

September 2001

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Agent Update

A publication for our independent agents and brokers

Opening the door

to enhanced client status information

Arkansas Blue Cross and Blue Shield is working to make life easier for agents. One example of that effort will be realized in the near future.

Soon, agents no longer will be the last to know if a client has been classified as delinquent or cancelled. That line of communication between Arkansas Blue Cross and its agent community is being enhanced.

Arkansas Blue Cross is on the verge of implementing a program that will inform agents on a weekly basis of those clients whose individual policies have been classified delinquent or



been cancelled.

The program will issue two reports a week that will be sent directly to agents. The reports will detail for each agent which clients have been classified delinquent or cancelled and include all pertinent information such as the client's name, address, amount owed and policy number.

The program will not issue carbon copies, but reports tailored to each agent and his list of clients. If an agent has no delinquent or cancelled clients, that agent will not receive a report.

2001 readership survey included inside

It's time for you, our agent community, to help us make *Agent Update* a more valuable tool for you. Included in this issue is the 2001 readership survey.

Please take a moment and give us your thoughts on this publication

and how we can better serve you. When finished, just place the survey in the enclosed, business-reply envelope and send it back to us (or fax them to 501-378-2969).

All survey responses should be returned by Oct. 1.

We'll announce the results in our next issue, as well as the winner of a random drawing of survey participants.

Thank you for your help in making *Agent Update* as valuable a tool as possible.

Why health care is so expensive

twelve factors driving up medical costs

*A perspective from Raymond Bredfeldt, M.D.,
medical director for Arkansas Blue Cross and Blue Shield's Northwest Region, headquartered in Fayetteville*

As a physician in Arkansas, I'm acutely aware of the rapidly rising cost of health care. And you, as a person with health insurance and someone who sells it to others, no doubt are feeling the direct effects of these rising costs.

When the cost of medical care goes up, so does the cost of health insurance. But why is this happening? What is causing medical costs to rise rapidly, which in turn causes the cost of health insurance to increase?

Here are 12 major drivers of higher health care costs in Arkansas:

1. Changing demographics — As a nation, our work force is getting older. As we age, we consume a greater amount of health care. In Arkansas, our median age increased from 33.8 years in 1990 to 36.0 years in 2000, both of which are higher than the national average.

2. New technologies — Today, we are able to provide incredible new treatments such as organ transplants, which were not available just a few years ago. While these advances have improved our quality of life, they have come at significant costs. Take the example of pharmaceutical advances. In 2000, a new drug was approved for people with rheumatoid arthritis. Some experts now believe that this drug should be used for almost everyone with this illness. It improves the quality of life for many people with this crippling disease. However, this drug costs \$1,000 per month. Provide this drug for the approximately 4,800 of our insured members who may need it would result in a 6 percent premium increase for all 480,000 members who are fully insured through Arkansas Blue Cross and Blue Shield and Health Advantage. That's right — one drug for 1 percent of our members could raise premiums by 6



percent for everyone. And, there are several other \$1,000 per month drugs for other illnesses available or in development.

3. Patient demand — Americans are heavy consumers of medical services, and demand choices in health care. They want access to heavily advertised drugs and services, and want more choice of providers.

4. Increasing litigation/regulations — Both the federal and state governments periodically develop new rules and regulations which apply to insurers. Each of these mandates results in premium increases. In addition, fear of litigation has caused many of the restrictions of managed care to be lifted in the past few years. With the reduction in these cost containment efforts have come increases in medical services and costs.

5. Increasing supply of physicians — During the past 10 years, the number of physicians has grown at a rate that is 28 percent higher than the overall population. Studies show that as the supply of physicians increases, so does the number of services people receive from physicians. People see doctors more frequently for more minor problems today than ever before. While the number of physicians is increasing nationally, there still is an unequal distribution of physicians — many rural areas have too few physicians and many urban areas have too many.

6. Shortage of non-physician professionals — Arkansas and the nation are experiencing a shortage of nurses. This is causing hospitals to compete for these health care professionals with higher salaries, thus driving up employment costs. There is a similar, but less acute, shortage of physical therapy and occupational therapy health care professionals.

