REPORT TO THE CONGRESS

Opportunities For Improving Administration Of Government-Wide Indemnity Benefit Plan Of Health Insurance For Federal Employees And Annuitants B-164562

Civil Service Commission

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

MAY 22, 1972

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164562

To the President of the Senate and the
Speaker of the House of Representatives

This is our report entitled "Opportunities for Improving Administration of Government-wide Indemnity Benefit Plan of Health Insurance for Federal Employees and Annuitants." The Plan is administered by the Civil Service Commission under a contract with the Aetna Life Insurance Company, Hartford, Connecticut.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget, and to the Chairman, Civil Service Commission.

Elmer B. Staats

Comptroller General
of the United States

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COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

OPPORTUNITIES FOR IMPROVING ADMINISTRATION OF GOVERNMENT-WIDE INDEMNITY BENEFIT PLAN OF HEALTH INSURANCE FOR FEDERAL EMPLOYEES AND ANNUITANTS

Civil Service Commission B-164562

D I G E S T

WHY THE REVIEW WAS MADE

The Civil Service Commission contracts for health benefit plans under the Federal Employees Health Benefits Program (Program). One of these plans is the Indemnity Benefit Plan (Plan) which provides Government-wide health insurance and which is the second largest of the health benefit plans, in numbers of employees enrolled.

This Plan offers high and low health insurance benefits (or options) covering medical costs of Federal employees and certain members of their families or survivors. Cash payments are provided either to employees enrolled or, at their request, to doctors and hospitals.

The Aetna Life Insurance Company carries out the Plan under contract with the Commission.

The contract provides that Aetna reinsure, with other companies, portions of the total insurance written. About 91 percent of the insurance under the Plan has been reinsured by about 120 other companies; Aetna has insured about 9 percent of the Plan.

The General Accounting Office (GAO) reviewed the administration of the Plan because of the considerable costs being incurred by Federal employees, as well as by the Government, for the health benefits. GAO previously reported on the administration of the Service Benefit Plan--Blue Cross and Blue Shield--the largest Government-wide plan, which provides benefits by direct payments generally to doctors and hospitals (B-164562, October 20, 1970).

FINDINGS AND CONCLUSIONS

The biweekly premiums paid under the Plan by enrollees and the Government have more than doubled since 1960. A comparison follows.

Options	Period effective 7-1-60	Period effective 4-16-72	Increase Amount	Increase Percent
High--self only	$3.12	$ 9.79	$ 6.67	214
High--self and family	8.06	24.26	16.20	201
Low--self only	2.60	5.36	2.76	106
Low--self and family	6.24	12.80	6.56	105

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These increases were due principally to increased payments for health benefits. From 1960 through 1971 health benefits charged to the Plan ($1.3 billion) amounted to about 93 percent of premiums paid which the Commission forwarded to Aetna ($1.4 billion). For calendar year 1971, premiums were about $192 million and health benefit charges were about $161 million.

The Plan's enrollment decreased from 490,000 in 1961 to about 474,000 at the end of 1971. Enrollment in the Plan's high options changed little until 1968 but since then has decreased substantially. Enrollment in the Plan's low options has increased gradually. (See p. 12.)

Study of premium rates

The Program follows the customary practice of group insurance by using average premiums and by not requiring evidence of insurability. It differs from customary underwriting practice by allowing enrollees to change insurance plans and types of coverage after their original selections. (See p. 18.) Such changes are permitted during a special period, called an open season. (See p. 19.)

A study by GAO showed that:

--Average health costs and related premiums tended to increase as the age of the enrollees, as a group, increased.

--The Aetna Plan's enrollees, as a group, were older than those enrolled in the Service Benefit Plan.

--Substantial numbers of young enrollees transferred from the Aetna Plan to other plans during the 1969 open season, which increased the average age and average health costs of those still carried by the Plan.

The Plan's losses of enrollees may be attributed in part to the Plan's premium rates. Other causes, such as differences in health benefits covered, may have contributed to these losses.

Specific causes of the Plan's enrollment losses should be identified, and changes should be made to minimize future increases in the average age of enrollees. Unless this is accomplished, the Plan ultimately may be forced to withdraw from the Program because employees may be reluctant to participate if they consider premium charges disproportionate to their anticipated health costs. In such an event Federal employees would have no choice of Government-wide plans.

For 1972, the premiums for the high options of the Service Benefit Plan increased significantly but the premiums of the Indemnity Benefit Plan did not change. This may or may not deter future transfers from the Indemnity Benefit Plan. (See p. 19.)

Contingency reserves

Both the Commission and Aetna maintain Plan reserves which may be used to meet the costs of the Plan. From 1960 through December 31, 1971, the combined total of these reserves at the end of each contract period ranged from 6.2 percent to 32.3 percent of premiums. The Commission had not made studies to determine the combined amounts of contingency reserves needed.

Contingency reserves in excess of the amounts needed to protect the Plan's enrollees result from unnecessarily high premium rates. GAO believes that the combined contingency reserves for the Plan should be maintained at the minimum levels necessary to provide protection against adverse variations in claims costs.

GAO actuaries calculated that combined contingency reserves of about 5 percent of annual premiums would be sufficient protection against adverse variations in claims costs, if premium rates were established by taking into consideration the Plan's claims experience for various underwriting factors, such as different age, sex, and geographical groupings of its participants.

The Commission's contract did not provide that the Commission's contingency reserves be used to help pay allowable charges under the Plan if the contract were terminated and if the Plan reserves held by Aetna were insufficient to cover the unpaid charges. Because the Commission's contingency reserves are derived principally from premium payments by enrollees, it would be fair to amend the contract to provide for these reserves to be made available to pay allowable charges in the event of contract termination. Commission officials stated that the Commission and Aetna had agreed to such an amendment, effective January 1, 1972. (See p. 39.)

Risk charges and reinsurers' expense allowances

From inception of the Plan in 1960 through 1971, the Commission's contract with Aetna provided for payments to Aetna as the insurer and to the reinsurers for risk charges and for reinsurers' expense allowances, based on percentages of annual premiums. The Commission and Aetna agreed to provide a flat-rate service charge of $1.3 million for 1972 in lieu of the risk charge.

The contract has provided for payments to certain reinsurers of additional allowances to compensate for Federal income taxes payable by these reinsurers on their risk charges.

For the contract periods through December 30, 1971, the risk charges, income tax allowances, and reinsurers' expense allowances totaled about $19.5 million.

The purpose of the risk charge is to compensate Aetna and the reinsurers for the underwriting risks and to provide a fee or profit. GAO believes

that there is little or no risk in underwriting the Plan and no need for paying Aetna and the reinsurers for underwriting risks. (See p. 49.)

To recognize the services provided by Aetna, a reasonable fee or profit could be provided in addition to Aetna's actual administrative expenses that are reimbursed under the Plan.

The amounts paid under the Plan for the reinsurers' expense allowances may have been considerably higher than the cost incurred by the reinsurers in carrying out their responsibilities. There appears to be a need for the Commission to reassess the reasonableness of the amounts allowed for reinsurance expense allowances.

Payments, such as those to some reinsurers for Federal income taxes paid by them, are not an insurance industry practice and tend to shift part of the tax liability of the reinsurers to the Federal Government and the enrollees and result in higher premiums. The Commission has agreed to take another look at Federal income tax allowances on risk charges. (See p. 49.)

Investment income

Aetna's practices in computing interest income credits to the Plan appeared to have resulted in credits of amounts lower than the amounts that had been earned by Aetna on Plan funds made available for investment. In most instances Aetna agreed with GAO's conclusions and promised to make appropriate adjustments to correct some of the prior interest income credits to the Plan. (See p. 58.)

Administrative expenses

Savings to the Plan of $971,000 for 1970 and 1971 resulted from cancellation of a proposed amendment to the Aetna contract questioned by GAO. Under this amendment Aetna would have been allowed amounts for administrative expenses substantially in excess of its actual costs.

RECOMMENDATIONS OR SUGGESTIONS

The Commission should:

- --Review the changes in enrollment which occur during the next open season to ascertain (1) why enrollees changed plans or options and (2) whether the age of the Plan's enrollees, as a group, increased at a greater rate than the age of enrollees in other plans in the Program. Revisions of benefit coverage or other changes should be made, if warranted, to ensure that Federal employees continue to have a choice of Government-wide plans. (See p. 30.)

- --Encourage Aetna to refine its methods of establishing premium rates for the Plan by utilizing, to the extent practicable, the results of studies

of claims experience for different age, sex, and geographical groupings of the Plan's participants. (See p. 46.)

--Determine the combined amounts of the reserves needed to be maintained by the Commission and Aetna to protect against adverse variations in claims costs and consider such determinations before approving premium rates for the Plan. (See p. 46.)

--Reassess the reasonableness of the amounts allowed Aetna and the reinsurers for risk charges and for the reinsurers' expense allowances. (See p. 56.)

--Amend the contract with Aetna to formalize Aetna's practice of crediting the Plan with interest on certain reserve funds. (See p. 61.)

--Review the practices followed by Aetna in arriving at the amount of investment income to be credited to the Plan and, during this review, give particular attention to the fairness of the amounts so credited and to the need for adjustments for inadequate amounts credited in prior years. (See p. 67.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

The Commission was generally receptive to GAO's proposals and either took action, or agreed to take action, in line with most of them.

The Commission did not agree with GAO's recommendations for (1) encouraging Aetna to refine its method of establishing premium rates for the Plan and (2) reassessing the reasonableness of the amounts allowed Aetna and the reinsurers for risk charges. (See pp. 46 and 56.)

MATTERS FOR CONSIDERATION BY THE CONGRESS

The amounts of the combined Plan reserves held by Aetna and the Commission have been higher than needed to protect against adverse variations in claims costs. In view of the minimal risks under the Plan and the substantial costs that have been charged to the Plan in connection with reinsurance, the Congress may wish to consider amending section 8902(c) of Title 5, United States Code, to eliminate the mandatory provision for reinsurance under this Plan. (See p. 56.)

The report also contains information which may be useful to the Congress in its deliberations on proposed legislation to exempt premiums under the Federal Employees Health Benefits and Federal Employees Life Insurance Programs from taxation by States and political subdivisions (H.R. 21, 92d Cong.) and on various bills proposing to amend the provisions of the Federal Employees Health Benefits Act of 1959.

CHAPTER 1

INTRODUCTION

The Indemnity Benefit Plan is one of the two Government-wide health benefit plans of the Federal Employees Health Benefits Program authorized by the Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901), to provide health benefits for Government employees, annuitants, and certain members of their families or survivors. The Program is administered by the Civil Service Commission, and the Plan is carried out by the Aetna Life Insurance Company under contract with the Commission. The costs of the plan are shared by the enrollees and the Government.

The act authorized the Commission to contract for or approve the following four types of plans:

1. Indemnity Benefit Plan--a Government-wide plan which provides benefits by cash reimbursements either to the enrollees or, at their request, to doctors and hospitals.

2. Service Benefit Plan--a Government-wide plan which provides benefits generally through direct payments to doctors and hospitals.

3. Employee organization plans--plans which are available only to employees who are, or who become, members of the sponsoring organizations and which provide benefits generally by cash reimbursement either to the employees or, at their request, to doctors and hospitals.

4. Comprehensive medical plans--plans which are available only in certain localities and which are either (a) group-practice plans that provide benefits in the form of medical services by teams of doctors and technicians practicing in their own medical centers or (b) individual-practice plans that provide benefits in the form of direct payments to doctors with whom the plans have agreements. These plans also provide hospital benefits.

The act requires that two levels of benefits--high and low options--be offered to enrollees under the two Government-wide plans. Premiums are higher and benefits are greater under the high options than under the low options. The employee organization plans and the comprehensive medical plans may offer either one or two levels of benefits. A Commission report showed the following enrollment in the various types of plans as of December 31, 1971.

	Number of plans	Total enrollees	Enrollees under high option	Enrollees under low option
Government-wide plans:				
Service Benefit Plan	1	1,672,323	1,474,518	197,805
Indemnity Benefit Plan	1	473,923	317,978	155,945
Employee organization plans	15	394,535	315,141	79,394
Comprehensive medical plans:				
Individual-practice plans	7	45,749	40,855	4,894
Group-practice plans	16	134,097	127,753	6,344
Total	40	2,720,627	2,276,245	444,382

In terms of enrollment the Indemnity Benefit Plan has been the second largest in the Program since its inception. Enrollment in this Plan increased from about 490,000 in 1961 to about 543,000 in 1968. There were substantial decreases in enrollment during 1969 and 1970, and as of December 31, 1971, the enrollment was about 474,000--16,000 fewer than at the end of the first contract period of the Program. The changes in enrollment resulting from the 1969 open season are discussed in detail on page 19.

Subscription charges (premiums) for the Plan increased from about $102 million for the 16-month first contract period of July 1, 1960, to October 31, 1961, to about

$192 million for the 12-month contract period of January 1 to December 31, 1971. Appendix I shows cumulatively through December 31, 1971, and for calendar year 1971 the income and expenses of the Plan, exclusive of certain operations carried out by the Commission.

Within the Commission the Bureau of Retirement, Insurance, and Occupational Health is responsible for administering the Program. The principal officials of the Commission responsible for the administration of the Program are listed in appendix IV.

FINANCING

Each Federal agency is responsible for collecting its employees' contributions toward the cost of participation in a health benefits plan and for paying the related Government contributions from the agency's appropriations or funds available for the payment of salaries. Each payroll period the agencies send the Government and employee contributions to the Commission for deposit into the Treasury to the credit of the Employees Health Benefits Fund. The Commission withholds retirees' and survivors' contributions from their annuity payments, and the Congress appropriates funds to the Commission for the related Government contributions.

Upon notification from the Commission, the Secretary of the Treasury invests the amounts not needed to satisfy immediate cash requirements in interest-bearing obligations of the Government, generally in bonds. The interest earned on these investments is credited to the fund.

As authorized by the law, the Commission has set aside about 1 percent of all contributions to pay its administrative expenses and about 3 percent of all contributions to provide a contingency reserve. The Commission may transfer to the contingency reserves of the various plans in the Program the unused portions of the amounts set aside for its administrative expenses. The law requires the Commission to send the remainder of the contributions--about 96 percent--to the insurers. If available, funds from the Commission's contingency reserve are transferred to reserves maintained by the insurers if their reserves fall below prescribed amounts. Indemnity Benefit Plan reserves are discussed more fully in chapter 5.

CONTRACT FOR INDEMNITY BENEFIT PLAN

Effective July 1, 1960, the Commission entered into a contract with Aetna to provide the Government-wide Indemnity Benefit Plan to eligible Federal employees, annuitants, and certain members of their families or survivors. Amendments to the contract have been negotiated periodically to cover such matters as changes in premium rates and in health benefits. Either the Commission or Aetna may cancel the contract, but Aetna is required to give written notice of cancellation to the Commission at least 60 days prior to the end of any contract period.

As required by law (5 U.S.C. 8902(c)), the Commission's contract for the Plan provides for Aetna, the insurer, to reinsure portions of the total insurance under its contract with other companies which elect to participate. The law requires that the amount of reinsurance for each participating company be based on the total amount of each company's group health insurance benefit payments in the United States during the latest year for which the information is available. Since 1960, about 91 percent of the insurance under the Plan has been reinsured by other companies and Aetna has insured about 9 percent.

As provided for by the contract, Aetna receives premiums from the Commission and pays health benefits claims out of its 19 paying offices located throughout the country. Aetna also distributes risk charges and reinsurers' expense allowances to itself and to the reinsurers.

Aetna shares in the risk charges as the insurer and also shares in the reinsurers' expense allowance under the contract, which defines the allowance as expenses of the reinsurers in connection with the reinsurance ceded to them and similar expenses of Aetna in connection with its retained share of the insurance.

The contract requires Aetna to prepare and furnish to the Commission, not later than 90 days after the end of each contract period, a statement of operations for that period.

PRINCIPAL DIFFERENCES BETWEEN TWO GOVERNMENT-WIDE PLANS

Almost all permanent Federal employees are eligible to participate in the Program, and all eligible employees may enroll in either of the two Government-wide plans.

Each of the Government-wide plans offers high and low options of health benefits at different subscription rates. Because of differences in the health benefits offered by the two plans, an enrollee in a high or low option of one plan may receive benefits not covered under the corresponding option of the other plan. Also, with respect to certain types of health benefits covered under both plans, an enrollee under one plan may be required to bear a greater share of the charges for a benefit than would be borne by an enrollee in the other plan for the same type of benefit.

