthcare services and calls for federal laws to protect consumers led to the passing of the Patients' Bill of Rights legislation in both the U.S. House of Representatives and the U.S. Senate. Prior to the terrorist attacks on September 11,2001, the Congress was working to resolve differences between the two versions, and sign the bill into law. National security interests, a slowing economy, and the war in Iraq in early 2003 have since forced the debate to the backburner, but a resolution is still on the horizon.

Some of the contested provisions include:

- Requiring health plans to expand emergency services, access to specialists, and prescription drug coverage.
- Expanding the patient's right to sue health plans and employers if those entities *directly* participate in claim determinations.
- Prohibiting health plans from any involvement in medical necessity determinations.
- Direct access for women and children to OB/GYNs and pediatricians, respectively.
- Mandating that federal laws should override existing state laws.
- Extending proposed protections to all of the insured population, versus just to those who are covered by self-insured plans (those that are exempt from state law and regulated only by ERISA).

Both the House and Senate bills add a number of process mandates that could increase healthcare costs. One analysis, for example, found that health plans would need to follow over 700 new legal requirements if a Patients' Bill of Rights were passed. The scope of their potential impact on costs is widely debated.

While much of the concern about the political environment surrounding the managed care industry is regarding pending legislation, there is no doubt that recent regulations have resulted in increased costs for health plans. Additional issues, such as prescription drugs for seniors, Medicare reform, and coverage for the uninsured will play a big role on political and legislative agendas in the coming years, and will undoubtedly continue to place upward pressure on costs.

Increased Utilization and Consumer Demand

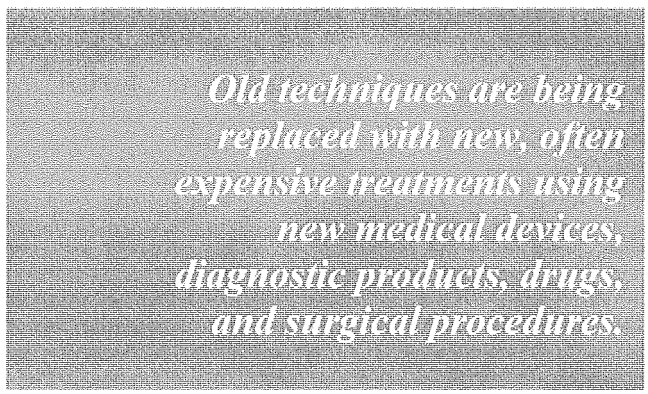
Utilization of many healthcare services has risen over the decade. A number of factors such as improvements in medical procedures and technology, the influence of managed care, elevated consumer awareness and demand, and a boost in the number of practicing physicians, caused health services like the number of surgical procedures and the number of prescription drugs dispensed to rise significantly. Other services, such as breast cancer screenings, immunizations for children, and diagnostic procedures like CT and MRI have also experienced sharp utilization increases.

Clearly as utilization increases, there is upward pressure on medical loss ratios, which ultimately influences the rates charged by insurance carriers.

New Medical Technology

Life expectancy and disease-specific mortality rates in the U.S. are steadily improving. Developments in medical technology, including methods for early detection of disease and the introduction of new treatments and medications for acute illness, have played a major role in enhancing these statistics. Old techniques are being replaced with new, often expensive treatments using new medical devices, diagnostic products, drugs, and surgical procedures. These include everything from digital mammography to hip replacement to radioactive "seeds" used to treat prostate cancer.

It is not surprising that these new procedures come with hefty price tags, and therefore drive the overall cost of healthcare — and subsequently health plan rates — upward.



Weakening of the Managed Cure System

The booming economy of the late 1990s, consumer demand, and the regulatory environment discussed above have led to a general weakening of the managed care system.

In the early 1990s, managed care was seen as a temporary fix to high medical inflation. By cutting payments to doctors and hospitals and requiring strict oversight of expensive drugs and procedures, managed care reduced insurance rate increases for a few years (average premium increases per year from 1994 to 1998 were only 2%). Without the surge in managed care plans, the total amount spent on healthcare nationally — about 14.1% of the gross domestic product — would be higher.

During the economic boom of the late 1990s, patients and employers migrated away from the tightest forms of managed

care, HMOs. Employers seeking to hire the best employees in the tight job market moved towards offering plans that allow patients to see doctors that are "out-of-network" or have much less strict referral processes, such as Point-of-Service (POS) plans. In addition, many employers making health plan purchase decisions focused on keeping employees happy by ensuring that most doctors in an area were in the chosen network, rather than choosing narrower networks with deeper discounts.

Provider contracting has also placed a strain on the managed care system. Many hospitals that have taken a beating due to the Balanced Budget Act of 1997 — which cut billions of dollars from Medicare managed care payments — and by other financial difficulties are now willing to walk away from health plans that they view as offering insufficient reimbursement rates and prohibitive payment practices. In many cases, these threats have won hospitals and other providers significant increases in reimbursement for the first time in several years. These actions are having a domino effect as other providers become more courageous and attempt to exert power during negotiations with health plans.

With the level of premium increases seen over the last several years expected to continue, more employers are backing away from their attempts to offer richer benefits, and instead are trying a number of tactics to reduce costs.

Healthcare Spending and Medical Cost Inflation

Overall healthcare spending and medical cost inflation are ascending, often due to many of the factors discussed above. Below are summaries of each of these trends.

NATIONAL HEALTHCARE SPENDING

The Centers for Medicare & Medicaid services' (CMS) annually releases national health expenditures projections. Some of their most recent findings include:

> National healthcare spending accelerated 8.7% in 2001, reaching $5,035 per capita.
>
> Prompted mostly by the sluggish economy and to some extent by faster-paced healthcare spending, healthcare spending as a portion of GDP[2] spiked 0.8 percentage points in 2001 to 14.1%.
>
> National health expenditures are projected to reach $2.8 trillion by 2011, growing at a mean annual rate of 7.3% from 2001-2011. CMS expects health spending to grow 2.5% per year faster than GDP, so that by 2011 it will make up nearly 17.0 percent of GDP (compared to its 2000 level of 13.2%).

The projected growth in health spending over the next decade will be fueled in part by rapid increases in spending for prescription drugs, as the conditions that encouraged expanding prescription drug expenditures since 1995 are expected to continue over the next decade.

