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Report to the Chairman, Permanent Subcommittee on Investigations, Committee on Governmental Affairs, U.S. Senate

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BLUE CROSS AND BLUE SHIELD

Experiences of Weak Plans Underscore the Role of Effective State Oversight

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Health, Education, and
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The Honorable Sam Nunn
Chairman, Permanent Subcommittee on
Investigations
Committee on Governmental Affairs
United States Senate

Dear Mr. Chairman:

The 1990 failure of Blue Cross and Blue Shield of West Virginia left thousands of people and numerous health care providers with millions of dollars in unpaid claims. More recently, congressional investigators uncovered serious financial problems as well as mismanagement at three other "Blues" plans[1] and raised questions about the oversight of these plans by their boards of directors and state regulators. Investigators also questioned the oversight role of the Blue Cross and Blue Shield Association that licenses the Blue Cross and Blue Shield trademarks and coordinates plan activities.

The nation's 69 Blues plans play an integral role in providing private health insurance, collectively insuring about 67 million Americans. Due to concerns that the financial and management problems identified at a few plans may also afflict other Blues plans, you asked us to study the plans and their Association. Based on discussions with your office, we agreed to (1) determine the extent of financial weaknesses among Blues plans; (2) identify factors that contributed to plans' weak financial conditions; and (3) determine the measures taken by plans, the Association, and states to address plan weaknesses. We also agreed to describe the oversight and other roles played by the Association and discuss the implications of health care reform on Blues plans.

To identify the plans with financial problems, we used information from Weiss Research, Inc.—the only insurance rating agency that evaluates the financial condition of most Blues plans.[2] We then obtained proprietary information from the Association on the financial condition of each plan rated weak or very weak by Weiss. We did not independently assess the

[1]The plans were Blue Cross and Blue Shield of Maryland, the National Capital Area (District of Columbia), and Empire Blue Cross and Blue Shield (New York City).

[2]The Weiss ratings were based on plan data as of June 30, 1993. Weiss did not rate six Blues plans because the data these plans submitted to their state insurance departments were incompatible with Weiss's rating models.

financial condition of these Blues plans. We visited six plans[3] that differed in financial performance, regulatory environment, location, size, and product mix. We also conducted a telephone survey of insurance department officials in all 50 states and the District of Columbia to compare the state regulatory requirements that apply to Blues plans with those that apply to commercial insurers. (App. I contains a more detailed description of our scope and methodology.)

Background

The revelation that several Blues plans were in poor financial condition prompted fundamental questions about all Blues plans because of the large number of Americans they insure. Are the plans run by a single corporate headquarters, or do they each operate as an independent business? How do Blues plans differ from commercial health insurers? How many Blues plans are in financial trouble and why? What are the responsibilities of the Blues Association when plans have financial problems?

The 69 Blues plans are independently operated, not-for-profit corporations, each governed by a board of directors. They are linked to the Blue Cross and Blue Shield Association through a licensing agreement. The Association is governed by a board of directors composed of the chief executive officers (CEO) from most Blues plans and is primarily funded by plans' dues. (App. II contains a more detailed description of the Association and its relationship to individual plans.)

Early Blues plans were the predominant providers of private health insurance in the United States. They were established during the Depression because health insurance was virtually nonexistent, and the inability of many Americans to pay for medical care placed a financial strain on the voluntary hospital system. Blues plans were organized on a not-for-profit basis and were dedicated to fulfilling a community service role. Accordingly, these plans sought to offer affordable coverage to all individuals, regardless of health status.

Following World War II, the health insurance industry changed significantly. By the early 1950s, commercial health insurers, formerly a minor presence in the industry, had surpassed the Blues plans in total enrollment. Commercial health insurers competed with Blues plans by offering lower priced policies to healthier, lower risk individuals and

[3]GAO visited Blue Cross and Blue Shield of Illinois, Massachusetts, Michigan, New Jersey, and Oregon, and Blue Cross of California.

groups. Some Blues plans, either voluntarily or by state requirement, became the only insurers that continued to accept high-risk individuals and groups excluded by commercial insurers and to base premiums on the average expected cost of the entire applicant community. A plan that performs this role is commonly called the "insurer of last resort." Other Blues plans de-emphasized their community service role by adopting practices similar to their commercial competitors.

Blues plans today differ considerably from one another in such areas as market share, management philosophy, and the types of products they offer to their three primary market segments—individual, small group, and large group. Plans also differ in the degree to which they serve, if at all, as the insurer of last resort. Currently, fewer than 20 plans serve this role in their state. In addition, 24 Blues plans are members of state life/health guaranty associations that provide limited continuation of coverage and pay benefits to policyholders and beneficiaries of failed insurers. (App. III summarizes several important differences among Blues plans.)

State insurance regulators are responsible for monitoring the financial solvency of Blues plans and other insurers to protect consumers and ensure that plans offer insurance that is affordable and accessible.[4] A commonly used indicator of an insurer's ability to cover unexpected losses and measure of insurer solvency is surplus—the difference between an insurer's assets and liabilities.

Most state insurance departments regulate Blues plans pursuant to special enabling statutes, some of which prescribe a community service role for the plan, typically in the individual and small group markets. In recognition of their community service role and to offset the costs associated with insuring all risks, Blues plans were given federal and state tax exemptions and other statutory benefits, such as discounts on hospital charges that were not available to commercial insurers.[5]

[4]For more information on how state insurance departments regulate health insurance, see Health Insurance Regulation: Wide Variation in States' Authority, Oversight, and Resources (GAO/HRD-94-26, Dec. 27, 1993).

[5]The Tax Reform Act of 1986 rescinded the federal tax exemption for Blues plans and subjected them to taxation as stock insurance companies. However, the act also entitled Blues plans to a special deduction equal to 25 percent of the claims and expenses incurred during the taxable year less the adjusted surplus at the beginning of the year. In addition, some states have rescinded tax exemptions or other statutory benefits given to Blues plans.

Results in Brief

Although recent publicity has raised questions about the financial condition of Blues plans, 53 of 64 plans are rated in fair to excellent financial condition by Weiss Research. The remaining 11 plans, which insure about one-quarter of all Blues subscribers, are rated in weak to very weak financial condition because of several factors.[6] Recent financial assistance provided by Blues plans and the Association appears to have stabilized the financial condition of some weak plans. However, the success of other longer term Association actions and state insurance reforms is unclear because they have either been in place only for a short period of time or have not yet been implemented. In addition, the potential challenges posed by health care reform could strain the finances of any plan, particularly those in weak condition.

The financially weak plans in our study[7] experienced problems for several reasons. Mismanagement contributed to the financial weaknesses of some plans. These plans were slow to respond to changing market conditions or made poor investment decisions—such as investments in money-losing subsidiaries and ineffective claims processing systems. Also, in some states, rate-setting constraints and coverage requirements applicable only to Blues plans put them at a competitive disadvantage. Unlike commercial insurers, Blues plans that are required to serve as insurer of last resort must cover high-risk applicants and may not receive regulatory permission to set premium rates at levels sufficient to cover costs.

In addition, weaknesses in the oversight roles played by plan boards of directors and state regulators allowed plans' financial problems to persist. The boards of directors of some plans in our study did not adequately perform their oversight roles because they were misled by plan management or uninformed. Regulators' oversight efforts have been hampered by the conflict in their roles of ensuring plans' solvency and ensuring that plans offer affordable premiums. Moreover, questions have been raised about whether an inherent conflict in the Association's trademark licensor role has made it unwilling to enforce its membership standards by revoking the license of a financially troubled plan.

[6]Weiss Research defines weak plans as those demonstrating significant weaknesses that could adversely impact policyholders. Plans in very weak condition have failed some basic tests of fiscal stability and experienced weaknesses that could pose significant risks to policyholders, even in a favorable economic environment.

[7]Our study focused on the six plans we visited and the four plans investigated by the Senate Permanent Subcommittee on Investigations. Using data from June 30, 1993, Weiss rated six of these plans in weak or very weak financial condition.

The Association, individual plans, and states have acted to remedy the problems of financially troubled plans. In some instances, these actions have helped improve their financial condition and better enabled troubled plans to respond to changing market conditions. Because other efforts have not yet been fully implemented, their effect is not yet known.

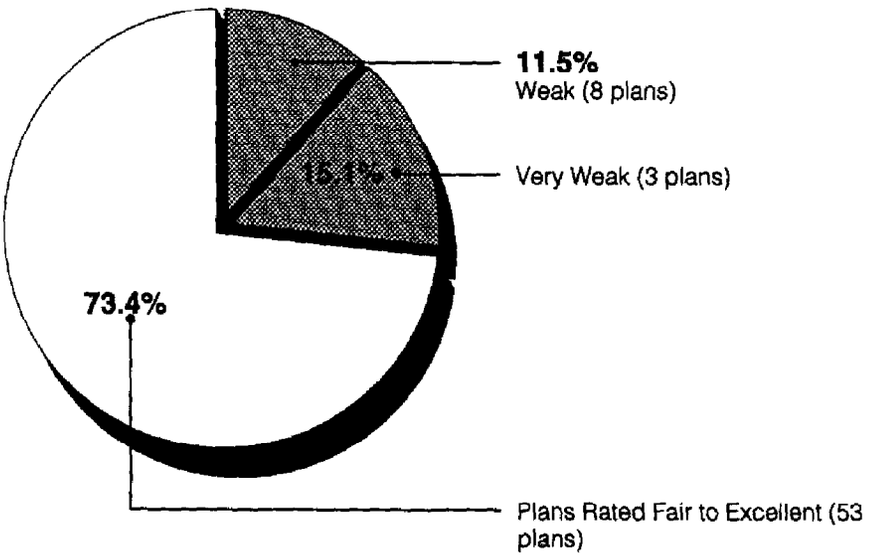
Health care reform could significantly affect Blues plans and commercial insurers by altering the competitive nature of the health insurance market. Reform may require insurers to accept any applicant regardless of health status and use community rating to set premium rates. Health insurance companies and health care providers may also form increasingly large and more complex financing and delivery entities to better manage health care costs under reform. The combined effect of these reforms may strain the financial condition of health insurers.

The role of state insurance regulators in monitoring the financial solvency of Blues plans and protecting subscribers' and providers' interests will become increasingly more important and challenging under reform. Therefore, it is essential that state insurance regulators have the tools necessary to enforce new requirements on Blues plans and other health insurers.

Some Blues Plans Have Financial Problems

While most Blues plans are financially sound, eight plans are in a weak condition, and three plans are in a very weak financial condition, according to Weiss Research ratings. These 11 plans insure about 27 percent of the subscribers of Blues plans rated by Weiss (see fig. 1). Figure 2 shows the states where these financially weak plans are located.

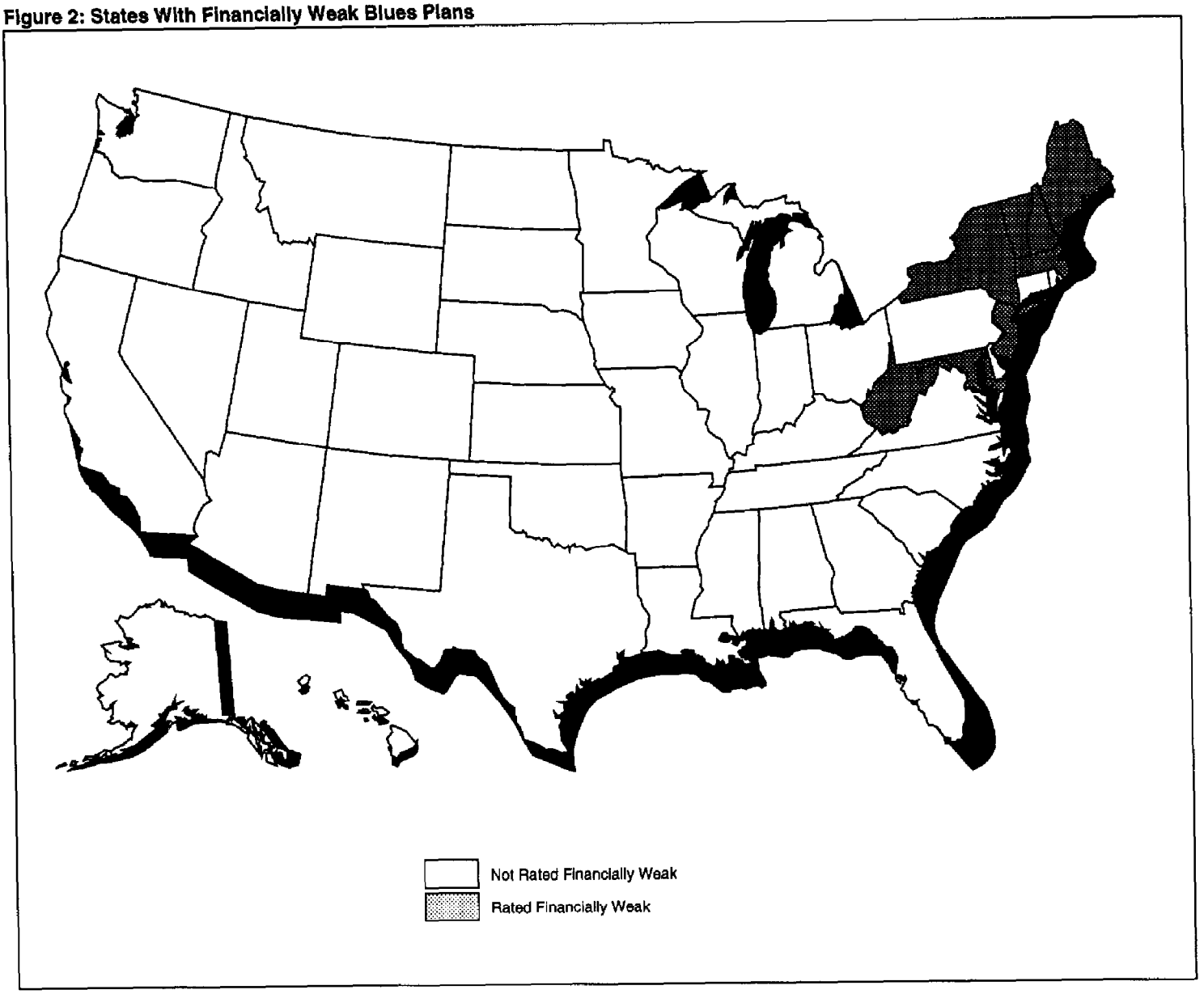
Figure 1: Percentage of Blues Subscribers by Plans' Financial Ratings



Weiss did not rate six plans with about 6.3 million members because of data limitations. Based on Association data, one of these plans, with an enrollment of about 540,000, is in weak financial condition.