The Indemnity Benefit Plan is carried out by a stock insurance company; the Service Benefit Plan is carried out by nonprofit organizations. As a result the Indemnity Benefit Plan is required to pay certain taxes which are not payable to the same extent by the Service Benefit Plan. These taxes are discussed on pages 68 and 71.

CHAPTER 2

SUBSCRIPTION CHARGES, HEALTH BENEFIT CLAIMS, AND ENROLLMENT

As shown on page 14, the subscription rates for each of the Indemnity Benefit Plan's options have more than doubled since 1960. Our review showed that these rate increases were due principally to increased payments by the Plan for health benefits.

According to Department of Labor consumer price indexes, the costs of health care, nationwide, have been increasing considerably faster than the average costs of all items. The price index for February 1971, which used 1967 as the base year, showed the costs of health care as 125.8; the index showed the costs for all items as 119.4.

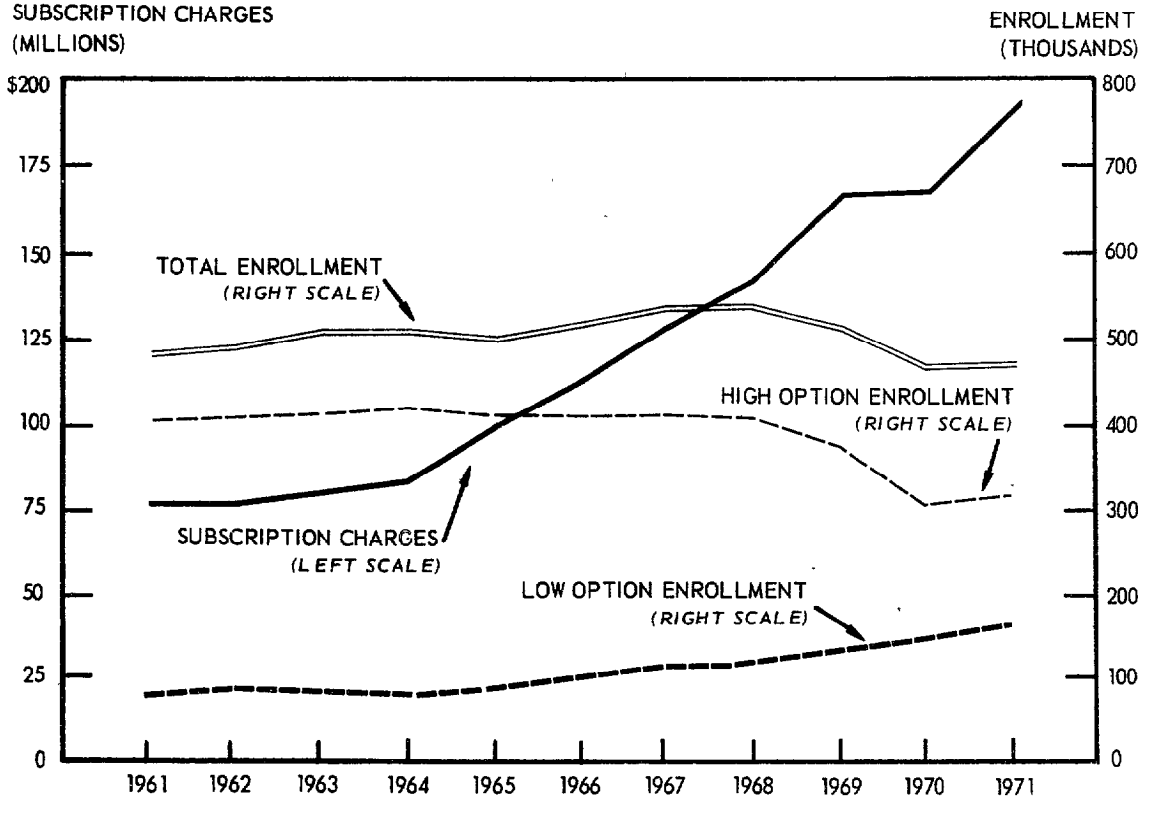
From inception of the Plan in 1960 through 1971, the health benefits charged to the Plan amounted to about 93 percent of the subscription charges which the Commission forwarded to Aetna. Following is a summary for the 4 calendar years 1968-71 of the subscription charges paid to Aetna and the related health benefit claims recorded by Aetna.

Year	Subscription charges	Amount of health benefit claims	Percent of subscription charged
1968	$139,156,034	$137,503,867	98.8
1969	169,921,447	152,962,821	90.0
1970	168,994,816	159,563,291	94.4
1971	191,781,550	161,198,004	84.1

The subscription charges paid to Aetna have increased each year since 1960, except for a slight decrease in 1970. The increases in subscription charges resulted, in part, from increases in enrollment and, in part, from increases in subscription rates. The enrollment in the Plan's high options changed very little until 1968 but since then has decreased substantially. Enrollment in the Plan's low options has gradually increased. The following chart shows

the enrollment at the end of each calendar year from inception of the Plan through 1971 and the related subscription charges.

INDEMNITY BENEFIT PLAN
SUBSCRIPTION CHARGE AND ENROLLMENT TRENDS
FROM PLAN INCEPTION THROUGH DECEMBER 31, 1971



The distribution of the Plan's enrollees between self-only coverage and self-and-family coverage at December 31, 1971, is shown below.

	Number of enrollees	Percent of total
Self only--high option	114,605	24.2
Self only--low option	33,150	7.0
	147,755	31.2
Self and family--high option	203,373	42.9
Self and family--low option	122,795	25.9
	326,168	68.8
Total	473,923	100.0

The open season which commenced in November 1971 was extended by the Commission until the end of January 1972, and enrollment statistics for the Plan as of the end of this open season were not readily available when we completed work on this report.

BIWEEKLY SUBSCRIPTION RATES

Since 1960 there have been a number of increases in the subscription rates payable by enrollees and the Government. In total the biweekly subscription rates have increased under the high options

--214 percent for self-only enrollment and
--201 percent for self-and-family enrollment

and under the low options

--106 percent for self-only enrollment and
--105 percent for self-and-family enrollment.

The Government's contributions were increased for the high options at the beginning of 1966 and 1971 and for the low options at the beginning of 1968, 1969, and 1971. Public Law 91-418, approved September 25, 1970, provides that, for pay periods starting after December 31, 1970, the Government's contributions will equal 40 percent of the average premium for the high options offered under six selected plans in the Program.

The tabulation on the following page shows, for each option, the biweekly subscription rates from inception of the Plan through 1972, and the increases in these rates.

Indemnity Benefit Plan

Option	Biweekly subscription rates effective										Increase 7-1-60 to 4-16-72	
	7-1-60	11-1-63	11-1-64	1-1-66	1-1-68	1-1-69	1-1-70	1-1-71	1-1-72	4-16-72	Amount	Percent
High--self only:												
Individual	$1.82	$1.82	$ 2.84	$ 3.14	$ 3.72	$ 5.34	$ 6.68	$ 6.33	$ 6.20	$ 6.00	$ 4.18	229.7
Government	1.30	1.30	1.30	1.68	1.68	1.68	1.68	3.46	3.59	3.79	2.49	191.5
Total	$3.12	$3.12	$ 4.14	$ 4.82	$ 5.40	$ 7.02	$ 8.36	$ 9.79	$ 9.79	$ 9.79	$ 6.67	213.8
High--self and family:												
Individual	$4.94	$5.64	$ 7.73	$ 7.86	$ 9.30	$13.31	$16.64	$15.62	$15.30	$14.78	$ 9.84	199.2
Government	3.12	3.12	3.12	4.10	4.10	4.10	4.10	8.64	8.96	9.48	6.36	203.8
Total	$8.06	$8.76	$10.85	$11.96	$13.40	$17.41	$20.74	$24.26	$24.26	$24.26	$16.20	201.0
Low--self only:												
Individual	$1.30	$1.30	$ 1.30	$ 1.30	$ 1.46	$ 2.11	$ 2.89	$ 2.68	$ 2.68	$ 2.68	$ 1.38	106.2
Government	1.30	1.30	1.30	1.30	1.46	1.68	1.68	2.68	2.68	2.68	1.38	106.2
Total	$2.60	$2.60	$ 2.60	$ 2.60	$ 2.92	$ 3.79	$ 4.57	$ 5.36	$ 5.36	$ 5.36	$ 2.76	106.2
Low--self and family:												
Individual	$3.12	$3.12	$ 3.12	$ 3.12	$ 3.50	$ 4.99	$ 6.84	$ 6.40	$ 6.40	$ 6.40	$ 3.28	105.1
Government	3.12	3.12	3.12	3.12	3.50	4.10	4.10	6.40	6.40	6.40	3.28	105.1
Total	$6.24	$6.24	$ 6.24	$ 6.24	$ 7.00	$ 9.09	$10.94	$12.80	$12.80	12.80	$ 6.56	105.1

PROCEDURES FOLLOWED IN NEGOTIATING CHANGES IN BENEFITS AND SUBSCRIPTION RATES

Each year the Commission sends a letter to the various carriers participating in the Program, asking them to submit proposals for changes in benefits and/or subscription rates by a specified date and setting forth the Commission's guidelines for preparing the proposals. In April 1971 the Commission changed its regulations to require that carriers' proposals for benefit changes be submitted by April 30 of each year; the regulations previously required such proposals to be submitted by June 30.

The Commission's Office of the Actuary and the Commission's Legislative and Policy Division of the Bureau of Retirement, Insurance, and Occupational Health review the carriers' proposals to determine whether the proposed changes in benefits are desirable and consistent with Commission policy and whether the proposed changes in subscription rates are justified. The Commission may accept or reject a carrier's proposal or may make counterproposals. Negotiation meetings usually are held when the Commission disagrees with a carrier's proposal or when either the Commission or the carrier desires to discuss or explain a proposal, rejection, or counterproposal. For out-of-town carriers, such as Aetna, some of the negotiations may be held by telephone.

The Commission's Office of Management Analysis and Audits, in a November 1970 report on review of the Bureau of Retirement, Insurance, and Occupational Health, stated that the Commission had not maintained adequate files documenting the nature and results of its negotiations. Instead, copies of correspondence and related documents were filed in several locations and were not in such order as to permit ready reference. The report stated also that minutes of negotiation meetings usually had not been prepared.

In response to a recommendation in the report, the Director of the Bureau agreed to establish a system for filing all pertinent negotiation documents in one location in the Bureau and to include documentation of all contract negotiation meetings in the files.

In April 1971 the Subcommittee on Retirement, Insurance and Health Benefits of the House Committee on Post Office and Civil Service commenced a series of hearings on the administration of the Program. In response to the Subcommittee's request, Aetna furnished to the Subcommittee the following data regarding the actions taken by the Commission on Aetna's requests for benefit changes since 1967.

Policy year	Benefit changes requested by Aetna	Action by Commission
1967	Increase annual high option automatic restoration from $1,000 to $2,000	Accepted
	Add provision for paying 100% of allowable expenses exceeding $10,000 in a calendar year under the high options	Accepted
	Add dental benefit	Denied
1968	Expand coverage for mental and nervous disorders, but have a $500 calendar year limitation	Accepted subject to removal of the requested limitation
	Add dental benefit	Denied
1969	Increase lifetime high option maximum benefit for each person from $40,000 to $50,000	Accepted
	Increase annual low-option automatic restoration from $500 to $1,000	Accepted
	Add convalescent facility benefit	Denied

Policy year	Benefit changes requested by Aetna	Action by Commission
1970	Increase lifetime low-option maximum benefit per person from $15,000 to $20,000	Accepted
	Add convalescent facility benefits	Denied
1971	Liberalize psychologist coverage	Accepted
	Impose 52-visit calendar year limitation for mental and nervous disorders	Denied

In testimony before the Subcommittee, the Commission's Director, Bureau of Retirement, Insurance, and Occupational Health, stated that, for the past several years, the Commission's initial letters to the carriers had suggested that, because of the substantial increases in premiums that had been required and because of the fact that the premiums were burdensome to Federal Government employees, the Commission would be receptive only to changes which were of a perfecting nature rather than to major expansions of benefits which would require substantial increases in premiums.

CHAPTER 3

STUDY OF PREMIUM RATES

From inception of the Program in 1960 through 1971, the combined enrollment in the two Government-wide Plans--the Indemnity Benefit Plan and the Service Benefit Plan--represented about 80 percent of the total enrollment in the Program. A study by our actuarial science staff showed that average health costs tended to increase as the age of the enrollees, as a group, increased and that the Indemnity Benefit Plan's enrollees, as a group, were older than the enrollees of the Service Benefit Plan. Under such circumstances the Indemnity Benefit Plan's health costs would tend to be higher than those for the Service Benefit Plan.

Our study showed also that substantial numbers of young enrollees transferred from the Indemnity Benefit Plan to other plans during the 1969 open season. These transfers resulted in increasing the average age and average health costs of the Plan's remaining enrollees. Data regarding enrollment changes during the open season that began in November 1971 were not available when we completed our audit work in March 1972.

DIFFERENCES BETWEEN PROGRAM AND CUSTOMARY GROUP INSURANCE

Although the Program follows the customary underwriting practice of group insurance by using average premiums and by not requiring evidence of insurability, it differs from such practice by, among other things, allowing enrollees to change insurance carriers and levels of insurance after their original selections.

The tradition for group insurance is to establish subscription rates based on average net premium--the average health costs for all enrollees in a group--instead of premiums for different classifications based on individual underwriting specifications. An average premium represents the average costs for all persons in a group at the time for which it is calculated and is not the premium that each person in the group would have to pay on the basis of his own characteristics.

A plan using an average premium procedure has a good chance for success if an employer pays a sufficient part of the total premiums and if the amount remaining to be paid by enrollees does not require average contribution rates in excess of the cost of providing the benefits for the young healthy participants. The chances of success are diminished, however, if enrollees are required to pay for all or most of the premiums, because the young and healthy employees in a group may be reluctant to participate if the average premiums are higher than they believe are warranted by their anticipated health costs.

CHANGES IN ENROLLMENT RESULTING FROM 1969 OPEN SEASON

An open season is a period during which a Federal employee who (1) is not covered under the Program may choose to be enrolled in a plan and (2) is covered under the Program is allowed to change his option within a plan or transfer to another plan.

The Commission initially established regulations requiring that open seasons be held not less frequently than once every 3 years. Early in 1971 the Commission revised its regulations to require that open seasons be held annually, beginning November 1971.

An open season was held in November 1969--the first in 3 years. Following is an analysis, prepared by us from data reported by the Commission, of the changes in enrollment under the Indemnity Benefit Plan resulting from the 1969 open season.

	Option		Increase or decrease(-)
	High	Low	
New enrollees	2,728	4,725	7,453
Transfers from other plans	1,578	2,571	4,149
Option changes (net)	-15,217	15,217	-
Transfers to other plans	-54,112	-14,954	-69,066
Total	-65,023	7,559	-57,464

As shown above the Plan lost 57,464 enrollees--more than 10 percent of its total enrollees--during the open season. The loss consisted of 69,066 transfers to other plans, less a total of 11,602 new enrollees and transfers from other plans. In addition, a net total of 15,217 of the Plan's enrollees changed from the high option to the low option.

We analyzed the Plan's high- and low-option enrollment data by age groups as of May 1969 and May 1970--before and after the open season--and found that the age of the enrollees, as a group, had increased because of the changes made during the open season. Our analysis showed that, for both the high and the low options, the ratio of annuitants to active employees had increased as a result of the changes during the open season. For the low options, which had a net increase in enrollment, more than half of the increase in enrollment consisted of annuitants.

An Aetna paper on the Plan, dated April 21, 1970, stated that the substantial drop in enrollment during the 1969 open season had been expected, because enrollees had been asked to pay a 30-percent premium increase effective January 1, 1969,(1) and because, prior to the open season, it had been announced that the Plan would need a further rate increase of 19.1 percent effective January 1, 1970.(2)

The paper stated also that Aetna had reviewed data for a small, randomly selected group of enrollees to learn more about the quality of the risks which the 57,000 lost enrollments represented. The paper also said that the review

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[1] The premium increase paid by enrollees effective January 1, 1969, was about 43 percent. The increase for the Plan, as a whole, including the Government's contribution, was about 30 percent.

