GAO

United States
General Accounting Office
Washington, D.C. 20548

General Government Division
B-244726

June 23, 1992

The Honorable Bob Graham
United States Senate

Dear Senator Graham:

Recently, we briefed you on our report entitled Federal Health Benefits Program: Stronger Controls Needed to Reduce Administrative Costs (GAO/GGD-92-37, Feb. 12, 1992). Subsequent to that briefing, you requested additional cost and other information on the Federal Employees Health Benefits Program (FEHBP) and nonfederal employer-sponsored health insurance programs. In response to your request, the enclosures to this letter provide information developed from our past reviews of those programs.

If you have any questions, please call me at (202) 275-5074 or Larry Endy at (202) 275-8867. We would be pleased to meet with you or your staff to discuss the information at your convenience.

Sincerely,

Bernard L. Ungar

Bernard L. Ungar
Director, Federal Human Resource
Management Issues

Enclosures (7)

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ABBREVIATIONS

FEHBP	Federal Employees Health Benefits Program
HMO	health maintenance organization
IG	Inspector General
OPM	Office of Personnel Management
PPO	preferred provider organization

ENCLOSURE I

FEHBP COSTS COMPARED TO THE AVERAGE COSTS OF PRIVATE, STATE, AND LOCAL GOVERNMENT PROGRAMS, 1984-1991

From 1984 to 1991, FEHBP's cost per enrollee increased from $1,816 to $3,265, or 80 percent. In comparison, the average cost for private, state, and local government programs increased from $1,645 to $3,605, or 119 percent. One reason that the increase in FEHBP's costs was lower than the increase for other programs was that FEHBP had cost decreases in 1985 and 1986. The decreases reflected the drawdown of surplus reserves, which had accumulated after 1982 when benefits were cut and enrollee deductibles and coinsurance were installed programwide. From 1987 to 1991, the average annual percentage increases in costs were about the same--16 percent for FEHBP and 14 percent for the other programs. Also, the cost comparison does not address the wide variety of program differences that affect costs, such as medical services covered; enrollee characteristics, such as age and sex; health care utilization; and out-of-pocket costs paid by enrollees.

Table I.1: Percentage Change in Cost per Enrollee for FEHBP and Nonfederal Programs, 1984-1991

Year	FEHBP		Private, state, and local government programs	
	Cost per enrollee	Percentage change	Cost per employee	Percentage change
1984	$1,816		$1,645	
1985	1,796	-1%	1,724	5%
1986	1,592	-11	1,857	8
1987	1,869	17	1,985	7
1988	2,353	26	2,354	19
1989	2,830	20	2,748	17
1990	3,078	9	3,217	17
1991	3,265	6	3,605	12
Cumulative change	$1,449	80%	$1,960	119%
Average annual change	$207	9%	$280	12%

Source: Compiled by GAO from unpublished OPM data and Foster Higgins Health Care Benefits Survey, 1991, A. Foster Higgins & Company (Princeton: 1992).

COST CONTROL EFFORTS IN THE PRIVATE SECTOR AND FEHBP

In 1990 we reported that private sector employers were seeking to control the growth of health care costs through a variety of cost containment measures. Although changes in coverage by large employers had been modest, industry sources believed the trend could intensify if health cost increases continued or the economy entered a recession. The measures being taken included

-- limiting eligibility for coverage,

-- shifting costs to employees,

-- self-insuring the risk of loss, and

-- reducing utilization.[1]

Except for limiting eligibility, similar measures have been used within FEHBP, in varying degrees, to contain costs.

LIMITING ELIGIBILITY

To help cut costs, some private employers were limiting eligibility for benefit coverage by

-- hiring more temporary, part-time, self-employed, and contract workers who are not eligible for coverage;

-- limiting or eliminating coverage of annuitants;

-- screening job applicants' health status and denying coverage because of preexisting conditions or high risk of future medical impairment; and/or

-- establishing waiting periods following the beginning of employment.