Sources: Weiss ratings based on June 30, 1993, data, and June 1993 enrollment data from the Blue Cross and Blue Shield Association.

Figure 2: States With Financially Weak Blues Plans



The 11 plans are Blue Cross and Blue Shield of Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Vermont, New York City (Empire), West Virginia (Mountain State), Western New York (Buffalo), Blue Cross of Rochester (New York), and Blue Cross and Blue Shield of the National Capital Area (District of Columbia). Three additional plans located in New York are not rated financially weak: Blue Cross and Blue Shield of Utica-Watertown, Central New York (Syracuse), and Blue Shield of Rochester.

Financial information obtained from the Association further indicates that two plans, Empire Blue Cross and Blue Shield (New York City) and Blue Cross and Blue Shield of the National Capital Area (Washington, D.C.), are in the most severe financial condition. However, the respective state insurance regulators for these two plans told us that the plans had stabilized under recent recovery measures and were no longer in imminent danger of insolvency.

Several Factors Contributed to Plans' Financial Weaknesses

Plan mismanagement and regulatory requirements that states imposed on Blues plans but not commercial insurers contributed to the financial weakness of plans in our study. Although the contributing factors are independent, their effects were not separable. Therefore, we could not determine the relative effect of each factor.

Plan Mismanagement

Plan management's slow response to changes in the marketplace contributed to the current or previously weak financial condition of four Blues plans in our study. These plans did not adequately respond to customer demand for different types of insurance policies or for lower prices. For example, in certain markets, plans were slow to recognize customers' preference for lower cost insurance products, such as managed care. The experience of several plans during the mid to late 1980s illustrates this point.

In New Jersey, the Blues plan's competitors began to offer policies with coinsurance features and high deductibles to lower the price of their products, while the Blues plan continued to focus on high-cost policies without deductibles. Blues plans in California, Massachusetts, and New York did not adequately respond to the increasing market acceptance of managed care plans, like health maintenance organizations (HMO) and preferred provider organizations (PPO), to control premium costs.

Plans attributed delays in offering lower cost or innovative products in part to management complacency. This complacency was prompted by historical factors, including plans' dominant positions in relatively stable, less competitive markets. One plan CEO told us that the plan had been successful for so long, it had become insulated and inwardly focused and lost touch with its market. This unresponsiveness contributed to the plan's weak financial condition in the late 1980s.

Investment decisions that seven plans in our study made to remain competitive or otherwise strengthen their financial condition also contributed to the decline in their financial performance. These decisions primarily involved investments in money-losing subsidiary ventures and in poorly developed and implemented claims processing and information systems.

During a recent 3-year period, the surplus of the Washington, D.C., plan was significantly depleted when its 30 subsidiaries, many of which were unrelated to its core health insurance business, incurred about $89 million in losses. Ironically, the plan's core health insurance business would have otherwise increased the plan's surplus in each of these years.[8] In Maryland, the Blues plan created or acquired 29 subsidiaries between 1986 and 1991. In 1992, congressional investigators reported that, since 1986, the subsidiaries collectively lost about $72 million.[9]

The Maryland Blues plan also spent millions of dollars in developing a claims processing system that has been plagued with problems and delays. Initially, the system was estimated to cost about $9 million and be fully implemented by mid-1990.[10] However, the plan estimates the final cost to be about $31 million with full implementation not occurring until 1994.[11] Similarly, the Massachusetts Blues plan invested in a claims processing system that a private consulting firm concluded was ill planned and poorly implemented. According to the consultant's report,[12] the plan's investment in this system totaled $50 million in a 21-month period (December 31, 1987, to September 30, 1989), which represents about 50 percent of the decrease in the plan's surplus.

State Regulatory Requirements

Eight of the 11 plans having financial difficulties operated in states that impose the greatest number of rate-setting and coverage requirements on

[8]U.S. Senate Permanent Subcommittee on Investigations Hearings on Oversight of the Insurance Industry: Blue Cross and Blue Shield of the National Capital Area, staff statement (Washington, D.C.: 1993).

[9]U.S. Senate Permanent Subcommittee on Investigations Hearings on Oversight of the Insurance Industry: Blue Cross and Blue Shield of Maryland, staff statement (Washington, D.C.: 1992).

[10]U.S. Senate Permanent Subcommittee on Investigations Hearings on Oversight of the Insurance Industry: Blue Cross and Blue Shield of Maryland.

[11]Report of the Special Litigation and Indemnification Committee of the Board of Directors of Blue Cross and Blue Shield of Maryland, Inc. (Baltimore, MD: 1993).

[12]Blue Cross Blue Shield of Massachusetts Corporate Review: Final Report, Cresap-Tillinghast, (New York, NY: 1990).

Blues plans. (App. IV describes the regulatory requirements imposed on each Blues plan.) The relationship between regulatory requirements and financial performance does not hold true for all plans, however, because 11 other plans that were held to similar requirements are rated as financially sound.

In some states, Blues plans were the only insurers required to (1) set premiums based on the average expected cost of the entire applicant community, known as community rating (nine states), or (2) cover all applicants, regardless of their health status (seven states). In addition, several plans had to charge state-approved premium rates that were lower than what they had requested.

These requirements placed some of the financially troubled Blues plans at a competitive disadvantage with commercial insurers, which could increase premium rates without state-imposed limits and control their claims costs by excluding high-risk applicants. In New Jersey, for example, state regulators acknowledged that they approved a smaller rate increase than the plan requested in 1991 to ensure that the plan's premiums remained affordable. While this had the effect of reducing the plan's income, the state also increased the plan's costs by requiring it to insure all applicants, regardless of health status. In 1992, the plan reported losses of $78 million in its lines of insurance subject to these requirements. We did not determine to what extent these losses were attributable to premium rate and coverage requirements.

Losses experienced by other financially troubled plans have also been concentrated in the individual and small group lines of insurance that were subject to state-mandated premium rate-setting and coverage requirements. For example, external consultants reported that about 87 percent of the New York (Empire) plan's losses in 1992, and the majority of its losses during the preceding 3 years, occurred in the plan's lines of insurance subject to rating and coverage requirements.[13] Similarly, external consultants of the Massachusetts plan estimated that, from December 1987 to September 1989, the plan lost $135 million in the lines of insurance subject to similar requirements.[14]

[13]Management and Financial Audit of Empire Blue Cross and Blue Shield: Final Report, Arthur Andersen and Co. (New York, NY: 1993). In September 1993, Empire officials acknowledged that the plan overstated these reported losses in 1989, 1990, and 1991.

[14]Blue Cross Blue Shield of Massachusetts Corporate Review: Final Report.

State insurance regulators for four of the six plans we visited agreed that regulatory requirements imposed only on Blues plans, such as a public premium rate approval process, have placed plans at a competitive disadvantage with commercial insurers. However, three of the six regulators told us that mismanagement also contributed to the weak financial condition of the Blues plans in their states.

Oversight Weaknesses May Have Allowed Blues' Solvency Problems to Persist

Plans' boards of directors and state insurance regulators are each responsible for ensuring the financial solvency of Blues plans. In addition, because of its interest in protecting the value of the Blue Cross and Blue Shield trademarks, the Association also performs certain oversight functions. However, weaknesses in the oversight provided by these groups has allowed some Blues plans' solvency problems to persist and could place plan subscribers at risk of losing insurance coverage and health care providers at risk of not having claims paid.

Plan Boards of Directors

The board of directors for each Blues plan serves as the first line of oversight to detect financial weaknesses and plan mismanagement. The board's role is particularly important because Blues plans are not-for-profit and thus have no shareholders to whom the plan's board must answer. However, recent congressional investigations found that the boards of directors of some financially troubled plans had not adequately performed their oversight roles.

For example, the board of directors of the Empire Blues plan in New York relied almost entirely on management for information concerning plan performance and finances and was unaware of several key measures of the plan's weakening performance.[15] Plan management dominated the board, the plan's CEO served as chairman of the board of directors, and outside board members lacked sufficient knowledge to ask appropriate questions of plan management.

Similar weaknesses existed in the oversight role played by plan boards of directors in West Virginia and Washington, D.C.[16] In West Virginia, plan management went so far as to create a separate class of hand-picked

[15]U.S. Senate Permanent Subcommittee on Investigations Hearings on Oversight of the Insurance Industry: Empire Blue Cross and Blue Shield (NY), staff statement (Washington, D.C.: 1993).

[16]U.S. Senate Permanent Subcommittee on Investigations Hearings on Efforts to Combat Fraud and Abuse in the Insurance Industry, Part VI, staff statement (Washington, D.C.: 1992) and U.S. Senate Permanent Subcommittee on Investigations Hearings on Oversight of the Insurance Industry, Blue Cross Blue Shield of the National Capital Area, staff statement (Washington, D.C.: 1993).

board members, referred to as a "super board." The super board, which included the plan CEO, essentially became a new governing body that dominated the legislatively mandated plan board of directors. In Washington, D.C., former board members conceded that they were frequently misled by plan management and did not have sufficient information to fully perform their oversight roles.

State Regulation

The unique status of many Blues plans—their large share of the health insurance market and their role in some states as insurer of last resort—has challenged regulators to determine the most appropriate steps to take to improve the financial condition of weak plans. The principal responsibility of state insurance regulators is to protect consumers by monitoring the solvency of insurance companies. At the same time, some regulators must administer state requirements that are intended to ensure that health insurance is affordable. In monitoring Blues plans, however, the two objectives sometimes conflict.

The failure of the Blues plan in West Virginia might have been prevented, or its effects minimized, if state insurance regulators had taken more decisive action as the plan's financial and management problems became apparent.[17] Moreover, plan officials and others contend that the regulator also contributed to the plan's failure by not granting timely and adequate rate increases.

In a 1984 on-site examination of the plan, regulators identified serious weaknesses in the plan's financial condition and management. Although a follow-up examination in 1986 reaffirmed the plan's precarious financial condition and mismanagement, state insurance regulators took no action to protect the plan's subscribers.

The plan's financial condition continued to decline until October 1990, when regulators declared the plan insolvent and placed it in receivership. Until this time, regulators permitted the plan to continue marketing its products to unsuspecting subscribers, even though its future viability was in serious doubt. Regulators attributed their inaction to insufficient resources, a lack of authority,[18] and assurances from the Association and external auditors that the plan's condition would improve.

[17]U.S. Senate Permanent Subcommittee on Investigations Hearing on Efforts to Combat Fraud and Abuse in the Insurance Industry, Part VI, staff statement (Washington, D.C.: 1992).

[18]The National Association of Insurance Commissioners is currently examining the adequacy of laws and regulations governing state oversight of Blues plans.

Weaknesses in the state oversight of the Empire Blue Cross and Blue Shield in New York may have allowed that plan's financial problems to worsen. In contrast to West Virginia, the New York State insurance department devotes a relatively large amount of resources to regulating health insurance and ranks second in expenditures and third in staffing among all state insurance departments.[19] Nonetheless, it has been criticized for being too lenient in its regulation of Empire on several occasions. For example, congressional investigators reported that state regulators (1) permitted the plan to continue operating an HMO that from 1986 to 1992 drained more than $115 million from the plan's surplus, (2) did not require the plan to correct deficiencies and weaknesses identified by state examiners, and (3) allowed the plan to borrow from its surplus without documenting how it would restore those funds.[20] Regulators stated that a conflict existed between the goals of ensuring that the plan remained solvent while continuing to offer affordable premiums to a large number of the state's residents.

