REPORT TO THE CONGRESS

The Government-wide Service Benefit Plan--Blue Cross And Blue Shield For Federal Employees--Needs Improved Administration

B-164562

Civil Service Commission

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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WASHINGTON, D C 20548

B- 164562

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

This report presents our findings regarding the need for improved administration of the Government-wide Service Benefit Plan--Blue Cross and Blue Shield for Federal employees--by the U S. Civil Service Commission Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C 67)

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

Comptroller General
of the United States

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D I G E S T

WHY THE REVIEW WAS MADE

The Government-wide Service Benefit Plan (Plan) has more participants than the 37 other Federal employee health plans combined--about 1.5 million at December 31, 1969. It is administered by the Civil Service Commission under contract with two nonprofit corporations--the Blue Cross Association and the National Association of Blue Shield Plans (Corporations) on behalf of 165 autonomous Blue Cross and Blue Shield corporations (local plans). The Plan provides hospital, surgical, and medical insurance to Federal employees and annuitants and their dependents or survivors. (See p. 5.)

The General Accounting Office (GAO) reviewed the administration of the Plan, because of the considerable cost to Federal employees and to the Government for such insurance. For example, the 1970 biweekly premium rate for self and family high-option coverage is $13.59 for the Federal employee and $4.10 for the applicable Government contribution. Premiums totaled $496.2 million for calendar year 1969. In addition, the Special Studies Subcommittee of the House Committee on Government Operations had expressed a particular interest in Federal employee health programs.

FINDINGS AND CONCLUSIONS

Loss of investment income

Instead of investing all cash not needed for promptly discharging the Plan's obligations, Group Hospitalization, Inc., kept substantial amounts in non-interest-bearing checking accounts. As a result, the Plan lost perhaps as much as $400,000 of interest income annually. (Group Hospitalization, Inc., which is the Blue Cross local plan for the Washington D.C., area, acts, nationwide, as Operations Center for the Corporations.) (See p. 11.)

Also, Group Hospitalization, Inc., retained for long periods several hundred thousand dollars of Plan funds it collected from local hospitals before remitting even a portion of the funds to the Operations Center. This deprived the Plan of income that otherwise would have been earned by investing the funds. (See p. 16.)

The Operations Center advanced funds to certain local plans, apparently in excess of the amounts needed by these plans to meet current obligations and thus reduced the funds available for investment. This happened because a formula used for computing the needed amounts overstated the number of days required by the local plans to obtain reimbursement. (See p. 19.)

Administrative expenses

Certain administrative expenses charged to the Plan by the Corporations and the local plans were questioned. These expenses related to travel, entertainment, and allocations of actuarial expenses. (See p. 24.)

Allowances for contingency reserves

The laws of some States require the local plans to maintain contingency reserves in addition to their other reserves. The contract authorizes the Corporations to make annual allowances to local plans in amounts necessary for satisfying these laws. Allowances of $2.1 million were granted to 31 local plans in nine States from inception of the Plan in 1960 through December 31, 1969. GAO questioned the equity of continuing to make such allowances, because the Commission and the Corporations maintain contingency reserves adequate for protecting the enrollees' interest. The enrollees have to pay for these allowances in the form of increased premiums. (See p. 41.)

Allocations of investment income

The Corporations allocate their investment income among the reserves of the high and low insurance options provided under the Plan. The balances of the special reserves for the high options were understated and the balances for the low options were overstated, because the Corporations' method of allocating interest income among these reserves had not resulted in distributing interest income in proportion to the sources of the funds invested to earn such income. Because changes in premium rates are based, in part, on the balances of the special reserves, premium rates could be established for the options that are higher or lower than required to pay the related benefit claims and expenses. (See p. 38)

Miscellaneous

Information is also included in this report on:

--Amounts of biweekly subscription charges paid by the Government and the enrollees. (See p. 21.)

--Amounts of taxes on insurance premiums paid to the States and other taxing jurisdictions and charged to the Plan. (See p. 28.)

--Reductions in risk charge allowances to local plans. (See p. 29.)

--Earnings resulting from investment of Plan funds held by the Commission. (See p. 36.)

--Maintenance of reserves by the Commission and the Corporations. (See p. 32.)

--Approval of the Commission's accounting system for the Federal Employees Health Benefits Program (Program). (See p. 46)

--The Commission's audits of operations under the Plan. (See p. 46.)

RECOMMENDATIONS OR SUGGESTIONS

GAO's major proposals to the Commission for improving administration of the Plan related to:

--Increasing the interest income earned by the Plan by ensuring that:

1. The Corporations' Operations Center promptly invests all funds not immediately needed to discharge the obligations incurred under the Plan. (See p. 11.)

2. Local plans promptly remit to the Operations Center any Plan funds collected from hospitals. (See p. 18.)

3. Advances of funds to local plans by the Operations Center do not exceed the amounts needed by them to meet current Plan obligations. (See p. 19)

--Making a study to determine the reasonableness of and the necessity for continuing to make allowances to local plans to assist them in meeting State contingency reserve requirements. (See p 41.)

--Requiring the Corporations to allocate interest income to the reserves of the different options in a manner consistent with the sources of the funds used in earning such income. (See p. 38.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

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

The Intergovernmental Relations Subcommittee, House Committee on Government Operations, held hearings on various aspects of the administration of the Plan during May, June, and July 1970. Testimony during the hearings revealed that certain high officials of Group Hospitalization Inc.,

also were officers of the banks in which the Operations Center maintained the non-interest-bearing checking accounts (See p. 13)

Commission officials stated during the hearings that they had commenced a review to (1) resolve any conflict of interest problems, (2) make retroactive interest adjustments, if appropriate, for the period during which excess funds had been kept in non-interest-bearing accounts, and (3) ensure prompt and prudent investment of funds not needed for immediate disbursement (See p 14)

At the hearings an official of Group Hospitalization, Inc , stated that the Operations Center had maintained balances in checking accounts in accordance with instructions received from the Corporations and expressed the opinion that no conflicts of interest had been involved He said, however, that arrangements had been made to ensure the daily investment of all available cash except that needed to cover disbursements for that day. (See p. 15.)

MATTERS FOR CONSIDERATION BY THE CONGRESS

GAO is issuing this report to the Congress because of the continuing congressional concern over Federal employee benefit programs.

The report may be useful to the Congress in its deliberations on proposed legislation, such as House bill 769, Ninety-first Congress, first session This bill would exempt insurance premiums under the Program from taxation by States and by political subdivisions.

CHAPTER 1

INTRODUCTION

The General Accounting Office has reviewed certain aspects of the administration of the Government-wide Service Benefit Plan of the Federal Employees Health Benefits Program. The Plan is administered by the U.S. Civil Service Commission under a contract with the Blue Cross Association and the National Association of Blue Shield Plans (Corporations) both nonprofit corporations of Chicago, Illinois. The scope of our review is described on page 48.

The Program, which was established in 1960 pursuant to the Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901), provides hospital, surgical, and medical insurance to Government employees and annuitants and to their dependents or survivors. The cost of the Program is shared by the participants and by the Government. The act assigned the responsibility for administering the Program to the Commission and authorized the Commission to contract for or approve the following four types of plans.

1. The Service Benefit Plan--A Government-wide plan which provides benefits generally through direct payments to physicians and hospitals.

2. The Indemnity Benefit Plan--A Government-wide plan which provides benefits by cash reimbursements either to the employees or, at their request, to doctors and hospitals.

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

4. Comprehensive medical plans--These plans, which are available only in certain localities, are either group-practice plans that provide benefits in the form of medical services by teams of physicians and technicians practicing in their own medical centers or individual-practice plans

that provide benefits in the form of direct payments to physicians with whom the plans have agreements. The plans also provide hospital benefits.

The act requires that two levels of benefits be offered under the two Government-wide plans. These levels of benefits are known as options--a high option and low option. Both premiums and benefits under the high options are greater than under the low options. The employee organization plans and the comprehensive medical plans may offer either one or two levels of benefits.

Since inception of the Program, the Plan has had more participants than all the other plans combined and it has continued to grow. Enrollment increased from about 1 million enrollees at the end of the first contract period (October 31, 1961) to about 1.5 million enrollees at the end of the ninth contract period (December 31, 1969). Appendix I shows the number of enrollees at the end of each contract period.

Subscription charges (premiums) increased from $230 million for the 16-month first contract period of July 1, 1960, to October 31, 1961, to $496 million for the 12-month contract period of January 1 to December 31, 1969. Appendix II shows, for 1969 and cumulatively since inception of the Plan, the income and expenses of the Plan, exclusive of certain operations carried out by the Commission.

Within the Commission, the Bureau of Retirement, Insurance and Occupational Health is responsible for administering the Program. The financial transactions of the Program are accounted for by the Bureau through the Employees Health Benefits Fund.

The principal officials of the Commission responsible for the administration of matters discussed in this report are listed in appendix IV.

CONTRACT FOR THE PLAN

The Commission entered into a contract with the Corporations, on behalf of the local plans, to provide the Plan

to eligible Federal employees and annuitants and to their dependents or survivors. Benefits provided by the Plan are underwritten by certain local plans under agreements with the Corporations.

The contract with the Corporations sets forth the basic and supplemental benefits provided by the Plan. Basic benefits provide protection for hospital services, surgery, in-hospital medical care, maternity care, and certain other physicians' services. Supplemental benefits, with a deductible,[1] cover usual, customary, and reasonable charges for medically necessary covered services and supplies in or out of a hospital that are prescribed or ordered by a physician, to the extent that such charges are not covered by basic benefits. Both basic and supplemental benefits are subject to certain exclusions and limitations, and supplemental benefits are also subject to coinsurance requirements.[2]

The initial contract, which was effective July 1, 1960, has been renewed each year. Amendments to the contract have been negotiated periodically to cover such matters as changes in premium rates and health benefits. Either the Commission or the Corporations may cancel the contract by giving written notice to the other party at least 60 days prior to the end of any contract year.

BLUE CROSS AND BLUE SHIELD ORGANIZATIONS ADMINISTERING THE PLAN

The Blue Cross and Blue Shield organizations administering the Plan and their principal functions, as they relate to matters discussed in this report, are as follows:

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[1]The deductible is the amount of expense each person covered by the Plan must incur in each calendar year for covered services or supplies before supplemental benefits are payable.

[2]The Plan pays 80 percent of the covered services in excess of the deductible under the high options and 75 percent under the low options.

Corporations

The contract is administered by the Joint Contract Administration Committee of the Corporations pursuant to policies approved by the board of governors of the Blue Cross Association and the board of directors of the National Association of Blue Shield Plans. The Corporations establish the policies and approve the procedures to be followed by the local plans.