Rather than limiting eligibility for coverage under FEHBP, amendments to the Federal Employees Health Benefits Act of 1959 have generally extended coverage to more categories of individuals. Although some categories of employees, such as non-full-time employees without a prearranged regular tour of duty, are excluded by regulation, the authorizing legislation provides coverage for part-time career employees as well as annuitants who

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

participated at least 5 consecutive years immediately before retirement. Recently, eligibility was extended to temporary employees under certain circumstances. Also, the act precludes the health plans from denying coverage because of an individual's health status, and the regulations permit eligible new employees to enroll in the plan of their choice within the first 31 days of employment.

COST SHIFTING OF EMPLOYERS' COSTS

Many employers have attempted to control their health benefits costs by shifting more costs to employees. From 1988 to 1991, more employers required employees to share in the premium cost for their and their families' coverage. The percentage of Foster Higgins survey respondents that required employees to contribute to fee-for-service plan premiums rose for self-only coverage from 39 percent to 55 percent and for family coverage from 69 percent to 76 percent.[2] In 1991, employees who were required to contribute to their premiums paid an average of 20 percent for self-only coverage and 28 percent for family coverage.

FEHBP enrollees have always shared in the premium costs of both self-only and family coverage by paying the difference between the total premium for the plan they chose and the government's share. The government's contribution for both self-only and family coverage is determined through what is commonly called the "Big Six formula." For nonpostal employees, the government pays the dollar amount equal to 60 percent of the average premiums for the two governmentwide high-option plans, two largest employee organization plans, and two largest prepaid plans (commonly called health maintenance organizations)--up to 75 percent of the premium for any particular plan.[3]

The Big Six formula has caused the government's share of premiums to increase because the premiums of the governmentwide high-option plans rose faster than average premiums. However, the government's contribution varies by plan, and nonpostal enrollees

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[2]Foster Higgins Health Care Benefits Survey, 1988 and Foster Higgins Health Care Benefits Survey, 1991; A. Foster Higgins & Company (Princeton: 1989 and 1992).

[3]After the governmentwide Aetna high option plan terminated in 1990, legislation was enacted that substituted a "phantom premium," which was that plan's 1989 premium plus the simple average increase in the premiums of the other five plans.

pay at least 25 percent of their plans' premiums. In 1989, nonpostal enrollees paid an average of 33 percent of their premium costs. The Postal Service's share of plan premiums, which is determined through collective bargaining, is limited to 75 percent of the Big Six formula and 93.75 percent of the premium for any particular option. In 1989, postal employees paid an average of 13 percent of their premium costs.

Employers are also shifting more of their costs to employees through deductibles, copayments, and out-of-pocket maximums. The median deductible for self-only coverage reported by Foster Higgins survey respondents increased in 1991 from $150 to $200, and the median out-of-pocket maximum increased from $1,000 to $1,050. Although the coinsurance paid by employees for hospital and physician services has remained at 20 percent, the percentage of employers requiring such payments has increased. For example, the percentage of employers requiring employee coinsurance for outpatient surgery increased from 50 percent in 1986 to 65 percent in 1991.

In FEHBP, the fee-for-service plan deductibles, coinsurance, and out-of-pocket maximums also vary by plan. In 1991, most plans had deductibles that ranged from $150 to $325 per person. The coinsurance paid by enrollees varied by type of service as well as by plan and ranged from 0 to 25 percent. The plans' out-of-pocket maximums ranged from $700 to $2,500 for self-only coverage to $1,000 to $5,000 for family coverage.

SELF-INSURANCE

According to the Foster Higgins 1991 survey, rather than purchase health insurance, most employers self-insure the risk that health care costs will exceed premiums. Self-insured employers avoid state-mandated benefits, premium taxes, insurance risk charges, and contributions to state risk pools and gain control over their own insurance reserves from which they can generate investment income.