[2] The premium increases paid by enrollees effective January 1, 1970, were about 25 percent for the high options and 37 percent for the low options.

indicated that these lost enrollments accounted for about $20.7 million in 1969 premiums and about $9.1 million in 1969 claims. Although the paper emphasized that the results of the review should be interpreted cautiously because the sample size was small and because additional 1969 claim payments could be expected subsequent to the date of the paper, it said that the review seemed to indicate that the 57,000 lost enrollees, as a class, were better than average risks.

In 1969 and 1970 the amounts of the enrollees' shares of the subscription rates for the high and low options were higher for the Indemnity Benefit Plan than for the Service Benefit Plan. Although some of the Indemnity Benefit Plan's loss of enrollees to the Service Benefit Plan during the 1969 open season may have been caused by differences between the health benefits offered, or by other reasons, it appears probable that the difference in subscription rates had a significant effect.

Following is a comparison of the amounts of the enrollees' shares of the biweekly subscription rates for the two plans during 1969 and 1970.

	1969		1970	
	Indemnity Benefit Plan	Service Benefit Plan	Indemnity Benefit Plan	Service Benefit Plan
High options:				
Self only	$ 5.34	$ 4.98	$ 6.68	$ 5.57
Self and family	13.31	12.16	16.64	13.59
Low options:				
Self only	2.11	1.76	2.89	2.16
Self and family	4.99	4.24	6.84	5.30

INFLUENCE OF ENROLLEES' AGE, SEX, AND GEOGRAPHICAL LOCATION ON PREMIUMS

In establishing subscription rates, the largest item for consideration is the cost of health benefits (net premiums), which varies by the ages, sexes, and geographical locations of the persons covered. The following table, which we developed from Aetna's statistics on health costs incurred under the Plan during 1969, shows the effects of age and sex on the Plan's annual health costs by age group for all active employees and annuitants covered under the high options. This table does not include cost data with respect to dependents of enrollees having self-and-family coverage, because Aetna did not maintain statistical data which would permit us to relate dependents' costs to enrollees by age and sex groups.

Indemnity Benefit Plan
1969 Health Costs for all
Enrollees Having High-Option Coverage

Age group	Active employees		Age group	Annuitants
	Male	Female		Male and female
15 to 19	$ 49.65	$ 83.10		
20 to 24	53.79	85.07		
25 to 29	57.43	87.37		
30 to 34	61.73	90.19		
35 to 39	68.68	110.63		
40 to 44	85.58	139.69		
45 to 49	116.20	180.44	Under 50	$226.98
50 to 54	160.72	173.09	50 to 54	230.79
55 to 59	218.95	176.58	55 to 59	233.35
60 to 64	302.56	258.44	60 to 64	230.07
65 to 69	276.99	222.71	65 to 69	225.62
			70 to 74	223.74
			75 and over	287.10

As shown above the Plan's health costs for females were higher than those for males through age 54 and were lower from that age on. The health costs for annuitants (male and female) were higher than those for active employees through age 59. The Plan's health costs for both active employees

and annuitants generally increased for each age group through age 64 and decreased slightly for the 65 to 69 age group.

The decrease in the Plan's health costs for the 65 to 69 age group appears to have been attributable to Medicare coverage held by employees and annuitants. For those enrollees who have Medicare coverage, only health costs not paid by Medicare are payable by the Plan. Therefore the total health costs for this age group were much higher than the amounts paid by the Plan.

The Medicare program provides eligible persons aged 65 or over with two basic forms of protection against the costs of health care services. One form, designated as part A, covers inpatient hospital services and posthospital care at extended-care facilities and at patients' homes. The second form, designated as part B, is a voluntary program and covers physician services and a number of other medical and health benefits, including hospital outpatient services and certain home care.

The following table, which is based on 1969 claim data supplied by Aetna, shows the differences between what the Plan paid and what it would have paid if Medicare coverage had not existed for certain claimants aged 65 and older.

Claimants aged 65 and older	Plan paid	Plan would have paid	Difference	Percent paid by Plan
Having Medicare parts A and B	$4,856,000	$13,355,000	$8,499,000	36
Having Medicare part A only	1,559,000	2,783,000	1,224,000	56
Having Medicare part B only	2,314,000	2,599,000	285,000	89

Our study did not cover the effects on average health costs of the geographic distribution of the Plan's enrollees, because Aetna did not have readily available statistical data regarding the geographic locations of the Plan's enrollees. The general effects of such distributions were demonstrated, however, in a report on a January 1970 survey of

hospital charges made by the American Hospital Association, which showed that hospital costs may vary significantly between geographical areas. Aetna and Commission officials agreed that the Plan's claim costs were affected by the geographical locations of the enrollees.

EFFECTS OF CHANGES IN AGE AND SEX COMPOSITION OF EMPLOYED ENROLLEES

The age and sex composition of the enrollees in the different options of the Plan changed as a result of the November 1969 open season because many of the enrollees either transferred to other plans or switched options within the Plan. After the open season the age of the employed enrollees, as a group, and the proportion of employed female enrollees had increased.

To demonstrate the effects of the changes in age and sex composition, we used Aetna's 1969 health cost statistics for the Plan as a basis for computing 1969 average net premiums (average health costs) for male and female employees under both options and took into consideration the age and sex composition of the Plan's employed enrollees in May 1969 and January 1970--periods before and after the open season. The results of our computations are summarized below.

Computed Average 1969 Health Costs of the Indemnity Benefit Plan's Employed Enrollees

	Computed by using age and sex composition of the Plan as of May 1, 1969	Computed by using age and sex composition of the Plan as of January 1, 1970	Increase	
			Amount	Percent
Male:				
High option	$130.78	$144.33	$13.55	10.4
Low option	74.20	78.78	4.58	6.2
Female:				
High option	158.90	165.41	6.51	4.1
Low option	104.30	109.08	4.78	4.6
Combined:				
High option	137.57	149.76	12.19	8.9
Low option	80.81	85.36	4.55	5.6

As shown above, because of the changes in age and sex composition between May 1969 and January 1970, the average annual net premiums required to cover the Plan's health costs for employed enrollees increased by 8.9 percent and 5.6 percent for the high and low options, respectively.

To further illustrate the effects of the changes resulting from the 1969 open season, we computed, as shown in the following table, what the Plan's health costs for 1969 would have been if the employed enrollees had had the same age and sex composition as the employed enrollees of the Service Benefit Plan.

Computed Average 1969 Health Costs of The Indemnity Benefit Plan's Employed Enrollees

	Computed by using age and sex composition of the Indemnity Benefit Plan as of January 1, 1970	Computed by using age and sex composition of the Service Benefit Plan as of December 31, 1969	Increase or decrease(-) Amount	Percent
Male:				
High option	$144.33	$127.43	$16.90	11.7
Low option	78.78	79.25	-.47	-.6
Female:				
High option	165.41	146.70	18.71	11.3
Low option	109.08	98.20	10.88	10.0
Combined:				
High option	149.76	132.13	17.63	11.8
Low option	85.36	84.94	.42	.5

If the Indemnity Benefit Plan had had the same mix (age and sex) of employed enrollees as the Service Benefit Plan, the average health costs for the Indemnity Benefit Plan's high options would have been $17.63 less. For the low options, however, there would have been no appreciable difference in the average health costs.

POTENTIAL EFFECTS OF HIGH RATIO OF ANNUITANT ENROLLEES

A December 31, 1970, report by the Commission showed the ratios of annuitants to total enrollees for the 38 plans then in the Program. The ratio for the Indemnity Benefit Plan was higher than the ratios of the other plans, except for four employee organization plans whose combined enrollment was only about 2 percent of the total enrollment in the Program.

These ratios are summarized below.

Ratios of Annuitants to Total Enrollees as of December 31, 1970

Plan	Enrollees		Percentage of annuitants to total enrollment
	Total	Annuitants	
Government-wide plans:			
Service Benefit Plan	1,625,262	274,462	16.9
Indemnity Benefit Plan	471,768	124,771	26.4
Employee organization plans	386,160	61,281	15.9
Individual-practice plans	44,514	6,216	14.0
Group-practice plans	129,125	18,004	13.9
Total for Program	2,656,829	484,734	18.2

As indicated by the table on page 22, health costs tend to be higher for annuitants than for employed enrollees. Thus it seems probable that a plan's average health costs would be increased if the ratio of annuitants to total enrollees increased.

A precise computation of the effects of the increased ratio of annuitants on the Plan's subscription rates after the 1969 open season is not possible at this time because adequate data is not available regarding sex and geographical distribution and other characteristics which might affect

health costs of the annuitants transferring into the Plan or switching options. Nevertheless, to obtain some indication of the potential effects of these changes in ratio, we used the Plan's 1969 health costs (net premiums) as a basis for computing what the 1969 net premiums for the high and low options would have been if the Plan's ratios of annuitants to total enrollees had been those of May 1969 and June 1970 and if there had been no other changes in the characteristics of the group.

The following table shows the ratios of annuitants to enrollees before and after the 1969 open season and the effect that the increases in these ratios would have had on the average health costs for the self-only coverage under the high and low options of the Plan.

Self-only coverage	Date		Increase
	May 1969	June 1970	
Ratio of annuitants to total enrollees:			
High option	30.1%	35.7%	5.6%
Low option	24.9	34.1	9.2
Average health costs:			
High option	$172.57	$177.26	$4.69
Low option	101.09	102.75	1.66

Also we made a study to determine what the effect would have been if the Indemnity Benefit Plan's annuitant to enrollee ratios in June 1970 had been the same as those of the Service Benefit Plan in June 1970--24.7 percent and 20.9 percent for the high and low options, respectively. The study showed that the Indemnity Benefit Plan's average costs for self-only enrollees would have been $168.07 ($9.19 less) for the high options and $98.95 ($3.80 less) for the low options. In other words self-only enrollees in the Indemnity Benefit Plan are paying more for their health benefits than they would have paid if the ratios of annuitants to total enrollees had been the same as those of the Service Benefit Plan in June 1970.

REPORT OF COMMISSION'S CONSULTANT ACTUARIES AND VIEWS OF AETNA OFFICIAL

In a January 1969 report on the two Government-wide plans, consultant actuaries of the Commission described the process--called an assessment spiral--which occurs when, because of enrollment changes, the average age of enrollees of one insurance program, as a group, increases faster than the average age of enrollees of another insurance program, resulting in higher costs for the first program. The report points out that, if higher premiums were needed by the first insurance program because of the effect of aging on claim costs, current enrollees might question whether the plan offered by the first insurance program was as favorable as that offered by the second.

The report continued that the healthier persons would be likely to move to the second program but that the less healthy ones would be inclined to hold on to their current benefits. Premium rates then would have to be increased to reflect the experience of the less healthy persons, which would allow the selection process to occur again and would result in the eventual collapse of the first insurance program unless methods were developed to counter the trend.

The Commission's consultant actuaries were of the opinion that the Plan may be in jeopardy over the long run unless the faster aging of the Plan's enrollees was checked.

In testimony before the Subcommittee on Retirement, Insurance and Health Benefits, House Committee on Post Office and Civil Service, on April 22, 1971, an Aetna official expressed the opinion that a basic principle underlying the Program was that Federal employees should have free choice of a broad variety of health benefit plans competing on a reasonably equitable basis. He stated that this principle was in jeopardy, however, because certain inequities had developed; namely, adverse annuitant to employee ratios, taxes on premiums, and discriminatory charging practices of many hospitals resulting from special agreements between hospitals and local Blue Cross organizations participating in the Service Benefit Plan. He added that, if the inequities were not eliminated, they would so discriminate against certain plans that employees desiring to enroll, or remain enrolled, in those plans would be unable to afford it.

The Aetna official indicated that the annual premiums of some plans were higher than the premiums of others because some plans had a higher proportion of annuitants than the other plans. He added that, because the Federal Government's contribution was a uniform percentage, the effect was to pass on to the employed enrollees most of the extra cost attributable to annuitants and that this difference restricted a person's freedom of choice by applying economic pressure to select one plan over another. He concluded that, unless corrective action was taken promptly to eliminate inequities between plans, Federal employees might soon be left with a substantially reduced choice of plans and perhaps ultimately with only one choice.

CONCLUSIONS

Prior to the 1971 open season, the Indemnity Benefit Plan had an older employee enrollee population and a higher annuitant ratio than the Service Benefit Plan. Older employee and annuitant enrollees incur higher health costs than younger employee enrollees, and these higher costs are reflected in the premiums which must be paid by all the Indemnity Benefit Plan's enrollees.

It appears to us that the losses in the Plan's high-option enrollment during the 1969 open season probably were attributable, in part, to the Plan's high subscription rates. We recognize, however, that differences in the health benefits coverage of the various plans and perhaps other causes may have contributed to these losses. We believe that, unless the causes of the Plan's losses are identified and changes are made to curb the potential assessment spiral, the Plan ultimately may be forced to withdraw from the Program because employees may be reluctant to participate in the Plan if the premiums charged are higher than they believe are warranted by their anticipated health costs.

We noted that, effective with the first pay period in January 1972, the Commission had authorized a significant increase in the premiums for the high option of the Service Benefit Plan covering most of that plan's enrollees but that the premiums for both options under the Indemnity Benefit Plan stayed the same as for 1971. This change may or may not have a deterrent effect on the potential assessment spiral under the Plan.

RECOMMENDATIONS TO THE CHAIRMAN
CIVIL SERVICE COMMISSION

In view of the provisions of law authorizing the Commission to contract for two different types of Government-wide health insurance plans, it appears to us that the Congress intended for Federal employees to have a choice of Government-wide plans.

We recommend that the Commission review the changes in enrollment which occur during the next annual open season to find out:

--Why enrollees changed plans or options. This could be done by asking those who changed plans or options to state their reasons for the change.

--Whether the proportions of older active employees and annuitants in the Indemnity Benefit Plan continued to increase and, if so, the extent to which such increases will affect the Plan's average health costs.

We recommend also that, if the review indicates that revisions of benefit coverage or other changes are needed to ensure that Federal employees continue to have a choice of Government-wide plans, the Commission initiate actions necessary to accomplish such changes. If the actions to ensure that Federal employees continue to have a choice of Government-wide plans cannot be taken within the framework of the existing legislation, the Commission may wish to propose changes in the Program for consideration by the Congress. Such changes might include such matters as

--authorizing the Commission to make varying premium payments to the carriers of the different plans under the Program, so as to minimize the effects of differences in health costs caused by differences in age and sex compositions, annuitant to employee ratios, and geographic locations, or

--providing, as a substitute for the high and low options of the various plans, specified basic benefits at a uniform cost to all enrollees and providing additional benefits which would be made available by

the carriers to those enrollees who wish to pay for such supplementary coverage.

AGENCY COMMENTS

In commenting on a draft of this report, the Commission stated that for 1972 the Service Benefit Plan's premium rates had been increased so that the high-option self and family rates, covering 64 percent of that plan's enrollees, were about 11 percent higher than those for the Indemnity Benefit Plan. The Commission stated also that, if higher rates were a primary reason for changing plans, the large rate increase for the Service Benefit Plan should be reflected in changes during the open season started in November 1971.

The Commission expressed the opinion that, because of the lead time required to prepare and distribute forms asking employees' reasons for changing plans, the complex problems involved in establishing 1972 rates under the Program, and the extended open season, the 1971 open season was not appropriate for a detailed study of the enrollment changes taking place during that open season. The Commission said, however, that it would continue to develop data on the trends of annuitant coverage under the Program and would review the need for obtaining detailed statistics on employee reasons for changing plans.

The Commission said also that, if the downward trend in the number of enrollees in the Plan continued, it would undertake a broader study of the reasons for the trend and determine what, if anything, should be done to change the situation.

We believe that the Commission's proposed actions are consistent with the objectives of our recommendations.

CHAPTER 4

HEALTH BENEFITS

The principal hospital, surgical, and medical benefits offered by the high and low options of the Plan and the deductible and coinsurance features of each option are shown in appendix II of this report.

Aetna processes enrollees' claims through 19 paying offices located in various cities in the United States. A paying office verifies that an enrollee is eligible for benefits and that the claimed services are covered, determines the amount payable, and sends payment to the enrollee or, at his option, directly to the doctor or hospital. The amount payable is based on the allowable amount of a claim, less the applicable deductible and coinsurance amounts.

In paying approved claims, Aetna's branch offices issue drafts drawn on a Hartford, Connecticut, bank and provide pertinent information to the Aetna home office concerning the drafts. After the bank has notified Aetna of the drafts presented for payment, Aetna transfers funds to the bank to cover the total amount of the drafts accepted for payment.

