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Report to the Chairman, Subcommittee on Health, Committee on Ways and Means House of Representatives

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HEALTH INSURANCE

Comparing Blue Cross and Blue Shield Plans With Commercial Insurers

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July 11, 1986

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

Your October 21, 1985, letter requested that we examine the potential impact of taxing Blue Cross and Blue Shield plans (the plans) on the availability of health insurance. As you are aware, section 1012 of the proposed Tax Reform Act of 1985 (H.R. 3838), passed by the House of Representatives in December 1985, would effectively revoke the plans' current tax exemptions under section 501(c)(4) of the Internal Revenue Code. The bill allows for special treatment, at the discretion of the Secretary of the Treasury, for that portion of the plans' business related to high-risk individuals and small groups.

Background

Section 501(c)(4) exempts from federal income tax "civic leagues or organizations not organized for profit but operated exclusively for the promotion of social welfare." According to Internal Revenue Service (IRS) regulations, such "an organization is operated exclusively for the promotion of social welfare if it is primarily engaged in promoting in some way the common good and general welfare of the people of the community." Further, an organization is not "operated primarily for the promotion of social welfare if its primary activity . . . is carrying on a business with the general public in a manner similar to organizations which are operated for profit."

IRS has recognized the exemption of the plans as social welfare organizations since their inception in the 1930's. These exemptions were initially recognized when the plans pioneered health insurance, offering one community rate to all subscribers. At that time, lack of information on the actuarial soundness of this type of venture deterred commercial companies from underwriting the costs of hospital care. After commercial companies entered the field in the 1940's, a competitive for-profit health insurance industry developed.

Scope

As agreed with your office, our work focused on comparing the plans with commercial insurers to identify potential differences in the provision of health insurance, especially to high-risk individuals. We compared health insurance offered to 129 high-risk test cases identified by the plans in California, Connecticut, the District of Columbia, Illinois, Maryland, and New York to insurance available from five commercial insurers—Prudential, Bankers Life and Casualty, Metropolitan Life, The Travelers, and Mutual of Omaha. In addition, we obtained information nationwide on certain underwriting practices used by the plans and commercial insurers.

Findings

We observed more similarities than differences with regard to high-risk individuals At least one commercial health insurance alternative was available for 67 percent of the plans' high-risk test cases. The other one-third of the cases, however, were rejected by all five commercial insurers. Further, the commercial insurers and three of the six plans offered high-risk individuals less comprehensive coverage than other individuals. Both the plans and commercial insurers experience-rate their large groups, which constitute the majority of their business. The plans' pricing methods for individuals have also come to resemble the experience-rating methods used by commercial insurers as they set separate rates for high-risk individuals. Also, the plans are operating for-profit businesses on which they pay federal income taxes. For example, 30 plans sell life insurance. These activities tend to further reinforce the perception that the plans are operating in a manner similar to commercial companies.

In examining insurance for individuals offered by the plans and commercial companies, we observed some differences in underwriting practices. There were significant variations among the plans with regard to medical underwriting. For example, in 15 states and the District of Columbia, the plans offered open enrollment programs in which individuals under age 65 received coverage regardless of health status. In two of the three locations we studied that had open enrollment, the plans limited benefits. In 35 states, however, the plans offered no form of open enrollment to individuals under age 65. But commercial insurers did not offer open enrollment in any state.

We also examined the IRS' longstanding consideration of the continued recognition of exemption of nonprofit insurers. IRS officials have found that the significant differences between nonprofit and for-profit insurers that may have justified the initial tax exemptions have been

eroded by competitive developments In April 1986 testimony on the Tax Reform Act of 1985, the Assistant Secretary of the Treasury for Tax Policy stated that, while IRS had not taken a formal position on the plans' tax exemptions, it was his understanding that IRS would hold adversely on the issue of exemption for the plans under the existing law.

Making Blue Cross and Blue Shield plans taxable should not affect the availability of health insurance for most Americans, who are insured as members of large, employer-paid groups. The large-group business of the plans and commercial insurers is essentially identical, according to industry experts. Any potential adverse effect on the availability of health insurance would be concentrated in the individual and small-group markets. Moreover, any adverse effects would be further limited to high-risk individuals and small groups because commercial companies would underwrite other individuals and small groups.

We were unable, however, to determine the overall effect that changes in the tax-exempt status of the plans would have on both the availability and affordability of health insurance to high-risk individuals and small groups because:

- the Blue Cross and Blue Shield Association did not estimate the percent of the plans' individual and small group business that is high-risk, as we requested, and as would be required to qualify for special treatment under H.R. 3838,
- in the absence of tax-exempt status, the willingness of the plans to continue providing coverage to high-risk individuals and small groups is speculative,
- in an altered competitive environment, the extent to which commercial insurers would expand their coverage of high-risk individuals and small groups is unknown,
- the likelihood that the plans would qualify or would change their practices to qualify for special tax treatment under H.R. 3838 is unknown, and
- the availability of commercial insurance for 67 percent of the high-risk test cases cannot be projected nationally.

Matters for Consideration by the Congress

The Congress should decide whether the current exemptions for Blue Cross and Blue Shield plans under section 501(c)(4) are warranted. If the Congress decides not to continue the current exemptions, but to offer special tax treatment for insurers who provide coverage to high-risk individuals by amending the tax code, we believe it should establish

specific criteria for granting such treatment. The criteria could include such factors as whether an insurer (1) offers continuous open enrollment, (2) fully covers medical services for high-risk conditions, (3) offers coverage to high-risk individuals at the same rates charged to other individual policyholders, and (4) offers coverage without regard to age or employment status.

Agency Comments

We asked the Blue Cross and Blue Shield Association (the association), the Health Insurance Association of America (HIAA), and IRS to comment on a draft of this report. The association stated that the facts presented in the report show major differences between Blue Cross and Blue Shield plans and commercial health insurers. Specifically, the association expressed concern about

- the conclusion that Blue Cross and Blue Shield benefits for high-risk subscribers are limited,
- the conclusion that Blue Cross and Blue Shield pricing practices are similar to those of commercial companies,
- the methodology we used to verify information submitted by commercial insurers, and
- the omission of certain Blue Cross and Blue Shield practices that assure widely available affordable coverage.

After analyzing the association's comments in detail (see app. II), we continue to believe that despite data limitations caused by delays in receiving information, the methodology used was appropriate and GAO's conclusions are sound. Based on the additional documentation provided by the association, we have revised the report to show that three of the six plans currently offer the same coverage to all individuals. In the other three locations, however, the plans offered high-risk individuals less comprehensive benefits than other individuals. Specifically, the plans offered only their least comprehensive policies to open enrollment subscribers in Maryland and the District of Columbia; in California, the plan excluded high-risk conditions from coverage.

With regard to pricing methods, the association did not disagree that the extent of the subsidy for high-risk individuals is reduced because large groups are experience-rated. Furthermore, the association did not refute our finding that two of the plans charge different rates for high-risk individuals than other individuals. We maintain that using multiple community rates resembles commercial experience-rating practices. Finally, the association suggested that we examine other practices that measure

availability and affordability of coverage offered by the plans and commercial companies, but did not provide us adequate data on which to base a comparison.

HIAA provided general observations in support of its contention that the plans have an unfair competitive advantage. HIAA also commented that a more precise definition of high-risk business that would qualify for tax exemption is needed. IRS provided technical comments, but did not comment on the conclusions of the report. Comments are discussed in more detail in appendixes I and II.

As agreed with your office, we are sending copies of this report to the Blue Cross and Blue Shield Association, the Health Insurance Association of America, the Secretary of the Treasury, and other interested parties. Copies will also be made available to others upon request.

Sincerely yours,

Richard L. Fogel
Director

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Abbreviations

HIAA	Health Insurance Association of America
IRS	Internal Revenue Service
HMO	Health Maintenance Organization

Comparing Blue Cross and Blue Shield Plans With Commercial Insurers

Introduction

On December 16, 1985, the House of Representatives passed the Tax Reform Act of 1985 (H.R. 3838). Section 1012 of the bill, which is estimated to raise $1.7 billion in federal revenues over the next 5 years, would effectively eliminate the existing tax exemption granted to Blue Cross and Blue Shield plans (the plans). The bill allows for special treatment, at the discretion of the Secretary of the Treasury, for that portion of the plans' business related to high-risk individuals and small groups. According to the Blue Cross and Blue Shield Association, all individuals and small groups constitute about 27 percent of the plans' business. The Senate version of H.R. 3838 is silent on the tax-exempt status of the plans.

The Chairman of the Subcommittee on Health, House Committee on Ways and Means, asked us to provide information to assist the conferees in determining whether the plans' tax-exempt status is warranted. In response to the chairman's request, we compared certain practices of the plans with those of for-profit health insurance companies, particularly as these practices affect the availability of coverage for high-risk persons. Typical conditions classified as high-risk by both the plans and commercial insurers include hypertension, obesity, heart disease, cancer, alcoholism, mental disorders, and diabetes.

Background

Currently, 77 Blue Cross and Blue Shield plans insure approximately 79 million persons. In comparison, more than 800 commercial health insurance companies provide coverage to nearly 111 million persons.

The plans pioneered health insurance in the 1930's at a time of community need and were recognized as exempt from taxes. Lack of information on the actuarial soundness of this type of venture prevented commercial companies from underwriting the costs of hospital care until the 1940's. Since then, a competitive for-profit health insurance industry has developed.

For tax purposes, the Internal Revenue Service (IRS) has recognized exemption of the plans as social welfare organizations under section 501(c)(4) of the Internal Revenue Code. That section exempts "civic leagues or organizations not organized for profit but operated exclusively for the promotion of social welfare" from federal income tax. IRS regulations (26 C.F.R. 1.501(c)(4)-1(2)(i) and (ii)) provide that "an organization is operated exclusively for the promotion of social welfare if it is primarily engaged in promoting in some way the common good and general welfare of the people of the community," but not ". . . if its

primary activity . . . is carrying on a business with the general public in a manner similar to organizations which are operated for profit." For some time, recognition of this exemption has been under reconsideration, according to IRS.