Other factors contributing to the expected growth in health spending include rising provider costs, insurers' inability to negotiate increasing price discounts, and greater income growth.

MEDICAL COST INFLATION

Medical cost inflation figures tell a similar story. However, inflation differs from overall spending in that the GDP figures depict *actual dollars spent* on healthcare services in a year, while inflation reflects the *cost difference* for medical services relative to a base year.

One measure of inflation in the United States is the Consumer Price Index[3] (CPI). The U.S. Department of Labor Bureau of Labor Statistics recently released CPI figures for the period ending June 30,2003.

Exhibit 4, below, shows the percent change in the CPI for various consurner expenditure categories since 1995. *Medical Care* is one of the categories.

Overall consumer prices rose 2.4% during 2002, down from a high of 3.4% in 2000. So far in 2003, overall consumer prices have risen 2.2%.

Costs for goods and services in the Medical Care category rose 5.0% in 2002, and 2.6% as of June 2003 — higher than the overall inflationary rate. One can see that medical costs are increasing at a higher rate than the overall inflation rate, and more than most of the other expenditure categories.

In general, with medical care expenditures and inflation accelerating at a higher rate than in the recent past, it is easy to see why there is also upward pressure on health plan rates.

Annual Percent Change in CPI[4], 1995-2003

	1995	1996	1997	1998	1999	2000	2001	2002	2003*
All Items	**2.5%**	**3.3%**	**1.7%**	**1.6%**	**2.7%**	**3.4%**	**1.6%**	**2.4%**	**2.2%**
Food & Beverages	2.1%	4.2%	1.6%	2.3%	2.0%	2.8%	2.8%	1.5%	2.6%
Housing	3.0%	2.9%	2.4%	2.3%	2.2%	4.3%	2.9%	2.1%	2.9%
Apparel	.1%	-.2%	1.0%	-.7%	-.5%	-1.8%	-3.2%	-1.8%	-3.9%
Transportation	1.5%	4.4%	-1.4%	1.7%	5.4%	4.1%	-3.8%	3.8%	2.7%
Medical Care	***3.9%***	***3.0%***	***2.8%***	***3.4%***	***3.7%***	***4.2%***	***4.7%***	***5.0%***	***2.6%***
Recreation	2.8%	3.0%	1.5%	1.2%	.8%	1.7%	1.5%	1.1%	1.7%
Education and Communication	4.0%	3.4%	3.0%	.7%	1.6%	1.3%	3.2%	2.2%	.2%
Other Goods & Services	4.6%	3.6%	5.2%	8.8%	6.1%	4.2%	4.5%	3.3	1.6%

Source: United States Department of Labor Bureau of Labor Statistics, news release, Consumer Price Index, June 2003.

Employers React — What Can You Do?

You and other employers are undoubtedly trying to determine how to keep accelerating health plan rates from having debilitating repercussions on your organization. Many firms have been trying to absorb most of the costs because of attraction and retention issues, but are now realizing that they will have to pass portions of the costs on to their employees in the form of increased contributions or out-of-pocket expenses. Small businesses in particular are facing the critical decision to raise employee contributions, or to discontinue offering the coverage altogether.

Firms around the U.S. are undertaking a variety of measures to help minimize the effect of rate increases on their organizations. **Exhibit** 5, below, shows results from the Towers Perrin TP *Track* "The Changing Face of Health Care: Balancing Employer and Employee Needs" survey regarding actions employers anticipate taking to manage healthcare costs.

According to the survey, employers are focusing on interventions that they deem effective in managing costs — typically tactical, short-term approaches that shift costs to employees. The survey also found that employers tend to choose those tactics that they consider to be the most effective in controlling costs in the short-term. For example, three of the most prevalent tactics that are being used were also cited in the survey as having the most impact on cost savings.

Selective changes in copayments or coinsurance for prescription drug plans. This approach is either in use currently or planned to be used in the future by 85% of the survey respondents, and is likewise reported as effective by 85% of respondents.

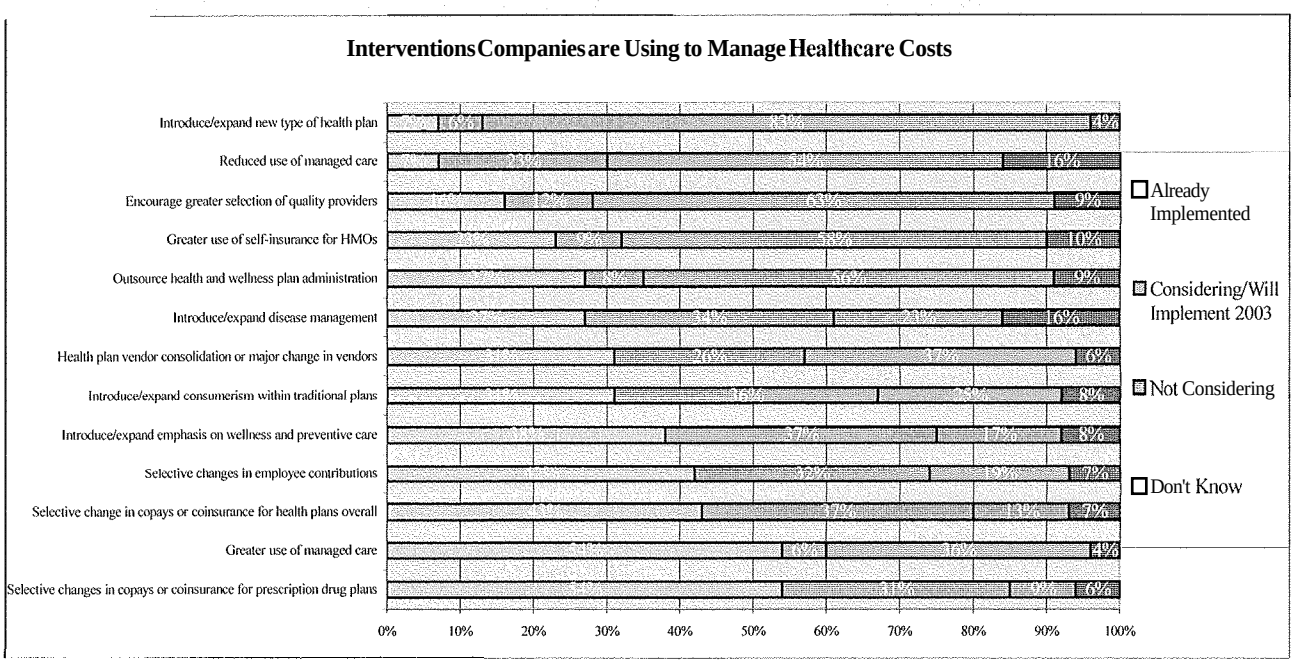
Selective changes in copayments or coinsurance for health plans overall. This tactic, designed to encourage cost-effective use of healthcare, is in use or planned by 80% of respondents and is reported as effective by 72%.

