The United States General Accounting Office (GAO), the investigative arm of Congress, recently released its findings from a study it conducted to help Congress understand the reasons behind rising medical malpractice insurance rates. During the past several years, large increases in medical malpractice insurance premium rates have raised concerns that physicians will no longer be able to afford malpractice insurance and will be forced to curtail or discontinue providing certain services.

Also, a lack of profitability has led some large insurers to stop selling medical malpractice insurance, furthering concerns that physicians will not be able to obtain coverage.

The GAO study sought to (1) describe the extent of the increases, (2) analyze the factors that contributed to those increases, and (3) identify changes in the medical malpractice insurance market that might make this period of rising premium rates different from previous periods.

What the GAO found was that multiple factors, including falling investment income and rising reinsurance costs, have contributed to recent increases in premium rates in the seven states it analyzed. However, the GAO found that losses on medical malpractice claims — which make up the largest part of insurers’ cost — appear to be the primary driver of rate increases in the long run. Although losses for the entire industry have shown a consistent upward trend, insurers’ loss experiences have varied dramatically across the seven sample states, leading to wide variations in premium rates.

Also, factors other than losses can affect premium rates in the short run, exacerbating cycles within the medical malpractice market. For example, high investment income or adjustments to account for lower than expected losses may legitimately permit insurers to price insurance below the expected cost of paying claims. However, because of the long lag between collecting premiums and paying claims, underlying losses may be increasing while insurers are holding premium rates down, requiring large premium rate hikes when the increasing trend in losses is recognized.

The AMA Responds

With medical malpractice insurance rates on the rise, the American Medical Association (AMA) is stepping up calls to reform our nation’s medical liability system. In a statement released by the AMA, the organization’s president, Donald J. Palmisano, M.D., said, “[The] GAO report confirms what we have long held: since 1999, medical liability premiums have skyrocketed in
A key point that appears to be recurring in nature is that the more we automate (implement high tech), the greater is the need to ensure that our traditional “high touch” approach to effective customer service is not lost or overly compromised. For those of us who have been at Arkansas Blue Cross and Blue Shield for an extended period of time (more years than some of us would care to admit), the latest generation of customer service-oriented technology is a dream come true. For years the prospects we’re enjoying today appeared just beyond our reach, due to some combination of cost justification and the state-of-the-art of the technology itself. This new wave of technology-supported customer service capabilities now includes the new leading-edge customer service workstation and online access to claims and related documents via new digital imaging capabilities. It also includes the profound impact that AHIN represents in servicing our customers at the point of delivery of medical care in the physician’s office or in the hospital setting. Now that we have a “bird in the hand,” so to speak, relative to these new capabilities, it may be a good time to step to the sidelines and refine our focus on the objectives we’re seeking to achieve.

Without question, the technology-based advances listed above hold great promise for better customer service and more competitive administrative costs, but there are additional positives, which I believe should not go unnoticed. For example, this new generation of customer service support represents a major step forward in our enterprise objective of making more of our associates within the enterprise truly “knowledge workers” in nature. By this I mean utilizing these advances in technology to accommodate many of the rote and boring functions so that an increasing number of staff positions are oriented toward more cognitive and fulfilling job content. All this should likewise lead to greater accuracy and free up the critical time necessary to interact with our customers (both internal and external) to perpetuate the quality service reputation that is our trademark.

Looking to the future, these advances in our customer service capabilities and support operations could not have come at a more opportune time. Increasingly, we are seeing a growing interest by employers throughout Arkansas in new products and programs commonly referred to as “consumer-directed health care.” The common theme here is that employers and their health insurance carriers/health plans will deploy a series of new coverage plans. These plans are designed so that employees and their family members have a much greater role in managing the medical services they elect to consume and in the financial implications of these decisions. Without going into great detail, these new approaches typically have a combination of front-end benefits composed of employee-funded Section 125 dollars and employer-contributed Section 105 funds.

The net effect is that employees will typically control the first $5,000-$7,000 in annual medical expenses through these Section 125 and 105 accounts and then become eligible for comprehensive major medical benefits above these thresholds. Obviously, in an environment such as this, increased levels of customer service by those health insurance/health plans offering these new-generation products will be a critical element in determining their ultimate success.