Although FEHBP is an insured program, it has the above benefits associated with self-insurance except for the avoidance of risk charges, which we estimated were $8 million for 1989.[4] However, self-insured employers may also be able to obtain administrative services at a lower price because they can use competitive bidding to select the most cost-effective contractors. Enclosure

[4]Federal Health Benefits Program: Stronger Controls Needed to Reduce Administrative Costs (GAO/GGD-92-37, Feb. 12, 1992).

VII discusses how the absence of competitive bidding has affected FEHBP's administrative costs.

REDUCING UTILIZATION

Most large employers, including the government, have attempted to contain health benefits costs by limiting utilization through managed care and utilization reviews. Managed care includes health maintenance organizations (HMOs), which provide benefits only through specified providers, or fee-for-service plans with preferred provider organizations (PPO), which offer employees who use designated providers enhanced benefits or reduced out-of-pocket costs. Utilization reviews include second surgical opinions, precertification of hospital admissions, concurrent reviews of continued hospital stays, and large case management.

FEHBP has offered employees the choice between fee-for-service plans and HMOs since its inception. Enrollment in the HMOs increased from 14 percent of the program's total participants in 1984 to 28 percent in 1991. Also, most of the fee-for-service plans have established PPOs to help contain benefit costs.

Before 1991, the use of cost containment measures in FEHBP was up to the carriers and, thus, varied among the fee-for-service plans. However, the Office of Personnel Management (OPM) now requires those plans to have programs for the precertification of hospital admissions and management of catastrophic cases to ensure the most appropriate and cost-effective treatment of severely injured or ill persons. The plans also are required to coordinate the payment of claims with Medicare to ensure that physician charges do not exceed statutory maximums. For 1993, OPM encouraged the plans to eliminate second surgical opinions, which it believed caused risk segmentation and confusion among enrollees, and also encouraged the plans to add or expand PPOs. OPM also recently issued a request for proposals to assess the effectiveness of the plans' precertification and case management programs and recommend improvements or additional programs.

ENCLOSURE III

GAO RECOMMENDATIONS TO OPM FOR IMPROVED OVERSIGHT OF FEHBP

OPM administers FEHBP through contracts with various types of organizations, known as carriers, that reimburse, provide, or pay for the cost of health care services and supplies under group health insurance plans. The Federal Employees Health Benefits Act of 1959, as amended, authorizes OPM to set minimum standards for the health plans and carriers and to continuously study the operation, administration, and experience of the plans.

We recently issued two reports that address inadequacies in OPM's oversight of the carriers' operations and administrative costs. OPM generally agreed with our recommendations and has taken or planned actions to improve its oversight of the program. However, OPM's ability to effectively implement many of the planned actions depends on its obtaining additional resources, which will be hard-won given the continuing federal budget deficits.

INADEQUATE CONTROLS TO GUARD AGAINST FRAUD AND ABUSE IN FEHBP PLANS

In July 1991, we reported that program funds paid to the fee-for-service plans were highly vulnerable to fraud and abuse.[5] Although OPM had recognized the potential for loss and implemented some new controls, it conducted only limited oversight of the plans. Consequently, it did not know whether the carriers' financial and claims processing controls were adequate to prevent and detect fraudulent and abusive claims or misappropriation of funds similar to cases that had been identified within the plans in the 1980s. Also, OPM had not developed an aggressive policy for pursuing fraud and abuse by enrollees and health care providers or implemented the statutory authority it has had since 1989 to administratively penalize providers who commit fraud or program-related offenses.

Our recommendations to improve OPM's oversight of plan operations and the actions it has taken or planned are summarized in table III.1.

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[5]Fraud and Abuse: Stronger Controls Needed in Federal Employees Health Benefits Program (GAO/GGD-91-95, Jul. 16, 1991).

