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FEDERAL HEALTH BENEFITS PROGRAM

Stronger Controls Needed to Reduce Administrative Costs

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The Honorable William L. (Bill) Clay
Chairman, Committee on Post Office
and Civil Service
House of Representatives

The Honorable Gary L. Ackerman
Chairman, Subcommittee on Compensation
and Employee Benefits
Committee on Post Office and
Civil Service
House of Representatives

This report responds to your request that we review the administrative costs of the Federal Employees Health Benefits Program (FEHBP). You were particularly interested in how FEHBP costs compare with those of other large employer-sponsored health benefits programs, including the Department of Defense's Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and whether opportunities exist to reduce FEHBP costs. The scope of our review was limited to the fee-for-service (FFS) plans that provide health benefits by paying claims filed by enrollees and providers of health services and supplies. We focused our efforts on calendar year 1988, the latest year for which complete data were available at the time of our review. We briefed your offices on the preliminary results of our work and agreed to provide a final written report. Appendixes I through V provide the details of the briefing we provided your offices.

Background

The Office of Personnel Management (OPM) administers FEHBP by contracting with carriers to provide health insurance plans for federal employees and retirees and their dependents. Enrollees may select (1) FFS plans, which permit them to choose their doctors and other service providers with the cost of these services either partially or fully reimbursed by the plans, or (2) plans commonly called health maintenance organizations (HMO), which use a specific group of health care providers to provide enrollees with services. Each plan has its own benefits structure and premium levels.

In fiscal year 1988, 25 FFS plans and over 400 HMO plans provided health benefits to almost 4 million federal employees and retirees at a cost of over $9 billion. All of this $9 billion, except for $10 million spent by OPM to administer the program, was paid to carriers for enrollee health benefits and administrative costs. The program was financed through premiums

paid by the government and enrollees and through interest income on program funds. In 1988, the government paid $6.1 billion, or 68 percent, of the premiums; and enrollees paid $2.8 billion, or 32 percent. Over 3 million, or 78 percent, of the program enrollees were enrolled in FFS plans.

In calendar year 1988, the government and enrollees together paid $7.4 billion to the 25 FFS plans, which used about $6.7 billion to pay benefits and $564 million for administrative costs. These administrative costs consisted of

- $458 million for the operational expenses charged by carriers for claims processing, customer service, overhead, open-season expenses, and other costs related to plan operations;
- $57 million for premium taxes imposed by state and local governments, U.S. territories, and the Republic of Panama on the portion of premium income paid to insurance underwriters by participating plans;[1]
- $48 million for service charges (profits) negotiated by OPM and the carriers under OPM regulations; and
- $2 million for state statutory reserves required of insurance carriers by some states to build reserves for health insurance plans.[2]

CHAMPUS provides health care coverage for dependents of active-duty members of the military and other beneficiaries. Although CHAMPUS does not require the payment of premiums, beneficiaries must meet annual deductibles and pay a percentage of allowable charges. CHAMPUS' fiscal year 1988 budget for the payment of benefits and administration of the program was over $2.5 billion. CHAMPUS benefits are funded through annual appropriations. In 1988, a demonstration project (CHAMPUS Reform Initiative) was implemented in two states. Instead of contracting only for the processing and payment of medical claims, the project uses a competitively selected contractor, which shares the government's financial risk for the financing and delivery of all CHAMPUS health care services in the two states. The project, which is intended to contain costs for both the government and beneficiaries, is being evaluated. It has been expanded to the city of New Orleans and may be expanded to other states.

In 1990, the Subcommittee held hearings on two proposals to reform FEHBP: H.R. 4958, introduced by the Chairman of the Subcommittee, and an administration-supported proposal. Both proposals would have changed

[1]The requirement for FEHBP to pay premium taxes was eliminated by the Omnibus Budget Reconciliation Act of 1990.

[2]The component amounts do not add to $564 million because of rounding.

the program's current structure. Under the current program, the government contracts with many carriers to offer enrollees a choice of various benefits packages. The carriers have a limited insurance risk because if annual benefit claims and expenses exceed premiums, losses can be recovered from enrollees and the government through premium increases in subsequent years. However, several underwriters suffered financial losses when their subcontracts with employee organization plans were terminated. Under the 1990 proposals, the government would have offered a more uniform benefits structure and self-insured the program by assuming all of the insurance risk. Regional contractors would have been competitively selected to process claims and provide cost containment services. Neither of these proposals was enacted.

On April 16, 1991, H.R. 1774 was introduced by the Chairman of the Subcommittee as the successor to H.R. 4958. This bill differed from the 1990 proposals in that the government would share the risk with competitively selected, licensed insurers. In addition to processing claims, the insurers would be required to have "provider agreement programs" under which participating providers would agree to provide health services and supplies under mutually agreed upon terms and conditions, presumably including discounted fees. The insurers' profits or losses would be affected by the extent to which discounts were obtained and the percentages of FEHBP enrollees using the networks of providers. We have agreed to assist your offices in determining how to minimize the program's administrative costs under this risk-sharing approach.

Results in Brief

In 1988, for each $100 of benefits paid, the FFS portion of FEHBP cost $8.56 to administer. This cost ratio was 51 percent more than the average cost ratio for the large insured nonfederal programs in our review, 84 percent more than the cost ratio for CHAMPUS, and 89 percent more than the average cost ratio for the self-insured nonfederal programs. Also, within FEHBP, there was a wide variation in the 17 largest FFS plans' administrative costs. Even when we excluded premium taxes and state statutory reserves, which were not paid by all of the plans, the cost ratios for all but three of those plans were higher than the average ratio for large insured nonfederal programs.

Some of the cost differences may be attributable to the work involved in conducting annual open seasons, processing enrollment changes, and other factors that we were unable to measure because sufficient data were not available. Those factors included differences in benefits structures;

enrollee characteristics, such as age; and activities to contain benefit costs, such as precertification of hospital admissions. Although the programs and FEHBP plans may differ in many respects, they all provide health benefits through claims that are processed and paid by contractors. Thus, the processing of claims is a primary administrative function of any FFS-type health benefits program. However, factors related to the cost of processing claims that we evaluated as possible causes of the variation in FEHBP plan administrative costs explained very little of the variation. Together, this fact and the large difference in cost between FEHBP and the other programs suggested to us that FEHBP's administrative costs can be reduced.

The structure of FEHBP contributed to its high administrative cost and made OPM's administration of the program difficult. Because the program was legislatively structured to include certain plans regardless of the cost effectiveness of their operations, OPM cannot use competitive procedures to select only those carriers that provide the most cost-effective administrative services. OPM believes this structure and the automatic annual renewal of plan contracts would make it difficult to terminate a plan solely on the basis of a carrier's high administrative costs. Thus, the carriers have not had to contain operational expenses to levels competitive with other claims processors, and OPM's ability to negotiate administrative cost reductions has been weak.

Nevertheless, we believe that OPM has not provided carriers with sufficient incentives to improve efficiency and reduce costs. The carriers have been reimbursed for the operational expenses they have incurred under negotiated ceilings that historically have allowed large expense increases each year. Although OPM has negotiated a new method for adjusting expense ceilings to limit future increases to inflation and enrollment growth (except for cost-containment activities), it has not attempted to negotiate reductions in the expense ceilings or determine if the historic expense levels, on which the carriers' ceilings have been based, were reasonable or excessive.

Legislation that would require FEHBP contractors to be selected through competitive procedures could strengthen OPM's ability to obtain administrative services at prices more comparable to the prices of the other programs in our review. Regardless of whether the program is legislatively reformed, however, OPM needs to do more to ensure that the carriers provide quality services at a reasonable price.

Approach

We obtained data on OPM's and the 25 FFS plans' administrative costs for 1988—the latest year for which the plans' costs were available at the time of our review. We then compared FEHBP administrative cost data with cost information we obtained for CHAMPUS and large health benefits programs in the private sector and other government entities. FEHBP and the other programs provide benefits through claims processed and paid by contractors. Although the comparison of 1988 cost data might not be perfectly representative of current costs, we are not aware of any factors that would have caused the cost difference between FEHBP and the other programs to change enough to significantly affect our findings.

We obtained information on nonfederal health insurance programs from a private sector consulting firm that conducts an annual survey of employers concerning their health insurance programs. We obtained information on CHAMPUS' administrative costs by reviewing our past reports and interviewing officials of the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS). We did not attempt to evaluate whether CHAMPUS or the nonfederal program operations were economical and efficient.

As agreed with your offices, our principal analysis assumed that a reformed program would have a more uniform benefits structure and be self-insured by the government. We considered whether savings would be generated under such a program by using competitive, fixed-price contracts for claims processing services. In addition, we offer observations on potential savings under the current program that could result from improving OPM's controls over the plans' administrative costs.

Details on our objectives, scope, and methodology are contained in appendix VI.

How Do FEHBP Administrative Costs Compare to Those of Other Programs?

Our analysis showed that in 1988, the 25 FEHBP fee-for-service plans' administrative costs (operational expenses, profits, premium taxes, and state statutory reserves) and OPM's administrative costs totaled $8.56 for each $100 of benefits paid under the program. This amount was $2.88 more than the average for large insured programs in our review, $3.90 more than CHAMPUS' costs, and $4.04 more than the average for large self-insured programs. The weighted average of the operational expenses and profits of the 17 FFS plans with 10,000 or more enrollees was $7.52 for each $100 of benefits paid. The cost ratios for the individual plans varied from about $4.44 to $9.10. Only 3 of the 17 FEHBP plans had

administrative cost ratios similar to the ratios for CHAMPUS and the nonfederal health benefits programs we reviewed.

Why Does FEHBP Cost More to Administer Than Other Programs?

Because FEHBP is an insured program, its administrative costs included premium taxes, state statutory reserves, and underwriter charges for the insurance risk, which were not included in the costs of CHAMPUS and the self-insured programs in our review. However, the differences in cost between FEHBP and those programs were only partially attributable to the additional costs associated with the purchase of insurance, and FEHBP's administrative costs also were higher than the other large insured programs in our review. Therefore, we identified other major factors that could have made FEHBP more costly to administer in order to determine if the wide variation in the FEHBP plans' operational expenses was related to those factors.

Some of the factors we identified pertained to the plans' claims processing functions—economies of scale, percentage of enrollees eligible for Medicare benefits, the number of claims processors per enrollee, claims processor salaries and turnover rates, and the size of the customer service staff compared to the size of the claims processor staff. However, those factors did not explain the variation in plan operational expenses.

The other factors we identified involved differences in health plan benefits structures, such as annual deductibles; enrollee characteristics, such as age; and cost containment activities, such as hospital precertification. Although we believe those factors could affect the individual plans' benefit payments, work loads, and operational expenses, sufficient data were not available to determine if the variation in the plans' operational expenses was caused by those factors.

FEHBP Carriers Did Not Compete on the Basis of Administrative Costs

The current FFS plan carriers entered and can remain in FEHBP without having to compete with other claims processors that might provide administrative services at a reduced price. And although carriers have competed for enrollees, we believe that enrollment decisions would not have been influenced by expense reductions because the portion of the annual premium paid by individual enrollees would not have been reduced by a significant amount.

Plan Contracts Did Not Provide Sufficient Financial Incentives to Control Operational Expenses

OPM's contracts with the carriers have been self renewing and have not contained sufficient incentives that would have encouraged the carriers to contain or reduce their operational expenses. The carriers have been reimbursed for their actual, allowable operational expenses up to annually negotiated ceilings. Although cost control has been a factor in determining annual profit awards, efforts to control operational expenses have not necessarily been rewarded because the emphasis has been on controlling benefit payments, which comprise over 90 percent of the program's costs. This method of compensation might have encouraged carriers to spend the full amount allowed under their expense ceilings rather than control their expenses. If the carriers were paid a fixed price for administrative services, they would have more incentive to reduce their operational expenses below the established price.

Spending Limits Established by Ceilings Were Excessive

OPM's primary control over FEHBP's administrative costs was the annually negotiated ceilings on reimbursements of carrier operational expenses. From 1982 through 1988, the operational expenses of the 25 FFS plans increased 86 percent from $246 million to $458 million. The ceilings did not contain this rapid expense increase because they were higher than the carriers' actual, allowable expenses at the beginning of the period and were adjusted on the basis of the plans' premiums, which largely reflected the cost of medical services and supplies. From 1988 through 1990, OPM negotiated a new method for adjusting ceilings from year-to-year on the basis of inflation and plan enrollment changes. Although we did not assess the FEHBP-wide effect of the new methodology, it should provide better control over future expense increases. However, we do not believe it will substantially lessen the wide variation in expenses among plans or encourage the carriers to operate more efficiently because the negotiated baselines for the ceiling adjustments were set at the carriers' past spending levels.

Expenses Were Reimbursed Without Adequate Oversight

OPM considers FFS plan operations the responsibility of the carriers and generally limits oversight to (1) OPM's Inspector General audits of whether the expenses charged by the carriers were actually incurred and were allowable under the terms of the contracts and program regulations and (2) reviews of annual financial reports submitted by the carriers that focus on ensuring that expense reimbursements did not exceed the negotiated ceilings. Little analysis had been done of the carriers' expenses, and the expense and work-load information reported by carriers was too limited and inconsistent to use for determining the reasons for the variation in plan

costs, determining whether an individual carrier's expenses were reasonable or excessive, or negotiating appropriate expense ceilings.

What Can Be Learned From CHAMPUS and Other Programs?

Before 1976, CHAMPUS' administrative costs were also higher when the expenses of its claims processing contractors were paid on a cost-reimbursable basis, and the contractors with high costs and low productivity were not replaced. But in 1976, when it began converting from cost-reimbursable to competitive, fixed-price contracts, CHAMPUS reduced its claim processing contract costs by about $7.6 million in the first year of using the new contracts. And the savings continue today as a result of the periodic rebidding of these contracts—the average cost per claim processed in 1990, after adjusting for inflation, was about one-third the cost per claim in 1976. However, after converting to fixed-price contracts in 1976, OCHAMPUS had to increase its monitoring of contract performance because the fixed-price contractors had an incentive to process claims quickly to minimize expenses but lacked an incentive to pay claims accurately and meet other performance standards.

If costs were reduced under the current or a reformed program structure, OPM would need to ensure that contract performance was maintained. CHAMPUS and state programs we contacted generally had prescribed standards for quality, accuracy, and timeliness in processing claims; and OPM will also need to prescribe standards. OCHAMPUS currently monitors contractor performance under 38 standards on a monthly basis and provides monetary rewards or imposes penalties on the basis of how well the standards are met. Our telephone survey of 14 states with large programs that provide employee health benefits by paying claims showed that 13 had established performance standards for the timely processing of claims, 9 had standards relating to the accuracy of claims payments, and 7 had customer service standards. At least six of these states imposed penalties on carriers that did not meet the standards.

In contrast, OPM has not directly monitored the quality of service that carriers have given to FEHBP enrollees, although carriers we looked at had their own performance standards. It negotiated a standard plan contract for 1991 that required the carriers to have quality assurance programs and requested that they identify their quality control procedures for ensuring the accuracy and timeliness of claims payments, detecting and recovering overpayments, and serving customer needs. However, OPM has not established uniform performance standards or compared the carriers' operating performances. Because FEHBP is a governmentwide program, and

comparative information on carrier performance is not available to enrollees when they choose their plans, we believe OPM should ensure that plan services do not fall below a standardized minimum level.

Other lessons we learned from OCHAMPUS' administration of claims processing contracts are discussed in appendix III.

What Is the Annual Savings Potential?

FEHBP's administrative costs could be reduced by as much as $200 million annually if FEHBP could obtain administrative services at prices comparable to those of CHAMPUS and the nonfederal health insurance programs in our review. However, to achieve those prices, we believe that the program would have to be reformed to allow for the procurement of administrative services under competitive, fixed-price contracts. In the 1970s, OCHAMPUS used this type of contract to reduce its contractors' administrative costs, and CHAMPUS' 1988 costs were within the range of the insured and self-insured nonfederal programs in our review.

Annual savings may also be possible under the current program structure. One of the larger FEHBP carriers operated at an expense level, which if achieved by all of the carriers, would produce savings of over $150 million programwide. However, the probability that all of the carriers could operate at that same expense level is remote. Although we believe that OPM should work toward reducing FEHBP's administrative costs to the level of other large insured programs over time, most carriers would have to reduce their operational expenses by 40 to 50 percent. It does not seem realistic to assume that those carriers could agree to such large expense reductions without significantly reducing the timeliness and accuracy of their claims processing services. However, we do believe that reduction of the carriers' operational expenses is a reasonable goal that could be achieved by determining what the expense levels for efficient administration of the individual plans ought to be. If a 7- to 10-percent reduction of expenses was achieved programwide, the annual savings would be from $35 to $52 million.