COMPARISON OF CHARGES ALLOWED UNDER INDEMNITY BENEFIT PLAN WITH CHARGES ALLOWABLE UNDER SERVICE BENEFIT PLAN

We compared the amounts that had been allowed for certain physician and hospital services under the Indemnity Benefit Plan with the amounts that would be allowable for similar services under the criteria used by two Service Benefit Plan local organizations[1] covering the same geographical areas. We compared the gross amounts allowable

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[1]Payments for covered services under the Service Benefit Plan are made by about 150 local Blue Cross and Blue Shield plans.

under the different plans rather than the amounts paid, because there were differences between the plans as to the portions of the costs of benefits required to be borne by the enrollees.

Our comparison covered the physician and hospital services included in a statistical sample of drafts paid in May, June, and July 1970. This sample covered 139 drafts issued by Aetna's Portland, Oregon, office to Oregon enrollees and 94 drafts issued by Aetna's Springfield, Massachusetts, office to Massachusetts enrollees. Our comparison indicated that the total of the amounts allowed under the Indemnity Benefit Plan was higher than the total of the amounts that would have been allowable under the criteria applicable to the Service Benefit Plan.

Physician services

Aetna has furnished broad guidelines to its paying offices for use in determining the amounts allowable as customary and reasonable charges for physician services. These guidelines provide for taking into consideration the nature and extent of services performed; the range of prevailing fees; the physician's usual charges; and the training, experience, and standing of the physicians. Aetna has provided its paying offices with a general fee schedule for consideration in determining the reasonableness of charges for surgery. Although Aetna's paying offices may use this general fee schedule or other guides in determining the reasonableness of surgery and other charges, they are allowed to use judgment in determining whether charges are customary and reasonable.

We compared the amounts that had been allowed for the claims for physician services included in our sample of Springfield and Portland drafts under the Indemnity Benefit Plan with the amounts that would have been allowable by the Service Benefit Plan organizations--Massachusetts Medical Service and Oregon Physician Services--as reasonable charges for such services under the Service Benefit Plan high option.

The Service Benefit Plan allows usual, customary, and reasonable charges for physician services covered by the plan. The Service Benefit Plan brochure, which is incorporated into the Commission's contract by reference, contains the following criteria for determining such charges:

> "The Carrier will determine whether a charge is usual, customary and reasonable by comparing it with the charge ordinarily made for similar services or supplies provided under similar circumstances."

The Indemnity Benefit Plan brochure, which also is incorporated into the Commission's contract, contains similar criteria:

> "This Plan has no set schedule of fees, but pays benefits for allowable charges to the extent they are reasonable and customary. Whether a particular charge is reasonable and customary is determined by comparing it with the charge ordinarily made for similar services and supplies provided under similar conditions to people in like circumstances."

Under the Service Benefit Plan, both Massachusetts Medical Service and Oregon Physician Services maintain physicians' usual-charge profiles (schedules of usual charges by each physician) and customary fee schedules for use in determining whether physicians' charges are reasonable. Both carriers are required by their procedures to determine that a charge does not exceed either (1) the individual physician's usual charge for the service rendered or (2) the upper limit of the customary charges in the area. Massachusetts Medical Service uses only a customary fee schedule for physician services covered under supplementary benefits--allowable benefits not payable under the basic benefits provided for in the Service Benefit Plan brochure.

Our sample of drafts paid by Aetna during May, June, and July 1970 included 331 charges for physician services. Our comparison showed that the amounts allowed under the Indemnity Benefit Plan exceeded by 6.5 percent the amounts that were shown as allowable under either the usual-charge

profiles or the customary fee schedules used by the Service Benefit Plan carriers.

By applying the results of our comparison to the total payments made by Aetna in the two States during the 3 months involved, we estimated, at a 95-percent confidence level, that the amounts allowed for physician services in Oregon and Massachusetts during May, June, and July 1970 were about $26,800 higher (plus or minus $14,930) than would have been allowable under the Service Benefit Plan.

The higher amounts allowed under the Indemnity Benefit Plan appeared to have resulted from differences between the methods used by the plans in determining allowable charges for physician services. The usual-charge profiles used by the Service Benefit Plan local organizations in determining reasonable charges were applicable to the specific physicians whose charges were being reviewed and the customary fee schedules used were applicable to physician services in specified geographical areas. In determining reasonable charges under the Indemnity Benefit Plan, the Aetna paying offices used general fee schedules covering the pertinent geographical areas but had no usual-charge profiles to use for individual physicians.

Aetna officials informed us that they were developing profiles of physicians' usual charges for future use in their health insurance operations, including the Indemnity Benefit Plan. In six States where Aetna was the carrier for the Medicare program, Aetna was using profiles of physicians' customary charges and of the prevailing charges for the different areas in determining whether charges under the Medicare program were reasonable and customary.

Hospital services

Under the Indemnity Benefit Plan, the amounts allowed for services usually are the amounts charged by hospitals. Under the Service Benefit Plan, the amounts allowed for hospital services are usually the lower of the hospital costs or charges for the particular services. Initial payments to a hospital usually are made at rates less than those charged by the hospital; additional payments are made to, or refunds are collected from, the hospital if subsequent

audit shows that the hospital costs, computed on the basis of a prescribed cost-reimbursement formula, are more or less than the total of the amounts initially paid.

Our sample of Indemnity Benefit Plan drafts covered charges in excess of $100 by 14 Massachusetts hospitals. We compared the amounts allowed for these hospital services with amounts which would have been allowable for the same hospital services under the Service Benefit Plan, by using data made available to us by the local Blue Cross carrier. Our comparison revealed that the Indemnity Benefit Plan allowed $10,630 whereas $9,704 would have been allowable under the Service Benefit Plan--a difference of $926, or about 9.5 percent more.

On the basis of the results of our comparison, we estimated, at a 95-percent confidence level, that the amounts allowed under the Indemnity Benefit Plan for hospital services in Massachusetts during May, June, and July 1970 were $18,991 higher (plus or minus $11,896) than would have been allowable under the Service Benefit Plan.

Aetna and Commission officials agreed that the amounts allowed for hospital services generally were higher under the Indemnity Benefit Plan than under the Service Benefit Plan. They pointed out that the local Blue Cross (Service Benefit Plan) carriers had negotiated agreements with many hospitals which provided for the hospitals to accept payments for services on the basis of the lower of the hospital costs or charges whereas the Indemnity Benefit Plan usually allowed the amounts charged by the hospitals.

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Our review indicated that the amounts allowed for physician and hospital services under the Indemnity Benefit Plan had been higher than the amounts that were allowable for similar services under the Service Benefit Plan.

The lower allowances for hospital services under the Service Benefit Plan appeared to be attributable to the local practices, under the Service Benefit Plan, of negotiating agreements with many hospitals to accept payments for

services on the basis of the lower of the hospital costs or charges.

In our opinion, the development and use of adequate profiles of physicians' usual charges would improve the procedures used by Aetna's paying offices in determining the amounts allowable for physician services under the Indemnity Benefit Plan and would help reduce the costs of the Plan. Therefore, in a draft of this report, we proposed that the Commission encourage Aetna to develop and use adequate profiles of physicians' usual charges for determining whether charges for physician services under the Indemnity Benefit Plan were reasonable.

AGENCY COMMENTS

In commenting on our draft report, the Commission questioned the validity of our conclusion regarding the percentage difference between the amounts allowable for physician services under the Indemnity Benefit and Service Benefit Plans, because our comparisons involved the amounts allowed by Aetna for specific services by certain physicians and assumed allowances to other physicians under other circumstances.

We believe that our comparisons were adequate to provide a basis, for the months and States involved, for establishing the percentage difference between the amounts allowable under the two plans. The amounts we assumed to be allowable under the Service Benefit Plan were the amounts shown as allowable under either the usual-charge profiles or the customary fee schedules used by the Service Benefit Plan carriers, and, in many cases, our comparisons involved the amounts allowable for similar services performed by the same physicians.

The Commission stated, with respect to our proposal, that Aetna had developed and started using profiles of physicians' usual charges in determining whether charges for physician services were reasonable.

We believe that, if properly developed, maintained, and used, Aetna's usual-charge profiles should tend to provide

increased assurance that future charges to the Plan for physician services are within the prescribed criteria of being reasonable and customary.

CHAPTER 5

RESERVES

Both the Commission and Aetna maintain Plan reserves which may be used to meet the costs of the Plan.

CONTINGENCY RESERVE MAINTAINED BY COMMISSION

As authorized by law the Commission maintains in the Treasury an Employees Health Benefits Fund applicable to the Program. The Commission deposits into this fund about 4 percent of the total contributions made by employees, annuitants, and the Government to provide for a contingency reserve and for the Commission's administrative expenses related to the Program. The law states that the contingency reserve may be used to defray increases in future premium rates, to reduce the contributions of employees and the Government, or to increase the benefits provided by the plans from which the reserve was derived.

The Commission maintains separate contingency reserves for each plan in the Program. At December 31, 1971, the Commission's contingency reserve for the Plan totaled about $23.2 million.

RESERVES MAINTAINED BY AETNA

Aetna maintains two reserves for the Plan, one representing funds held to pay health benefit claims (called claim reserves) and another (called Special Reserve) representing funds held to pay possible future costs. The Special Reserve comprises two funds.

--An Experience Credit Fund representing the difference between the cumulative Plan income received by Aetna and the cumulative Plan costs.

--A Deposit Fund representing funds transferred from the Commission's contingency reserve but not yet needed by Aetna to pay costs incurred by and chargeable to the Plan.

Claim reserves

At December 31, 1969, 1970, and 1971, the Plan reserves held by Aetna for unpaid claims amounted to about $39.5 million, $40.5 million, and $42 million, respectively. Claim reserves generally are expended in the following year.

We calculated the amounts required for unpaid claims at the end of 1967, 1968, and 1969; the amounts of the claim reserves established by Aetna were considered by us to be reasonable in relation thereto.

Special Reserve

As indicated by the summary of Aetna's financial reports in appendix 1, from inception in 1960 through December 31, 1971, the cumulative income received by Aetna from Plan subscriptions and interest on investments was sufficient to cover the Plan's cumulative costs (benefit payments and operating expenses) and provide a Special Reserve of about $34.7 million. The Commission's contract with Aetna provides that, upon termination of the contract, any balance remaining in the Special Reserve after all allowable charges have been made will be returned to the Commission.

The Commission's regulations have provided that, if the total of all the reserves held by a carrier at the end of a contract period is less than the total of the last 5 months' subscription charges paid to the carrier, the Commission remit to the carrier from its contingency reserve the lesser of (1) the amount needed to maintain the carrier's plan reserves equal to 5 months' subscription charges or (2) the excess of the contingency reserve held by the Commission for the plan over 1 month's premium (the preferred minimum balance to be held by the Commission).

We noted that Aetna's income from subscriptions and interest had not been sufficient to cover all costs of the Plan incurred by Aetna in certain years. Funds had been made available from the Commission's contingency reserve and Aetna's Special Reserve to cover the operating losses at the end of each year except 1968.

At the end of 1968, Aetna's Special Reserve had a deficit of about $6.7 million. This deficit represented the excess of Aetna's cumulative Plan costs over its cumulative Plan income. The Plan's subscription rates for 1969 had been increased by about 30 percent, and, as a result, the Plan's income for 1969, including funds transferred from the Commission's contingency reserve, was sufficient to pay the costs for the year, eliminate the cumulative deficit, and provide a Special Reserve of $3.6 million.

According to Aetna, premium rates for the Plan have been established on the basis of actuarial studies of (1) the anticipated claims for the policy year concerned by using past experience adjusted for observable trends and other expected changes, (2) estimated amounts needed for expenses, taxes, and risk charges, (3) any amount needed for recovery of prior losses, and (4) a margin to cover chance variations in anticipated claims. We understand, on the basis of our review and discussions with Aetna officials, that these actuarial studies of past experience have not specifically singled out the underwriting experience for different age, sex, and geographical groupings of the Plan's participants.

Our review indicated that statistical data for this type of detailed analysis of claims experience under the Plan was obtainable from records maintained by Aetna in computer-usable form, such as magnetic tapes.

We believe that the wide fluctuations in financial results of the Plan for different years may have resulted from Aetna's practice of establishing subscription rates on bases which did not specifically take into consideration the results of the claims experience for different age, sex, and geographical groupings of the Plan's participants.

Aetna officials pointed out that they would have preferred to operate with a somewhat greater margin to cover variations in anticipated claims but that, in their judgment, this would not have been feasible unless the Commission had required all carriers to operate with similar margins so that the premium rates for the Indemnity Benefit Plan would not be placed in an uncompetitive position. We believe that higher margins would be unnecessary if the premiums were determined in the manner recommended in this report.
(See p. 46.)

STUDY OF CONTINGENCY RESERVES

From inception of the Plan in 1960 through December 31, 1971, the totals of the Commission's contingency reserve for the Plan and the Special Reserve held by Aetna (combined contingency reserves) at the end of each contract period ranged from a low of 6.2 percent to a high of 32.3 percent of the period's subscription charges. At December 31, 1971, these combined reserves totaled $57.8 million, or 30.1 percent of the 1971 subscription charges.

We asked an official of the Commission's actuarial staff how the combined contingency reserve needs had been determined. In response, the official stated that no studies had been made by the Commission for the purpose of calculating the amounts of combined contingency reserves needed. He indicated that this might be due to provisions of the Commission's regulations which, since early in the Program, have provided for transferring funds from the Commission's contingency reserve to carriers' reserves if the total of the carriers' reserves do not equal specified amounts at the end of contract periods.

Using risk theory we calculated the percentage of premiums which we believed would be needed, in total, by the Commission in its contingency reserve and by Aetna in the Plan's Special Reserve to cover adverse chance variations in claim costs if premium rates were established on bases which specifically take into consideration the claims experience for various underwriting factors, such as different age, sex, and geographical groupings of the Plan's participants.

Risk theory relates to adverse chance variations from average frequencies and claim amounts. Adverse chance variations represent variations which do not occur in regular order in the frequencies and amounts of claims. For purposes of our calculations, we used techniques of risk theory to derive mathematical formulas for measuring the probabilities within which claims would randomly vary from expected average frequencies and claim amounts.

Our calculations indicated that year-end combined reserves of about 5 percent of the annual subscription charges

would be large enough to cover adverse chance variations in claim costs 99.95 percent of the time, provided subscription rates for the Plan were established on the basis of the claims experience for various underwriting factors, such as different age, sex, and geographical groupings of the Plan's participants. The following table shows the results of our calculations.

Percent of reserve to annual subscription charges	Needed annual risk charges (note a)
-	$645,931.00
3.77	592.86
5.00	9.40

[a]This means that, with a 5-percent reserve, the needed annual risk charge would be negligible ($9.40) for adverse chance variations. With a 3.77-percent reserve, the needed annual risk charge would be only $592.86. Risk charges are described in greater detail in ch. 6.

We brought the results of our calculations to the attention of a Commission official, who questioned whether combined contingency reserves equal to 5 percent of annual subscription charges would be adequate, because there had been wide year-end fluctuations in the amounts of the combined reserves.

We believe that, if subscription rates had been based on studies which included detailed analyses of claims experience by age, sex, and geographical groupings, there could have been a closer relationship between the amounts of premiums received and the claim costs experienced and, therefore, a lesser degree of fluctuation from year to year in the financial results of the Plan. It follows therefore that the large year-end fluctuations in the combined contingency reserves for the Plan have been largely attributable to Aetna's practices in establishing subscription rates.

The Commission's contract with Aetna did not provide for the use of the Commission's contingency reserves to help

pay allowable charges under the Plan if the contract were terminated and if the reserves held by Aetna were insufficient to cover the unpaid charges. We believe that it would be equitable to make the Commission's applicable contingency reserves available for payment of allowable charges in the event a contract under the Program is terminated, because the contingency reserves are derived principally from premium payments by the enrollees of the plans.

An Aetna representative cited the possibility of a deficit in Aetna's Plan reserves in the event of contract termination as an element of risk under the Plan because of uncertainty as to the availability of the Commission's contingency reserve held for the Plan. In a letter to the Commission dated March 10, 1971, we suggested that this uncertainty could be eliminated through a contract amendment which would authorize the use of the Commission's contingency reserve for the Plan if warranted at the time of contract termination.

Commission officials informed us that the Commission and Aetna had agreed to such an amendment, effective January 1, 1972. A Commission official advised us early in March 1972 that the contract amendments for 1972 had not been formally executed by the parties.