In its December 7, 1985, report on H.R. 3838, the House Committee on Ways and Means raised concerns that exempted social welfare organizations that provided insurance were "engaged in an activity whose nature and scope is so inherently commercial that tax-exempt status is inappropriate." IRS officials and other health insurance experts have expressed the view that, in meeting the competition of for-profit health insurers, the plans have adopted the business practices of commercial insurers.

The Blue Cross and Blue Shield Association (the association), which represents its member plans, contends that section 1012 of H.R. 3838 should not be included in the final tax reform act and that the plans' current exemption is warranted for several reasons:

- The plans are nonprofit community service organizations that finance health care for individuals and small groups who could not obtain health insurance elsewhere.
- For-profit insurers have an obligation to their stockholders to be selective in the risks they underwrite, while the plans have an obligation as social welfare organizations to offer coverage to the widest possible segments of the population. They meet this obligation by cross-subsidizing individual high-risk lines of business with surplus earnings from their large group business. Without tax-exempt status on their entire business, continuing such subsidies would be financially impossible.
- If taxed, the plans may no longer be as willing to insure high-risk individuals, and this would add to the public sector's burden of caring for the medically uninsurable.

On the other hand, the Health Insurance Association of America (HIAA), which represents the commercial health insurers, contends that the plans sell the same health insurance products in the same markets as for-profit insurers who pay federal income tax. The plans' pricing methods and underwriting practices are virtually indistinguishable from those of commercial health insurers, HIAA maintains. As evidence that the plans are not unique in insuring high-risk individuals, HIAA cites the

recent establishment of 11 state pools[1] for the medically uninsurable and the fact that commercial insurers also accept substandard health risks. Therefore, the tax exemption creates an unfair competitive advantage for the plans, according to HIAA, which favors its repeal.

Objectives, Scope, and Methodology

The objective of our review was to identify differences between commercial health insurers and Blue Cross and Blue Shield plans with regard to (1) availability of insurance, (2) coverage, (3) underwriting practices, and (4) pricing methods. We also determined the views of IRS on the exemption of nonprofit health insurers, including the plans.

Our methodology consisted primarily of

- collecting and analyzing data on commercial insurance options for high-risk individuals accepted by the plans in five states and the District of Columbia,
- conducting surveys to determine where insurance brokers[2] would place high-risk individuals,
- reviewing literature pertaining to business practices of the plans and commercial insurers,
- analyzing IRS regulations and internal documents,
- comparing pricing methods, benefits, underwriting, and other business practices of the plans and commercial health insurance companies, and
- interviewing officials of the Blue Cross and Blue Shield Association and two member plans, the Health Insurance Association of America, the Internal Revenue Service, and other health insurance experts.

Scope

We focused on the availability of coverage for high-risk individuals under age 65 because practices of the plans and commercial insurers do not differ significantly in other markets—large groups, where pricing methods are essentially the same, and Medicare supplemental policies, where uniform federal guidelines exist. Time constraints prevented a similar analysis of the small group market, although we present some limited data.

[1]The pools provide insurance to medically uninsurable individuals—persons rejected by health insurers because of severe health conditions. Licensed insurers in the states are mandated to share in the financial burden associated with insuring these individuals

[2]Sales representatives who handle insurance for clients, generally selling insurance of various kinds for several companies

We did our work in six locations: Maryland, New York, Illinois, California, Connecticut, and the District of Columbia. These represented significant variation in the plans' medical underwriting practices. Specifically, Maryland and New York offered continuous open enrollment (a period when an insurer does not reject applicants based on health conditions); the District of Columbia offered an annual, 1-month open enrollment period; and Illinois, California, and Connecticut offered no form of open enrollment to individuals under age 65 but instead medically underwrote (applied health criteria to decide whether to accept applicants) all individuals. The plans in the six locations also varied along other important dimensions. For instance, Connecticut levied a 2-percent premium tax on both the plan and commercial insurers, unlike other states in our study which taxed only commercial insurers. The California plan operated where health maintenance organizations had a large market share.

Methodology

To evaluate the insurance options available to high-risk individuals, we asked the Blue Cross and Blue Shield Association and the Health Insurance Association of America to act as conduits of data from the plans and commercial insurers. We believed the cooperation of the two associations was necessary because we did not have a statutory right to access information from either party. Moreover, given the tight time constraints of the work, the coordinating efforts of the associations were especially important.

We compared health insurance offered to 129 high-risk test cases identified by the plans in the six locations to insurance available from five commercial insurers as follows:

1. The plans gave us examples of their individual high-risk insureds under age 65 accepted during 1984 and 1985—21 cases in Maryland, 29 in New York (the plan limited cases to New York City, Long Island, and Westchester County), 12 in Illinois, 21 in California, 16 in Connecticut, and 30 in the District of Columbia.

2. We verified the accuracy of the data on these test cases, especially demographic information (e.g., age, sex, height, weight, and employment status), as commercial insurers base underwriting decisions in part on this information. We also verified that enrollees had high-risk medical conditions at the time of enrollment.

3. We sent these test cases through HIAA to five major commercial insurers that sell individual insurance coverage in the six locations, asking for probable underwriting decisions, i.e., acceptance or rejection of the cases, coverage available, and rates that would have been offered had these individuals actually submitted applications. The five companies were the Prudential Insurance Company of America, Bankers Life and Casualty, Metropolitan Life Insurance Company, The Travelers Indemnity Company, and Mutual of Omaha Insurance Company.

4. We asked the commercial insurers to corroborate their favorable underwriting decisions by giving us copies of actual policies written for high-risk individuals with health conditions similar to those of the test cases. Where insurers were concerned about the confidentiality of their policyholders, we agreed to accept copies of underwriting guidelines in lieu of actual policies.

5. We surveyed, by telephone, a sample of insurance brokers that did business with both commercial insurers and the plans in the District of Columbia, Maryland, and California. In each location, we asked 10 brokers about insurance options available to five randomly selected test cases.

Limitations of the Data

We faced several data limitations in our work. First, the five commercial insurers participating in our study together provided about 13 percent of all commercial nongroup policies, according to HIAA. But, as there were more than 800 commercial health insurers in the industry with small market shares, we could not survey a larger aggregate share of the market without significantly increasing the number of companies in the study. We believe our results fairly represent the availability of commercial health insurance for the 129 test cases, however, because the participating companies are representative of most health insurers, according to HIAA. Moreover, we used the broker survey (discussed on page 14) as a broader indicator of the availability of health insurance for high-risk persons from other commercial insurers the brokers represent.

Second, commercial insurers and the association did not provide all the data we requested. All five commercial companies submitted underwriting decisions, but three did not submit corroborating cases. One indicated that it would not insure enough of the cases to make corroboration

necessary, and two did not corroborate responses due to time constraints. Because the data collection effort was dependent on the cooperation of the association and HIAA, slippage in the schedule was beyond GAO's control. Because the plans were over 2 months late in providing most test cases, we adjusted our methodology to a limited extent to accommodate shorter turnaround times for commercial health insurers. Based on the detailed information provided by the companies on the basis for their underwriting decisions, however, we believe that their responses were reasonable.

Third, we were unable to determine the overall effect that changes in the tax-exempt status of the plans would have on both the availability and affordability of health insurance to high-risk individuals and small groups because:

- the association did not estimate the percent of the plans' individual and small group business that is high-risk, as we requested and as would be required to qualify for special treatment under H.R. 3838,
- in the absence of tax-exempt status, the willingness of the plans to continue providing coverage to high-risk individuals and small groups is speculative,
- in an altered competitive environment, the extent to which commercial insurers would expand their coverage of high-risk individuals and small groups is unknown,
- the likelihood that the plans would qualify or would change their practices to qualify for special tax treatment under H.R. 3838 is unknown, and
- the availability of commercial insurance for 67 percent of the high-risk test cases in the six locations we studied cannot be projected nationally.

Finally, we were unable to compare the cost of providing comparable coverage for the 129 test cases because of differences in benefits offered by the plans and commercial health insurers in the six locations. Among the factors that prevented such an assessment were riders that excluded coverage for certain conditions, varying limits on hospitalization (e.g., 30-day maximums per episode), and wide ranges of deductibles, coinsurance, and maximum benefits.

Except as noted above, our work was done in accordance with generally accepted government auditing standards.

Do the Plans and Commercial Insurers Make Comprehensive Health Insurance Available to High-Risk Individuals?

Both the commercial insurers and three of the plans were offering less comprehensive coverage to high-risk than other individuals. The three plans limited the coverage offered to high-risk subscribers or would not cover the high-risk medical condition. Commercial insurers frequently would not cover the high-risk medical conditions or charged extra premiums to do so.

Was Commercial Insurance Available for the Plans' High-Risk Individuals?

At least one commercial insurance alternative was available for 67 percent (87 of 129) of our high-risk test cases But the companies often permanently excluded coverage for many high-risk medical conditions or charged extra premiums generally ranging from 15 to 150 percent of their standard rate. The incidence of acceptances and requirement of riders or extra premiums for the six locations studied are shown in table I.1.

Table I.1: Acceptance of High-Risk Test Cases by at Least One Commercial Insurer

	High-risk test cases		
State	No. of cases	Percent accepted	Percent of accepted cases with rider/extra premium
Maryland[a]	21	29	67
New York[a]	29	55	75
District of Columbia[b]	30	87	62
California	21	100	52
Connecticut	16	50	38
Illinois	12	83	70
Total/average	**129**	**67**	**61**

[a]The plans offer continuous open enrollment

[b]The plan offers annual open enrollment for 1 month

Although commercial alternatives were frequently available for our test cases, insurance brokers were less likely to use commercial alternatives in states where the plans offered some form of open enrollment. Specifically, the brokers reported that they would probably place with commercial alternatives only 2 percent of high-risk test cases in Maryland, where the plan had continuous open enrollment; as much as 40 percent in the District of Columbia, which had an open enrollment season; but as much as 78 percent in California, which had no open enrollment.

All five commercial insurers rejected 33 percent of our high-risk test cases. The five most common health conditions of the rejected individuals were multiple conditions (50 percent); cancer (17 percent); mental disorders and drug and alcohol abuse (14 percent); heart disease (10 percent); and other chronic conditions (8 percent). Together these conditions accounted for 99 percent of the health-related rejections.

What Limits Do the Plans and Commercial Insurers P ace on Coverage for High-Risk Individua s?