To achieve savings under either a reformed or the current FEHBP structure, OPM would need to strengthen its administrative cost controls and oversight. It would also need to provide incentives that would encourage carriers to improve their efficiency and establish performance standards and measures to ensure that the quality of services related to claims processing is not sacrificed when expenses are reduced. Incentives and performance monitoring may require an increase in OPM resources that would partially

offset the estimated savings. In response to our recent recommendation that OPM increase its oversight of the carriers' fraud and abuse controls, OPM said it would seek additional funds for oversight, but the budget situation will make the funds difficult to obtain.[3]

Conclusions

We believe that the administrative costs of the FFS portion of FEHBP were higher than those costs for the other large health benefits programs we reviewed primarily because the carriers were not provided sufficient incentives to reduce their operational expenses. Regardless of whether the current program structure is reformed or retained, the key to reducing FFS plan administrative costs is the establishment of appropriate incentives to control those costs. We estimate that potential annual savings could range from at least $35 million in the short term, by improving OPM controls over the operational expenses of the FFS plans, to about $200 million by legislative reforms that change the way contractors are selected and paid.

Incentives can be more effectively provided through the competitive selection of contractors. If FEHBP is restructured to provide more uniform benefits, with the government self-insuring the program and contracting only for services related to claims processing, then the contractors should be competitively selected, cost-effectiveness should be a primary selection criterion, and the contracts should be periodically rebid.

Because over 90 percent of the FFS plans' costs are for benefit payments, we recognize that control of benefit costs should have a greater impact in determining program structure than control of administrative costs. However, although small in relation to benefit payments, the program's administrative costs—at over one-half of a billion dollars in 1988—are significant. If the program were restructured to have competitively selected commercial insurers assume all or part of the insurance risk, we believe that the cost of the program's administrative services could be better controlled. One way to control administrative costs would be to require that the administrative services portion of the contracts be negotiated separately by OPM and the insurance contractors.

Incentives can also be provided under the current structure of the program. The carriers would have an incentive to reduce operational expenses if, rather than being reimbursed for costs incurred, they were paid a fixed price for administrative services. However, in order to negotiate fixed

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

prices under either the current or a reformed program structure, OPM would need to obtain better expense and performance information from the carriers so that it could determine why some plans cost more to administer than others and how much the plans' operational expenses could be reduced. If the program were reformed, OPM would need this information to specify work and performance requirements when requesting and evaluating proposals for competitive bids. If the current program structure were retained, OPM could use this information to (1) either negotiate and adjust baseline ceilings or negotiate fixed prices that would make the cost of the carriers' administrative services more comparable to the cost of other programs and (2) provide monetary rewards and/or impose penalties that would encourage the carriers to lower their operational expenses while maintaining an acceptable level of performance. However, the use of noncompetitive, self-renewing contracts may make it difficult for OPM to negotiate changes in the way the carriers are compensated for their operational expenses.

Matters for Congressional Consideration

We believe that the Committee and the Subcommittee, in considering program reform, should consider plan administrative costs, which totaled $564 million in 1988. If a reformed program would provide a more uniform benefits structure and would be self-insured, the Committee and the Subcommittee should require that claims processing services be procured through competitive, fixed-price contracts that are periodically rebid. We believe that these reforms could reduce FEHBP's administrative costs by as much as $200 million.

If FEHBP were reformed to have licensed insurers assume all or part of the insurance risk, the Committee and the Subcommittee may wish to consider the merits of providing for the separate negotiation of the administrative services portion of any contracts with competitively selected insurance contractors or claims processors. This separation would help ensure that the program's claims processing services are procured at the lowest possible price.

Recommendations

We recommend that the Director, OPM, take action to better control administrative costs of FFS carriers. Specifically, OPM should require the carriers to report expense information and work-load indicators in uniform formats and use this data to

- routinely analyze and compare the carriers' operational expenses, efficiency, and efforts to control expenses;
- negotiate baseline cost ceilings for the carriers' expenses on the basis of analyses of carriers' operations rather than historical costs; and
- negotiate adjustments to the baseline ceilings as necessary in subsequent years for changes affecting costs, such as inflation, work load, and enrollment.

After the ceilings have been appropriately adjusted, we recommend that the Director amend the health plan contracts to provide a monetary incentive that would encourage the carriers to reduce their operational expenses for the year. In doing so, OPM should consider paying the carriers a fixed price for their administrative services rather than reimbursing them for their actual, allowable expenses.

To ensure that a minimum acceptable level of carrier performance is maintained FEHBP-wide, we recommend that the Director establish performance standards and measures pertaining to the accuracy and timeliness of claims payments and responsiveness to enrollees. The carriers should be required to periodically report information that can be used to measure and compare performance. We also recommend that the standards be enforced by penalizing carriers that fail to meet them.

We do not believe that OPM should delay implementation of these recommendations pending program reform because it will need to have more information on plan operations and costs to effectively implement and administer a reformed program. Furthermore, OPM could achieve some savings during the time it would take to enact and implement a new health benefits program.

Agency Comments and Our Evaluation

OPM provided written comments on a draft of this report. (See app. VIII.) The Director agreed with many of our observations, including our conclusion that the program should be able to operate at reduced administrative expense levels. She said that while expense reductions under the current program structure would have to be achieved through explicit OPM actions, the current structure of the program mitigates against OPM's success. She agreed that OPM lacks the leverage large nonfederal programs have to negotiate quality services at the most reasonable price because the plan contracts are noncompetitive and self-renewing. She also agreed that OPM cannot rely on the plans' competition for enrollees to bring about

administrative savings because of the negligible effect that expense reductions would have on premiums.

The Director said that because 90 percent of program funds are spent for benefits, OPM's focus has been on benefits and initiatives to contain benefit costs. However, she agreed to pursue the identification of the factors underlying the wide variation in the carriers' expenses and use the results to attempt to negotiate more reasonable expense ceilings and incentives to achieve administrative cost reductions. She said OPM has requested that the carriers provide data related to their operating performance, and she will request OPM's independent Inspector General to develop data during audits of the carriers that could be used to set more realistic administrative expense ceilings. Also, OPM is requesting additional resources to better monitor carrier operations in response to recommendations we made in a separate report.[4]

We believe the planned actions mentioned in the OPM Director's comments will help OPM better control the carriers' operational expenses and identify ways to achieve savings. It was not clear to us from the Director's comments, however, if the data OPM requested from the carriers included expense and work-load information in formats that would better enable it to analyze and compare plan expenses. Although we agree that useful information on plan expenses could be obtained during Inspector General audits, we believe that reporting requirements are needed. Because the Inspector General audits are infrequent—about once every 5 years—the information obtained may be out-of-date. Also, absent standardized reporting requirements, the information obtained may not be similar enough to facilitate comparisons among the plans. For example, because the carriers measure their claims work loads differently, we were unable to compare their administrative costs in relation to the numbers of claims received or processed. We believe that OPM could work with the carriers to identify key work-load and expense information that could be reported to OPM in uniform formats and used by OPM and the carriers to evaluate and improve the plans' administrative efficiency and effectiveness.

The Director did not comment on our recommendation that OPM establish minimum performance standards and measures. Although she said OPM was aware that expense reductions should not result in reduced internal controls and oversight over benefit payments or the disruption of service levels, we believe that standards and measures are needed to ensure that

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

any expense reductions do not cause the quality and effectiveness of the carriers' administrative services to fall below acceptable levels.

Technical comments on a draft of this report were provided by the OCHAMPUS Director and were incorporated where appropriate.

Plan Comments and Our Evaluation

We requested comments on a draft of this report from the 15 FFS plans that participated in FEHBP in 1991. The Blue Cross and Blue Shield, Mail Handlers, American Postal Workers Union (APWU), and Panama Canal plans provided written comments, which are reproduced in appendixes IX, X, XI, and XII, respectively. The Special Agents Mutual Benefit Association (SAMBA) and Government Employees Hospital Association (GEHA) plans provided oral comments on the draft report. Our responses to the plans' comments are presented below and in appendixes IX through XII. The other nine plans did not provide comments.

The plans that commented on the draft report did not dispute our conclusion that FEHBP's administrative costs can be reduced. The Blue Cross and Blue Shield and Mail Handlers plans agreed that FEHBP's costs are probably higher than necessary and could be reduced without harm to the program. However, Blue Cross and Blue Shield, Mail Handlers, and APWU contended that the efficiency of their operations has improved since the period covered by our review. Also, except for GEHA, the plans strongly objected to much of the analyses in our report. Although the plans may have improved their efficiency, we continue to believe that incentives are necessary to achieve the maximum savings we estimate are possible FEHBP-wide. Moreover, we were not convinced by the plans' other objections that the results of our analyses were incorrect, and we continue to believe that our recommendations should be implemented.

Blue Cross and Blue Shield, Mail Handlers, APWU, and SAMBA Comments

Program Reform

The Blue Cross and Blue Shield, Mail Handlers, APWU, and SAMBA plans did not comment on our proposals concerning the administrative cost controls that we believe the Committee and Subcommittee should consider if FEHBP's health benefits structure is redesigned. However, they disagreed with changing FEHBP into a self-insured program. Although Blue Cross and Blue Shield and Mail Handlers said that FEHBP may cost more to administer

because of plan competition for enrollees, they maintained that competition has made FEHBP more cost effective than CHAMPUS and self-insured programs that contract only for services related to the processing of claims. According to Mail Handlers, FEHBP carriers have to build and maintain a steady stream of premium income because of the insurance underwriting risk, which the other programs' contractors do not have. However, Blue Cross and Blue Shield and Mail Handlers believed the government and enrollees have benefited from the competition for FEHBP enrollees because the competition is waged on the basis of improved benefit values, stable rates, and excellent customer service. APWU said the high level of service provided federal employees by the plans could be jeopardized if the program was competitively bid and the least expensive plan was selected.

Additionally, the Blue Cross and Blue Shield plan referred to its testimony before the Committee, which addressed the funding hazards of programs self-insured by the government. The Mail Handlers plan questioned why the report used CHAMPUS as a model because annual funding struggles for that program and Medicare have resulted in constant changes, reduced benefits, and cost shifting that have enraged beneficiaries and the medical community.

We did not evaluate the costs and benefits resulting from competition for FEHBP enrollees because our review was not structured to address whether or how the program structure should be changed. Also, we are not proposing that CHAMPUS' structure be used as a model for reforming FEHBP. However, if FEHBP is to be self-insured, we do not believe that it would have the same funding problems experienced by CHAMPUS. The funding of CHAMPUS' health benefits is determined through the annual appropriations process. In contrast, the bill to change FEHBP into a self-insured program (H.R. 4958; 101st. Cong.) would have funded FEHBP's benefits through premiums determined annually on the basis of past claims experience, not through the appropriations process. Although we are not endorsing one type of program structure over another, we believe controls to ensure the efficient use of administrative funds are an important aspect of program effectiveness regardless of the structure.

Current Program Controls

The Mail Handlers plan did not specifically comment on our recommendations to the OPM Director. APWU endorsed our recommendations that OPM gain better control of the plans' administrative costs under the current program structure. APWU cautioned, however, that efforts to set target cost levels for the plans should recognize the relationship of administrative

costs to necessary or desirable programs and services. It also said that the ceilings established should be sufficient to cover activities for managing health care costs and to provide service levels that are satisfactory to federal employees. We agree with APWU's comment.

SAMBA agreed with our recommendation that the carriers should be provided an incentive to reduce their operational expenses. Although SAMBA agreed that the variation in FEHBP plan expenses should be further analyzed, it questioned whether OPM has adequate resources to perform the analysis. Blue Cross and Blue Shield also agreed that the plans' operational expenses could be reduced by providing the right incentive. However, it maintained that the best dynamic for ensuring cost effectiveness is the competition for enrollees. It also commented that OPM's resources were inadequate to maximize FEHBP's total cost effectiveness.

We continue to believe that the competition for enrollees is not a sufficient incentive for improving administrative efficiency for the reasons stated on pages 50 and 51. In its response to the draft of this report, OPM agreed that the competition for enrollees could not be relied on to effect administrative savings. It also indicated that it was seeking additional resources to improve its administration of the program (see app. VIII).

Interrelationship of Administrative and Benefit Costs

Blue Cross and Blue Shield and APWU criticized our methodology. They said it ignored the interrelationship between administrative and benefit costs. They were specifically concerned that the report did not recognize that administrative activities to contain health benefit costs, including managed care and preferred provider organizations, increase the plans' administrative costs but save more in benefit payments than they cost. Blue Cross and Blue Shield maintained that the inclusion of HMOs in our review would have demonstrated the cost-effective relationship between administrative and benefit costs because (1) those plans typically spend more of their total income on administrative costs than FFS plans and (2) the more effective the HMO, the higher the administrative cost ratio. Additionally, Blue Cross and Blue Shield and APWU emphasized that any savings achieved from arbitrary reductions in the plans' administrative costs would be more than offset by benefit payment increases that could result from the elimination of cost-containment activities.

Our reasons for excluding HMOs are stated on page 70. Although our review did not specifically address the relationship between FEHBP's administrative and benefit costs, we agree that funds spent on administrative activities to contain benefit costs could result in net

program savings. Nevertheless, we do not believe the potential for benefit costs savings eliminates the need to ensure that the plans' administrative operations—including their cost-containment activities—are efficient and cost effective.

Beginning with the 1991 contract year, expenses for cost-containment activities were subtracted from the carriers' baseline ceilings and funded separately. Thus, the funding for those expenses would not be affected even if the expense ceilings for the carriers' other administrative activities were to be reduced. Also, the carriers are required to account for their cost-containment and other operational expenses separately in the financial reports to be filed for 1991. Thus, OPM will be able to evaluate the cost effectiveness of those activities apart from the analyses of carrier efficiency that we recommended.

We did not intend to imply that our estimates of potential savings should be achieved through indiscriminate reductions in the carriers' operational expense ceilings. We revised the discussion of savings under the current program structure to clarify how we believe those savings could be achieved.

Appropriateness of Administrative Cost Comparisons

All four plans contended that it was inappropriate to compare FEHBP's administrative costs to the costs of CHAMPUS and the other programs. SAMBA said that, in contrast to FEHBP, CHAMPUS is a tightly controlled program that is not influenced by plan sponsors whose primary goal is to collect dues and service members. The Blue Cross and Blue Shield, Mail Handlers, and APWU plans said that the comparisons are misleading because the contractors that process claims for CHAMPUS and self-insured programs do not have the expenses FEHBP carriers incur for functions, such as benefit design, actuarial services, enrollment changes, and cost-containment activities.

We included CHAMPUS and self-insured programs in our review to provide the Committee and Subcommittee with information on the relative costs of different administrative structures. However, we agree that the administrative cost ratios for the nonfederal plans in the draft of this report did not make that distinction, and we revised the cost ratios for the nonfederal programs shown in the report on the basis of whether they were insured or self-insured.

Because the functions mentioned by the plans would generally be performed by the insurers, we believe that the costs of those functions

would have been included in the cost ratios reported for the insured programs. We have no way of determining if the costs of all of those functions were included in the cost ratios reported by the self-insured programs. However, 93 percent of the self-insured programs reported cost-containment activities similar to those performed by the FEHBP plans (precertification of hospital admissions, large case management, concurrent review of hospital services, and second surgical opinions). Because the Foster Higgins 1988 Health Care Benefits Survey Report indicated that the cost-containment activities for those programs were most often performed by their claims processors, we believe that the costs of those activities generally would have been included in their administrative cost ratios. (See footnote 1 on p. 37.)

Ratio Used to Analyze Administrative Costs

The Blue Cross and Blue Shield, Mail Handlers, and APWU plans also objected to the cost ratio we used for our analysis. The plans said we should have compared program and plan administrative costs on the basis of work performed—such as cost per claim or cost per enrollee—rather than on the basis of the cost per $100 of benefit payments. Mail Handlers asserted that its plan processes more claims than other plans because its benefit design does not limit dental coverage or impose annual deductibles, which encourages enrollees to combine their medical bills into one large claim.

