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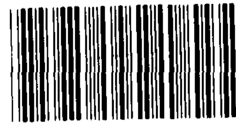
Briefing Report to the Chairman, Subcommittee on Civil Service, Post Office, and General Services, Committee on Governmental Affairs, U. S. Senate

December 1986

HEALTH INSURANCE

Comparison of Coverage for Federal and Private Sector Employees



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Human Resources Division

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December 31, 1986

The Honorable Ted Stevens
Chairman, Subcommittee on Civil Service,
Post Office, and General Services
Committee on Governmental Affairs
United States Senate

Dear Mr. Chairman:

This briefing report responds to your April 30, 1985, request concerning certain benefit features of the Federal Employees Health Benefits Program (FEHBP). The President's Private Sector Survey on Cost Control, commonly known as the "Grace Commission," reported in January 1984 that private firms were more cost-effective than FEHBP in delivering health care. In reviewing the Grace Commission's position, we concluded that the report did not provide convincing evidence that FEHBP is more expensive than private sector health care coverage because the Grace Commission did not demonstrate that private sector benefits were comparable to federal benefits.

To develop further information on this issue, you requested that we compare coverage for selected health benefits in the federal and private sectors for a 6-year period (1980-85). We also examined three other aspects of federal coverage: (1) what it has recently cost plans to add coverage for certain health benefits; (2) what benefit changes have been made for mental health coverage; and (3) what use plans are making of certain cost containment efforts, such as second opinion programs and hospital utilization review.

Background

In the United States, permanent employees both in the federal government and in medium and large firms in the private sector typically receive health insurance coverage as part of their compensation benefit package. In a survey of employee benefits in medium and large firms, the Bureau of Labor Statistics (BLS) found that between 1980 and 1985, about 97 percent of the 21 million workers included were provided health insurance.

FEHBP, established in 1959, offers health insurance to federal workers and annuitants and their dependents. The Office of Personnel Management (OPM) administers the program and contracts annually with various health plans to provide health care coverage. Each health plan

varies in its provisions and covered benefits. Enrollees select their preferred health plan and may change their selection during open seasons, typically held annually. For 1985, about 300 plans participated in FEHBP, covering about 10 million enrollees and collecting premiums of about $6.4 billion.

Virtually all enrollees in the federal and private sectors are covered for the major categories of medical care, such as hospital room and board, physician and surgeon fees, and laboratory work. Less universally covered benefits, such as dental care and alcoholism treatment, are the subject of this report.

Methodology

Information on federal health benefits was obtained from OPM by reviewing the coverage for 18 FEHBP plans representing about 90 percent of the program enrollment. Private sector health benefits information came from BLS's survey Employee Benefits in Medium and Large Firms. We chose this survey as our base for comparison because of the detail it includes on health benefits and because it is representative of the nation's medium and large firms. We did not verify data in the survey. We compared coverage for employee health benefits between the federal and private sectors for the period 1980 to 1985—the most recent period for which private sector data were available. For selected benefits in FEHBP, we also collected information on 1986 and 1987 coverage. (A detailed discussion of our methodology can be found on pp. 8-11.)

Results in Brief

In brief, our comparison showed that in 1985, federal enrollees were more likely than private sector employees in medium and large firms to be covered for routine physicals, to be covered for hospice care, and to have catastrophic protection, but less likely to be covered for dental, home health, alcohol and drug abuse treatment, and extended care services. A comparable percentage of federal and private sector employees were covered for mental health care in 1985.

Our 6-year comparison also showed that federal enrollees pay more of their health care costs in premiums, deductibles, and coinsurance than do enrollees in the private sector. All federal enrollees pay part of the premiums, whereas in 1985, 39 percent of private sector enrollees did so. BLS reported that the average 1985 employee contribution for the private sector was about $12 per month for single coverage and about $38 for family coverage, but exact premiums were not uniformly reported

by firms. Federal enrollee monthly premiums were higher than the private sector in 1985—about $38 for individual coverage and about $70 for family coverage.

Similarly, federal enrollees paid more for their health care costs in deductibles and coinsurance than did their private sector counterparts. All federal enrollees were subject to deductibles of $150 or more, compared to about 20 percent of private sector enrollees in 1985. Federal enrollees were also more likely to pay higher coinsurance than their private sector counterparts.

We also observed from our 6-year trend data that private sector benefits were more stable than the federal benefits. Abrupt changes in certain benefits sometimes occurred in FEHBP when large plans dropped or added coverage for a certain feature. For example, Blue Cross and Blue Shield high option added both dental and alcohol treatment coverage in 1981, only to drop coverage for alcohol benefits in 1982 and dental benefits in 1983. These changes in a single plan's benefits caused 30- to 40-percent shifts in FEHBP coverage of these benefits from year to year.

Federal health plan coverage of benefits changed further in 1986 and 1987. For example, one federal health plan added dental benefits and three added home health benefits. As a result, FEHBP's coverage of dental care and home health care has become more comparable to the private sector. Furthermore, in 1987, coverage of alcohol and drug abuse and hospice care was universally offered by the 18 plans we reviewed.

A benefit-by-benefit analysis of federal and private sector trends begins on page 12.

The cost to add benefits in FEHBP depends on the design of the benefit and expected use by the enrollees. Recent benefit changes typically neither raised nor lowered the premium by more than 5 percent. (See p. 42 for the costs associated with benefit changes made by 12 plans to their hospice coverage, catastrophic protection, and deductibles in either 1985 or 1986.)

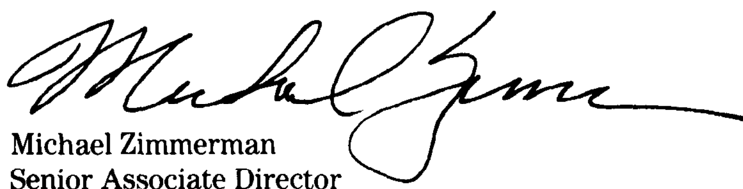
Mental health coverage in FEHBP has been restructured in recent years and now is characterized by higher deductibles and greater coinsurance, hospital limits, outpatient visit limits, and maximum dollar coverage. Our analysis of five likely mental health treatment scenarios shows that FEHBP enrollees can expect to pay a substantial portion of billed charges for mental health. (Results of our analysis can be found on pp. 43-49.)

In recent years OPM encouraged FEHBP plans to adopt numerous measures designed to contain health care costs. Such activities as mandatory second surgical opinion programs, preferred provider organizations, and utilization reviews were among the more popular cost containment measures added by some FEHBP plans. We do not know how effective these measures have been in curbing FEHBP cost growth. (See pp. 50-53 for our discussion of FEHBP plans that use these features.)

As requested by your office, we did not obtain written agency comments on this briefing report; however, the chief, Program Planning and Evaluation Division, of OPM's Office of Insurance Programs and the BLS labor economist responsible for developing the information we used in this report provided oral comments on a draft of this report. Their comments were incorporated where appropriate.

Unless you publicly announce its contents earlier, we plan no further distribution of this briefing report until 30 days from its issue date. At that time, we will send copies to OPM, BLS, the House Committee on Post Office and Civil Service, FEHBP health plans, and other interested parties upon request. If you have any questions regarding the contents of this document, please call me on 275-6195.

Sincerely yours,



Michael Zimmerman
Senior Associate Director

Contents

Letter

Health Insurance: Comparison of Coverage for Federal and Private Sector Employees

	8
Objectives, Scope, and Methodology	8
How Do Selected Employee Health Benefits in the Federal and Private Sectors Compare?	11
What Have Been the Costs to Add Selected Benefits to FEHBP?	42
How Have Mental Health Benefits Changed in FEHBP?	43
How Many FEHBP Plans Have Used Various Cost Containment Measures?	50

Tables

Table 1: Total Amount Paid by Nine FEHBP Plans for Mental Health—Scenario 1	45
Table 2: Total Amount Paid by Nine FEHBP Plans for Mental Health—Scenario 2	46
Table 3: Total Amount Paid by Nine FEHBP Plans for Mental Health—Scenario 3	47
Table 4: Total Amount Paid by Nine FEHBP Plans for Mental Health—Scenario 4	48
Table 5: Total Amount Paid by Nine FEHBP Plans for Mental Health—Scenario 5	49
Table 6: Summary of Cost Containment Measures Practiced by Largest FEHBP Plans (1986)	50

Figures

Figure 1: Federal and Private Sector Enrollees Covered by a Routine Physical Benefit (1980-85)	12
Figure 2: Federal and Private Sector Enrollees Covered by a Dental Care Benefit (1980-85)	14
Figure 3: Federal and Private Sector Enrollees Covered by an Extended Care Benefit (1980-85)	16
Figure 4: Federal and Private Sector Enrollees Covered by an Alcohol and Drug Abuse Care Benefit (1980-85)	18
Figure 5: Federal and Private Sector Enrollees Covered by a Hospice Care Benefit (1980-85)	20
Figure 6: Federal and Private Sector Enrollees Covered by a Home Health Care Benefit (1980-85)	22
Figure 7: Federal Enrollees Covered by a Nurse Midwife Benefit (1980-85)	24

Figure 8: Federal and Private Sector Enrollees Covered by a Mandatory Second Surgical Opinion Benefit (1980-85) 26
Figure 9: Federal and Private Sector Enrollees Subject to 75-Percent Coinsurance (1980-85) 28
Figure 10: Federal and Private Sector Enrollees Subject to 80- to 90-Percent Coinsurance (1980-85) 28
Figure 11: Federal and Private Sector Enrollees Subject to Flat Rate Deductibles of $150 or More for Major Medical Benefits (1980-85) 30
Figure 12: Federal and Private Sector Enrollees Provided First Dollar Coverage for Hospital Room and Board (1980-85) 32
Figure 13: Federal and Private Sector Enrollees Subject to Coinsurance With No Catastrophic Protection (1980-85) 34
Figure 14: Federal and Private Sector Enrollees With Catastrophic Protection Limits of $1,200 or Less (1980-85) 36
Figure 15: Federal and Private Sector Enrollees With Catastrophic Protection Limits Over $1,200 (1980-85) 36
Figure 16: Federal and Private Sector Enrollees Who Contribute Toward Health Insurance Premiums (1980-85) 38
Figure 17: Federal and Private Sector Enrollees Provided a Mental Health Benefit (1980-85) 40
Figure 18: FEHBP Mental Health Benefits—Percent of Billed Amount Paid (1980, 1982, and 1984) 44

Abbreviations

AFGE	American Federation of Government Employees
APWU	American Postal Workers Union
BLS	Bureau of Labor Statistics
FEHBP	Federal Employees Health Benefits Program
GEHA	Government Employees Hospital Association
OPM	Office of Personnel Management
NALC	National Association of Letter Carriers
PPO	preferred provider organization
SAMBA	Special Agents Mutual Benefit Association

Health Insurance: Comparison of Coverage for Federal and Private Sector Employees

Objectives, Scope, and Methodology

Our review had four objectives: (1) compare selected health care benefits provided under the Federal Employees Health Benefits Program (FEHBP) and private sector health insurance programs over a 6-year period, (2) identify the cost of adding to the federal program selected health care benefits, (3) analyze levels of FEHBP coverage for mental health benefits, and (4) obtain information on the use of selected health care cost containment measures in FEHBP.