ENCLOSURE III

Table III.1: OPM's Response to GAO Recommendations for Stronger Controls to Prevent Fraud and Abuse in FEHBP Plans

GAO recommendation	OPM response
Assess the adequacy and effectiveness of the carriers' internal financial and claims-processing controls.	OPM asked the carriers to report on their internal controls and will use the information to develop standards and follow-up procedures when resources become available.
Conduct program analysis and on-site visits.	Using limited available resources, OPM began to visit carriers and develop the protocol for reviews. These activities will be stepped up as resources become available.
Ensure carriers implement audit recommendations to improve internal controls.	Systematic follow-up of internal control deficiencies has been implemented as part of OPM's audit resolution process.
Implement a program to prevent and detect fraud and abuse by enrollees and health care providers.	The IG's fraud hotline number was printed in the 1992 plan brochures, and a direct link was established between the carriers and the IG. Additional actions are to be identified.
Monitor magnitude of enrollee and provider fraud and abuse cases.	OPM established a semiannual reporting requirement for fraud and abuse cases.
Implement authority to administratively sanction fraudulent and abusive providers.	The IG is developing a program to implement the sanctions.
Implement a 3- to 5-year audit cycle for fee-for-service plans.	The IG's request for additional resources for fiscal years 1992 and 1993 to shorten the audit cycle was not approved.

INADEQUATE CONTROLS OVER FEHBP PLANS' ADMINISTRATIVE COSTS

In February 1992, we reported that FEHBP's 1988 administrative cost per $100 of benefits paid was 51 percent higher than the average cost ratio for other large insured health benefits programs that we reviewed and 89 percent higher than the average ratio for programs that were self-insured by the employer.[6] Although differences in the programs' health benefits and operations may have contributed to FEHBP's higher cost, we found that its structure and administration were contributing factors.

Because FEHBP was structured to include certain plans, OPM cannot use competitive procedures to select only carriers that provide the most cost-effective administrative services. Also, because the annual contracts are automatically renewed, the carriers do not have to contain their administrative expenses to levels competitive with other claims processors. Although these aspects of the program's structure may make it difficult for OPM to reduce the expense ceilings it has negotiated with the carriers, we found it had not obtained the expense and work load information needed to evaluate the appropriateness of those ceilings or offered the carriers sufficient incentives to improve efficiency and reduce costs.

We recommended that OPM strengthen controls over the carriers' administrative costs by improving the expense and work load information reported by the carriers and using that information to (1) evaluate carrier expense levels, (2) negotiate appropriate ceilings on the amounts to be paid, and (3) negotiate subsequent ceiling adjustments to reflect work load and other changes that affect expenses. We also recommended that after the ceilings have been appropriately adjusted, OPM offer monetary incentives to encourage expense reductions and establish performance standards and measures to ensure that the carriers' administrative services are maintained at acceptable levels. OPM agreed to obtain better data to evaluate the carriers' expenses and negotiate expense ceilings and incentives to reduce the carriers' administrative costs. It has also requested additional resources to better monitor plan operations.

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[6]GAO/GGD-92-37, Feb. 12, 1992.

ENCLOSURE IV

COULD THE FEDERAL GOVERNMENT PARTICIPATE IN EMPLOYER COALITIONS THAT CONTRACT FOR REDUCED HEALTH CARE COSTS?

According to the newspaper article attached to the request letter, a coalition of employers used their combined purchasing power and competitive bidding to obtain discounts from health care providers and encourage higher quality health care. In return for discounts of up to 20 percent, the employers agreed to steer their employees to the hospital that bid the lowest cost and an affiliated network of physicians by making the employees who went elsewhere pay more of the costs.

Although the government's participation in coalitions might increase the purchasing power of the government and/or other employers in various geographical areas, such an approach may be inconsistent with FEHBP's multiple-plan structure. Rather than providing uniform health benefits managed by the employer, FEHBP has several different fee-for-service plans that are managed by various insurers. Thus, enrollees have a choice of different types and levels of benefits for their premium dollars.