We did use the FEHBP plans' costs per enrollee to estimate the range for potential savings under the current program structure (see page 65) and to test for relationships between the plans' cost ratios and the factors that could have caused those ratios to differ (see page 72). We did not include those ratios in the draft of this report because the strong relationship we found between the plans' costs per enrollee and costs per $100 of benefit payments indicated that the results of our analyses would be similar regardless of which of the two measures we used. Nevertheless, some differences existed in the rank order of the plans' cost ratios under the two measures. For example, the Mail Handlers plan's cost per $100 of benefit payments was above the weighted average of the other large plans while its cost per enrollee was below the weighted average. Thus, we added the administrative costs per enrollee for the 17 largest FFS plans to the report as appendix VII.

Because the administrative costs of the nonfederal programs were reported as percentages of benefit payments, that ratio was the only measure available for comparing FEHBP's costs to those programs. Also, although we attempted to analyze the variation in FEHBP plan costs on the basis of

the plans' claims processing work loads, consistent data on claims were not available (see page 53). We believe our recommendations to the OPM Director adequately recognize the need to evaluate administrative costs in relation to plan work loads when negotiating the plans' expense ceilings.

Reasons for Cost Differences

The three plans maintained that the draft report did not adequately address the factors that cause FEHBP to be more costly to administer than other health benefits programs. Specifically, Blue Cross and Blue Shield and APWU said the report too readily dismissed high percentages of Medicare-eligible enrollees as a major cause of the cost differences. The Mail Handlers plan attributed FEHBP's high cost to (1) complex and costly government procurement regulations, accounting guidelines, and audits; and (2) antiquated enrollment, eligibility, premium reconciliation, and other practices.

We disagree that the percentages of Medicare-eligible enrollees caused the administrative costs of some FEHBP plans to be high relative to those costs of others for the reasons discussed on pages 27 and 28. Although we did not evaluate the costs associated with contract regulations and requirements cited by the Mail Handlers plan, we believe that OPM could explore ways to reduce those costs in conjunction with its implementation of our recommendations.

Panama Canal and GEHA Comments

The Panama Canal plan said the high cost of health care confronting FEHBP was a national problem that would not be solved by program reform or the implementation of the recommendations in this report. It also provided revised information on its 1988 administrative costs, and we modified table II.1 to show the plan's revised ratio.

GEHA provided oral comments on the draft report. It pointed out that the FFS plan profits shown in table II.2 were for 1988 rather than 1989, and we made that correction to the table. The plan also said its administrative costs may have been low in relation to the costs of the other FEHBP plans in 1988 because at that time the plan was not spending as much on cost-containment activities as it is now. We agree that the plans' administrative costs are affected by their cost-containment activities. However, sufficient data were not available for us to determine if the variation in plan costs was caused by differences in their cost-containment activities.

As agreed with the Committee and Subcommittee, unless you publicly release its contents earlier, we plan no further distribution of this report until 7 days from the date of this letter. At that time, we will send copies to OPM and other interested parties and make copies available to others upon request.

The major contributors to this report are listed in appendix XIII. Please contact me at (202) 275-5074 if you or your staff have any questions concerning the report.

Bernard L. Ungar
Director, Federal Human Resource
Management Issues

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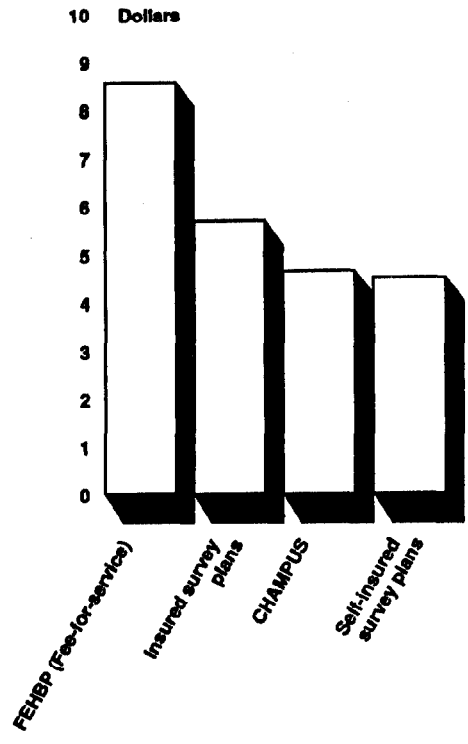
Abbreviations

ACT	Association of Civilian Technicians
AFGE	American Federation of Government Employees
APWU	American Postal Workers Union
BACE	Beneficial Association of Capitol Employees
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CPI-U	Consumer Price Index for All Urban Consumers
FEHBP	Federal Employees Health Benefits Program
FFS	Fee-for-service
GEBA	Government Employees Benefit Association
GEHA	Government Employees Hospital Association
HCFA	Health Care Financing Administration
HMO	Health maintenance organization
NAGE	National Association of Government Employees
NALC	National Association of Letter Carriers
NAPUS	National Association of Postmasters
NATA	National Association of Treasury Agents
NFFE	National Federation of Federal Employees
NTEU	National Treasury Employees Union
OCHAMPUS	Office of CHAMPUS
OPM	Office of Personnel Management
SAMBA	Special Agents Mutual Benefit Association

How Do FEHBP Administrative Costs Compare to Those of Other Programs?

Figure I.1: Administrative Costs for Each $100 of Benefits Paid (1988)



Source: GAO calculations based on data from OPM, A. Foster Higgins & Company, and OCHAMPUS.

We used the ratio of administrative costs per $100 of health benefits paid to compare the FFS portion of FEHBP's costs to the administrative costs of other large insured and self-insured employer-sponsored health benefits programs. This expense ratio provides a measure of efficiency by showing how much it costs to pay each $100 of health benefits. Although other large employer-sponsored health benefits programs may differ from FEHBP in benefit coverage and eligibility, they provide benefits by paying claims submitted by enrollees and providers of health care services, and their benefit claims are processed and paid by contractors—as is the case with the FEHBP FFS plans.

Our analysis showed that in 1988, FEHBP cost $8.56 for each $100 of benefits paid. The costs covered OPM's administrative expenses and the plans' total operational expenses, premium taxes, profits, and state statutory reserves. In contrast, the costs of insured programs included in our analyses averaged $5.68; CHAMPUS cost $4.66; and the costs of self-insured programs averaged $4.52. Stated another way, for each $100 of benefits

paid, FEHBP cost $2.88 (51 percent) more to administer than the insured programs; $3.90 (84 percent) more than CHAMPUS; and $4.04 (89 percent) more than the self-insured programs. Figure I.1 shows the magnitude of the differences in costs between FEHBP and the other programs included in our analysis.

One reason for the large cost differences between FEHBP and the other programs could be the ratio used to compare the costs. Because the ratio measures administrative costs in relation to the dollar cost of benefits, programs that cost the same to administer but provide different levels of benefits could have different ratios. We did not determine the relative benefit values of FEHBP and the other programs in our comparison. However, the Congressional Research Service reported in 1989 that private sector health benefits were typically 15 percent higher than the typical FEHBP plan benefits. This difference was primarily because of more generous dental benefits, mental health coverage, and lower enrollee cost-sharing requirements in private sector plans.[1] If FEHBP's benefits had been 15 percent higher and its administrative costs had remained the same, FEHBP's expense ratio would have been $7.44 rather than $8.56. Nevertheless, FEHBP would still have cost $1.76 (31 percent) more to provide $100 of benefits than the insured programs in our analysis and $2.92 (65 percent) more than the self-insured programs.

Also, OPM officials told us they believed another reason FEHBP could have a higher expense ratio than the other programs in our comparison was because FEHBP covered a large percentage of retirees, many of whom were also eligible for Medicare. They said CHAMPUS does not cover Medicare-eligible retirees, and private sector programs generally do not provide such coverage. Medicare is the primary payor for retirees aged 65 or older, and FEHBP only pays the portion of the covered benefits not reimbursed by Medicare. Thus, OPM officials contended that FEHBP's benefit payments for those enrollees were low in relation to the administrative costs, which caused FEHBP's cost ratio to appear high.

Although we agree that FEHBP's administrative cost could have been higher for enrollees covered by Medicare than for other enrollees, we do not believe that this was a major reason for the large cost differences between FEHBP and the nonfederal programs. Contrary to what the OPM officials believed, about 80 percent of the private, state, and local government

[1]The Federal Employees Health Benefits Program: Possible Strategies for Reform. Prepared by the Congressional Research Service for the Committee on Post Office and Civil Service, U.S. House of Representatives; 101st Cong. (May 24, 1989).

programs included in our comparison also covered Medicare-eligible retirees.

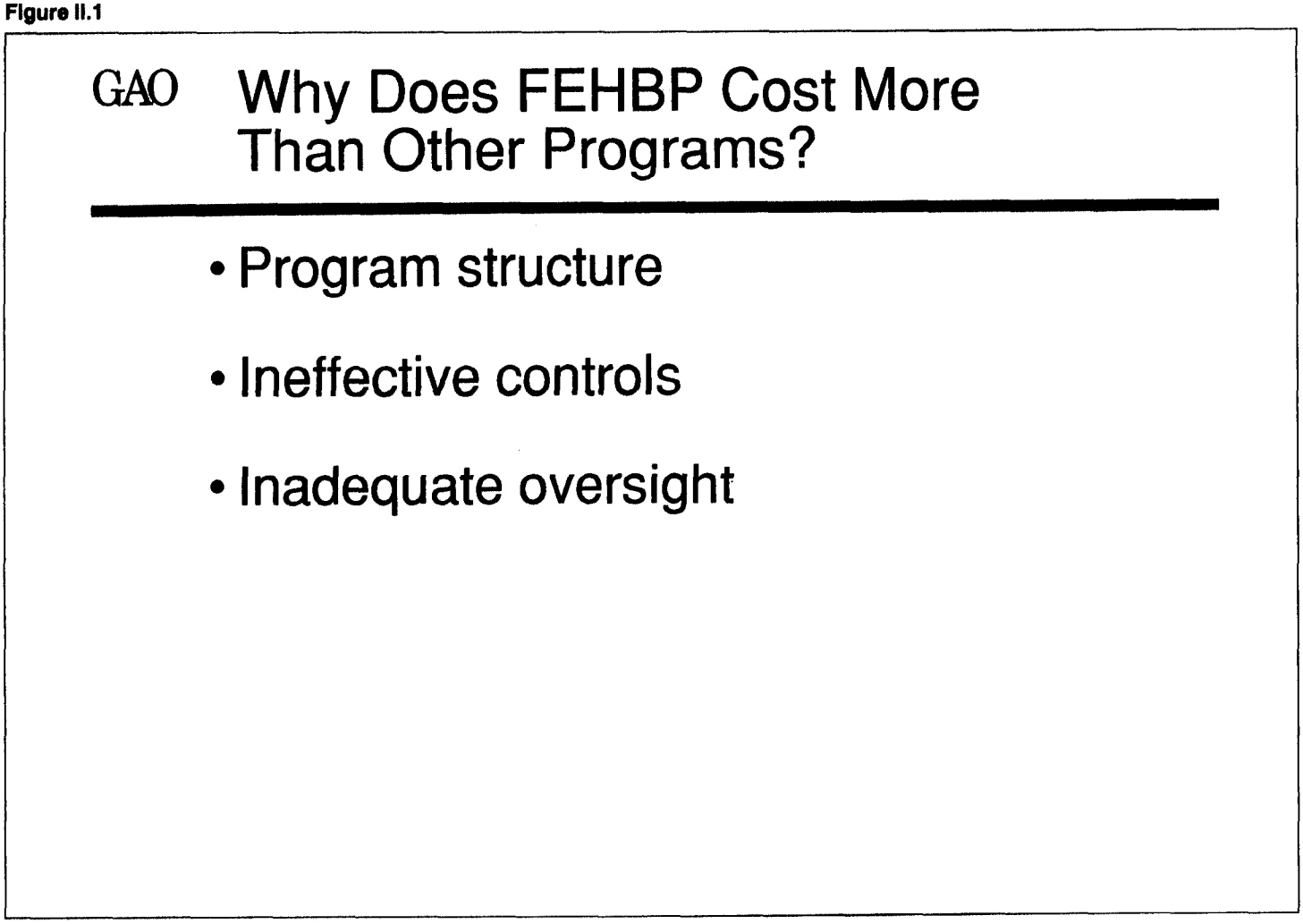
Additionally, we identified a wide variation in costs among the 17 FEHBP plans with 10,000 or more enrollees. Using OPM data on 1988 Medicare eligibility for FEHBP enrollees in 16 of those plans (the data were not available for the Postmasters plan), we found that the cost variation was not attributable to the percentages of Medicare-eligible enrollees. For example, in 1988, the Mail Handlers plan's operational expenses (excluding premium taxes, state statutory reserves, aand profits) were $8.14 for each $100 of benefits paid, and 4 percent of its enrollees were eligible for Medicare. In contrast, the National Association of Letter Carriers (NALC) plan had an expense ratio of $4.33, and 19 percent of its enrollees were eligible for Medicare. The variation among the plans is discussed in more detail in appendix II.

Nevertheless, in commenting on a draft of this report, the Blue Cross and Blue Shield and APWU plans stressed that high percentages of Medicare-eligible enrollees significantly increased their administrative cost ratios. Blue Cross and Blue Shield said it seriously doubted the other large health benefits programs replicated its enrollment experience, wherein 60 percent of its enrollees were annuitants. However, data we obtained from OPM indicated that, in 1988, 39 percent of Blue Cross and Blue Shield's annuitants were not eligible for Medicare. The data also indicated that FEHBP annuitants not eligible for Medicare received benefit payments ranging from 36 percent (65 or younger) to 182 percent (older than 65) more than the benefits paid to annuitants covered by Medicare. Thus, it appears to us that the effect of low benefit payments for Medicare-eligible annuitants on plan cost ratios may be balanced to some extent by high payments for annuitants not eligible for Medicare. To further analyze that effect, in October 1991, we asked Blue Cross and Blue Shield for information on benefit payments to annuitants covered by its 71 member plans in order to determine if relationships existed between that information and the member plans' administrative costs. However, as of January 1992, Blue Cross and Blue Shield had not provided the requested information.

We recognize that differences in health benefit coverage and eligibility could affect the programs' relative costs. Nevertheless, we believe that the differences in costs between FEHBP and the other programs and the variation in carrier operational expenses discussed later are large enough to conclude that opportunities exist to reduce FEHBP's costs to a level more in line with other large health benefits programs.

Why Does FEHBP Cost More to Administer Than Other Programs?

Figure II.1



We believe that one reason FEHBP's administrative costs are higher than those of the other programs we analyzed could be that program features, such as the eligibility for coverage and the large number of plans offering different benefit packages, add to plans' claims processing expenses. However, the 17 largest FFS plans' administrative costs per $100 of benefits paid varied widely, and possible causes suggested by OPM and carrier officials did not fully explain the variation.

Although we would expect administrative and work-load differences to cause some variation in the plans' costs, we also believe that the structure and management of the program contributed to FEHBP's high

administrative costs because the plans' services related to claims processing were procured without competition under self-renewing contracts and because OPM did not negotiate effective controls or conduct adequate program oversight to encourage the carriers to contain their expenses.

1988 FEHBP Plan Cost Variation

FEHBP's administrative cost for 1988 of $8.56 for each $100 of benefits paid included OPM's costs and the 25 FFS plans' total operational expenses, premium taxes, state statutory reserves, and profits. To determine why FEHBP cost more than the other programs in our review, we analyzed the 1988 administrative costs of FEHBP's 17 FFS plans with more than 10,000 enrollees. We excluded premium taxes and state reserves from this analysis because all of the plans did not incur those expenses. The plans had 99 percent of the total FFS plan enrollment. As shown in table II.1, the operational expenses and profits of the 17 largest plans ranged from $4.44 to $9.10 for each $100 of benefits paid and averaged $7.52.

The two largest plans—Blue Cross and Blue Shield and Mail Handlers—accounted for 66 percent of the 25 FFS plans' costs and were among the most costly to administer in relation to the value of health benefits paid. The Blue Cross and Blue Shield plan had about 1.4 million enrollees and incurred 51 percent of the FFS plans' costs. Its cost ratio was $8.91. Mail Handlers, which had about 491,000 enrollees, incurred about 15 percent of the plans' costs and had a cost ratio of $8.69.