Limitations on benefits for high-risk individuals varied for both Blue Cross and Blue Shield and commercial health insurance policies in the six locations we studied. Although the plans and commercial insurers used different methods to restrict coverage (see table I.2), the effects on coverage for high-risk individuals were comparable Some commercial insurers, however, gave the consumer the option of either limiting coverage by rider or purchasing coverage at increased rates.

Table I.2: Coverage of High-Risk Individuals by the Plans and Commercial Insurers Compared

	Limits on hospital coverage			
Insurer	**Days per episode**	**Amounts**	**Major medical available[a]**	**Guaranteed renewability**
Blue Cross/ Blue Shield				
California	Unlimited	$2 million[b]	Yes	Yes
Connecticut	Unlimited	$1 million	Yes	Yes
District of Columbia	40[c]	None	No	Yes
Illinois	120	None	Yes	Yes
Maryland	30[c]	None	Yes	Yes
New York	120[c]	None	No	Yes
Commercial company				
The Travelers	Unlimited	None[b]	Yes	Yes
Metropolitan Life	Unlimited	$50,000[b]	Yes	Yes
Mutual of Omaha	Unlimited	$1 million[b]	Yes	Yes
Prudential	Unlimited	$1 million[b]	Yes	No
Bankers Life & Casualty	Unlimited	$1 million[b]	Yes	Yes

[a]Major medical policies contain a variety of deductibles and coinsurance and cover charges that are not paid for by basic hospitalization coverage, such as surgeons' fees, diagnostic procedures, physical therapy, chemotherapy, private nurses, medical appliances, and pharmaceuticals

[b]High-risk conditions might be excluded or extra premiums charged at the discretion of the insurers

[c]Hospital coverage offered to open enrollment subscribers

All commercial companies and two plans (California and Connecticut) offered comprehensive hospital benefits and major medical coverage without limiting the number of days covered for conditions not excluded from individual policies, as table I.2 shows. The plans included surgical benefits in their basic coverage while commercial insurers included these benefits in major medical programs. While two other plans (New York and Illinois) limited hospital coverage to 120 days per episode and the New York plan did not offer major medical coverage, the same limitations applied to all individual policyholders. The other two plans offered less comprehensive benefits to high-risk individuals. Specifically, (1) the District of Columbia plan placed a 40-day per episode limit on hospitalization for open enrollees compared with 180 days for medically underwritten individuals and did not offer major medical coverage to open enrollees, and (2) the Maryland plan restricted open enrollment subscribers to the 80/20 Co-pay Program but offered three more comprehensive policies to medically underwritten individuals.

The California plan used waivers to exclude coverage for high-risk conditions. As shown on page 14, commercial insurers also limited coverage by excluding high-risk conditions or charging extra premiums to cover these conditions.

Finally, renewability of policies and rates up to age 65 was guaranteed by all plans and four of the five commercial insurers. In other words, policies would not be cancelled nor rates raised except on a class or statewide basis.

Do the Plans' Underwriting Practices Differ From Commercial Insurers?

With regard to medical conditions at time of enrollment, the underwriting practices of the plans and commercial health insurers differed. Specifically, 38 percent of all Blue Cross and Blue Shield plans offered some form of open enrollment to individuals under age 65. During open enrollment, they did not medically underwrite applicants but accepted individuals regardless of their health conditions. Some commercial insurers, unlike the plans, used age and employment status to deny or limit coverage for new applicants.

Of the 77 plans nationwide, 22 offered continuous open enrollment for individuals under age 65 and an additional 7 held an open enrollment season for individuals that lasted for varying amounts of time. These 29 open enrollment programs were concentrated in 15 states and the District of Columbia. Not all plans in these states, however, offered open enrollment. For example, only one of three plans in Ohio provided open

enrollment coverage. According to the association, almost all plans offered open enrollment to small groups of 10 to 24 either continuously or during an open season. HIAA could not identify any commercial health insurers that offered open enrollment coverage for either individuals or small groups.

In the six areas we studied, the plans' open enrollment practices varied. In Maryland and New York, the plans offered continuous open enrollment, and in the District of Columbia the plan held a well-publicized annual 30-day open enrollment season. Prior to 1985, the three plans offered less comprehensive benefits under open enrollment. Since December 1985, however, the New York plan has offered one individual coverage program for all under-65 enrollees, and no longer medically underwrites individual policies. In contrast, in California, Connecticut, and Illinois, the plans medically underwrote individual business as did their commercial counterparts.

Commercial insurers used nonmedical factors in making underwriting decisions. Two companies stated that they generally would not offer coverage to new applicants over 59 years of age. Some commercial insurers would not offer coverage to unemployed individuals regardless of medical conditions, an HIAA official also told us. This was generally confirmed through our test cases, when two commercial insurers denied applicants on the sole basis of either age or employment status.

Do the Plans' Pricing Methods Differ From Commercial Insurers?

Over time, the plans' pricing methods have come to resemble those of commercial insurers. Specifically, changes in the plans' use of community rating (defined below) have reduced the subsidy for individuals in general and high-risk individuals in particular.

During the 1930's, when the initial tax exemptions were recognized, the plans offered one community rate. Under this system, all subscribers—group and individual—paid a uniform rate regardless of individual health status. Higher risk individuals benefited because their premiums were subsidized by lower risk individuals. Today, the plans experience-rate their large groups (which constitute most of their business) as do commercial companies. Experience-rating means the premiums are based wholly or partially on the group's health experience.

For their individual business, however, the plans continue to use a modified form of community rating. But the extent of the subsidy for individuals is significantly reduced because the large groups are

experience-rated. Moreover, the plans further reduce the subsidy of high-risk individuals by establishing different community rates for subgroups of their individual business. In Maryland and the District of Columbia, for example, we found at least two community rates for (1) healthier individuals accepted for medically underwritten coverage, and (2) sicker individuals accepted for open enrollment coverage. The more the plans use such rating classifications to reflect health experience, the less they differ from those commercial health insurers who charge extra premiums to high-risk individuals.

Do the Plans Engage in Commercial, Profit-Making Activities?

Blue Cross and Blue Shield plans engage in commercial, profit-making activities. In fact, the Blue Cross and Blue Shield Association acknowledges the growth in for-profit subsidiaries and affiliates but contends that the revenues generated from them help subsidize and defray costs of providing health insurance coverage to less desirable risks. The plans are taxed on these for-profit businesses, the association told us.

The plans' for-profit activities compete directly with products traditionally offered by commercial insurers, such as HMOs and disability and group life insurance. The association contends that the plans do not have a competitive advantage because their for-profit activities are taxed. According to a September 1985 survey by the National Association of Life Underwriters, 30 plans sell life insurance and 17 more intend to offer it.

What Are IRS' Views on Exemption of Nonprofit Insurers?

If nonprofit and for-profit insurers are alike, differential tax treatment is inconsistent with IRS' longstanding policy to "treat equal organizations equally." One internal IRS general counsel memorandum dated December 7, 1971, stated that the historical basis for exempt status for nonprofit insurers does not

> ". . . provide an adequate basis for continuing to hold them exempt under section 501(c)(4) if it appears their current activities merely duplicate, or otherwise provide a convenient alternative for services that have now come to be 'normally available through commercial channels' "

Later, a general counsel memorandum of May 19, 1976, stated that both for-profit and nonprofit health insurers

> ". . . by spreading the financial risks of illness are to a certain extent socially beneficial. The community clearly is harmed if families or individuals are ruined financially by extended illness or are unable to afford adequate medical care We do not

discern, however, a significant difference between the social benefits accruing to the community from [nonprofit insurers] and from commercial insurers."

Community rating by itself is insufficient justification for tax-exempt status, IRS officials told us. In the early days, community rating made insurance more affordable for low-income people. As competition with commercial health insurers increased, however, many plans were forced to abandon community rating. An internal IRS memorandum dated May 19, 1976, suggested that even with community rating, nonprofit health insurers may not warrant tax-exempt status in light of their provision of services exclusively to members (i.e., those who pay the premiums).

IRS and Treasury officials have considered extensively whether nonprofit insurers' tax-exempt status under the provision is still valid. IRS has not revoked the longstanding exemption, preferring instead to await the outcome of legislative changes under consideration by the current Congress. During the Senate Finance Committee's April 1986 markup of H.R. 3838, the Assistant Secretary of the Treasury for Tax Policy stated that, while IRS had not taken a formal position on the matter, it was his understanding that IRS would hold adversely on the issue of exemption for these plans under current law.

Conclusions

Since the 1930's, when Blue Cross and Blue Shield plans pioneered health insurance, a competitive, for-profit, health insurance industry has developed. Currently, the plans are exempt from federal income taxation as social welfare organizations under section 501(c)(4) of the tax code. IRS regulations provide that organizations are not social welfare organizations qualifying for such exemption if they are "carrying on a business with the general public in a manner similar to organizations which are operated for profit."

Making Blue Cross and Blue Shield plans taxable should not affect the availability of health insurance for most Americans, who are insured as members of large, employer-paid groups. The large-group business of the plans and commercial insurers, according to industry experts, is essentially identical. Potentially adverse effects on the availability of health insurance would be concentrated in the individual and small-group markets. Moreover, such effects would be further limited to high-risk individuals and small groups because commercial companies would underwrite other individuals and small groups. We were unable, however, to determine what overall effect changes in the tax-exempt status

of the plans would have on the availability and affordability of health insurance to high-risk individuals and small groups.

Similar treatment of high risks by the plans and commercial health insurers also diminishes the justification for the plans' tax-exempt status. Both the plans and commercial insurers in three locations we studied offered coverage to high-risk individuals that was less comprehensive than coverage available to other individuals. In addition, for most of their business, both the plans and commercial insurers used similar pricing methods (i.e., experience-rating). Furthermore, the plans' modified forms of community rating, including separate rates for high-risk individuals, have come to resemble the experience-rating methods used by commercial insurers. Lastly, some plans are operating for-profit businesses on which they pay taxes. All these activities tend to reinforce the perception that the plans are similar to commercial companies.