This new generation of products, heavily supported by Web-based and related technologies, also appears to represent a “two-edged sword” for the enterprise. On one hand, our brand presence, provider networks, service reputation and regional office-based services are major pluses. This is particularly true as employees/patients desire to seek assistance in navigating their options relative to increasingly making both the clinical and financial decisions associated with their health care.
Making the most of the Automatic Bank Draft process

Many of our members rely on the convenience of automatic bank drafts to pay their premiums. This service provides advantages for everyone involved, including members, agents and Arkansas Blue Cross and Blue Shield.

However, for the process to be effective, it is important that all the information needed is submitted with each application. For example, if you are submitting both a health and a dental application for the same customer, please attach a voided check to each application. (We also will accept photocopies or a deposit slip.)

It also is vital that the draft form is accurately completed and legible. Otherwise, the form has to be returned, which leads to delays in getting your customer’s policy in force. This also holds true for applications that are submitted — they must be properly completed and legibly signed in ink. If an application is not properly signed, it will be returned to you to obtain the proper signature.

Applications also will be returned if there is an alteration to the applicant’s signature or if “white out” is used, as it voids the application.

Your attention to these details will help us provide better customer service to you and your clients.

Blue Notes

Study sheds light on medical malpractice insurance

After reading much of a study done by the U.S. General Accounting Office on malpractice premiums and their effect on the cost of health care, I asked for an article in this issue on the economic repercussions that result and the need for tort reform. (See Malpractice article, page 1)

Additionally, I talked with one of our network providers and asked him to say a few words about his malpractice insurance premiums.

“Trying to say a few words about the medical malpractice crisis is like trying to extinguish the Great Chicago fire with a thimble. As more people have turned to the courts, liability insurance rates have escalated. I, personally, have seen my malpractice premiums double a couple of times. It now takes delivering 20-25 babies just to pay the annual premiums. At one time, I had four malpractice cases working against me, two of which were totally frivolous, and the other two were for bad outcomes over which I had no control. The litigation crisis has turned every patient encounter into a potentially antagonistic situation. I, as well as other providers I speak with, have to think during every patient visit, ‘How can this patient sue me?’ This has dramatically added to the spiraling health care costs and the way I practice medicine.”

(Name withheld by request)

Effective Date Changes

Effective date changes continue to be a source of frustration for the agents as well as internal personnel. With this in mind, we have decided to alter the method in which we assign effective dates. Beginning Oct. 1, 2003, the policy effective date will be the 15th of the following month if the application is approved on the 11th-25th of the current month OR the 1st of the month after next if the application is approved on the 26th through the end of the current month or the 1st-10th of the following month.

Here’s an example with September being the “current” month. If the application is approved on Sept. 23rd, your policy effective date will be Oct. 15th. If your application is approved on October 3rd, your policy effective date will be Nov. 1st.

We hope this change will enable us to meet the needs of our agent community and your clients by alerting you to the assigned effective date prior to receipt of a policy and in adequate time to terminate an existing contract if it is the intent of the client to cancel. Please continue to carefully review your status updates, since effective dates are indicated on any approved files listed in the report.

Let me know if you have any comments or questions.
some states and specialties — and increasing awards are the main driver.”

Palmisano said the report also puts to rest two other trial lawyer smokescreens: that insurance company gouging and/or stock market losses have caused the medical liability crisis.

“[It] makes clear that bonds make up 80 percent of insurers’ investments and that ‘no medical malpractice insurers experienced a net loss on their investment portfolios.’ The GAO report also states that insurer ‘profits are not increasing, indicating that insurers are not charging and profiting from excessively high premium rates.’”

He said the medical liability crisis in this country cannot be ignored. “The debate in the Senate is not over whether the medical liability system is in crisis — but rather how we will solve this crisis. Today’s GAO report points to the main culprit: increasing awards. The reasonable cap on noneconomic damages that has been working in California is clearly the answer to the crisis.

Susan Laudicina, director of state services research for the Blue Cross and Blue Shield Association, said sharply rising expenses for medical malpractice insurance resulted in the passage of comprehensive reforms in a number of states this year.