To facilitate the administration of the plan and to act as liaison with the Commission on contractual matters, the Corporations established an Office of the Director, Federal Employee Program, in Washington, D.C.

Operations Center

The Corporations contracted with Group Hospitalization, Inc., to serve, nationwide, as Operations Center for the Plan. Group Hospitalization, Inc., is also the Blue Cross local plan for the Washington, D.C., area. In general, the Operations Center receives and accounts for all funds made available by the Commission; maintains claims status records for enrollees; reimburses local plans for paid claims, administrative expenses, and other allowable charges; processes and pays enrollee supplemental benefit claims for local plans that underwrite but do not process such claims; prepares accounting and statistical reports required by the contract with the Commission; and issues instructions to local plans to assist them in their operations under the contract.

Local plans

Local plans are headed by governing boards and are autonomous corporations, chartered by the individual States, to provide hospital, surgical, and medical care insurance for people in the local plans' communities. As of December 31, 1969, 80 Blue Cross plans and 85 Blue Shield plans were providing insurance coverage to about 75 million persons, including Plan enrollees.

Each Blue Cross local plan has agreements with hospitals in its area, called member hospitals. The agreements

specify the benefits covered by the local plan and provide for reimbursement to member hospitals for the costs of providing the benefits.

Initially, most Blue Shield local plans had agreements with physicians in their areas, called participating physicians. These agreements provided that, subject to certain specified conditions, the participating physicians would accept the local plan's fee schedule allowances as payment in full for covered services provided to patients having incomes of less than a specified amount. Most Blue Shield local plans have now replaced these agreements with agreements providing for payment of "usual, customary, and reasonable" fees.

There are two types of agreements between the Corporations and the local plans. If a local plan acts only as a claims-paying agent, the agreement is known as a servicing agreement. If a local plan also underwrites the health benefits provided in the contract, the agreement is known as a participating plan agreement.

The Corporations reimburse the local plans for benefit payments made and for administrative and other allowable expenses incurred.

FINANCING

Each Federal agency is responsible for collecting its employees' contributions toward the cost of participation in a health benefits plan and for paying the related Government contributions. Employees' contributions are withheld from their earnings; the Government's contributions are paid from the agency's appropriations or other funds available for the payment of salaries. Each payroll period the agency transmits the total of the Government's and employees' contributions to the Commission for deposit into the Treasury to the credit of the Employees Health Benefits Fund. With respect to retirees and survivors, the Commission withholds contributions from annuity payments; the Congress appropriates funds to the Commission for the Government's share.

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

The Commission makes disbursements from the Employees Health Benefits Fund to (1) reimburse the Commission's salaries and expenses appropriation for expenses incurred in administering the Program, subject to limitations set forth in the appropriation acts, (2) pay to the insurers as subscription charges all amounts collected from both the Government and enrollees, except funds reserved for administrative expenses and contingencies, and (3) increase Program reserves maintained by the insurers in cases where the reserves fall below prescribed amounts. The law provides that the Commission may set aside up to 1 percent of all contributions to pay its administrative expenses and up to 3 percent of all contributions to provide a contingency reserve. Plan reserves are discussed more fully on page 32.

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By letter dated April 30, 1970, the Chairman of the Commission provided us with his views on matters contained in a draft of this report. His letter is included as appendix III, and his comments have been incorporated in the body of the report, where appropriate.

CHAPTER 2

MANAGEMENT AND CONTROL OF FUNDS

The Corporations use the funds received from the Commission primarily for reimbursing local plans for benefits paid, making advances to local plans, and paying allowable charges. The contract with the Commission requires the Corporations to invest all funds on hand which, in the judgment of the Corporations, are in excess of those needed to discharge promptly the obligations incurred under the Plan.

The contract provides that the Corporations, not later than 120 days after the end of each contract year, prepare and furnish to the Commission a statement of operations for that year. These statements are required to include information on:

1. Subscription charges received and accrued.

2. Benefit payments made and liabilities incurred on behalf of enrollees.

3. Other charges, consisting of (a) the administrative expenses incurred, ~~but not to exceed 4.5 percent of subscription charges,~~ (b) all taxes incurred, (c) ~~a~~ risk charges ~~in an amount equal to a specified percentage of subscription charges,~~ and (d) the amount necessary to satisfy State contingency reserve requirements of participating local plans ~~to the extent such requirements exceed the plans' portion of~~ the risk charge.

Any excess of income over expenses and other charges accrues to a special reserve held by the Corporations for the Plan.

EXCESS CASH HELD IN NON-INTEREST-BEARING BANK ACCOUNTS

We found that the Operations Center, instead of investing all cash in excess of that needed for promptly discharging

the obligations incurred under the Plan, had maintained substantial amounts of such excess cash in non-interest-bearing checking accounts. After we brought this matter to the attention of the Operations Center, action was taken to provide for the investment of these funds.

The Operations Center maintained checking accounts with four Washington banks. The main account, which was maintained with the National Savings and Trust Company, was used to reimburse local plans for claims they had paid and to replenish checking accounts at the three other banks. Each of the other three accounts was used to pay a different type of expense. None of these checking accounts earned interest. The cash not deposited in checking accounts was transferred to the Corporation's investment custodian in Chicago, Illinois, for short- and long-term investments in securities.

The Operations Center receives premium income (subscription charges) from the Commission twice a month. At the inception of the program, it was the policy for the Center to keep about 3 weeks' benefit payments in the checking accounts and to invest the remaining portion. Early in 1962, the cash management policy was changed to provide that the amount kept in the checking accounts be approximately 2 weeks' benefit payments.

In an October 1964 audit report, the Commission recommended that the investment program be reviewed by the Corporations. In response to this recommendation, the cash management policy was again revised and the Operations Center followed the practice of limiting the amounts in the checking accounts to $5 million plus about 1 week's benefit payments.

We found that the month-end cash balances in the four checking accounts for the year 1967 averaged about $7.6 million. For the months of January, July, and November 1967, the daily cash balances averaged $7.2 million, $11.2 million, and $8 million, respectively. Because the cash disbursements during 1967 averaged less than $1.5 million a day, we concluded that the cash balances in the checking accounts were substantially in excess of the amounts required to meet current obligations. Accordingly, we suggested that

the Center revise the cash management policy to provide for investment of excess funds.

Officials of the Operations Center adopted our suggestion in December 1967. The revised cash management policy provided for depositing the cash not required for immediate disbursements in an interest-bearing savings account established at the National Savings and Trust Company. An Operations Center official stated that under the revised policy the balances in the four checking accounts would be reduced so as not to exceed a combined total of $280,000. At the time of its establishment, the savings account yielded interest at 4 percent per annum compounded monthly on the average daily balance.

In commenting on our draft report (see app. III), the Commission stated that the interest earned on the savings account in 1968 had been $206,000. An official of the Commission later stated, during hearings before the Intergovernmental Relations Subcommittee that the interest earned on the savings account had been $254,000 in 1969. He stated also that some of the funds released by the change in the cash management policy may have been invested in securities instead of deposited into the savings account and that the interest earnings resulting from the change in policy could have totaled more than $400,000 annually.

Hearings before Intergovernmental Relations Subcommittee

The Intergovernmental Relations Subcommittee held hearings regarding certain aspects of the Commission's administration of the Plan on May 21, June 30, and July 1, 1970. Testimony during these hearings revealed that the chairman of the board of trustees of Group Hospitalization, Inc., which serves as Operations Center for the Plan, was also a member of the board of directors of the National Savings and Trust Company, the bank in which the Operations Center's main checking account was maintained.

The testimony further brought out that the treasurer of Group Hospitalization, Inc., who was also a member of its board of trustees, was president and chairman of the board of directors of the National Savings and Trust Company and

that two other members of the board of trustees of Group Hospitalization, Inc., also were officials of other banks in which Group Hospitalization, Inc., maintained checking accounts.

In summarizing the testimony received during the hearings on May 21, 1970, the Chairman of the Subcommittee said that he could not conceive of any prudent businessman's keeping literally millions of dollars, for years at a time, in a non-interest-bearing account and he expressed the opinion that, if there had been an earlier policy that prevented such investments, it was a violation of fiduciary responsibility on the part of someone not to have changed that policy.

In June 1970, a complaint was filed in the U.S. District Court for the District of Columbia on behalf of three individuals against the Corporations; Group Hospitalization, Inc.; the National Savings and Trust Company and two other banks; and certain officers individually and in their capacities with Group Hospitalization, Inc., and the three banks.

The plaintiffs charged the three banks with unjust enrichment and charged all defendants with a breach of their fiduciary obligations in failing to invest the large sums of money which were held in the non-interest-bearing checking accounts.

The plaintiffs asked that a decree be entered compelling the defendants to render an accounting of all monies and property received in connection with, or arising out of, the operations of the Plan that had been subject to their administration, management, care, custody, or possession from the inception of the Plan; determining the amounts by which the defendants had been unjustly enriched and the amounts by which the beneficiaries of the Plan had been damaged by reason of the defendants' breaches of their fiduciary obligations; and ordering the defendants to reimburse such amounts to the Employees Health Benefits Fund for credit to the Plan.

In a statement presented during the hearings before the Intergovernmental Relations Subcommittee on June 30, 1970,

the Director, Bureau of Retirement, Insurance and Occupational Health, Civil Service Commission, stated that immediately after the May 21, 1970, hearing the Commission had commenced a review of the Operations Center's investment policy.

The Director stated also that the Commission's review would be concerned with improvements for the future and with the question of whether there was a legal basis for seeking retroactive adjustments for the period when excess funds of the Plan had been maintained in non-interest-bearing checking accounts. He stated further that the Commission, working with responsible officials of the Blue Cross and Blue Shield organizations, would (1) resolve any problems of conflict of interest, (2) make retroactive adjustments, if appropriate, and (3) ensure prompt and prudent investment of funds not needed for immediate disbursement.

During the hearings before the Subcommittee on July 1, 1970, the president of Group Hospitalization, Inc., stated that the Operations Center had maintained balances in checking accounts in accordance with instructions received from the Corporations. He said that the officials of Group Hospitalization, Inc., who were also officials of the banks in which checking accounts were maintained, had not had any opportunity to influence the amounts of money to be deposited in their banks, and he expressed the opinion that no conflicts of interest had been involved.