7. The consumer is not the direct payer for health care — Few people realize that the drug for

which they paid a \$15 or \$20 co-pay actually costs \$150 or more. People are not aware that the few minutes they spend seeing a doctor for a common cold results in an average total cost of \$200 or more (doctor's fees, lab/x-rays, pharmacy). Co-pays and deductibles have not kept up with medical cost inflation, making the consumer less aware of actual costs. While most forms of property and casualty insurance cover catastrophic events (floods, fires, accidents), health insurance generally covers many common, everyday medical services, in addition to catastrophic services.

8. Health status of the population — The health status of the Arkansas population is poor, ranking 46th in the nation. We have high rates of obesity, smoking, cancer and heart disease.

9. Emerging diseases — The emergence of new diseases, or re-emergence of old ones, such as AIDS, Hepatitis C and tuberculosis, are driving up medical costs, as are such factors as environmental pollution and resistance to antibiotics.

10. Increasing number of uninsured — As health insurance premiums increase, so does the number of people who decide to drop their insurance. This raises costs in two ways. First, the people most likely to drop their insurance tend to be those who are healthy and believe that they can get along without insurance. As healthy people leave the insurance pool, the people left with insurance tend to be those with more health problems. This causes overall premiums to increase for those left behind in the insurance pool. Second, uninsured people tend to utilize higher cost

Did you know?

With rising medical costs causing health insurance premiums to increase, it's important to understand that Arkansas Blue Cross and Blue Shield is a not-for-profit, mutual insurance company.

That means that we are owned by our policyholders, not by stockholders. All revenues earned by Arkansas Blue Cross are utilized in only two ways:

- *To pay providers and members for covered benefits;*
- *To pay associated administrative expense.*

Any revenues received that are greater than these two categories of expense are held as unassigned funds (surplus) for future payment of claims and expenses for the benefit of our members. Health insurance is historically a cyclical business, and in those years when claims and expenses exceed revenues, surplus is used to meet those obligations to our members.

And while Arkansas Blue Cross is not-for-profit, it is not exempt from taxes. The company pays state premium and federal income taxes like any other health insurer. In 2000, this tax liability amounted to more than \$7.6 million.

Another important point is that Arkansas Blue Cross is better able to serve its members because it maintains low operating costs. In 2000, our administrative costs were approximately 12.5 percent of premiums, which is lower than the industry average. This means that more than 87 cents of every premium dollar in 2000 was used to pay for actual medical care received by our members.

care in emergency rooms for routine problems since ERs cannot turn anyone away. Often, these services go unpaid. This raises the cost of health care for everyone else, as these costs are passed on to others.

11. Variability in physician practice patterns — No two doctors handle the same problems exactly alike. For example, in Arkansas the average cost to treat a common cold in 1999 was \$178 (it is closer to \$225 in 2001). One doctor averaged \$728 for every person he saw with a cold in 1999. He ordered much more lab work than the average physician. Similar degrees of variability occur with every type of illness. There is probably no other industry in which that kind of variability exists in the delivery of a service.

12. Excess use of avoidable care — People tend to go to doctors for more minor problems today than they did 10 years ago. They also get many more medical services. People have assumed that more is always better in regard to medical treatment. For example, it has been estimated by the American Academy of Family Physicians that

Americans receive 50 million unnecessary prescriptions every year for antibiotics. These unnecessary prescriptions cause side effects and are the reason that so many bacteria are now resistant to antibiotics.

Dr. Bredfeldt is a board-certified family practice physician. He served for 10 years as director of the UAMS-AHEC Family Practice Residency Program at Fayetteville.

Individual and group health insurance —

Make sure your clients know the facts

Editor's note: While some of the information included in this article may be well known to you, it might be helpful in discussion with your clients.

If one of your clients is considering leaving a job in the corporate world to become self-employed, you — as his or her agent — will want to make sure he or she understands the difference between individual and group health insurance before they make the switch.

If your client leaves a job, he or she should understand his or her health insurance options. While your client may have been accepted into the employer's group health insurance plan with no hesitation, it might not be so easy when your client is looking for individual health insurance.