To accomplish our first objective, we obtained information on private sector health benefits from the Bureau of Labor Statistics (BLS) annual survey of employee benefits in medium and large firms.[1] The employee benefits survey, which was originally designed to enable the Office of Personnel Management (OPM) to compare federal and private sector benefits, provided representative data for 21 million full-time employees in a cross-section of the nation's private industries. The survey generally presented data as a percentage of full-time participants covered for selected benefit provisions. We used surveys for 1980 through 1985. We selected this survey because it included more detail on health benefits coverage than other available sources and because alternatives available to us were not statistically representative of the nation as a whole.

We developed information on FEHBP health benefits coverage by reviewing plan brochures published by OPM and verifying our coverage determinations with the chief, Program Planning and Evaluation Division, of OPM's Office of Insurance Programs. Because FEHBP included more than 200 plans in 1985, many of which had few enrollees, we selected a sample of 18 FEHBP health plans. The sample included all plans with an enrollment over 20,000 for each of the 6 years from 1980 to 1985, and included about 90 percent of the total FEHBP enrollment for each of the years. The following 18 plans were reviewed:

Fee-for-Service Plans (13 Plans)

- Blue Cross and Blue Shield Association (high and standard options).[2,3]
- Aetna Life Insurance Company (high and standard options).[2,3]
- American Federation of Government Employees (AFGE).[3]
- National Alliance of Postal and Federal Employees (Alliance).[3]
- Government Employees Hospital Association Benefit Plan (GEHA).
- American Postal Workers Union, AFL-CIO (APWU).[3]

[1]Generally includes private sector establishments employing at least 100 or 250 workers, depending on the industry; excluded are small firms and state and local governments.

[2]High and standard option plans are counted as separate plans for Blue Cross/Blue Shield and Aetna Life Insurance Company.

- National Post Office Mail Handlers, Watchmen, Messengers, and Group Leaders Division of LIUNA, AFL-CIO (high option, Mail Handlers).[3]
- National Association of Letter Carriers, AFL-CIO (NALC).[3]
- National League of Postmasters of the United States (high option, Postmasters).
- National Rural Letter Carriers' Association (Rural).
- Special Agents Mutual Benefit Association (SAMBA).

Comprehensive Medical Plans (5 Plans)

- Group Health Incorporated, New York.
- Kaiser Foundation Health Plan, Inc., Northern California Region (Kaiser, North).
- Kaiser Foundation Health Plan, Inc., Southern California Region (Kaiser, South).
- Group Health Association, Inc., Washington, D.C.
- Hawaii Medical Service Association, Honolulu, Hawaii.

For each benefit (such as dental and nursing home care), we determined the percentage of participants covered. If all 18 plans in our sample offered a benefit, we reported the coverage as 100 percent. If fewer than 18 plans offered the benefit, we reported (as a percentage) the number of enrollment contracts[4] held by the plans offering the benefit, divided by the total number of contracts in our 18-plan sample.

Certain features are available only with plans that have major medical benefits.[5] In those cases, we eliminated from our sample, plans that, by design, would not offer these features. For example, health maintenance organizations generally do not have coinsurance, so these plans were excluded from our comparison.

To identify the costs of adding selected benefits, we obtained, from OPM, each plan's calculation of the premium changes resulting from adding or modifying benefits. To deal with current costs, we restricted our review to 1985 and 1986 benefit changes. The Subcommittee was interested in

[3]Plans that were included in our review of mental health benefits.

[4]An enrollment contract may include one person for self-only coverage or more than one person for family coverage.

[5]Major medical benefits cover many categories of expenses, such as hospital, physician, and laboratory costs, some of which are not covered under basic benefits, and others for which basic coverage limits have been exhausted. These benefits are characterized by deductible and coinsurance provisions that are applied across categories of care.

three benefit areas—hospice care, deductibles, and catastrophic protection. Recent changes to mental health benefits—a fourth area of interest to the Subcommittee—were made with no change to premiums.

To analyze FEHBP mental health benefits, we developed information on the benefits for 3 years—1980, 1982, and 1984—because these were years of significant changes in mental health coverage in FEHBP. Initially, we developed information on the plans' mental health benefits, such as what copayments and deductibles applied and whether the benefit was limited in scope by covering only a prescribed number of hospital days, a limited number of outpatient therapy sessions, or a limited dollar amount of services.

Because so many features were involved, we decided to illustrate the level of mental health coverage through a case study approach. In short, we compared how much in mental health benefits each of nine of the largest FEHBP plans would pay, using five likely mental health treatment scenarios. The plans were selected judgmentally to represent the range of mental health coverage available in the federal sector.[6] The treatment scenarios were developed by the American Psychiatric Association and included (1) short-term inpatient care, (2) short-term outpatient care, (3) recurrent care (two hospitalizations in 1 year), (4) long-term inpatient care, and (5) long-term outpatient care.

We calculated the amount and percentage of billed charges the nine FEHBP plans would have paid for each of these five scenarios in 1980, 1982, and 1984. The nine plans verified our calculations. Only fee-for-service plans were reviewed because coverage that comprehensive plans would offer would be limited to services provided or arranged by plan physicians.

To obtain descriptive information on cost containment measures in FEHBP, we relied on OPM's 1985 survey[7] of FEHBP plan cost containment initiatives and updated that information by contacting plans that OPM indicated had recently adopted other cost containment measures. We also reviewed 1985, 1986, and 1987 brochures for the 18 plans. We obtained information on cost containment efforts from the Health

[6]The nine plans are identified on the list of plans on pages 8 and 9.

[7]The survey covered cost containment initiatives practiced or contemplated by FEHBP plans during 1984.

Research Institute,[8] a review of available literature, and our previous study on important issues for constraining national health care expenditures.[9]

Our work was conducted between July 1985 and October 1986 and conforms with generally accepted government auditing standards.

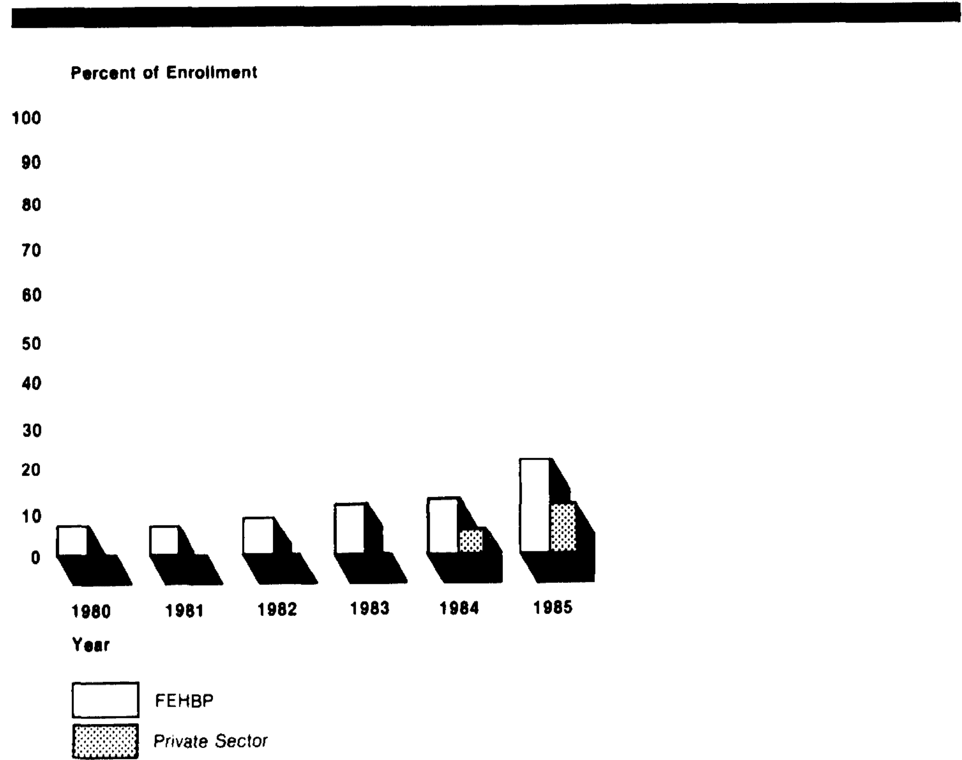
How Do Selected Employee Health Benefits in the Federal and Private Sectors Compare?

The following sections summarize the level of coverage for each of 14 benefits and features for FEHBP and private sector health benefits. For each benefit or feature, the report presents a definition, the results of our analysis, and, for selected benefits, information on changes that occurred in FEHBP in 1986 and 1987.

[8] A private, nonprofit corporation dedicated to health care cost control, planning, research, and education.

[9] Constraining National Health Care Expenditures: Achieving Quality Care at an Affordable Cost (GAO/HRD-85-105, Sept. 30, 1985).

Figure 1: Federal and Private Sector Enrollees Covered by a Routine Physical Benefit (1980-85)



Routine Physical

Definition

Routine physical benefits include preventive medical care and services, such as periodic checkups and immunizations. Checkups may include checking the medical history, weight, height, reflexes, blood pressure, eyes, ears, nose, throat, neck, lungs, heart, chest, abdomen, muscles, and back. Routine physical benefits may also include well-baby care.