Selective changes in employee cotttributions. Employers use this intervention to encourage cost-effective selection of plans. It is in use or planned by 74% of respondents, and is considered effective by 72%.

The survey also indicates that while basic cost-shifting is still a prevalent means for managing costs, there is evidence of a movement toward a more strategic approach that includes longer-term consumer-oriented solutions. Those companies that want to balance cost and employee relations are incorporating more of a consumerist focus into their plans for 2003 and beyond.

Essentially, employers are finding ways to make healthcare a shared responsibility and commitment between employer and employee by putting more decision making power (and potentially cost-management power) into the hands of the employees. Then, by providing appropriate tools and education, employers can help employees assume this responsibility.

For example, more than one-third of the survey's respondents indicated they planned to introduce and expand wellness and preventive care programs. In addition, 36% plan to introduce or expand consumer-oriented elements within their traditional plans, while almost the same percentage will introduce or expand their disease management initiatives.



Source: Towers Perrin TP Track The Changing Face of Health Care Balancing Employer and Employee Needs, October 2002.

One potential trend to note is the increasingly popular move toward using the Internet to help employees become more educated healthcare consumers. The TP *Track* survey found that most employers are using Web-based solutions to implement consumer-oriented elements into their traditional plan designs. For example, many companies are providing Web-based employee health portals — often as part of an overall human resources portal — to support preventive care and wellness initiatives.

Which solution is right for you? Should you pass costs on to employees, at the risk of losing some of them? Or, should you try to manage costs in some of the other ways discussed above. Ultimately, it is a decision that you need to come to through thoughtful and detailed analysis of your plans, and with the advice of your broker-consultant.

Below are some questions you can address in order to begin developing an effective strategy that is right for your organization.

- Is our program structure, plan design, and pricing appropriate?
- Do we have the right vendors, services, contracting, and funding in place?
- Are our employee communication efforts appropriate and effective?
- Do we have the right disease and case management programs for our employees?
- Do our pricing and plan design features encourage cost-conscious behavior on the part of our employees?
- Do our employee communication efforts and resources motivate our employees to become educated and effective healthcare consumers?

What Should I Tell My Employees?

It's a fact: healthcare costs and health plan rates are increasing at a higher rate than during most of the past decade. You want to continue to offer valuable health benefits to your current and future employees, and you want those benefits to help you attract and retain good employees. However, you also need to consider the cost-effectiveness of those benefits at a time when hefty rate hikes are the norm, rather than the exception.

The information contained in this report is designed to help you understand why your renewal rates may have increased, and to consequently help you educate your employees about the reasons for any plan or contribution changes you may have to make. If your employees understand current trends in the healthcare industry, they will be more supportive of any such changes, and will appreciate the resources required to provide them with their healthcare benefits.

Many companies are providing Web-based employee health portals to support preventive care and wellness initiatives.

Notes:

[1]Formerly the Health Care Financing Administration (HCFA).

[2]Gross Domestic Product (GDP) is the total market value of all final goods and services produced within a country in one year.

[3]The Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. It is the most widely used measure of inflation. The CPI is generally expressed as an index relative to a reference base. Most CPI indices have a 1982-84 reference base, meaning that the Bureau of Labor Statistics (BLS) sets an average index level (representing the average price level) for the 36-month period from 1982 to 1984. The BLS then measures changes in relation to that figure. The figures here represent changes in consumer prices for each year shown, relative to the 1982-1984 base year.

[4]Reference base: 1982-1984.

[5]Seasonally adjusted annual rate six months ended in June 2003.

PERSPECTIVES

PROVIDING INSIGHT INTO TODAY'S EMPLOYEE BENEFITS ISSUES

SPECIAL REPORT: Prescription Drug Costs and Your Employee Health Plan

Third Edition

Prescription Drug Spending Trends

Rising prescription drug costs are a primary cause of escalating overall spending on healthcare, and also represent an increasingly large portion of healthcare expenditures. Pharmaceutical research is continually providing treatment breakthroughs that should not be impeded, but the costs associated with this progress are beginning to and will continue to have a major impact on healthcare financing and delivery systems.

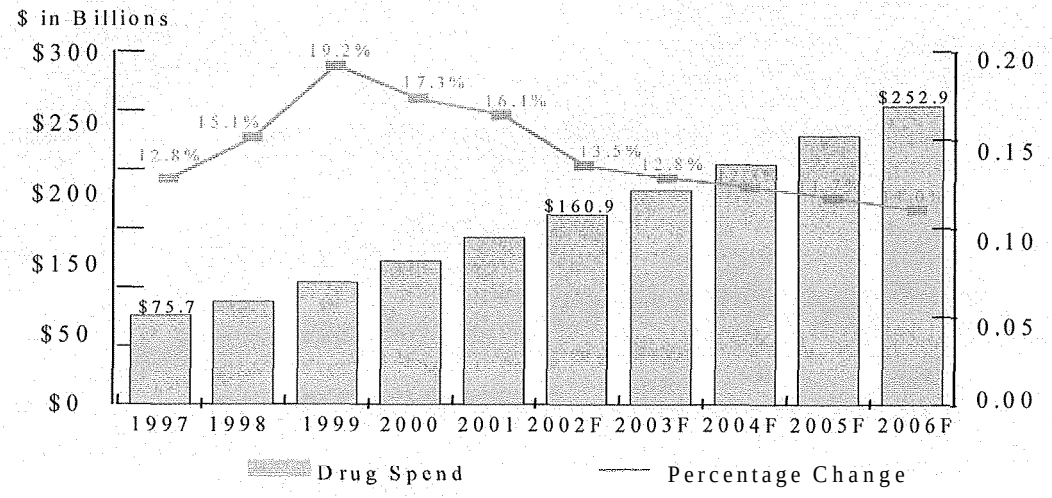
According to the Centers for Medicare & Medicaid Services (CMS) (formerly the Health Care Financing Administration/HCFA), overall national spending on healthcare has been rising steadily for over a decade, and will continue to rise sharply well into the new millenium. Overall healthcare expenditures were 8.8% of Gross Domestic Product (GDP) in 1980, and are projected to reach 17% of GDP by 2011.