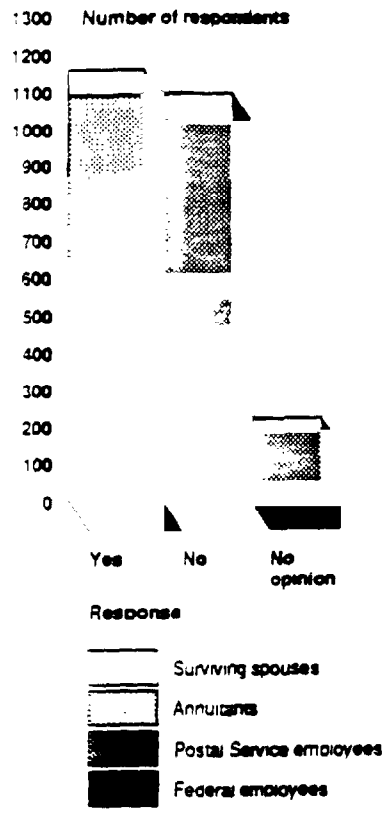
To some extent, FEHBP is realizing the cost containment benefits available through employer coalitions because OPM has strongly encouraged the individual insurers to establish and expand their PPOs. Because the PPOs are established by the insurers, the provider discount and enrollee incentive features may vary by plan. To reduce or eliminate this variation by establishing a single PPO for all plans in specified geographic areas may shift some of the insurers' responsibility for managing plan benefits to OPM and reduce the choices enrollees now have among different types and levels of benefits.

EFFECTIVENESS OF FEDERAL EMPLOYEES' PLAN SELECTIONS

Under FEHBP, federal employees have a wide selection of health plans from which to choose the benefits and premium levels that best suit their family circumstances and ability to pay. However, the cost effectiveness of these choices would be difficult to measure. In the debate over program reform, proponents of "choice" believe that employees are able to choose plans that best meet their health care needs and that the competition among plans for enrollees has resulted in better service and lower costs. Proponents of a more uniform benefits structure believe that it is difficult to understand the similarities and differences among plans and that the large number of plans has resulted in risk segmentation and divergent premiums for plans of similar value.

In 1989, an attitude survey of FEHBP participants was conducted to elicit their opinions on various coverage options under consideration by OPM. Many of the respondents said it was difficult to compare the benefits offered by the various plans (see fig. V.1) and that the program should be simpler and offer less choice (see fig. V.2). Also, the reason most frequently cited by the respondents for choosing a plan was that they were familiar with it (see fig. V.3).

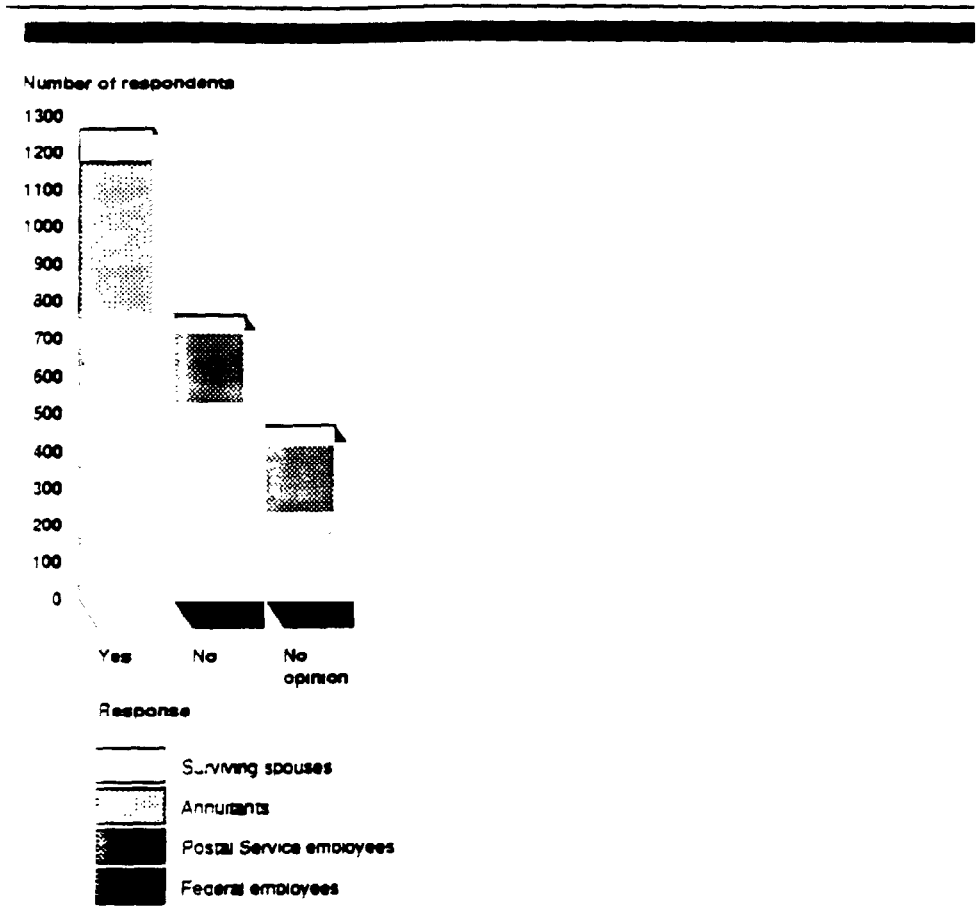
Figure V.1: Survey Respondents' Opinions on Whether Comparing FEHBP Plan Benefits Is a Problem During Open Season