The president said also that, upon advice of counsel, the savings account at the National Savings and Trust Company had been closed and that arrangement had been made to ensure the daily investment of all available cash except that needed to cover disbursements for that day. He said further that Group Hospitalization, Inc., to ensure meeting its responsibilities to enrollees and to the Corporations, had employed a nationally known, independent accounting firm to make a complete and thorough examination of the cash management policies, practices, and procedures.

We plan to examine into the adequacy of the actions taken by the Commission to improve the cash management practices of the Operations Center and into the reasonableness of decisions concerning retroactive adjustments.

DELAY IN RETURN OF PLAN FUNDS TO THE OPERATIONS CENTER

We found that Group Hospitalization, Inc., retained, for long periods of time, several hundred thousand dollars of Plan funds it had collected from local hospitals before remitting portions of the funds to the Operations Center. The retention of these funds deprived the Plan of the income that otherwise would have been earned by investing the funds.

The agreements between local plans and hospitals provide that the amounts advanced by the local plans to the hospitals represent tentative payments which are subject to adjustment, on the basis of a prescribed cost-reimbursement formula, at the end of each hospital's accounting period. These adjustments can result either in a local plan's making a supplementary payment to the hospital or in a hospital's making a refund to the local plan. The Operations Center reimburses the local plans for any supplementary payments made and recovers from the local plans any refunds collected.

The Operations Center reimburses local plans, generally within a few weeks, for normal or periodic claims paid to hospitals. The Operations Center also advances working capital funds to local plans in amounts sufficient to finance their activities for the period between claims payment and reimbursement. During 1965, the working capital advance to Group Hospitalization, Inc., was about $900,000; during 1967 the advance was increased to about $1 million. Because Group Hospitalization, Inc., had been advanced sufficient funds to pay its obligations under the Plan, it should have been in a position to remit promptly to the Operations Center any refunds it received from hospitals.

In February 1966, Group Hospitalization, Inc., collected a portion of the amounts due from hospitals for overpayments made during prior years. These amounts were deposited by Group Hospitalization, Inc., into its general fund, and the amounts in this fund in excess of current needs were invested in short-term Treasury bills. We estimated that, during the 17-month period February 1966 through June 1967 Group Hospitalization, Inc., had collected about $951,000 of Plan funds before it remitted a portion of these funds, about $556,000,

to the Operations Center in August 1967. Group Hospitalization, Inc., retained the interest it had earned on the investment of these funds.

We estimated that as of August 1, 1967, more than $20,000 of investment income could have been earned by the Plan if Group Hospitalization, Inc., had remitted the $951,000 of Plan funds to the Operations Center as the funds were collected.

Group Hospitalization, Inc., continued to recover overpayments from the hospitals but did not make another partial payment to the Operation Center until July 1968 when about $693,000 was remitted. We estimated that as of May 31, 1969, Group Hospitalization, Inc., had on hand about $750,000 of Plan funds that had been collected from hospitals.

During our review, an official of Group Hospitalization, Inc., expressed the opinion that refunds from hospitals should not be remitted to the Operations Center when collected but should be held by the local plan and remitted after a large amount had been collected. He expressed the opinion also that Group Hospitalization, Inc. should retain the interest income it earned on the Plan refunds because there was no contractual requirement that these refunds be returned to the Operations Center as they were collected from the hospitals. An official of the Operations Center informed us that no attempt would be made to collect from Group Hospitalization, Inc., the interest that was lost by the Plan because of the delay in receipt of the refunds.

In the draft report submitted to the Commission for comment, we concluded that, because Group Hospitalization Inc., had been advanced sufficient Plan funds to pay current obligations to hospitals, the funds collected by Group Hospitalization, Inc., from the hospitals because of overpayments should have been promptly remitted to the Operations Center; also, because Group Hospitalization, Inc., and the Operations Center were, for all intents and purposes, one entity with the same personnel keeping accounting records and processing payments to and receipts from local plans, there appeared to have been even more reason for Group Hospitalization, Inc., to have remitted promptly to the Operations Center the Plan's portion of refunds.

The other local plans which we reviewed in Alabama and New York had remitted to the Operations Center within relatively short periods of time the Plan portion of refunds they had received, although they had no specific contractual requirement to do so.

We believe that, because Group Hospitalization, Inc., retained the Plan's portion of the funds collected as refunds for unreasonably long periods of time, the Plan should receive the interest income it otherwise could have earned on such funds.

Accordingly, we proposed that the Commission initiate action to recover from Group Hospitalization, Inc., the interest income lost by the Plan as a result of the delays in remitting amounts collected from hospitals for refunds attributable to Plan operations.

In commenting on the draft of this report, the Commission stated that it had been informed on February 26, 1970, that Group Hospitalization, Inc., had initiated a new procedure for billing amounts to the Operations Center for supplementary adjustments. This procedure is to credit the Operations Center quarterly for all refunds received and to bill it for final payments made during the quarter. The Commission expressed the view that crediting refunds quarterly under the revised procedure would adequately resolve the problem revealed in our review. The Commission also informed us that it was proceeding to obtain an interest adjustment based on the retroactive application of the current policy of Group Hospitalization, Inc.

Recommendations to the Chairman
Civil Service Commission

We recommend that the Chairman, Civil Service Commission, evaluate the new procedure of Group Hospitalization, Inc., for billing amounts to the Operations Center for supplementary adjustments, after it has been in effect for a few months, to ensure that the interests of the Plan are adequately protected.

We recommend also that the Commission determine whether there have been delays by other local plans in remitting

refunds received from hospitals and, is so, initiate appropriate corrective actions, including the establishment of procedures for ensuring that all local plans promptly remit to the Operations Center any refunds which are applicable to their Plan operations.

ACTIONS TAKEN TO REDUCE AMOUNTS ADVANCED TO LOCAL PLANS

Our review indicated that the Operations Center had advanced funds to certain local plans that appeared to be in excess of the amounts needed by these plans to meet current Plan obligations, because a formula used in computing the amounts needed had resulted in overstating the number of days required by the local plans to obtain reimbursement. After we brought this matter to their attention, officials of the Office of the Director, Federal Employee Program, revised the method of computing the advance deposits needed by local plans. We believe that, if properly implemented, the revised method of computation will result in minimizing the amounts advanced to local plans and maximizing funds available for investment.

The Commission's contract provides that receipts be available to the Corporations for payment of obligations incurred under the contract:

> "*** and, in the sound discretion of the Corporations, to make an advancement to any Plan in such amount as is deemed required to relieve such Plan of the necessity of using its own funds to discharge obligations incurred."

The local plans process and pay claims submitted by Plan enrollees and subsequently receive reimbursement for these payments from the Operations Center.

The Operations Center advances funds to local plans to provide them with working capital. The amounts of these advances are subject to adjustment by the Office of the Director, Federal Employee Program, on the basis of annual studies or information submitted by the local plans in support of requests for adjustment of their advances. As of June 30, 1969, advances totaling $19.69 million were held by about 140 local plans.

In its annual studies, the Office of the Director had estimated the average amount of funds required by each local plan during a calendar year primarily by means of a formula that was based, among other things, on the average number of days it took for a local plan to be reimbursed by the Operations Center for claims paid and on the average amount of the reimbursements received during the last 6 months of the preceding year. Other factors, such as enrollment trends and changes in estimated benefits to be paid, also were taken into consideration in determining the amounts of the advances. Our review showed that in prior years amounts equal to about 80 percent of the amount computed by means of the formula usually had been advanced to local plans.

It appeared to us that the formula used by the Office of the Director had resulted in overstating the number of days required by local plans to obtain reimbursement and therefore could have resulted in an overstatement of their estimated average needs. Since these estimates had been used in determining the amount of the advance to which each plan was entitled, the advances held by some plans could have been in excess of their needs. Any excess funds advanced would not have been available for investment by the Operations Center and thereby would have resulted in a loss of investment income to the Plan.

We suggested certain changes in the formula which would have the effect of reducing the estimate of the average number of days required for local plans to obtain reimbursement for claims paid. Officials of the Office of the Director agreed with our suggestions and revised the formula accordingly.

The Office of the Director used the revised formula in 1969 in computing advances required by local plans. Our review showed that, as of June 30, 1969, a total of $19.7 million had been advanced to local plans. We estimated that, if the revised formula had not been used, these advances would have totaled about $20.2 million, or about $550,000 more than the amount actually advanced.

CHAPTER 3

SUBSCRIPTION CHARGES AND ENROLLEES' CLAIMS

Both subscription charges (premiums) and enrollees' claims have increased substantially since inception of the Plan in 1960. Following is a summary for the four calendar years ended December 31, 1969, of the portions of subscription charges which the Commission forwarded to the Operations Center and of the enrollees' claims recorded by the Operations Center.

Year	Subscription charges	Enrollees' claims	Underwriting profit or loss(—)
	(millions)		
1966	$302.7[a]	$272.8	$29.9
1967	378.0	342.2	35.8
1968	386.2	406.6	—20.4
1969	496.2[a]	487.9	8.3

[a]Includes payments from the Commission's contingency reserve of $15.8 million in 1966 and $17.5 million in 1969.

The following tabulation shows, for each option, the biweekly subscription charges from inception of the Plan through January 1, 1970, and the increases in subscription charges.

Service Benefit Plan

Option	Biweekly Subscription Rates Effective 7-1-60	11-1-64	7-18-66	1-1-67	1-1-68	1-1-69	1-1-70	Increase 7-1-60 to 1-1-70 Amount	Percent
High--self only									
Individual	$2 11	$ 2 92	$ 2 54	$ 3 32	$ 3 89	$ 4 98	$ 5 57	$3 46	164 0
Government	1 30	1.30	1 68	1 68	1 68	1 68	1 68	38	29 2
Total	$3.41	$ 4 22	$ 4 22	$ 5 00	$ 5 57	$ 6.66	$ 7 25	$3 84	112 6
High--self and family									
Individual	$5 82	$ 7 88	$ 6 90	$ 8 96	$ 9.50	$12 16	$13 59	$7 77	133 5
Government	3 12	3 12	4 10	4 10	4 10	4 10	4 10	98	31 4
Total	$8 94	$11 00	$11 00	$13 06	$13 60	$16 26	$17 69	$8 75	97 9
Low--self only									
Individual	$1 30	$ 1 30	$ 1.30	$ 1 68	$ 1 68	$ 1 76	$ 2 16	$ 86	66 2
Government	1.30	1 30	1 30	1 68	1 68	1 68	1 68	38	29 2
Total	$2 60	$ 2.60	$ 2 60	$ 3 36	$ 3 36	$ 3 44	$ 3 84	1 24	47 7
Low--self and family									
Individual	$3 44	$ 3 44	$ 3 28	$ 4 10	$ 4 10	$ 4 24	$ 5 30	$1.86	54 1
Government	3 12	3 12	3 28	4 10	4 10	4 10	4 10	.98	31 4
Total	$6.56	$ 6 56	$ 6 56	$ 8 20	$ 8 20	$ 8.34	$ 9 40	$2 84	43 3

As shown above, the increases in biweekly costs to individuals under the various options ranged from $0.86 to $7.77 and percentage increases ranged from 54.1 percent to 164.0 percent; the increases in biweekly costs to the Government under the various options ranged from $0.38 to $0.98, and percentage increases ranged from 29.2 to 31.4 percent. With respect to the high options, in which about 89 percent of the participants are currently enrolled, the subscription costs to individuals have more than doubled since 1960.