CONCLUSIONS

Accumulations of contingency reserves in excess of the amounts needed to protect the interests of the Plan's enrollees result from unnecessarily high subscription rates charged to the Government and the enrollees. In our opinion, the combined total of the contingency reserve held by the Commission for the Plan and the Special Reserve held by Aetna should be maintained at the minimum levels necessary to provide protection against adverse chance variations and in this way help to avoid unnecessarily high subscription rates.

We believe that the combined total of the Special Reserve of the Plan held by Aetna and the contingency reserve of the Plan held by the Commission have been higher than needed to protect against adverse chance variations in benefit claims. We believe that combined contingency reserves

equal to about 5 percent of annual subscription charges would be adequate to cover adverse chance variations, provided that subscription rates were established in such a manner as to give more specific consideration to the Plan's claims experience for various underwriting factors, such as different age, sex, and geographical groupings of its participants.

In our opinion, if the Plan's premium rates were computed as stated above, the total premiums would be more closely related to the actual claims experience than they were in the past. Also this method of computation would enable appropriate determinations of the amounts of contingency reserves required to cover adverse chance variations in claims and would tend to minimize wide fluctuations in premium rates, such as the large increase which occurred in 1969, to cover prior operating losses.

RECOMMENDATIONS TO THE CHAIRMAN CIVIL SERVICE COMMISSION

We recommend that the Commission (1) encourage Aetna to refine its method of establishing premium rates for the Plan by making and using, to the extent practicable, the results of studies of claims experience for different age, sex, and geographical groupings of the Plan's participants and (2) determine, by using principles of risk theory or other acceptable methods, the combined amount of the reserves needed to be maintained by the Commission and Aetna to cover adverse chance variations in claim costs and take such determinations into consideration before approving premium rates for the Plan.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on a draft of this report, the Commission questioned the need for Aetna, in establishing premium rates for the Plan, to make and utilize the results of studies of claims experience for different age, sex, and geographical groupings of the Plan's participants.

The Commission stated, among other things, that (1) the long-term effect of more accurate predictions of premium rates would be negligible on both the cost to the employee and the total contributions to the Plan because, under the existing procedures, any excess or deficit in the premium rates for a year would be taken into consideration in establishing the premium rates for the following year and (2) although the use of age, sex, and geographical distribution characteristics was a useful procedure in establishing initial rates for a plan, these characteristics were built into the experience rating procedure applicable to the Indemnity Benefit Plan under which actual experience is considered in establishing premium rates for future periods.

With regard to item (1) above, section 8902(i), Title 5, United States Code, states that the rates charged under the Plan shall reasonably and equitably reflect the costs of the benefits provided. Although the law permits the results of prior experience to be taken into consideration in establishing renewal premium rates, we believe that the annual

premium rates established for the Plan should represent, as nearly as practicable, the costs of the benefits to be provided in that year, to avoid inequities to current and future enrollees.

The potential for inequities to enrollees of the Plan under the current method of establishing premium rates is apparent from the operating results for 1971. The Plan's premium rates were increased by an average 17 percent effective January 1, 1971. As shown in appendix I of this report, the Plan had a gain from operations for 1971 of $19.6 million, or more than 10 percent of the total subscription charges recorded for the year.

Under the experience rating procedure applicable to the Plan, the 1971 gain from operations will be available for reducing, or curtailing increases in, future premium rates. However, the enrollees who discontinue their coverage under the Plan before such reduced rates become effective will receive no benefits from their contributions toward the net gain from operations in 1971.

Conversely, if the Plan's 1971 operations had resulted in an operating loss, any increases in future premium rates made for the purpose of recovering the loss would be paid by the enrollees, including new enrollees, in the Plan after the increased rates became effective and the enrollees who transferred to other plans would not help pay the loss resulting from their health insurance coverage.

With regard to the use of age, sex, and geographic distribution characteristics, we recognize that it would not be possible for Aetna to consistently establish annual premium rates for the Plan with such accuracy that there would be no annual gain or loss from operations. However, we are of the opinion that basic premium rates determined by measurable underwriting characteristics, such as age, sex, and geographic locations, would provide a better prediction of future premium needs than would a single aggregate average for a heterogeneous grouping of risks.

The published studies of mortality and morbidity for the past 20 years or more, which have been used for life and health insurance premium calculations, have been based

on homogeneous groupings of risks determined by these underwriting characteristics. In our opinion, the use of homogeneous groupings based on underwriting characteristics in determining basic premium rates for a plan (or carrier) in the Program not only would help to achieve a more refined projection of premium needs for future years but also would facilitate determinations as to why the average aggregate premium of one carrier differs from that of another carrier.

With respect to our recommendation that the Commission determine, by use of principles of risk theory or other acceptable methods, the combined amount of reserves needed to be maintained to cover adverse chance fluctuations in claim costs, the Commission stated that our suggested use of principles of risk theory to determine necessary reserve levels constituted a novel application of actuarial theory that was not generally used in industry or Government.

Our review of the study material for the examinations of the Society of Actuaries since 1964 and other literature published by actuarial societies does not support the Commission's conclusion. Although risk theory may not have been applied to as great an extent in the group health insurance area as in other insurance areas, the concept of using risk theory to determine necessary reserve levels generally is accepted by actuaries, worldwide.

The Commission also said that, because there was no one standard actuarial policy for determining excess reserve levels of group health insurance and because the rates for a plan would not be adversely affected over the long run by a conservative reserve level, it had followed the practical policy of maintaining reasonable reserves for all the plans in the Program. The Commission stated, however, that its actuaries would make a study of the various reserve levels for all plans and that the theoretical and practical aspects of the level of reserves to be maintained would be considered in this study.

CHAPTER 6

RISK CHARGES AND REINSURERS' EXPENSE ALLOWANCES

As pointed out on page 10, section 8902(c) of Title 5, United States Code, requires that the Commission's contract for the Indemnity Benefit Plan include provision for reinsurance by any eligible company that elects to participate. From inception of the Plan in 1960 through 1971, the Commission's contract with Aetna provided for payments by Aetna to itself as the insurer and to the reinsurers of the Plan of risk charges and reinsurers' expense allowances, based on specified percentages of subscription charges. The contract provided also for payments to certain reinsurers of additional allowances to compensate for Federal income taxes payable by these reinsurers on their risk charge allowances.

For 1970 and 1971 the Commission's contract provided for the payment of risk charges equal to 1 percent of the total subscription charges made available to Aetna for the year. Previously the contract provided for risk charges equal to either 1 percent or 1.3 percent of subscription charges. The amount depended on the balance of the Special Reserve held by Aetna at the end of the contract period. Since inception of the Plan, the contract has provided for payments of reinsurers' expense allowances equal to 0.2 percent of the subscription charges.

For the contract periods through December 31, 1971, Aetna charged the Plan for risk charges; related Federal income tax allowances, where applicable; and reinsurers' expense allowances, as follows:

Contract period Number	Date ended	Total	Risk charges	Federal income tax allowance on reinsurers' risk charges	Reinsurers' expense allowances
1	10-31-61	$ 1,646,881	$ 1,329,675	$112,640	$ 204,566
2	10-31-62	1,029,014	776,882	96,756	155,376
3	10-31-63	1,075,721	807,498	106,724	161,499
4	10-31-64	1,300,106	1,109,460	19,960	170,686
5	12-31-65	1,924,077	1,554,662	130,236	239,179
6	12-31-66	1,388,801	1,140,318	20,420	228,063
7	12-31-67	1,840,698	1,562,917	37,332	240,449
8	12-31-68	1,841,768	1,939,614	-396,248[a]	298,402
9	12-31-69	3,018,183	2,208,979	469,361	339,843
10	12-31-70	2,094,465	1,686,469	70,006	337,990
11	12-31-71	2,388,152	1,917,815	86,774	383,563
Total		$19,547,866	$16,034,289	$753,961	$2,759,616

[a]Adjustment of prior years' charges to the Plan.

There have been varying numbers of reinsurers under the Plan. During 1969, 1970, and 1971, there were 124, 121, and 120 reinsurers, respectively. The risk charges and reinsurers' expense allowances have been distributed among Aetna and the reinsurers in proportion to the amount of insurance held by each. Of the total risk charges ($16 million) and reinsurance expense allowances ($2.8 million) totaling $18.8 million as shown above, Aetna retained about $1.7 million (about 9 percent) as its proportionate share and distributed the balance of about $17.1 million (about 91 percent) among the reinsurers.

RISK CHARGES

The Plan is experience rated; i.e., premium rates are established in advance not only on the basis of the anticipated health benefits and other costs for a year but also on the basis of cumulative results of prior operations. Therefore, as long as the Plan continues in operation--i.e., the contract is not terminated--the risk to Aetna and the reinsurers is minimized because, if the Plan's operations for a year result in a deficit, the premium rates for the following years can be increased to recover the deficit. The risks borne by Aetna and the reinsurers of the Plan are discussed in detail on page 42.

According to Aetna officials the purpose of the risk charge is to compensate Aetna and the reinsurers for the underwriting risks involved and to provide a fee or profit. A Commission official advised us that the law and its legislative history clearly indicated that the Congress intended the Plan to be underwritten by the insurance industry. He said that inherent in this concept was the idea that the industry should earn a risk charge (or fee or profit) for the services provided. The Commission official agreed that the term "risk charge" was intended, in a very general sense, to cover risk, but more basically to provide a fee or profit.

As pointed out on page 55, the combined amount of the contingency reserves held by the Commission and Aetna has been above 5 percent of annual subscription charges--higher than needed to protect against adverse chance variations--since the first year of operation. Therefore we believe that no significant risk has been involved from adverse chance variations. We suggested, in a letter dated March 10, 1971, that the Commission might wish to consider reducing the risk charge allowances by eliminating the part intended to cover risk. We also questioned whether risk charge allowances should be based on a fixed percentage of premiums and suggested establishing alternative means of determining such allowances, such as the use of a fixed fee in payment for services.

In a letter to us dated July 21, 1971, the Director, Bureau of Retirement, Insurance, and Occupational Health, stated, in part, that:

> "From the beginning of the program the Commission has recognized that the amount of risk has been low compared to most other group insurance policies. We have also recognized that the risk charge provided the only element of profit available to the Plan, though the exact portions applicable to risk and profit were not stipulated. Risk and profit are complementary parts of one charge--if the risk experience (which is not available until after a contract is terminated) is favorable, a profit results. Reducing the allowance for risk will not reduce the risk, but will only reduce the profit. Thus, the

question appears to us to be one of how much profit, if any, should be allowed. ***"

* * * * *

"The Commission has continually been concerned about the allowances for risk and other expenses charged to the program. These issues have been raised as a part of the annual negotiations of each contract, and we will continue to consider reductions wherever possible."

Commission officials subsequently advised us that the Commission and Aetna had agreed to amend the 1972 contract to provide for a flat-rate service charge of $1.3 million in lieu of the prior risk charge of 1 percent of premiums. On the basis of the premiums for 1971, we estimate that, if this proposed amendment had been in effect for that year, the charges to the Plan for risk charges (service charge) would have been reduced by about $600,000. As of early March 1972, the agreed-upon amendments to the 1972 contract had not been formally executed.

FEDERAL INCOME TAX ALLOWANCES ON RISK CHARGES

The commission's contract for the Plan states that:

> "The aggregate amount of charges for United States Federal Income Taxes *** shall be the amount which, subject to the approval of the Commission, the Aetna determines will have to be paid, by reinsurers of the Plan *** and which would otherwise operate to produce substantial inequity among the several types of reinsurers as to their risk charges."

From inception in 1960 through December 31, 1971, the charges to the Plan for Federal income tax allowances on the risk charges of certain reinsurers totaled about $754,000, of which $518,000 had been paid to the reinsurers and the remainder of $236,000 had been accrued.

Aetna informed us that certain reinsurers of the Plan were required to pay Federal income taxes on the amounts they received for risk charges, but that other reinsurers (life insurance companies and, since 1963, mutual insurance companies) were not required to pay such taxes. The amounts of Federal income taxes payable on risk charges vary according to the corporate tax liabilities of the different reinsurers.

An Aetna official informed us that it was not insurance industry practice to provide Federal income tax allowances on risk charges received on reinsurance contracts and that he believed that three health insurance plans operated by Aetna--the Indemnity Benefit Plan, the Federally assisted Government-wide plan under the Retired Federal Employees Health Benefits Program, and a private health plan for former enrollees under the Indemnity Benefit Plan--were the only health insurance plans which had such allowances. He expressed the opinion that these allowances resulted in each reinsurer's receiving an equitable share of the risk charge. A Commission official expressed the opinion that the Federal income tax allowances on risk charges were necessary to achieve a broad base of reinsurers.

We noted that, from inception in 1960 through 1970, the number of Plan reinsurers that received Federal income tax allowances and the percent of reinsurance held by them had ranged from a high of 32 reinsurers holding about 14 percent of the total reinsurance during the first two contract periods to a low of 14 insurers holding about 6 percent of the total reinsurance during 1970.

The Federal income tax allowances on risk charges represent costs of the Plan to be recovered through premiums. In the draft of this report, we questioned whether Federal income tax allowances on risk charges were desirable because such allowances represent a cost not generally allowed under health insurance contracts and because the effect of the allowances is to shift to the enrollees of the Plan and the Federal Government part of the Federal income tax liability of the reinsurers involved. In commenting on our draft report, the Commission agreed to take another look at the matter of Federal income tax allowances on risk charges.

REINSURERS' EXPENSE ALLOWANCES

We visited three of the major reinsurers and inquired as to the types of costs which were associated with being a reinsurer under the Indemnity Benefit Plan. Officials of these reinsurers informed us that the costs usually consisted of the expense of making entries in the accounting records but that their companies, along with Aetna and six other major reinsurers of the Plan, incurred additional costs in April 1970 by sending representatives to a meeting in New York City for the purpose of discussing possible solutions to problems resulting from decreasing Plan enrollment during open seasons.

The 1970 reinsurers' expense allowances for the 10 companies that attended this meeting ranged from $9,542 to $31,123 and totaled over $200,000, or an average of about $20,000 for each of the 10 companies.

The Commission's contract for the Plan provides that Aetna may obtain reimbursement for necessary expenses incurred in carrying out its functions under the Plan. Consequently any such expenses incurred by Aetna in its

capacity as insurer of the Plan could be claimed by Aetna as reimbursable expenses of the Plan.

CONCLUSIONS

We recognize that, under the provisions of the Commission's contract with Aetna, there may have been a possibility of loss to Aetna and the other reinsurers if the plan were terminated. If the contract is amended to authorize the use of the Commission's contingency reserve to pay claims and related administrative costs in excess of the available Plan funds held by Aetna at the time of contract termination, as has been agreed upon (see pp. 43 and 44), there seems to be little or no risk of loss in underwriting the Plan and no need for paying Aetna and the reinsurers for underwriting risks. Therefore we believe that the Commission should reassess the reasonableness of the amounts allowed Aetna and the reinsurers for risk charges. To recognize the services provided by Aetna in administering the Plan, a reasonable fee or profit could be provided, in addition to Aetna's actual administrative expenses applicable to the Plan.

Our review indicates that the amounts paid under the Plan for reinsurers' expense allowances might have been considerably higher than the cost incurred by the reinsurers in carrying out their responsibilities under the Plan. We believe that the Commission should reassess the reasonableness of the amounts allowed under the Plan for reinsurers' expense allowances. Such a reassessment seems particularly warranted when considering the fact that (1) the reinsurers' expense allowances have been arrived at on the basis of a fixed percentage of subscription charges, (2) subscription charges have more than doubled since inception of the Plan, and (3) the reinsurers' expenses have been related primarily to the making of entries in the accounting records.

RECOMMENDATION TO THE CHAIRMAN CIVIL SERVICE COMMISSION

We recommend that the Commission, in its negotiations with Aetna for future contract periods, reassess the reasonableness of the amounts allowed Aetna and the reinsurers for (1) risk charges (service charge) under the Plan and (2) reinsurers' expense allowances.

MATTER FOR CONSIDERATION BY THE CONGRESS

As shown by our studies discussed in the preceding chapter, the combined amounts of the Special Reserve of the Plan held by Aetna and the contingency reserves of the Plan held by the Commission have been higher than needed to protect against adverse chance variations in benefit claims. In view of the minimal risks under the Plan and the substantial costs (see p. 50) that have been charged to the Plan in connection with reinsurance, the Congress may wish to consider amending section 8902(c) of Title 5, United States Code, to eliminate the mandatory provision for reinsurance under this Plan.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on a draft of this report, the Commission cited its actions effective January 1, 1970 (reducing the risk charge allowance for the Plan to 1 percent of premiums), and January 1, 1972 (reducing the allowance to a flat-rate service charge of $1.3 million), and stated that it considered these actions to essentially satisfy our recommendation that the Commission, in its negotiations with Aetna for future contract periods, reassess the reasonableness of the amounts allowed Aetna and the reinsurers for risk charges (service charges).