Results

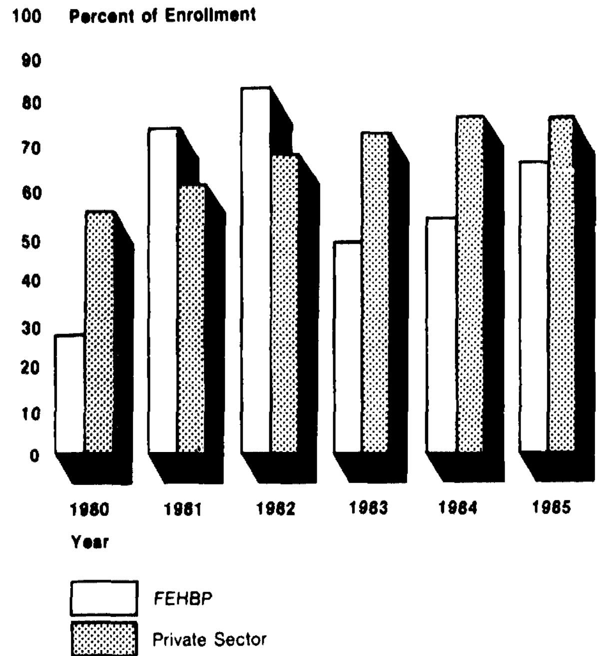
Compared to the private sector, about twice as many federal employees (23 versus 13 percent) were in plans offering a routine physical benefit in 1985.[10] Eight of the 18 federal health plans offered this benefit in 1985.

The percentage of federal enrollees provided a routine physical benefit more than doubled between 1980 and 1985. Two plans added this benefit in 1985, leading to about half the increase over the 6-year span. Increased enrollment in the GEHA plan (which increased its enrollment from 3 percent in 1980 to 9 percent in 1985) also contributed to higher FEHBP coverage for this benefit in 1985 than in 1980.

One federal health plan added well-baby care to its covered benefits in 1986, and two additional plans added well-baby care in 1987.

[10]BLS did not report this benefit before 1984.

Figure 2: Federal and Private Sector Enrollees Covered by a Dental Care Benefit (1980-85)



Dental Care

Definition

Dental care benefits include routine diagnostic and preventive services, such as checkups, X-rays, cleaning and polishing of teeth, fillings, extractions, removal of impacted teeth, or bone impactions. Some plans limit coverage to preventive services for children only.

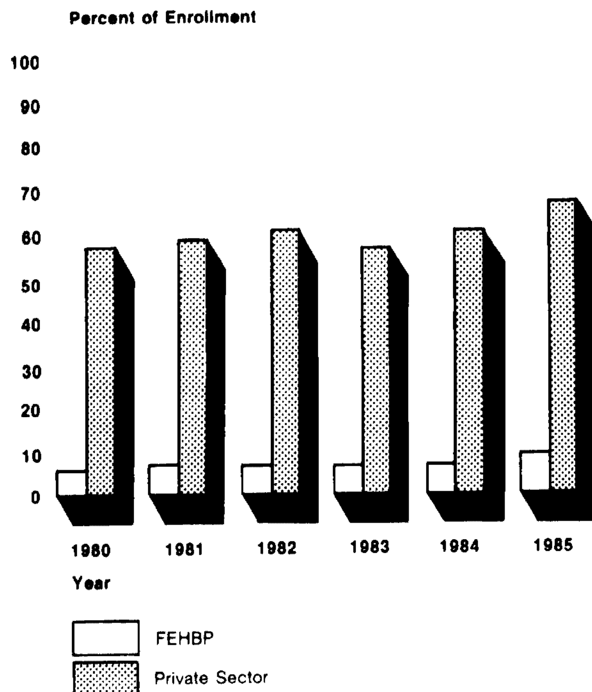
Results

Dental care coverage in the federal and private sectors is becoming more comparable. In 1985, dental care coverage for the private sector was 76 percent compared to 64 percent in FEHBP. Over the 6-year period, private sector coverage generally increased 3 to 7 percent annually until 1985, when there was a 1-percent decrease in coverage. BLS reported that dental care benefits increased from 56 to 76 percent of enrollment between 1980 and 1985.

In contrast, the federal health program has had large year-to-year changes—increases and decreases—for 3 of the 6 years. Changes in coverage by the Blue Cross high and standard option plans most affected the federal sector availability of this benefit from 1980 to 1983. In 1981, Blue Cross added dental care benefits to its high option plan. This increased the portion of enrollees receiving this benefit from 29 to 74 percent. In 1982, Blue Cross standard option (11 percent of enrollment) also added dental care, thereby raising the portion of enrollees receiving this benefit to 83 percent. In 1983, Blue Cross high option dropped dental benefits. This reduced total enrollment to about 50 percent for the dental care benefit.

In 1986 one more federal plan added dental care, bringing the total to 14 plans offering the dental benefit. No plans added or dropped the benefit in 1987.

Figure 3: Federal and Private Sector Enrollees Covered by an Extended Care Benefit (1980-85)



Extended Care

Definition

Extended care includes full-time skilled nursing in an extended care facility, provided in lieu of hospitalization. An extended care facility may also provide drugs, supplies, and medical equipment.

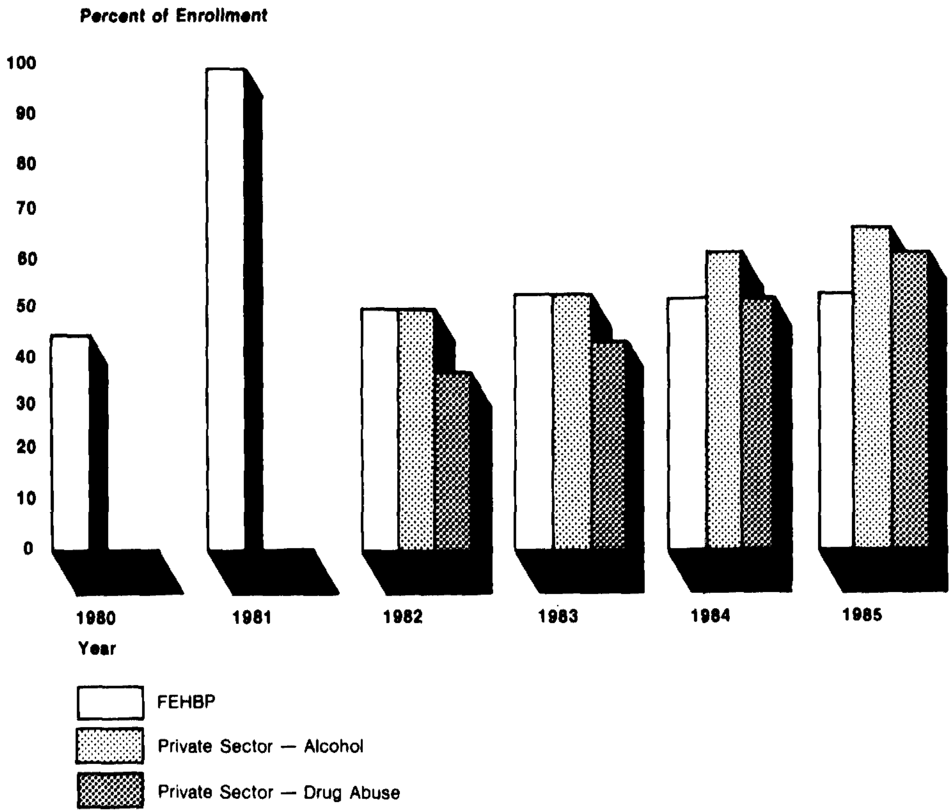
Results

Private sector enrollees were much more likely than federal enrollees to be covered for extended care services. The percentage of enrollees covered was relatively unchanged for both private sector and federal health programs during the 6-year period. The private sector varied between 58 and 67 percent of participants covered, and the federal program remained between 7 and 10 percent each year.[11]

In 1985, two FEHBP plans added an extended care benefit, bringing federal coverage for this benefit to eight plans covering 10 percent of enrollment, compared to 67 percent of private sector enrollees. Since 1985, there has been no change in the FEHBP plans covering extended care.

[11] Before 1983, BLS reported extended care and home health care as combined figures. In 1983, they were reported separately. This was the primary cause of the decline in reported private sector enrollment for extended care. (See pp. 22-23 for our discussion of home health care.)

Figure 4: Federal and Private Sector Enrollees Covered by an Alcohol and Drug Abuse Care Benefit (1980-85)



Alcohol and Drug Abuse Care

Definition

Alcohol and drug abuse care is the treatment of alcoholism, drug addiction, and drug abuse. Included are inpatient and outpatient programs that provide counseling services, educational programs, nutritional and medical therapies, and recreational activities. Inpatient care is generally limited to 20 to 30 days per year.

In addition, treatment may include medical and hospital services related to acute care or detoxification. Acute care is treated the same as any other illness or condition. All federal and private sector health plans cover acute care even if they do not cover alcohol or drug abuse treatment.

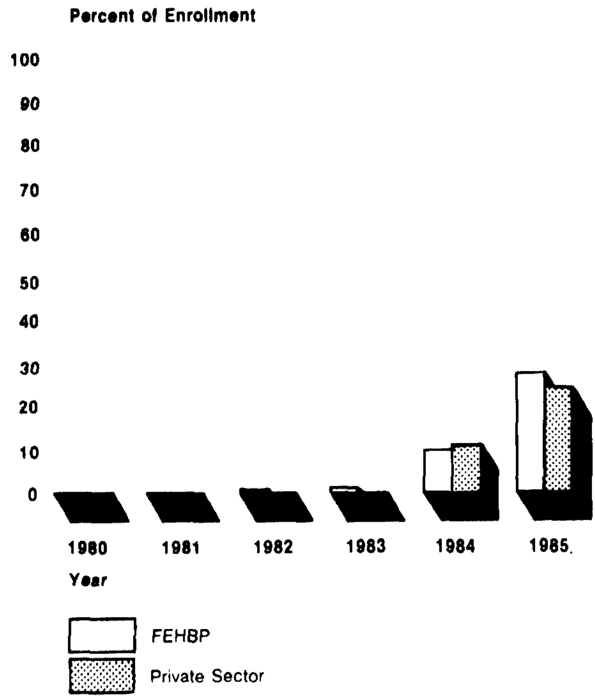
Results

The percentage of coverage for alcoholism and drug abuse treatment is slightly greater for the private than for the federal sector. In FEHBP, the number of plans providing this benefit decreased from 15 in 1980 to 14 in 1985, while the percentage of enrollment increased from 44 to 53 percent. Most of this increase was due to changes in enrollment for the 14 plans covering the benefit. The large increase in 1981 and the big drop in 1982 were primarily due to Blue Cross adding this coverage in 1981 and dropping it in 1982. In 1986, no plans added or dropped this benefit, and in 1987, four plans added alcohol and drug abuse care, bringing FEHBP coverage to 100 percent.

In the private sector, BLS reported coverage for alcoholism treatment and drug abuse treatment separately for 1982 through 1985.[12] Coverage for alcoholism treatment increased from 50 percent in 1982 to 68 percent in 1985; for drug abuse treatment, coverage increased from 37 to 61 percent.