In September 1968 the Commission contracted with a consultant actuarial firm to make a study of the increases in operating costs and subscription charges and certain other aspects of the two Government-wide plans--the Service Benefit Plan and the Indemnity Benefit Plan. The consultant actuaries issued two reports as a result of this study.

In an October 1968 report, the consultant actuaries recommended that (1) increases in subscription charges to cover anticipated claims, including a reasonable projection of trends in utilization, costs, and benefit changes, be permitted every 2 years and that (2) changes in subscription

charges in the intervening periods be discouraged and limited to the anticipated cost of benefit changes made at that time, or changes in anticipated claims over those originally projected.

The Commission had not taken official action with respect to the above recommendations of the consultant actuaries. In July 1970 we discussed these recommendations with Commission officials who expressed the opinion that, because of rapid increases in health benefits costs, the amount of premium increase required to support the benefit structure for a 2-year period would be prohibitively high for the first year.

In a January 1969 report "Analysis of Premium and Experience Trends 1960-1968 and for the Future," the consultant actuaries stated that premium increases for both Government-wide plans had been several times greater than the benefits added--about eight times greater for the high option plans and about three times greater for the low option plans.

They stated also that increases in claim payments under original benefit provisions had accounted for much of the premium increase and that claim payments had paralleled the inflation in hospital and medical costs. They expressed the opinion that payments for physicians' services and hospital costs would continue to increase and concluded that, for the next several years, premiums for both Government-wide plans could be expected to increase between 10 percent and 35 percent every 2 years, and probably would average between 20 percent and 25 percent every 2 years from 1969 to 1976.

CHAPTER 4

ADMINISTRATIVE EXPENSES

Administrative expenses of the Plan include those charged by the Commission, the Corporations, and the individual local plans.

ADMINISTRATIVE EXPENSES OF THE CIVIL SERVICE COMMISSION

The law provides that a portion not to exceed 1 percent of all contributions made by the employees, annuitants, and the Government be set aside in the Employees Health Benefits Fund to pay the Commission's expenses of administering the Program. The Commission does not allocate its administrative expenses among the individual benefit plans. For calendar years 1968 and 1969, the Commission's administrative expenses charged to the entire Program amounted to $1.3 million and $1.2 million, respectively.

ADMINISTRATIVE EXPENSES OF THE CORPORATIONS AND LOCAL PLANS

Under the Commission's contract the Corporations are entitled to reimbursement for:

> "*** the actual necessary expenses incurred in connection with the administration of this contract, determined by the corporations on an equitable and reasonable basis, with proper justification and accounting support."

The contract contains no other guidelines for determining either the types of expenses which may be charged or the amounts allowable; however, the annual allowances for administrative expenses may not exceed 4.5 percent of subscription charges for the contract year.

The administrative expenses charged to the Plan have included expenses incurred by the participating local plans; the Office of the Director, Federal Employee Program; the

Operations Center in Washington, D.C.; and the national offices of the Corporations in Chicago, Illinois.

The Operations Center receives funds from the Commission and reimburses the national offices of the Corporations and the participating local plans for administrative expenses incurred in connection with the Plan. The Blue Cross Association in Chicago pays the expenses of the Office of the Federal Employee Program Director in Washington, D.C., and, in turn, is reimbursed by the Operations Center.

Each participating local plan receives from the Operations Center monthly an administrative expense allowance based on its actual program administrative costs for the preceding contract year, which is adjusted to reflect rising price levels. Following the end of a contract year, the plans submit to the Operations Center reports showing their actual administrative expenses applicable to the Plan for the year. On the basis of these reports, the Operations Center charges or credits a local plan with the difference between the total expense allowance received and the actual administrative expenses charged during the year.

The administrative expenses charged to the Plan amounted to $10.3 million for 1966, $12.5 million for 1967, $15.7 million for 1968, and $22.2 million for 1969. A summary of these charges by organizational unit follows.

	Administrative expenses charged for contract year ended December 31			
	(millions)			
	1966	1967	1968	1969
Local plans:				
Blue Cross	$ 4.1	$ 4.8	$ 5.7	$ 7.4
Blue Shield	3.8	4.9	6.5	10.7
Operations Center	2.2	2.5	3.3	3.6
National associations	.2	.3	.2	.5
Total	$10.3	$12.5	$15.7	$22.2

Our review of the administrative expense charges, which was made principally in 1967 and 1968, covered selected charges by the national offices of the Blue Cross Association and the National Association of Blue Shield Plans in Chicago, Illinois; by the Office of the Director, Federal Employee Program, in Washington, D.C.; and by the local plans in Birmingham, Alabama; New York, N.Y., and Washington, D.C.

We did not make a comprehensive review of the administrative expense charges by the Operations Center and by the local plans in Washington, D.C., because officials of the local plans advised us during our review that the procedures for allocating administrative expenses were being revised and that the allocations for 1966 and 1967 would be recomputed.

An official of the Operations Center later advised us that the reallocations of administrative expenses for 1966 and 1967 had been completed. These reallocations resulted in a net decrease of $360,047 in the total administrative expenses charged to the Plan for the 2 years. This net decrease represented a reduction of $341,537 for the Blue Cross local plan, a reduction of $234,494 for the Blue Shield local plan, and an increase of $215,984 for the Operations Center.

With respect to the other administrative expense charges covered in our review, we noted certain questionable charges, principally by the Corporations, which were brought to the attention of the Commission's Bureau of Retirement, Insurance and Occupational Health. These questioned charges related mainly to travel and entertainment expenses and to allocations of the costs of actuarial services.

The Director of the Bureau agreed that many of the individual items we had questioned represented questionable charges, and he said that the Commission would make a further review to determine whether these charges were allowable under the contract. The Chief of the Commission's Office of Systems and Audits subsequently advised us that audit exceptions had been taken with respect to the charges

for administrative expenses and that the Corporation had agreed to make adjustments totaling about $25,000 with respect to charges of the types we had questioned.

We noted also that, as a result of a change in policy, the Alabama Blue Cross and Blue Shield local plan had recorded as capital assets certain equipment which had been previously charged off to expenses. Under this revised accounting procedure, the Plan might ultimately have been charged twice for a portion (about $19,000) of the cost of the equipment--once when the equipment was initially purchased and charged as an expense and again in future annual depreciation expense charges.

After we brought this matter to his attention, the local plan's controller advised us that depreciation would not be charged on equipment previously charged to expenses. The Executive Director of the Commission informed us that a memorandum cautioning against possible duplicate charges for depreciation of equipment previously charged to expense had been issued to all participating local plans.

CHAPTER 5

REIMBURSEMENTS FOR STATE PREMIUM TAXES

The contract with the Corporations provides for charging to the Plan all taxes incurred pursuant to operations under the contract. The local plans in 14 States have been required to pay premium taxes levied by the States. From inception of the Plan in 1960 through December 31, 1969, the Operations Center had reimbursed local plans $1,280,813 for such taxes, as shown in the following tabulation.

State	Amount	Percent
Alaska	$ 6,334	.49
Connecticut	31,835	2.49
Illinois	12,639	.99
Indiana	40,859	3.19
Maine	336	.02
Mississippi	282,145	22.03
Nebraska	66,150	5.16
New Mexico	120,134	9.38
North Carolina	73,520	5.74
Ohio	2,262	.18
South Dakota	111,149	8.68
Tennessee	493,768	38.55
Virginia	31,486	2.46
Washington	8,196	.64
Total	$1,280,813[a]	100.00

[a]In addition, State premium taxes of $223,119 had been accrued by the Operations Center but not reimbursed to local plans.

We noted that proposed legislation (H.R. 769, 91st Cong., 1st sess.) introduced in the House of Representatives on January 6, 1969, would provide for exempting premiums under the Federal Employees Health Benefits Program and the Federal Employees' Group Life Insurance Program from taxation by States and political subdivisions.

CHAPTER 6

RISK CHARGE ALLOWANCES

Since inception of the Plan in 1960, the Commission's contract with the Corporations has provided for annual risk charge allowances equal to specified percentages of subscription charges. The purpose of these allowances has been to compensate the local plans for the underwriting risks involved. Through December 31, 1969, the allowances amounted, in total, to $33.7 million, or 1.24 percent of the total subscription charges.

The contract for the first 3 contract periods provided for a risk charge allowance of 1.5 percent of subscription charges. Effective November 1, 1963, the contract was amended to provide for a sliding scale risk charge allowance which was to be determined on the basis of the number of months' subscription charges in the total Plan reserves held by the Corporations at the end of the year, as indicated below, for the 1966 contract.

Number of months' subscription charges	Percent of subscription charges allowable as risk charge
3.127 or more	1.0
2.139 but less than 3.127	1.1
1.151 " " " 2.139	1.2
Less than 1.151	1.3

For 1967 the method of computing the risk charge allowance was the same as that in 1966 except that the maximum allowance was 1.2 percent of the subscription charges. For 1968 and 1969 a flat rate of 1.15 percent of subscription charges was allowed. For 1970 a flat rate of 1 percent of subscription charges will be allowed--one third less than the 1.5 percent rate allowed when the program started in 1960. The amounts of the total subscription charges and risk charge allowances for the last 4 years were as follows:

Year	Subscription charges	Risk charges
	(millions)	
1966	$302.7	$3.6
1967	378.0	4.2
1968	386.2	4.4
1969	496.2	5.7

The Commission's regulations provided that, if the reserves held by the Corporations at the end of a year were less than a specified amount, the Corporations were entitled to a payment from the contingency reserve held by the Commission. The regulations provided also that the Corporations would credit the amount so paid to a special reserve for the plan.

On the basis of the Corporations' reserves at December 31, 1965, the Commission, in 1966, paid $15.8 million from the contingency reserve for the Plan and allowed a risk charge of 1.2 percent of the $15.8 million, or about $190,000. We questioned this portion of the risk charge allowance, because it appeared to us that the 1966 contract provisions for the Plan could have been interpreted as not permitting a risk charge on the contingency reserve payment.