The two least costly plans to administer—GEHA, with an administrative cost ratio of $4.44, and NALC, with a ratio of $5.01—were the third and fifth largest plans. Together, those plans had 534,000 enrollees, or 17 percent of the FFS plans' enrollment, and incurred about 13 percent of the FFS plans' costs. The other 13 plans with more than 10,000 enrollees had a total enrollment of about 650,000 and incurred about 20 percent of the costs. Their combined cost ratio was $6.82 for each $100 of benefits paid.

Table II.1: 1988 FEHBP Plan Cost Variation

Plans with more than 10,000 enrollees	Enrollees (in thousands)	Costs per $100 of benefits[a]
NAGE[b]	18	$9.10
Blue Cross/Blue Shield	1,372	8.91
NTEU	11	8.90
NFFE[b]	18	8.82
Postmasters	31	8.71
Mail Handlers	491	8.69
Postal Supervisors[b]	46	7.67
APWU	121	7.30
AFGE[b]	28	7.29
Panama Canal	16	7.09
NAPUS	15	6.96
Alliance	35	6.40
SAMBA	24	6.05
Aetna[b]	237	6.01
Rural Letter Carriers	46	5.22
NALC	230	5.01
GEHA	304	4.44
Total	**3,043**	**$7.52[c]**

[a]Costs include operational expenses and profits. Premium taxes and state statutory reserves are not included.

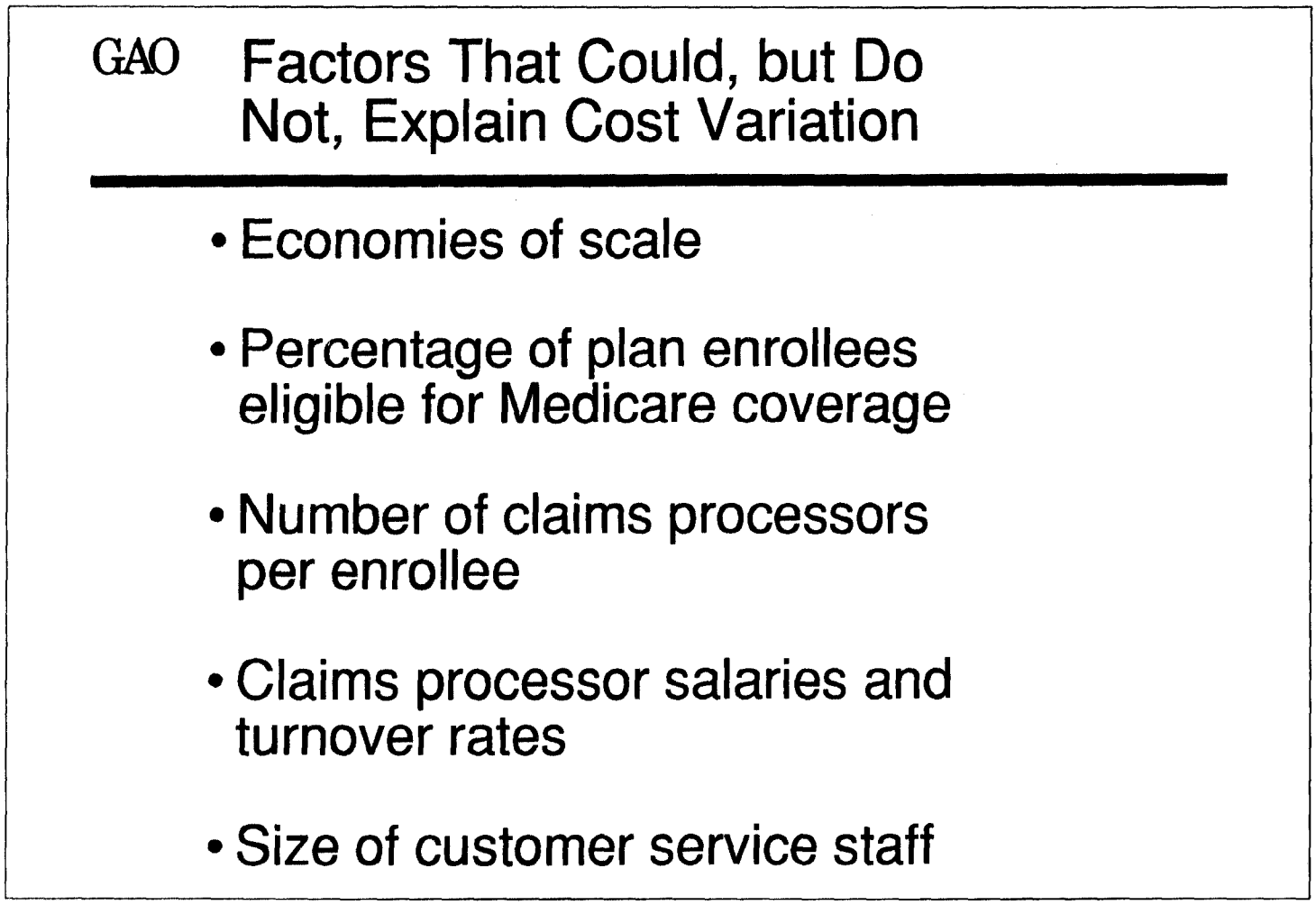
[b]Plan no longer in FEHBP.

[c]This figure is the weighted average.

Source: GAO calculations based on data from OPM.

The cost ratios for GEHA and NALC were lower than the average ratio of $5.68 for the large insured programs in our review. However, because those plans were not underwritten by commercial insurers, they were not subject to the premium taxes generally paid by insured programs. When the premium taxes paid by the other FEHBP plans were included in their ratios, those ratios were higher than the average ratio for the other insured programs. For example, Blue Cross and Blue Shield's ratio, including premium taxes, was $9.23; Mail Handlers' ratio was $11.16; and the other 13 plans that paid premium taxes had a combined ratio of $8.47. On the other hand, of the 35 insured programs we reviewed, 28 (80 percent) had ratios lower than $8.00; and the ratios for 14 (40 percent) were under $5.00.

Figure II.2



Factors That Could, but Do Not, Explain Variation in FEHBP Plan Costs

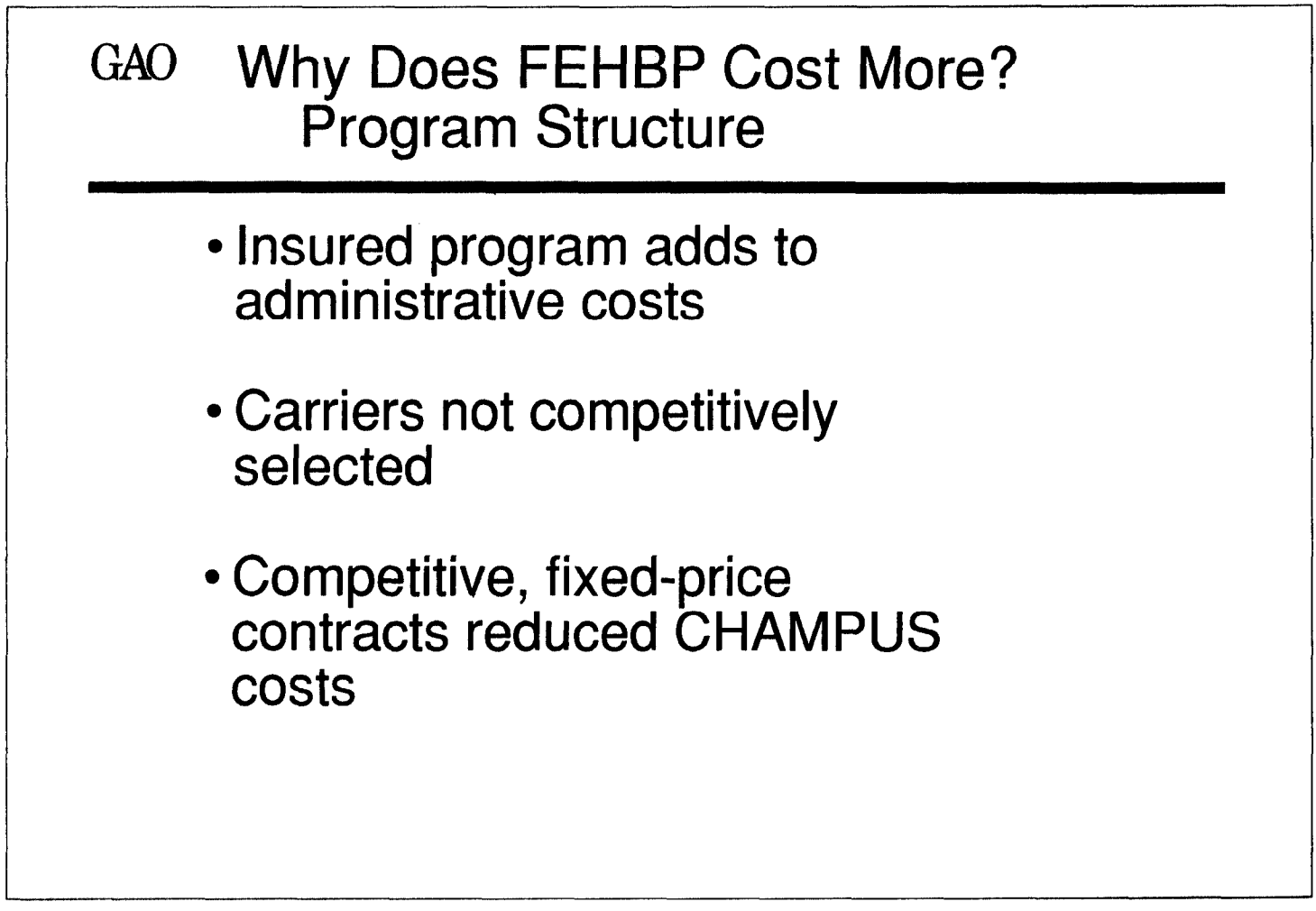
To determine why some FEHBP plans cost more to administer than others, we asked OPM and selected plan officials to provide reasons that might explain the wide cost variation. The factors they cited included (1) economies of scale, (2) the percentage of plan enrollees eligible for Medicare coverage, (3) the number of claims processors per enrollee, (4) claims processor salaries and turnover rates, and (5) the size of the customer service staff compared to the size of the claims processing staff. Although the factors pertained to the processing of benefit claims—a major function of FFS plans—we did not find any strong relationships between the factors and the plans' operational expenses. Thus, although the factors may have

affected an individual plan's expenses, they do not explain the wide variation in plan operational expenses.

Although the Blue Cross and Blue Shield plan is the largest plan in FEHBP, its health benefit claims were processed by its 71 member plans, which varied widely in the number of FEHBP enrollees serviced. Because we were able to obtain information on the member plans' 1988 operational expenses and claims processing work loads, we also tested for economies of scale in the processing of major medical, institutional, and dental claims within the Blue Cross and Blue Shield plan. Our analysis showed that economies of scale existed for the processing of dental claims, which accounted for 19 percent of the member plans' claims work load and 8 percent of their operational expenses. However, we did not find economies of scale for the processing of major medical or institutional claims, which represented the bulk of the member plans' claims work load.

Other reasons for the variation cited by OPM and plan officials involved differences in health plan benefits structures, such as medical coverage and amounts paid by enrollees for deductibles and copayments; (2) enrollee characteristics, such as age and medical benefits usage; and (3) benefit cost-containment activities, such as hospital preadmission certification and large-case management. Although we believe those factors could affect the individual plans' benefit payments, work loads, and operational expenses, sufficient data were not available to determine if the variation in plan operational expenses was caused by those factors.

Figure II.3



FEHBP's Program Structure Adds to Its Administrative Costs

FEHBP was structured to provide enrollees with an annual choice of different benefit packages through plans sponsored by private insurers, employee organizations, and providers of health care services, which are known within the program as "carriers." FEHBP's costs could be higher than those of other large health benefits programs because the other programs generally involve a single employer and offer a limited choice of benefit packages whereas the FEHBP carriers have to conduct annual open seasons and work with numerous federal agencies to process enrollment changes and reconcile premium payments. Also, FEHBP's administrative costs included some expenses that would not have been incurred if (1) the

government had self-insured the insurance risk and (2) the carriers had only been responsible for activities related to claims processing and cost containment.

FEHBP was structured to allow the existing carriers to enter and remain in the program without competing for the right to participate. Thus, the carriers were not selected on the basis of their administrative efficiency and were not required to maintain their operational expenses at levels charged by competing firms. We believe that the absence of competition was a major cause of the high cost of administering FEHBP relative to other programs as well as the wide variation in FEHBP plan costs. CHAMPUS demonstrated the positive effect that competition can have on costs when it substantially reduced its claims processing expenses through the use of competitive, fixed-price contracts.

Insured Programs Cost More Than Self-Insured Programs

Although FEHBP is an insured program, most of the other large, employer-sponsored health benefits programs in our analysis were self-insured. Of the 199 private, state, and local government programs that reported their funding method, 164, or 82 percent, were self-insured. The administrative costs of the self-insured programs generally were less per $100 of benefits paid than for the insured programs. For example, the self-insured programs' expense ratios for 1988 averaged $4.52 compared with an average of $5.68 for the insured programs.

Several articles we reviewed indicated that one reason employers self-insure their health benefits programs is to avoid paying premium taxes. Although FEHBP's 1988 administrative costs included $57 million for premium taxes, the Omnibus Budget Reconciliation Act of 1990 exempted FEHBP carriers from these taxes. In addition to premium taxes, other costs incurred by FEHBP because of its structure as an insured program included $2 million paid in 1988 for state statutory reserves and the portion of the profits paid to the carriers for insurance risk, which we estimated was about $8 million in 1989.

The Federal Employees Health Benefits Act of 1959, as amended, requires that the member Blue Cross and Blue Shield plans have an opportunity to participate in the governmentwide plan, and most of the employee organization plans have commercial underwriters. Because of this, "middleman" costs are added to the operational expenses of carriers that subcontract for insurance underwriting and/or claims processing services.

If the program had been self-insured, the government could have performed or contracted for these services directly and thus could have eliminated some of the middleman costs incurred by the Blue Cross and Blue Shield Association and employee organizations sponsoring underwritten plans. For example, the Mail Handlers' union charged the program about $295,000 for its expenses. Mail Handlers strongly objected to our characterization of the sponsoring organizations as middlemen. Subsequent to reviewing a draft of this report, an official informed us that the union's 1988 expenses included $99,000 for an audit required by OPM of potentially fraudulent claims. Also, the plan's official comments stated that the union reduced its expenses to $150,000 after 1988. We recognize that all of the sponsoring organizations' expenses would not have been eliminated by self-insurance because some of their functions would have had to have been performed by OPM or claims processing contractors. However, OPM did not have data that would enable us to estimate the middleman portion of the expenses these organizations charged to FEHBP or the potential programwide savings.

Also, if the program had been self-insured, additional savings could have been achieved through the centralization or elimination of some functions that are now performed by each carrier. These functions include actuarial services, benefits and rate negotiations, open season marketing of the plans, and others. Because OPM does not require the carriers to report their operational expenses on a functional basis, we could not estimate how much could have been saved programwide. However, data we obtained for the Blue Cross and Blue Shield plan showed that in 1988, its member plans' expenses for actuarial, statistical, public relations, and marketing expenses totaled over $9 million.

In commenting on a draft of this report, Blue Cross and Blue Shield agreed its administrative costs were undoubtedly higher because the plan was administered through local Blue Cross and Blue Shield plans rather than one national, centralized company. However, it believes its localized character enables it to better manage benefit costs and the quality of its service to enrollees, which results in lower total program costs and higher customer satisfaction than is found in centralized plans.

Carriers Not Competitively Selected

According to the Foster Higgins 1988 Health Care Benefits Survey Report, one reason insured programs cost more to administer than self-insured programs may be that the administrative fees are built into the premiums for insured programs, whereas for self-insured programs, there may be more latitude in negotiating the fees.[1] OPM conducts separate negotiations with the carriers for the plans' rates and benefits, profits, and operational expense ceilings. However, in negotiating the expense ceilings, the carriers do not have the pressure of competing firms to keep their operational expenses low. Also, administrative inefficiency is not one of the regulatory criteria specifically listed as a cause for termination of carrier participation in the program. OPM believes it would be difficult to sustain the termination of a carrier solely on the basis of high administrative costs.

The Federal Employees Health Benefits Act of 1959 exempted the health plan contracts from the government's competitive bidding requirements and allowed the 1-year contracts to be automatically renewed. Because the program was structured to include the Blue Cross and Blue Shield and employee organization plans, OPM is effectively precluded from competitively selecting the carriers for all but the governmentwide indemnity plan, which OPM chose not to offer when Aetna dropped out of the program in 1990. This structure and the automatic renewal of the annual plan contracts may make it difficult for OPM to negotiate reductions in the carriers' operational expenses.