[12] BLS did not report coverage for the benefit before 1982.

Figure 5: Federal and Private Sector Enrollees Covered by a Hospice Care Benefit (1980-85)



Hospice Care

Definition

Hospice care is a coordinated program of home and inpatient supportive care for a terminally ill patient and the patient's family. Hospice care is provided by a medically supervised specialized team under the direction of a licensed or certified hospice care facility or agency.

Results

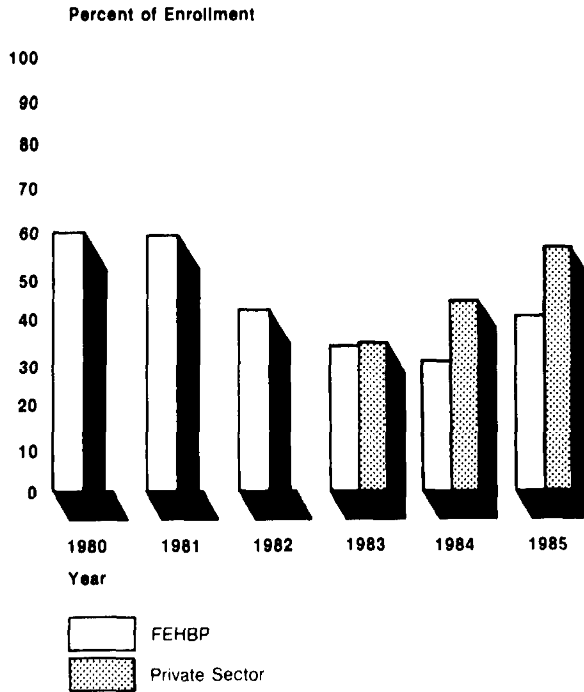
The percentage of enrollees covered by a hospice care benefit was slightly greater in the federal than the private sector in 1985—27 versus 23 percent.

On the federal side, 10 plans added a hospice care benefit from 1982 to 1985.[13] Six more plans added a hospice care benefit in 1986, and the remaining two plans added a hospice benefit in 1987, bringing coverage to 100 percent in the federal sector.

In the private sector, BLS reported that 11 percent of the sample population was provided the hospice benefit in 1984 and that coverage rose to 23 percent in 1985.

[13]None of the federal health plans in our sample offered hospice benefits in 1980 or 1981. BLS first reported this benefit in 1984.

Figure 6: Federal and Private Sector Enrollees Covered by a Home Health Care Benefit (1980-85)



Home Health Care

Definition

Home health care is medically supervised care and treatment in the patient's home in lieu of hospitalization. The care is provided by a home health care agency, which provides such services as skilled nursing care, dressing changes, injections, monitoring of vital signs, physical therapy, prescription drugs and medications, nutrition services, medical social work, and medical appliances or equipment.

Results

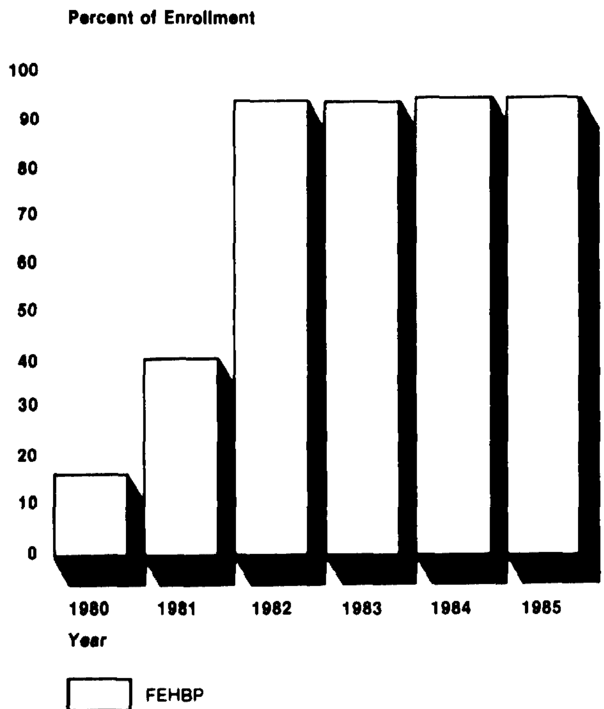
Private sector enrollees are more likely than federal enrollees to have home health care coverage. Measured as a percentage of enrollment, federal coverage for home health care declined over the 6 years, while private sector coverage increased. The percentage of enrollees in federal health plans that provided home health care benefits dropped by about one-third (60 to 42 percent of sample enrollment), although one plan added and one plan dropped this benefit during the 6 years. In contrast, the private sector showed a 19-percentage-point increase in this benefit, from 37 percent in 1983 to 56 percent in 1985.[14]

Through 1984, 7 of the 18 federal health plans offered the home health care benefit. The percentage of enrollment for this benefit dropped primarily because of reduced enrollment in Blue Cross high option, which offers home health care, and because Blue Cross standard option (9 percent of enrollment) dropped the home health care benefit in 1982, when another smaller plan added the benefit.

Four FEHBP plans in 1985, two in 1986, and one in 1987 added home health care benefits. By 1987, 14 of the 18 FEHBP plans offered home health coverage.

[14]Before 1983, BLS reported extended care and home health care as combined figures. (See pp. 16-17 for our discussion of extended care benefits.)

Figure 7: Federal Enrollees Covered by a Nurse Midwife Benefit (1980-85)



Nurse Midwife

Definition

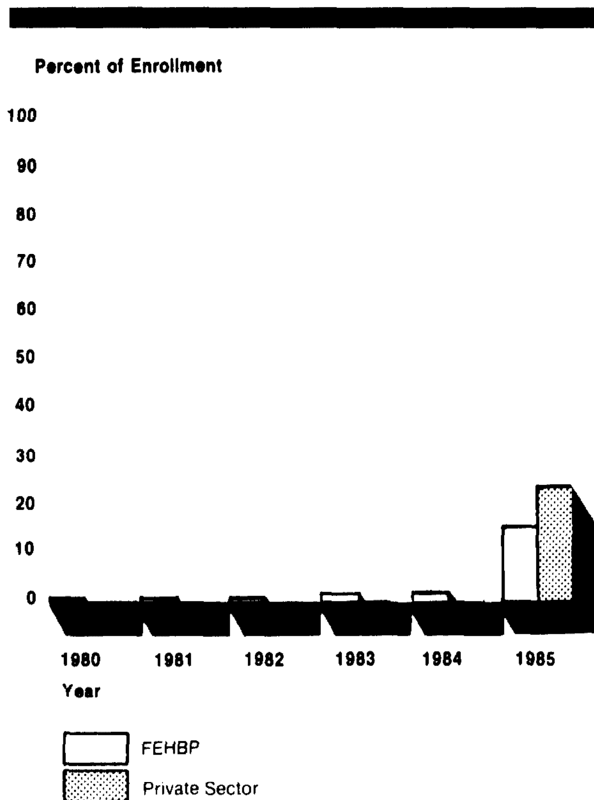
A nurse midwife is a person certified by either a state agency or the American College of Nurse Midwives for the prenatal and postnatal care of pregnancies.

Results

The nurse midwife benefit was covered by 16 of the 18 federal health plans in our sample and is available to about 96 percent of the sample enrollees in 1985. BLS did not report any data on nurse midwife benefits.

In FEHBP, the nurse midwife benefit increased from 3 plans with 7 percent of enrollment in 1980 to 16 plans with 96 percent of enrollment in 1985. There was no change in the list of plans providing nurse midwife benefits in 1986 or 1987.

Figure 8: Federal and Private Sector Enrollees Covered by a Mandatory Second Surgical Opinion Benefit (1980-85)



Second Surgical Opinion

Definition

Second surgical opinion benefits pay for an independent consulting doctor's second or third opinion regarding the necessity of surgery. Second opinion programs may be voluntary or mandatory. A voluntary program usually has no incentives or penalties to encourage the enrollee to obtain the second opinion. Plans will usually pay for the second opinion in the same way as a normal doctor's visit or as a special benefit. For example, the Mail Handlers benefit will pay up to $50 per consultation.

In a mandatory program, coinsurance and deductibles may be adjusted to encourage enrollees to obtain a second opinion for a specified list of elective surgical procedures. For example, Aetna will reduce the coinsurance for its high option plan from 80 to 50 percent if a second opinion is not obtained for 15 nonemergency procedures.

Results

Since 1980, all FEHBP fee-for-service plans have offered voluntary second opinion benefits. In 1980 and in 1983, two FEHBP plans added mandatory second opinion programs; four plans in 1985 and two FEHBP plans in 1986 made second opinions mandatory. No other plans made second opinions mandatory, in 1987.

In 1985, BLS reported that 50 percent of private sector participants were in plans that offered some specified form of second opinion program, either voluntary or mandatory, in 1985.[15] About 24 percent of enrollees were in plans that required second surgical opinions.

[15] BLS did not report mandatory second surgical opinions before 1985.