Another example of the conflict between solvency and affordable premiums occurred in 1992 when New Jersey insurance regulators had to weigh policyholders' need for affordable health insurance against the New Jersey Blues plan's request for a major rate increase. The regulators said they approved a smaller rate increase than the plan requested to ensure that the plan's premiums remained affordable. The regulators estimated that their decision to limit the rate increase would leave the plan with a deficit of $74 million, increasing its deficit by $38 million, according to plan officials.

In another instance, congressional investigators reported that the then Maryland insurance commissioner postponed a routine financial examination of the Maryland Blues plan, even though she suspected that the plan was in a weak financial condition. One Maryland regulator explained that if the examination found that the plan had exhausted its surplus, publicity about this condition could have jeopardized the plan's future viability.

[19]Health Insurance: How Health Care Reform May Affect State Regulation (GAO/T-HRD-94-65, Nov. 5, 1993).

[20]U.S. Senate Permanent Subcommittee on Investigations Hearings on Oversight of the Insurance Industry: Empire Blue Cross and Blue Shield (NY), staff statement (Washington, D.C.: 1993).

The Blue Cross and Blue Shield Association

As part of its trademark licensor role, the Association requires plans to comply with 10 membership standards to protect the value of the Blue Cross and Blue Shield trademarks.[21] The Association regularly monitors the plans' compliance with financial and other membership standards. If a plan fails to meet a membership standard, the Association can terminate its trademark license with a majority vote of the Association membership, composed of a representative of each plan.

Before the failure of the West Virginia plan in 1990, the Association was reluctant to enforce its membership standards by revoking the trademark license of a financially troubled plan. For example, Association data indicate that, from 1987 through 1990, 20 plans did not comply with the financial standard for at least 2 consecutive years. An Association official acknowledged that, throughout the 1980s, some plans continually failed to comply with the Association financial and other membership standards. Nevertheless, since 1982, the Association has terminated the trademark license of only one plan for this reason.[22]

Although the Association's interest as a trademark licensor is to ensure that plans comply with membership standards, thereby protecting the value of the trademarks, revoking the trademark license of a financially troubled plan could tarnish the reputation of other member plans and the Blue Cross and Blue Shield trademarks. The views of several Blues plan officials suggest that the Association's reluctance to enforce its membership standards may have resulted from an inherent conflict in the Association's trademark licensor role. For example, one plan's general counsel said the termination of a plan's trademark license was considered a draconian measure that would reflect poorly on all plans. A plan CEO said that before the insolvency of the West Virginia plan, no Blues plans took the Association's financial standards seriously, nor envisioned they would be enforced.

[21]See appendix II for more details on the Association's trademark licensing role and the 10 membership standards.

[22]The Association terminated the license of Blue Cross and Blue Shield of West Virginia, Inc., in October 1990, shortly before state regulators were to place the plan in receivership. On four other occasions from 1982 through November 1993, the Association initiated the process to terminate the trademark license of a financially troubled plan. However, the terminations never took effect because of a court decision and plan recovery actions.

Association, Plans, and States Have Acted to Improve Financial Condition of Plans

The Association, individual plans, and states have acted to improve the financial performance of troubled plans. Certain measures have succeeded or shown promise, including financial and management assistance from other plans and the Association, plans' improved responsiveness to the market, and state reforms intended to create a "level playing field" by placing the same regulatory requirements on all insurers. The Association has also developed measures that are intended to improve its oversight of plans. Because these measures have not yet been fully implemented, their value in ensuring plans' continued viability is not yet known.

Association and Plan Measures Contributing to Plans' Recovery

In the last 5 years, financial assistance from the Association and several other Blues plans appears to have stabilized the short-term financial condition of three weak plans. Generally in the form of a loan, the assistance increased plans' surplus. For example, a consortium of 37 plans recently made financial commitments to the Washington, D.C., plan that increased the plan's surplus by $60 million. In all three instances, the financial assistance was accompanied by management restructuring—replacement of most members of the Washington, D.C., plan's board of directors and a merger and an affiliation with other Blues plans in the latter two cases. Restructuring plan management is essential in addressing the underlying problems that contribute to a plan's poor financial performance.[23]

Individual plans have also responded to their assessment of changing market demands, by replacing CEOs, reorganizing, developing new insurance products, and, in certain markets, increasing their emphasis on managed care. For example, in 1986, under new management, Blue Cross of California changed its organizational structure by establishing strategic business units that focus on specific segments of the insurance market, such as individuals, and small or large employer groups. This structure, according to plan officials, has helped the plan respond more quickly to market changes and customer demands. In addition, Blue Cross of California expanded its managed care offerings from 15 percent of its total business in 1986 to more than 85 percent in 1992. In 1992, the plan was the fastest growing insurer in the state.

Related to the increasing emphasis on managed care is the emerging trend toward closer relationships between plans and health care providers, sometimes called community care partnerships. Under the partnerships,

[23]Insurer Failures: Regulators Fail to Respond in Timely and Forceful Manner in Four Large Life Insurance Failures, (GAO/T-GGD-92-43, Sept. 9, 1992).

plans negotiate with hospitals to provide all necessary health care services to subscribers for a predetermined price. Because of the close working relationships and market power, plans can exert greater pressure on providers to contain costs and better monitor subscribers' health outcomes to ensure quality service. Oversight of these new arrangements will be essential to ensure that consumers receive timely and quality care.

The Illinois Blues plan is currently developing such a partnership with four hospital systems in the state. The plan will pay the hospitals a flat annual fee for each subscriber to cover all necessary health care services, including primary and specialist care and hospital services. The annual fee paid to the hospitals is not to increase by more than the rate of inflation for 5 years, thereby creating a strong cost-containment incentive for the participating hospital systems. Similarly, a partnership recently announced between the Michigan Blues plan and two hospital systems will also limit fee increases paid to hospitals as a cost-containment incentive.

State Measures Likely to Contribute to Plans' Financial Health

Under recent state health insurance reforms, several states have set uniform regulatory requirements for premium rates and coverage for all health insurers in the state. Such reform measures have been implemented in Maine, Massachusetts, New Jersey, New York, and Vermont for certain types of coverage. These measures require all health insurers to accept any applicant, regardless of risk, and to use community rating for establishing premiums. Several other states are considering similar reform measures.

Seven of the financially weak plans operate in states that have enacted comprehensive rating and coverage reforms. Although it is too soon to know what effect these reforms will have on plans' financial performance, they appear to remove the regulatory requirements that placed Blues plans at a competitive disadvantage and allow them to operate under the same rules as other insurers.

Effect of Other Association Measures Is Not Yet Known

Beginning in 1991, the Association made several changes concerning the oversight and management of Blues plans. According to the Association, these changes are intended to (1) provide it with a better measure of plans' financial condition, (2) allow it to more quickly identify plans with financial problems before they become serious, (3) clarify the oversight role of plan boards of directors, (4) provide state insurance regulators with certain information on plans' financial condition, and (5) better protect consumers in the case of a plan failure.

The Association revised its financial membership standard by using a risk-based capital formula to determine minimum plan surplus requirements. According to the Association, the new surplus requirements more accurately reflect each plan's business risks. The guidelines to administer these new standards were also changed. According to Association officials, they now have more explicit authority to terminate the license of any plan that fails to meet the surplus requirement. The new guidelines also establish an early warning system that Association officials said will enable them to identify plans with financial problems sooner than in the past so that corrective action can be taken more quickly. For example, according to Association officials, it has twice initiated the process to terminate the license of a plan approaching noncompliance since these standards went into effect.

The effectiveness of these revisions is currently uncertain, however, because the new surplus requirement is initially very low,[24] and the Association has not changed its process for terminating a plan's trademark license. A termination decision still requires a majority vote of the Association membership. Thus, the apparent conflict in the Association's trademark licensing role that may have kept it from enforcing its membership standards in the past remains.

The views of officials at the Blues plans we visited also suggest that questions remain about whether the recent changes will improve the Association's oversight of plans' financial condition. For example, two plan CEOs suggested that the new minimum surplus requirement was insufficient to protect the value of the trademarks. According to another plan CEO, a group of newer Blues executives believes the Association's trademark licensing function should be performed by an independent body of non-Blues employees that would have the will to enforce the membership standards.

The Association has also just implemented or is in the process of implementing several other changes. For example, as of December 31, 1993, all plans must provide state regulators information on the financial condition of their subsidiaries in accordance with the National Association of Insurance Commissioners' (NAIC) model holding company act. Also as of December 31, 1993, all plans must adopt policies that describe the plan board of directors' oversight roles and fiduciary obligations. Plans must annually certify to the Association that they have adopted procedures to enforce these policies and that the policies are being followed. Finally, as

[24]Appendix V examines the effect of the Association's new surplus requirement in more detail.

of December 31, 1994, each plan must either have joined its state's life/health guaranty fund or established another method to ensure payment of its subscribers' claims and continued coverage in the case of its insolvency.

Implications of Health Care Reform

Health care reform could significantly affect Blues plans and commercial insurers by altering the competitive nature of the health insurance market. For example, many reform proposals could require all insurers to accept any applicant for coverage, regardless of health status, and use community rating for setting premiums.

Reform could also intensify competition among insurers by changing the way health care is purchased. Most proposals envision the creation of purchasing cooperatives to pool the purchasing power of individuals and small employers. These cooperatives could allow consumers to better compare competing health plans by providing them with information about each plan's premium rates, provider networks, and member satisfaction.

Health insurance companies and health care providers may also form increasingly large and more complex financing and delivery entities to better manage health care costs under reform. In addition, the extent of health care coverage provided through fee-for-service plans may further decline as traditional insurers begin providing care as prepaid health care reimbursement systems under regional purchasing cooperatives.

Concluding Observations

Under health care reform, the role of state insurance regulators in monitoring the financial solvency of Blues plans and protecting subscribers' and providers' interests will become increasingly important and challenging. Regulators have not always adequately monitored troubled Blues plans in part because of the size and important role the plans have played in their markets. The large integrated financing and delivery entities likely to be created under reform may also play an important role in the markets they operate and pose similar challenges to state regulators' resources and expertise. Therefore, it is essential that state insurance regulators have the tools necessary to enforce new requirements on Blues plans and other health insurers.

Although health care reform may level the playing field by eliminating the competitive disadvantage that contributed to the financial problems of

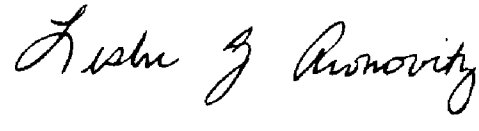
some Blues plans, reform could also change the health insurance industry in ways that strain the finances of any plan, particularly those currently in weak financial condition. While the financial condition of Blues plans appears stable at present, health care reform will likely require Blues plans to more quickly adjust to increased competition, changing market conditions, and customers' needs—an adjustment that has in the past been difficult for some plans and contributed to their financial problems.

We obtained written comments from the Blue Cross and Blue Shield Association on a draft of this report. (App. VI contains the Association's letter and our comments.) The Association generally agreed with our findings concerning plan financial weaknesses and their causes, but disagreed with our assessment of the Association's new surplus requirements and our conclusion that conflicts in the Association's trademark licensing role may hinder its enforcement of plan membership standards. We have reviewed the Association's comments and made changes to this report where appropriate.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Association, its 69 member plans, the NAIC, state insurance commissioners, and other interested parties. Copies will also be made available to others on request.

Please call me on (202) 512-7119 if you or your staff have any questions about this report. Major contributors are listed in appendix VII.

Sincerely yours,



Leslie G. Aronovitz
Associate Director
Health Financing Issues

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Abbreviations

BSCA	Business Systems Corporation of America
CEO	chief executive officer
CSC	Capital Services Corporation
HMO	health maintenance organization
ITS	Inter-plan Teleprocessing System
NAIC	National Association of Insurance Commissioners
NASCO	National Account Service Company
PIF	Plan Investment Fund
PLIC	Plan Liability Insurance Company
PPO	preferred provider organization

Scope and Methodology

The purpose of this report, based on discussions with staff of the Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs, was to (1) determine the extent of financial weaknesses among Blues plans; (2) identify factors that contributed to plans' weak financial conditions; and (3) determine the measures taken by plans, the Association, and regulators to address plan weaknesses. This report also discusses the implications of health care reform on Blues plans.

To determine the extent of financial weaknesses among Blues plans, we (1) obtained Weiss Research, Inc.'s ratings of Blues plans based on plan data as of June 30, 1993; (2) reviewed proprietary Association information on the performance and financial condition of the 11 plans identified as weak or very weak by Weiss; (3) reviewed information from the congressional investigations of Blues plans in West Virginia, Maryland, Washington, D.C., and New York (Empire); and (4) interviewed officials at six individual Blues plans (Blue Cross and Blue Shield of Illinois, Massachusetts, Michigan, New Jersey, and Oregon, and Blue Cross of California), and their respective state regulators.