Competitive, Fixed-Price Contracts Reduced CHAMPUS Costs

OCHAMPUS, which contracts for claims processing services, was able to substantially reduce the administrative costs of the program by using competitive, fixed-price contracts. Before 1976, CHAMPUS claims were processed by about 100 fiscal agents under cost-reimbursable contracts. During 1975 and 1976, the contractors' costs ranged between $3.50 and $11.31 per physician claim and between $6.20 and $38.40 per hospital claim. The average cost per claim processed was $7.82.

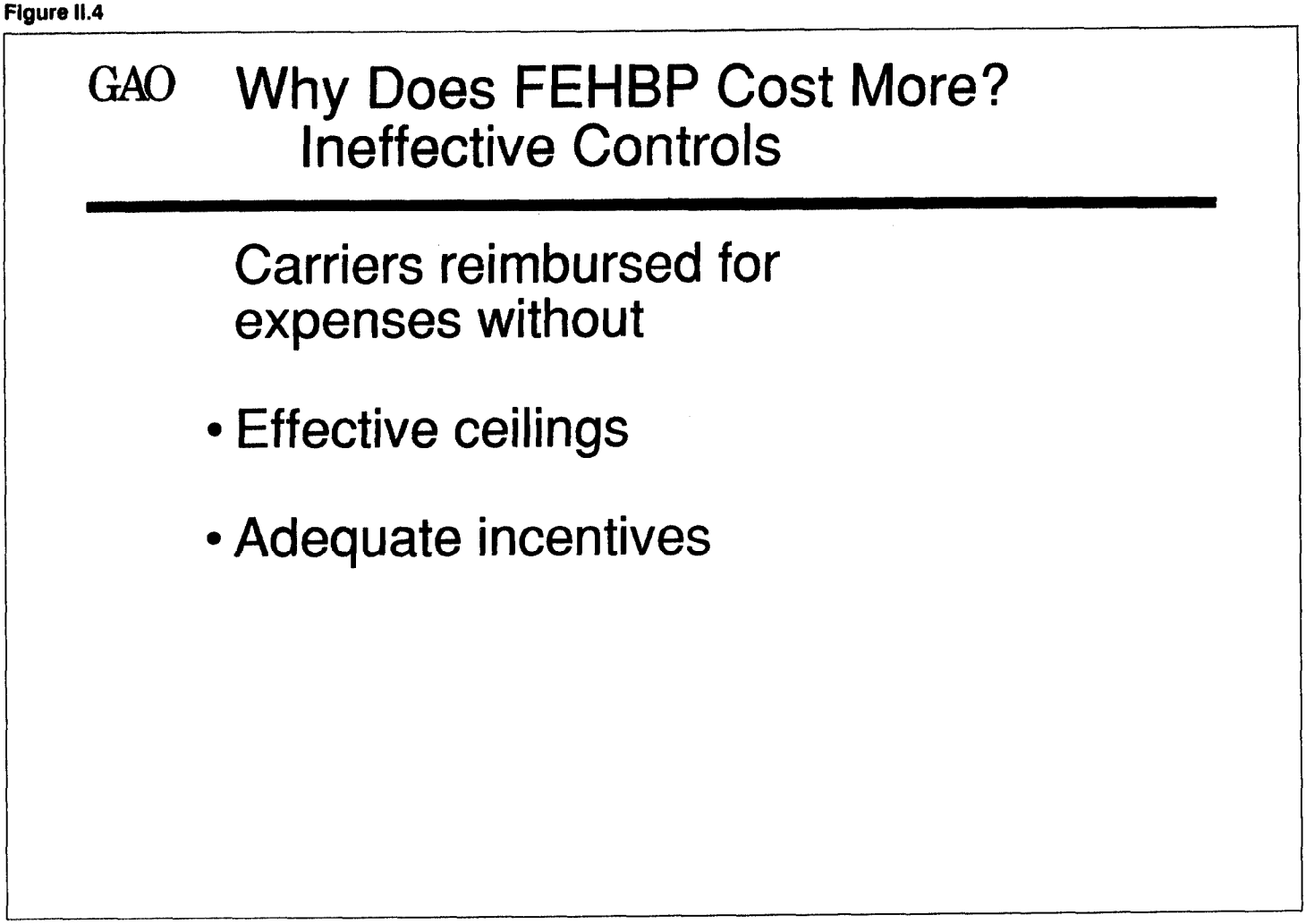
In 1976, OCHAMPUS began reducing the number of contractors and phasing in competitive, fixed-price contracts. During the first 12 months that these contracts were used, CHAMPUS saved $7.6 million. If OCHAMPUS had continued to use the cost-reimbursable contracts, the 1976 average administrative cost per claim of $7.82, adjusted for inflation as of July 1990, would have been $18.69. In contrast, under the fixed-price contracts, OCHAMPUS paid an average rate per claim in July 1990 of $6.30.

[1]Foster Higgins Health Care Benefits Survey, 1988, A. Foster Higgins & Company (Princeton: 1989).

Moreover, the average fixed-price rate of $6.30 per claim processed represented a 25-percent reduction from the 1988 average rate of $8.41. We believe a contributing factor to this rate reduction was the periodic rebidding of the claims processing contracts. Rather than allowing automatic renewals of the contracts for an indefinite time, CHAMPUS' 1-year contracts limit the automatic renewals to 4 years. Thus, the incumbent contractors must compete for CHAMPUS' business at least every 5 years.

Although competitive, fixed-price contracts reduced CHAMPUS' costs, problems involving the contractors' performance had to be resolved (see app. III). Also, OCHAMPUS officials expressed some concern that CHAMPUS now has only three contractors for its five regions. According to the officials, when a regional contract is rebid, there are usually only from two to five bidders, and most of them already process claims for another CHAMPUS region. They said that nonincumbent firms have difficulty overcoming the initial cost of developing a claims processing system for a relatively small program. Officials also told us that when CHAMPUS' regional contractors change, they receive many congressional and beneficiary complaints about slow processing while the new contractor gets its claims processing system up and running and converts the previous contractor's claims database to its system.

Figure II.4



OPM Has Not Implemented Effective Controls Over the Carriers' Operational Expenses

The health plan contracts negotiated by OPM and the carriers provide for the reimbursement of operational expenses up to a ceiling amount. From 1982 through 1988, the ceiling amounts were based on percentages of the plans' premiums and allowed generous increases in the carriers' expenses. To better control future increases, OPM negotiated a change that limits subsequent ceiling adjustments to the Consumer Price Index for All Urban Consumers (CPI-U) increases and changes in enrollment. However, OPM did not attempt to negotiate reductions in the baseline expense levels for the plans. Consequently, we do not believe carriers have been provided sufficient incentives to lower their costs.

Expenses Reimbursed up to Ceilings

The FFS plan contracts are negotiated fixed-price contracts that allow for price adjustments by raising or lowering the next year's premium to reflect the past year's benefit costs. Although the annual plan premium constitutes a fixed price, the portion of the premium paid to the carriers for their operational expenses is determined on a cost-reimbursable basis. That is, the carriers are reimbursed for actual, allowable expenses subject to a negotiated ceiling that may not be exceeded without OPM's approval.

Whereas a fixed price makes the contractor responsible for expenses and provides a profit incentive for controlling costs, the reimbursement of costs shifts the responsibility for expenses to the government. Consequently, expenses are generally only paid on a cost-reimbursable basis when they cannot be estimated with sufficient accuracy to pay a fixed cost-price. According to the Federal Acquisition Regulation, when a cost-reimbursable contract is used

- the government should conduct adequate surveillance to provide reasonable assurance that the contractor uses efficient methods and effective cost controls, and
- the contractor should have an accounting system adequate for determining costs applicable to the contract.

As discussed in the following sections, we believe that the expense ceilings negotiated by OPM were ineffective in controlling the carriers' expenses and, thus, contributed to the wide variation in the plans' costs and FEHBP's high cost compared with other health benefits programs. Also, we do not believe that OPM conducted adequate oversight of the carriers' operations. In a separate report, we addressed the need for OPM to better ensure that the carriers have established adequate internal controls to prevent fraud and abuse in the program.[2] In response to that report, OPM indicated it would seek additional resources for program oversight.

Because a primary function of the carriers is to process FEHBP benefit claims—a routine function that FEHBP carriers and many commercial firms have been performing for many years—it should be feasible for OPM to specify the administrative services to be performed by the carriers in sufficient detail to negotiate a reasonable fixed price for that work. Paying operational expenses on a fixed-price rather than on a cost-reimbursable basis would make the carriers fully responsible for the expenses incurred. It would also give them a profit incentive to improve their efficiency and

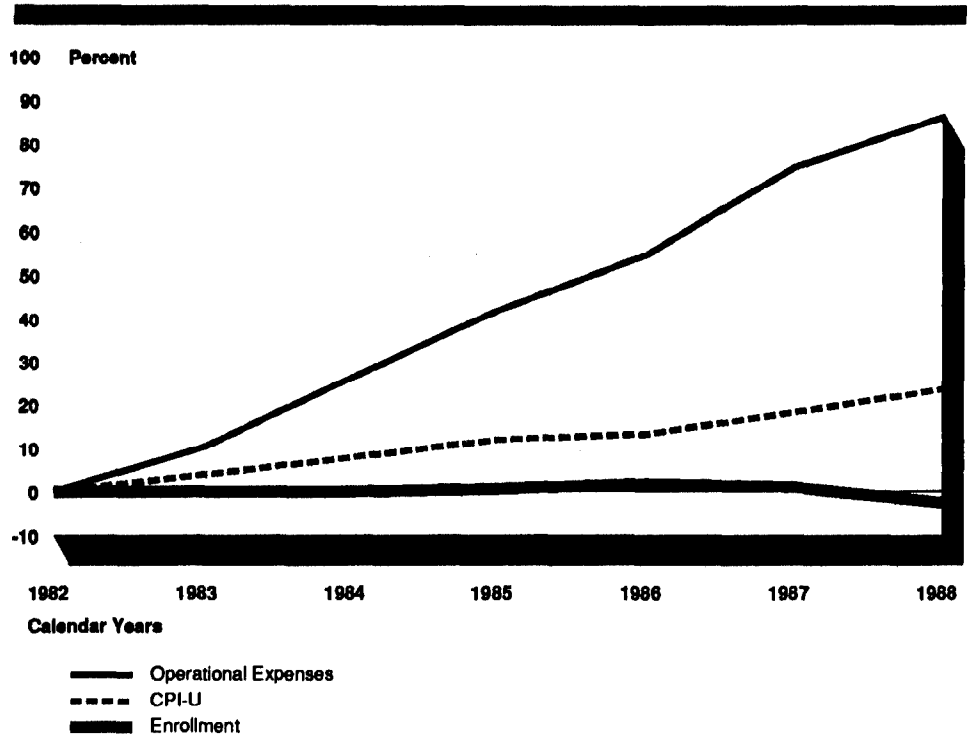
[2]Fraud and Abuse: Stronger Controls Needed in Federal Employees Health Benefits Program (GAO/GGD-91-95, July 16, 1991).

productivity, which could enable them to offer a lower fixed price in subsequent years. In commenting on a draft of this report, the Mail Handlers plan also pointed out that the reimbursement of only those expenses allowable under the Federal Acquisition Regulation was a limitation for the carriers not generally placed on government fixed-price contractors. According to the plan, carriers cannot receive reimbursement for various substantial costs otherwise considered legitimate business expenses, such as travel costs in excess of federal per diem restrictions, and must comply with onerous record-keeping requirements. Although our review did not address unallowable costs or record-keeping requirements, we recognize that another benefit of paying fixed prices for plan operational expenses would be that the carriers would not have to account for their expenses and the government would not have to audit those expenses. However, as we discuss later in this appendix, OPM currently lacks adequate information on the carriers' work loads and costs to judge the reasonableness of price proposals.

Ceilings Allowed Rapid Increases in Carrier Expenses

OPM used annually negotiated administrative expense ceilings as its primary cost control measure, but the ceilings did not effectively control the carriers' expenses. From 1982 through 1988, the operational expenses for the 25 FFS plans increased from $246 million to $458 million, or 86 percent. We found that the increase could not be attributed to enrollment growth because enrollment in the FFS plans declined during that period by 3 percent. Also, we believe that only a small portion of the increase could have been caused by inflation, which, during the 6-year period, was 23 percent, as measured by the CPI-U. Figure II.5 compares the cumulative percentage changes in the FFS plans' operational expenses, the CPI-U, and the FFS plans' enrollment from 1982 through 1988.

Figure II.5: Changes in Expenses, Inflation, and Enrollment (1982-1988)



Source: GAO calculations based on data from OPM and the Department of Labor.

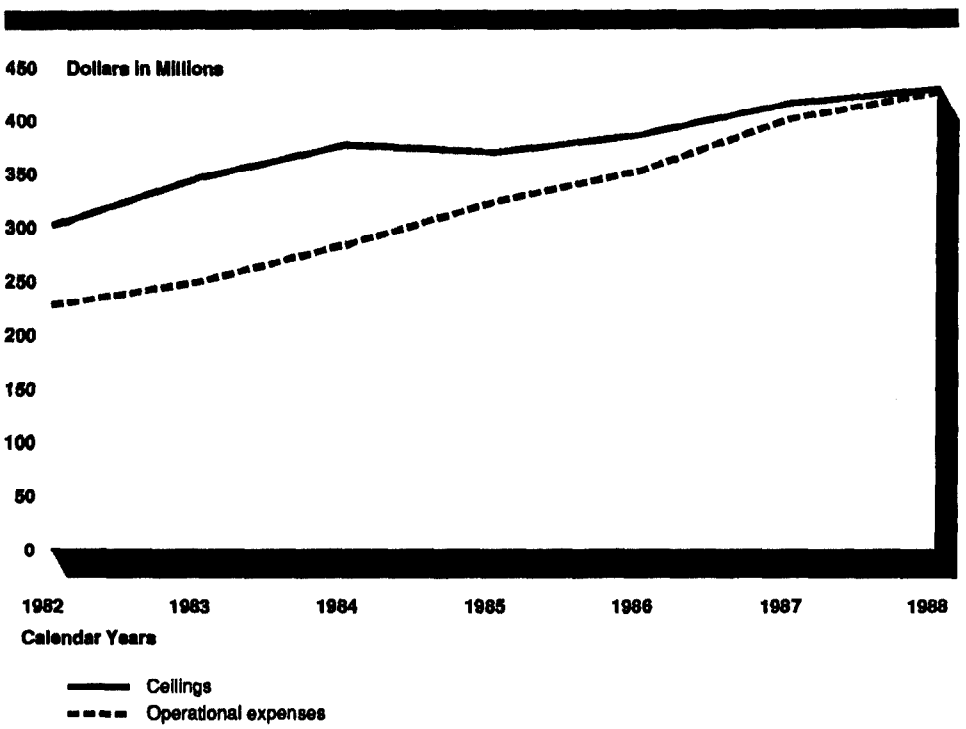
We believe that the negotiated ceilings allowed the plans' expenses to increase at a rapid rate because they were set higher than historically needed and were generally established as percentages of the plans' premium income. The percentages resulted in dollar limitations that often were higher than the amounts actually spent by the carriers for the previous year. Because premium income largely reflects estimated benefit costs, increases in the amounts that the carriers were allowed to charge the program were tied to the cost of medical services and supplies rather than to the cost of processing claims and related administrative functions.