Figure 9: Federal and Private Sector Enrollees Subject to 75-Percent Coinsurance (1980-85)

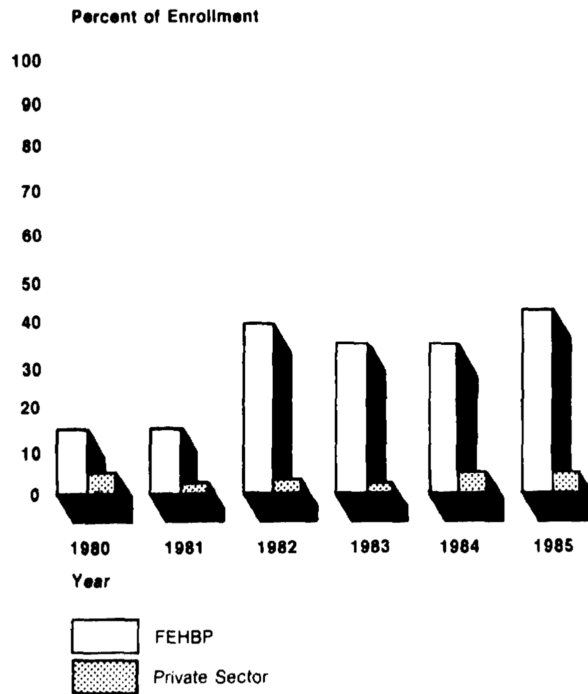
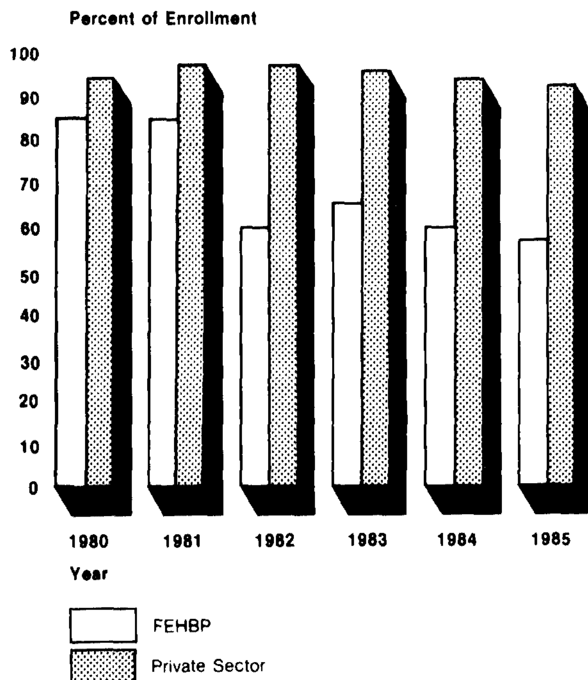


Figure 10: Federal and Private Sector Enrollees Subject to 80- to 90-Percent Coinsurance (1980-85)



Coinsurance for Major Medical Benefits

Definition

Coinsurance is the fixed percentage of covered medical charges that the plan will pay. The balance is paid by the enrollee. For example, if a plan offers enrollees a coinsurance rate of 75 percent, the plan would pay 75 percent and the individual would pay 25 percent. Major medical benefits cover many categories of expenses, such as hospitalization, physician service, and laboratory fees, some of which are not covered by basic benefits and others for which basic coverage limits have been exhausted. Major medical benefits are characterized by deductibles and coinsurance.

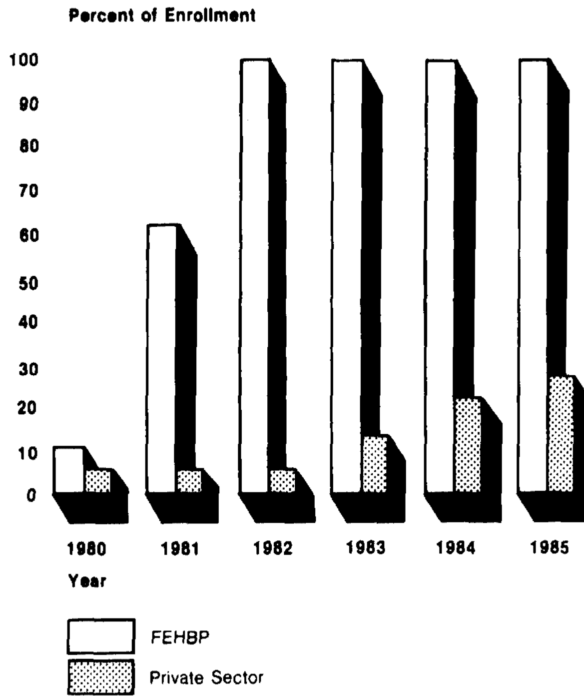
Results

About 80 to 90 percent of federal and private sector enrollees were subject to coinsurance. Compared to the private sector, however, FEHBP enrollees were likely to pay a greater share of their medical costs through coinsurance. In 1985, as shown in figures 9 and 10, about 95 percent of private sector enrollees paid 10 to 20 percent of their bills; the other 5 percent typically paid 25 percent of their bills.[16] The figures for federal workers show, however, that only 56 percent paid the lowest category—10 to 20 percent—while 44 percent paid the higher amount—25 percent.

In 1986 and 1987, there were no significant changes in coinsurance offered by the FEHBP plans that we studied.

[16]About 5 percent of private sector enrollees subject to coinsurance are in plans that are other than 80 percent, 85 percent, or 90 percent. According to a BLS labor economist, this primarily includes plans with 75-percent coinsurance.

Figure 11: Federal and Private Sector Enrollees Subject to Flat Rate Deductibles of $150 or More for Major Medical Benefits (1980-85)



Flat Rate Deductible for Major Medical Benefits

Definition

A flat rate deductible is the amount of covered charges that an enrollee must pay before his or her health plan pays any benefits. Deductibles are usually applied on a calendar year basis; however, they may be applied on a per-admission basis for in-hospital treatment.

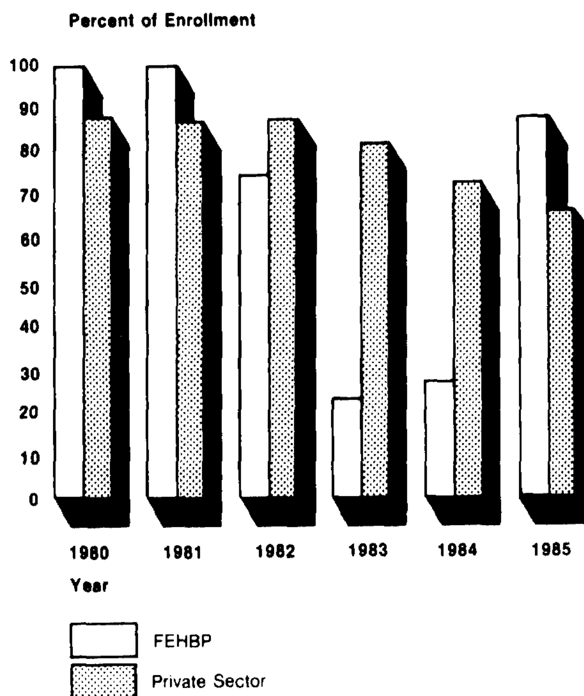
Results

About 80 to 90 percent of federal and private sector enrollees were in plans that had deductibles for major medical coverage.

As shown in figure 11, all federal enrollees have been subject to deductibles of $150 or more since 1982. About 29 percent of private sector enrollees were subject to this same level of deductibles in 1985, a substantial increase from prior years. The remaining private sector enrollees paid less than $150 in deductibles.

In 1986 and 1987, deductibles in FEHBP remained at $150 or more for all plans with this feature.

Figure 12: Federal and Private Sector Enrollees Provided First Dollar Coverage for Hospital Room and Board (1980-85)



First Dollar Coverage for Hospital Room and Board

Definition

First dollar coverage for room and board means that the plan pays initial hospital room and board costs. Room and board charges may be paid separately or included in basic hospital benefits. A plan may charge a nominal copayment (e.g., inpatient deductible) before reimbursement begins.

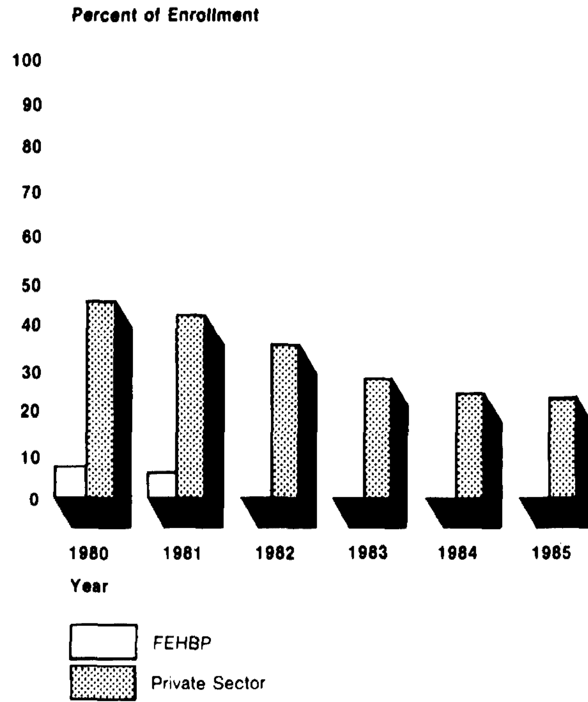
Results

In both the federal and private sectors, there has been a decrease in the number of enrollees with first dollar coverage for room and board, but FEHBP enrollees were more likely to be covered by this benefit in 1985. From 1980 to 1984, the percentage of federal health plan enrollees in our sample with first dollar coverage decreased from 100 percent and 18 plans to 29 percent and 7 plans. In 1985, eight plans restored first dollar coverage for hospitalization, bringing the FEHBP coverage to 88 percent.

No FEHBP plans changed their first dollar coverage for room and board in 1986, and one plan added it again in 1987.

In the private sector, BLS reported that first dollar coverage for room and board benefits decreased from 88 to 66 percent of enrollment between 1980 and 1985.

Figure 13: Federal and Private Sector Enrollees Subject to Coinsurance With No Catastrophic Protection (1980-85)



Catastrophic Protection

Definition

Catastrophic protection is a feature of fee-for-service plans that limits the amount enrollees would have to pay in a calendar year in the event of unusually large medical bills. The catastrophic limit is the maximum amount of covered expenses the enrollee would have to pay. The limits generally apply to the enrollee's share of coinsurance, but could also include the calendar year deductible. The out-of-pocket limits do not include premium contributions. FEHBP plans generally have separate catastrophic limits for surgical-medical expenses and inpatient mental health care.

Results

Private sector enrollees were less likely than federal enrollees to have catastrophic protection. However, when covered by catastrophic benefits, private sector enrollees generally had better protection than their federal counterparts.

Since 1982, all FEHBP enrollees have had catastrophic protection; however, for the latest year in which figures are available—1985—23 percent of private sector enrollees still lacked catastrophic coverage. (See fig. 13.)