We visited six Blues plans that differed in financial performance, regulatory environment, size, types of products offered, and location to obtain a clear understanding of the unique markets in which individual Blues plans operate and the varying roles they play in them. Blue Cross and Blue Shield of Massachusetts and New Jersey are currently experiencing financial weaknesses while the other four are not. However, the plans in California, Illinois, and Michigan have previously experienced financial weaknesses. The Blues plan in Oregon has historically been financially sound.

To identify factors that contributed to plans' weak financial conditions, we (1) interviewed state regulators and officials from the National Association of Insurance Commissioners, the Association, and individual plans; (2) reviewed three management audits of financially weak plans; and (3) reviewed data from congressional investigations of troubled Blues plans in three states and the District of Columbia. The three management audits we reviewed were conducted between 1988 and 1993 by the private consulting firms of Ernst & Whinney, Cresap-Tillinghast, and Arthur Andersen. These audits, requested by state regulators, examined the financial and operating performance of Blues plans in New Jersey, Massachusetts, and New York (Empire), respectively.

We also surveyed insurance regulators in every state and the District of Columbia to obtain information on the oversight of Blues plans and commercial insurers. Between April and July 1993, we used a structured telephone interview to obtain information on each state's regulations for health insurers. This included information on premium rate and coverage requirements, limitations on pre-existing condition exclusions, and surplus and capital requirements. Through these telephone interviews, we determined each state's regulatory activities as of December 1991. We also obtained information about any regulations that were implemented by December 1993 because of state health reform initiatives.

To determine the measures taken by plans, the Association, and regulators to address plan weaknesses, we (1) reviewed the Association's reform proposals and discussed them with Association officials; (2) reviewed the Association's financial membership standard and guidelines for monitoring plans' compliance with this standard; and (3) interviewed individual plan officials, state regulators, and NAIC representatives. Interviewers asked questions about the response of plans and the Association to the financial problems of individual Blues plans, the Association's reform initiatives, and the implementation of health insurance reforms in certain states.

To understand the Association's role, we (1) reviewed current and historic literature on the origin and evolution of plans and the Association, including academic studies and trade journal articles; (2) obtained an overview of the Association's functions and related Association documents; and (3) discussed each plan's evolution and its relationship to the Association with officials at the six plans we visited.

To determine the implications of health care reform on Blues plans, we (1) reviewed the Administration's and other health care reform proposals; (2) reviewed industry outlooks from insurance rating services, including A.M. Best and Standard and Poor's; and (3) discussed health care reform with Association officials, individual plans, and some state regulators.

We conducted our review from November 1992 through December 1993 in accordance with generally accepted government auditing standards.

Role of the Blue Cross and Blue Shield Association

The role of the Association and its impact on the operation and finances of Blues plans has recently been scrutinized by state insurance regulators and congressional investigators. As part of its ongoing evaluation of the adequacy of state laws and regulations over Blues plans, the National Association of Insurance Commissioners has also raised questions about the Association's relationship to individual Blues plans. This appendix describes the Association's purpose, governance, revenue sources, and oversight of individual Blues plans and provides an overview of the affiliated corporations owned jointly by the Association and plans.

Purpose

The Blue Cross and Blue Shield Association is the national trade association and coordinating agency of the 69 independent Blues plans and the owner and licensor of the Blue Cross and Blue Shield names and trademarks. The Association performs three primary roles—those of a trademark licensor, a trade association, and provider of various business and coordinating plan services.

As a trademark licensor, the Association acts to protect the value of the Blue Cross and Blue Shield names and trademarks by requiring plans to comply with terms of a license agreement. The agreement defines the geographic boundaries within which plans may use the names and trademarks and the conditions of that usage. As a trade association, the Association represents the collective interests of plans before the federal and state governments and certain other national organizations. As a plan service provider, the Association administers programs designed to coordinate plan coverage nationwide for private business and government contracts and provides consulting services to individual plans.

The Association has no authority to regulate Blues plans' compliance with state insurance laws. This regulatory authority rests with each state. Further, the Association is not an insurance company and is therefore accountable neither to insurance regulators nor plan subscribers.

Governance

The Association, headquartered in Chicago, is an Illinois not-for-profit corporation that employed 677 people as of December 1993. The Association's members include the 69 Blues plans located in the United States and Puerto Rico. As members of the Association, Blues plans collectively govern the Association's affairs pursuant to written bylaws. Under these bylaws, the Association is governed by a board of directors. The board of directors consists of the CEOs of most plans and the

Association president. Plan representatives to the membership meetings may or may not be the plan CEO.[1] For practical purposes, meetings of the Association's board of directors and its membership comprise largely the same individuals.[2] The board of directors meets at least four times annually, while meetings of the members are held at least once each year.[3]

The Association's board annually elects a chairman and officers of the Association, while the membership elects the board's executive committee. The executive committee comprises the chairman of the board, the president of the Association, and 24 members and acts on behalf of the board of directors when the board is not in session. The chairman of the board, a plan CEO, is the only Association officer who is also a Blues plan employee. The executive committee establishes compensation levels for Association officers.

The board also appoints members to standing committees that oversee the Association's activities in specific areas. Organizational units of the Association directly support these committees. For example, the Association's Licensure and Financial Services Division monitors Blues plans' compliance with the membership standards and reports directly to the board's Plan Performance and Financial Standards Committee, which makes recommendations to the board on plan licensure decisions.

Decisions on significant issues relevant to all plans are generally decided by a vote of the Association membership. Examples of significant issues include the termination of a plan's membership license or the amendment of the Association's bylaws. The membership voting process combines a straight vote—one member, one vote—and a weighted vote. Under weighted voting, each member plan is entitled to one vote for each $1,000 of annual dues it pays to the Association. Because dues are based on plan premium volume, the larger plans receive a greater number of weighted votes than smaller plans.

For a membership vote to pass, the bylaws generally require a majority of both the straight and weighted votes of the members. However, this rule has exceptions. For example, the termination of a plan's trademark license

[1]In addition to regular member plans domiciled in the United States, the membership includes Associate and Affiliate member plans domiciled outside of the United States that do not fully participate in the Association's coordinating programs. Associate members retain membership voting rights but do not have a representative on the board of directors. Affiliate members have no voting rights.

[2]The difference between the board of directors and the membership was more significant before 1991 because the Board had a much smaller number of CEOs.

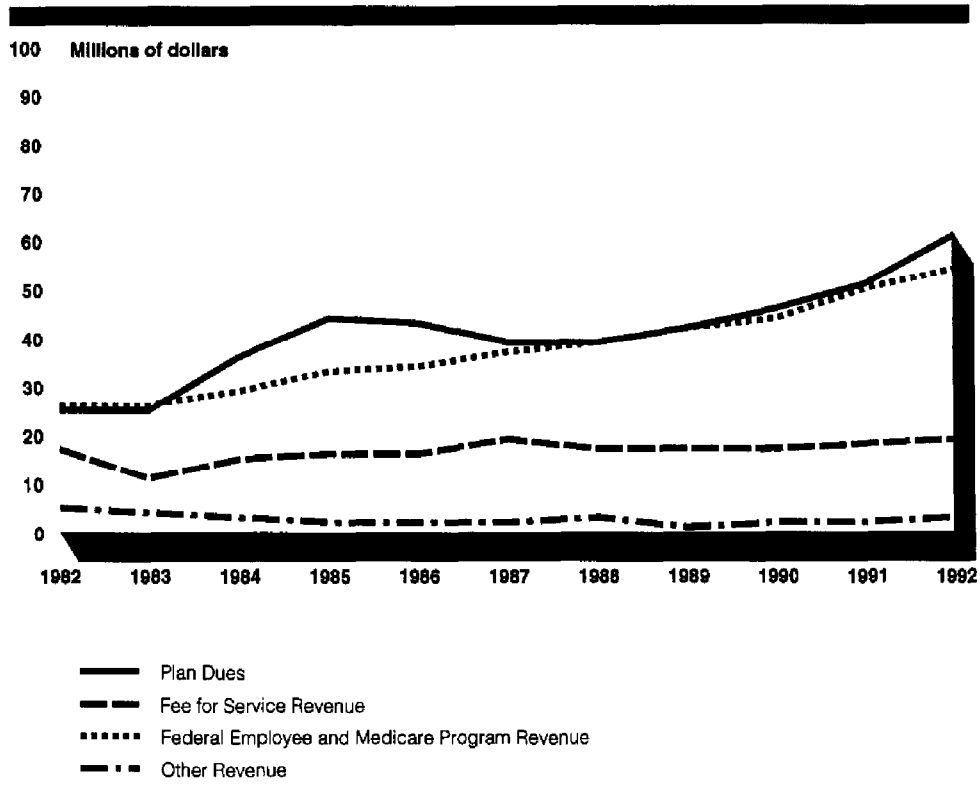
[3]Members of the board of directors are not compensated for their time, but may be reimbursed for expenses incurred while attending board meetings.

requires at least three-fourths of the straight vote and three-fourths of the weighted vote rather than a simple majority. An amendment to the Association bylaws, on the other hand, requires one-half of the straight vote and two-thirds of the weighted vote.

Association Revenue

The Association's revenue comes primarily from plan membership dues, fees from its administration of government programs, and fees from consulting and individual plan services. In 1992, total Association revenue was $137 million. From 1982 through 1992, about 59 percent of the Association's revenue was generated by member plans—42 percent from membership dues and 17 percent from consulting and other service fees. During the same period, about 39 percent of the Association's revenue came from its administration of contracts under the Medicare and Federal Employee Health Benefits programs. Figure II.1 shows Association's annual revenue by source from 1982 through 1992.

Figure II.1: Association Revenue



Source: Blue Cross and Blue Shield Association.

The Association determines the funding level necessary to accomplish its objectives through an annual budgeting process. The process starts when the Association's president outlines the objectives of the Association for the upcoming year. Division directors then develop plans and budgets consistent with the corporate priorities established by the president. After consulting with the directors, the president formulates an operating plan and budget and submits the package for approval first to the executive committee, then to the board of directors, and finally to the plan membership.

Once the annual budget is adopted by the membership, dues assessments are calculated for each plan using a formula with a graduated scale based on revenues from insurance premiums and other business. Dues represent

a relatively minor expense for plans. In 1992, all plans paid dues that were much less than 1 percent of their net subscription revenue.[4]

Association Authority Over Plan Operations

Although Blues plans are independent corporations, they are bound by terms of the license agreement with the Association. This section summarizes key terms of the license agreement.

License Agreement

To use the Blue Cross and Blue Shield names and trademarks, each Blues plan must sign a license agreement with the Association. The agreement does not constitute a partnership or joint venture, and the Association has no obligations for the debts of member plans.

The license agreement restricts plans from using the trademark outside their prescribed service area to prevent competition among plans using the Blue Cross and Blue Shield names and trademarks. Use of the trademark is also restricted to nonprofit health care plans or mutual health insurers acting on a not-for-profit basis in the sale, marketing, and administration of health care services. The agreement does not restrict plans from engaging in any lawful business activity itself or through a subsidiary that does not use the Blue Cross and Blue Shield trademarks.

A plan's subsidiary or affiliate may also use the trademarks if the plan obtains a controlled affiliate license from the Association. A controlled affiliate license may be granted to Blues plans for any health care plan or related service organization, as long as it does not violate its controlled affiliate license agreement. Plan affiliates and subsidiaries may be for-profit or nonprofit but must be controlled by the plan.

A plan must remain a member in good standing of the Association by (1) paying its dues, (2) complying with the membership standards and all applicable laws, and (3) permitting the Association to inspect its records.

The Association can seek judicial enforcement of the license agreement or terminate a plan's license if it fails to comply with the terms of the agreement or for other reasons is determined to threaten the reputation of all Blues plans. Under these circumstances, license termination requires a three-fourths weighted and three-fourths straight vote of the Association membership. Termination is to be automatic under certain other

[4]Net subscription revenue is defined as premiums less all applicable premium taxes.

circumstances, such as a plan's bankruptcy, receivership, nonpayment of dues, or the assumption of plan control by state regulators.

Membership Standards

All plans must adhere to membership standards as required by the license agreement. These standards may be revised only by a three-fourths straight and three-fourths weighted membership vote. The 10 standards in effect during 1993 are summarized below.

- Standard 1: Not-for-Profit Operation—A plan must be organized and operated on a not-for-profit basis.
- Standard 2: Board Control—A plan's board of directors must have a majority of members who are not health care providers and adopt policies that set forth the director's fiduciary responsibilities.
- Standard 3: Reports and Records—A plan must provide the Association with timely and accurate reports and records related to compliance with the membership standards.
- Standard 4: Financial Responsibility—A plan must maintain adequate financial resources to protect subscribers and to meet its financial obligations.
- Standard 5: Availability of Cost-Effective Health Care Services—A plan must use its best efforts to contract with cost-effective providers of health care services.
- Standard 6: Responsiveness to Customers—A plan must be responsive to customer needs and requirements by meeting minimum enrollment trends and service levels and offering a managed care product in certain metropolitan areas.
- Standard 7: Participation in National Programs—A plan must participate in national programs that provide portability of membership between Blues plans and ease claims processing for customers that receive benefits outside of its service area.
- Standard 8: Financial Performance Requirements—A plan must ensure that it can meet its financial commitments under national programs.
- Standard 9: Certain Disclosures—A plan must disclose to third parties information related to its financial condition and the independent nature of each Blues plan.
- Standard 10: Cooperation With the Monitoring Program—A plan must cooperate with the Association's monitoring program and address performance problems identified by the Association.

