5. CONCLUDING COMMENTS

As of mid- 1987, the Kaiser Permante Northern California Region (K PNCR) did not have a disproportionate share of AIDS cases; its share of northern California A 1 DS cases (23.7 percent) was almost equivalent to the proportion of northern California residents enrolled in its health plan (25 percent). H o w e v e r, on a national basis, Kaiser Permanence's share of AIDS cases may exceed that of other national carriers, because it attracts such a significant proportion of its enrollment from northern California. This im - pact ma y eventua11y affect Kaiser Permanence's ability to compete, especially in instances where the buyer seeks geographical-Iy broad-based coverage alternatives, such as in the Federal Employees Health Benefits Plan or in other national or Statewide organ i-zat ions.

K PNCR believes that it is extremely vulnerable to future adverse selection for several fundamental reasons, including the following:

- As a federally qualified heal t h maintenance organization, KPNCR is required to enroll all group-sponsored applicants regardless of preexisting con-d it ions. In contrast, many indemnity insurers and self- insured employers are able to to limit coverage of preexisting cond it ions or otherwise restrict the coverage of AIDS.

- K PNCR'S conclusion that its benefit package is generally more comprehensive than its competitors' and therefore more attractive to enrollees who perceive themselves at high risk of disease.

- KPNCR research indicating that a disproportionate share of its A IDS cases are among individual or small group m e m bers. Only a few of KPNCR'S competitors are currently active in the individual or small group markets. Consequently, over time, the program may have a disproportionate number of individual and small group AIDS-related cases. This situation may be aggravated if self- insured employers are free to determine whether they will cover the costs of treating A IDS patients.

KPNCR contends that as the AIDS epidemic continues, a growing number of insurers and employers may be motivated to take action to avoid covering the high cost of treatment for A IDS patients. KPNCR believes that there are already many signs that this is occurring, including legislative contriversies over the use of human im - munodeficiency virus test results to exclude high-risk persons from coverage, the use of other tests (e. g., T-cell subset studies) to screen high-risk persons, and modifications in other insurers' marketing strategies to reduce exposure.

KPNCR believes that legislative action may be necessary to address the breakdown of health insurance coverage for AIDS and suggests that legislation not only could create a financing mechanism for AIDS patients who do not have health benefits coverage but also could assure that no single segment of the health benefits industry bears a disproportionate share of the AIDS burden. Such legislation, KPNCR believes, should provide incentives for health benefits plans to maintain or increase their enrollment of persons with AIDS rather than avoid covering them, and legislation should also encourage providers to deliver high-quality and cost-effective AIDS-related care,