Figure 14: Federal and Private Sector Enrollees With Catastrophic Protection Limits of $1,200 or Less (1980-85)

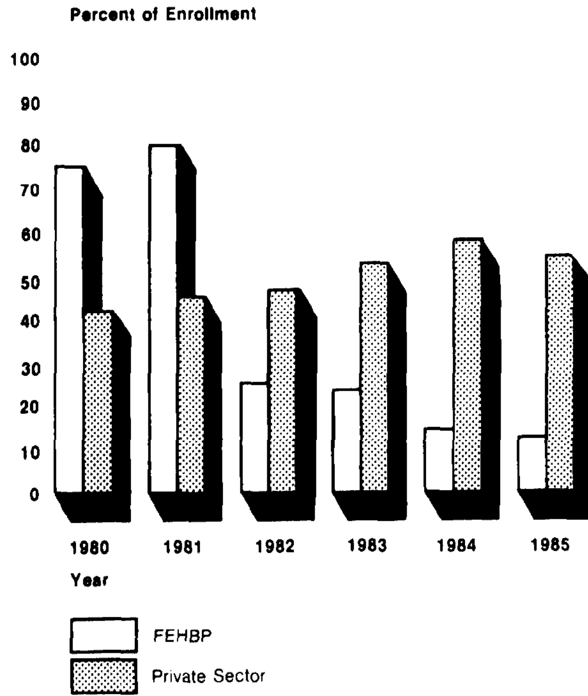
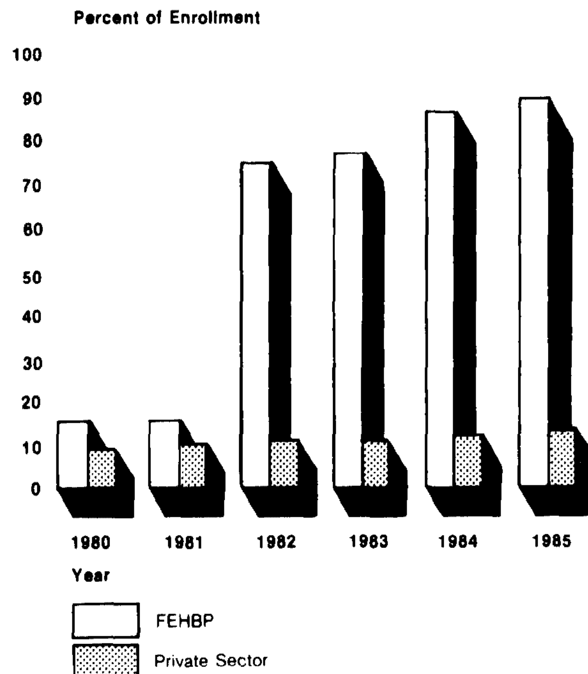


Figure 15: Federal and Private Sector Enrollees With Catastrophic Protection Limits Over $1,200 (1980-85)

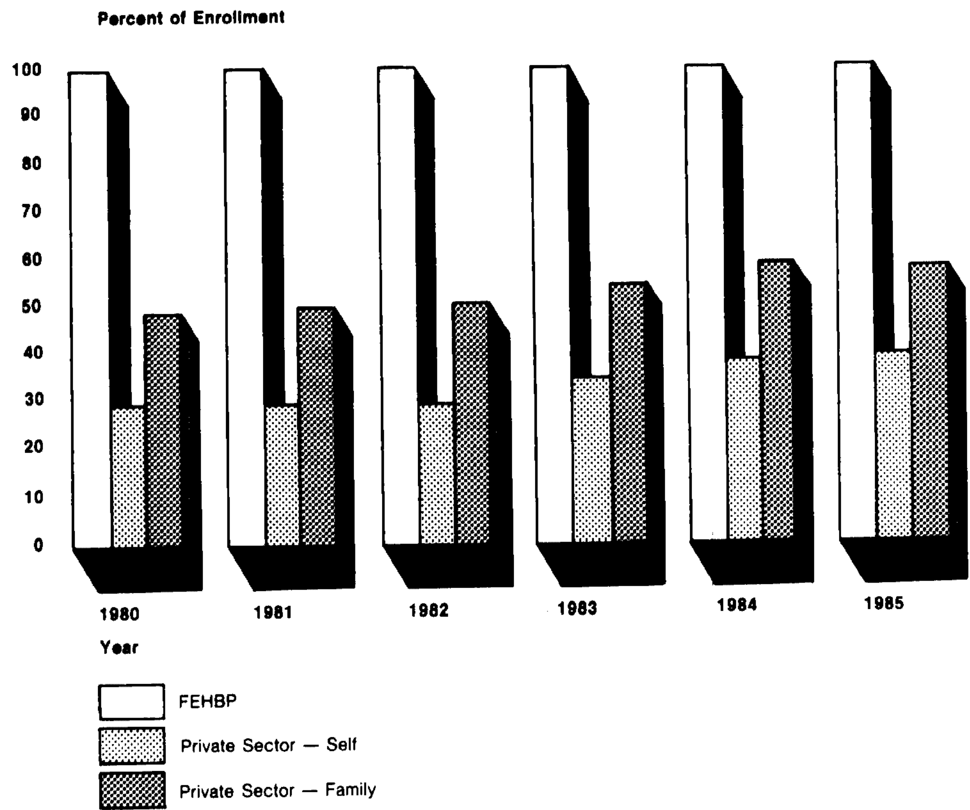


Catastrophic Protection (Continued)

In 1985, about 88 percent of federal enrollees compared to 14 percent of private sector enrollees would have to pay more than $1,200 in medical expenses before their plan covered all remaining benefit expenses. (See fig. 15.) In this category, federal enrollees typically would have to pay $1,500 to $2,500 before catastrophic protection begins. About 12 percent of federal enrollees compared to 58 percent of private sector enrollees were protected against out-of-pocket medical costs of $1,200 or less in 1985. (See fig. 14.) Private sector enrollees typically would have to pay $500 to $1,200 before catastrophic protection would begin.

There were no significant changes in FEHBP catastrophic protection limits in 1986 or 1987.

Figure 16: Federal and Private Sector Enrollees Who Contribute Toward Health Insurance Premiums (1980-85)



Health Insurance Premiums

Definition

Many private sector employers pay the entire cost of health insurance premiums for full-time employees and their dependents. In contrast, federal employees have shared in the cost of their health insurance since FEHBP's inception.

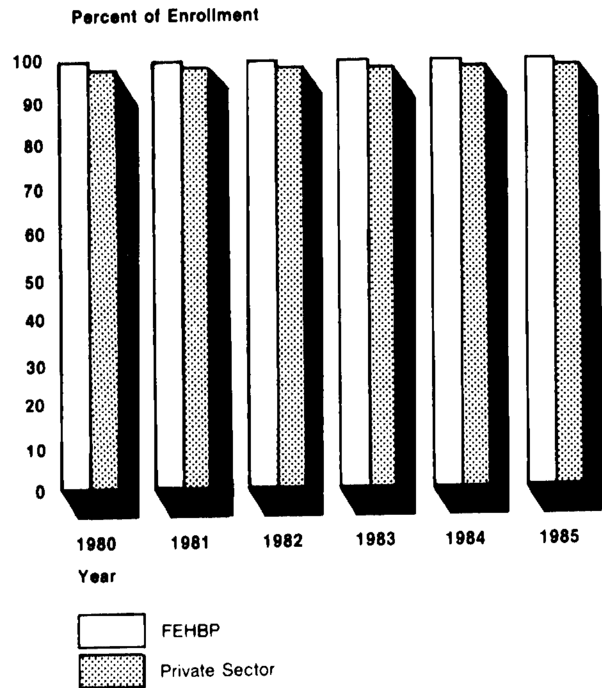
Results

Since 1980, the percentage of full-time private sector employees who pay a portion of their health insurance premiums has increased from about 29 percent to about 39 percent in 1985. Likewise, the percentage of employees contributing toward family coverage has increased from 49 to 58 percent in 1985.

BLS reported that employee-paid premiums for health insurance for 1985 averaged about $12 per month for single coverage and about $38 per month for family coverage. In some instances, employees received free basic medical coverage but paid a separate premium for supplemental coverage, such as dental care.

The employee-paid portion of FEHBP premiums for 1985 averaged about $38 per month for single coverage and about $70 per month for family coverage.

Figure 17: Federal and Private Sector Enrollees Provided a Mental Health Benefit (1980-85)



Mental Health

Definition

Mental health benefits generally include inpatient treatment at hospitals and outpatient therapy sessions. Mental health treatment generally is provided for such conditions as psychosis, neurotic disorders, and personality disorders. Treatment may also include drug or alcoholism therapy.

Results

Virtually all health plan enrollees—both in the federal and private sectors—have mental health benefits. All federal plans offered inpatient care, but the level of coverage has declined over the 6-year period. In 1980, 16 of the 18 FEHBP plans in our sample provided basic benefits for mental health inpatient care, and 12 provided major medical benefits for outpatient care. Basic benefits cover the initial expenses incurred for medical care. Fifteen of the 18 plans in our sample paid 100 percent of the initial expenses for a specified time or up to a specified dollar limit. Since 1980, all 13 of the fee-for-service plans have reduced the amount of inpatient benefits that would be paid for most mental health treatment by adding or increasing deductibles and coinsurance and by adding lifetime maximums. Most fee-for-service plans have also added catastrophic protection for inpatient care.

All federal enrollees were covered for outpatient care until 1982, when one plan (about 10 percent of enrollees) dropped outpatient coverage. For outpatient care in 1980, 16 of the 18 plans either had deductibles or coinsurance or annual dollar or visit limits. Since 1980, outpatient benefits for most plans were reduced by reducing dollar or visit limits and/or by increasing deductibles or coinsurance.

In the private sector from 1980 to 1985, 98 to 99 percent of participants were covered for mental health inpatient benefits, and 91 to 97 percent were covered for outpatient care.

What Have Been the Costs to Add Selected Benefits to FEHBP?

Each year FEHBP plans submit benefit and rate proposals to OPM for the following year's contracts. OPM reviews the plans' proposals for benefit modifications and the plans' estimates of their impact on premium rates. According to an OPM actuary, these cost estimates are based on such factors as the projected use of the benefit by the plan's enrollees and the design of the benefit. For example, a plan with an older population would expect to have a lower use rate for dental benefits than a plan with a younger population and more children.

We reviewed examples in which FEHBP plans added or modified their benefits for hospice care, catastrophic protection, and major medical deductibles. We are not able to disclose the estimated costs submitted with these changes because the estimates were part of the plan's annual rate filings and are considered proprietary data.

In 1985 and 1986, 12 plans made changes in at least one of these three areas. In most cases, the changes affected the biweekly premium cost of the plan (either savings or added cost) by from 1 cent to more than $2. Hospice care was the least expensive change, with biweekly premium costs for adding as much as $3,000 of hospice care ranging from a savings of 14 cents to a cost of 18 cents per contract. The hospice benefit can result in plan savings when it is designed as an alternative to more costly hospital care. Changes to catastrophic protection and major medical deductibles resulted in much larger changes in premiums, ranging from a savings of $2.13 to a cost of $1.89. For example, a $50 to $100 reduction in major medical deductibles resulted in added biweekly premium costs ranging from about 37 cents to $1.89 for family coverage.

How Have Mental Health Benefits Changed in FEHBP?