Open enrollment was one area where the plans' underwriting practices for individuals under age 65 differed from commercial insurers in 15 states and the District of Columbia. In these locations, the plans offered programs through which individuals received coverage regardless of health status. In two of the three locations offering such coverage, however, the plans limited benefits. Moreover, in 35 states, the plans offered no form of open enrollment to individuals under age 65. Another difference between the plans and commercial insurers was the use of nonmedical factors such as age and employment by two commercial insurers to deny or limit coverage. None of the Blue Cross and Blue Shield plans reviewed used these factors to deny coverage, nor did three commercial companies.

Matters for Consideration by the Congress

The Congress should decide whether the current exemptions for Blue Cross and Blue Shield plans under section 501(c)(4) are warranted. If the Congress decides not to continue the current exemptions, but to offer special tax treatment for insurers who provide coverage to high-risk individuals by amending the tax code, we believe it should establish specific criteria for granting such treatment. The criteria could include such factors as whether an insurer (1) offers continuous open enrollment, (2) fully covers medical services for high-risk conditions, (3) offers coverage to high-risk individuals at the same rates charged to other individual policyholders, and (4) offers coverage without regard to age or employment status.

Blue Cross and Blue Shield Comments

The Blue Cross and Blue Shield Association stated that the facts presented in the report show major differences between Blue Cross and Blue Shield plans and commercial health insurers. Specifically, the association expressed concern about

- the conclusion that Blue Cross and Blue Shield benefits for high-risk subscribers are limited,
- the conclusion that Blue Cross and Blue Shield pricing practices are similar to those of commercial companies,
- the methodology we used to verify information submitted by commercial insurers, and
- the omission of certain Blue Cross and Blue Shield practices that assure widely available affordable coverage.

After analyzing the association's comments (see app. II) in detail, we continue to believe that despite data limitations caused by delays in receiving information, the methodology used was appropriate and our conclusions are sound. Using the additional documentation provided by the association, we revised the report to show that three of the six plans currently offer the same coverage to high-risk and other individuals. In the other three locations, however, the plans offer high-risk individuals less comprehensive benefits than other individuals. Specifically, the plans offer only their least comprehensive policies to open enrollment subscribers in Maryland and the District of Columbia; in California, the plan excludes high-risk conditions from coverage.

With regard to pricing methods, the association did not disagree that the extent of the subsidy for high-risk individuals is reduced because large groups are experience-rated. Furthermore, the association did not refute our finding that two of the plans charge different rates for high-risk individuals than other individuals. We maintain that using multiple community rates resembles commercial experience-rating practices. Finally, the association suggested that we examine other practices that measure availability and affordability of coverage offered by the plans and commercial companies, but did not give us adequate data on which to base a comparison.

HIAA Comments

The Health Insurance Association of America provided general observations in support of its position that the plans have an unfair competitive advantage (see app. III). In regard to possible continuation of the plans' tax-exempt status, HIAA said that it was unfortunate that GAO was not given an estimate of the percentage of the plans' business that is

high-risk. HIAA also questioned the value of the plans' coverage of high-risk individuals because (1) 11 state high-risk pools have been established and (2) commercial insurance alternatives were available for over two-thirds of the plans' high-risk test cases. HIAA believes that a small percent of high-risk business would imply that the tax exemption, if any, should apply only to that portion of the plans' business.

Further, HIAA commented that a more precise definition of high-risk business that would qualify for tax exemption is needed. Such a definition should take into account (1) full coverage of high-risk individuals, (2) exclusion of waiting periods for pre-existing conditions, and (3) well advertised open enrollment periods.

Finally, HIAA said that the plans with continuous open enrollment in the study receive substantial hospital discounts and exemption from state premium taxes. According to HIAA, this helps the plans offset losses under open enrollment programs.

IRS Comments

IRS provided technical comments, which we have incorporated where appropriate, but did not comment on our conclusions.

Advance Comments From the Blue Cross and Blue Shield Association and GAO's Evaluation

Note GAO comments supplementing those in the report text appear at the end of this appendix

Blue Cross
and
Blue Shield
Association

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Vice President

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June 26, 1986

Mr. Richard L. Fogel
Director
Human Resource Division
U.S. General Accounting Office
Washington, D. C. 20548

Dear Mr. Fogel:

We appreciate the opportunity to comment on your draft report entitled "Comparing Blue Cross and Blue Shield with Commercial Insurers."

We recognize the difficulties presented by any attempt at such a comparison, especially within a limited timeframe. We are deeply concerned, however, that there are serious inaccuracies in the report. We cannot accept that the facts presented support the conclusion that there are more similarities than differences between Blue Cross and Blue Shield Plans and commercial insurers. A close reading of the more substantive parts of the report indicates that there are major differences that have a profound effect on the availability of health insurance to high risk subscribers.

More specifically, we have four major concerns:

- The conclusion that Blue Cross and Blue Shield Plan benefits for high risk subscribers are limited. The facts are that benefits are absolutely identical for all individual subscribers in four of the six Blue Cross and Blue Shield Plans studied; the other two Plans have open enrollment and offer people with otherwise uninsurable medical problems coverage options that are available to, and selected by, anyone in the community including healthy applicants.

- The conclusion that Blue Cross and Blue Shield pricing practices are similar to those of the commercial companies. A Blue Cross and Blue Shield Plan charging $8.00 more a month for those with otherwise uninsurable conditions who enroll during an open enrollment period is described as "similar" to a commercial company charging someone with a medical problem a premium that is as much as 2 1/2 times the premium for a healthy person.

- The methodology used to verify the information submitted by commercial companies. Contrary to the methodology for the study agreed to by us and GAO staff, the commercial carriers were not required to submit actual cases of people they had insured along with full documentation that the person had the medical problem in question at the time of enrollment. Blue Cross and Blue Shield Plans were required to submit actual cases and those cases were subjected to exhaustive audit and reverification. Only two of the five commercial companies submitted any cases and we do not know whether these cases were audited to the same extent as the Blue Cross and Blue Shield cases (the study protocol called for us to review the commercial cases just as they were allowed to review our cases; we were not given that opportunity). It is possible that many or even all the instances in which a commercial insurer said they would accept a Blue Cross and Blue Shield high risk subscriber were decisions that were not supported by a corroborating case.

- The study fails to examine major practices of Blue Cross and Blue Shield Plans that assure widely available affordable coverage. The study fails to compare the percentage of premiums returned to subscribers as benefits for either under-65 or Medicare supplementary subscribers; the availability of open enrollment for small employee groups; practices in the Medicare supplementary market; and the offering of affordable conversion coverage.

We believe these conclusions and omissions are misleading and should be addressed prior to the issuance of the final report. Our more detailed comments on each of these points follow.

See comment 1

As during the study, we are pleased to provide information supporting our contentions and to discuss these issues with your staff.

I request that this letter in its entirety be attached to your final report.

Sincerely,

Mary Nell Lehnhard

Attachments

The following are GAO's comments on the Blue Cross and Blue Shield Association's letter dated June 26, 1986.

GAO Comments

1. The association comments presented on the following pages have been extracted verbatim from its June 26, 1986, letter. Page and table numbers have been changed to reflect those in this final report. Each section of the association's comments is followed by our evaluation.

Benefits for High Risk Subscribers

Association Comments

Numerous statements throughout the report either explicitly state or imply that all six Blue Cross and Blue Shield plans are engaged in practices that limit the coverage provided to high risk enrollees and that the plans with open enrollment are not providing comprehensive benefits. These statements are inaccurate.

We cannot agree with the conclusion that, when compared to commercial insurers, the plans with open enrollment have practices that "are comparable in their effects on coverage for high risk individuals." This is, in effect, concluding that plans that offer absolutely everyone comprehensive benefits— regardless of the severity of their medical problem—are similar to commercial companies that reject applicants for any coverage. We would offer the following comments on each of the plans with open enrollment.

GAO Evaluation

On page 16 of the report, we recognized that plans offering open enrollment differ from other plans and commercial insurers that always use medical underwriting practices. As discussed on pages 16 and 17 of the report, however, three of the six plans limited the benefits or coverage available to the high-risk test cases. The plans' open enrollment practices in Maryland and the District of Columbia resulted in high-risk individuals being offered less comprehensive coverage than that available to other individuals. A December 1985 change in the open enrollment practices of the New York plan, which resulted in equal coverage for high-risk and other individuals, has been reflected in the final report. The

report has been clarified to show that three plans did not offer less comprehensive coverage to high-risk individuals.

Association Comments

Empire Blue Cross and Blue Shield (New York) offers one individual coverage program for all under-65 enrollees. The program includes comprehensive benefits including hospital and medical-surgical services. The benefits are available on a year-round basis to anyone regardless of medical condition.

GAO Evaluation

Empire Blue Cross and Blue Shield established continuous open enrollment in December 1985. At that time, it eliminated the use of medical underwriting and exclusion riders. The test cases submitted by the plan were accepted prior to establishment of continuous open enrollment. The change in the plan's underwriting practices has been added to page 17 of the report.

Association Comments

Blue Cross and Blue Shield of Maryland offers four programs to individuals under age 65. The program costs and benefits vary to allow applicants to select a program that meets both their health coverage and budget needs. Open enrollment subscribers are eligible for the 80/20 co-pay program which is offered at a very low rate to all applicants who want a lower cost option. This program provides comprehensive hospital and medical-surgical services. In addition, any applicant, including open enrollment applicants, may purchase a catastrophic coverage rider. Further, low income subscribers in the 80/20 program are protected from out-of-pocket costs for physicians' services when they use a Blue Shield participating physician (over 80 percent of the physicians in Maryland participate).

GAO Evaluation

Although the Maryland plan offers continuous open enrollment, it offers medically underwritten individuals the choice of three additional coverage programs not available to open enrollment subscribers. For example, the 80/20 co-pay program offered to high-risk individuals under open enrollment has a 30-day per episode limit on hospital coverage whereas other individuals have the option of purchasing more comprehensive coverage with a 70-day per episode limit with no copayment. In effect, this places limits on the coverage available for high-risk medical conditions similar to commercial insurers' use of riders to limit coverage.

Association Comments

Blue Cross and Blue Shield of the National Capital Area offers two programs to individuals under 65. The standard option is available to all applicants, regardless of medical condition during the plan's annual open enrollment period. Anyone enrolling during this period (at least one month a year) pays an additional nominal amount ($8 for individuals). The higher option is not available to open enrollment subscribers. The benefits for the standard option, however, include comprehensive hospital and medical-surgical services.