“The escalating cost of medical malpractice insurance and its impact on health care affordability commanded lawmakers’ attention in the first half of 2003,” said Laudicina. “In response to this situation, 34 states debated a variety of solutions, and 10 enacted significant tort reform measures.”

The tort reform laws enacted so far this year include: (1) caps on both non-economic and punitive damages (Idaho); (2) caps on punitive damages alone (Arkansas); (3) caps on non-economic damages (Ohio, Oklahoma, Texas, West Virginia); and (4) court venue reform (Arkansas, Georgia, Texas, West Virginia).

Palmisano concluded, “The time for Senate action on America’s liability crisis is past due. We must act now to fix our broken medical liability system. We just need a little common sense in our courtrooms — so that every patient can have access to physicians — in emergency rooms, operating rooms and delivery rooms.”

*The seven states in the GAO study were California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania and Texas.

Sources: www.gao.gov/new.items/d03702.pdf, American Medical Association and BCBSHealthIssues.com

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**HHS Study Finds —**

**Malpractice limits linked to higher physician staffing**

States that have imposed financial limits on medical malpractice awards have a higher number of physicians working in those states, according to a new study by the Health and Human Services’ (HHS) Agency for Healthcare Quality and Research (AHRQ).

The AHRQ study finds that states that have placed caps on non-economic damages in medical liability suits have a 12 percent higher physician staffing level than states with no such caps. In 2000, states that had enacted caps had, on average, 135 physicians for every 100,000 residents, while those without caps had only 120 physicians per 100,000 residents.

“Our broken medical litigation system is affecting patients’ ability to find a doctor,” HHS Secretary Tommy Thompson said in a statement. “This study confirms and quantifies the association between reasonable limits in medical lawsuits and the supply of physicians available to treat patients who need them … In the current system, the fear of excessive awards stimulates wasteful defensive medicine and deters doctors and hospitals from identifying and addressing medical errors, thus increasing costs and decreasing quality.”

In March, the House passed legislation that would cap non-economic damages, such as those for pain and suffering, at $250,000 and limit punitive damages. However, most Senate Democrats and some Republicans oppose the measure, arguing that the cap is too low, especially for catastrophic cases. While Senate Republicans are pursuing alternatives that would permit larger awards for damages, it is unclear whether legislation will pass the Senate this year.

Source: BCBSHealthIssues.com
Arkansas Blue Cross and Blue Shield, Health Advantage and BlueAdvantage Administrators of Arkansas customers now can access personal health insurance information with a simple telephone call.

The new interactive voice response (IVR) system recognizes speech patterns to help answer questions when customers call current customer service telephone lines. When customers call a customer service line, the new system immediately answers the call and by simply responding to the questions asked by the system — with no buttons to push — customers can get numerous questions answered quickly and easily. My BlueLine is available 24 hours per day, seven days a week. The new system can help customers who have questions about benefits, status of claims, and premium payments; and help customers order a new ID card, a provider directory or a claim form. And, during regular business hours, customers can request — at any time during the telephone call — to speak to the next available customer service representative.

Because the IVR system can’t help customers with all of their needs, Arkansas Blue Cross and its family of companies will always have customer service representatives available. The IVR system is a service to our customers who have simple questions they need answered quickly; it’s there when they need it. The new IVR system is another way to meet the varying needs of our customers. And, for our agents, it’s a great selling point for Arkansas Blue Cross products and a helpful time-saving tool for agents as well.

New over-the-counter drugs

In December 2002, Claritin, a popular allergy medication, became available without a prescription at a very low price. And now, Prilosec, a popular medication for gastritis, will be available over the counter, also at a very low price.

These two prescription brand-name medications recently lost their patent protection, which means that generic equivalents of both drugs are now in the marketplace. This usually results in a decrease in sales for the brand-name medications. As a result, some pharmaceutical companies are taking their brand-name medications “over the counter” to save their market share. This is what happened with both Claritin and Prilosec.