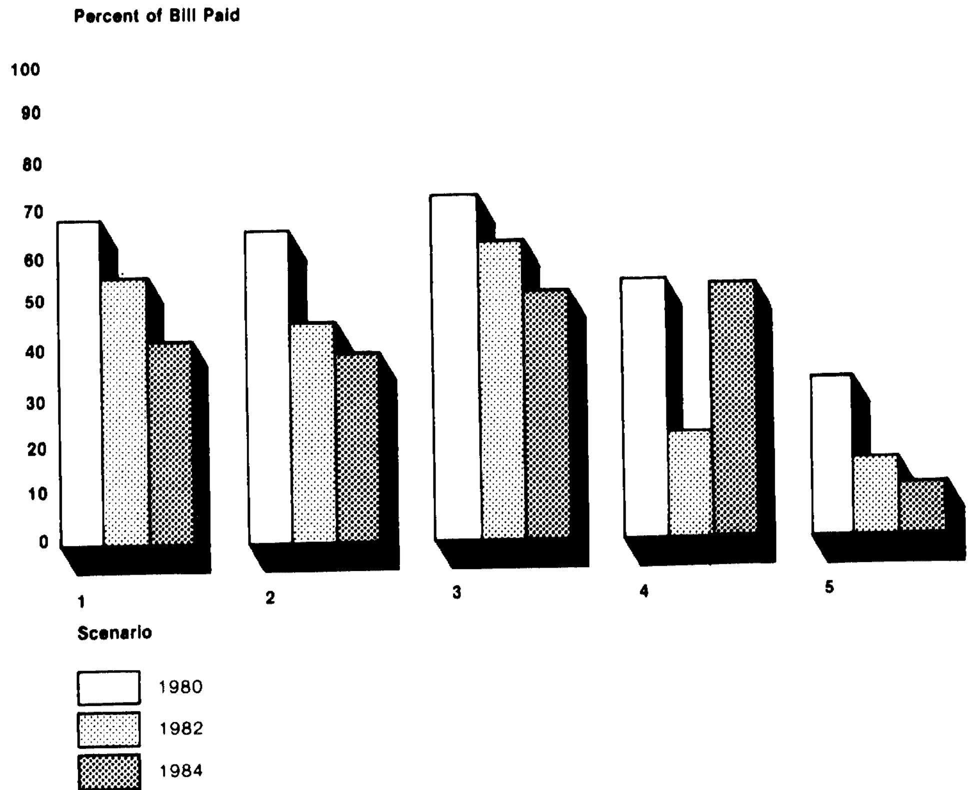
FEHBP plans have generally curtailed the mental health benefit since 1980, in areas such as the number of days of hospitalization covered, the total benefits paid, and the level of deductibles and coinsurance the enrollee must pay. In 1980, most FEHBP plans (15 of the 18 largest) paid 100 percent of initial mental health expenses for a specified time or to a specified dollar limit. But in 1982, mental health coverage was substantially curtailed. Plans reduced their mental health benefits by (1) covering fewer days of hospitalization, (2) limiting the covered treatment costs, (3) limiting the number of outpatient treatments, (4) raising deductibles, or (5) lowering coinsurance rates. In 1984, OPM asked the plans to restructure the benefit to improve long-term inpatient coverage by adding catastrophic protection. In doing so, the plans further reduced coverage for outpatient care and short-term hospitalization. Also, in 1984, 12 plans limited their lifetime inpatient mental health coverage to a specified maximum, typically ranging from $50,000 to $75,000. Before this change only four plans had lifetime maximums.

To measure these changes, we calculated the amount of charges nine large FEHBP plans would pay for each of five likely treatment scenarios developed for us by the American Psychiatric Association.[17] (See fig. 18.) The five mental health treatment scenarios include both long-and short-term inpatient and outpatient care and a recurrent care model with two hospitalizations. The five scenarios are described below:

- For short-term inpatient care of 10 days combined with 62 outpatient treatment visits, average coverage was 69 percent of charges in 1980, declining to 56 and 42 percent in 1982, and 1984, respectively.
- For short-term outpatient treatment of 18 visits, average coverage was 66 percent of charges in 1980, declining to 46 and 40 percent in 1982 and 1984, respectively.
- For two hospitalizations of 15 to 20 days each combined with 85 outpatient treatment visits, coverage declined from 74 percent of charges in 1980 to 63 and 52 percent in 1982 and 1984, respectively.
- For long-term hospitalizations of 180 days combined with 75 outpatient treatment visits, coverage declined from 54 percent of charges in 1980 to 23 percent of charges in 1982 and then increased to 53 percent in 1984.

[17] Billed charges were calculated using $425 per day and $65 per visit.

Figure 18: FEHBP Mental Health Benefits—Percent of Billed Amount Paid (1980, 1982, and 1984)



- For long-term outpatient treatment consisting of 120 sessions, coverage declined from 34 percent of charges in 1980 to 17 and 11 percent in 1982 and 1984, respectively.

A plan-by-plan analysis of the five scenarios follows:

Scenario 1

Scenario 1 involved short-term inpatient care of 10 days in the hospital ($4,250) and 62 outpatient treatment visits ($4,030). The total bill amounted to $8,280.

The percentage of the total bill covered decreased for all nine FEHBP plans, from 69 percent in 1980, to 56 percent in 1982, to 42 percent in 1984. One plan, Mail Handlers, dropped outpatient benefits in 1982 and paid only inpatient benefits.

The range of benefits paid by each of the nine selected plans varied by more than a factor of two. In 1980, the amounts covered ranged from $2,950 to $7,434. In 1984 the amount covered ranged from $2,175 to $5,495.

The reduced benefits were caused by the addition of day or visit limits or increased deductibles and the addition or decrease in coinsurance rates. For example, APWU would have paid $5,650 in 1980 and $2,175 in 1984, a decrease of $2,375 for inpatient care and $1,100 for outpatient. The decrease was due to the addition of a $500 deductible and 50-percent coinsurance for inpatient care and a $300 maximum for outpatient care.

Table 1: Total Amount Paid by Nine FEHBP Plans for Mental Health—Scenario 1

	Year		
	1980	1982	1984
Blue Cross high	$7,394	$6,135	$5,495
Blue Cross standard	7,123	4,981	4,144
Aetna high	4,800	4,038	3,600
Aetna standard	4,188	3,550	3,188
Alliance high	6,970	5,800	4,250
GEHA	4,596	3,585	2,625
APWU	5,650	4,820	2,175
Mail Handlers	2,950	2,500	2,375
NALC	7,434	6,190	3,125

Scenario 2

Scenario 2 involved short-term outpatient care of 18 treatment visits ($1,170).

The average percentage paid for the nine plans decreased from 66 percent in 1980, to 46 percent in 1982, to 40 percent in 1984. For six of the nine plans the amount of the total bill paid decreased from 1980 to 198 but showed either a small increase or no change from 1982 to 1984. Tw plans decreased each year, and one plan dropped outpatient care in 1982.

The range of benefits paid by the plans varied from $370 to $1,105 in 1980 and $0 to $776 in 1984.

The changes were due to increased deductibles and coinsurance. For example, Blue Cross high option increased its outpatient deductible fron $100 in 1980 to $200 in 1982 and 1984 and decreased coinsurance from 80 percent in 1980 to 70 percent in 1982 and 1984.

Table 2: Total Amount Paid by Nine FEHBP Plans for Mental Health—Scenario 2

	Year		
	1980	**1982**	**198**
Blue Cross high	$856	$679	$67
Blue Cross standard	728	690	69
Aetna high	876	728	77
Aetna standard	750	644	69
Alliance high	952	510	27
GEHA	370	250	25
APWU	1,105	800	30
Mail Handlers	450	•	•
NALC	896	510	51

:enario 3

Scenario 3 involved recurrent inpatient care with two hospitalizations of 15 to 20 days each (35 days total and $14,875) and 85 outpatient treatment visits ($5,525). The total bill amounted to $20,400.

The average percentage of the bill covered by the nine plans deceased from 74 percent in 1980, to 63 percent in 1982, to 52 percent in 1984. For six of the nine plans, the amount of the total bill paid decreased each year. For the other three plans, the amount paid increased in 1984 over 1982.

The range of benefits paid varied in 1980 from $5,450 to $19,255 and in 1984 from $7,488 to $13,955.

The decrease in benefits paid resulted from added or decreased day, dollar, or visit limits; reduced coinsurance; and increased deductibles. For example, NALC added a $500 deductible and 50-percent coinsurance for inpatient care in 1984, which reduced the amount paid from $14,875 in 1982 to $6,938. The calendar year maximum for outpatient care was reduced from $5,000 in 1982 to $1,250 in 1984. The amount paid decreased from $2,688 to $1,250.

ıble 3: Total Amount Paid by Nine :HBP Plans for Mental Health— :enario 3

	Year		
	1980	1982	1984
Blue Cross high	$19,215	$16,510	$13,955
Blue Cross standard	18,869	13,181	10,444
Aetna high	13,300	12,006	12,100
Aetna standard	12,156	10,988	11,156
Alliance high	17,595	16,425	13,813
GEHA	14,371	11,023	7,738
APWU	16,275	13,090	7,488
Mail Handlers	5,450	5,000	9,625
NALC	19,255	17,563	8,188

Scenario 4

Scenario 4 involves long-term inpatient care with 180 days in the hospital ($76,500) and 75 outpatient treatment visits ($4,875). The total b amounted to $81,375.

The average percentage of the bill covered by the nine plans decrease from 54 percent in 1980 to 23 percent in 1982 and increased to 53 percent in 1984. For seven of the nine plans, the amount paid decreased from 1980 to 1982, and in two plans the amount paid remained the sar in 1980 and 1982. In eight of the nine plans, the amount paid increase from 1982 to 1984. The ninth plan, Blue Cross standard option, showe a small decrease from 1982 to 1984 because it did not add catastrophic protection.

The range of benefits covered varied from $2,950 to $80,320 in 1980 and from $10,519 to $74,635 in 1984.

The change in benefits paid in 1984 was due to the combined effects of catastrophic protection limits and lifetime maximums. Seven of the nin plans were over both limits and consequently paid the lifetime maximum for this scenario. As for the other two plans, one (Blue Cross high option) was at about its lifetime maximum of $75,000 and the other (Blue Cross standard option), which did not add catastrophic protectio paid about the same amount it did in 1982.

Table 4: Total Amount Paid by Nine FEHBP Plans for Mental Health—Scenario 4

	Year		
	1980	1982	19
Blue Cross high	$80,320	$27,385	$74,6
Blue Cross standard	70,442	13,481	10,5
Aetna high	21,000	21,000	51,0
Aetna standard	15,750	15,750	50,7
Alliance high	66,470	14,300	50,7
GEHA	75,250	18,460	50,5
APWU	22,650	13,320	25,3
Mail Handlers	2,950	2,500	25,0
NALC	42,110	40,613	51,2

Scenario 5

Scenario 5 involved long-term outpatient care of 120 treatment visits ($7,800).