GAO Evaluation

Like the Maryland plan, the District of Columbia offers medically underwritten individuals the option of purchasing more comprehensive coverage not available to high-risk individuals under open enrollment. For example, hospital coverage available to high-risk enrollees is limited to 40 days per episode, while medically underwritten individuals can purchase high-option coverage with a 180-day limit.

Association Comments

Exhibit A describes the benefits for all six Blue Cross and Blue Shield Plans studied.

GAO Evaluation

Exhibit A (see pages 49 to 51) does not show that high-risk open enrollment applicants are offered less comprehensive benefits than other individuals.

Association Comments

With respect to the three plans with open enrollment, we believe the availability of comprehensive benefits in all cases and absolutely identical benefits in the case of New York makes it incorrect for GAO to make the statement, "in the three locations we studied that had open enrollment, the plans limited benefits."

GAO Evaluation

The report has been revised to reflect the recent change in open enrollment practices in New York (see pages 4 and 17). As discussed above, the Maryland and District of Columbia plans continue to limit the benefits available to open enrollment, high-risk subscribers.

Association Comments

In the case of the three other locations—Connecticut, Illinois, and California—each plan offers absolutely the same benefit package to all enrollees regardless of their health status. There is not a "different set"

of benefits for higher risk subscribers. (In California a rider may be placed on a medical condition but the covered benefits—e.g., days of hospitalization—are identical.)

GAO Evaluation

In states such as Connecticut, Illinois, and California that do not offer open enrollment, the issue is not the comparability of benefit packages but the availability of coverage. Because these plans medically underwrite all policies, some high-risk individuals may not be able to obtain coverage from them.

Association Comments

It is misleading to make the sweeping generalization that "both the plans and commercial health insurers offered similar, although limited coverage to high risk individuals in the six locations we studied." Four plans (New York, Illinois, Connecticut, and California) provide absolutely identical benefits to all subscribers and two plans (District of Columbia and Maryland) provide comprehensive benefits on an open enrollment basis.

GAO Evaluation

As noted above, only New York offers identical coverage to all applicants, regardless of health status. The Illinois, Connecticut, and California plans medically underwrite all applicants and may, like commercial insurers, deny coverage to individuals with certain high-risk conditions. The Maryland and District of Columbia plans offer open enrollment subscribers less comprehensive coverage than that available to other medically underwritten individuals.

Comparison of Pricing Practices

Association Comments

In several statements, the draft report implies that the pricing practices of Blue Cross and Blue Shield plans and commercial companies are similar.

These statements are inaccurate. The pricing methods of commercial insurers and Blue Cross and Blue Shield plans are substantially different.

GAO Evaluation

As discussed on page 17, both the plans and the commercials experience-rate their large groups, which constitute most of their business. In addition, the plans' use of multiple community rates for individuals and small groups has, as discussed below and on pages 17 and 18, come to resemble experience-rating.

Association Comments

As noted in the report itself, commercial insurers evaluate the risk associated with each applicant. "Applicants are then asked to pay a premium that reflects the level of risk." (Statement of the Health Insurance Association of America, November 1, 1985, Committee on Energy and Commerce.) The draft report clearly states that commercial companies will charge a beneficiary a higher rate depending on the severity of his or her medical problems. The premium for a person with medical problems, according to the report, can be as much as two and one-half times the premium for a healthy person.

GAO Evaluation

For our high-risk test cases, one or more commercial insurers indicated that they would provide coverage to 59 percent of the high-risk individuals at the same premium charged to other individuals.

Association Comments

Blue Cross and Blue Shield plans continue to use community rating for nongroup programs and do not establish a rate on the severity of an individual applicant's medical problem. Over 29 percent of all subscribers in Blue Cross and Blue Shield plans are in community-rated programs.

GAO Evaluation

As discussed on page 18, the Maryland and District of Columbia plans establish separate community rates for open enrollment and medically underwritten subscribers. The use of separate rates to reflect the health experience of open enrollment and medically underwritten subscribers resembles the practice of commercial health insurers of charging extra premiums.

Association Comments

In four of the six plans studied (New York, California, Connecticut, Illinois), there is only one set of rates charged for each type of nongroup coverage. Rates may vary because of deductible levels selected, but not because of medical condition.

GAO Evaluation

As discussed on pages 17 and 18, the extent of the subsidy for high-risk individuals is reduced because large groups are experience-rated. The subsidy is further reduced because separate community rates are set for individuals over and under 65 and small groups. The use of multiple rates resembles experience-rating.

Association Comments

In two locations, Maryland and the District of Columbia, all high risk applicants are accepted by the plans for their open enrollment products. Applicants are never denied coverage, nor are they subjected to riders for specific conditions. They may purchase a specific program which is available to, and selected by, a broad selection of all applicants in the community, including those without medical problems. In Maryland, the cost for this coverage is lower, not higher, than other nongroup programs. In the District of Columbia, all open enrollment subscribers pay only $8.00 per month more for individual coverage ($28 per month more for family coverage).

GAO Evaluation

The District of Columbia plan charges high-risk individuals from 10- to 17-percent higher premiums under open enrollment than are available to medically underwritten individuals. Although the Maryland plan has a lower premium for open enrollment coverage, it offers less comprehensive coverage. The plans' use of separate community rates for open enrollment and medically underwritten individuals, in effect, establishes separate rates for high-risk and other individuals similar to the practices of commercial insurers.

Association Comments

To summarize, it is incorrect to state that the pricing practices of Blue Cross and Blue Shield plans, who never charge a rate that reflects individual risk of an applicant, are similar to commercial practices that can result in a premium that is more than twice as high for a person with medical problems as for a healthy person.

GAO Evaluation

As discussed above, both the Maryland and District of Columbia plans clearly charge different rates based on health status.

Methodological Problems

Association Comments

There are several discussions in the methodology section of the draft report that cast significant doubt on the validity of the report's findings. When GAO's study methodology was first presented to us, we expressed concern about accepting commercial insurers' estimations of acceptance of individuals they knew at the time of application were high risk without submission of corroborating evidence. We were assured by GAO that corroboration, in the form of specific previously accepted cases, which clearly documented that the person had the medical problem at the time of enrollment, would have to be provided before commercial insurers' responses were accepted. Furthermore, we were informed on several occasions that we would be able to review commercial insurer submissions as they had reviewed our submissions. Now that the report has been prepared, we find:

GAO Evaluation

Although we had to make adjustments to our methodology because of delays in receiving high-risk test cases from the plans and responses from the commercials, we do not, for the reasons discussed below, believe that the adjustments affected the validity of our findings.

Association Comments

- Only two of five commercial carriers submitted corroborating cases to support their underwriting decisions.

GAO Evaluation

The corroborating cases submitted by the two commercial insurers substantiated their probable underwriting decisions on the high-risk test cases.

Association Comments

- No corroborating cases were submitted by three of the commercial carriers used in the study. GAO has no documentation at all that responses of these carriers were accurate. On the other hand, Blue Cross and Blue Shield plans were told that the only acceptable evidence would be actual cases that were audited in detail by the GAO. Plans were not allowed to

submit any "other detailed information" to support their underwriting decisions as commercials were allowed to do.

GAO Evaluation

We adjusted our methodology because of delays beyond GAO's control in receiving test case data from the plans. Since the plans needed more time to provide the test cases than they originally anticipated (nearly 4 months), three commercial companies were unable to provide corroborating data in addition to underwriting decisions in the remaining time (1 month). Nevertheless, acceptance rates for companies not providing corroborating evidence were comparable to those of the two companies that submitted data. In addition, as noted on page 13, we believe the responses were reasonable based on the detailed information provided by the companies. Further, the plans, like the commercials, were allowed to submit other information to support their underwriting decisions. In Maryland, the plan submitted detailed claims histories to support high-risk conditions and we accepted the plan's assurance that the conditions existed at time of application.

Association Comments

- The Blue Cross and Blue Shield Association has not had the opportunity to review the cases that were submitted by the two commercial insurers that provided cases.

GAO Evaluation

Neither the association nor HIAA was given access to corroborating evidence or actual policies to protect the confidentiality of the insured.

Association Comments

Importantly, the commercial companies used by the study are not even identified. This lack of public accountability makes the methodology—and the conclusions—even more questionable.

GAO Evaluation

Names of the commercial insurers have been added to the report.

Association Comments

This outcome has led us to conclude:

- GAO used significantly different standards in reviewing data supplied by Blue Cross and Blue Shield plans and commercial insurers.

- The study methodology that the Blue Cross and Blue Shield Association agreed to at the beginning of the study was not used.
- The report's findings are not based on reasonable standards of documentation and their validity is questionable, especially in light of data that we have collected ourselves.

GAO Evaluation

As discussed above, although we modified the methodology where necessary because of the plans' and commercial insurers' inability or unwillingness to provide all data requested within the limited time available for our review, we believe that adequate standards were applied to all data received and that the validity of the results was not compromised.

Association Comments

Our specific methodological concerns are discussed in the paragraphs that follow.

On page 12 of the draft report, the following statement is made: "We believe, however, that our results fairly represent the availability of commercial health insurance for the 129 test cases because the participating companies are representative of other insurers, according to HIAA" (emphasis added).

GAO Evaluation

We selected the five commercial insurers with the largest percentage of the individual market. We relied on HIAA to identify the companies because data on market share are generally not available. Including additional companies in our study could increase the number of high-risk test cases for which a commercial alternative was available, but could not decrease the number.

Association Comments

Apparently, GAO did not conduct an analysis of the general availability of individual coverage provided by commercial carriers and, instead, simply accepted HIAA's undocumented conclusion. In fact, of the 10 largest commercial health insurers, six do not actively participate in the individual market. In 1984, three of the ten largest commercial carriers did not offer coverage to individuals at all (Connecticut General, Continental, Bankers Life of Iowa). Three others offered coverage, but only to a very small number of people (for Prudential, Aetna and Travelers, less than 2 percent of health insurance premium revenues in 1984 were for individual coverage). Of the remaining four carriers (Equitable, New

York Life, Metropolitan Life, and Mutual of Omaha), only Mutual of Omaha sold a policy that could be described as similar in comprehensiveness of benefits to Blue Cross and Blue Shield coverage. The lowest deductible offered by Equitable is $2,000; the New York Life and Metropolitan Life policies have limits on payments per day for hospital care and significant limits on the total surgical expenses covered. The Mutual of Omaha policy is available with deductibles from $250 to $50,000. It is referred to by Mutual of Omaha as a catastrophic policy; it is always medically underwritten and is not available to unemployed people. Nevertheless, it is the only policy offered by one of the top 10 commercial health insurers that is comparable in benefits to Blue Cross and Blue Shield coverage. It is offered at much higher rates and returned only 62.4 percent of the premiums to beneficiaries as benefit payments in 1984, according to Mutual of Omaha's submissions to state insurance departments.