As a prescription medication, the average cost of Claritin was $3.25 per tablet. As an over-the-counter medication, Claritin costs $1 or less per tablet. Alavert, an over-the-counter medication that has the same ingredients as Claritin, sells for 85 cents or less per tablet. The generic equivalent of Claritin (loratidine) sells for 50 cents or less per tablet. It makes sense for consumers (and health insurance companies) to prefer the over-the-counter medications when equivalent prescription medications such as Allegra, Clarinex and Zyrtec range in price from $2.90 to $3.75 per dose.

Prilosec OTC sells for approximately $1 per capsule. As a prescription medication, it sells for an average of $4.60 per capsule (20 mg) and $6.62 per capsule (40 mg). The generic version of Prilosec (omeprazole) costs approximately $3.50 per capsule. Again, it makes sense for consumers to purchase Prilosec OTC at their local store.

It’s important to be an educated consumer. Remind your clients to ask for generics when they are available and to watch for when their prescription medications will be available as over-the-counter medications. By making informed decisions, your clients will save money now … and in the long run, when it comes to their health insurance.
Prescription Drug Information

The Arkansas Blue Cross and Blue Shield family of companies provides on-line services to offer members convenient access to their health plan benefits. You may want to tell your clients that Arkansas Blue Cross, Health Advantage and BlueAdvantage Administrators of Arkansas members now have on-line access to their prescription history. To get to this history, they should visit www.ArkansasBlueCross.com, www.HealthAdvantage-hmo.com or www.BlueAdvantageArkansas.com.

On the Arkansas Blue Cross and Health Advantage sites, the link called Prescription Drug Information is on the home page. On the BlueAdvantage site, the link is on the “Members” page.

The link opens the https://arbcbsAdvanceRx.com site, which is customized for Arkansas Blue Cross and Health Advantage members by AdvancePCS, our pharmacy benefit manager.

The site also allows members to locate a network pharmacy, determine if a drug is covered, compare drug prices, and review extensive information about drugs, their uses, side effects and interactions. To access the full menu of information, a member must register on the site. The member will need the information from his or her health plan ID card or drug card to register. To view prescription history, the member must enter a recent prescription number. This extra step helps protect the privacy of members’ personal information.

The initial registration process requires a member to enter an e-mail address and select a password. Once logged in, the member should click on the Prescriptions link in the blue bar near the top of the page to locate the link to prescription history. On the “Prescriptions” page, the link says, Click here to view prescription claims history now.

This opens the member’s prescription record for the past 12 months. It includes drug name, prescription number, days’ supply, fill date, retail price, what the member paid, cost savings (what the insurance company paid), pharmacy that filled the prescription and prescribing physician. A member may sort the history by time period, drug name, prescribing physician or pharmacy.

To see drug coverage and pricing, a member should click on the Look Up Drug Coverage & Pricing link on the home page. A page that explains what a formulary is and how it is used appears.

The link called Search Your Formulary allows members to look up a drug by name or category to see if it is on the formulary. When the drug information appears, the member can request other drugs in the same class and drug pricing information on any of the drugs listed.

For a complete description of the drug, its uses, dosage and side effects, site visitors may click on Drug Dictionary on the home page of the site or on the drug name on the formulary search results page. To check interactions, a link at the bottom of the drug description page or on the home page called Drug to Drug Interaction Checker allows a member to enter a list of drugs and check for interactions.

A link called Locate a Pharmacy on the home page allows members to locate a pharmacy that participates in their health plan network. The search requires a ZIP code or address, the distance the member is willing to travel and any services required (open 24 hours, delivery, drive through, etc.). A list of in-network pharmacies that meet the search criteria, as well as a map and driving directions, results.
Web sites provide instant access to information

**My Blueprint**

Don’t forget that members can access their medical claims information by registering for My Blueprint on the Arkansas Blue Cross and Blue Shield, Health Advantage or Blue Advantage Administrators of Arkansas sites. They have easy access 24 hours a day, and they don’t have to wait for their explanation of benefits (EOB) to arrive in the mail.