Source: Compiled by GAO from Federal Employee Health Benefits Program: A Survey of Participant Attitudes (Feb. 5, 1990), which was prepared for the U.S. Office of Personnel Management by Science Management Corporation.

ENCLOSURE V

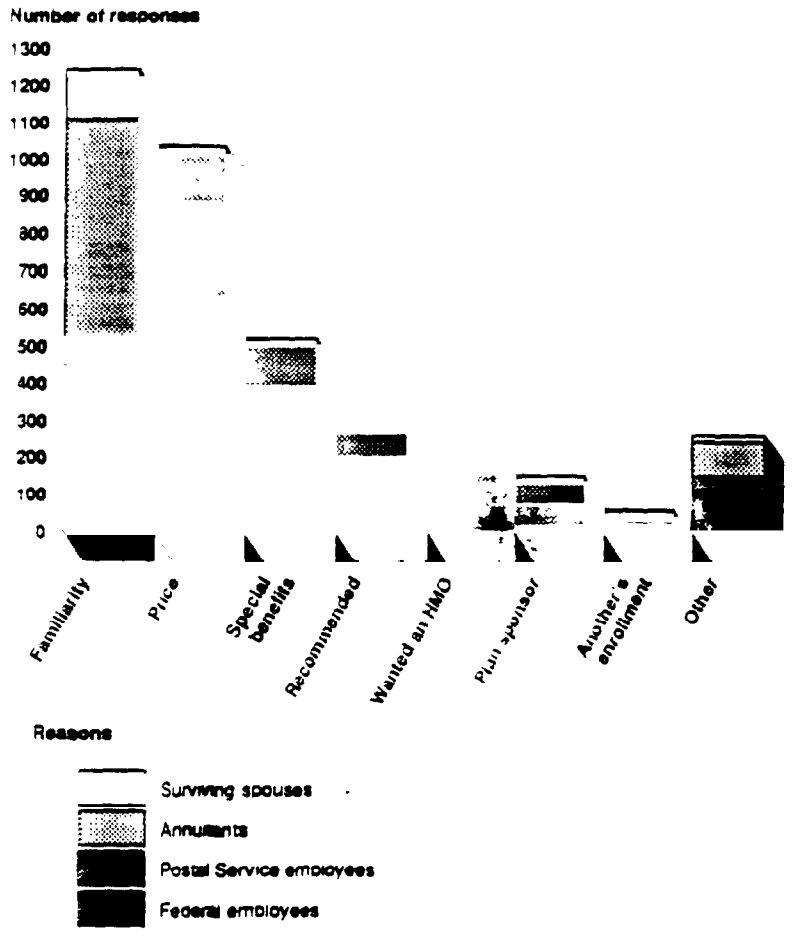
Figure V.2: Survey Respondents' Opinions on Whether FEHBP Should Be Simpler and Have Fewer Plans



Source: Compiled by GAO from Federal Employee Health Benefits Program: A Survey of Participant Attitudes (Feb. 5, 1990), which was prepared for the U.S. Office of Personnel Management by Science Management Corporation.