Ceilings Were Initially Much Higher Than Actual Expenses

The FFS plans' benefit costs increased by 64 percent during the 6-year period, while their operational expenses increased by 86 percent—a 34 percent higher rate than the benefit costs. The percentage increase in expenses was greater than the increase in benefit costs because, at the beginning of the period, the actual expenses charged to the program were well below the ceiling amount, whereas by the end of the period, the expenses charged were close to the maximum amount allowed. For

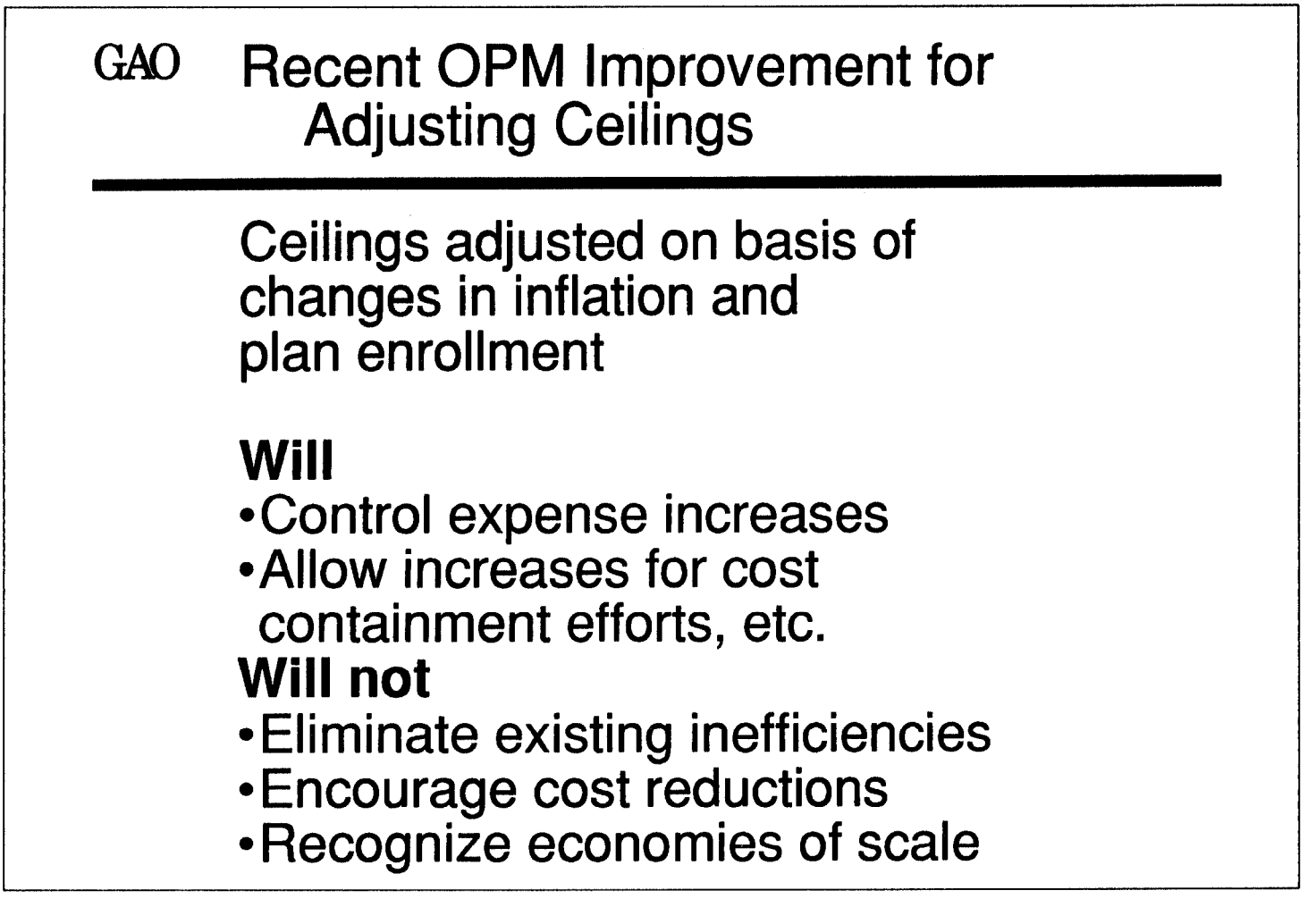
example, in 1982, the expenses charged to the program by nine of the largest FFS plans averaged 64 percent of their combined ceilings, but, by 1987, the amount charged averaged 97 percent of their ceilings. The nine plans were Blue Cross and Blue Shield, Mail Handlers, Aetna, GEHA, NALC, APWU, Postmasters, Postal Supervisors, and Rural Letter Carriers. The 1988 ceilings for these plans were not set until after the year had ended and were generally about the amount actually spent. However, in commenting on a draft of this report, Mail Handlers said that in 1988 it was not reimbursed for $8.2 million of expenses in excess of its negotiated ceiling. Figure II.6 shows the combined ceilings and operational expenses charged to the program for 1982 through 1988 for the nine plans.

Figure II.6: Ceilings Used by Nine Largest FFS Plans (1982-1988)



Source: GAO calculations based on data from OPM.

Figure II.7



Recent Change for Adjusting Ceilings Will Not Substantially Lessen Expense Variation

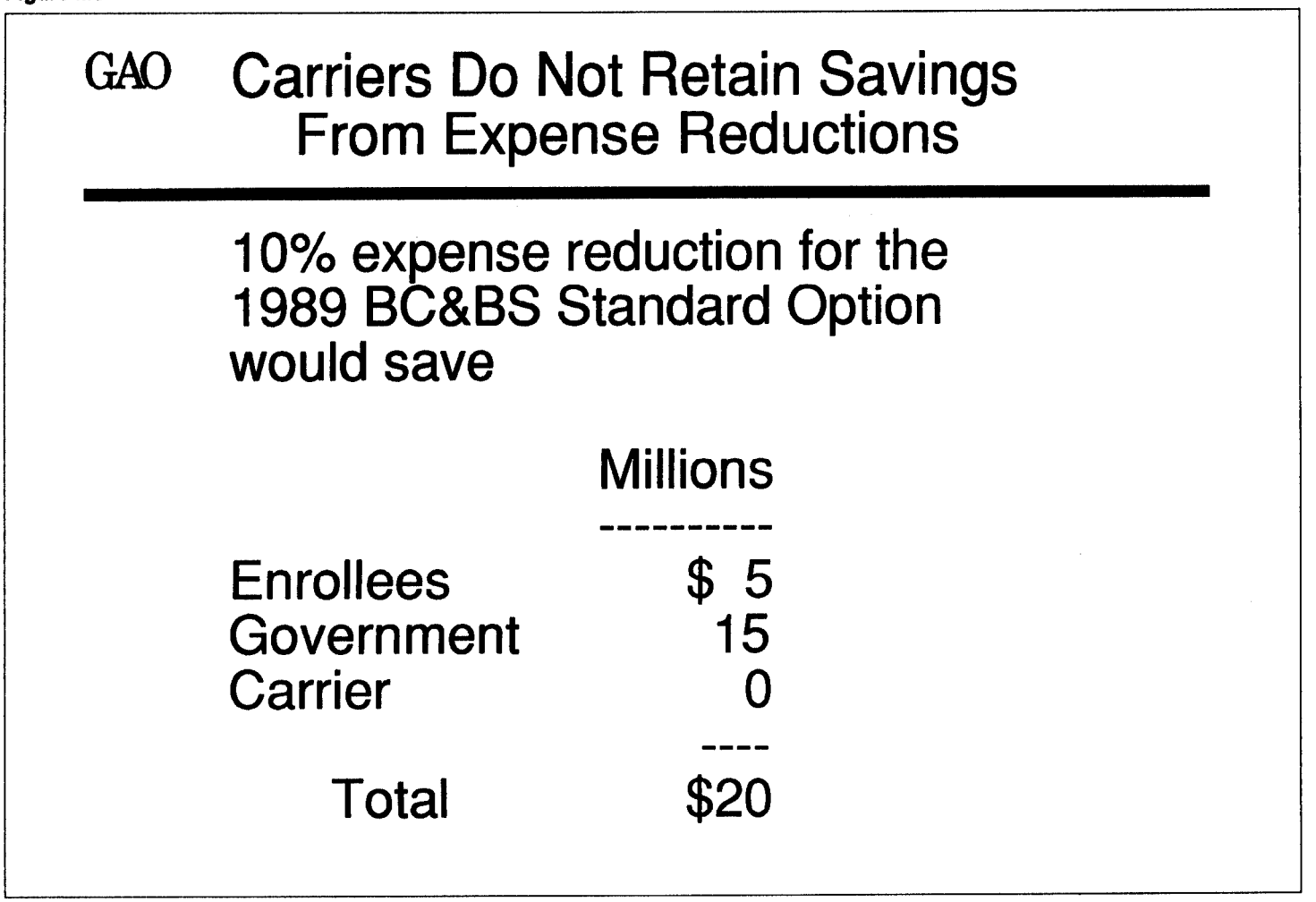
From 1988 through 1990, OPM negotiated a new method for determining the plans' operational expense ceilings. We believe this method will help to control future cost increases. The new method established the plans' ceilings at a base amount, to be adjusted annually for percentage changes in enrollment and CPI-U. In addition, the carriers can ask OPM to approve expenditures above their ceiling amounts for such things as benefit cost-containment activities.

If the ceilings had been adjusted for inflation and enrollment changes from 1983 through 1988, operational expenses for the 25 FFS plans would have

increased by 29 percent rather than by 86 percent. Also, in 1988 the operational expenses charged to the program by the carriers would have been $140 million less. The lower expenses would have equated to about a 2-percent reduction in the plans' total costs. The plans' premiums could have been reduced accordingly.

Although the new method for determining ceilings is a step in the right direction, we do not believe that it will substantially lessen the wide variation in the plans' expenses because it does not encourage the carriers to improve their efficiency or implement effective cost controls. The base amounts negotiated beginning in 1988 were generally the actual amounts charged to the program for the previous year. OPM has not attempted to negotiate reductions in the expense ceilings or determine if the historic expense levels, on which the carriers' ceilings have been based, were reasonable or excessive. Thus, the carriers did not have to reduce their expenses through productivity increases or cost-cutting measures. Also, we do not believe that the plans' expenses will necessarily rise or fall in direct proportion to percentage changes in enrollment. For example, it seems reasonable to assume there could be fixed-cost decreases on a per-enrollee basis or on the basis of other economies of scale when enrollment grows.

Figure II.8



Carriers Would Not Share in Savings From Expense Reductions

The FFS plan contracts do not contain incentives that would encourage the carriers to contain or reduce their operational expenses. Because the carriers are reimbursed for their actual, allowable expenses, they would not retain any savings achieved from reducing their expenses through increased efficiency or the implementation of cost controls. However, the savings to the program, which could be passed on to the government and enrollees through premium reductions, could be substantial.

For example, if Blue Cross and Blue Shield had reduced the operational expenses for its standard self and self and family options by 10 percent in

1989, it would not have directly received any of the savings. However, the program's expenditures would have been $20 million less. If the premiums had been reduced by a corresponding amount, the government, which paid 75 percent of the standard options' premiums, would have saved $15 million and the plan's enrollees would have saved $5 million.

In contrast, if the plan contracts had provided for the payment of services related to claims processing on a fixed-price basis, the carriers would have a profit incentive to reduce their plans' operational expenses. In the preceding example, Blue Cross and Blue Shield would have retained the $20 million savings achieved from the 10-percent reduction in expenses. Although the plan's premiums would not have been reduced, the reduction in operational expenses could be passed on through premium adjustments to the program in subsequent contract periods.

Negotiated Profits Do Not Provide an Adequate Incentive to Reduce Expenses

The FEHBP carriers are paid a profit, which is negotiated by OPM and the carriers at the end of the contract year. However, we believe that the profits offered the carriers little, if any, incentive to reduce the plans' operational expenses. The program's acquisition regulation limits the maximum profit that can be paid to a carrier to 1.1 percent of incurred claims and expenses. In 1988, the profits awarded ranged between 0.30 percent and 0.95 percent of premium income, and the weighted average for all the FFS plans was 0.67 percent. Table II.2 shows the profits paid to the FFS plans for 1988.

Table II.2: FFS Plan Profits (1988)

Plan	Profit	Percentage of incurred claims and expenses
Postal Supervisors[a]	$1,190,000	0.95
Aetna[a]	5,012,808	0.90
Foreign Service Overseas[a]	27,540	0.83
Postmasters	669,264	0.76
Blue Cross/Blue Shield	23,000,000	0.74
SAMBA	444,000	0.69
Panama Canal	240,916	0.67
NALC	4,400,000	0.65
APWU	1,800,000	0.63
NAGE[a]	315,000	0.63
Foreign Service	134,460	0.62
Secret Service	27,000	0.62
Rural Letter Carriers	730,000	0.61
GEBA[a]	52,000	0.61
NTEU	140,000	0.59
ACT[a]	2,000	0.58
NFFE[a]	301,000	0.56
Federal Managers[a]	15,721	0.55
AFGE[a]	448,100	0.53
Mail Handlers	4,791,000	0.50
GEHA	3,500,000[b]	0.45
Alliance	290,000	0.44
NATA[a]	4,200	0.40
BACE	20,000	0.37
NAPUS	146,000	0.30
Total	**$47,701,009**	**0.67[c]**

[a]Plan no longer in FEHBP.

[b]Adjusted to $4.1 million in 1989. Other amounts shown also may be subject to adjustment.

[c]This figure is the weighted average.

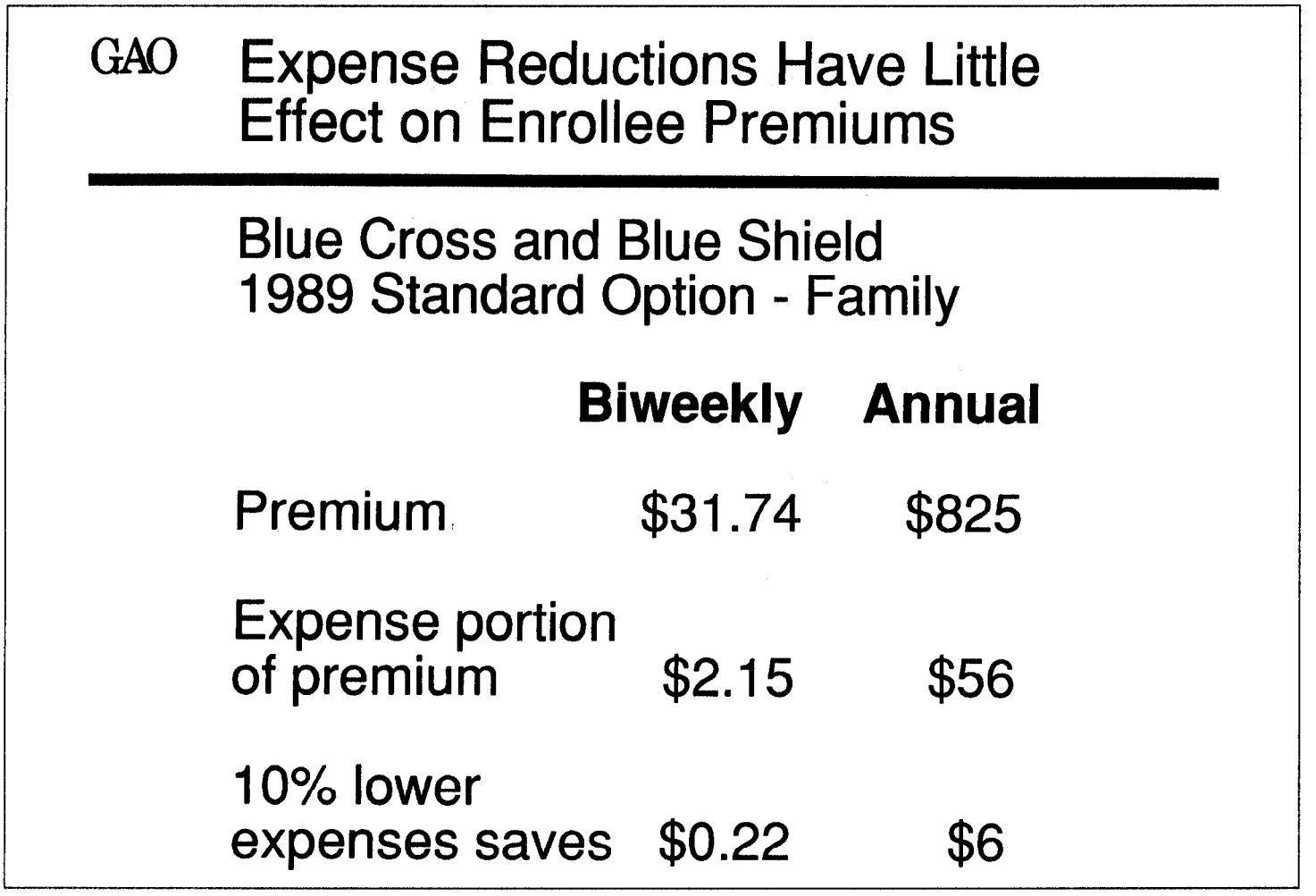
Source: GAO calculations based on data from OPM.