The contract contained no provisions relating to payments from the contingency reserve, but it did specify that the subscription charges paid by the Commission would not include amounts set aside by the Commission for the contingency reserve and that the risk charge allowance would be computed as a percentage of subscription charges.

We discussed these matters with Commission officials who informed us that both the Commission and the Corporations had understood that payments from the contingency reserve were to be treated as subscription income and that a risk charge would be allowed on such payments. These officials said, however, that, as long as there was any possible question as to the intent of the parties, the contract with the Corporations would be amended to clarify the intent. The contract was amended effective January 1, 1969, to

specify that subscription charges would include payments from the contingency reserve.

The consultant actuaries' report dated October 1968 (see p. 22) stated that, because of the apparent financial success of the Program and the availability of needed resources in the form of premium increases, special reserves, and excess contingency reserves, the risk charge could be reduced to a uniform 1 percent for the two Government-wide plans. The contracts for the two Government-wide plans were amended effective January 1, 1970, to provide for risk charge allowances equal to 1 percent of subscription charges.

A Commission official informed us that, for the Plan, the reduction of the risk charge allowance from 1.15 percent of subscription charges to 1 percent of subscription charges would reduce expenses by about $900,000 for 1970.

CHAPTER 7

RESERVES

The ability of the Corporations to fulfill their commitment to provide benefits to Federal employees enrolled in the Plan depends first on the adequacy of the rates charged. As a backstop to the income received during a year, the Plan has accumulated reserves from operations of prior years. These reserves are maintained in part by the Commission and in part by the Corporations.

CONTINGENCY RESERVE MAINTAINED BY COMMISSION

Pursuant to the authorization in the Federal Employees Health Benefits Act, the Commission has retained about 3 percent of all contributions to provide a contingency reserve. The Commissions' contingency reserve has been used to increase the Corporations' reserves in cases where they fell below prescribed amounts. At December 31, 1968 and 1969, the Plan's contingency reserves totaled about $76.2 million and $81.3 million, respectively. In May 1970 the Commission transferred about $38.8 million of these reserve funds to the Corporations.

RESERVES MAINTAINED BY CORPORATIONS

Pursuant to their contract with the Commission, the Corporations, in addition to maintaining reserves for accrued claims, maintained a special reserve and a carrier reserve. The provision authorizing the maintenance of the carrier reserve was deleted from the 1970 contract. Following are comments regarding each of these types of reserves.

Reserves for accrued claims

The Corporations determine at the end of each quarter the liability that exists to make future payments to the Plan's participants on illnesses and claims for benefits that began prior to the valuation date. Such payments represent liabilities charged against the subscription income earned for the period ending on the valuation date.

Following is an analysis showing, as of the end of 1969 and 1968, the portions of the reserves for accrued claims attributable to the high and low options.

Reserves for accrued claims	December 31 1969	1968
	(millions)	
High option	$133.7	$108.2
Low option	7.9	5.7
Total	$141.6	$113.9

The procedures followed by the Corporations in establishing their reserves for unpaid claims involved the use of certain actuarial estimates, and we did not review these estimates. We noted, however, that consultant actuaries employed by the Commission had reviewed the Corporation's estimating procedures for periods prior to 1968 and had concluded that the estimates of liability were fairly reliable.

Special reserve

The special reserve, which was established to provide for possible future operating losses, represents the excess of income over all allowable charges.

The balances in the special reserve have ranged from a low of about $20.9 million at the end of the ninth contract period, December 31, 1969, to a high of about $70 million at the end of the seventh contract period, December 31, 1967. Despite increases in subscription charges, the reserve was reduced by about $35 million in 1968 and by about $14 million in 1969, mainly because of substantial increases in health benefit costs for these years.

The contract between the Commission and the Corporations provides that, upon termination of the contract, any balance remaining in the special reserve after settlement of accrued liabilities and certain liquidation expenses will be returned to the Commission.

Carrier reserve

As a result of a July 1962 amendment retroactive to the first year of the Plan, the contract between the Commission and the Corporations provided that any investment income remaining after distributing the risk charge portion of the investment income to the Corporations, the local plans, and the special reserve be credited to a carrier reserve held by the Corporations to supplement the special reserve or, after notice to the Commission, for other purposes of the Plan. The contract contained no provision for the disposition of the carrier reserve.

In May 1963 the Commission proposed to amend the contract to abolish the carrier reserve by merging it with the special reserve. The Corporations rejected the proposal but agreed to "freeze" the carrier reserve at October 31, 1963, at which time it totaled about $697,000. Therefore the contract was amended effective November 1, 1963, so as to eliminate the provision for adding to this reserve.

Over the next several years the Commission periodically renewed its proposal for merging the carrier reserve with the special reserve. These proposals were rejected by the Corporations, however, on the basis that such a merger would constitute surrender of Plan funds to which the Blue Cross and Blue Shield organizations felt they had title.

In March 1968 the Corporations informed the Commission that they planned to use a portion of the carrier reserve funds to defray the costs of two proposed research projects. The Commission agreed that both of the proposed projects were worthwhile, and in June 1968, the Corporations engaged a private research institute to make a study of the procedures for processing claims for supplemental benefits. Through March 31, 1970, payments of $119,807 had been made to the private research institute, and payments of $1,200 had been made to the National Association of Blue Shield Plans for related incidental expenses, for total charges to the carrier reserve of $121,007.

An official of the Corporations informed us that the research institutes' proposed system for processing

supplemental claims would be implemented, at a cost of about $70,000. Annual savings of about $530,000 were expected to be realized through implementation of this system.

In the draft of this report forwarded to the Commission for comments, we expressed our belief that a reversionary clause in the contract similar to the one provided for the special reserve would have avoided any misunderstanding as to the ownership and ultimate disposition of the carrier reserve funds and suggested that, in any future contract changes involving reserves, the Commission should require the inclusion of appropriate language providing a reversionary interest to the Plan.

Agency comments and our evaluation

The Chairman of the Commission informed us that (1) the carrier reserve had been established in an effort to pioneer a change in the insurance industry practice of retaining, as part of their reserves, the interest earned on funds reserved to pay claims, (2) the Corporations had transferred all but $200,000 of the carrier reserve to the special reserve for use in offsetting underwriting losses incurred in 1968, and (3) in negotiating the 1970 contract, the parties had agreed to delete the provision for a carrier reserve and to transfer to the special reserve any portion of the $200,000 originally earmarked for the supplemental benefits system analysis project that was not used for the project.

Although the questions relating to ownership and disposition of the carrier reserve funds have now been resolved, we believe that, to avoid possible misunderstandings and to preserve the assets of the Plan's enrollees, the Commission should require reversionary interest provisions to be included in any future contract amendments authorizing the establishment of reserves by either the Corporations or the local plans.

CHAPTER 8

INVESTMENT INCOME

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

INTEREST ON FUNDS CONTROLLED BY THE COMMISSION

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

At December 31, 1969, the Secretary of the Treasury had invested about $140 million of Program funds in U.S. Treasury bills, bonds, and notes. These securities had maturity dates ranging from January 31, 1970, to November 15, 1998, and were earning interest at annual rates ranging from 3-1/2 percent to 7-1/2 percent. We estimated that the average yield on such investments for 1969 was about 5.1 percent.

For 1968 and 1969 the total interest income earned on Employees Health Benefits Fund investments was $5.2 million and $6.3 million, respectively. Of these amounts, the Commission allocated about $3.5 million to the Plan for 1968 and about $4.1 million for 1969.

INTEREST ON INVESTMENTS BY CORPORATIONS

The Commission's contract requires the Corporations to invest all Plan funds on hand which, in their judgment, are in excess of the amount needed to discharge promptly the obligations incurred under the contract (see p. 11 for additional discussion on investment of Plan funds) and to

distribute part of the investment income among the Corporations and the participating local plans.

The total amount to be distributed to local plans is computed by multiplying half of the amount of the risk charge for the contract year by the average rate of investment income earned during the year. The amount to be distributed to each participating plan is computed on the basis of the amount of health benefit payments incurred by the plan in relation to the total amount incurred by all participating plans. Any remaining investment income is added to the special reserve held by the Corporations. (See p. 33.)

Appendix II shows, for 1969 and cumulatively since inception of the Plan, the gross investment income and the portion of this income distributed to participating local plans.

At December 31, 1969, the Operations Center had about $6.5 million of Plan funds in an interest-bearing savings account and had invested additional Plan funds in securities having maturity dates ranging from February 1970 to January 1979. The types and amounts of these securities are summarized below.

Type of security		Cost
U.S. Treasury obligations		$17,470,545
Obligations of:		
Federal home loan banks	$ 3,000,000	
Federal land banks	13,740,430	
Federal National Mortgage Association	39,685,343	
Farmers Home Administration	10,771,456	
Export-Import Bank of the United States	11,500,000	78,697,229
Others		2,195,000
Total		$98,362,774

During the year ended December 31, 1969, interest income on all investments amounted to $6,135,212, of which $144,529

was allocated to participating local plans and $5,990,683 was credited to the special reserve held by the Corporations.

ALLOCATIONS OF INVESTMENT INCOME AMONG THE HIGH AND LOW OPTIONS

The Corporations allocate the portion of the interest income credited to the special reserve among the reserves applicable to the high and low options for Blue Cross and Blue Shield insurance and for supplemental benefits. Our review indicated that the balances of the special reserves for the high options were understated and that the balances for the low options were overstated, because the allocation method used by the Corporations had not resulted in distributing interest income among the options in proportion to the amount of each option's funds used in earning such income.

Because changes in premium rates are based, in part, on the year-end balances of the special reserves, overstatements or understatements of the various options could result in the establishment of premium rates for the high and low options which are higher or lower than the rates required to pay the related benefit claims and expenses.

Of the interest income of about $6 million credited to the Corporations' special reserve in 1969, about $1.1 million (18 percent) was allocated to the high-option reserves and about $4.9 million (82 percent) was allocated to the low-option reserves. These allocations were made by the Corporations under an allocation method which took into consideration only the special reserve balances at the beginning and end of a year, exclusive of the interest income earned during the year.

We believe that the allocation method used by the Corporations did not result in distributing interest income among the options in the proper ratios because it did not take into consideration the substantial amount of interest earned on funds held for payment of future benefit claims, most of which were applicable to the high options. The balances of the special reserves at the end of a year

represent the cumulative surplus or deficit from operations after (1) deducting the liability for expenses and health benefits on which claims had not been received or processed and (2) adding any subscription income earned but not received.