Individual health insurance

As you know, the most important thing to remember is that a person *enrolls* in a group insurance plan with the employer (he or she can not be excluded), but a person *applies* for individual health insurance.

The two insurance options are unrelated, and when a person leaves the protection of the group insurance plan, he or she is starting from the beginning in the search for health coverage. Being enrolled in an Arkansas Blue Cross and Blue Shield group insurance plan does not guarantee that a person's application for individual health insurance will be

approved.

Additionally, being in one of Arkansas Blue Cross' individual health insurance plans does not guarantee acceptance into another.

To change plans, applicants must go through medical underwriting and start the whole process again — there is no transfer of credit toward meeting deductibles or pre-existing periods.

"Individual business does not take into account previous health insurance coverage," said Ron DeBerry, vice president of Statewide and Individual Business. "If you apply for individual coverage, it doesn't matter if you were on another Arkansas Blue Cross individual health plan or moved here from the woodlands of Canada, you are starting from scratch."

Applicants for individual health insurance plans (such as BlueSelect®, BlueCare PPO and BlueCare PPO Plus) at Arkansas Blue Cross are subject to the following:

- 1) *Medical underwriting.*
- 2) *A 12-month pre-existing condition clause.*

Individual health insurance plan rates are set on a singular basis, and assume everyone is new to the health insurance medical underwriting

process. And, of course, individual coverage plans do not offer continuous coverage or deductible credit.

There are four things Arkansas Blue Cross may do when someone has requested individual coverage (for the applicant and/or applicant's family):

- 1) *Approve as applied* — Applicant will receive the coverage requested at the standard rate.
- 2) *Approve with exclusions* — Arkansas Blue Cross may exclude a condition or body part from coverage.

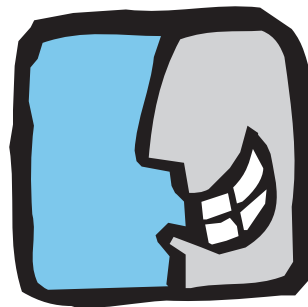
3) *Approve with a surcharge* — An applicant may be charged an additional percentage of the base rate if the applicant is a smoker, regularly uses a specific medication, etc.

- 4) *Reject the application.*

Approximately 75 percent of all applicants are approved for individual health insurance, with 60 percent of applicants being approved as applied (15 percent are approved with exclusions or surcharges).

Standard rates for individual health insurance plans are based on the applicant's ability to pass full medical underwriting. When a person applies for individual health insurance, and wants to include family members, each family member also must pass medical underwriting.

If the applicant misrepresents or



— Just what *is* the difference, anyway?

omits medical history information and does not disclose conditions or medications he or she is taking, the individual coverage may be rescinded. Many prospects may already have group coverage, but find that they can receive a more affordable rate for their children or spouse with individual coverage. As you know, people with individual insurance only pay for the benefits they need.

For example, a single 25-year-old male may share the cost of maternity coverage in a group plan but could eliminate that cost with individual health insurance. With individual plans, the insured may pay less in premium costs but may be required to pay a higher deductible or more out-of-pocket expenses and co-insurance. Occasionally, an agent will ask why a client is being issued a large amount of life insurance on a standard basis and is “rated up” for health insurance by Arkansas Blue Cross.

There is a huge difference between mortality and morbidity issues. For example, a person with a herniated vertebral disc is not of particular concern from a mortality standpoint, but the morbidity issue is that this condition frequently requires an expensive surgical procedure.

A similar situation may occur with certain female problems. The medical problems may not be life-threatening, but if the remedy for the problem is a hysterectomy, the claim may be thousands of dollars. Thus, morbidity frequently requires that we

charge an extra premium or exclude a specific condition when life insurance may be issued on a standard, or even a preferred basis.

Group health insurance

As you are aware, group health insurance plans work differently than individual health insurance plans.

If a person is employed with a company that offers group health insurance, generally all he or she has to do is enroll and pay a share of the premium, subject to the rules of the plan for timely enrollment.

While large group (50-plus employees) insurance generally is based on the group’s historical claims and medical history, for small group coverage (two to 50 employees), a person is required to complete medical applications for both him or herself and family members that the applicant plans to include in group coverage.