In our opinion, the Commission's actions in reducing the risk charge (service charge) allowances under the Plan do not fully satisfy the objectives of our recommendation.

We pointed out in the preceding sections of this report that, in view of the total reserves held by the Commission and Aetna, the ability of Aetna to request increases in premium rates to recover a prior year's operating deficit,

and the Commission's agreement to authorize use of its contingency reserve for the Plan to pay claims and related administrative costs in excess of the available Plan funds held by Aetna at the time of contract termination, there appears to be little or no risk in underwriting the Plan and therefore no need for paying Aetna and the reinsurers for underwriting risks.

We pointed out also that, in recognition of the services provided by Aetna in administering the Plan, a reasonable fee or profit could be provided to Aetna, in addition to its actual administrative expenses applicable to the Plan.

If the $1.3 million service charge allowance is to be distributed among Aetna and the reinsurers in proportion to the amounts of insurance held--as risk charges were distributed in previous years--about 91 percent ($1,183,000) will be paid to the reinsurers and about 9 percent ($117,000) will be retained by Aetna.

In our opinion, the amounts of the service charges payable by the Plan to Aetna and the reinsurers should be commensurate with the risks and services performed. This does not now appear to be the case with respect to the reinsurers. Therefore we believe that there is need for further reassessment by the Commission of the reasonableness of the amounts charged to the Plan for service charges payable to the reinsurers.

With respect to our other recommendation, the Commission stated that it would reassess the reinsurers' expense allowances to determine whether reductions could be made and that it would explore the possibility of determining the amounts by some method other than a percentage of premiums. We believe that these proposed actions would be in line with the objectives of our recommendation.

CHAPTER 7

INVESTMENT INCOME

The Federal Employees Health Benefits Program earns investment income from Program funds in the Treasury of the United States and from funds held by the carriers of the various health insurance plans.

INTEREST ON FUNDS CONTROLLED BY THE COMMISSION

The Commission deposits the premiums collected on the various health insurance plans into the U.S. Treasury to the credit of the Employees Health Benefits Fund. The fund is available, without fiscal-year limitations, for paying subscription charges to the carriers and for paying the administrative expenses of the Commission related to the Program. Funds not immediately needed for Program operations are invested by the Secretary of the Treasury in interest-bearing securities of the United States.

At December 31, 1971, the Secretary of the Treasury had invested about $224.6 million of Program funds in U.S. Treasury securities. The securities, which had maturity dates ranging from January 1, 1972, to November 15, 1998, were earning interest at annual rates ranging from 3.25 percent to 7.5 percent. We estimated that the average yield on such investments for 1971 was about 5.6 percent.

For 1969, 1970, and 1971 the total interest income earned on the Employees Health Benefits Fund investments was $6.3 million, $6.8 million, and $11.1 million, respectively. Of these amounts, the Commission allocated to the Indemnity Benefit Plan's contingency reserve about $0.9 million for 1969, about $1.1 million for 1970, and about $1.9 million for 1971.

INTEREST ON FUNDS CONTROLLED BY AETNA

As shown in appendix I, the gross investment income credited to the Plan from inception in 1960 through December 31, 1971, amounted to $16.3 million, from which Aetna deducted $5.6 million for related Federal corporate income

taxes and credited the balance of $10.7 million to the Special Reserve of the Plan. For 1971 the yield on Aetna's investments of Plan funds amounted to about $2.8 million, or 6 percent, before taxes and about $2.1 million, or 4.4 percent, after taxes.

A problem relating to Aetna's deductions for Federal corporate income taxes is discussed on page 68.

Interest on Special Reserve funds

For the first three contract periods (July 1, 1960, to October 31, 1963), the Commission's contract provided for the Plan to be credited with interest on the Special Reserve funds at rates that were determined in advance of the contract periods. The rates for each contract period, which were subject to Commission approval, were required to be applied to the mean (average) of the balances of the Plan's Special Reserve at the beginning and end of the contract period.

For the contract periods subsequent to November 1, 1963, the contract has provided that the rate of interest to be used by Aetna in determining the interest applicable to the Special Reserve funds for the period will be the higher of (1) the effective rate of interest credited by Aetna on the mean of its group accident and health insurance ledger assets at the beginning and end of the calendar year in which such policy year commenced or (2) the rate of interest guaranteed by Aetna on similar group accident and health insurance contracts.

Cumulatively from inception in 1960 through December 31, 1971, the credits to the Plan for interest income on the Plan's Special Reserve funds amounted to about $5.2 million.

We noted that the predetermined rates used during the first three contract periods for computing credits to the Plan for interest on the Special Reserve funds were lower than the effective interest rates which Aetna had earned on its investments during the first three contract periods. We estimated that, if interest rates based on Aetna's interest earnings for the first three contract periods had been used, the interest credits to the Plan would have been

increased by about $322,800. Also, had these rates been used during the first three contract periods, additional interest of about $190,300 on the $322,800 would have been credited to the Plan in succeeding contract periods through December 31, 1971.

We discussed the above matter with Aetna officials who pointed out that the credits had been computed in accordance with the requirements of the contract. We discussed also these matters with Commission officials who stated that the Commission had negotiated predetermined interest rates for the first three contract periods because interest rates were fluctuating during these periods and that the Commission believed that guaranteed interest rates might be in the best interests of the Plan. They pointed out that interest rates could have gone down as well as up and that the contract had been amended, effective November 1, 1963, to delete the provision for predetermined rates after it became apparent that interest rates were continuing to increase.

Interest on Other Reserve funds

In addition to the Special Reserve funds, Aetna has Plan funds, called Other Reserves, which consist principally of funds held to pay accrued claims, less accrued subscription charges due from the Commission. At December 31, 1971, such Other Reserve funds amounted to about $27.6 million and consisted of accrued claims of $42 million and other accrued and prepaid expenses totaling $4.5 million, less accrued subscription charges of $18.9 million.

The Commission's contract is silent with respect to interest credits on the Other Reserve funds. Since inception of the Plan in 1960, Aetna has credited the Plan with interest on these funds. An Aetna official informed us that these credits had been made pursuant to an oral agreement with the Commission.

Aetna maintains a Participating Department and a Non-Participating Department, each with separate accounts for assets and disbursements. The net investment income realized by each department is allocated to the lines of business operated by each department, as though each were a separate company. The Non-Participating Department includes seven

of Aetna's major lines of business, including all accident and health insurance written by Aetna.

For the first three contract periods, Aetna credited the Plan with interest on Other Reserve funds on the basis of rates derived by dividing the net investment income of the Non-Participating Department--exclusive of capital gains and losses--by the average of the ledger asset balances of that department at the beginning and end of the calendar year in which the contract period had begun.

For the contract periods from November 1, 1963, through December 31, 1971, Aetna credited the Plan with interest on Other Reserve funds at the same rates it used for crediting interest on the Plan's Special Reserve funds.

From inception of the Plan in 1960 through December 31, 1971, a total of about $5.5 million in interest income on the Other Reserve funds was credited to the Plan. These credits represented gross interest income of $11.1 million, less Federal corporate income taxes of $5.6 million.

To eliminate any possible questions regarding the intents of the parties and to protect the interests of the Government and the Plan's enrollees, we believe that arrangements for crediting the Plan with interest income on Other Reserve funds should be formalized and not be dependent on an oral agreement between Aetna and the Commission.

Therefore we proposed in the draft report that the Commission initiate action to amend its contract for the Indemnity Benefit Plan to provide for the Plan to be credited with interest on Other Reserve funds and to set forth the basis upon which such credits are to be computed.

In commenting on our proposal, the Commission stated that it would take action to incorporate such a provision into its contract with Aetna.

QUESTIONABLE PRACTICES RELATING TO INVESTMENT-INCOME CREDITS

For the most part Aetna does not identify the sources of funds used for investments by its Non-Participating Department. In determining the Plan's share of the investment income of this department, Aetna initially allocates its net investment income among the various lines of business which have made funds available for investment and then calculates interest rates which it applies to the Plan's funds made available.

We reviewed Aetna's computations and noted several practices which appeared to have resulted in credits to the Plan of amounts lower than the amounts that had been earned by Aetna on Plan funds made available for investment. These practices related to (1) the allocations of investment income to the Group Accident and Health line of business, which includes the Indemnity Benefit Plan and other plans insured by Aetna, (2) the methods of calculating the interest rates used for computing investment-income credits, and (3) the applications of such interest rates.

Allocations of investment income

In crediting investment income to the Plan for the period November 1, 1963, through December 31, 1971, Aetna allocated most of the net investment income of the Non-Participating Department to the various lines of business on the basis of cash-contribution ratios which represented the funds made available by each line of business in relation to the total funds made available by all lines of business. Because some of this department's investments are financed from capital surplus funds, Aetna considers the department's capital surplus as a line of business for investment-income allocation purposes.

We noted that, in crediting investment income to the Plan for the contract periods from November 1, 1963, through December 31, 1970, Aetna had allocated short-term investment income on the basis of the cash-contribution ratios applicable to funds made available for investment prior to 1962. We questioned Aetna's treatment of this item because the short-term investment income had been earned from investments

financed by the funds made available to the department in all years, not just the funds made available prior to 1962.

It was our view that the credits to the Plan for investment income would have been more in line with the income Aetna had earned on Plan funds if short-term investment income had been treated as if all funds made available for investment had contributed to such income. We estimated that, if Aetna had allocated short-term investment income on such a basis, the investment-income credits to the Plan for the contract periods November 1, 1963, through December 31, 1970, would have been about $24,000 larger than the amounts actually credited.

We discussed the above matter with an Aetna official who considered our conclusions to be valid and who stated that Aetna would review its allocation practices with respect to the items involved. Aetna subsequently informed us that it had developed a revised method for allocating short-term investment income in line with our suggested approach and that the revised method had been used for 1971.

Computations of interest rates

For each of the contract periods since November 1, 1963, Aetna calculated the interest rate used for computing investment income to be credited to the Plan by dividing the investment income allocated to the Group Accident and Health line of business for a calendar year by the mean of its ledger asset balances at the beginning and end of the year. The ending ledger asset balance used by Aetna included the investment income allocated to the line during the year.

The rate so determined by Aetna was then applied to the amount of Plan funds available for investment during the year to compute the amount of investment-income credit to the Plan for the year. We noted, however, that the amount of Plan funds available for investment, against which the rate was applied, did not include the amount of investment income earned during the year by Plan funds. In our opinion this inconsistency in method of computation resulted in investment-income credits to the Plan for each year which were less than the amounts Aetna had earned on Plan funds during the year.

We believe that, to obtain appropriate amounts of investment income allocable to the Plan, either the investment income allocated to the Group Accident and Health line for a year should be excluded from the ending ledger asset balances of the line in computing the rate of earnings on invested assets or, if the investment income is not so excluded, the allocable amounts of investment income should be included in the ending ledger asset balances of both the Group Accident and Health line and the Plan.

We noted that the National Association of Insurance Commissioners, in its instructions for completing life and accident and health annual statement blanks to be submitted to State insurance departments, provides for computing the rate of earnings on invested assets by means of a formula which has the effect of excluding the net investment income for a period from the ending ledger asset balances. We noted also that, for the three contract periods ended October 31, 1963, Aetna had excluded investment income from the ending ledger asset balances of the Non-Participating Department and the Plan in arriving at the rates of interest used for computing investment-income credits to the Plan on Other Reserve funds.

We noted another inconsistency in Aetna's method of computing investment-income credits. Aetna included capital gains and losses in the Group Accident and Health line's funds available for investment but did not include these amounts as part of the line's investment income subject to distribution to the Plan. This practice also resulted in investment-income credits to the Plan of amounts lower than the amounts Aetna had earned on Plan funds.

We estimated that, if Aetna had been consistent in its methods of computing the rates of earnings on invested assets of the Plan, the amounts of the investment-income credits to the Plan from November 1, 1963, through December 31, 1971, would have been about $232,000 greater than the amounts of investment-income credits that were received by the Plan.

In a January 1972 letter to the Commission, Aetna agreed that there had been some inconsistencies in the application of the formula for determining the mean ledger assets at the beginning and end of the year. Aetna said that,

in its final accounting to the Commission for 1972, an appropriate adjustment would be made to correct the inconsistency.

Applications of computed interest rates

In computing the investment-income credits on certain Plan reserves for the first five contract periods--from July 1, 1960, through December 31, 1965--Aetna used interest rates that were computed for the calendar years in which the contract periods commenced.

We believe that Aetna's use of such rates resulted in credits to the Plan of amounts which were lower than the amounts of interest Aetna had earned from investment of the Plan funds involved because each of the contract periods overlapped by 2 calendar years and because interest rates increased each year during the period.

We noted that, for the first five contract periods, Aetna had credited the Plan with interest on Other Reserve funds at the rates computed for the calendar years in which the contract periods had begun. Each of these contract periods covered portions of 2 calendar years. For example, for the contract period November 1, 1963, to October 31, 1964, the rate used for computing the interest credit on the Plan's Other Reserve funds was the 4.51-percent rate which Aetna had computed for calendar year 1963. Because the interest rate for calendar year 1964 was higher than the interest rate for calendar year 1963, the rate used by Aetna in crediting interest for the contract period ended October 31, 1964, dit not equitably relate earnings to funds available for investment under the Plan.

We believe that a more equitable method for computing the investment-income credit to the Plan for this contract period would have been to use the 4.51-percent rate applicable to calendar year 1963 for the first 2 months of the contract period and the 4.65-percent rate applicable to calendar year 1964 for the last 10 months of the contract period.

We noted also that, in computing investment-income credits on the Special Reserve funds of the Plan for the fourth and fifth contract periods, Aetna had similarly used

interest rates applicable to only the first 2 months of the respective contract periods. Aetna officials advised us that the investment-income credits on Special Reserve funds had been computed in the manner required by the contract for the Plan.

The contract is silent with respect to interest on Other Reserve funds. We noted an Aetna internal memorandum, however, which stated that interest on Other Reserve funds had been credited to the Plan in accordance with a 1960 oral agreement with the Commission that Aetna should neither gain nor lose because of interest earned on such funds. It appears therefore that Aetna's method of computing interest credits on Other Reserve funds for the first five contract periods did not conform to Aetna's understanding of its agreement with the Commission.

We discussed the above matters with Commission officials who pointed out that the problem no longer existed because the contract periods had coincided with calendar years after 1966. The officials stated, however, that the Commission would look into these matters for the contract periods prior to 1966.

We estimated that, if Aetna had computed investment-income credits on the basis of the rates applicable to the calendar-year periods involved, the amounts credited to the Plan for the first five contract periods would have been about $67,000 greater than the amounts actually credited. Of this amount, about $48,000 would be applicable to the Plan's Other Reserve funds and about $19,000 would be applicable to the Plan's Special Reserve funds.

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We believe that there is a need for the Commission to review Aetna's practices for crediting investment income to the Plan and to reach agreement as to an acceptable method to be followed for this purpose.

Recommendation to the Chairman, Civil Service Commission

Therefore we recommend that the Commission review the practices followed by Aetna in arriving at the amount of investment income to be credited to the Plan and that during this review it give particular attention to the equitableness of the amounts so credited and to the need for adjustments for inadequate amounts credited in prior years.

Agency comments

In commenting on the draft report, the Commission stated that it had always considered the investment income credited to the Plan by Aetna to be one of the more important financial areas needing periodic review and that it would continue to review the allocations of such income to the Plan.

INVESTMENT-INCOME CREDITS REDUCED BECAUSE OF FEDERAL INCOME TAXES

The Commission's contract provides that the expenses charged to the Plan may include the accrued amount of all governmental fees and taxes directly attributable to the Plan, as determined by Aetna.

According to the accounting statements which Aetna had submitted to the Commission from inception of the Plan in 1960 through 1971, Aetna has allocated a total of $11.1 million to the Plan for investment income on Other Reserve funds. The net credits to the Plan for investment income on these funds amounted to $5.5 million because of deductions by Aetna of about $5.6 million for Federal corporate income taxes on such investment income. No Federal income tax deductions were made by Aetna on the investment income applicable to the Plan's Special Reserve funds.