Prescription drugs are making up an increasingly large portion of those expenditures. Overall healthcare spending rose 8.7% from 2000 to 2001, while spending on prescription drugs rose 16.4% — more than any other personal health category.

Not all the news is bad, however. CMS does predict that while prescription drug spending has hit an all-time high, the upward trend may be slowing. Despite remaining the fastest-growing health expenditure category, drug spending slowed in 2000 and 2001. In 1999, prescription drug spending grew by 19.7%, in 2000 by 17.3%, and in 2001 by 16.4%. This slowed growth is attributable to several factors, including a deceleration in the rate of new product development, a continuing shift to tiered benefit plans that incorporate different copayments for generic and brand-name drugs on and off plans' formularies, and the increase in consumer cost-sharing that typically accompanies those plan design changes.

Exhibit 1, below, depicts overall drug spending from 1997 to 2006 (projected), as well as the percent change from year to year.

Annual Prescription Drug Spending, 1997 to 2006 (Projected)



Note: 2002 – 2006 data are projections. Total Drug Spend includes uninsured expenditures.

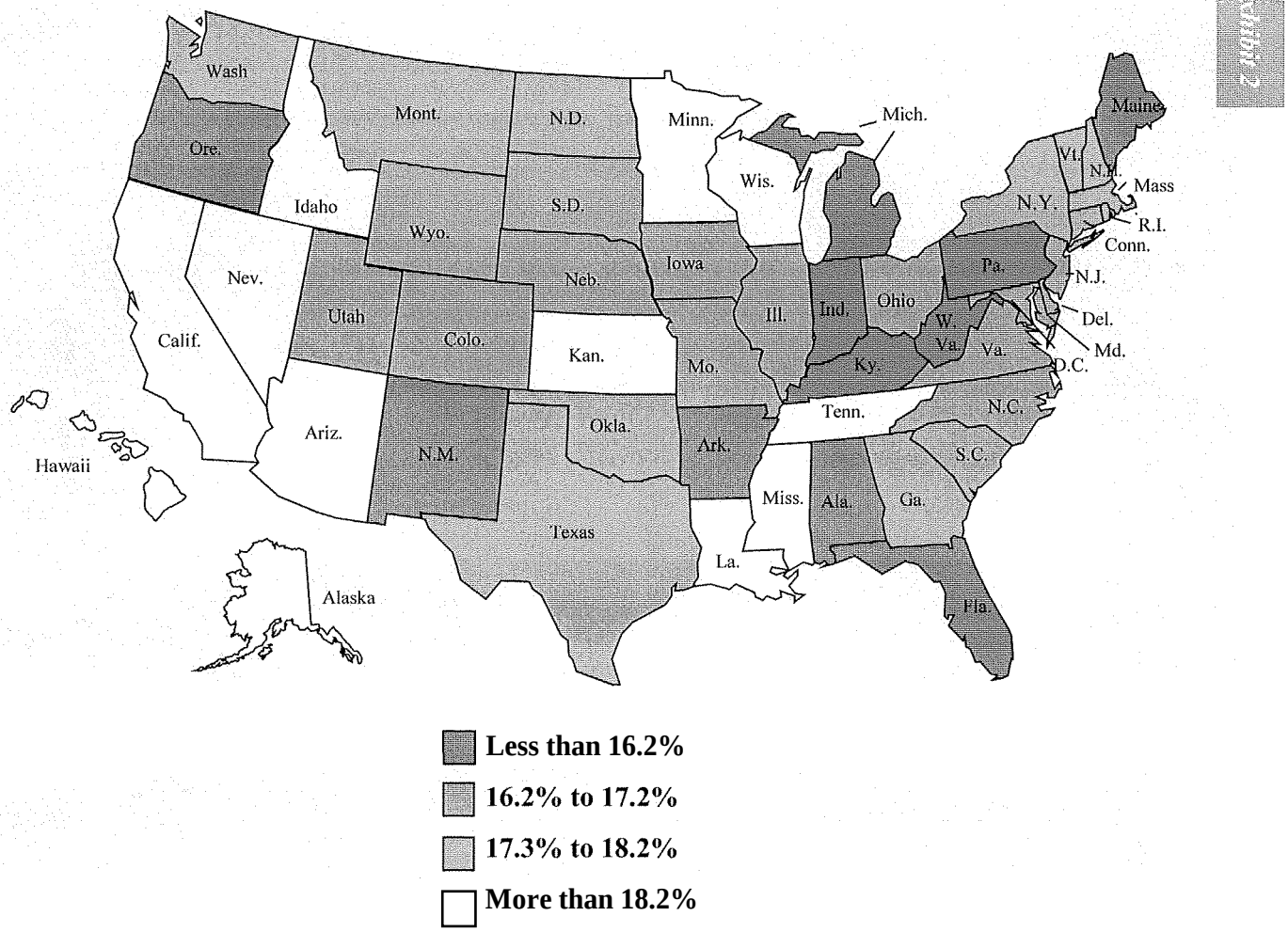
Source: Centers for Medicare and Medicaid Services (CMS), 2002.

While national spending on prescription drugs was up 16.4% in 2001, research has shown there is wide variation in spending hikes on a state-by-state level. Maine saw the lowest increase at just 12%, while Alaska had the highest rate of growth at 25.2%. For most states, the increase in total spending was caused more by growth in the average price per prescription, rather than by rising utilization. Average prescription price hikes varied from less than 8% to more than 11%. Four states — Arkansas, New Mexico, Kentucky, and New Jersey — reported a 4% increase in utilization, while Louisiana, Nevada, Idaho, Mississippi, and Alaska saw more than 10% utilization growth.

Exhibit 2, below, depicts how the growth in prescription drug spending varied among states from 2000 to 2001.