At December 31, 1969, the balances of the Corporations' special reserves, exclusive of the investment income earned during the year, totaled about $14.8 million, whereas about $104.9 million was invested in securities and a savings account. Most of the difference of about $90 million represented funds held by the Corporations to pay future benefit claims. We believe that these funds were principally applicable to the high options because, from inception of the Plan in 1960 through 1969, more than 90 percent of the subscription charges paid to the Corporations were derived from high-option premiums.

In the draft of this report, we proposed that the Commission initiate action toward the adoption of a method of allocating investment income that would result in reasonable and equitable distributions between the high- and low-option reserves. We suggested, as a possible means of achieving such distributions, that the method of allocating interest income among the high and low options be revised to take into consideration the estimated amounts required for payment of future benefit claims and the estimated amounts of subscription charges earned but not received from the Commission.

Agency comments and our evaluation

In commenting on our draft report, the Chairman of the Commission stated that our suggested method of allocation had been discussed with the Corporations and that they had agreed to use this method of allocation commencing with calendar year 1969.

Although the action of the Chairman carries out the recommendation in our draft report, we now believe that the revised method of allocation should be applied retroactively for each year since inception of the Plan because the balances of the reserves, used as one factor in determining

subscription rates for the different options, will otherwise continue to be based, in part, on the prior inequitable allocations of investment income.

In August 1970 we discussed our views with a responsible official of the Commission. He stated that our conclusion regarding the desirability of retroactive application of the revised method of allocation appeared to have some merit, and he said that the Commission would discuss this matter further with the Corporations.

Recommendation to the Chairman,
Civil Service Commission

We recommend that the Chairman, Civil Service Commission, require verification, as part of the Commission's periodic audits of the activities of the Operations Center, that the Corporations' allocations of investment income among the options are reasonable in relation to the sources of the funds used in earning such income.

CHAPTER 9

STUDY TO BE MADE OF NEED TO CONTINUE MAKING ALLOWANCES TO LOCAL PLANS FOR MANDATORY CONTINGENCY RESERVES

The laws of some States require local plans to maintain contingency or epidemic reserves in addition to their other reserves. The requirements for annual additions to the contingency reserves differ from State to State ~~in accordance with the State law~~; however, all of the States have laws which provide for discontinuance of such annual additions when a local plan's contingency reserve reaches a specified maximum.

The ~~Commission's~~ contract with the Corporations provides for annual allowances to participating local plans of amounts necessary to satisfy their mandatory contingency reserve requirements to the extent that such requirements exceed the pro rata shares of the risk charges applicable to such plans. Pursuant to this provision, contingency reserve allowances totaling $2,057,877 were charged to the Plan during the period July 1, 1960, through December 31, 1969. According to data furnished us by the Corporations in June 1970, about $1.4 million of the total allowances had been paid to 31 local plans in nine States; the remainder had been accrued but not paid. The cumulative payments to local plans ranged from $96 to $215,021 each. The allowances charged for 1969 totaled $384,643.

We noted that the State of New York had revised its law in 1965 to require local plans to add annually to their contingency reserves amounts equal to 1 percent of their annual net premium income with a maximum accumulation of 5 percent of such income; the ~~State~~ law had previously required annual additions to contingency reserves equal to 2 percent of annual net premium income with a maximum accumulation of 15 percent of such income.

We examined into the effect of the change in the requirements on a local plan in New York State which previously had

been paid allowances of Plan funds totaling about $80,000 to assist in meeting the statutory reserve requirements. Our review showed that between December 31, 1964, and December 31, 1965, this local plan's statutory reserve had been reduced by about $14.6 million. Also, because there was no provision in the Commission's contract requiring a return of funds in cases where statutory reserve allowances were no longer required, the local plan had been permitted to retain the $80,000 of Plan funds it had previously received.

Reserve Agreements Needed

On the basis of the balances totaling $111.4 million at December 31, 1968, of the reserves held by the Commission and by the Corporations (see p. 32.) and of the ability of the Corporations to obtain frequent increases in subscription charges to cover increases in health benefit costs, it appeared to us that additional contingency reserves were not needed to protect the interests of the Plan enrollees. Therefore we proposed in the draft of this report that the Commission undertake a study to determine the reasonableness of and the necessity for continuing to make allowances to local plans to assist them in meeting statutory reserve requirements.

AGENCY COMMENTS AND OUR EVALUATION

In responding to our draft report, the Commission cited certain comments it had received from the Corporations relating to mandatory statutory reserves but did not otherwise comment on our proposal that the Commission make a study to determine the reasonableness of and the necessity for continuing to make mandatory statutory reserve allowances to local plans. The cited comments consisted principally of an explanation of the nature, use, and legal basis for mandatory statutory reserves.

The essence of the Corporations' explanation is that (1) a typical State statute requires a local plan annually to set aside in a restricted reserve a specified percentage of the subscription income received from all sources until the reserve reaches a prescribed maximum, (2) after allocation to such a reserve, the funds lose their identity with respect to any particular line of business and are irretrievably commingled, and (3) the use of mandatory reserve funds depends on the overall underwriting experience of the local

plan rather than any single line of business, e.g., in the event of overall adverse underwriting experience, a local plan would use any available unassigned surplus to cover the loss before using its mandatory reserve, which generally may not be used without obtaining advance consent from the State insurance department.

The Corporations stated that they could not consider deleting the provision for mandatory statutory reserves allowances from the contract and expressed the opinion that such an act would be inequitable because it would result in shifting the Federal employees' and Government's obligations to the local plans' other enrollees.

We do not agree that deletion of the contract provision for statutory reserve allowances would be inequitable. To the contrary, we believe that, because the Commission and the Corporations maintain contingency reserves which, in our opinion, are adequate to protect the interests of the Plan's enrollees, the allowances to local plans for the purpose of establishing additional contingency reserves are inequitable to the Plan's enrollees, who are required to pay for the unneeded additional contingency reserves in the form of increased premiums.

After receiving the Commission's comments, we made a further review of the statutory reserve requirements of 10 States, including seven of the nine States in which payments had been made to local plans for statutory reserve allowances.

The laws of each of the 10 States permitted local plans to invest their contingency reserve funds without placing any restrictions on the use to be made of the interest earnings on such investments and the laws of four of these States used the term "surplus" in describing the required contingency reserves. Nine of the States permitted local plans to retain custody of their contingency reserve funds; one State required that the contingency reserve funds be forwarded to the State for custody but specifically provided that local plans could arrange for investment of such funds. Thus, although the use of contingency reserve funds may be restricted, the local plans receive continuing benefits from the establishment of the contingency reserve.

The laws of some States specifically authorize the State insurance departments to exercise judgment with respect to the amounts of contingency reserves to be required. Since the maintenance of substantial contingency reserves by organizations other than insurance carriers, such as those maintained by the Commission and the Corporations, probably is unique in the insurance industry, we believe that, if the Program and the effects of the State requirements were adequately explained to State insurance officials, it might be possible to obtain the elimination of the contingency reserve requirements applicable to the operations of the local plans under the Plan.

In July 1970 we discussed our views on the above matters with officials of the Commission. These officials stated that, in view of the potential for obtaining reductions in State contingency reserve requirements, the Commission would undertake a comprehensive study of the reasonableness of and the necessity for continuing to make allowances to local plans for assisting them in meeting statutory reserve requirements.

We plan to examine into the adequacy and effectiveness of the Commission's actions after it has completed its study.

CHAPTER 10

FINANCIAL MANAGEMENT ASPECTS OF PROGRAM

The Bureau of Retirement, Insurance and Occupational Health is responsible for administering the Federal Employees Health Benefits Program. These responsibilities include, among other things:

1. Negotiating with insurance underwriters, employee organizations, and other health benefits carriers to provide the health benefits authorized,

2. Determining that carriers meet the established standards and eligibility requirements and comply with contract provisions,

3. Prescribing regulations, procedures, and forms for carriers, employing agencies, and enrolled employees and annuitants,

4. Determining the eligibility of enrolled employees to continue receiving health benefits after retirement and determining the eligibility of survivors of active employees and survivors of annuitants for continuing benefits,

5. Receiving, depositing, and accounting for employee withholdings and agency contributions to the Employees Health Benefits Fund and maintaining necessary control accounts and records,

6. Withholding and depositing subscription charges from annuity payments of retirees and survivors, and

7. Conducting a continuing study of the operation and administration of the Program, including surveys and reports on health benefits plans available to employees and on the experience of the plans.

APPROVAL OF ACCOUNTING SYSTEM FOR PROGRAM

In furtherance of our interest in the financial management practices of Federal agencies, we made a number of suggestions to the Commission for improving its accounting for and reporting on the Program operations.

In line with our suggestions, the Commission made certain revisions in its procedures which would provide full disclosure of the financial results of Program activities. The more significant revised procedures provide for recording in Program financial records and including in the financial statements:

--the Program funds held by insurance carriers as reserves. At December 31, 1969, these reserves totaled about $57.5 million of which about $20.9 million was held by the Corporations under the Plan.

--the interest earned on the reserve funds held by the health benefits carriers. For the year ended December 31, 1969, such interest income amounted to about $8 million, of which about $6 million had been earned on funds held by the Corporations for the Plan.

After reviewing and testing the operation of the Commission's accounting system for the Program, we approved the system on November 25, 1968, as being adequate and in conformity with the principles, standards, and related requirements of the Comptroller General.

COMMISSION'S AUDITS OF OPERATIONS UNDER THE PLAN

The Commission's external audits of activities at the Corporations' Operations Center and at participating local plans are performed by the Office of Systems and Audits. The Chief of this Office reports to the Director, Bureau of Retirement, Insurance and Occupational Health. ~~Such~~ The audits are performed as an aid to the administration of the contract rather than as part of the Commission's central internal audit function which is carried out by the Office of

Management Analysis and Audits, Bureau of Management Services.

We reviewed the most recent audit report of the Office of Systems and Audits on review of the activities of the Corporations and the Operations Center, which covered the first three contract periods that began on July 1, 1960, and ended on October 31, 1963. We also reviewed the latest report on audit of the Washington, D.C., local plans, which covered the five contract periods ended December 31, 1965. All of these audits had been directed primarily toward selected aspects of financial operations.

We noted that no reviews or evaluations had been made by the Commission's internal auditors of the activities relating to the Commission's negotiations of the contract with the Corporations and amendments thereto or of the Bureau's general administration of the Plan activities.