GAO Evaluation

Neither the association nor HIAA provided documentary evidence on the number of individual policies written by their member companies. However, the evidence the association presents to suggest that 6 of the 10 largest commercial health insurers do not actively participate in the individual market contradicts evidence previously presented by the association. Specifically, a study prepared for the association by the Center for Health Policy Studies showed that (1) the three commercial insurers the association said did not participate in the individual market in 1984 did offer individual coverage and (2) two of the three commercial insurers the association claimed obtained less than 2 percent of premium revenue from individual coverage, received over 2 percent of revenues from individual coverage. In addition, as shown by the table on page 15, both Metropolitan Life and Mutual of Omaha offer health insurance benefits to individuals that are similar to benefits offered by Blue Cross and Blue Shield plans. The association provided no documentation to support its claims on specific coverage offered by commercial companies and we were unable to verify the data ourselves due to time constraints.

Association Comments

The variance in availability of coverage from major commercial carriers makes it highly unlikely that the five companies are representative of the rest of the commercial insurance industry. Some carriers do offer major medical programs but nearly all are constrained in ways that are similar to those identified above. For example, Banker's Life and Casualty of Illinois offers a comprehensive major medical program but it, too,

is limited by features such as limits on hospital daily room and board and limits on the total surgical expenses covered. It is clear that only a very small number of commercial carriers offer coverage that is comparable to Blue Cross and Blue Shield coverage and that these carriers' premium rates greatly exceed those of Blue Cross and Blue Shield plans, while their payout ratios fall far below those of plans. It is unlikely that five commercial carriers used for comparison provide coverage that is comparable to Blue Cross and Blue Shield coverage and far more unlikely that these carriers are representative of the commercial insurance industry.

GAO Evaluation

Companies participating in our study provided copies of brochures delineating the coverage offered to the test cases. These coverages are summarized and compared to the plans' coverage in table I.2. We obtained limited premium information from two commercial companies. The data indicated that average rates, including extra premiums for high-risk conditions, were not significantly different from the plans' community rates.

Association Comments

On page 14, the draft report makes a statement: "The commercial insurers responses showed that at least one commercial alternative was available for 67 percent (87 of 129) of the plans' high risk test cases."

This conclusion is questionable for at least two important reasons. First, since the majority of commercial companies that responded did not submit corroborating cases, it is possible that all of the "acceptances" are from the carriers that did not present any corroboration.

GAO Evaluation

As stated on page 32, the acceptances from the three commercial insurers who did not present any corroborating data were comparable to those from the two insurers who submitted such data.

Association Comments

Second, the findings, as displayed in table I.1 on page 14 are inconsistent. One hundred percent (100%) of the California cases and 83 percent of the Illinois cases were recorded as accepted although these cases consisted primarily of conditions that are identified on page 15 as the most common causes for complete rejection by commercial carriers. Sixty-two percent of the California cases were for cancer, mental disorders, drug and alcohol abuse, heart disease and other chronic conditions, which are

identified as accounting for 99 percent of commercial insurer rejections. Sixty-seven (67) percent of the Illinois cases were also for these conditions. For this reason, it is difficult to understand the 100 percent acceptance rate for California and the 83 percent acceptance rate for Illinois. Since little additional medical information other than these conditions were available for review by commercial insurers, it is clear that the cases were reviewed inconsistently.

GAO Evaluation

The high acceptance rates in California and Illinois reflect, in our opinion, the similar treatment of high-risk individuals by the plans and commercial insurers. For example, in California, both the plan and commercial insurers medically underwrite all individuals and used riders to exclude coverage for the high-risk conditions of those individuals they accepted. Furthermore, the broker survey in California indicated that commercial insurers' responses were consistent.

Association Comments

It is also clear that the cases used for the District of Columbia Plan for which an 87 percent acceptance rate is indicated, were the pretest cases that were collected and not the cases submitted by the Blue Cross and Blue Shield Association. It was our understanding that the pretest cases were collected solely to determine whether the data that were presented would be sufficient for commercial insurers to respond. The District of Columbia Plan cases which were collected according to the same protocol as other plans and submitted to GAO were not used in the study.

GAO Eva uation

The District of Columbia plan could not verify that the high-risk medical conditions existed at the time of enrollment for the additional test cases submitted. The plan agreed that the pretest cases, selected from individuals who were previously medically underwritten with exclusions, were representative of high-risk individuals covered by the plan.

Association Comments

Table I.2 presented on page 15 has three factual errors. First, the Maryland and Illinois plans are described as not offering major medical coverage to individuals, when in fact, they do offer such coverage. Maryland offers a catastrophic major medical program and major medical coverage is available to HIA program subscribers in Illinois. It also should be noted that Empire Blue Cross and Blue Shield (New York) has had a major medical offering under development for almost a year and it will soon be available to all applicants irrespective of their medical

risk. As noted in the Table, California and Connecticut offer major medical coverage. The District of Columbia plan is the only plan that does not offer major medical coverage to high risk individuals It is important to understand, however, that the District of Columbia plan offers comprehensive hospital and medical-surgical benefits in their basic program. Commercial insurers include these benefits in their major medical program.

GAO Evaluation

Based on additional evidence provided by the association, we have revised table I.2 to show that both Maryland and Illinois offer major medical coverage.

Association Comments

The use of major medical coverage as a standard for comprehensiveness is also misleading. In the draft report, the following statement appears: "high-risk individuals typically need major medical because its benefit maximums typically range from $50,000 to $1 million." [This sentence was deleted from the final report.] Blue Cross and Blue Shield basic coverage (for hospital and medical-surgical services) covers most expenses without any lifetime dollar limit on benefits. Blue Cross and Blue Shield subscribers with basic benefits have protection that is at least comparable to an extensive commercial insurers' major medical benefits. Furthermore, many commercial insurers major medical policies have limits on daily room and board charges and limits on the total payment for surgical services. These limits are likely to expose subscribers to large out-of-pocket payments. The use of days of hospital coverage per episode of illness as a benefit is a common benefit structure for all types of Blue Cross and Blue Shield hospital coverage. More importantly, plans that use a specified number of (renewable) days of hospital care for individual coverage make the same number of days available to both healthy and high-risk subscribers.

GAO Evaluation

Evidence provided by the association shows that the plans in Maryland and the District of Columbia do not make the same number of covered hospital days available to high-risk and other subscribers. In addition, the California plan limits coverage by excluding coverage for the high-risk conditions. For these reasons, some plans make less comprehensive coverage available to high-risk subscribers.

Association Comments

The second inaccuracy in Table I.2 is the failure to show that medical-surgical benefits are available from all Blue Cross and Blue Shield plans. The use of only hospital and major medical benefits implies that those are the only benefits available. Blue Cross and Blue Shield plans in New York, Maryland, Illinois, and the District of Columbia provide medical-surgical benefits as part of their basic coverage while commercial insurers include these benefits only in their major medical programs.

GAO Evaluation

The discussion on page 16 was revised to indicate that the plans offered inpatient medical-surgical benefits.

Association Comments

The attached Exhibit A provides a detailed review of the comprehensive benefits provided by all six Blue Cross and Blue Shield plans.

GAO Eva uation

See page 27 for a discussion of the limitations on the data presented.

Association Comments

Finally, Table I.2 fails to recognize the importance of the price of coverage in comparisons of Blue Cross and Blue Shield plans' and commercial insurers' individual coverage. Access to coverage is a financial issue as well as an availability issue. If coverage is available from a commercial insurer, but only at several times the price of Blue Cross and Blue Shield coverage, it is inappropriate to compare coverages without regard to affordability. In the draft report, it is indicated that commercial insurers may charge 2-1/2 times their standard rate to some individual subscribers. It should be understood that some commercial carriers' standard rates can be more than three times Blue Cross and Blue Shield rates. For example, the standard rates for Aetna's Comprehensive Medical Expense Plan in most categories are more than three times as high as rates for Blue Cross and Blue Shield plans in New York, Maryland, the District of Columbia and California. When standard rates can be multiplied by a factor of 2.5 for high risk individuals, it is possible for some commercial insurers' rates to be more than 7 times Blue Cross and Blue Shield rates. Without consideration of premium rates, the conclusions drawn with respect to availability from Table I.2 are misleading.

GAO Evaluation

As discussed above, limited premium information provided by two commercial insurance companies indicated that the commercial insurers' average rates, including extra premiums for high-risk conditions, were not significantly different from Blue Cross and Blue Shield community rates. Further, as discussed on page 13, comparisons of premiums are meaningless without a comparison of differences in the benefits offered. For example, the Maryland plan's premiums for the medically underwritten comprehensive program were about six times higher than the rates charged high-risk individuals under the 80-20 Co-pay program. The differences are due to the limited coverage provided under the 80-20 Co-pay program.

Important Plan Practices Omitted From the Comparison

Association Comments

The draft report fails to compare a number of practices that are important measures of whether insurers are offering coverage on a basis that makes it as affordable and widely available as possible.

GAO Evaluation

We recognized that other measures could be used to compare the plans and commercial insurers. We limited our evaluation to those practices for which the association and HIAA provided adequate data on which to base a comparison. Our detailed evaluation of the individual comments follows.

Association Comments

Percentage of Premiums Returned as Benefits. The most important of these practices is the percent of premiums that are returned to subscribers as benefits. According to a report of the House Aging Committee, "the economic value of insurance policies is determined by the percentage of premiums returned to the insured in the form of benefits." (Report No. 95-160) This percentage of premiums paid out is particularly important in the less competitive individual segment of the health insurance market.