Plan Performance Monitoring Program

The Association obtains financial and other performance information from all plans on a quarterly basis that it uses to identify plans having

performance problems. Plans that fail certain performance thresholds may be placed in a monitoring program and subjected to increasing levels of scrutiny. The monitoring program provides the Association with a method of identifying plans with performance problems so that the Association can act to protect the value of the trademarks.

Plans in the monitoring program are generally required to submit a recovery plan to the Plan Performance and Financial Standards Committee of the Association's board for approval. Once approved, each plan's performance is to be monitored against the terms of its recovery plan until performance exceeds the thresholds and the plan is removed from the monitoring program. If necessary, the Association or other Blues plans may provide financial or management assistance to a troubled plan, although they have no legal obligation to do so. In addition, the Association may directly contact a plan's board of directors or its state insurance regulators to seek resolution.

Coordinating Programs

All plans must participate in certain programs to coordinate the coverage of Blues plans nationwide as required under membership standard 7. This section provides an overview of each program.

Inter-plan Service Benefit Bank and Reciprocity

The Inter-plan and Reciprocity programs facilitate the processing of claims when Blues subscribers travel and receive medical care outside their plan's service area. The programs are intended to enhance the portability of benefits, simplify claims processing, and expand access for all Blues subscribers to the provider discounts negotiated locally. The programs work as follows.

When Blues subscribers travel outside of their "home" plan's service area and receive medical care, they present their Blues card to providers who generally honor it as though it were issued by the local Blues plan. These providers submit claims directly to the local or host plan, which then pays the claim according to the contract between the home plan and the subscriber. Through a financial clearinghouse, the host plan then is reimbursed by the home plan for the cost of the claim plus an administrative allowance. Under these programs, the Association functions primarily as the financial clearinghouse and performs all accounting functions necessary for the bimonthly settlement and transfer of funds between home and host plans. It also operates the inter-plan data telecommunications link that allows plans to exchange information.

The Inter-plan and Reciprocity programs will be replaced by the Out-of-Area program in 1994. The Out-of-Area program will serve the same objectives and, according to the Association, include a number of technological and procedural changes to improve the flow of funds and information among plans. Under this program, accounts will be settled daily, and an independent financial institution rather than the Association will perform the financial clearinghouse functions.

Inter-plan Teleprocessing System

The Inter-plan Teleprocessing System (ITS) is a combination of operations, procedures, and technical systems that facilitates the exchange of information necessary for plans to carry out inter-plan activities. ITS is designed to interface with each plan's information systems and its membership, claims processing, customer service, and managed care functions, linking the functions and systems in any one plan to the corresponding functions and systems in every other plan. ITS will serve as the primary data system for the Out-of-Area program.

Uniform Identification Card Program

This program was developed to foster consistency in the appearance and content of Blues subscriber identification cards. All cards that use the Blue Cross and Blue Shield names and symbols must adhere to rules pertaining to the use of account- or plan-specific identification codes and the proper use of the Blues names and symbols.

Inter-plan Transfer Agreement

This program establishes a mechanism for transferring the membership of subscribers who move permanently to an area served by another Blues plans. Under the program, continuity of coverage is provided to subscribers through requirements that all plans offer certain minimum benefits and limits on the nature and extent of coverage restrictions (such as pre-existing condition clauses) that plans may impose.

Inter-plan Data Reporting Program

The Inter-plan Data Reporting program is a national reporting network designed to facilitate data reporting and analysis for Blues plans' national accounts.[5] The system is based on software developed and licensed by the Association.

[5]A national account is a contract for a Blues plan to provide health insurance for a business's employees, even though the employees are located in at least one other plan's service area. On a voluntary basis, plans agree to share with the primary contracting plan in the risk of insuring these individuals. A plan may choose not to participate in a national account but is required by the license agreement to forward claims from employees in its service area to the contracting plan in return for a transaction fee.

National Account Equalization Program	This program provides a model formula plans can use to allocate the gains, losses, and administrative expenses of national account business among control plans and other participating plans.
Central Certification Program	For certain large national accounts with geographically dispersed members, this program provides a mechanism for participating plans to determine eligibility of employee claims without maintaining eligibility files on each employee. It was discontinued as a mandatory participation program after March of 1994 because of its limited usefulness.

System Affiliates

The Association and various Blues plans jointly own and control six affiliated stock corporations. The affiliates are for-profit corporations whose stock is held by the Association and various Blues plans. They were created to perform services for plans that the Association itself cannot or does not perform. Profits generated by the affiliates are returned to the Association and plans that share in their ownership.

BCS Financial Corporation

BCS Financial is an insurance holding company. Its two insurance subsidiaries provide insurance and insurance services to Blues plans, including reinsurance and health, life, and property and casualty insurance. A subsidiary of BCS Financial was recently formed to contribute $60 million to the Washington, D.C., Blues plan. BCS Financial is owned by the Association and 55 Blues plans. Its 1992 gross revenues were $105.7 million.

Business Systems Corporation of America (BSCA)

BSCA is a software development and support company that also provides fee-for-service consulting. Its primary product is a comprehensive business information system for subscribers, claims, and financial processing that is currently licensed to 14 Blues plans. BSCA is owned by the Association and nine Blues plans. Its gross revenues in 1992 were $9.8 million.

Health Plans Capital Services Corporation (CSC)

CSC is a finance cooperative that makes direct loans to Blues plans, assists Blues plans in obtaining funds from other sources, administers plan investments, and provides financial and related consulting services. CSC is owned by the Association, BCS Financial, and 24 Blues plans. At year-end 1992, CSC managed $60.2 million in assets.

National Account Service Company (NASCO)

NASCO operates a central processing system that is linked to selected Blues plans by a telecommunications network. Developed by Electronic Data Systems Corporation, this technology allows plans to coordinate the health benefits of employees of certain national accounts nationwide. NASCO's processing services include subscribers, claims, customer service, client reporting, and managed care support. NASCO is owned by the Association and five Blues plans. Its 1992 gross revenues were $66.5 million.

Plan Investment Fund (PIF)

PIF is a Security and Exchange Commission-registered Maryland corporation created in 1985 to provide investment services to Blues plans. It is a management investment company that administers a money market portfolio and a short-term investment portfolio. PIF is owned by the Association and about 50 Blues plans. At year-end 1992, PIF managed $586.2 million in assets.

Plan Liability Insurance Company (PLIC)

PLIC is an Ohio-based insurance corporation formed in 1986 to provide property/casualty and general liability insurance to plans and to reinsure a portion of the coverage written by BCS Insurance. It is owned by the Association, BCS Financial, and more than 40 Blues plans. Its 1992 gross revenues were $4.6 million.

Differences Among Blues Plans

Our study found that Blues plans differ considerably in organization, operations, and regulation.

For example, plans operate within different legal contexts. As of May 1993, 54 plans were regulated pursuant to special enabling statutes, 14 as mutual insurers, and 2 as not-for-profit stock insurers (see column 1 of table III.1). Enabling statutes often prescribe a unique role for Blues plans that may set them apart from commercial insurers, while others, especially those organized as mutual insurers, are generally regulated the same way as commercial health insurers.

To varying degrees, plans perform a community service role by covering all applicants, regardless of health status, or by basing premiums on the average expected costs of the applicant pool. As shown in column 6 of table III.1, 30 plans were required to offer coverage to all applicants through open enrollment provisions in 1993, while 7 plans did so voluntarily. Column 7 of the table indicates that, in 1993, 32 plans were limited in their ability to adjust premium rates by applicant. Further, 24 plans were required to participate in their state life/health guaranty funds as of June 1993 (see column 4).[1]

Plans also differ considerably in their size, market share, and the extent of their managed care business. For example, Empire had about 7 million subscribers compared to 78,000 subscribers for the Blues plan in Wyoming (see column 2). Similarly, Blue Shield of California had only a 4.9 percent share of its health insurance market, while the Blues plans in Rochester, New York, had a 73 percent share (see column 3). Further, about 90 percent of the Minnesota Blues Plan's and Blue Cross of California's business was in managed care, while the Blues plans in Arkansas, Idaho, and Wyoming offered no managed care products.

[1]The Association recently revised its financial membership standard to include a requirement that all Blues plans must, by December 31, 1994, guarantee the payment of claims liabilities and the continuation of coverage in case of an insolvency. This standard may be met through participation in the state guaranty fund or through some other method approved by the Association.

Table III.1: Differences Among Blues Plans

Plan name	(1) Enabled (E) or mutual (M) 5/1/93	(2) Number of enrollees 6/30/93	(3) Market share (%) 6/30/93	(4) Member of state guaranty fund 6/93	(5) Managed care (%) 6/30/93	(6) Required (R) or voluntarily offer (V) open enrollment[a]		(7) Apply pure (P) or limited (L) community rating methods[a]	
						91[b]	93[c]	91[b]	93[c]
BC/BS of Alabama	E	2,008,773	44.4	No	75.7	V			
Arkansas BC/BS	M	372,064	15.7	Yes	0.0				
BC/BS of Arizona	E	413,199	10.4	No	83.5				
BC of California	E	2,712,233	8.4	No	88.2		R		
BS of California	E	1,569,940	4.9	No	74.6		R		
BC/BS of Colorado[d]	E	553,975	8.7	No	48.1			L	L
BC/BS of Connecticut	M	890,804	26.6	Yes	20.9	R[e]	R[e]	L	L
BC/BS of the National Capital Area	E[f]	920,818	29.4	Yes	64.4	[g]	V	[g]	
BC/BS of Delaware	E	213,315	32.2[h]	No	18.0[h]				
BC/BS of Florida	M	1,759,620	12.5	Yes	81.2		R		L
BC/BS of Georgia	E	1,171,425	17.0	No	23.7				
BC/BS of Hawaii	E	621,727	53.7	No	58.0	R	R	[i]	[i]
IASD Health Services Co.[j]	M	1,020,568	29.7	Yes	40.2		R[e]		L
BC of Idaho Health Service	E	241,222	23.7	No	6.2		R[e]		L
BS of Idaho	E	242,251	23.3	No	0.0		R[e]		L
BC/BS of Illinois	M	2,487,614	21.0	Yes	59.6				
BC/BS of Indiana	M	1,197,470	19.6	Yes	28.7				
BC/BS of Kansas	M	749,793	38.2	Yes	33.3		R[e]		L
BC/BS of Kentucky	M[k]	894,756	24.1	Yes	52.1				
BC/BS of Louisiana	M	360,280	8.7	No	20.0				
BC/BS of Massachusetts	E	2,101,523	33.5	No	34.5	R	R	P	P
BC/BS of Maryland	E	1,289,840	35.2	Yes	58.0	V	V	L	L
BC/BS of Maine	E	383,397	30.2	No	3.6	V	R		L
BC/BS of Michigan	E	4,622,817	49.0	No	22.4	R	R	P	P
BC/BS of Minnesota	E	1,145,874	24.3	Yes	91.1		R	L	L
BC/BS of Kansas City (MO)	E	300,266	15.4	Yes	77.3				
BC/BS of Missouri	E	806,821	20.0	Yes	65.5				
BC/BS of Mississippi	E	417,150	16.2	No	14.5				
BC/BS of Montana	E	206,157	26.1	No	11.0				
BC/BS of Nebraska	M	395,830	25.1	Yes	19.2				
BC/BS of Nevada[d]	E	[d]	[d]	No	[d]				

(continued)