Growth in Prescription Spending Varies Significantly Among States

Percent Change in Total Sales of Retail Prescriptions, 2000-2001



NOTES: This data comes from Verispan Scott Levin's Source™ Prescription Audit, which collects over 140 million prescriptions on a monthly basis from nearly 37,000 retail stores including chains, independents, mass merchandisers, and food stores. The sample covers 71% of all retail dispensing activity nationwide and 1,300 regional zones to ensure the measures are not biased by regional differences in the prescription marketplace (e.g. managed care penetration, PBMs, state-level controls).

DEFINITIONS: Prescriptions: All products dispensed in retail pharmacies, including new prescriptions and refills. These products do not include medicines purchased without a prescription (i.e. over-the-counter items).

SOURCE: The Kaiser Family Foundation, State Health Facts Online Data Source: Verispan Scott-Levin, Source™ Prescription Audit. Special Data Request, 2001.

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Impact on Health Plans and Employers

The fast and steep ascent of the cost of prescription drugs is undoubtedly having an impact on insurance carriers and managed care organizations, and consequently on employers who sponsor employee health plans. Prescription drug costs have become a major component of health plan costs, with managed care plans hit especially hard because of the generous drug benefits they tend to provide.

CMS reports that prescription drug expenditures make up 11% of overall national health expenditures, and project that figure to reach 14.5% by 2012. Recognizing this trend, payers and plan sponsors have moved toward more aggressive plan designs — like higher copayments or three-tier copayment plans — that shift more of the cost burden to members.

AdvancePCS's latest analysis, *Health Improvement Report Spring 2002*, finds that plan sponsors who have adopted cost sharing and utilization management techniques are experiencing lower rates of drug spending.

Driving Forces

Pharmaceutical costs are rising due to a variety of factors that can be linked to two major driving forces: the increased flow of new drugs to market, and increased utilization.

Flow of New Drugs to Market

A primary force behind the growth of overall prescription drug spending is the introduction of new branded drugs to the marketplace. New drugs are classified as those approved by the Food & Drug Administration (FDA) since 1992. Expedited by a rise in the number of FDA new drug approvals, federally funded research, and growth in private research and development spending, the number of new drugs being introduced to the marketplace is greatly accelerating. These new drugs are often more effective than old therapies that they replace, yet this innovation bears a hefty price tag.

- ✓ According to the *Medical Cost Reference Guide* developed by the BlueCross BlueShield Association in June 2003, new and pipeline drugs account for a majority of prescription drug spending growth. In 2002, existing drugs accounted for only 3.6% of drug spending growth, while new and pipeline drugs accounted for 10.6% of the growth in drug spending.

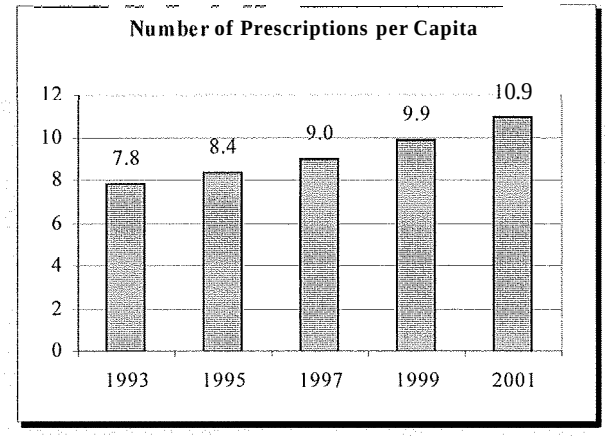
- ✓ Other recent studies indicate that while new drugs are still a major driver of drug spending increases, the number of new drugs being introduced is falling. AdvancedPCS reports that the proportion of prescriptions for drugs approved within the previous three years decreased from 14.4% in 2000 to 12.6% in 2001. However, while there were fewer prescriptions written for newer drugs, the new drugs that were introduced were more expensive than ever.

Increased Utilization

It is a fairly simple concept: more people are using more prescription drugs, thereby driving overall spending upward. The number of prescriptions dispensed has been growing dramatically from 1992 to the present, and is projected to continue at a similar pace for years to come.

Exhibits 3 A and **3B**, below, illustrate the growth in the number of prescriptions per capita and total prescriptions dispensed from 1993 to 2001.

A



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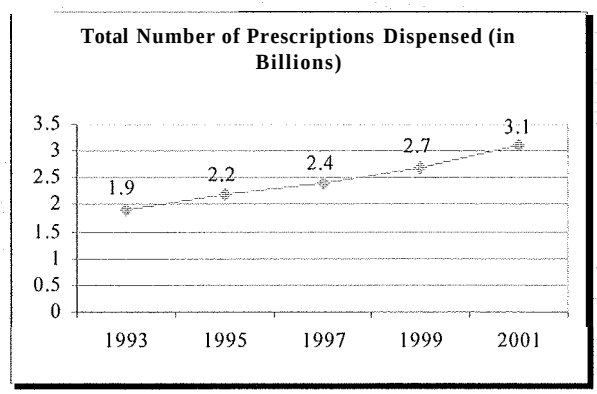

Source: Adapted from National Institute for Health Care Management, 2002; U.S. Census Bureau, 2002, as reported in BlueCross BlueShield Association *Medical* Cost *Reference Guide*, Revised June 2003.

There are a number of reasons for the growth in utilization of prescription drugs. They include the following.

INSURANCE COVERAGE FOR PRESCRIPTION DRUGS

Individuals with insurance are more likely to use prescription drugs than those without, and the growing prevalence of managed care plans — which often offer generous drug benefits — has fueled greater drug utilization. Only 10% of drug costs were funded by third party coverage in 1970; in 2003, private health insurance paid for 50% of drug costs. Likewise, consumers paid for 80% of drug costs out-of-pocket in 1970; currently out-of-pocket funding accounts for only 40% of drug costs.

THE AGING OF AMERICA

As discussed earlier in this article, Americans are growing older and are expected to live longer than ever before. With this general aging of the population there is a higher incidence of

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chronic disease, and a resultant increase in the use of pharmaceuticals to treat those conditions. This demographic trend is the leading cause of increased utilization of prescription drugs.