They’ll find eligibility information — who is covered and each covered person’s eligibility dates. They’ll not only be able to check the status of a claim, but they’ll also be able to see their claims history as far back as that data is stored on Arkansas Blue Cross, Health Advantage and Blue Advantage computer systems. On the Health Advantage site, members can click on the word complete under status to see an EOB for that claim. The EOB is printable. The other sites will add this feature soon.

**Agents’ Portal**


Included in the agents portal on the Arkansas Blue Cross and Blue Shield sites are the following links:

- **Agent Update**, an archive of the quarterly newsletter exclusively for agents;
- **Forms for Agents**, a section that links to miscellaneous forms for agents;
- **Group Administrator’s Manual**, procedures and guidelines for your employer groups to make the job of administering their company’s health plan easier;
- **Health Plans & Services**, brief descriptions of product offerings and services that provide added value to members;
- **Wellness Discounts**, a list of discounted health club memberships, weight-loss programs and sporting goods for members;
- **About Us**, information on Arkansas Blue Cross history, structure, financial stability and A.M. Best rating;
- **Provider Directory**, searchable lists of physicians, dentists, hospitals, pharmacies and other health care providers and facilities participating in Arkansas Blue Cross networks;
- **SIC Codes**, a reference for determining standard industry classification (SIC);
- **Find Help** to answer common questions about health plans and services;
- **Glossary** of health insurance terms;
- **Contact Us** section for information on how to get the answers you need from Arkansas Blue Cross.

**What new features would you like to see added to our Web sites?** Our annual Readership Survey, included in this issue, is the perfect way to share your ideas, comments and suggestions for creating on-line tools that are useful to you. Please take a few moments and let us know what you think.
Inactive lifestyles can lead to illness and chronic diseases that cost billions of dollars in health care costs each year. Regular physical activity — just 30 minutes of moderate exercise daily — can significantly improve the health of millions of Americans, and help control the rising cost of health care.

The benefits of regular physical activity are many — we look better, we feel better and our overall health could improve. And that’s not all, by exercising regularly we can help control the rise of health care costs for everyone. In fact, according to a study by the Centers for Disease Control, increasing regular moderate physical activity among the more than 88 million inactive Americans age of 15 and older might reduce annual health care costs by as much as $76.6 billion.

We all have a role to play in keeping health care affordable. And because we all pay for the rising cost of health care through increased premiums, copays and deductibles, we all have a stake in this.

Being physically inactive significantly increases the risk of developing many chronic diseases and conditions, such as heart disease, stroke, colon cancer, diabetes, obesity, arthritis and osteoporosis. Total health care costs related to these conditions total more than $600 billion nationally.

Fortunately, each of us has the power to help control health care costs by exercising every day. For example, brisk walking for 30 minutes a day, three times a week, can not only improve personal health, but also can reduce the need for medical services.

Talk with your doctor to find the best way to add physical activity to your daily routine.

To make it easier for our members to take the first step toward a healthier lifestyle, Arkansas Blue Cross and Blue Shield has negotiated discounts for wellness with health and fitness clubs, sporting goods and fitness equipment stores across the state. Health and fitness clubs can help you lose weight, tone your body and increase your overall sense of health. For added value, the Discounted Wellness program includes weight management plans as well as sporting goods, fitness and safety equipment vendors offering discounted retail items. Getting your discount is easy; simply show your individual or family health insurance ID card bearing the Arkansas Blue Cross logo at the time of club enrollment, purchase of services or retail transactions. To find out more about available services and product discounts, please call the individual clubs, fitness specialists and other vendors. A listing of participating vendors is located on our Web sites in the sections entitled “Members” and “Customer Service.”

When it comes to the cost of health care, your choices make a difference. Visit www.bcbs.com or www.ArkansasBlueCross.com to discover more ways each of us can help keep health care affordable.
New advertising campaign emphasizes how —

Blue Comes Through.

Arkansas Blue Cross and Blue Shield has begun a new print advertising campaign. The four-ad series gives examples of how Arkansas Blue Cross provides more affordable health insurance options, quick and accurate claims payment, more information about benefits and staying healthy, and quick and convenient problem resolution. Two of the ads are featured in this issue (shown here and on page 11).
“Soliciting agent only. Not authorized to issue policies.” This concise statement is the revised language Arkansas Blue Cross and Blue Shield has developed to replace the lengthy legal disclaimer agents have been required to use in ads promoting Arkansas Blue Cross products.