In 1987, OPM revised the program's acquisition regulation to provide a "weighted guidelines structured approach" for establishing its prenegotiation objectives for the profits to be awarded. Under this approach, OPM scores the carriers on

- performance, which is based on OPM's assessment of disputed claims, enrollee complaints, open-season conduct, and compliance with reporting instructions;
- risk, which takes into account plan size, demographics, and the financial assistance rendered by the carrier in view of the experience-rated nature of the contracts;
- independent development, for example, enhanced customer support systems;
- federal socioeconomic programs, for example, drug and substance abuse deterrents; and
- cost control, for example, improved benefit design and new cost-sharing features.

The acquisition regulation relates the cost control factor to benefit costs and does not specifically refer to operational expenses. Benefit cost controls should be one of the major determinants of profits because over 90 percent of the program's costs are for benefit claims and, thus, have the potential for generating the largest amount of savings. But the carriers' operational expenses, which totaled $458 million in 1988, are still a significant program cost. As long as carriers are reimbursed for their actual, allowable expenses, we believe that a monetary incentive is needed to encourage the carriers to improve their operational efficiency and implement effective administrative cost controls.

Figure II.9



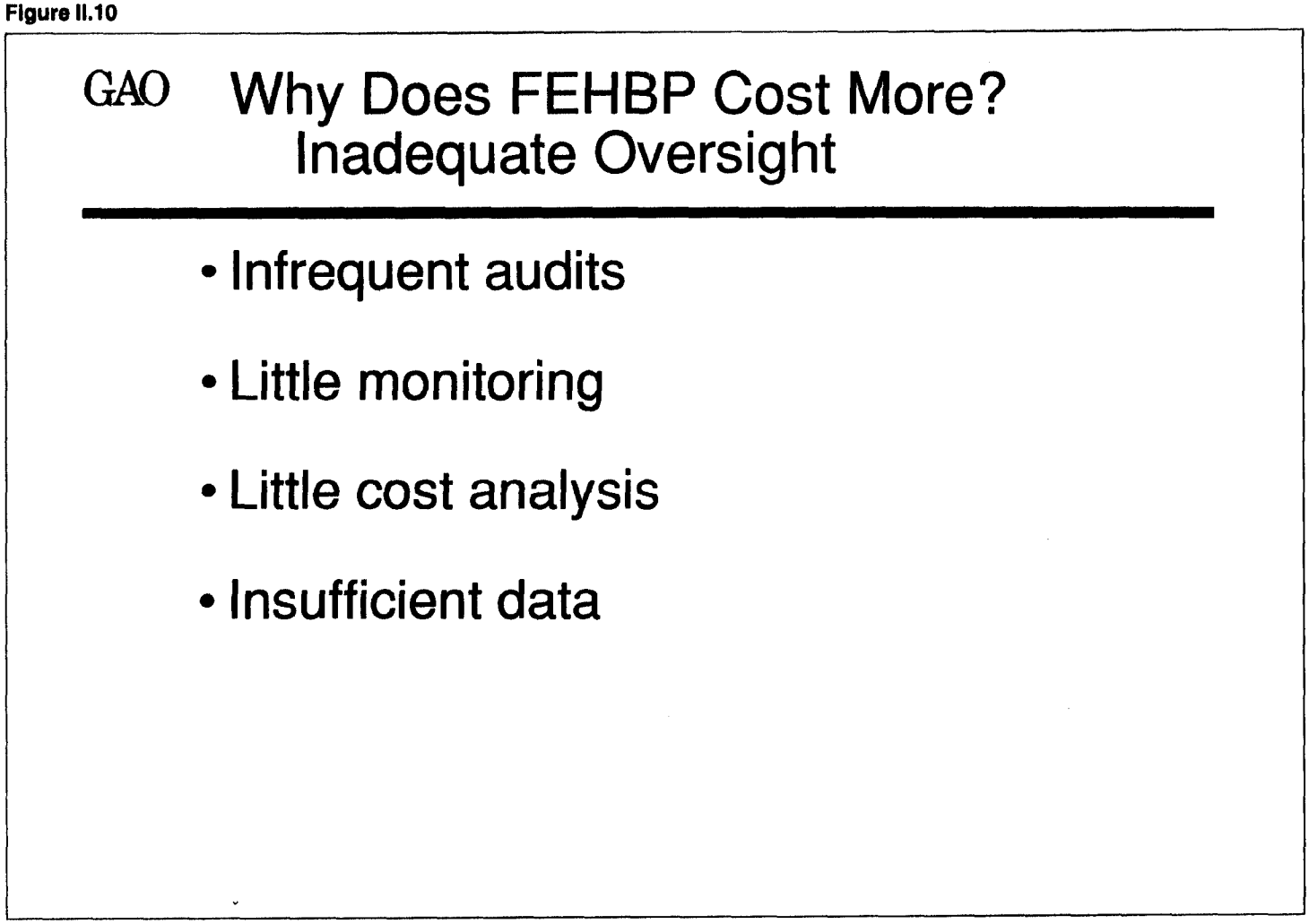
Expense Reductions Unlikely to Affect Enrollment Decisions

We do not believe the competition between FEHBP plans for enrollees provides FFS plans an adequate incentive to reduce operational expenses. Because the plan's expenses represent only a small percentage of the biweekly premium paid by an enrollee, even a 10-percent reduction is unlikely to influence enrollment decisions. For example, in 1989, the biweekly premium paid by enrollees for the Blue Cross and Blue Shield standard family option was $31.74, or about $825 per year. Operational expenses for the plan were about 6.8 percent of premiums or $2.15 of the biweekly premium. A 10-percent reduction in operational expenses would

therefore reduce the biweekly premium by only 22 cents, or less than $6 per year.

Also, enrollees are not provided information concerning the percentage of their premiums spent for administrative costs. Thus, for example, enrollees who choose the Mail Handlers plan because its premiums are among the lowest of the FFS plans are not likely to be aware that the plan's administrative cost per $100 of benefit payments is among the highest of the FFS plans.

Figure II.10



Expenses Have Been Reimbursed Without Adequate Oversight

OPM officials viewed the operation of the plans as a carrier responsibility. Thus, they were concerned that the carriers stay within their operational expense ceilings but not whether they operated efficiently or implemented effective administrative cost controls. OPM's primary oversight of the operational expenses charged to the program by the carriers has been the Inspector General's audits of the carriers' compliance with the terms of the health plan contracts. Our review of the audit reports indicated that the audits were infrequent—each carrier was audited about every 5 years. Also, the audits focused on whether the expenses charged by the carriers were actually incurred and were allowable under the terms of the contracts and program regulations. The reasonableness and/or necessity of the expense charges were seldom questioned.

Other than the Inspector General audits, the only program oversight that OPM routinely conducted was the monitoring of plan financial stability through annual financial reports submitted by the carriers. The reports represented the plans' financial positions on the basis of the past year's activities. Over the past few years, the reporting requirements were expanded, and responsible carrier officials now are required to certify the authenticity of the reports. However, OPM's reviews of the operational expenses reported normally were limited to assuring that the expenses charged did not exceed the negotiated ceilings and determining if anything out of the ordinary was shown.

OPM did not conduct any formal analyses of the carriers' operational expenses. It determined the carriers' expenses per enrollee in conjunction with ceiling negotiations but generally only used that data to assess an individual carrier's expenses in terms of its past year costs.

Moreover, OPM did not require the carriers to submit sufficient cost or work-load data and, therefore, was not in a position to analyze either the large percentage increase in the carriers' operational expenses from 1982 through 1988 or the wide variation in their expenses. The carriers are required to summarize their expenses by object classes such as salaries, rent, and data processing. However, we did not find these data to be very useful because OPM did not provide the carriers with instructions about which expenses to include in each class. Therefore, the data reported in the various classes were not consistent. For example, the 1988 financial report for the GEHA plan did not show any data processing expenses; and the report for the Aetna plan did not show any expenses for office supplies, utilities, or maintenance. We believe that it is reasonable to assume that the

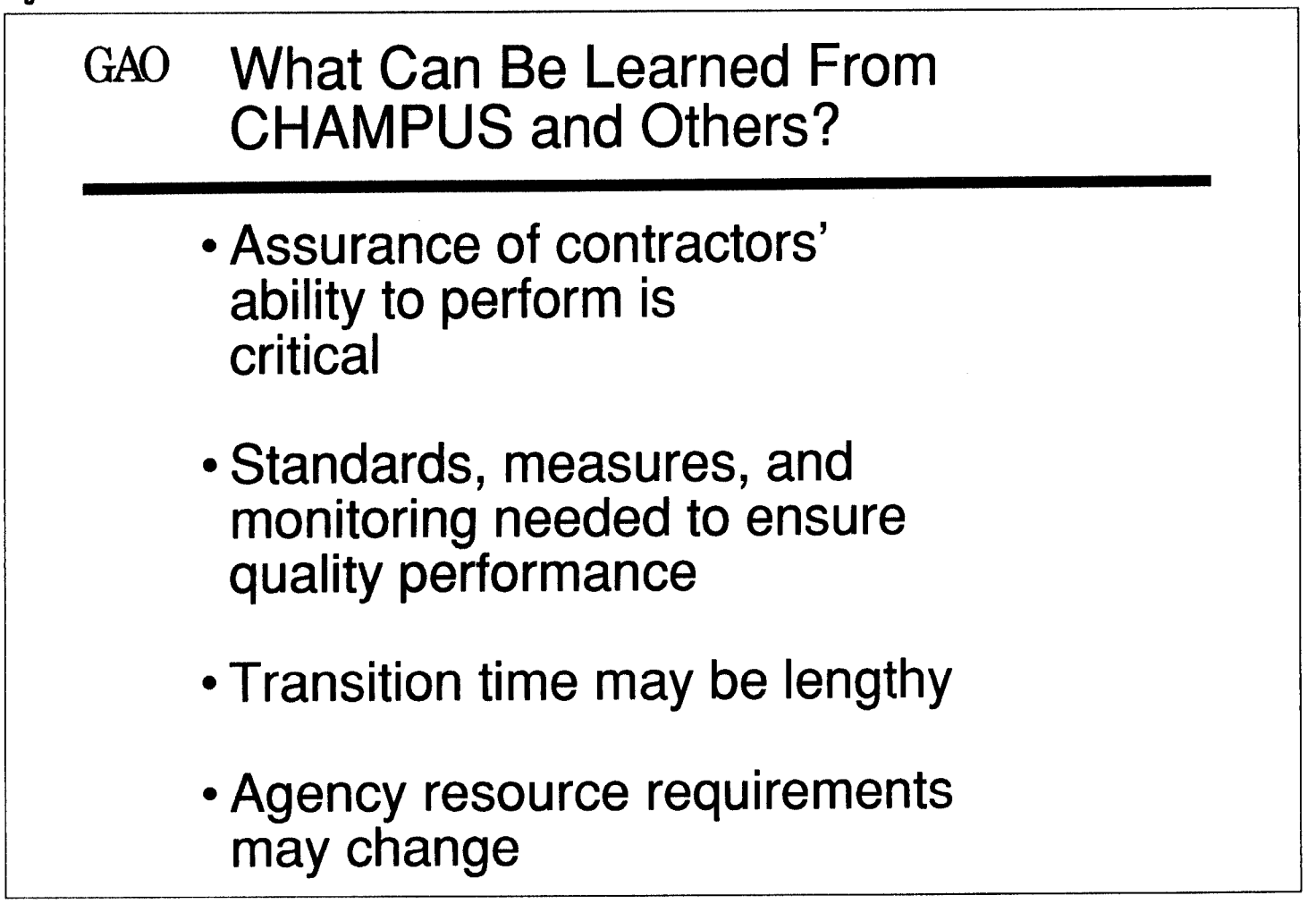
carriers incurred these expenses but combined them with the expenses reported for other object classes.

Also, the reporting of expenses by object class did not enable us to determine or compare the costs of the basic functions performed by all of the carriers, such as processing claims, providing customer service, and conducting open seasons. We believe that there may be a wide variation in the resources devoted to, and the definitions of, the various functions because data we obtained from four of the carriers indicated that the percentage of total expenses spent for claims processing ranged between 35 percent and 60 percent.

Although OPM requires carriers to report the number of claims processed, it has not developed a common definition of claims. Consequently, there is not a uniform measure of the size of the carriers' work loads. For example, a carrier that reported the number of individual medical bills submitted by an enrollee as separate claims would appear to have a larger work load than a carrier that reported all of the bills submitted as one claim. Several carrier officials told us that the increase in their plans' expenses occurred because of a growth in the claims submitted per enrollee. However, we did not attempt to verify whether claims work loads had increased because the carriers could have changed the way they counted claims. For example, data that we obtained for the GEHA plan showed a 30-percent increase in claims work load that was attributable to a 1987 change in its definition of a claim.

What Can Be Learned From CHAMPUS and Others?

Figure III.1



Our past reviews of OCHAMPUS' conversion to, and administration of, competitive, fixed-price claims processing contracts identified some important lessons that we believe should be considered in reforming FEHBP. These lessons are that (1) the claims processors' ability to perform should be a major criteria in evaluating contract proposals; (2) performance standards, measures, and monitoring should be established to ensure that quality is not sacrificed for lower costs; and (3) the transition time for implementation should allow for adequate testing of claims-processing systems. Also, on the basis of this review, we believe changes in the level, type, and focus of OPM's resources are likely to be required.

Assurance of Contractors' Ability to Perform Is Critical

Although CHAMPUS' claims processing expenses were substantially reduced through the use of competitive, fixed-price contracts, the first regional contractor—selected in 1976—was unable to fulfill its contract; and the contract was terminated before the end of the first year. Serious problems in the contractor's claims processing system had resulted in a claims backlog that would have taken 30 months to eliminate. Additionally, OCHAMPUS officials determined that the contractor had not (1) processed claims accurately; (2) detected overutilization, duplicate claims, and other potential abuses; (3) fully explained the disposition of claims to beneficiaries and providers; or (4) produced timely and accurate management reports.

The contractor had bid the lowest price per claim and had received the highest technical rating. However, a CHAMPUS task force, the Department of Defense Inspector General, and we subsequently identified the need to strengthen OCHAMPUS' procurement and monitoring process by

- better documenting proposal evaluation criteria and the rationale for contract award decisions;
- better assessing offerors' price, past experience, and ability to perform the operations promised in their proposals; and
- providing for more systematic and thorough assistance to, and evaluations of, contractor operations.[1]

We also reported that with 20 years experience in procuring claims processing services under cost-reimbursable contracts, it should have been possible to detail the functions to be performed by the fixed-price contractor and reasonably estimate the cost. Furthermore, OCHAMPUS had not included detailed work statements or standards for measuring performance in the cost-reimbursable contracts, and it had done little analysis of the contractors' claims processing costs.[2] OCHAMPUS subsequently revised its methods for assessing the offerors' price, experience, and ability to perform the operations contained in their proposals.

The limited monitoring of FEHBP carriers and the minimal carrier reporting requirements make it appear that OPM currently lacks the knowledge and information it would need to adequately evaluate the claims processing proposals it would receive if competitive, fixed-price contracts were to be

[1]CHAMPUS Has Improved its Methods for Procuring and Monitoring Fiscal Intermediary Services to Process Medical Claims (HRD-85-56, Aug. 23, 1985).

[2]Analysis of Variations in Claims Processing Costs of Fiscal Agents for the Civilian Health and Medical Program of the Uniformed Services (HRD-77-93, June 8, 1977).

used. We believe that OPM needs to have reasonably precise and accurate information on the current carriers' operations, performance, and costs to be able to ensure the selection of contractors that have the ability to perform.

Standards, Measures, and Monitoring Needed to Ensure Quality Performance

In 1981, we reported that competitive, fixed-price CHAMPUS contracts provided an incentive to process claims quickly to minimize costs but did not provide an incentive to pay claims accurately, which could increase the program's benefit costs. We found that the original contracts did not have standards for claims-processing accuracy; and, after they were added, OCHAMPUS did not have a method for measuring how well the standards were being met. Additionally, OCHAMPUS lacked sufficient measures and reporting requirements to determine if the contractors were meeting other performance standards.[3] OCHAMPUS currently monitors contractor performance under 38 standards on a monthly basis and provides monetary rewards or penalties on the basis of the results.

In 1990, we reported to the Director, OPM, on the need for better performance standards and measures in OPM's programs, including FEHBP.[4] During this review, we found that the carriers generally had established performance standards and measures for their own use. These standards and measures varied, however, and the carriers did not report any performance data to OPM.