AGGRESSIVE DIAGNOSIS AND TREATMENT METHODS

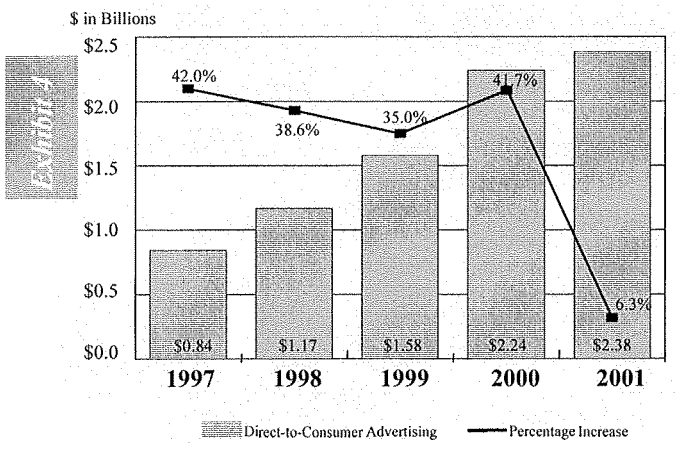
New technology and clinical protocols have brought increasingly aggressive diagnosis and treatment methods, and a greater emphasis on preventive measures. Pharmaceuticals often play a primary role in these more aggressive ways of diagnosing and treating diseases.

DIRECT-TO-CONSUMER (DTC) ADVERTISING OF PRESCRIPTION DRUGS

In 1985, the FDA lifted its moratorium on DTC advertising of prescription drugs. Prior to this change, pharmaceuticals were marketed solely to physicians and other medical professionals. However, spending on DTC advertising of prescription drugs grew from $55 million in 1991 to $1.58 billion in 1999. From 1999 to 2001, DTC advertising spending rose from $1.58 billion to $2.38 billion. Prescription drugs have become one of the most highly marketed product categories, and many feel this promotional push is creating inappropriate consumer demand that is contributing to unnecessary utilization. In addition, critics of the drug companies charge that pharmaceutical prices could be lower if exorbitant amounts of money were not being spent on advertising.

Exhibit 4, below, shows how DTC ad spending for prescription drugs has more than doubled since 1997.

Direct-to-Consumer Advertising Reaches Peak



Source: Med Ad News, June 2002.

Ad spending for prescription drugs has more than doubled since 1997.

What Can Employers Do?

Several opportunities exist to help you keep your employee health plan's prescription drug costs in control. Through careful analysis and consideration, and with the advice of your benefits consultant, you may decide that one or several of the following cost saving tools is right for your particular needs.

Offer a plan with an open formulary. The open formulary encourages the use of appropriate, cost-effective prescription drugs through physician education, voluntary therapeutic substitution, member communication, and by higher copayment requirements for non-formulary drugs.

Offer a plan with a closed formulary. The closed formulary excludes coverage for certain drugs.

Increase coinsurance or copayments. Sharing costs with employees encourages more responsible drug utilization by increasing patient sensitivity to drug costs.

Require generic substitution. Requiring employees to substitute appropriate generic medications for more expensive brand-name drugs will have a substantial impact on your plan's prescription drug spending.

Offer a plan that utilizes therapeutic/pharmacy interventions. This means that utilization of preferred drugs is encouraged over non-preferred drugs when clinically appropriate.

Make utilization management a part of your prescription drug plan. This includes measures such as prior authorization, step therapy, and managed drug limitations such as restricting refills for certain medications depending upon clinical guidelines.

Use a narrower pharmacy network. Greater discounts can often be achieved by using a narrower network.

Offer a mail order drug benefit. Mail service pharmacies can generally negotiate deeper discounts from drug wholesalers and manufacturers than retail pharmacies can. These savings can be passed on to the payer.

Clearly there are many options to explore if you are trying to better manage your health plan's prescription drug costs. And again, educating your employees about the reasons for rising drug costs and their impact on your health plan will be the key to successfully introducing changes to your plan or the out-of-pocket amounts required of your employees.

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BenefitNews.com Printer Friendly Output

Higher costs spur desire for better health coverage

BenefitNews Connect • October *21, 2003*

Americans' desire for comprehensive health coverage is at a fever pitch these days, as consumers appear willing to sacrifice pay raises, higher-paying jobs and their tax dollars to get it, recent surveys find.

One survey, conducted by Stony Brook (http://www.sunysb.edu/surveys/HPAAugO3.htm)University's Center for Survey Research, finds 71% of employees would take a lower-paying job with health benefits, while less than one-fourth (24%) would take a higher-paying job with no health coverage. Even when asked to rate the issues independently, just 37% say a higher salary is very important, versus 73% who rated health benefits as very important.

Adequate coverage is so important, in fact, that 56% of respondents to a *Wall* Street *Journal*/Harris Interactive poll say they would forego a pay raise in order to keep their current health benefits. Some workers are willing to give up pay altogether, as 90,000 grocery workers and 2,000 transit mechanics in California are striking (http://www.aflcio.org/issuespolitics/healthpolicy/nslO172003.cfm) to maintain affordable health coverage.

And as costs continue to rise and more Americans go without health insurance (43.6 million, according to up-to-date census data), consumers believe the federal government should step in. A Washington Post-ABC News (http://www.washingtonpost.com/wp-dyn/articles/A50281-20030ct19.html) poll reveals eight in 10 who believe it is more important to provide health care coverage for all Americans even if it means higher taxes. In addition, 62% say they would prefer a universal health care system.

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Published Friday
September 26, 2003

Hospital-insurance flap could cost patients

BY NICHOLE AKSAMIT
WORLD-HERALD STAFF **WRITER**

Children's Hospital is warning some families that they may have to pick up more of the bill for care at the hospital, its emergency room and urgent-care centers - including treatments they have received since Sept. 13 - pending the outcome of a dispute with an insurance company.

The Omaha hospital sent a letter to recent patients who have coverage from United HealthCare Inc.

The letter said the hospital and the insurer have entered binding arbitration to resolve a dispute over how United HealthCare reimburses the hospital for pediatric patient services.

"It is possible that United will consider Children's to be an out-of-network provider after September 13, 2003," the letter warned. "The result could be additional out-of-pocket costs, which would be your personal responsibility."

A statement issued by United HealthCare Chief Executive Kathleen A. Mallatt said that Children's is unnecessarily alarming patients and putting them in the middle of a dispute about money. She indicated that the outcome would not affect patients' bottom line.