However, no matter what conditions the applicant has or may have had, he or she can not be excluded from the group plan. Underwriting may use the information to rate the group as a whole, but it will not exclude the person from receiving medical coverage.

Again, just as with individual health coverage, if a person misrepresents or omits medical history information or does not

disclose conditions or medications he or she is taking, group coverage will be rescinded or terminated, and he or she will not be able to obtain health insurance from Arkansas Blue Cross in the future.

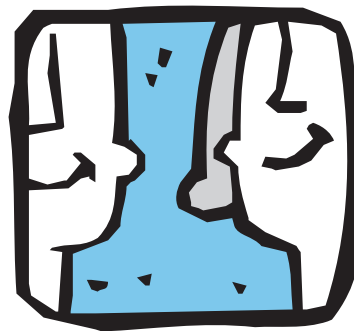
“If you are a diabetic and fail to disclose it on your medical enrollment form for group health insurance, you can lose your coverage,” said David Greenwood, director of Enterprise Underwriting. “We can’t exclude you from the health insurance plan for having diabetes if it is disclosed; we just need everyone to be truthful in completing their applications for rating purposes.

“It’s not enjoyable for us to have to call someone and tell them their insurance is being canceled because the information on their medical enrollment form was inaccurate. It’s a very difficult thing to have to do. It is something we would prefer that everyone could avoid.

“People with health problems are aided by the small group insurance laws and regulations,” Greenwood added. “While disclosure may impact the group rates, it helps ensure health insurance coverage will be there when needed.”

Some agents may recall the Health Insurance Portability and Accountability Act (HIPAA), and may

(See **FACTS**, Page 7)



Recent influx should not result in backlog

By now, all of you have learned that as of Aug. 31, 2001, Conseco is out of the individual health market in Arkansas.

It's unfortunate, but having been in the business for more than 20 years, I've seen many companies have left our state. Because of Conseco's exit, we have experienced an increase in the number of applications received. However, three underwriters have applied to Arkansas Blue Cross and Blue Shield, and hopefully they will be offered and will accept positions with us. Because of new procedures and additional automation, we should not see the kind of backlog that was created in October of last year and which, subsequently, took several months to work through.

EXTREMELY IMPORTANT: A recent COBRA awareness brochure addressed a recent court case.

An employee was terminated, but her employer did not advise her of her option to continue her health insurance coverage. Her policy was individual (not group) coverage, list billed to the employer. The court ruled that because the employer made a contribution to her coverage, it was an employer-sponsored plan and fell under COBRA law, even though the employer argued that all she would have had to do was pay her premium. The employee argued that she had not been told this. As I said, the court ruled in her favor. Alert your list-billed employers of this, as obviously, it can expose them to possible litigation if they do not advise employees who are list-billed that they can continue their coverage upon termination.

I have had several agents ask about employers making a contribution to individual coverage. Please note that another court case more than three years ago ruled in favor of a disgruntled employee who (because of a health impairment) did not get the same benefits as other employees. The employer was making a contribution to the coverage. The employee filed suit against the employer and won. The employee was awarded punitive damages, and the employer was required to pay any out-of-pocket expenses that other employees normally wouldn't have had. Any person covered by CHIP would have this option, if the employer is contributing.

Be extremely cautious with list-billed accounts. They are **NOT** group, and the employers' mind set must be changed or they can get into possible litigation problems, which of course means that your E&O coverage had better be good.



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Pre-certification requirement dropped for hospital stays

Arkansas Blue Cross and Blue Shield has eliminated hospital admission pre-certification requirements for members who have insurance with Arkansas Blue Cross and Blue Shield and Health Advantage HMO.

What does this mean for your clients covered by Arkansas Blue Cross? It means that physicians and members are no longer required to call for pre-certification (or approval) when members are admitted to an in-state participating hospital.

The physician will continue to make all decisions regarding admissions and stays in the hospital.

Admission pre-certification will no longer be required for routine hospital admissions, which includes hospitalization, surgery and diagnostic testing performed at in-network facilities.

However, if services are performed at an out-of-network facility or outside the state of Arkansas, it will continue to be the member's responsibility to notify our utilization management company by calling the pre-certification number on the ID card.