During our survey of the Plan early in November 1969, we asked an Aetna official why Federal income taxes should be payable on the investment income applicable to the Plan funds held by Aetna to pay claims incurred but not yet paid (Other Reserves), when such taxes were not payable on the investment income applicable to the Plan funds held by Aetna to pay possible future claims (Special Reserve).

The Aetna official informed us that, in submitting accounting statements to the Commission, Aetna had treated the investment income credited to the Plan's Special Reserve funds as not being subject to Federal corporate income taxes because such income was required to be paid to the policyholder (Commission) and therefore was considered as an item of expense under section 805(e) of the Internal Revenue Code. The official informed us also that, because Aetna had not considered the investment income applicable to Other Reserve funds as interest required to be paid to the policyholder, the investment income applicable to the Other Reserve funds had been treated as being subject to Federal corporate income taxes.

In response to our inquiry as to whether Aetna had paid all the Federal income taxes that had been reported to the Commission as deductions from the investment income of

Other Reserve funds, we learned that, in its tax returns for periods through 1968, Aetna had reported as taxable about $3.1 million of the gross investment income of about $6.6 million, which had been allocated to the Plan as applicable to Other Reserve funds; in its accounting reports to the Commission, however, Aetna had made deductions for Federal corporate income taxes on the basis that all the investment income ($6.6 million) on Other Reserve funds had been taxable. During the years involved the gross corporate tax rates averaged about 50 percent.

In response to our questions concerning this matter, an Aetna official stated that Aetna had originally intended to report all the investment income on Other Reserve funds as taxable but that, due to an oversight by Aetna's tax department, a part of the investment income on Other Reserve funds had been shown on Aetna's early tax returns as interest required to be paid to the policyholder, which resulted in reporting a lower amount as taxable. They stated also that all the investment income on Other Reserve funds would be shown as taxable on Aetna's tax returns for 1969 and subsequent years.

The following excerpt from an Aetna letter to the Commission dated November 26, 1969, explains Aetna's treatment of investment income on Other Reserve funds in its tax returns.

> "*** It had been our original intent not to deduct any of the other reserve interest in our Return, but due to a misunderstanding the other reserve interest, net of anticipated income taxes, was included as a Phase I [section 805(e)] deduction. So as not to 'rock the boat' we decided to perpetrate this level of deduction, pending a final ruling concerning the deductibility of claim reserve interest ***"

According to information obtained from Aetna, back taxes owed by Aetna at March 15, 1970, totaled about $1.75 million on which Aetna had earned interest income of about $409,000.

In September 1971 an Aetna official informed us that the question of whether interest applicable to the Plan's

Other Reserve funds was subject to Federal corporate income taxes had been discussed with an officer of the appellate division of the Internal Revenue Service in meetings held in May and July 1971. He said that Aetna had presented arguments against such taxation at the July meeting and that a ruling on the matter was expected to be obtained during a future meeting with the Internal Revenue Service. The Aetna official said also that Aetna's future actions on this matter would depend on the ruling obtained.

Conclusions

We believe that Aetna's accounting reports to the Commission should be considered as tentative until a final ruling has been obtained from the Internal Revenue Service concerning the taxability of interest earned by Aetna from investment of Other Reserve funds of the Plan. When a ruling is obtained, there still remains for consideration by the Commission, however, the treatment to be afforded to the interest earned by Aetna on the funds charged against the Plan for taxes which were not promptly paid.

Agency comments

In a January 1972 letter to the Commission concerning our draft report, Aetna stated that there was no question but that unresolved issues under the Federal income tax law had made it virtually impossible for either the Commission or Aetna to know the appropriate net amount of investment-income credits due under the Plan. Aetna stated also that it had given assurance to the Commission that the investment-income credits would be appropriately adjusted when the income tax issues were finally resolved.

CHAPTER 8

PREMIUM TAXES

The Commission's contract authorizes Aetna to charge the Indemnity Benefit Plan for all taxes directly attributable to the operations under the contract. Aetna has been required to pay premium taxes levied by the 50 States and by certain municipalities, counties, Puerto Rico, and Canadian Provinces.

From inception in 1960 through December 31, 1971, the Plan had been charged about $32 million for premium taxes. At December 31, 1971, about $30.4 million of these taxes had been paid and the balance, about $1.6 million, had been accrued. The table below shows the amounts and percentages of premium taxes paid to the States which had received the 10 highest amounts in relation to the total premium tax payments.

	Amount (millions)	Percent
California	$ 4.44	14.6
Virginia	2.71	8.9
Texas	2.56	8.4
Oklahoma	1.83	6.0
New York	1.26	4.2
Maryland	1.14	3.8
Alabama	1.13	3.7
Ohio	1.01	3.3
Pennsylvania	0.91	3.0
Illinois	0.88	2.9
Other	12.51	41.2
Total	$30.38	100.0

We found that clerical errors made during the 1966 and 1967 contract periods had resulted in overstating by $3,074 the amount charged the Indemnity Benefit Plan for premium taxes. We also found an error involving advance premium tax payments which resulted in a $30,151 overstatement of the Plan's 1969 interest income.

We brought the above matters to Aetna's attention, and Aetna corrected the errors in the Plan's 1970 accounting statement. An Aetna official informed us that certain related adjustments for interest which were not made on the 1970 statement would be made on a subsequent statement.

EFFECT OF PREMIUM TAXES ON SUBSCRIPTION RATES

Premium taxes represent a substantial cost to the Plan which is recovered through subscription charges (premiums). From inception of the Plan in 1960 through 1971, the costs for premium taxes (about $32 million) equaled about 87 percent of Aetna's administrative expenses for the Plan; for 1969 the premium taxes exceeded Aetna's administrative expenses by about $300,000.

We noted that the other Government-wide plan, the Service Benefit Plan, did not pay premium taxes in most States. In 1969 premium tax costs under the Service Benefit Plan amounted to about $277,000, or .06 percent of the year's subscription charges, compared with premium tax costs under the Indemnity Benefit Plan of $4,081,142, or 2.4 percent of the year's subscription charges.

PENDING LEGISLATION

Proposed legislation (H.R. 21, 92d Cong., 1st Sess.), introduced in the House of Representatives on January 22, 1971, would exempt premiums under the Federal Employees Health Benefits Program and the Federal Employees Group Life Insurance Program from taxation by States and political subdivisions.

CHAPTER 9

ADMINISTRATIVE EXPENSES

Administrative expenses of the Indemnity Benefit Plan include those of the Commission and Aetna.

ADMINISTRATIVE EXPENSES OF THE CIVIL SERVICE COMMISSION

The law provides that a portion, not to exceed 1 percent, of all contributions made by the employees, annuitants, and the Government be set aside in the Employees Health Benefits Fund to pay the Commission's expenses of administering the Program. The Commission does not allocate its administrative expenses among the individual benefit plans. For calendar years 1969, 1970, and 1971, the Commission's administrative expenses charged to the entire Program amounted to $1.2 million, $1.3 million, and $1.8 million, respectively.

ADMINISTRATIVE EXPENSES OF AETNA

The Commission's contract for the Plan provides for reimbursing Aetna for:

> "*** necessary incurred expenses determined on an equitable and reasonable basis, with proper justification and accounting support."

The Commission's original contract provided for limiting the annual allowance for administrative expenses to 5.5 percent of premiums. This limitation was reduced to 4.25 percent effective November 1, 1964, and to 4 percent--the current limitation--effective January 1, 1968.

From inception in 1960 through 1971 (11 contract periods), the administrative expenses charged by Aetna have not exceeded the annual limitations. As shown below, in recent years the administrative expenses, as a percentage of subscription charges, have been decreasing from the preceding year, except for 1970, when the rate increased to 2.44 percent from 2.23 percent in 1969.

Contract period	Subscription charges	Administrative expenses	Percent of subscription charges
1	$ 102,282,712	$ 3,360,806	3.29
2	77,688,205	2,244,319	2.89
3	80,749,782	2,574,852	3.19
4	85,343,042	3,019,458	3.54
5	119,589,401	3,469,948	2.90
6	114.031,753	2,959,191	2.60
7	130,269,441	3,413,300	2.62
8	139,156,034	3,502,197	2.52
9	169,921,447	3,783,829	2.23
10	168,994,817	4,121,571	2.44
11	191,781,550	4,443,395	2.32
Total	$1,379,808,184	$36,892,866	2.67

SAVINGS RESULTING FROM CANCELLATION OF PROPOSED CONTRACT AMENDMENT

The Commission's 1969 contract for the Plan provided for (1) reimbursing Aetna for its actual administrative expenses up to 4 percent of premiums and (2) paying to Aetna and the reinsurers of the Plan (a) risk charges equal to either 1 percent or 1.3 percent of premiums, depending on the balance of the Special Reserve held by Aetna at the end of the contract period, and (b) reinsurers' expense allowance equal to 0.2 percent of premiums.

We analyzed a proposed amendment to the 1970 contract for the Indemnity Benefit Plan which would have provided a total flat-rate retention charge by Aetna, based on a single percentage of annual premiums, for all expenses (administrative, risk charges, and reinsurers' allowances) of administering the Plan, except taxes. Our analysis indicated that under this arrangement Aetna would have been allowed amounts for administrative costs substantially in excess of its actual administrative costs.

In February 1970 we brought this matter to the attention of officials of the Commission. At that time the proposed amendment had been agreed upon by both parties, signed by Aetna, and forwarded for signature of the Chairman,

Civil Service Commission. The Commission decided not to incorporate the flat-rate retention charge concept in the 1970 contract and did not include it in the 1971 contract for the Plan.

On the basis of the actual premiums and expenses, Aetna would have been allowed for 1970 and 1971 about $433,000 and $485,000, respectively, in excess of its actual administrative expenses, if the proposed flat-rate retention provision had been included in the 1970 and 1971 contracts. In addition, because the Plan was not charged for these amounts, the Special Reserve funds available for investment were larger than they would have been, with the result that Aetna credited the Plan with $12,000 and $41,000 more interest income for 1970 and 1971, respectively, than it would have credited had the proposed amendment been in effect. The total savings and credits to the Plan that resulted from cancellation of the proposed contract amendment amounted to about $971,000 for the 2 years.

CHAPTER 10

COMMISSION'S AUDITS OF OPERATIONS UNDER THE PROGRAM

The Commission's external audits of activities under the Federal Employees Health Benefits Program are performed by the Office of Systems and Audits. The Chief of this Office reports to the Director, Bureau of Retirement, Insurance, and Occupational Health. The audits by the Office of Systems and Audits are performed as an aid to the administration of the contracts rather than as part of the Commission's central internal audit function, which is carried out by the Office of Management Analysis and Audits, Bureau of Management Services.

The Commission's Office of Management Analysis and Audits, in a November 1970 report on a review of the Bureau of Retirement, Insurance, and Occupational Health, stated that the activities of the Office of Systems and Audits were to (1) conduct external audits of insurance carriers and plans, including the Indemnity Benefit Plan, and (2) design and install internal systems. The report, which was transmitted to the Commission's Executive Director, stated that improvements were needed in both areas in order for the Office of Systems and Audits to fully meet its assigned responsibilities.

With respect to external auditing, the report contained recommendations that the Office of Systems and Audits

--establish a consistent policy in determining which insurance plans are to be audited,

--prepare a formal audit schedule,

--expand the scope of audit coverage,

--standardize audit reporting requirements,

--establish adequate procedures to ensure follow-up on audit findings,

--develop a system for documenting and maintaining audit workpapers,

--improve external as well as internal communications, and

--adjust manpower deployment.

With respect to internal systems, the report contained a recommendation that the Office of System and Audits be provided with sufficient resources to effectively carry out its systems responsibilities.

The Director of the Bureau of Retirement, Insurance, and Occupational Health generally agreed with the findings and recommendations in the report and said that the Bureau was in the process of implementing the necessary changes, with various target dates for completion.

CHAPTER 11

SCOPE OF REVIEW

We evaluated the policies, procedures, and practices followed by the Commission in administering its contract with Aetna for providing health benefits under the Indemnity Benefit Plan. Our review included actuarial studies of (1) the various Plan reserves and (2) the effects of recent changes in enrollees' age and sex characteristics on the Plan's health costs. The review also included a comparison of the amounts allowed under the Plan for selected types of medical care with amounts which would have been allowable for similar types of care under criteria applicable to the Service Benefit Plan.

We reviewed the basic legislation authorizing the Program and its related legislative history. We reviewed, among other things (1) the reasonableness of the negotiated provisions of the Commission's contract with Aetna and (2) the propriety and reasonableness of the amounts Aetna had credited to the Plan as interest income and had charged to the Plan for administrative and other types of expenses authorized by the contract.

Our review was performed at Commission headquarters in Washington, D.C.; at Aetna offices in Hartford, Connecticut; Springfield, Massachusetts; and Portland, Oregon; at the offices of the Service Benefit Plan carriers in Massachusetts and Oregon; and at the offices of three of the major reinsurers of the Indemnity Benefit Plan.

SUMMARY PREPARED BY GAO OF STATEMENTS FURNISHED BY

THE AETNA LIFE INSURANCE COMPANY TO THE

U.S. CIVIL SERVICE COMMISSION

ON ANNUAL ACCOUNTING AND RESERVES

UNDER THE INDEMNITY BENEFIT PLAN

CUMULATIVE FROM JULY 1, 1960, TO DECEMBER 31, 1971

AND FOR CONTRACT PERIOD JANUARY 1 TO DECEMBER 31, 1971

	Cumulative from July 1, 1960, to Dec. 31, 1971		Contract period Jan. 1 to Dec. 31, 1971	
SUBSCRIPTION INCOME:				
Subscription income received and accrued		$1,355,722,359		$191,781,550
Additional subscriptions received from Civil Service Commission's contingency reserve		24,085,825		-
Total subscription income		1,379,808,184		191,781,550
HEALTH BENEFIT CHARGES PAID AND ACCRUED (note a)		1,279,005,538		161,198,004
EXCESS OF SUBSCRIPTION INCOME OVER HEALTH BENEFIT CHARGES		100,802,646		30,583,546
EXPENSES INCURRED:				
Administrative		36,892,866		4,443,395
State and local taxes on premiums		31,981,226		4,181,413
Risk charges		16,034,289		1,917,815
Federal income taxes on risk charges		753,961		86,774
Reinsurers' expense allowances		2,759,616		383,563
Total expenses		88,421,958		11,012,960
GAIN FROM OPERATIONS		12,380,688		19,570,586
INVESTMENT INCOME:				
Gross investment income	$16,316,208		$2,847,312	
Less Federal corporate income taxes	5,565,939	10,750,269	780,003	2,067,309
FUNDS RECEIVED FROM SERVICE COMMISSION NOT TRANSFERRED TO SUBSCRIPTION INCOME		11,520,447		7,381,273
SPECIAL RESERVES, BEGINNING OF PERIOD		-		5,632,236
SPECIAL RESERVES, END OF PERIOD		$ 34,651,404		$ 34,651,404

[a]Includes the accrued liability for health benefits for which claims had not been received or processed. At December 31, 1971, the accrued liability for such claims totaled about $42 million. Funds held to pay such claims are referred to by Aetna as claim reserves.

Note: The basic financial statements used in preparing this summary have not been audited by GAO.

COMPARISON OF PRINCIPAL BENEFITS UNDER THE

INDEMNITY BENEFIT AND SERVICE BENEFIT PLANS

	High options		Low options	
	Indemnity Benefit Plan	Service Benefit Plan	Indemnity Benefit Plan	Service Benefit Plan
Hospital room and board (Allowable expenses up to those of a semi-private room)	All of first $1,000 of allowable expenses plus 80 percent of any balance in each calendar year for each enrollee and eligible family member.	All allowable expenses up to 365 days of care for each hospital confinement in member hospital,[2] after 365 days 80 percent of allowable expenses after a deductible has been satisfied.[3]	All of first $500 of allowable expenses plus 75 percent of any balance in each calendar year for each enrollee and eligible family member.	All allowable expenses up to 30 days of care for each hospital confinement in a member hospital,[2] after 30 days 75 percent of allowable expenses after a deductible has been satisfied.[3]
Other hospital expenses	80 percent of allowable expenses after a $25 deductible in each calendar year.[1]	Same coverage as for room and board.	75 percent of allowable expenses after a $25 deductible in each calendar year.[1]	Same coverage as for room and board.
Physician services, drugs and nursing services[4]	80 percent of allowable expenses over first $50 of allowed expenses in each calendar year.	Basic benefits generally paid in full. Drugs and nursing services are not covered under basic benefits. Expenses not covered under basic benefits but covered under supplemental benefits--80 percent of allowable expenses after deductible.[3]	75 percent of allowable expenses over first $50 of allowed expenses in each calendar year.	Basic benefits paid according to a fee schedule by geographic location. Drugs and nursing services are not covered under basic benefits but covered under supplemental benefits--75 percent of allowable expenses after deductible.[3]
Maternity (Family enrollments only)	Same benefits as those related to an injury or illness as shown above.	Same benefits as those related to an injury or illness as shown above.	Same benefits as those related to an injury or illness as shown above.	Up to $150 for covered hospital expenses and up to $125 for physicians' services.