The average percentage of the charges covered by the nine plans decreased from 34 percent in 1980 to 17 percent in 1982, and to 11 percent in 1984. For seven of the nine plans the amount paid decreased from 1980 to 1982, and two plans paid the same amount all 3 years. Three plans paid less in 1984 than in 1982, and five plans paid the same amount in 1982 and 1984. One plan did not offer outpatient benefits in 1982 and 1984.

The range of benefits paid by the plans varied in 1980 from $450 to $6,160 and in 1984 from $0 to $2,135.

The decrease in benefits paid was caused primarily by decreased dollar or visit limits. For example, Blue Cross high option added a 50-visit limit in 1982, which decreased the amount paid from $6,160 to $2,135.

Table 5: Total Amount Paid by Nine FEHBP Plans for Mental Health—Scenario 5

	Year		
	1980	1982	1984
Blue Cross high	$6,160	$2,135	$2,135
Blue Cross standard	5,700	1,031	1,031
Aetna high	1,000	1,000	1,000
Aetna standard	750	750	750
Alliance high	2,720	1,550	750
GEHA	670	550	550
APWU	1,400	800	300
Mail Handlers	450	•	•
NALC	5,000	3,825	1,250

How Many FEHBP Plans Have Used Various Cost Containment Measures?

This section provides information on how many FEHBP plans are using measures thought to help curb health care costs. (See table 6.) Second surgical opinion programs, preferred provider organizations (PPOs), as well as reviews and controls of the medical necessity of hospitalization, are all options available to help deliver cost-effective health services. This section of our report describes various cost containment features used by FEHBP plans. Information on the cost impact of these features was not available.

Table 6: Summary of Cost Containment Measures Practiced by Largest FEHBP Plans (1986)

Name of plan	Preferred provider	Mandatory second opinion	Hospital utilization review: Preadmission review	Hospital utilization review: Concurrent review	Hospital utilization review: Retrospective review
Blue Cross high	Yes[a]	No	Yes[a]	Yes	Yes
Blue Cross std	Yes[a]	No	Yes[a]	Yes	Yes
Aetna high	No	Yes	Yes[b]	No	Yes
Aetna std	No	Yes	Yes[b]	No	Yes
AFGE	Yes[a]	Yes	No	No	Yes
Alliance	Yes[a]	Yes	No	No	Yes
GEHA	No	Yes	No	No	Yes
APWU	Yes	No	Yes	No	Yes
Mail Handlers	Yes[a]	No	Yes[a]	No	Yes
NALC	No	No	No	No	Yes
Postmasters	No	Yes	No	No	Yes
Rural Carriers	No	Yes	No	No	Yes
SAMBA	No	Yes	No	Yes	Yes

[a]Available in specific geographical areas.

[b]For mental disorders and substance abuse admissions only.

Second Surgical Opinion

A second opinion by a qualified physician is, among other things, intended to contain costs by reducing the incidence of unneeded surgery. Second opinions are optional features of virtually all federal health plans. In most cases, the claim for a second opinion may be indistinguishable from the claim for any other office visit. In recent years, health plans have begun to require second opinions for selected lists of nonemergency procedures.

Optional second opinion programs generally have no incentives for obtaining a second opinion, but they may be subject to the plan's deductible and coinsurance provisions. The programs are voluntary and consequently depend on employee education to be successful.

A second opinion program is considered mandatory if it offers an incentive (either reward or penalty) to ensure the second opinion is obtained. Incentives are usually in the form of an increase or decrease in cost sharing (coinsurance or deductible) for the surgery. Most mandatory plans will offer the incentive even if the second opinion is nonconfirming and the enrollee has the surgery anyway. In addition, mandatory programs will generally pay the entire cost of the second opinion and will provide or make arrangements for the second opinion.

According to OPM's chief, Program Planning and Evaluation Division, all federal health plans will pay for a second opinion for surgery in the same manner they reimburse a doctor's office visit. Before 1985, second opinions were optional for all but 2 of the 18 largest federal health plans. In 1980, SAMBA added a mandatory second opinion program, and in 1983 the Postmasters' high option plan added a mandatory second opinion program. Under these programs, the plans paid the full cost of a second or third opinion before elective surgery. In addition, the percentage of reasonable and customary charges paid for the surgical procedure was reduced from 100 to 80 percent unless a second/third opinion was obtained. Both plans had lists of elective surgical procedures that required second opinions before the plans would pay their normal benefits. Some of the procedures on the lists included: appendectomy (nonemergency), hysterectomy, hemorrhoidectomy, hernia repair, and cataract removal.

In 1985 and 1986, six more plans added mandatory second opinion programs. Six of the eight plans with such programs will penalize enrollees by reducing benefits if a second opinion is not obtained, but will pay their normal surgical benefits even if the second opinion is nonconfirming and the enrollee has the surgery. One plan, Alliance high option, requires that the second opinion be confirming before it will pay its normal benefits.

Preferred Provider Organizations

PPOs are groups of health care providers (hospitals and physicians) that agree to reduce their fees to purchasers in return for a specified volume of patients. Employees are generally rewarded for using the PPOs through reduced deductibles or higher coinsurance rates.

By 1986, six FEHBP plans had initiated PPO options. Plans sponsored by the Blue Cross/Blue Shield federal employees' program, Alliance, APWU, Mail Handlers, and AFGE have PPO options available to enrollees in a few geographic areas. For example, AFGE offered PPO options available to

high option enrollees in the Washington/Baltimore, Denver, and Los Angeles areas in 1986. Under this plan, AFGE contracted with about 50 hospitals, which provided the plan with discounts of from 1 to 26 percent for PPO option enrollees who use those hospitals.

In return for using the PPO hospitals, AFGE enrollees do not have to pay the plan's $100 inpatient deductible and they may obtain prescription drugs for $2 each (copayment). Prescription drugs for non-PPO subscribers are subject to the plan's major medical deductible and coinsurance provisions. In 1985, enrollees selecting this option would have their surgery paid at 100 percent of usual and customary charges versus 80 percent for other surgery. In 1986 all surgery was paid at 100 percent of usual and customary charges.

According to the AFGE director of insurance, about 10 percent of Washington/Baltimore area enrollees selected the PPO option in 1985. AFGE did not have available information on savings resulting from the PPO program. AFGE plans to expand its PPO program to additional geographic areas in 1987.

Mail Handlers and Alliance also reduce the inpatient deductible for enrollees who use the PPO arrangement offered by their plans, but as with AFGE's program, these alternatives are available only in select locations.

The Blue Cross/Blue Shield federal employees' program had PPO arrangements in 12 geographic areas in 1986 covering about 28 percent of its subscribers. This PPO program will be expanded to additional areas in 1987. The most common incentives offered Blue Cross subscribers are waiving the inpatient deductible and paying physicians fees at a higher coinsurance rate. Each local Blue Cross plan designs its own PPO program. In some cases the local plans contract directly with individual hospitals and physicians, and in others the plans contract directly with existing PPOs.

APWU has a PPO arrangement with two nationwide hospital chains. According to an APWU official, the plan receives a 2-percent prompt payment discount from these hospitals. Enrollees' copayments are reduced if they use hospitals belonging to one of these chains. For 1987, Aetna also established preferred hospitals in many areas of the country.

Finally, for its 1987 contract, Postmasters intends to adopt Prudential's preferred provider network for residents of south Florida, California, Washington State, Nevada, Arizona, Colorado, and New Mexico.

Utilization Review

Utilization reviews assess the medical care services provided to enrollees to assure such things as quality, appropriateness in terms of length and level of care, and location of treatment. There are several types of utilization reviews, including prospective (preadmission), concurrent, and retrospective.

Prospective Utilization Review

Under prospective or preadmission review, the medical necessity and appropriate length of a hospital stay are evaluated before admission. The primary advantage to preadmission review over concurrent or retrospective review is that an inappropriate hospitalization can be prevented. A preadmission review also provides the employee with assurance that the admission will be paid for. Preadmission review generally applies to elective surgery and may include all or only selected procedures. In addition, preadmission review can affect medical practice patterns and quality of care by bringing practice patterns into line with professional norms and highlighting physicians who are outside those norms.

Preadmission reviews are generally conducted by a professional, such as a registered nurse or physician who uses medically accepted criteria to determine whether the treatment could be performed on an outpatient basis. Should the need for hospitalization be confirmed, preadmission reviews typically authorize a specified length of hospitalization. The process may also consider the need for extending the hospitalization.

Concurrent Review

Under concurrent review, the medical necessity and appropriateness of continued stays is evaluated while the enrollee is hospitalized. The review is based on diagnosis-specific criteria and occasionally a review of the patient's records. A primary goal of concurrent reviews is to reduce the length of stay in the hospital. The primary disadvantage of concurrent reviews is that they do not consider whether the procedure could have been done on an outpatient basis.

Retrospective Review

Under retrospective reviews, the hospital bill is compared to the medical chart, progress list, and other hospital documentation of the services

ordered by the physician. A retrospective review occurs after the patient is discharged. As a result, this form of utilization review cannot affect the duration of stay or level of treatment.

Use of Utilization Review in FEHBP

Most of the fee-for-service plans in FEHBP have some form of utilization review. Retrospective reviews are most common. Retrospective and concurrent reviews generally are conducted when a hospital stay exceeds dollar or length-of-stay guidelines. For example, NALC conducts concurrent reviews only for admissions that exceed 15 to 30 days.

Preadmission review programs in the FEHBP plans have generally been limited in scope and do not include all subscribers or types of treatment. For example, the 1986 Aetna program covers mental health hospital admissions only, and the 1986 Blue Cross program covers only three areas, Washington, D.C.; Cleveland, Ohio; and Kentucky. The Mail Handlers program covers 10 states. Only APWU's preadmission certification program assesses the need for hospitalization for all enrollees, regardless of location.

As is the case with mandatory second opinion programs, some FEHBP plans incorporate incentives for subscribers who use preadmission reviews. For example, Blue Cross and Mail Handlers will waive and/or reduce the hospital admission deductible when prior authorization of hospitalization is obtained.

For their 1987 contracts, FEHBP plans increasingly intend to require preadmission reviews of hospitalizations. Aetna intends to expand its preadmission reviews to include not only mental health admissions but also other medical admissions. AFGE and Alliance also added preadmission certification requirements to their 1987 contracts.

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