Plan name	(1) Enabled (E) or mutual (M) 5/1/93	(2) Number of enrollees 6/30/93	(3) Market share (%) 6/30/93	(4) Member of state guaranty fund 6/93	(5) Managed care (%) 6/30/93	(6) Required (R) or voluntarily offer (V) open enrollment[a]		(7) Apply pure (P) or limited (L) community rating methods[a]	
						91[b]	93[c]	91[b]	93[c]
BC/BS of New Hampshire	E	265,542	22.5	No	0.0	R	R	L	L
BC/BS of New Jersey	E	1,944,600	24.6	Yes	5.4	R	R	L	P
BC/BS of New Mexico[d]	E	[d]	[d]	No	[d]				
BC/BS of Western New York, Inc.	E	892,863	55.7	No	18.0	R	R	P	P
Empire BC/BS (NY)	E	6,968,697	46.8	No	3.7	R	R	P	P
BC and BS of the Rochester Area (NY)[l]	E	802,101[l]	72.9[l]	No	56.0[l]	R	R	P	P
BC/BS of Central NY	E	630,939	51.2	No	5.7	R	R	P	P
BC/BS of Utica-Watertown (NY)	E	292,144	31.8	No	3.3	R	R	P	P
BC/BS of North Carolina	E	1,680,156	24.4	No	26.9	V	R	L	L
BC/BS of North Dakota	E	350,644	57.0	Yes	2.3				
Community Mutual BC/BS (OH)	M	1,453,348	[m]	Yes	[m]				
BC/BS of Ohio	M	1,292,012	[m]	Yes	[m]				
BC/BS of Oklahoma	E	276,996	8.9	No	66.6				
BC/BS of Oregon	E	994,534	33.5	No	64.0		R[e]		
Pennsylvania BS	E	6,152,410	51.4	No	11.8	V	V	P	P
Capital BC (PA)	E	1,443,900	47.0	No	6.7	V	V	P	P
Independence BC (PA)	E	1,980,155	52.3	No	19.6	V	V	P	P
BC of Western Pennsylvania	E	2,565,011	62.7	No	6.0	V	V	P	P
BC of Northeastern Pennsylvania	E	653,453	59.3	No	8.6	V	V	P	P
La Cruz Azul de Puerto Rico	E	543,390	15.1	No	20.7	[m]	[m]	[m]	[m]
Triple-S (PR)	[n]	467,518	13.0	Yes	0.0	[m]	[m]	[m]	[m]
BC/BS of Rhode Island	E	536,544	52.5	No	41.0	V	R[e]	P	P
BC/BS of South Carolina	M	813,673	22.3	Yes	75.2				
South Dakota BS	E	121,443	17.4	No	4.1			L	L
BC/BS of Tennessee	E	1,350,220	33.5	No	75.2		R[e]		
BC/BS of Memphis (TN)	E	241,986	25.3	No	80.6		R[e]		
BC/BS of Texas	E	1,131,625	6.2	Yes	12.2				
BC/BS of Utah	E	451,725	25.2	Yes	15.4				
BC/BS of Virginia	M	1,669,797	30.5	Yes	28.1	R	R	L	L
BC/BS of Vermont	E	172,987	29.7	No	2.0	R	R	P	P
BC of Washington and Alaska	E	570,224	9.5	No	65.1				
King County Medical BS (WA)	E	782,744	36.9	No	60.0				
Washington Physicians Service	[n]	131,296	12.7	No	30.4				

(continued)

Plan name	(1) Enabled (E) or mutual (M) 5/1/93	(2) Number of enrollees 6/30/93	(3) Market share (%) 6/30/93	(4) Member of state guaranty fund 6/93	(5) Managed care (%) 6/30/93	(6) Required (R) or voluntarily offer (V) open enrollment[a]		(7) Apply pure (P) or limited (L) community rating methods[a]	
						91[b]	93[c]	91[b]	93[c]
Medical Service Corp. of Eastern Washington	E	241,612	37.1	No	53.8				
Pierce County Medical Bureau (WA)	E	163,256	26.0	No	76.7				
Mountain State BC/BS (WV)	E	264,344	15.2	Yes	7.0			L	L
BC/BS United of Wisconsin	E	376,242	7.5	No	23.4		R[e]		
BC/BS of Wyoming	E	78,020	17.9	No	0.0		R[e]	L	L

(Table notes on next page)

[a]These coverage requirements and rating methods only apply to individual or small employer group insurance products. Under open enrollment, plans accept all applicants for coverage, regardless of their health status, prior claims experience, or demographic factors. In pure community rating, the plans are not permitted to use any factors, including geography, age, gender, industry, health status, or actual claims experience to adjust premium rates. Plans that must apply limited community rating methods cannot use health status nor actual claims experience to adjust premium rates.

[b]12/31/91.

[c]12/31/93.

[d]The Blues plans in Colorado, New Mexico, and Nevada are affiliated. Therefore, the Association combines statistics from the three plans under the name Rocky Mountain Health Care Corporation.

[e]Due to small employer insurance reform legislation, all insurers are required to guarantee access to small employer groups for a minimum benefits plan designed by the state.

[f]Blue Cross and Blue Shield of the National Capital Area is a congressionally chartered health service corporation.

[g]Blue Cross and Blue Shield of the National Capital Area was not subject to regulation by the District of Columbia insurance department until February 1993. Before that time, the plan was regulated jointly by insurance regulators in Virginia and Maryland.

[h]Data from year-end 1992 were the most recent available.

[i]The Hawaii department of insurance does not review the plan's premium rate filings. According to a survey conducted by the Blue Cross Blue Shield Association, BC/BS of Hawaii does not use the following factors to adjust rates: geography, age, gender, or industry/occupation.

[j]IASD Health Services is one corporation that does business under two trade names: Blue Cross Blue Shield of Iowa and Blue Cross of South Dakota.

[k]On July 1, 1993, the plan reorganized as a health maintenance organization to merge with BC/BS of Indiana.

[l]Blue Cross of the Rochester Area and Blue Shield of the Rochester Area are affiliated organizations. Therefore, the Association combines their statistics when compiling its quarterly reports.

[m]Data were not available for this plan.

[n]The Blues plan is organized as a stock insurer.

Sources: Columns 1,6,7: GAO State Health Insurance Telephone Survey (1993).
Columns 2,3,5: Association Report: Plans' Enrollment Results at March 31, 1993.
Column 4: Association's Legal Affairs Bulletin, June 1993.

State Regulation of Blues Plans

To obtain information about the regulation of health insurers and to determine what differences, if any, existed in the regulation of Blues plans and commercial insurers, we conducted a telephone survey of insurance regulators in the 50 states and the District of Columbia.[1] We also used information collected from a prior GAO survey of state insurance officials.[2] The information collected from these two surveys was organized according to the rate-setting and coverage requirements placed upon Blues plans or commercial insurers (see tables IV.1 and IV.2).[3]

States placed the following types of rate-setting requirements on Blues plans or commercial insurers.

- Prior rate approval: Insurance departments required insurers to submit detailed rate filings that were reviewed by the department. Blues plans and commercial insurers could not use the rates until approved by the insurance department.
- Actuarial memorandum: Insurance departments required Blues plans and commercial insurers to submit actuarial data that justified their rates. These data, certified by a qualified actuary, usually included the expected morbidity for the anticipated or currently insured applicant pool.
- Public hearings: Insurance departments subjected Blues plans' rate filings to public hearings, but not those of commercial insurers. During these hearings, citizens could express their opposition to the requested premium rate. Some regulators reduced or disapproved the plans' rate filings due to this highly publicized review process.
- Pure community rating: Insurance departments required the Blues plans, but not commercial insurers, to establish premium rates based on pure community rating.[4] Each applicant was charged the same rate for the same type of coverage. The rate charged could not be adjusted on a per applicant basis using age, sex, geography, industry, health status, or actual claims experience.
- Limited rating adjustment factors: Insurance departments did not permit Blues plans and commercial insurers to adjust an applicant's community

[1]The methodology for our telephone survey of state insurance regulators is discussed in appendix I.

[2]The results of GAO's questionnaire survey of insurance department officials in the 50 states and the District of Columbia appear in Health Insurance Regulation: Wide Variation in States' Authority, Oversight, and Resources (GAO/HRD-94-26, Dec. 27, 1993). All but one state responded to the questionnaire.

[3]These rate-setting and coverage requirements only apply to individual or small employer group insurance products.

[4]Premium rates that were established using pure community rating were based on the average expected health care utilization of the applicant community.

rate using health status or actual claims experience. However, insurers could adjust the premium rate using the applicant's age, sex, geography, and occupation or industry.

States placed the following two coverage requirements on Blues plans or commercial insurers:

- open enrollment—insurance departments required insurers to accept all applicants for coverage throughout the year or during specific time periods and
- guaranteed renewal—regulators required insurers to renew lapsing health insurance policies at the request of the policyholders regardless of their health status or use of health services.

Table IV.1 shows state rate-setting and coverage requirements for Blues plans.[5] Plans are grouped by the total number of state requirements that they were subject to and then organized alphabetically by state within each group.

[5]Blue Cross and Blue Shield of the National Capital Area is not included because the District of Columbia insurance department did not have regulatory authority over the plan until February 1993. The two plans located in Puerto Rico are not included either.

Table IV.1: State Regulatory Requirements for Blues Plans (as of 12/31/91)

		RATE-SETTING					COVERAGE		
							Required open enrollment		
	Plan	Required prior rate approval[a]	Required actuarial memorandum[b]	Required public hearing[c]	Required pure community rating[d]	Required limited rating adjustment factors[e]	Year-round	Partial	Required guaranteed renewal
MA	**Boston**	**X**	**X**	**X**	**X**			**X**	**X**
NY	**Buffalo**	**X**	**X**	**X**	**X**		**X**		**X**
NY	**New York City**	**X**	**X**	**X**	**X**		**X**		**X**
NY	**Rochester BC**	**X**	**X**	**X**	**X**		**X**		**X**
NY	Rochester BS	X	X	X	X		X		X
NY	Syracuse	X	X	X	X		X		X
NY	Utica	X	X	X	X		X		X
CT	North Haven	X	X			X	X		X
MI	Detroit		X		X	X	X		X
NJ	**Newark**		**X**	**X[f]**		**X**	**X**		**X**
NH	**Concord**	**X**	**X**			**X**	**X**		
SD	Sioux Falls	X	X			X			X
VA	Richmond		X			X	X		X
VT	**Montpelier**		**X**		**X**		**X**		**X**
WV	**Parkersburg**	**X**	**X**			**X**			**X**
CO	Denver		X			X			X
PA	Camp Hill	X	X		X				
PA	Harrisburg	X	X		X				
PA	Philadelphia	X	X		X				
PA	Pittsburgh	X	X		X				
PA	Wilkes Barre	X	X		X				
RI	Providence		X	X	X				
TN	Chattanooga		X	X					X
TN	Memphis		X	X					X
AZ	Phoenix	X	X						
ID	Boise		X						X
ID	Lewiston		X						X
MD	**Baltimore**		**X**			**X**			
ME	**Portland**		**X**	**X**					
MN	St. Paul		X			X			
NC	Durham		X			X			
NE	Omaha	X	X						
NM	Albuquerque		X						X

(continued)

		RATE-SETTING					COVERAGE		
							Required open enrollment		
	Plan	Required prior rate approval[a]	Required actuarial memorandum[b]	Required public hearing[c]	Required pure community rating[d]	Required limited rating adjustment factors[e]	Year-round	Partial	Required guaranteed renewal
OR	Portland	X	X						
SC	Columbia		X						X
TX	Dallas		X						X
AL	Birmingham		X						
AR	Little Rock		X						
CA	San Francisco								X
FL	Jacksonville		X						
HI	Honolulu						X		
IA	Des Moines		X						
IN	Indianapolis		X						
KS	Topeka		X						
KY	Louisville		X						
MS	Jackson	[g]	X						
ND	Fargo		X						
NV	Reno		X						
OH	Cincinnati		X						
OH	Cleveland		X						
UT	Salt Lake City		X						
WI	Milwaukee		X						
WY	Cheyenne					X			
CA	Woodland Hills								
DE	Wilmington								
GA	Atlanta								
IL	Chicago								
LA	Baton Rouge								
MO	Kansas City								
MO	St. Louis								
MT	Helena								
OK	Tulsa								
WA	King								
WA	Seattle								
WA	Spokane								
WA	Tacoma								
WA	WPS								

(Table notes on next page)

Financially weak plans appear in boldface type.

These rate-setting and coverage requirements only apply to individual or small employer group insurance products. Blue Cross and Blue Shield of the National Capital Area is not included because the District of Columbia insurance department did not have regulatory authority over the plan until February 1993.

[a]Prior approval was determined by insurance department review of first-time or change rate filings. The rate filing could be used only after the plan received notice from the department, and for most plans there was no specified time limit in which the department had to notify the plan.

[b]Actuarial memorandum was determined by insurance department review of first-time or change rate filings.

[c]Public hearing was determined by insurance department review of first-time or change rate filings.

[d]Regulators stated that the plans could not use any factors to adjust premium rates on a per applicant basis, including geography, age, gender, industry, health status, or actual claims experience.

[e]Regulators stated that plans could neither use health status nor actual claims experience to adjust premium rates on a per applicant basis.

[f]Although the Department of Insurance had the authority to hold hearings to review rate increases, the Public Advocate also had this authority.

[g]No data available.

Sources: Column 1: GAO State Health Insurance Questionnaire Survey (1991).
Columns 2-7: GAO State Health Insurance Telephone Survey (1993).