Nationally, Blue Cross and Blue Shield plans return 89 cents of every premium dollar collected for individual coverage. The six plans

examined by the GAO had payout ratios in 1984 ranging from 105 to 73 percent; five of the plans had payout ratios greater than 92 percent.

The average payout ratio for all commercial companies for nongroup coverage was 54 percent in 1984. The ratios for the nine commercial insurers that are most active in the nongroup market ranged from 47.7 to 65.5 percent in 1984. (These ratios represent only their health business.)

Since the companies used in the GAO report are not identified, it is not possible to determine the percentage of premiums they returned to subscribers as benefits.

GAO Evaluation

According to the House Aging Committee report cited by the association, "loss ratios in and of themselves are not conclusive proof of the economic value of policies." In addition, "experts caution that the loss ratio should be only one factor in picking a policy. The stability, integrity, and financial position of the company is another factor to consider." The report also stated that the loss ratio experience of companies should be compared over more than 1 year.

A 1-year comparison of payout ratios is more a reflection of the effectiveness of insurance companies in estimating health care costs in the premium year than a measure of the availability and affordability of coverage. Health insurance premiums are set in advance and based on estimates of such factors as expected utilization of benefits and inflation in the premium year. If actual health care utilization or inflation in the premium year exceeds expectations, payouts and the payout ratio will increase. Conversely, if utilization or inflation is less than expected, the payout ratio will be less. Because payout ratios are so sensitive to changes in utilization, inflation, and premium setting methods, a 1-year comparison, such as that presented by the association, does not, in our opinion, provide a sound basis for comparison of the availability and affordability of coverage.

In addition, we have several concerns about the reliability of the association's comparison. Specifically, the association (1) did not show that payout ratios were consistently and accurately calculated by the plans and commercial insurers, (2) compared overall individual payout ratios for the plans, including all policies offered, to payout ratios for specific commercial insurance policies even though the commercial insurers also offered multiple policies, and (3) compared 1985 payout ratios for the

plans to 1984 ratios for the commercials. Furthermore, we obtained published data showing that loss ratios for commercial insurers are higher than the association contends. In 1984, for instance, the loss ratios for the five commercial insurers in our study ranged from 54.6 to 81.1, and in 1983, they ranged from 60.0 to 83.5 and averaged 68.9.

Association Comments

Commitment to Providing Nongroup Coverage. We believe a major point of investigation by the GAO should have been the degree to which commercial companies even engage in offering insurance to those who are not part of an employee group. The report states that "... our results fairly represent the availability of commercial health insurance for the 129 test cases because participating companies are representative of other insurers, according to HIAA" (emphasis added). Six out of the ten largest health insurance companies in the United States are not active participants in the nongroup market. We question how GAO can draw the conclusion that these companies involved in offering nongroup coverage are representative of the entire industry. All Blue Cross and Blue Shield plans offer comprehensive, community-rated individual coverage on a year-round basis.

GAO Evaluation

According to HIAA's Source Book of Health Insurance Data, 1984-1985, commercial insurers provided coverage to over 24 million persons under individual policies during 1983. By contrast, the Blue Cross and Blue Shield Association told us that their member plans cover about 11 million persons under individual policies.

Association Comments

Small Group Coverage. Another major area of importance in assuring that health insurance is widely available is the offering of coverage to very small groups regardless of the medical condition of the employees and their dependents. According to the HIAA's Course in Group Health and Life Insurance:

"For small groups, the possibility of adverse selection by the employer against the insurer is high. Under a certain size (usually 10 employees), most insurance companies feel that even the most restrictive of contractual provisions on pre-existing conditions will not protect them against situations . Some insurers decline to write the entire group if even one of the employees is not insurable Other insurers have provisions for having the uninsurable individual waive coverage and then covering only those that are insurable. .Most insurers attempt to control certain hazards inherent in small groups . . by requiring medical evidence of insurability of the individual employees and perhaps their dependents "

The report notes that HIAA was unable to identify any commercial health insurers who offer open enrollment for either individuals or small groups.

The Blue Cross and Blue Shield plans included in the study accept even the smallest groups without regard to the health status of the employees or their dependents. The six plans will accept the following size groups on an open enrollment basis:

Blue Cross of California: 4 employees
BCBS of Connecticut: 3 employees
District of Columbia: 2 employees
BCBS of Illinois: 2 employees
BCBS of Maryland: 2 employees
Empire BCBS (New York, NY): 3 employees

Ninety-nine (99) percent of all Blue Cross and Blue Shield plans accept groups of 10 to 24 on an open enrollment basis. Significantly, 60 percent accept groups sized five (5) and smaller without regard to the medical condition of the employees or their dependents.

GAO Evaluation

We attempted to compare small group coverage, but the association did not provide adequate data on which to base a comparison. Specifically, the association did not provide an estimate of the number of persons covered under small groups or the percentage of their small-group business that is high-risk. In addition, only two of the six plans provided small-group test cases, and those cases were submitted too late to be included in our analysis.

Association Comments

Medicare Supplementary Coverage. The study states that "...Plans and commercial insurers are not significantly different in the...Medicare supplementary policy market, where uniform federal guidelines exist." We strongly disagree that Blue Cross and Blue Shield plans are not "significantly different" in this market. Importantly, plans return to subscribers a very high share of the premiums collected (payout ratio) for this coverage. Nationally, Blue Cross and Blue Shield plans return 88 cents of every premium dollar collected for nongroup (individual) supplementary coverage from Medicare subscribers. This high return also includes premiums collected from those who are entitled to Medicare because they are totally and permanently disabled. The federal standard

for Medicare supplemental policies requires that only 60 percent of non-group premiums be returned; this percentage was necessary to permit commercial insurers to meet federal certification requirements. The payout ratios for the six Blue Cross and Blue Shield plans studied ranged from 73 percent to 103 percent.

GAO Evaluation

We did not focus on Medicare supplementary coverage because an association consultant told us that would not be a good basis for comparison since the plans and one commercial insurer dominate the market. Further, as stated on page 10, there are uniform federal guidelines that both the plans and the commercials must adhere to in offering this coverage. Finally, as discussed above, a 1-year comparison of payout ratios is not an appropriate comparison.

Association Comments

Conversion Coverage for Those Who Lose Group Coverage. Blue Cross and Blue Shield plans have always voluntarily offered conversion to individuals and their dependents who have lost their eligibility for employer-sponsored benefits for whatever reason—divorce, layoff, or voluntary termination. The same is true for the dependents of deceased workers. Conversion coverage is available for as long as needed. About 1.5 million conversion subscribers are enrolled in Blue Cross and Blue Shield plans nationwide. Plans keep this coverage as affordable as possible, and, in fact, return 97 percent of all premiums collected from conversion coverage on a national basis.

In recent years, 31 states have passed laws requiring all commercial companies to offer conversion coverage in an effort to protect group subscribers who have commercial coverage. Commercial companies, however, will often price their conversion coverage so as to discourage enrollment. For example, one of the 10 largest commercial companies recently offered conversion to a family of four (husband age 50-54) for a premium of $10,368 a year.

GAO Evaluation

The evidence provided by the association indicates that the availability of conversion coverage is not a significant difference between the plans and commercial insurers in at least 31 states because of mandated coverage. The association, in citing a rate reportedly offered by an unidentified commercial insurer to one family, does not provide adequate evidence that commercial companies price conversion coverage to discourage enrollment.

Association Comments

Inaccuracies and Statements Needing Clarification. There are a number of statements that we believe should be corrected and, in some cases, clarified.

Transmittal Letter:

Page 1: The letter states that the plans' business related to high risk individuals and small groups would remain tax-exempt under the House language. This is not the case. The House language states that the Secretary of the Treasury "may prescribe regulations which provide, for Blue Cross and Blue Shield and their affiliates, special treatment for activities with respect to high risk individuals and small groups." The action is totally at the discretion of the Secretary and is, we believe, too vague to be implementable. Furthermore, merely designating part of plans' business as tax-exempt would not provide assurance that they would be able to continue their practices with respect to high risk groups.

GAO Evaluation

Both the transmittal letter and report have been revised to state more specifically the provisions of H.R. 3838.

Association Comments

Page 2: "Both the plans and commercial insurers experience-rate their large groups which constitute about 85 percent of their business." The conclusion from this statement is that plans community-rate only 15 percent of their business. This is incorrect. Twenty-nine percent (29%) of all Blue Cross and Blue Shield plans' business is community-rated. It is also incorrect to imply that commercial companies use community rating at all.

GAO Evaluation

Wording has been clarified to show that commercial insurers experience-rate individuals. Because the association was unable to provide documentation on the percentage of the plans' business that is large group, small group, and individual, we deleted the specific percentage of large group business from the final report.

Association Comments

Page 2: "In 36 states, however, the plans did not offer any form of open enrollment." This statement is incorrect. Seventy-six (76) of 77 Blue Cross and Blue Shield plans (99%) offer open enrollment to one or more of the following categories: individuals under age 65; individuals 65 and

over; and small groups of 1 to 24 members. (This same statement also appears on page 20.)

GAO Evaluation

The statement has been clarified to indicate that in 35 states the plans did not offer any form of open enrollment to individuals under age 65.

Association Comments

Page 2: "For example, in 14 states and the District of Columbia, the plans offered open enrollment programs. (This same statement appears in two places in the report: on pages 16 and 20.) It should be clarified that these statements refer only to open enrollment programs for under age 65 individuals and the total number of states should be corrected. Fifteen (15) states and the District of Columbia have open enrollment programs for individuals under age 65.

GAO Evaluation

The statement has been clarified to indicate that (1) the discussion of states and plans with open enrollment programs relates to individuals under age 65, and (2) 15 states and the District of Columbia offer enrollment to individuals under age 65. The association told us that one of the four plans in Washington state offers open enrollment to individuals under age 65. Officials had previously told us that none of the Washington plans offered open enrollment.

Association Comments

Report: Page 8: "All individuals and small groups (20 and fewer) constitute about 14 percent of plans' business." This statement is incorrect. All individuals and small groups constitute about 27 percent of the plans' enrollment.

GAO Evaluation

The report has been revised to provide the association's estimate of individual and small group enrollment.

Association Comments

Page 8: "The Association maintains that the plans' insurance activities are not commercial." We have never maintained this; rather, we have argued that plan practices justify tax exemption.