ENCLOSURE V

Figure V.3: Survey Respondents' Reasons for Choosing Their FEHBP Plans



More than one choice allowed.

Source: Compiled by GAO from Federal Employee Health Benefits Program: A Survey of Participant Attitudes (Feb. 5, 1990), which was prepared for the U.S. Office of Personnel Management by Science Management Corporation.

HOW DO THE ADMINISTRATIVE COSTS OF FEHBP AND OTHER PROGRAMS COMPARE, AND HAS THE ABSENCE OF COMPETITIVE BIDDING AFFECTED FEHBP'S COSTS?

Our report on FEHBP's administrative costs compared the cost of its fee-for-service plans in 1988 to the costs of large insured and self-insured programs sponsored by private, state, and local government employers, which had responded to a health benefits survey conducted by A. Foster Higgins & Company, a consulting firm.[7] The report shows that FEHBP cost $8.56 to administer for each $100 of benefits paid. In contrast, the costs of the other large insured programs averaged $5.68 and the costs of the self-insured programs averaged $4.52.

Although we believe that FEHBP's benefits and administrative structure may make it more expensive to administer than other programs, we also believe that the lack of competitive bidding has added to its costs. The plans do not have to compete with other claims processors on the basis of the cost effectiveness of their administrative services and otherwise lack sufficient incentives for keeping their costs low. Also, the plans' noncompetitive, self-renewing contracts weaken OPM's ability to negotiate cost reductions.

If Congress reforms FEHBP to provide a more uniform benefits structure and allow for the competitive selection of the contractors that perform the program's administrative services, we believe that FEHBP's administrative costs could be reduced by as much as $200 million.

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[7]GAO/GGD-92-37, Feb. 12, 1992.

ENCLOSURE VII

BLUE CROSS AND/OR BLUE SHIELD MEMBER PLANS' ADMINISTRATIVE COSTS PER FEHBP CLAIM PROCESSED, 1988

State	Plan		Type of claim					
			Institutional		Major medical		Dental	
	Location	Cod	Number	Cost	Number	Cost	Number	Cost
AL	Birmingham	010	64,448	$12.65				
		510			553,806	$6.53	113,057	$3.86
AK	Little Rock	020	19,305	8.06				
		520			162,347	6.36	34,942	4.63
AR	Phoenix	030	24,967	22.52				
		530			192,585	18.00	31,001	16.80
CA	Los Angeles	040	137,123	22.14				
	San Francisco	542			844,281	11.28	150,345	4.75
CO	Denver	050	36,412	14.87				
		550			247,067	9.48	42,408	4.35
CT	North Haven	060	9,649	25.75				
		560			47,713	7.64	20,048	5.47
DC	Washington	080	237,844	23.91			611,730	2.69
		580			1,394,137	12.25		
DE	Wilmington	070	8,778	23.82				
		570			25,893	17.38	11,330	6.69
FL	Jacksonville	090	125,497	16.09				
		590			1,112,602	8.07	180,474	4.35
GA	Atlanta	100	85,770	10.31				
		600			402,256	7.91	143,605	4.05
HI	Honolulu	471	1,370	18.33				
		971			15,510	18.27	2,644	19.00
IA	Des Moines	140	19,324	12.73				
		640			133,507	8.75	46,301	3.52
	Sioux City	141	9,146	18.45	230	99.53		
ID	Boise	110	7,760	22.55				
		610			37,742	11.83	16,238	8.48
	Lewiston	611			4,757	5.88	1,224	4.30
IL	Chicago	121	82,360	13.98				
		621			301,001	9.29	99,406	5.40
IN	Indianapolis	130	49,453	16.82				
		630			239,462	8.03	69,710	3.54
KS	Topeka	150	22,962	11.60				
		650			176,982	6.61	50,612	3.48