Table IV.2: State Regulatory Requirements for BC/BS Plans (BP) and Commercial Insurers (CI) (as of 12/31/91)

	RATE-SETTING										COVERAGE					
	Required prior rate approval[a]		Required actuarial memorandum[b]		Required public hearing[c]		Required pure community rating[d]		Required limited rating adjustment factors[e]		Required open enrollment				Required guaranteed renewal	
											Year-round		Partial			
State	BP	CI	BP	CI	BP	CI	BP	CI	BP	CI	BP	CI	BP	CI	BP	CI
AL			X													
AR			X	X												
AZ	X	X	X	X												
CA															X[f]	
CO			X	X					X	X					X	X
CT	X	X	X	X					X	X	X	X			X	X
DE																
FL			X	X												
GA																
HI											X	X				
IA			X	X												
ID			X	X											X	X
IL																
IN			X	X												
KS			X	X												
KY			X	X												
LA																
MA	**X**		**X**	**X**	**X**		**X**						**X**		**X**	
MD			**X**	**X**					**X**	**X**						
ME			**X**	**X**	**X**											
MI			X	X			X		X		X				X	
MN			X	X					X	X						
MO																
MS	[g]	[g]	X													
MT																
NC		X	X	X					X	X						
ND			X	X												
NE	X	X	X	X												
NH	**X**	**X**	**X**	**X**					**X**		**X**					
NJ			**X**	**X**	**X**[h]				**X**		**X**				**X**	
NM			X	X											X	X
NV			X	X												
NY	**X**	**X**	**X**	**X**	**X**		**X**				**X**				**X**	

(continued)

	RATE-SETTING										COVERAGE					
	Required prior rate approval[a]		Required actuarial memorandum[b]		Required public hearing[c]		Required pure community rating[d]		Required limited rating adjustment factors[e]		Required open enrollment				Required guaranteed renewal	
											Year-round		Partial			
State	BP	CI	BP	CI	BP	CI	BP	CI	BP	CI	BP	CI	BP	CI	BP	CI
OH			X	X												
OK																
OR	X	X	X	X												
PA	X	X	X	X			X									
RI			X	X	X		X									
SC			X	X											X	X
SD	X		X	X					X	X					X	X
TN			X	X	X										X	
TX			X	X											X	X
UT			X	X												
VA			X	X					X		X				X	
VT			**X**	**X**			**X**				**X**				**X**	
WA				X												
WI			X	X												
WV	**X**	**X**	**X**	**X**					**X**	**X**					**X**	**X**
WY									X	X						

(Table notes on next page)

States that contain a financially weak BC/BS plan appear in boldface.

These rate-setting and coverage requirements only apply to individual or small employer group insurance products. The District of Columbia is not included because its insurance department did not have authority for Blue Cross Blue Shield of the National Capital Area until February 1993. Alaska is not included because it did not have a domiciled Blues plan, and U.S. territories are not included as well.

[a]Prior approval was determined by insurance department review of first-time or change rate filings. The rate filing could be used only after the plan or insurer received notice from the department, and for most plans or insurers there was no specified time limit in which the department had to notify them.

[b]Actuarial memorandum was determined by insurance department review of first-time or change rate filings.

[c]Public hearing was determined by insurance department review of first-time or change rate filings.

[d]Regulators stated that the plans could not use any factors to adjust premium rates on a per applicant basis, including geography, age, gender, industry, health status, or actual claims experience.

[e]Regulators stated that plans or insurers could neither use health status nor actual claims experience to adjust premium rates on a per applicant basis.

[f]The California Department of Corporations, which had authority over Blue Shield of California, required the plan to offer guaranteed renewable policies. The California Department of Insurance, which had authority over Blue Cross of California, did not place this requirement on the plan.

[g]No data available.

[h]Although the Department of Insurance had the authority to hold hearings to review rate increases, the Public Advocate also had this authority.

Sources: Column 1: GAO State Health Insurance Questionnaire Survey (1991)
Columns 2-7: GAO State Health Insurance Telephone Survey (1993)

Effect of New Association Surplus Requirements

Partly in response to the insolvency of the West Virginia Blues plan, the Blue Cross and Blue Shield Association announced, in late 1990, its intention to improve its financial oversight of plans by establishing a minimum surplus requirement for all plans and more rigorously enforcing this requirement. The Association developed a new surplus requirement intended to more closely reflect a plan's business risk. However, the new surplus requirement was initially much lower than the previous surplus level that the Association used to determine whether plans were maintaining adequate financial resources to protect plan subscribers. As a result, plans that lacked sufficient financial resources to meet the previous standard now comply with the Association's new surplus requirement. Although the Association intends to gradually increase the minimum surplus requirement, it is not yet clear whether the current requirement is sufficient to protect plan subscribers.

Pre-1991 Minimum Surplus Requirements

Before 1991, the Association used a set of guidelines to evaluate each plan's compliance with its membership standards. The guidelines identified the "minimum acceptable level of performance" that each plan needed to achieve to be considered in compliance with a standard.

The Association's guidelines for the financial responsibility standard stipulated, "A plan shall maintain adequate financial resources to protect the interests of its subscribers." According to the guidelines, the adequate level of financial resources that each plan needed to maintain was a surplus sufficient to pay claims and expenses for 1-1/2 months. If a plan's surplus dropped below this, it was to be considered out of compliance with the financial membership standard and could be placed in the Association's monitoring program, where it was subjected to increased scrutiny and required to submit and implement a recovery plan.

The guidelines in place at this time permitted the Association to terminate the license of a plan only if it (1) was not in compliance for 2 consecutive years and (2) failed to submit and implement a recovery plan. According to Association officials, their authority to terminate a plan's license was unclear because all financially troubled plans submitted and attempted to implement recovery plans. Association officials said that they only had the legal authority to terminate a license if a state regulator was to declare a plan insolvent, as in West Virginia.

New Minimum Surplus Requirements

In 1991, the Association's new minimum surplus requirement took effect. Rather than identify a minimum resource level to protect subscribers, the new standard only required plans to remain solvent—maintain a surplus of no less than $0—to comply with the Association's financial responsibility standard. Plans in a deficit position when the new standard took effect were given 2 years to come into compliance.

As of December 31, 1993, plans are subject to new risk-based surplus requirements tailored to each plan's business risk environment. For example, a plan with risky investments would be subject to a higher surplus requirement than a plan with less risky investments. Association officials said that the risk-based surplus requirements will be raised in 1995 and thereafter until an appropriate level is reached.

Benefit of New Association Surplus Requirements Unclear

Under the $0 surplus requirement in effect from 1991 through 1993, all plans complied with the Association's financial responsibility standard, even though several were rated in weak or very weak financial condition. If the pre-1991 minimum surplus requirement remained in effect, 12 plans with almost 21 million subscribers would have failed the requirement as of June 30, 1993.[1] Although the risk-based surplus requirements in effect for 1994 and planned for 1995 exceed the surplus requirement in effect from 1991 through 1993, they remain low. When we applied the 1994 and 1995 requirements to plans' financial condition as of June 30, 1993, none of the plans failed the 1994 requirement, and only one plan failed the 1995 requirement.

The new surplus requirement has been criticized by some senior officials of Blues plans. One plan CEO told us that the Association's ability to protect the value of the trademarks was diminished by the $0 surplus requirement. This official suggested that the Association will be subject to continued criticism until the standards are "responsibly raised." Another plan's general counsel said the new requirements are too low and should be set significantly higher than the levels planned for 1994 and 1995.

[1]These plans would not necessarily have been subject to license termination, however, because under the old standard, termination also required noncompliance for 2 consecutive years and a plan's failure to make progress toward an approved recovery plan.

Comments of the Blue Cross and Blue Shield Association

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

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Bernard R. Tresnowski
President and
Chief Executive Officer

February 11, 1994

Ms. Leslie G. Aronovitz
Associate Director
Health Financing Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. Aronovitz:

Thank you for the opportunity to review and comment on your draft report on the Blue Cross and Blue Shield Association and its 69 independent Member Plans.

First and foremost, we congratulate GAO on its recognition that the vast majority of Blue Cross and Blue Shield Plans are financially strong and well-managed.

We are pleased that your report also recognizes the important and evolving role played by Blue Cross and Blue Shield Plans in our nation's health care system. You describe well the community service roots of Blue Cross and Blue Shield Plans and the historical challenges Plans have faced and met. We believe it is vital that those concerned with the future of health care in this country be mindful of the past. A past that includes over 60 years of security, service, innovation and leadership in health care provided by Blue Cross and Blue Shield Plans.

Your report also appropriately points out that there have been troublesome instances in the past where some have failed to live up to the examples set by the vast majority of Plans. As an organization, we have taken continual action to address the causes of such problems when they have become apparent. Your report notes the breadth of our efforts to learn lessons and improve in such areas as financial monitoring, oversight of Plan activities, and protecting subscribers.

Financial Monitoring

In the late 1980s a combination of rising costs, inappropriately applied regulation and management missteps placed a few Plans in troubled financial condition. This culminated with the demise of the old West Virginia Plan in 1990 and taught us that more effective financial oversight of Plans was a first priority. Accordingly, since 1990 we have adopted a series of measures to address this:

- In 1990 and 1991 we adopted new licensing rules that for the first time established an absolute minimum surplus requirement and made clear that a Plan would lose its right to use the Blue Cross and Blue Shield names, without any further considerations, if its capital position fell below the specified number.

- In February 1992, we adopted increases in the minimum surplus requirement for year-end 1993 and year-end 1994. These increases were graduated to allow Plans with low capital, and their regulators, sufficient time to raise the Plan's capital position above our minimum requirements without massive disruption to subscribers.

- In October 1992 we converted the old "months in reserve" measure of capital to a new measure which, like the NAIC's risk-weighted formula approach for insurers, is a better measure of the actual capital needs of a Plan. We also adopted additional minimum liquidity requirements.

See comment 1.

- In November 1993 we continued the gradual increase in the minimum capital requirement by adopting higher requirements for year-end 1995. This level will ensure that within the next two years all Plans will have capital levels over 60% above the level at which the NAIC's model act requires a regulator to take over an insurer and 15% above the level at which the model act allows a regulator to take control of an insurer.

See comment 2.

Plan Oversight

Recent examples of a few troubled Plans demonstrated the need for more focused oversight by the Plan's Board of Directors and its regulators. Accordingly, all Plan Boards must now adopt stringent policies on the conduct of Plan personnel and on the discharge of the Board's own fiduciary duties. And the Association now requires that each Plan's subsidiary activity be regulated the same as all commercial health insurers in its state.

Protecting Subscribers

The old West Virginia Plan's insolvency highlighted the fact that, because of their unique history, some Plan's were not included in state guaranty funds and had no "safety net" for subscribers. By the end of this year all Plans will either be in their state guaranty fund or establish another mechanism to assure that claims payment and continued coverage are guaranteed.

See comment 3.

We believe actions in these and other areas stand as proof of Blue Cross and Blue Shield Plans' continuing accountability to their subscribers.

THE ROLE OF STATE REGULATION

Your report is commendable for recognizing that state regulators also share responsibility for assuring strong and stable Plans. This is most evident in those states you identify as "highly regulated environments." The necessary balance between affordability and solvency in these states has often been resolved in favor of keeping a Plan in very weak financial condition. We believe this practice, ill-advised in the past, must end under coming health care reform. We look forward to a level playing field on which all insurers follow the same rules and state regulation is applied in a uniform and balanced way.

See comment 4.

THE ROLE OF THE ASSOCIATION

While state regulators have ultimate responsibility for assuring Plan solvency, your report notes that the Association has a role to play in its application of licensing requirements. Your conclusion that the Association's commitment to strongly enforce its minimum surplus requirements is open to question, however, may mislead some into believing that falling below our minimum will be tolerated. Acting on such an incorrect assumption would be a mistake.

See comment 5.

Since 1991, when the Association first established a specific surplus level below which a Plan would be terminated without any further considerations, no Plan has been allowed to fall short. In two recent cases where Plans appeared in imminent danger of breaching the minimum surplus requirements, commencement of termination proceedings resulted in the Plans securing help from others to get over their financial and managerial crises. While some may question the Association's resolve to continue absolute adherence to its minimum financial requirements, the vast majority of Plans recognize that strict enforcement is the best means of protecting their own good name. Their commitment has been demonstrated by recent examples and will continue.

SPECIFIC COMMENTS

In the interests of making your report as accurate as possible, we will comment on a few remaining areas in whcih a reader may be left with a less than complete or accurate impression.

Particular Plans Situations

See comment 6.

We are concerned that your report may be misread to suggest that some missteps by some Plans' management in the late 1980s are representative of the current situation. In earlier times some Plans may indeed have been "slow to recognize customers preference for lower-cost insurance products, such as managed care." But, the three Plans you discuss in the most detail, New Jersey, Massachusetts and California Blue Cross, have emerged from the 1980s today as leaders in their states in innovative managed care products.

- The Massachusetts Plan's HMO Blue has been the fastest growing HMO in the state with a projected enrollment gain of 143,000 members for 1993. While offering high-quality and obviously popular managed care products, HMO Blue has managed its finances well, earning nearly $1 million in surplus during its first year of operation alone. Your report notes that the Massachusetts Plan has had problems in the past but does not indicate that, from all appearances and most recent data, it is recovering well.

- In New Jersey the Plan has recently set up breakthrough provider networks which allow the offering of a full range of managed care products. Given the regulatory environment, which your report touches upon, and its historical financial condition, the Plan has made great strides on the road to recovery.