"Customers should continue to use Children's as they always have," the statement said. ". . . We commit to holding our customers harmless, so that their financial responsibility for services at Children's will remain the same, regardless of the arbitrator's decision."

United HealthCare spokesman Mike Strand said the company also is negotiating with other Omaha hospitals, including the Alegent Health System and the Nebraska Medical Center, and intends to reach agreements with them and with Children's.

But leaders at other health systems are also upset with the pace of negotiations with United HealthCare.

Great Plains Regional Medical Center in North Platte has been unable to reach a contract agreement with the insurance company. Some people in the area, including

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some dependents of Union Pacific Railroad employees, are paying out-of-network rates.

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The chief executive officer at Great Plains Medical Center, Cindy Bradley, said the hospital and United HealthCare have tried but have not come to terms on the financial aspects of a contract.

Strand said the insurance company has a contract with Ogallala Community Hospital, about 50 miles away, that will start Wednesday, and is working toward a contract with doctors there.

"We know it's a gap, and we're working diligently to obtain a contract" with the North Platte hospital, he said.

In Omaha, Methodist Hospital and a couple hundred Methodist-affiliated doctors recently sent notice that they won't be a part of the insurance company's network at the end of this year.

That means that people with United HealthCare insurance may have to pay out-of-network charges for Methodist health services, starting next year. Many of Omaha's largest employers offer a United HealthCare plan.

Last-minute negotiations could get Methodist and its doctors back in the insurance network without disruption to patients, said Ken Klaasmeyer, president of Methodist Health Partners, an organization that aids the Methodist hospital and doctors in their negotiations over insurance contracts.

But he is not optimistic. United HealthCare hasn't provided them with a proposed list of rates it will pay for health-care services under a new contract. Methodist expected such a proposal months ago, Klaasmeyer said.

"From our standpoint, United has not negotiated like they need us in the network or want us in the network," he said.

Strand, the United HealthCare spokesman, said, "Of course we want Methodist and its physicians in the network. And we intend to continue to negotiate in good faith to ensure that happens.

"But it's also a two-way street. That's why we bargain, to come to an agreement, not to capitulate to demands."

He declined to comment on the list of proposed rates.

"It's a bargaining process, and we are sad to see these things being played out in the public, which only raises everyone's concerns unnecessarily," he said.

Children's spokeswoman Laura Gell said Thursday that the hospital continues to file insurance claims with United HealthCare and conduct other business as usual, as if the relationship were unchanged.

"But," she said, "we felt it was our ethical obligation to tell our patients that we were entering into arbitration, rather than telling them afterward when there may be a change."

In addition to the reimbursement issues, it appears the hospital and United HealthCare disagree on the expiration date of the contract between them.

Gell said the terms of the three-year contract expired on April 30, 2003. When efforts to agree to new terms failed, she said, the hospital notified United HealthCare in August of its intention to end the contract Sept. 13. Instead, she said, both sides agreed to enter arbitration and let a third party decide the matter.

United HealthCare's statement said the contract is valid until at least April 30, 2004, and that it would notify customers directly and in a timely fashion of any changes to its provider network.

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It isn't known how long arbitration will take.

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Children's has contracted with United HealthCare since 1991. Those insured with United HealthCare have seen double-digit increases in their premiums in recent years.

Karla Macdissi, a sales executive for the Grace-Mayer Insurance brokerage in Omaha, said she has told her business clients that customers will not have to pay extra medical costs and that they would receive proper notice if there were any changes in the insurance company's network of health-care providers.

"If it can't be worked out, we all lose," Macdissi said.

World-Herald staff writers Jeremy Olson and Steve Jordon contributed to this report, which also includes material from The Associated Press.

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Parents Get Insurance Letter From Children's Hospital

POSTED: 9:17 a.m. CDT September 25, 2003
UPDATED: 11:57 a.m. CDT September 25, 2003

OMAHA, Neb. -- Children's Hospital in Omaha sent a letter to parents this week that said, because of a dispute with an insurance provider, some Omaha parents may be responsible for medical bills at the hospital. The letter said Children's wants to terminate its contract with United Healthcare, effective Sept. 13.

"This was our last resort," said Laura Gell with Children's. "We would not have done this if there were any other way."

United Healthcare said Children's Hospital can't end the contract. The two sides are now relying on an arbitrator to settle the dispute. Children's said, if the arbitrator sides with the hospital, parents covered by United Healthcare could be stuck with the hospital bill.

A spokesperson for United Healthcare said, regardless of the outcome of arbitration, the insurer will not leave parents holding the bag.

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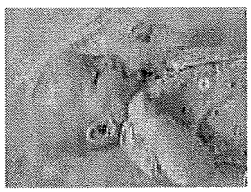
Update: Children's Insurance Dispute 'Absolutely Not' Scare Tactic

United Healthcare Clarifies Parent Responsibilities During Dispute

POSTED: 9:27 p.m. CDT September 25, 2003
UPDATED: 9:34 p.m. CDT September 25, 2003

OMAHA, Neb. -- A dispute between Children's Hospital in Omaha and insurer United Healthcare is leaving some patients caught in the middle. The hospital and health care provider hope to settle their differences in arbitration.

In the meantime, the hospital notified patients in a letter that they may end up footing more of their hospital bill than they expected. United health care said no matter how the arbitration is decided, parents will not be responsible for the bill at Children's.



Parents choose Children's for specialized health care for their children. One patient caught in the middle of this fight between the hospital and insurer is 2-month-old Nathan Osness (pictured, left), who spent several days in the hospital last week.

"We were there from Monday through Wednesday running a battery of tests," said Nathan's mom, Dawn. "They didn't really come up with anything, but a two-day stay could be costly."

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24.

Dawn said when her son was admitted to the hospital last week, she had no idea of the ongoing contract dispute between her provider, United Healthcare, and Children's Hospital. Her first notice that she could be liable for higher costs for her son's care came in the mail this week.

"We didn't get notification from either side telling us there may be a problem, that we could be liable for 30 percent rather than 10 percent of the bill," said Osness.

United Healthcare spokesman Michael Strand said patients will not be responsible for higher costs. "Our enrollees should not worry about the arbitration because no matter what happens, they will not be held responsible for excess charges above their normal coverage at that facility."