The new “fine print” is more succinct and was changed to make it easier for agents to run ads. The revised language must be included in all print, radio and television ads. It also affects the language agents must use when linking to the ArkansasBlueCross.com or HealthAdvantage-hmo.com sites from their Web sites.

Below is an outline of the revised policy on agent advertising (the new language is italicized):

- **Guidelines:**

  - In an agent ad, it must be clear who the ad represents by using the agency name and/or logo. If the Arkansas Blue Cross logo is used in an ad with the agency logo or the logos of other companies the agency represents, all logos should either be the same size or the agency logo larger.

  - The ad or any other printed material that refers to Arkansas Blue Cross must include the following statement: Soliciting agent only. Not authorized to issue policies.

  - The following statement must appear in all radio and television commercials: Soliciting agent only. Not authorized to issue policies.

  - Any variation from the above requires prior, written approval from an Arkansas Blue Cross officer (vice president or above).

  - Agents who want to link to the ArkansasBlueCross.com or HealthAdvantage-hmo.com site from their Web sites should follow these guidelines:

    - If the Arkansas Blue Cross logo is used on an agency Web site, the full logo, including the cross and shield symbols, the full company name and the fine print disclosure line (An Independent Licensee of the Blue Cross and Blue Shield Association) must be used. The Arkansas Blue Cross logo must be no larger in size than the logos of other companies the agency represents, and the agency logo should be larger than the Arkansas Blue Cross logo (so that the agency Web site cannot be visually construed to be an Arkansas Blue Cross Web site by virtue of logo prominence).

    - Any content on the agency site that refers to Arkansas Blue Cross (or Health Advantage) should include the following statement: Soliciting agent only. Not authorized to issue policies. The service area for Arkansas Blue Cross [and Health Advantage] is the state of Arkansas. Residents outside of Arkansas may visit www.bcbs.com for referral to the Blue Cross Blue Shield Plans licensed in other geographic areas.

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**We’re Here to Help**

If you have any questions or need approval on an ad, please call or fax a copy of the ad to Patrick O’Sullivan, vice president, Advertising & Communications

— telephone: (501) 378-2221; fax: (501) 378-2969.
You want your claims paid quickly and accurately?

No insurance company in Arkansas performs better at getting your claims paid quickly and accurately. It's one of the hallmarks of our service to members:

- **Fast turnaround** – After we receive your medical claims from your doctor or hospital, we process your claims in an average of six days. So, for most of the claims processed, you receive your explanation of payment within 10 days after we receive the claim.
- **High accuracy rate** – For the first six months of 2003, we achieved a dollar accuracy rate of 99.4 percent in paying your claims. This is impressive when you consider that we process more than 8 million claims each year.
- **Investment in Technology** – Arkansas Blue Cross has invested in technology that facilitates the electronic submission of claims from providers. As a result, approximately 70 percent of all claims are submitted electronically, speeding up the process. Arkansas Blue Cross now gives doctors and hospitals free access to the Advanced Health Information Network (AHIN), giving them access to eligibility, claims, claims-status and related data. A unique feature allows direct claims submission as well as on-line, real-time correction of claims.

Blue Comes Through.

For more information about your claims, call *My BlueLine* by using the Customer Service telephone number on the back of your ID card or visit the *My Blueprint* section of our Web sites … and let Blue come through for you.
On the other hand, developing and deploying these new products is expensive for an organization the size of Arkansas Blue Cross, serving a statewide population of only 2.6 million. Fortunately, there are both vendor product options and joint product development opportunities with other Blue Plans in which we can engage to overcome these disadvantages in scale.

Overall, our future appears bright so long as we are ever vigilant in maintaining our traditional “high touch” customer service commitment as we manage change (whether in the form of new technology or a new generation of consumer-directed health care products) in an ever increasing “high tech” world. From a personal perspective, I look forward to the exciting journey that lies in front of us as we continue to set the competitive standard for health insurance and related products in the state of Arkansas.

(TECH, continued from Page 2)