In our prior report to the Congress on the review of the Commission's internal auditing activities (B-160759, March 20, 1967), we expressed the view that the scope of the Commission's internal audit program should be expanded to include reviews of the external audit work and of the contract negotiation and administration activities of the Commission in the same manner as other Commission activities are reviewed to ascertain, on behalf of top management, whether they are being carried out properly and effectively.

Subsequent to the completion of our review, the Director of the Office of Management Analysis and Audits informed us that a review of the external audit and management aspects of the Plan would be included as part of a review of the activities of the Bureau and that such a review had been started.

CHAPTER 11

SCOPE OF REVIEW

Our review was directed principally toward an evaluation of certain aspects of the policies, procedures, and practices followed by the Commission in administering its contract with the Corporations for providing health benefits to Federal employees under the Plan. The review did not include an evaluation of the actuarial assumptions used by the Commission.

We reviewed the basic legislation authorizing the Program and its related legislative history. We examined pertinent records and interviewed officials of the Commission, the Corporations, and selected local plans concerning various aspects of Plan operations.

In our review we examined into, among other things, (1) the reasonableness of the negotiated provisions of the Commission's contract with the Corporations, (2) the propriety and reasonableness of the amounts charged to the Plan by the Corporations and local plans for administrative expenses (except as noted on p. 26) and other charges authorized by the contract, and (3) the effectiveness of the Operations Center's policies and procedures for the management and control of Plan funds. We also examined the Commission's audit reports and related working papers pertaining to the Plan.

Our review was performed at Commission headquarters in Washington, D.C. , and at the offices of the Blue Cross Association and the National Association of Blue Shield Plans in Chicago, Illinois; the Director, Federal Employee Program, in Washington, D.C.; the Operations Center in Washington, D.C.; Group Hospitalization, Inc., in Washington, D.C. (local Blue Cross plan); Medical Service of the District of Columbia in Washington, D.C. (local Blue Shield plan); Associated Hospital Service of New York, N.Y. (local Blue Cross plan); United Medical Service, Inc., New York, N.Y. (local Blue Shield plan); and Blue Cross-Blue Shield of Alabama in Birmingham, Alabama (local Blue Cross and Blue Shield plan).

APPENDIXES

GOVERNMENT-WIDE SERVICE BENEFIT PLAN

ENROLLEES AT END OF EACH CONTRACT PERIOD

Contract period ended	Number of enrollees		
	Total	High option	Low option
Oct. 31, 1961	1,000,318	824,405	175,913
" " 1962	1,098,498	942,042	156,456
" " 1963	1,147,102	985,812	161,290
" " 1964	1,218,260	1,087,165	131,095
Dec. 31, 1965	1,248,756	1,120,449	128,307
" " 1966	1,348,593	1,199,183	149,410
" " 1967	1,441,352	1,286,670	154,682
" " 1968	1,475,514	1,308,650	166,864
" " 1969	1,508,613	1,330,113	178,500

SUMMARY PREPARED BY GAO OF STATEMENTS FURNISHED BY

GROUP HOSPITALIZATION, INC , AS OPERATIONS CENTER TO THE

U S CIVIL SERVICE COMMISSION

ON ANNUAL ACCOUNTING AND RESERVES

UNDER THE SERVICE BENEFIT PLAN

CUMULATIVE FROM JULY 1, 1960, TO DECEMBER 31, 1969,

AND FOR CONTRACT PERIOD JANUARY 1 TO DECEMBER 31, 1969

	Cumulative from July 1, 1960 to Dec 31, 1969	Contract period Jan 1 to Dec 31, 1969
SUBSCRIPTION INCOME		
Subscriptions accrued	$2,685,190,226	$478,704,916
Additional subscriptions received from Civil Service Commission's contingency reserve	35,923,067	17,543,576
Total subscription income	2,721,113,293	496,248,492
HEALTH BENEFITS CHARGES INCURRED (note a)	2,586,274,581	487,920,569
GROSS UNDERWRITING INCOME	134,838,712	8,327,923
EXPENSE AND RISK CHARGES INCURRED		
Expenses of administering the Service Benefit Plan	103,502,440	22,160,940
State taxes on premiums	1,503,932	276,797
Risk charge	33,709,268	5,706,857
Contributions toward contingency reserves of local plans required by State laws	2,057,877	384,643
Total expenses and risk charge	140,773,517	28,529,237
GAIN OR LOSS(-) FROM OPERATIONS	-5,934,805	-20,201,314
INVESTMENT INCOME		
Gross investment income	27,696,463	6,135,212
Less risk charge share allocated to participating local plans	734,695	144,529
Net investment income	26,961,768	5,990,683
EXPENDITURES FOR SUPPLEMENTAL RESEARCH PROJECT (note b)	105,107	75,507
GAIN OR LOSS(-) FOR THE PERIOD	20,921,856	-14,286,138
SPECIAL RESERVES, BEGINNING OF PERIOD	-	35,207,994
SPECIAL RESERVES, END OF PERIOD	$ 20,921,856	$ 20,921,856

[a]Includes the accrued liability for health benefits for which claims had not been received or processed At December 31, 1969, the accrued liability for such claims totaled about $141 6 million.

[b]A discussion of the expenditures for the supplemental research project appears on page 34

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

UNITED STATES CIVIL SERVICE COMMISSION
WASHINGTON, D C 20415

IN REPLY PLEASE REFER TO

YOUR REFERENCE

Mr. Walter B. Hunter
Assistant Director, Civil Division
U. S. General Accounting Office
Washington, D. C. 20548

APR 30 1970

Dear Mr. Hunter:

This is in response to your December 24, 1969, letter enclosing a draft of your proposed report to the Congress, on the Commission's administration of the Government-wide Service Benefit Plan of the Federal Employees' Health Benefits Program.

This letter gives our views on the major audit points and recommendations in the proposed report. Comments were obtained from the Blue Cross and Shield corporations as you requested, and a copy of those comments is attached. Our staff will furnish a separate memorandum discussing items of an editorial nature, and some figures that need to be changed, which are not covered in this letter. Regarding the accuracy of the data presented, however, our staff has not retraced the GAO audit efforts to verify all the figures used in the report.

The GAO started the audit of the headquarters operations of Blue Cross/Shield in December 1966. To avoid concurrent audits at this location by our Bureau (BRIOH) staff and GAO staff, we have not made any in depth reviews of this activity since then. During this period the Bureau's audit effort has been concentrated on reviews at Blue Cross/Shield local Plans, and at some of the 40 or so other health benefit Plans.

We have considered each point and recommendation in the report. Some of them undoubtedly would improve operations and we have already acted to adopt them. We appreciate the GAO efforts and comments in these areas.

General Comments

The Blue Cross (hospital services) and Blue Shield (physician services) Plan, discussed in the report, provide health insurance for about 1.5 million Federal enrollees, or about 60% of the total Federal employees

and annuitants. Including family members, the Plan insures over 4.5 million persons under the Federal employee program for an annual premium of about $500 million (1969). There are currently about 80 Blue Cross and 80 Blue Shield locals participating in this program. The Federal employee portion comprises only about 6% of their total business.

The GAO report in essence discusses a few of the matters involved in starting, and operating the program for the first nine years. Although the draft report does not so state, the number and nature of the items discussed confirms our belief that the program is being effectively administered.

We are concerned however, that a reader of the report who is not aware of the size and background of program operations might gain a misleading impression. Particularly, the draft report does not relate the audit points to the scope of the Commission's own efforts regarding the same matters. Most of the items discussed in the draft report are refinements of or current extensions of the Commission's own efforts in getting these matters resolved For example, refer to our detailed comments regarding the first audit point, on Management of Funds, starting on page 3 of this letter Also refer to our detailed comments (p.11) on the point relating to obtaining interest credits on the claims reserves for all health benefit plans. This action by itself, has resulted in actual savings of over $15,000,000 to date.

[See GAO note, p. 65.]

We believe also that it is important that this report be considered in the light of the Congressional intent on administration of the program, as evidenced during the legislative process. The 1959 health benefits law provided for contracting with qualified health benefit carriers meeting certain requirements, without regard to the normal competitive bidding process. It was the intent of Congress that the Federal government was not to receive preferential treatment, but was to be in the role of a large employer contracting for health benefits coverage for its employees. The concept further provided that the insurers were to operate

in accordance with industry practices; and under State laws, including paying any required premium taxes, and maintaining reserves required by States. This concept adopted by the Congress, has for the past ten years provided a basis for a responsive program tailored to the needs of the employee.

Management of funds

The GAO draft states that "We found that funds in excess of the amounts needed to meet current obligations had not been invested by the Corporations. After we brought this matter to the attention of the Operations Center, actions were taken to provide for investment of these funds.

[See GAO note, p. 65.]

Minimizing the amount of funds held in non-interest-bearing checking accounts undoubtedly will result in improved earnings to the Federal Employee Plan. The discussion in the draft report however does not reveal that this point is merely a follow up on an earlier (1964) Bureau (BRIOH) audit report made available to GAO staff. The Bureau report stated--

> "The investment program based on excess funds not needed to discharge promptly all obligations should be re-examined by the Corporations. Experience factors such as checks outstanding, prompt bi-monthly payments from the Commission, a minimum cash-on-hand balance, and any other factors pertinent to the investment program should be considered in lieu of a constant requirement of one-half a month's subscription income."

At the time of the Bureau's report the Corporations' policy was to retain funds equal to two-weeks' benefit payments in checking accounts at the Operations Center. The Corporations thereafter changed their policy, to retain only one-week's benefit payments.

The potential for earnings from better fund management has increased rapidly in the last few years, because of large annual increases in premiums (benefits), and in interest rates.

Regarding the estimated additional earnings, the Corporations have indicated that because of sharp fluctuations in demand fund requirements, and judgemental factors involved, the GAO estimate of potential earnings

is higher than can reasonably be expected. We note that actual earnings in the savings account, in the first full year of operating under the revised procedure (1968) amounted to about $206,000

[See GAO note, p. 65.]

We note also that this audit point, submitted to the Commission as part of a draft report for comment, has already been reported to the Congress as part of another final report. (Compilation of Findings and Recommendations for improving Government operations -- B-138162, February 26, 1970.) The statements in that report should also be corrected with respect to the matters discussed above under this caption.

[See GAO note, p. 65.]

Return of Funds Due the Operations Center

The draft report discusses delays in refunding to FEP, certain overpayments collected from hospitals by the local Blue Cross Plan in Washington, D. C. (GHI).