ENCLOSURE VII

State	Plan		Type of claim					
			Institutional		Major medical		Dental	
	Location	Cod	Number	Cost	Number	Cost	Number	Cost
KY	Louisville	160	32,530	16.99				
		660			154,858	12.54	62,564	3.32
LA	Baton Rouge	170	24,264	16.95				
		670			131,284	10.99	27,862	4.12
MA	Boston	200	177,954	10.94				
		700			468,904	8.29	104,170	6.59
MD	Baltimore	190	113,353	19.43				
		690			566,415	9.17	200,963	5.98
ME	Portland	180	21,498	15.05				
		680			60,573	13.69	30,903	4.81
MI	Detroit	210	52,689	15.64				
		710			262,998	10.75	76,431	6.49
MN	St. Paul	220	15,360	15.92				
		720			128,021	11.57	38,140	4.78
MO	Kansas City	240	17,603	19.25				
		740			113,079	11.60	30,511	6.42
	St. Louis	241	33,208	29.91				
		741			212,483	9.93		
MS	Jackson	230	24,554	11.10				
		730			115,574	8.75	31,308	8.22
MT	Helena	250	6,537	13.68				
		751			44,955	8.69	13,007	8.15
NC	Chapel Hill	310	41,548	8.02				
		810			241,545	6.84	65,078	3.98
ND	Fargo	320	6,604	21.98				
		820			53,648	5.86	19,341	4.67
NE	Omaha	260	12,008	20.33				
		760			76,182	9.95	34,267	4.39
NH	Concord	270	17,609	12.96				
		770			102,016	8.67	31,198	5.07
NJ	Newark	280	37,140	19.30				
		780			251,249	14.92	69,918	3.33
NM	Albuquerque	290	19,617	13.61				
		790			91,369	9.28	25,621	5.78

ENCLOSURE VII

State	Plan		Type of claim					
			Institutional		Major medical		Dental	
	Location	Cod	Number	Cost	Number	Cost	Number	Cost
NY	Watertown	307	573	19.60				
	Buffalo	301	3,885	41.70	5 274	35.35		
		801			43,104	9.97	16,570	5.87
	New York	303	36,575	43.81			58,609	9.43
		803			251,382	10.42		
	Rochester	304	3,839	23.54				
		804			2,830	17.90	3,761	12.33
	Syracuse	305	2,851	21.61				
		805			7 740	13.81		
	Utica	306	3,692	20.89				
		806			8,044	12.27	4,922	5.95
OH	Columbus	334	10,804	27.23				
	Cincinnati	332	45,101	13.59				
		834			286,104	9.50	108,883	4.61
	Cleveland	333	16,317	36.27				
		833			4,612	14.77	20,051	6.85
	Toledo	337	6,496	19.39	3,791	12.40		
OK	Tulsa	340	36,190	19.11				
		840			276,283	11.20	73,717	6.81
OR	Portland	350	17,017	14.57				
		851			03,241	9.37	37,638	3.81
PA	Harrisburg	361	51,270	8.87				
	Pittsburgh	363	37,698	13.03				
	Camp Hill	865			04,015	8.20	232,806	2.84
	Philadelphia	362	82,978	17.94	56,735	17.04		
	Wilkes-Barre	364	15,080	15.25	1,100	5.94		
PR	San Juan	470	676	22.15				
RI	Providence	370	17,429	13.12			24,575	5.74
		870			39,301	10.34		
SC	Columbia	380	32,145	20.80				
		880			74,573	9.46	52,389	3.51
SD	Sioux Falls	889			5,544	4.89	14,601	4.56
TN	Chattanooga	390	28,241	14.09				
		890			64,893	7.36	47,865	2.69
	Memphis	392	8,389	20.69				
		892			7,781	11.22	14,034	3.77
TX	Dallas	400	94,091	20.92				
		900			2,935	10.55	122,113	4.36