For more information, contact Arkansas Blue Cross Customer Service or any of the medical management teams at your nearest Arkansas Blue Cross regional office.

Prenatal benefit amended

For members of a group (employer-sponsored) health plan with an Arkansas' FirstSource PPO policy or a comprehensive major medical policy from Arkansas Blue Cross and Blue Shield, the Routine Prenatal Care benefit has been amended, effective Oct. 1, 2001.

The amended portion of the policy (**OTHER COVERED MEDICAL SERVICES**, paragraph D), now states that, subject to the applicable deductible and co-insurance, the Company (Arkansas' FirstSource or Arkansas Blue Cross) will pay for routine prenatal care, maternity care, obstetrical care and complications of pregnancy.

Previously, prenatal services were paid at 100 percent.

For any pregnancy beginning after Oct. 1, routine prenatal care services will be paid at the

same level as all other covered benefits of the policy, subject to the applicable deductible and co-payment of that policy.

For purposes of claims administration, this means that if a member delivers anytime on or before July 1, 2002, prenatal care services will be paid at 100 percent. If a member delivers on July 2, 2002 or after, prenatal benefits will be paid at the same level as other covered benefits.

Bringing the prenatal benefit in line with all other benefits of the policy will help simplify the benefit administration process, reducing errors and speeding up the claims payment process, and ultimately help hold down costs to insured members.

The amendment does not affect individual policies with Arkansas Blue Cross, nor does it affect HMO or POS policies with Health Advantage.



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believe that it provides for portability of coverage when a client changes jobs — whether they are with a group or are seeking individual health insurance. That is a misconception.

It does allow an individual to continue *group* insurance coverage when there is a job change, but it does *not* apply to individual health insurance. If a state does not have a program for the uninsured, then the insurance company must accept all applicants for individual health insurance.

However, in Arkansas, there is a program for the uninsured called Comprehensive Health Insurance Program (CHIP). Because of CHIP, health insurance companies may reject applicants for individual health coverage.

Whether your clients are enrolled in a group or individual health insurance plan at Arkansas Blue Cross, it is always a good idea to look closely at all of their options with them when helping them make health insurance changes.

If one of your clients is thinking about leaving the protection of his or her group health insurance plan for an individual plan, be sure your client has the information he or she needs to make an informed decision. Health insurance should be an important part of any career decision.

If you have questions about individual health insurance products, please contact Deborah Benafield at 501-396-4110 (toll-free, 1-800-634-6314), or e-mail her at djbenafield@arkbluecross.com.

Mastectomy coverage law outlined

As a reminder, the Women's Health and Cancer Rights Act of 1998 introduced changes in insurance coverage for mastectomy.

In accordance with the law, all group and individual health plans that provide medical and surgical benefits for mastectomy now cover reconstructive breast surgery, if elected by the covered individual following mastectomy, including:

- Reconstructive surgery on the breast on which the mastectomy was performed.
- Reconstructive surgery on the unaffected breast needed to "produce a symmetrical appearance."
- Prostheses and treatment of complications of any stage of a mastectomy, including lymphedema.

The provisions of the Women's Health and Cancer Rights Act of 1998 apply to all group health insurance coverage effective on the first day of the plan year (which in most cases is the anniversary date of the group contract) after Oct. 21, 1998.

The law went into effect on all individual insurance policies (UniqueCare Blue, UniqueCare, etc.) issued, renewed or in effect on or after Oct. 21, 1998. These provisions apply to all policies issued by Arkansas Blue Cross and Blue Shield, Health Advantage and USABLE Administrators and are subject to the applicable co-payments, co-insurance, benefit limitations, exclusions and benefit maximums.

Diabetes walk set for Sept. 22

Arkansas Blue Cross and Blue Shield is the title sponsor for this year's Juvenile Diabetes Research Foundation (JDRF) Walk to Cure Diabetes in Little Rock. The 2001 Central Arkansas walk (5K) is set for Saturday, Sept. 22. It will begin at 9 a.m. from the River Market pavilions. For more information, contact Stephenie Hecke of JDRF at 372-7515.



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