From 1961 through 1965 the GHI contracts with 19 local hospitals provided for tentative payments to hospitals during the year, and final determinations at year end. As a result of a lengthy controversy between GHI and the hospitals over the amounts to be refunded, no settlements were made during these five years. Starting in February 1966 amounts due from 18 of the 19 member hospitals were gradually collected. Some of the amounts collected were again adjusted, with refunds going back to hospitals. GHI did not allocate the net collections, to insurance groups (including FEP), until final settlement with a particular hospital or group of hospitals.

The response from the Corporations states in part that --

> "It has been the practice of the Program to make adjustments for hospital costs in accordance with the practice of the local Plans in making adjustments for all lines of business. Since the inception of the Program in July of 1960 through December 31, 1968, the Operations Center has made payments to Plans of approximately $19,000,000 to reimburse them for net supplementary payments to hospitals. Depending on the Plans' local practice, varying periods of time elapsed between the time the Plans paid the hospitals and the time they were reimbursed by the Operations Center. Thus, the net effect of the practice for handling refunds from adjustments with hospitals has been more than fair to the Program.
>
> " * * *
>
> "Final settlements by GHI with hospitals in 1970 and subsequent years will no longer be accumulated and billed at one time since the settlements will be based on the fiscal year of each hospital. GHI has initiated a new procedure for billing amounts to the Operations Center for supplementary adjustments. This procedure is to credit the Operations Center quarterly for all refunds received and to bill it for final payments made during the quarter."

Crediting the refunds quarterly under procedures now adopted by the Corporations appears to adequately resolve this matter for the future. We are proceeding to obtain an interest adjustment, based on the retroactive application of the current policy which provides for quarterly crediting.

Administrative Expenses

The Corporations agreed to adjust for several items previously discussed by the GAO staff, and for questioned entertainment expenses.

[See GAO note, p. 65.]

Regarding the point on depreciation at the Alabama Blue Cross and Blue Shield Plan the draft report indicates that as a result of a change in policy the Plan had recorded as capital assets certain equipment which had been previously charged off to expenses. It is stated that the FEP might ultimately have been charged twice for a portion (about $19,000) of the cost of the equipment--once when the equipment was initially purchased and charged as an expense and again in future annual depreciation expense charges.

As indicated in the draft report, a memorandum was issued to all local plans participating in the Federal program, cautioning against possible duplicate charges to the program for depreciation of equipment previously charged to expense. It is noted however that though the plan recorded these items as capital assets, the draft does not make it clear that none of this depreciation on the assets had actually been charged to the Federal employee program.

Treatment of payments from contingency reserve

The draft report attempts to establish an interpretation of the Commission's contract with Blue Cross and Shield that was not intended by either of the parties to the contract. From the time of the first payments from the contingency reserve (1964) the Commission has consistently handled all payments from this reserve as part of subscriptions (premiums) paid to Plans. The amounts in the contingency reserve are collected as a part of the subscription charge to enrollees, and payments from it are used by the Plan for paying claims, in the same manner as other subscriptions paid biweekly to the Plan.

[See GAO note, p. 65.]

[See GAO note, p. 65.]

As evidenced above, there has been no doubt between the parties to the contract about the way in which payments from the contingency reserve were intended to be handled. Also, the risk charges on such payments have been paid in accordance with the intent of the contract and the contracting parties.

[See GAO note, p. 65.]

Mandatory Reserves

[See GAO note, p. 65.]

The Blue Cross/Shield corporations stated in their response to the draft report --

> "It appears that the GAO /draft/ Report reflects some misunderstandings as to the nature, use, and legal basis for the mandatory statutory reserves. They are required by state statute or by regulation having the force and effect of statute. A Plan cannot avoid setting aside such reserves in states where they are required. The typical statute requires their accumulation at the rate of 'X' percent of all subscription income per year, until they reach a prescribed maximum at which time contributions from all groups and lines of business cease, until the reserve falls below the maximum.
>
> "Although the mandatory reserve amount is taken off the 'top' of the subscription charge, and is levied, uniformly, against every group and every line of the Plan's business, perhaps the most important characteristic of these reserves is that once allocated, they lose their identity with respect to any particular group or line of business and are irretrievably co-mingled.

"Their use then depends upon the overall underwriting experience of the Plan rather than the experience of any single group or line of business. In the event of overall adverse underwriting experience, a local Plan will turn first to any unassigned surplus to cover the loss. If such funds are insufficient, the mandatory reserve is used (usually requiring the advance consent of the State Insurance Department). Use of these reserves relates in no way to the particular groups or lines of business that originally contributed them.

"The GAO Report suggests that provision for the payment of mandatory reserves to local Plans be deleted from Contract CS 1039. This the Corporations cannot consider, as such an act would simply shift the Federal Employees' and Government's obligation to the rest of the Plans' subscribers, a patently inequitable condition.

"Under this circumstance, the question as to whether or not a local Plan would continue to participate in the Program in the absence of provision for mandatory reserve payments becomes moot.

"The Report also suggests inclusion in Contract CS 1039 of a 'reversionary interest' clause to apply in the event of cancellation or reduction in mandatory reserve requirements, or termination of the master contract, or the participating agreement between the Corporations and any local Plan. Such a provision would be in direct conflict with the underlying purpose of the mandatory reserve (and perhaps with state statutes). This type of reserve is intended to guard against unanticipated severe adverse underwriting experience with respect to a local Plan's business as a "whole," not with respect to any particular group or line of business. Since, to the best of our knowledge, none of the states requiring mandatory reserves recognize any reversionary interest in them to particular groups or lines of business, the Corporations concur with the opinion of the BRIOH Director, that such a provision in Contract CS 1039 would result in preferential treatment to Federal Employees over local Plans' non-Federal subscribers, and is therefore inequitable and undesirable."

[See GAO note, p. 65.]

Allocations of Investment Income between the High and Low Options

The draft report suggests adoption of a different method of allocating investment income between the high and low options.

The suggested allocation method has been discussed with the Plan and they have agreed to use the method suggested in the draft report, starting with calendar year 1969.

Interest on claims reserve (carrier reserve, etc.)

The report draft describes in some detail the Commission's accomplishment in resolving a problem relating to interest earned on funds reserved for unpaid claims (claims reserve). When the Federal Employees' Health Benefit Act was passed in 1959 the intent of the Congress, as evidenced by the legislative history, was that the Federal employees health benefit program was not to receive preference over other policyholders of the insurers. When the first contracts were let, the Commission knew of no other large group insurance policies that directly credited the policyholder with interest earned on funds reserved to pay accrued claims--the established industry practice was that such earnings became part of the reserves of the insurers. Therefore none of the initial contracts with the 40 or so health benefit Plans provided for any special handling of such interest earnings. There was however, a contract clause requiring a credit for interest earned on Special Reserve funds, in which the program has a vested interest.

After a year's operations, and reviews of these operations by the Commission, the normal method of handling earnings on the claims reserve was questioned. As the recited history indicates, it took some time and effort to gain acceptance of a major policy change that was in variance with the established industry practice.

It should be noted that the question of interest earnings on funds retained to pay accrued claims was not peculiar to the Blue Cross Plan. The Commission took a similar position on the Aetna Plan and on the 40 or so other Plans. The Commission's efforts in pioneering this change in industry practice resulted in obtaining credit to the Federal Employee Program, for all interest on the claims reserve since inception, for all Plans. The interest credits obtained for the Federal program as a result of these efforts through 1969 exceeded $15 million for all Plans.

The following response from the Corporations, is in consonance with the above views of the Commission --

"The GAO Report is essentially accurate in its recitation /in the GAO draft/ of the history of both the Special and Carrier Reserves. As noted in the Report, the missing element is the rationale for establishment of the Carrier Reserve.

"At the time Contract CS 1039 was initially negotiated (1960), it was not anticipated that funds held by the Corporations to satisfy outstanding liabilities for incurred but unpaid claims would be available for investment. Shortly after the contract became effective it became apparent that funds from this source would be available for investment. At that time (1960) it was fairly common practice in the health insurance industry, and particularly in the case of Blue Cross and Blue Shield, for the Carrier to retain title to interest earned on such funds (although this type of carrier income was usually taken into account in calculating subscription charges).

"After extensive negotiations between the Corporations and the Commission (1961-1962) in which the chief issue was ownership of interest earned on these "float" funds, the Carrier Reserve was established as an equitable middle ground for the holding and use of this type of investment income. As the Program matured, the Commission and the Corporations increasingly became aware that the Carrier Reserve arrangement was unnecessary.

"The Corporations, in 1966, abandoned their original position by agreeing to dispose of the Carrier Reserve, partially by offsetting underwriting losses (in the same manner as the Special Reserve is used), and partially by conducting certain research projects exclusively for purposes of the Program. Underwriting experience was such that 1968 was the first year in which this decision could be implemented.

"At that time, as indicated in the GAO /draft/ Report, all but $200,000 was transferred to the Special Reserve. That amount was retained in the Carrier Reserve and earmarked for the Supplemental Benefits systems study as noted in the GAO Report.

"In negotiating the 1970 Contract the Parties agreed to delete from the Contract the provision for a Carrier Reserve. Of the originally earmarked $200,000 approximately $90,000 is being carried in an asset account to cover the remaining costs of the Supplemental Benefits Systems Analysis Project. To the extent it is not used, it will be transferred to the Special Reserve. Thus, the Program has received the entire benefit of the Carrier Reserve."

[See GAO note below.]

Commission's audits of operations

Starting at the bottom of page 50, the report states that: "We reviewed the Commission's most recent audit report on the Corporations and the Operations Center, which covered the first three contract periods beginning on July 1, 1960, and ending on October 31, 1963." Though the statement is technically correct it might be misleading, in that the audit work was performed, and the report issued in October 1964. Also, though no formal reports were issued, segments of the operations have since been reviewed in connection with audits of local Plans, and special reviews have been made of some segments.

The draft also states: "We also reviewed the latest audit report relating to the Washington, D. C. local Blue Cross-Blue Shield plans, which covered the five contract periods ended December 31, 1965." Here also, the report should show that the audit work was performed and the audit report issued in August 1967. In December 1966 the GAO audit staff commenced their field audit work at the same location, on the draft report to which we are responding. Consequently, as already stated, we delayed further in-depth audits at this location during that period.

Sincerely yours,

Robert Hampton

Robert E. Hampton
Chairman

Attachment

GAO note: The deleted comments relate to matters presented in the draft report which have been revised in the final report.

PRINCIPAL OFFICIALS

OF THE

UNITED STATES CIVIL SERVICE COMMISSION

RESPONSIBLE FOR THE ADMINISTRATION

OF THE

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

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

U.S. GAO, Wash., D C