[1]The first $25 of allowable other hospital expenses is payable by the enrollee for each person covered under this plan unless the deductible(s) has already been satisfied by the enrollee under the benefit category physician services, drugs, and nursing services. Deductibles for families are waived after three covered persons in a family have met their deductibles in any calendar year.

[2]Member hospital is any hospital with which any local Blue Cross Plan has an agreement to render hospital service to subscribers of such plan. Non-member hospital charges, other than charges of overseas hospitals, are not paid in full by this plan.

[3]Under the Service Benefit Plan, the deductible is the amount of covered expense that each person covered by the plan must incur in each calendar year before supplemental benefits are payable. The high option deductible is $100 for each person and the low option deductible is $150 for each person.

[4]Under the Indemnity Benefit Plan, charges of certain Christian Science practitioners and nurses are allowable expenses but under the Service Benefit Plan such charges are not allowable. Physicians' home and office visits are allowable expenses under the Indemnity Benefit Plan and under the supplemental benefits of the Service Benefit Plan.

UNITED STATES CIVIL SERVICE COMMISSION
BUREAU OF RETIREMENT, INSURANCE, AND OCCUPATIONAL HEALTH
WASHINGTON, D.C. 20415

IN REPLY PLEASE REFER TO

YOUR REFERENCE

MAR 3 - 1972

Mr. Philip Charam
Associate Director
U.S. General Accounting Office
Washington, D. C. 20548

Dear Mr. Charam:

This is in response to your December 13, 1971, letter enclosing a draft of your proposed report to the Congress, on the Government-wide Indemnity Benefit Plan of the Federal Employees' Health Benefits Program.

This letter gives our views on the major audit points and recommendations in the proposed report. Comments were obtained from the Aetna Life Insurance Company as you requested, and a copy of the comments is attached. Those comments are discussed in this response, where pertinent. Our staff has furnished a separate memorandum discussing items where there is a question of the accuracy of the information presented, and items of an editorial nature.

We note your footnote qualification indicating that you have not audited the basic financial statements which you summarized in the draft report. Similarly, Commission staff has not retraced the GAO audit efforts to verify all the figures used in the draft report.

Most of the recommendations in the draft report propose that the Commission make further reviews of activities. We will undertake these reviews, with a view to improving the phases discussed. We appreciate the GAO efforts toward improving administration of the Plan.

Proposed Study of Premium Rates

The GAO draft report recommends that the Commission review the changes in enrollment during the 1971 open season to find out why enrollees changed plans or options, and why the proportions of annuitants have continued to increase, and the extent to which such increases will affect the Plan's average health costs; also that the Commission make any revisions of benefit coverage or other changes that are needed, as a result of the proposed study, to insure that Federal employees will continue to have a choice of Government-wide plans.

The 1971 open season had already started before we received the GAO draft report. Thus it would not have been possible to revise and distribute a new form to enrollees to show the reasons for changing Plans or options. Due to the large number of employees and agencies involved, lead time required for such an undertaking is normally about six months. The specific reasons why employees shift to other Plans during an open season are not known. We believe, on the basis of long experience, that most enrollees change Plans because of rate, benefit, or claim service considerations. The value of further refining these three reasons must be weighed against the cost of gathering such information. For example, the knowledge that an individual changed Plans to seek a better psychiatric benefit would not be particularly useful. Data on the number of annuitants enrolled in each Plan, and the percent of annuitants to total enrollment has been maintained by the Commission from inception of the program. Current data indicates that Aetna has a larger proportion of annuitants than the Blue Cross and Shield Plan (26% vs. 17%).

The draft report discusses a consulting actuary's statements about an assessment spiral which causes higher rates, which in turn causes greater loss of enrollment. The inference is that the Aetna Plan is currently in such a spiral. For 1972 the Service Benefit Plan (Blue Cross and Blue Shield) rates have been raised, so that the high option family rates, covering 64 percent of the Plan's enrollees, are now about 11 percent above those for the Aetna Plan. Thus, if higher rates are a primary reason for changing Plans, the large rate increase for the Blue Cross and Blue Shield Plan should be reflected in changes during the open season started in November 1971.

Regarding possible revisions of benefits, the Commission has not attempted to make the benefits of the two government-wide Plans identical. It is evident that the closer the benefits of the two

government-wide Plans approach each other the less choice is available to an employee. If there is no choice in benefits there is little apparent value in assuring that Federal employees will continue to have a choice of Plans. This situation emphasizes the complexity of one of the policy matters the Commission has wrestled with since the program began in 1960.

We will review the need for obtaining more detailed statistics on employee reasons for changing Plans, and will continue developing data on trends of annuitants. If the current downward trend in the number of enrollees in the Aetna Plan continues we will undertake a broader study of the reasons for the trend, and determine what, if anything, should be done to change the situation. Because of the complex problems involved in establishing 1972 rates, and the extended open season, we believe the 1971 open season is not appropriate for a detailed study of the changes taking place in that period.

Health Benefits

This section of the draft report deals with a comparison of hospital and doctor charges allowed by Aetna, and the Blue Cross (hospital) and Blue Shield (physicians) Plan. The draft report does not state whether the GAO test compared fees charged by the same physician. It indicates only that the test compared amounts that had been allowed by Aetna for certain physicians, with "amounts that would be allowable for similar services according to the criteria used by two local service benefit Plans covering the same geographical areas." We interpret this to mean that fees of the same physicians were not compared for the two Plans. A comparison of what was actually allowed by Aetna in a specific set of circumstances with an assumed allowance to another physician under other conditions does not appear to be a valid comparison. To expand a comparison based on that premise to arrive at an overall 6.5 percentage difference in payments and then to project it further into a dollar difference seems to us to be questionable. We agree that proper use of physician profiles should produce similar results: we question only the basis for arriving at an estimate of the dollar difference. The report recommends that the Commission encourage Aetna to develop and use adequate profiles of physicians' usual charges for determining whether charges for physicians' services are reasonable. As noted in their comments on the draft report, Aetna had developed and started using such profiles in determining covered expenses for physicians' services in 1971. We believe that this should satisfy the recommendation.

The draft report discusses at length the difference in payments to hospitals by Aetna and by Blue Cross. Historically, Blue Cross has had discount arrangements with hospitals, which result in lower payments for that Plan, and result in comparatively higher payments for Aetna and most of the other 38 Federal Employee Plans. The draft report draws no conclusions nor makes any recommendation on this point.

Reserves

GAO recommends that the Commission (1) encourage Aetna to refine its method of establishing premium rates for the Plan by making and utilizing, to the extent practicable, the results of studies of claims experience for different age, sex, and geographical groupings of the Plan's participants; and (2) determine, by use of principles of risk theory or other acceptable methods, the combined amount of the reserve needed to be maintained by the Commission and Aetna to cover adverse chance fluctuations in claims costs, and consider such determinations before approving premium rates for the Plan.

The report dwells at some length on the extent of preciseness in developing annual premium rates. Even if the rates could be predicted more accurately the long term effect on the total contributions would be negligible. For instance, a premium that proved to be two percent more than was needed in one year would correspondingly reduce the increase needed the next year. The total payment over the two year periods would not be affected by the overage and underage. It is our opinion that the year-by-year fluctuations as shown by Aetna are reasonably low in consideration of the accelerating inflation and utilization in the last ten years and that any further refinement in the calculations would not appreciably improve the results.

Under the experience-rated concept used in many of the 40 or so Plans, the Plans account for the income and expenses of the Federal employee group, separately from other income and expense of their Plan. The difference between this income and expense represents the operating gain or loss for the year. The cumulative operating gain or loss since inception in 1960 is referred to in Commission contracts as the Special Reserve. It is termed a reserve because the gains, if any, are separated (reserved) from other operating results of the Plan, so that gains may be used for the benefit of the Federal Employee program only.

The Special Reserve has never been intended as part of the planned reserves because there is no reliable way of determining gains or losses a year and a half in advance, notwithstanding risk, or other theories. This was recognized by the General Accounting Office in commenting on the original legislation, where it was indicated that since the revenue for the reserves, from operating results and interest would be contingent on the experience of the carriers it may be that a positive source of funds for the purpose of establishing a reserve would be desirable.

The operating results have not fluctuated as much as might have been expected. The Aetna Plan had operating losses in four of the ten years of operations discussed in the draft, and gains in six years. In 1968, they ended the year with a cumulative loss equal to 4 percent of costs in the succeeding year; in 1969, a cumulative gain of 2 percent; and in 1970 a cumulative gain of 3 percent.

The draft indicates an objective of avoiding large fluctuations in rates from year to year. The objective of leveling annual rate increases is understandable and desirable, but it would not affect the ultimate cost to the employee. Rates in the Aetna high option for families (option with 43 percent of the total enrollees) increased 12 percent in 1968, 30 percent in 1969, 19 percent in 1970, and 17 percent in 1971. With more effort and cost the increases might have been leveled some, but they appear to be reasonably accurate for rates developed 6 to 9 months before the beginning of the year in which they apply.

The draft report concludes that the cost predictions could be refined by introducing changing age and sex characteristics as part of the rate procedure and by using principles of risk theory to determine the necessary level of reserves. Both of these concepts are novel applications of actuarial theory that, to our knowledge, are not currently accepted or generally used in industry or government.

The draft report recommends that the Commission encourage Aetna to consider age and sex characteristics of the population in the rate-making process. While this is a useful procedure in establishing initial rates for a plan, the experience rating procedure after the first year has age - sex characteristics built in since they are part of the experience.

We recognize that open seasons could result in abnormal shifts in these distributions which in turn could affect future experience and rates. However, there is no way to accurately predict

the shifts in the open season. It does not appear to be possible to introduce an allowance for open season changes into rates which themselves affect the open season changes. We will analyze the results of past open seasons and consider the possibility of using the results to predict the long range prospects for the Aetna program.

A second recommendation is that the Commission use the principles of risk theory to determine the combined amount of reserves needed to be held by the Commission and Aetna. By the very nature of the Federal Employees Health Benefits Program it is difficult to consider one Plan in isolation in determining reserve policy. The current policy of maintaining reasonable contingency and special reserves has little theoretical but much practical rationale. Since there is no one standard actuarial practice for determining excess reserve levels of group health insurance, the practical policy of maintaining reasonable reserves for all the plans in the program has been followed. Over the long run, the rates for a plan are not adversely affected by a conservative reserve level. In fact, to the extent that the larger reserve earns more interest, the rates are lower after the reserve has been built up.

The Commission's actuaries will make a study of the various reserve levels for all plans. The theoretical and practical aspects of the level of reserves to be maintained will be considered in this study.

Risk Charge and Reinsurers' Expense Allowance

GAO recommends that in negotiating future contracts with Aetna the Commission reassess the reasonableness of the amounts allowed for (1) risk charges (service charge) under the Plan, and (2) reinsurers' expense allowances.

As we pointed out in our July 21, 1971 letter to GAO, the Commission has recognized that the amount of risk has been low compared to most other group insurance. We have also recognized that the risk charge provided the only element of profit available to the Plan, though the exact portions applicable to risk and profit were not calculated or stipulated. The question appears to us to be one of how much profit, if any, should be allowed. It was with this

thought in mind that we wrote GAO on April 1, 1971, asking whether they believe that the Plan should be allowed a profit, and if so what they would consider to be a reasonable profit. Also, whether GAO found that the risk charge (service charge) produces a profit which is excessive when compared with profit margins allowed on other contracts. We would still be interested in GAO views on these three points.

The report suggests that the Commission consider reducing the risk charge by eliminating the portion intended to cover risk, and leaving only a portion for a service charge or profit. On January 1, 1970 the Commission reduced the risk charge (including profit) allowed Aetna to 1 percent of premiums. In 1972 the contract was changed to further reduce the profit. The allowance for risk and profit was reduced to a flat rate service charge of $1.3 million on this $170 million contract. We therefore consider that the recommendation has essentially been satisfied.

The reinsurers' expense allowance remains at 0.2 percent of premiums. In 1970 this allowance totaled $338,000 for all 121 reinsurers involved. The 1970 expense allowance ranged from 95 cents for the smallest reinsurer, to $31,133 for the largest.

As long as Congress requires that the Indemnity Benefit Plan be reinsured, we believe the reinsurers are entitled to reimbursement for expenses. The reinsuring companies have overhead costs attributable to their reinsurance contracts. The percentage allowance method of distributing such costs was adopted as an expedient, so that the costs involved in determining the actual expenses of the reinsurers would not be disproportionate to the expenses themselves.

We will reassess the reinsurers' expense allowance to determine whether reductions can be made. We will explore the possibility of determining the amounts by some method other than a percentage of premiums. We will also take another look at the matter of Federal income tax allowance on risk charges.

The report suggests also that Congress may wish to consider amending the law (5 U.S.C. 8902(c)) to eliminate the mandatory provision for reinsurance under this Plan. The Congressional intent, as evidenced during the legislative process, was that as many qualified insurance

companies as possible participate in the program through the reinsurance mechanism. As noted in your report, about 120 companies elected to participate.

[See GAO note.]

Investment Income

The draft report recommends that the Commission review the practices followed by Aetna in arriving at the amount of investment income to be credited to the Plan, with particular attention being given to the equitableness of the amounts so credited and to the need for adjustments for inadequate amounts credited in prior years.

Aetna pointed out in its comments on the draft report that the Government-wide Indemnity Benefit Plan is not a separate corporation or a separate line of business; it is one of many group health insurance policies underwritten by the Company. They note that State Insurance Department regulations require that Aetna's investment income allocation procedures be formally established and be applied on a consistent and non-discriminatory basis for all of their business. Aetna is attempting to bring the treatment of short-term investment income in line with the approach suggested in the draft report by refiling their allocation procedures with the New York Insurance Department. The Plan has agreed to correct an inconsistency in the application of the formula for determining the mean ledger asset balances at the beginning and ending of the year.

[See GAO note.]

We have always considered the investment income credited to the Plan by Aetna as one of the more important financial areas that need periodic review. We will continue to review the allocation of income from the Aetna Group Division to the Federal Employees Health Benefits Program. It is our understanding, however, that the GAO recommendation does not

GAO note: Material deleted from this letter concerns matters included in the report draft which have been revised in the final report.

intend for the Commission to require changes in practices customarily followed by insurance companies for arriving at their income figures, which are normally prescribed and regulated by the States. In view of the large amount of staff time already expended by GAO in the investment income area, we would hope to have workpapers made available, and perhaps more definitive ideas of suggested guidelines, so that the work that has already been performed will not have to be duplicated.

GAO also recommends that the Commission initiate action to amend its contract with Aetna to provide for the Plan to be credited with interest on Other Reserve funds and to set forth the basis upon which such credits are to be computed. We concur that the agreements with Aetna for crediting interest on Other Reserve funds should be inserted as a part of the formal contract. The Commission will take action to incorporate this provision into its contract with Aetna.

Sincerely yours,

Andrew E. Ruddock

Andrew E. Ruddock
Director

Attachment

APPENDIX IV

PRINCIPAL OFFICIALS

OF THE

UNITED STATES CIVIL SERVICE COMMISSION

RESPONSIBLE FOR THE ADMINISTRATION

OF THE

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

	Tenure of office	
	From	To
COMMISSIONERS:		
Robert E. Hampton, Chairman	Jan. 1969	Present
L. J. Andolsek	Apr. 1963	Present
Jayne B. Spain	June 1971	Present
John W. Macy, Jr., Chairman	Mar. 1961	Jan. 1969
Robert E. Hampton	July 1961	Jan. 1969
James E. Johnson	Jan. 1969	June 1971
EXECUTIVE DIRECTOR:		
Bernard Rosen	June 1971	Present
Nicholas J. Oganovic	June 1965	May 1971
DIRECTOR, BUREAU OF RETIREMENT, INSURANCE AND OCCUPATIONAL HEALTH (formerly Bureau of Retirement and Insurance):		
Andrew E. Ruddock	Sept. 1959	Present

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