Children's felt the letter to parents was necessary. "There was a potential something could happen," said Children's Laura Gell. "I'm glad United chose to clarify that."

"I think they've put our enrollees in an unfair position by placing them in the middle of a business dispute," said Strand. "I think it causes unnecessary alarm within the community."

KETV NewsWatch 7 asked Children's if the letter was a scare tactic to get parents to write the insurer and demand concessions.

"Absolutely not and I'm sorry United chooses to frame it that way," said Gell.

Osness just wants to know what she'll be responsible for when her son's bill comes in the mail. "We just don't want to be caught holding the bag because they can't agree."

Nebraska Medical Center is also in the midst of negotiations with United Healthcare. No word on how those talks are going. Alegent said it has a long-standing relationship with United Healthcare and that a contract is in place.

Questions about your United Healthcare coverage can be directed to its toll-free customer services number, (800) 641-1904.

Previous Stories:

- September 25, 2003: Parents Get Insurance Letter From Children's Hospital

Huskers Defeat Iowa State In Volleyball At Civic

25.

UnitedHealthcare Update
September 2003

Network Notice

From the desk of Rob Bates, Vice President of Network Management

UnitedHealthcare is concerned about what employers and consumers pay for their health care. To help control health care costs, we work hard to secure fair hospital reimbursement rates that reflect the need to limit spiraling health care costs on behalf of our customers. Providing broad access to high-quality, affordable health care services is our top priority.

In an effort to keep you better informed of key network negotiations, we want to share the following information, which involves UnitedHealthcare's long-term relationship with Children's Hospital of Omaha. Despite what is implied by an unfortunate letter Children's Hospital sent to its patients, UnitedHealthcare still has a valid contract in place with Children's Hospital. Our contract with Children's runs through April 30, 2004. The hospital, however, has claimed a breach of contract with respect to its reimbursements and unilaterally attempted to sever its relationship with UnitedHealthcare on September 13, 2003. Children's has requested arbitration to resolve its dispute with us, which is the contractually required method for settling such issues.

We are appalled that Children's has resorted to scare tactics to further its negotiating position. In sending the letter, Children's has chosen to confuse the parents of sick children about the status of its contract with UnitedHealthcare. We are confident of winning the arbitration with Children's Hospital and we commit to hold our customers harmless, so that their financial responsibility for services at Children's will remain the same, regardless of the arbitrator's decision. This means UnitedHealthcare customers may continue to obtain services from Children's Hospital without interruption or additional financial liability.

UnitedHealthcare's objective is to reach a fair, justifiable and affordable arrangement with Children's Hospital that addresses the business and health care needs of our customers, while also providing the resources necessary for Children's professionals to properly care for your families. However, at this time,

Children's Hospital continues to demand an excessive rate increase that would raise Children's reimbursement by more than 57 percent as compared to current levels. The requested rate increase goes far beyond both customary market norms and the medical inflation rate. Additionally, such rate increases jeopardize both the economic stability and affordability of health care in Omaha.

We realize that our customers depend on us for access to hospital and physician networks that provide high quality medical services at affordable premiums.

Please be assured that during the arbitration period, UnitedHealthcare will continue to pay participating benefits on Children's Hospital claims. Only Hospital services are impacted by these negotiations. Contracts with Children's physicians are not part of the current dispute, or contract negotiations. During arbitration, we anticipate that Children's Hospital will treat all UnitedHealthcare customers appropriately and with respect. If this does not occur, please call Customer Service at the number shown on your ID card so we can immediately address the situation.

If you would like to express your support for, we encourage you to contact President/CEO Gary Perkins, or Chief Financial Officer Michael J. Brown of Children's Hospital. Either may be contacted at the following address:

Children's Hospital
8200 Dodge Street
Omaha, Nebraska 68114-4113
(402) 955-5400

In these difficult economic times, a proposed rate increase of over 57 percent is a sharp departure from the serious economic issues at hand. The ongoing cycle of reduced benefits for employees, swollen ranks of the uninsured and mounting financial burdens for employers must stop. UnitedHealthcare is committed to working hard on behalf of our customers to manage these costs through a broad network of quality, affordable health care services.

We will be communicating this same information to our customers via email, fax, and U.S. mail. We sincerely regret any inconvenience or distress the Children's letter may have caused you, your customers, their employees or families. Should there be a change in our physician network, we will communicate such information to you directly and in a timely fashion.

Thank you

Millard Public Schools
Board of Education Legislative Resolutions
2004

1. State and local taxpayers share the responsibility for the Pre-K through 12th grade educational program; therefore the funding should be equally shared (2001).

2. School districts should be encouraged to support ongoing maintenance of school buildings; therefore spending and levy restrictions should be removed from the building fund (2001).

3. The state should never impose un-funded mandates on schools (2001).

4. Local boards of education are accountable to their community for making decisions regarding the educational program, and are in the best position to make decisions on curriculum, management and funding (2001).

5. The state should not have lids on spending or levies. Those decisions are best made at a local level where elected officials are most accountable to the community (2001).

6. The state should support efforts to raise teacher salaries by increasing funding to education (2001).

7. The state should continue ~~seek ways~~ to broaden the tax base in order to provide greater revenue sources for state aid with the goal of balancing funding from state and local sources (2001).

8. The state should eliminate reserve limitations on school districts' general accounts and debt service accounts (2001).

9. State appropriations should increase in order to offset the reductions in revenue at a local level caused by student fees legislation (2001).

10. School finance studies should focus on equity and adequacy of funding as well as determining the appropriate ratio for local and state funding (2002).

11. The Board does not support legislation that reverses state commitments and/or contracts for future dollars as in technology reimbursements and lottery funding (2002).

12. Additional state funding should follow any new requirements for new or revised assessments (2002).

13. Technology practices and requirements vary widely across the state. Representation on technology committees should consider input from small rural school districts to large urban ~~or~~ and suburban districts prior to establishing policies and procedures (2002).

14. The board of education does not support legislation that improves the state cash-flow position by delaying state aid payments to local school districts (2002).

New resolutions proposed for this year

15. Millard Public Schools believes that a legislative solution is the most effective way to resolve the issues that are represented in the current finance litigation (2003).

16. The Millard Public Schools support legislation that establishes a separate ESU system that serves students in the Millard Public Schools (2003).