GAO Evaluation

The statement has been deleted from the final report.

Association Comments	Page 11: "Illinois, California, and Connecticut do not offer any form of open enrollment." It should be made clear that this comment relates only to coverage for individuals under age 65. All three have open enrollment for very small groups (2, 5, and 3, respectively) and Medicare supplemental coverage for nongroup applicants.
GAO Evaluation	Statement has been clarified as suggested.
Association Comments	Page 11: The description of the New York City plan's service area suggests their open enrollment is "limited to New York City, Long Island, and Westchester County." Empire Blue Cross and Blue Shield (New York) offers continuous open enrollment in 28 counties.
GAO Evaluation	The discussion on page 11 has been revised to show that the plan offered continuous open enrollment in all counties but limited test cases to New York City, Long Island, and Westchester County.
Association Comments	Page 13: "(e.g., 30-day maximum)" For Blue Cross and Blue Shield plans, this is not a maximum but a 30-day coverage period renewable for every spell of illness.
GAO Evaluation	Statement has been clarified to show 30-day maximum per episode.
Association Comments	Page 14: "Although commercial alternatives were frequently (emphasis added) available for our test cases..." This is misleading. Only 25 percent of the test cases were accepted without riders or extra premiums.
GAO Evaluation	As the report shows on page 14, commercial insurers accepted a high percentage of the Blue Cross and Blue Shield test cases, but frequently imposed riders or extra premiums. The report also shows on pages 15 and 16 that two plans offered less comprehensive benefits to high-risk subscribers and a third plan imposed riders on high-risk medical conditions. Further, two of the plans also established separate community

rates for high-risk individuals accepted under their open enrollment programs. These practices are similar to commercial insurers' use of riders and extra premiums.

Association Comments

Page 17: "About 90% of the plans offered open enrollment to small groups of 10 to 24." This statement is incorrect. 99%, or 76 out of 77 plans, offer open enrollment to small groups of 24 or less.

GAO Evaluation

The report was revised to provide the association's estimate of the percent of plans offering open enrollment to small groups.

Association Comments

Page 18: The report states that "In Maryland and the District of Columbia there are at least three individual community rates for (1) healthier individuals accepted for medically underwritten coverage, (2) sicker individuals accepted for open enrollment coverage, and (3) individuals over age 65." It is misleading to include "(3) individuals over age 65" in comparing pricing policies for nongroup coverage. The coverage available for this group is Medicare supplementary coverage. This kind of policy offers benefits, for example, that cover Medicare's deductible and coinsurance requirements. Because of its very different structure, Medicare supplementary coverage must be rated separately. This reference should be deleted.

GAO Evaluation

The report has been revised to delete reference to Medicare supplementary coverage.

Association Comments

Page 18 (Section - "Do The Plans Engage in Commercial Activities"): This section of the report should be clarified to describe the facts more precisely and to remove the implication that ownership of for-profit subsidiaries is inconsistent with tax exemption. The Internal Revenue Service has long recognized that ownership of a for-profit subsidiary does not jeopardize the exemption of a tax exempt organization. Because revenues from for-profit activities are taxed there can be no possibility of "unfair competition" with other taxable entities.

GAO Evaluation

The report has been revised to incorporate the association's comments.

Association Comments

Conclusion. The Blue Cross and Blue Shield Association takes strong exception to the methodology and conclusions in GAO's draft report. Furthermore, we find it inappropriate for GAO to recommend certain actions with respect to the taxation of plans based on the methodology, narrow scope and questionable conclusions of the report.

GAO Evaluation

For the reasons discussed above, we believe the methodology and conclusions of the report are sound. Furthermore, we believe the information presented will assist the Congress in deciding whether the differences among the plans and between the plans and commercial insurers warrant modification of the tax-exempt status of Blue Cross and Blue Shield plans.

Exhibit A

Benefits Made Available to High-Risk Blue Cross and Blue Shield Subscribers

Blue Cross and Blue Shield Plan	Program	Benefits: Inpatient Hospital	Surgical	Medical	Outpatient Hospital
Empire Blue Cross and Blue Shield	120-Day Hospital Executive Indemnity II	120 days per episode of illness	All medically necessary surgery	All in-hospital care, all diagnostic services	All medically necessary
Blue Cross and Blue Shield of Connecticut	Comprehensive Health Care Plan	All medically necessary	All medically necessary	All medically necessary	All medically necessary
Blue Cross and Blue Shield of Illinois	Health Services Plan	120 days per episode of illness	All medically necessary	All in-hospital care, all emergency care, all diagnostic services	All medically necessary
	Health Improvement Association	All medically necessary	All medically necessary	All medically necessary	All medically necessary
Blue Cross and Blue Shield of Maryland	80/20 Program (Hosp) Physician Care — Plan "1"	30 days per episode of illness	All medically necessary	All in-hospital care, all emergency care, all diagnostic services	All medically necessary
	Catastrophic Coverage Rider	All medically necessary	All medically necessary	All medically necessary	All medically necessary
Blue Cross and Blue Shield of the National Capital Area	Standard (Hospital) Surgical-Medical	40 days per episode of illness	All medically necessary surgery	All in-hospital care, emergency care, all diagnostic services	All medically necessary
Blue Cross of California	Prudent Buyer Program	All medically necessary	All medically necessary	All medically necessary	All medically necessary

Benefits (continued)

Blue Cross and Blue Shield Plan	Program	Skilled Nursing Facility	Durable Medical Equipment	Prescription Drugs	Home Health Care
Empire Blue Cross and Blue Shield	120-Day Hospital Executive Indemnity II	None	All medically necessary	In hospital	All medically necessary
Blue Cross and Blue Shield of Connecticut	Comprehensive Health Care Plan	120 days following hospitalization	All medically necessary	All medically necessary	All medically necessary
Blue Cross and Blue Shield of Illinois	Health Services Plan	Following a hospitalization	All medically necessary	In-hospital	Following hospitalization (100% payment)
	Health Improvement Association	All medically necessary	All medically necessary	All medically necessary	Following hospitalization
Blue Cross and Blue Shield of Maryland	80/20 Program (Hosp) Physician Care — Plan "1"	None	None	In-hospital	Following hospitalization
	Catastrophic Coverage Rider	All medically necessary	All medically necessary	All medically necessary	All medically necessary
Blue Cross and Blue Shield of the National Capital Area	Standard (Hospital) Surgical-Medical	None	All medically necessary	In-hospital	Following hospitalization
Blue Cross of California	Prudent Buyers Program	All medically necessary	All medically necessary	All medically necessary	All medically necessary

		Other Features			
Blue Cross and Blue Shield Plan	Program	Deductible	Copayment	Lifetime Maximum	Restrictions on High-Risk Subscribers
Empire Blue Cross and Blue Shield	120-Day Hospital Executive Indemnity II	None	None on covered hospital services, unpaid amounts on fee schedule	No limit	None
Blue Cross and Blue Shield of Connecticut	Comprehensive Health Care Plan	3 options available - $400, $1,000, $1,500	20% up to $2,000	$1,000,000	None after acceptance
Blue Cross and Blue Shield of Illinois	Health Services Plan	$250	25%	No limit	None after acceptance
	Health Improvement Association	2 options available - $250, $1,500	20% up to $2,500 for $250 deductible, 20% up to $10,000 for $1,500 deductible	$1,000,000	None after acceptance
Blue Cross and Blue Shield of Maryland	80/20 Program (Hosp) Physician Care — Plan "1"	None	20% for inpatient care up to total of $225 per confinement	No limit	None
	Catastrophic Coverage Rider	$50,000	None	$1,000,000	None
Blue Cross and Blue Shield of the National Capital Area	Standard (Hospital) Surgical-Medical	None	None on covered hospital services, unpaid amounts on fee schedule	No limit	None
Blue Cross of California	Prudent Buyers Program	4 options available - $250, $500, $1,000, $200 on non-hospital services only	10%-20% depending upon service Stop-loss at $4,000 or $8,000	$2,000,000	High-risk conditions may be ridered

Advance Comments From the Health Insurance Association of America

HEALTH INSURANCE ASSOCIATION OF AMERICA

1025 Connecticut Avenue, N W, Washington, D C 20036 3998, (202) 223 7780

June 26, 1986

Mr. Richard Fogel, Director
Human Resources Division
General Accounting Office
441 G Street, N. W.
Washington, D. C. 20548

Dear Mr. Fogel:

Thank you for giving us the opportunity to review and make comment on the contents of the GAO draft report. What follows are our general observations.

The GAO comparison of the Blues plans and commercial insurers was based on a study of 129 high risk individuals covered under individual policies. The result, as shown in table 1 of the report, indicates 67% acceptance by at least one commercial insurer of the plans' high risk test cases covered under individual policies. The GAO also asked the five commercial insurers to assess 30 high risk individuals covered under the Blues' small group policies (16 in Connecticut and 14 in New York). The result of these underwriting evaluations indicates that one or more of the commercial insurers would accept 73% of these high risk individuals. These acceptance percentages might have been higher with greater representation of midwestern and western plans which are more comparable.

The reference in the report regarding coverage of unemployed individuals is misleading. Even the commercial insurers mentioned as denying coverage on the basis of unemployment offer coverage to temporarily unemployed individuals.

It is unfortunate that the plans did not estimate the percent of their individual and small group business that is high risk as requested by the GAO. The value of their coverage of high risk individuals is questionable in light of the need for eleven state high risk pools and the availability of coverage from commercial insurers for over two-thirds of these risks. A small percent of high risk business would imply the tax exemption, if any, should apply only to the high risk business, which needs more precise definition. A definition based on full coverage of high risk individuals should exclude those plans that have waiting periods for pre-existing conditions. A definition based on open enrollment should exclude those plans

Mr. Richard Fogel
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that have short open enrollment periods or open enrollment periods that are poorly advertised.

It should be noted that the three plans which offer continuous open enrollment also enjoy sizeable hospital discounts as well as exemption from premium taxes, both of which are important factors which offset losses under their open enrollment programs. These losses need to be quantified and compared to their other gains.

Again, we appreciate the opportunity to comment on this draft report. Your staff was most professional and thorough in explaining the process and procedures to follow.

Best regards,

Linda Jenckes

Linda Jenckes
Vice President, Federal Affairs

LJ:cjm

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