- Your report states that the California Blue Cross Plan was slow to adequately respond to market place changes towards managed care at some unspecified time in the past. But it appears that this occurred prior to 1986 since, as you later correctly point out, the Plan radically revamped its management beginning in 1986 and this has resulted in truly outstanding results in its marketing of managed care and its financial performance.

See comment 7.

These are not uncommon examples among the Plans. This year, Blue Cross and Blue Shield Plans had over 24 million subscribers enrolled in managed care programs around the country. The Plans collectively are far and away the largest managed care providers in the United States.

Association Monitoring Levels

Appendix V of the report reviews in detail the financial membership standards and guidelines in place before and after the adoption of the new 1991 License Agreements. You correctly identify the pre-1991 rules which set one and one-half months of reserves as the level of financial resources adequate for a Plan to be considered strong. If a Plan fell below that level, the Association began to monitor the Plan's performance and efforts to recover a strong financial position. This monitoring included a requirement that the Plan submit an acceptable plan to bring itself back to a strong capital position. If the Plan submitted a recovery strategy and used its best efforts to implement that strategy, and the regulator did not threaten to seize control of the Plan, the Association did not have clear authority to terminate the Plan's license. Prior to 1991, therefore, there was no specific level of reserves below which a Plan would lose its license without further considerations and some Plans had deficit reserve positions.

See comment 8.

Currently, the general level at which we begin monitoring a Plan's performance and its recovery efforts is on a par with the pre-1991 level. The improved "risk-weighted" measure we now employ allows a more accurate assessment of an individual Plan's capital needs. If a Plan falls below a level of 70% on our capital benchmark scale it is placed in the monitoring program.* Now, however, if a Plan falls below certain minimum capital levels its license will be terminated without further considerations. By the end of next year, our minimum surplus requirements will be substantially higher than the minimum levels at which regulators may take control of a insurer's operations under the NAIC's Risk Based Capital Model Act.

See comment 9.

See comment 2.

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* The capital benchmark formula is a measure of capital adequacy relative to each corporation's business risk. Given the fundamental differences in approach between capital benchmark and the old "months in reserve" approach, a direct comparison cannot be made. For purposes of illustration we estimate 70% of our risk formula is roughly equal to 1.24 months in reserve on a system wide basis. However, on a Plan-specific basis the relationship will vary significantly due to the differing risk profiles. For example, for one Plan 70% may equal 1.1 months while for another Plan 70% may equal 1.98 months. The primary purpose for moving to a risk-based formula is to account for differences in the risk profiles and attempt to ensure that monitoring activities are focused on the appropriate situations. This risk-weighted approach is deemed superior by those knowledgeable in the field and is the approach being pursued by the NAIC and others.

See comment 1.

West Virginia

The insolvency of the old Charleston, West Virginia Plan was a traumatic event for the Plan's subscribers. We believe it is important to note that much has been done to ease that trauma. The new Plan in West virginia, Mountain State Blue Cross and Blue Shield, took over the ongoing coverage obligations of subscribers so that thousands of people did not suddenly find themselves with no health insurance. The Association and the officials appointed by the West Virginia Insurance Department have agreed to a plan designed to reimburse subscribers for money owed directly to them by the old Plan and prevent providers from trying to collect from those subscribers any money owed the provider by the insolvent Plan.

See comment 10.

State Regulatory Requirements

Our experience over the years has led us to clear conclusions about the effects of state regulation on Plan solvency. Plans generally maintain adequate financial resources where they are regulated on a par with all other health insurers or where, although subject to special requirements, the Plan's need for adequate financial resources is recognized by the state regulator in rate-setting and other decisions. Plans generally do not do well when they are subject to different regulation than other health insurers and regulators fail to set rates and make other decisions to keep the Plan adequately capitalized. We believe that analysis of relevant available data, including that which we submitted to you, bears out this conclusion.

See comment 11.

Your report suggests that health care reform will increase the importance of state insurance regulators and they must have the "tools necessary to enforce new requirements on Blues' Plans and other health insurers." It is imperative that all concerned with reform and the future of health insurance regulation not lose sight of the need for balance in pursuing the goals of both affordability and solvency.

Our information on the various state regulatory requirements on each Plan differs from that presented in your Appendix IV for many states. We understand that this is partially attributable to differing sources for the information and we would be pleased to meet with GAO staff to compare all available information if you so desire.

See comment 12.

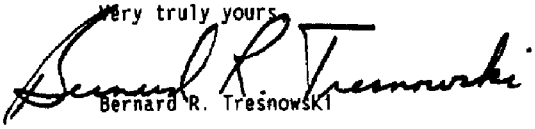
Association Dues

Although not incorrect, your statement that no Plan paid more than 1 percent of its net subscription revenue in dues to the Association could be misleading. In fact, in 1992 no Plan paid more than 0.181 percent of net subscription revenue in dues and the weighted average for all Plans was 0.089 percent.

See comment 13.

We appreciate your consideration in allowing us this opportunity to formally comment on your report. If we can be of any further assistance on these matters, please contact us.

Very truly yours,



Bernard R. Tresnowski

BRT:peb

#5008L

The following are GAO's comments on the BlueCross BlueShield Association's letter dated February 11, 1994.

GAO Comments

1. The Association suggests that its new capital benchmark formula better measures the actual capital needs of a plan because it is similar to the risk-weighted formula the National Association of Insurance Commissioners uses for life/health insurers. This assertion may create the misleading impression that the NAIC agrees that the formulas are similar. However, NAIC has not been provided the Association's formula and thus has not had an opportunity to determine whether the Association's formula better measures the actual capital needs of a plan.

2. The Association contends that by the end of 1995 all plans will be required to have capital levels above those at which the NAIC's model act requires a regulator to take over an insurer. This comparison suggests that the Association's capital standards are more stringent than NAIC's. In our view, such a comparison may be misleading for several reasons.

First, the comparison of the Association's formula with the NAIC's life/health risk-based capital model may not be valid. The NAIC model formula was designed for and tested on a group of primarily life insurers and therefore emphasizes an insurer's asset risk. The Association's formula was designed to reflect the specific risks and operating characteristics of Blues plans. A formula designed primarily for health insurers would likely concentrate on insurance underwriting risk. Accordingly, the NAIC is currently developing a risk-based capital model formula specifically for not-for-profit health plans like the Blues.

Second, the goals of the respective standards differ. NAIC's risk-based capital model was intended to establish the minimum capital requirements an insurer needed to function. In contrast, the Association's requirement is intended to protect the value of the trademarks. Thus, one would expect the Association's standards to be more stringent than the regulators to identify plans in weak financial condition long before their surplus levels reach the point where the regulators would assume control.

3. The Association states that several actions stand as proof of Blues plans' accountability to their subscribers. As an example, they mention the requirement that all plans join their state life/health guaranty funds or establish another mechanism to ensure that claims payment and continued coverage are guaranteed by the end of 1994. While this requirement should

help protect plan subscribers, progress toward complying with this new requirement appears to be slow. Although this standard was adopted in April 1993, the number of plans that meet the standard has essentially not changed since June 1993. As of February 1994, 24 plans belonged to their state guaranty associations,[1] while 8 others provided subscribers with a guaranty of claims payment and continued coverage through some other mechanism. The remaining 37 Blues plans are still considering how they will meet this standard by the end of 1994.

4. While we agree that regulators have, in some cases, been challenged to balance the competing objectives of maintaining insurer solvency and premium affordability, our report does not identify states with "highly regulated environments" as the Association suggests. Rather, our report suggests that rating and coverage requirements imposed only on Blues plans and not commercial insurers have contributed to the weak financial condition of some plans.

5. The Association contends that we have presented a misleading view of its commitment to strongly enforcing its minimum surplus requirements because we suggest that it will not act against a Blues plan that falls below its minimum standards. While the Association has initiated termination proceedings twice since the new standards took effect, we believe that the effectiveness of the Association's enforcement efforts remains uncertain for several reasons. First, the two termination actions were based on the low surplus requirements in place at that time. In our view, these actions may not be a good indicator of the Association's future willingness to enforce more stringent surplus standards. The skepticism expressed by some Blues plan officials supports this conclusion. Second, the Association continues to use the same procedures for license termination that have contributed to its historic reluctance to enforce its membership standards.

6. The Association is concerned that our report may be misread to suggest that our findings of plan mismanagement reflect the current situation among Blues plans. We believe our report clearly indicates that the examples of plan unresponsiveness to market demand come from the experiences of plans during the mid to late 1980s. (See pp. 8 and 9.) We also indicate that plans in our study have begun to respond to this demand. (See pp. 15 and 16.) For illustration purposes, we chose one plan, California Blue Cross, as a particularly vivid example because of its current competitive and financial strength. We did not mean to imply that

[1]One of the plans that belonged to its state guaranty association in June 1993 is no longer a Blues plan.

it is the only example. We did not use the Blues plans in Massachusetts and New Jersey as examples because, although they have made strides toward expanding their managed care programs, they continue to be rated as in weak financial condition.

7. Although the 69 Blues plans may collectively have more than 24 million subscribers enrolled in managed care programs, aggregating these statistics for all Blues plans obscures a wide variation in the proportion of each plan's business that is in managed care. As illustrated in appendix III, some plans have most subscribers enrolled in managed care programs, while other plans have no managed care programs whatsoever. Further, aggregating this type of information for all plans may be misleading since each plan is an independent corporation and its performance is unrelated to that of other plans.

8. We do not dispute the Association's contention that, before 1991, it may not have had clear authority to terminate a plan's license for failing the financial membership standard. As noted in our report, we found that the Association's reluctance in enforcing its financial and other membership standards before 1991 was due, in part, to a conflict in its trademark licensor role. (See p. 14.)

Further, the Association's suggestion that there was no requirement that plans maintain a specific level of surplus is, in our view, misleading. As discussed in appendix V, the Association guidelines, before 1991, identified a minimum surplus level that a plan needed to maintain adequate financial resources to protect its subscribers.

9. The Association contention that, currently, the general level at which they begin monitoring a plan's performance is similar to the pre-1991 levels is somewhat misleading. According to Association guidelines, the pre-1991 level was considered a minimum acceptable level of performance, rather than the level at which the Association should begin monitoring the plan's performance.

10. The Association indicates that it has done much to ease the trauma that resulted from the insolvency of the old West Virginia Blues plan. For example, the Association notes that it agreed to a plan to reimburse subscribers of the plan money owed them and prevent providers from trying to collect from subscribers any money owed them by the insolvent plan. Despite this agreement, as of February 1994, about $40 million in claims against the liquidated plan remained unpaid, and no money has yet

been paid to subscribers because claims against the assets of the liquidated plan are subject to ongoing litigation. Further, some providers have continued to bill subscribers for money owed by the liquidated plan.

11. We agree that disparate rate setting and coverage requirements contributed to the weak financial condition of some Blues plans. However, we also found that other factors contributed to plans' financial weaknesses.

Although the Association provided us information on state regulatory requirements from a survey of its member plans, we used the results of our survey of state regulators, who, in our view, were a better source of information on the regulatory requirements states imposed on Blues plans.

12. We recognize that differences may exist between our analysis of state regulatory requirements imposed on Blues plans and the Association's because we used different sources to obtain our information. However, as discussed in comment 11, we believe state regulators are a better source of information on state regulatory requirements.

13. We changed the text to indicate that each plan paid an amount in dues equal to much less than 1 percent of its net subscription revenue.

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Related GAO Products

Health Insurance Regulation: Wide Variation in States' Authority, Oversight, and Resources (GAO/HRD-94-26, Dec. 27, 1993).

Health Insurance: How Health Care Reform May Affect State Regulation (GAO/T-HRD-94-55, Nov. 5, 1993).

Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, Sept. 22, 1992).

Access to Health Care: States Respond to a Growing Crisis (GAO/HRD-92-70, June 16, 1992).

Access to Health Insurance: States Efforts to Assist Small Businesses (GAO/HRD-92-90, May 14, 1992).

Insurer Failures: Life/Health Insurer Insolvencies and Limitations of State Guaranty Funds (GAO/GGD-92-44, Mar. 19, 1992).

Small Group Market Reforms: Assessment of Proposals to Make Health Insurance More Readily Available to Small Businesses (GAO/HRD-92-27BR, Mar. 12, 1992).

Insurance Regulation: The Failures of Four Large Life Insurers (GAO/T-GGD-92-13, Feb. 18, 1992).

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Insurance Regulation: State Handling of Financially Troubled Property/Casualty Insurers (GAO/GGD-91-92, May 21, 1991).

Employee Benefits: Improvements Needed in Enforcing Health Insurance Continuation Requirements (GAO/HRD-91-37, Dec. 18, 1990).

Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting (GAO/HRD-90-68, May 22, 1990).

Health Insurance: Comparing Blue Cross and Blue Shield Plans With Commercial Insurers (GAO/HRD-86-110, July 11, 1986).

Public Representation on Boards and Blue Shield Allowance: Important Relationship Not Found (GAO/HRD-81-31, Dec. 31, 1980).

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