Until recently, OPM relied on enrollee complaints and disputed claims information as the only indicators of how well the carriers were performing. However, OPM officials told us a standard plan contract was negotiated for 1991 that required the carriers to have quality assurance programs with procedures to address the (1) accuracy of claim payments and recovery of overpayments, (2) timeliness of claim payments, and (3) quality of services and responsiveness to enrollees. Also, OPM has asked the carriers for information on their quality assurance procedures. Although, the officials indicated that standards and measures would become even more important if claims-processing services were to be procured under competitive contracts, OPM does not intend to establish any standards or measures related to the carriers' performance.

[3]Performance of CHAMPUS Fiscal Intermediaries Needs Improvement (HRD-81-38, Feb. 2, 1981).

[4]Office of Personnel Management: Better Performance Information Needed (GAO/GGD-90-44, Feb. 7, 1990).

We believe that performance standards, measures, and reporting requirements are important, regardless of whether the program structure is changed. Because comparative information on the carriers' performance is not available to enrollees, we believe enrollees choose their health plans primarily on the basis of the benefits offered and premium amounts. Also, because FEHBP is a governmentwide program, we believe that OPM should ensure that enrollees receive a standardized minimum level of service regardless of the plan they choose. Further, we believe that carriers lack an adequate incentive to ensure that benefits are paid accurately. The plans are experience rated, which means that benefit payments in excess of premium income can be recouped through premium increases in subsequent years. Thus, unless overpayments are recovered through the audit process, the cost is ultimately borne by government agencies and enrollees rather than by the carriers.

Most States Surveyed Had Performance Standards

We conducted a telephone survey of 14 states with large numbers of employees in their FFS-type health benefits plans. We found that all but 1 of the 14 states had established performance standards for their claims processors. The 13 states with standards had all set time frames for the processing of claims. Nine of the states had set standards relating to the accuracy of claim payments, and seven of the states had set customer service standards. Table III.1 shows the 14 states we surveyed and the type of performance standards they had established.

Table III.1: Results of a Survey of 14 States' Performance Standards

State	Accuracy	Timeliness	Customer service
Insured plans			
Connecticut	No	Yes	Yes
New York	Yes	Yes	Yes
Self-insured plans			
Georgia	Yes	Yes	Yes
Illinois	Yes	Yes	No
Kentucky	No	Yes	No
Louisiana	No	Yes	No
Maryland	Yes	Yes	Yes
New Jersey	Yes	Yes	No
North Carolina	Yes	Yes	No
Pennsylvania	No	No	No
South Carolina	Yes	Yes	Yes
Virginia	Yes	Yes	Yes
Washington	Yes	Yes	Yes
West Virginia	No	Yes	No

Source: Data compiled by GAO from telephone survey of states.

From copies of contracts and other information sent to us by officials of 11 states, we determined that at least 6 of the states imposed monetary penalties on claims processors for not meeting the standards. For example, New York requires its medical and surgical plan insurer to process claims within 14 days. If, during the second 6 months of the contract period, 75 percent of the claims are not processed within 14 days, the insurer is penalized 50 cents for every untimely processing. During the second year, the penalty increases to 75 cents per claim; and, during the third year, if 80 percent of the claims are not processed within 14 days, the penalty increases to $1 per claim. Washington requires its claims to be processed in an average of 10 working days. If the processing time averages from 11 days to 14 days, the processor's fee is reduced by 1.5 percent. If the processing time averages 15 or more days, the fee is reduced by 3 percent.

Transition Time May Be Lengthy

The proposed reforms to FEHBP contained in H.R. 1774 would take effect at the beginning of the first fiscal year beginning at least 12 months after the bill's enactment. This provision means that the new program would have to be operational within 12 to 24 months of the date of enactment. The failure of the initial fixed-price contract awarded for CHAMPUS in 1976 and the time OCHAMPUS currently requires to award new contracts suggest

that the lower end of this time range may not be sufficient to ensure a smooth FEHBP transition.

After the initial fixed-price CHAMPUS contractor failed to perform, a Department of Defense evaluation team concluded that the contractor did not

- sufficiently prepare for contract implementation,
- have its proposed processing system in operation,
- properly design the processing system to handle the large volume of claims,
- hire enough properly trained people for a program of CHAMPUS' size and complexity, and
- acquire the management expertise to run an efficient operation.

OCHAMPUS officials told us that it now takes from 9 to 12 months after the request for proposals is issued to award a new contract and an additional 6 months for a new contractor to develop the claims processing system, hire personnel, and test the system. We did not evaluate the reasonableness of this 15- to 18-month time frame. However, we believe that the various program changes proposed to date for FEHBP would require the development of new processing systems that would need to be thoroughly tested before implementation to avoid disruption of the payment of benefits. Since OPM lacks OCHAMPUS' experience in requesting, evaluating, awarding, and implementing claims-processing contracts, we doubt that OPM could implement a new health benefits program in less time than it takes CHAMPUS to implement its contracts.

Agency Resource Requirements May Change

In 1989, CHAMPUS paid health benefits of $2.6 billion, while FEHBP's 22 FFS plans paid benefits totaling $7.1 billion. Although CHAMPUS was a much smaller program than FEHBP, OCHAMPUS' administrative costs of $47 million were about 4 times more than OPM's costs of $12 million. OPM's costs included its administration of HMOs. OPM does not maintain its cost information in a manner that would enable us to determine how much of the $12 million pertained to those plans. Although there were about 400 HMOs in 1989, an OPM official told us that the negotiation and administration of the contracts for those plans required much less effort than for the FFS plans.

Our analysis of budget information provided by CHAMPUS officials indicated that $26.4 million, or 56 percent, of the $47 million was spent for activities

not performed by OPM. These costs, which may or may not be incurred by OPM under a revised program structure, were

- $11.0 million for the administration of demonstration projects, including the CHAMPUS Reform Initiative;
- $8.0 million for peer reviews of providers and case reviews;
- $6.4 million for payments to claims-processing contractors for contract changes; and
- $1.0 million for CHAMPUS' claims-processing costs in Europe.

The remaining $20.6 million of OCHAMPUS' administrative costs was for administrative and support functions similar to those performed by OPM. As shown in table III.2, our analysis of information provided by OCHAMPUS and OPM indicated that in 1989 OCHAMPUS had 178 positions allocated to program and contract administration compared with an allocation of 138 staff years by OPM.

Table III.2: OCHAMPUS and OPM Staffing Levels by Function (1989)

Function	OCHAMPUS (positions)	OPM (staff years)
Program management	20	17
Resource management	37	19
Contract administration	63	71
Customer service	19	7
Appeals	23	24
Demonstration projects and health care	16	0[a]
Total	**178**	**138**

[a]OPM did not perform this function.

Source: GAO analysis of data obtained from OCHAMPUS and OPM.

In addition to using staff resources for demonstration projects and health care reviews—which OPM does not do—OCHAMPUS had more staff positions in the customer service and resource management areas than OPM. OPM's current customer service activities involve responding to enrollee and congressional inquiries concerning program coverage and benefits. We assume that major changes to the program's structure and benefits would generate more inquiries, but we are not aware of any reasons for anticipating a permanent increase in the number of inquiries received.

The differences in staffing levels for the resource management area were primarily a result of the 20 positions OCHAMPUS had for providing automated information systems and statistical analyses in support of other program and contract administration activities. The number of staff years allocated by OPM for those activities was not readily available, but an OPM official told us that it would be comparatively small. In 1989, a Congressional Research Service report said that for OPM to effectively manage a reformed program it would need to develop data systems capable of collecting and retrieving the kinds of demographic, benefits, and administrative data needed to monitor program costs.[5] According to the report, the resource requirements would be considerable, but experience in the private sector had shown that the increase in administrative costs was more than offset by increased efficiency.

OPM May Need to Reallocate Its Resources Under a Reformed Program

An OPM official told us that a self-insured program using contractors to process claims would require changes in OPM's management approach. The bulk of OPM's work would shift from contract negotiations to contract administration. The contracts would require more monitoring, and OPM would need different controls and staff skills. The official said that OPM will not develop a specific plan for changing its activities until it becomes more clear what the nature of the new program will be.

In 1989, OCHAMPUS administered 9 claims-processing contracts, while OPM administered the contracts of 22 FFS plans. Thus, although table III.2 showed that in 1989, OPM allocated 71 staff years for contract administration while OCHAMPUS allocated 63 positions, OPM had more than twice as many contracts to administer. Also, our analysis indicated that the two offices concentrated their contract administration resources on different functions. As shown in table III.3, OPM allocated the largest percentage of its contract administration staff years (47 percent) to procurement, which involved annual contract negotiations and actuarial support. In contrast, OCHAMPUS allocated more of its contract administration positions (40 percent) to the organizational units responsible for monitoring contractor performance. OCHAMPUS and OPM devoted about the same percentage of their contract administration resources to program integrity reviews and audits, respectively. OCHAMPUS allocated about 22 percent of its positions for reviewing program integrity, including contractor operations and fraud

[5]The Federal Employees Health Benefits Program: Possible Strategies for Reform. Prepared by the Congressional Research Service for the Committee on Post OOffice and Civil Service, U.S. House of Representatives; 101st Cong. (May 24, 1989).

and abuse controls; and OPM allocated 30 percent of its staff years to auditing carrier compliance with contract requirements.

Table III.3: OCHAMPUS and OPM Contract Administration Resources (1989)

	Percentage of contract administration resources	
Contract administration function	**OCHAMPUS (positions)**	**OPM (staff years)**
Procurement	21	47
Monitoring	40	17
Audits/program integrity	22	30
Claims processing requirements	17	0[a]
Other	0[a]	6

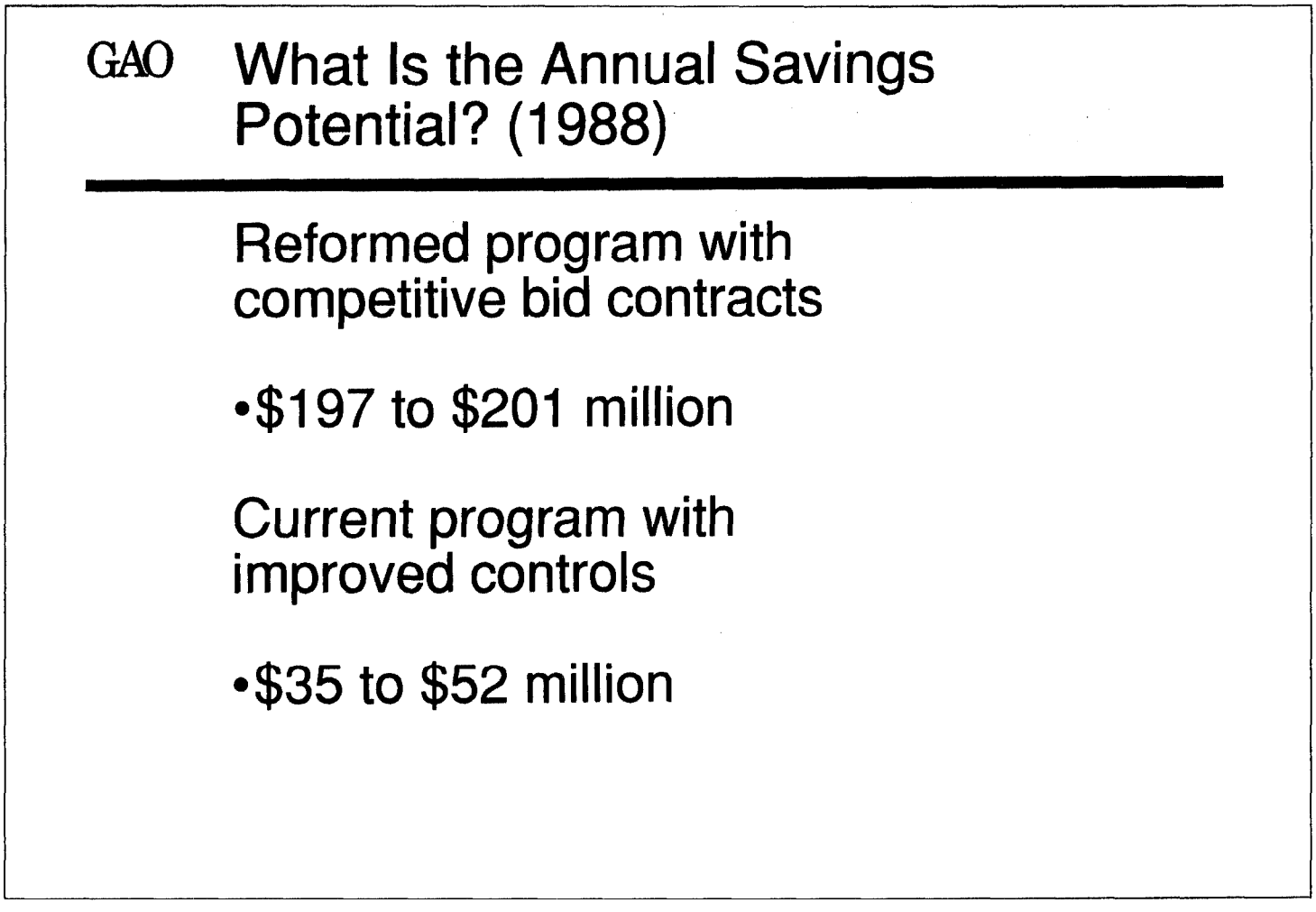
[a]Functions not performed.

Source: GAO analysis of data obtained from OCHAMPUS and OPM.

The remainder of OPM's contract administration staff years were used for monitoring carriers' performance (17 percent) and reviewing plans' benefits brochures, resolving audit findings, and conducting mini-open-seasons (6 percent). OCHAMPUS used the remainder of its contract administration positions for procuring contracts (21 percent) and developing requirements and specifications for its claims processing contracts (17 percent).

What Is the Annual Savings Potential?

Figure IV.1



We believe FEHBP's high administrative costs relative to those of other large employer-sponsored health benefits programs and the wide variation in the FEHBP carriers' costs indicated that opportunities exist to reduce the program's costs. However, the lack of adequate and consistent data on the carriers' operational expenses made it difficult to estimate the potential for administrative cost savings under either the current program structure or program reform.

Although the administration and Congress were considering major program reforms, changes to the administrative structure had not been agreed upon at the time of our review. Thus, to estimate the general

magnitude of the potential for reducing costs under program reform, we determined what FEHBP's 1988 administrative costs would have been if the program's administrative costs had been equivalent to either the insured or self-insured nonfederal programs in our review. We included premium taxes in FEHBP's costs in the savings estimate for an insured program because commercial insurers would typically be subject to those taxes, but we excluded premium taxes from FEHBP's costs in the savings estimate for a self-insured program underwritten by the government. Using the insured programs' average cost of $5.68 per $100 of benefit payments, we estimated that the FEHBP carriers' total administrative costs of $564 million (including premium taxes) would have been reduced to $368 million, for savings of $197 million, or 35 percent. Using the self-insured programs' average cost of $4.52 per $100 of benefit payments, we estimated that the FEHBP carriers' costs of $507 million (excluding premium taxes) would have been reduced to $307 million, for savings of $201 million, or 40 percent.

A few years ago, an OPM consultant reported that $200 million could be saved by reducing the plans' 1986 expenses per enrollee to the level of the lower cost plans. Although this estimate of the savings potential is within the range of savings that we believe would be achieved if FEHBP's benefits structure is reformed, we have strong reservations concerning the feasibility of achieving savings of this magnitude under the current program structure. We believe that if the program was changed to provide a more uniform program structure and competitive, fixed-price contracts for health benefits and/or claims processing services, the program would receive bids comparable to the prices charged other large programs for services related to claims processing.

However, because the cost of claims processing services may vary according to the plans' benefits structures, cost-containment activities, enrollee characteristics, and other factors, we doubt that all of the carriers could reduce their operational expenses to the level of the lowest cost carrier within 1 or 2 years without reducing the timeliness and accuracy of their claims payments. For example, the operational expenses per enrollee for the two largest plans, Blue Cross and Blue Shield and Mail Handlers, would have to be reduced by 42 percent and 33 percent, respectively. Moreover, under the current program structure, the operational expense ceilings are negotiated with carriers that know their contracts will be renewed each year, which could make it very difficult for OPM to obtain the carriers' agreement to reduce their expenses. For example, the new method for establishing ceilings was negotiated for the Blue Cross and

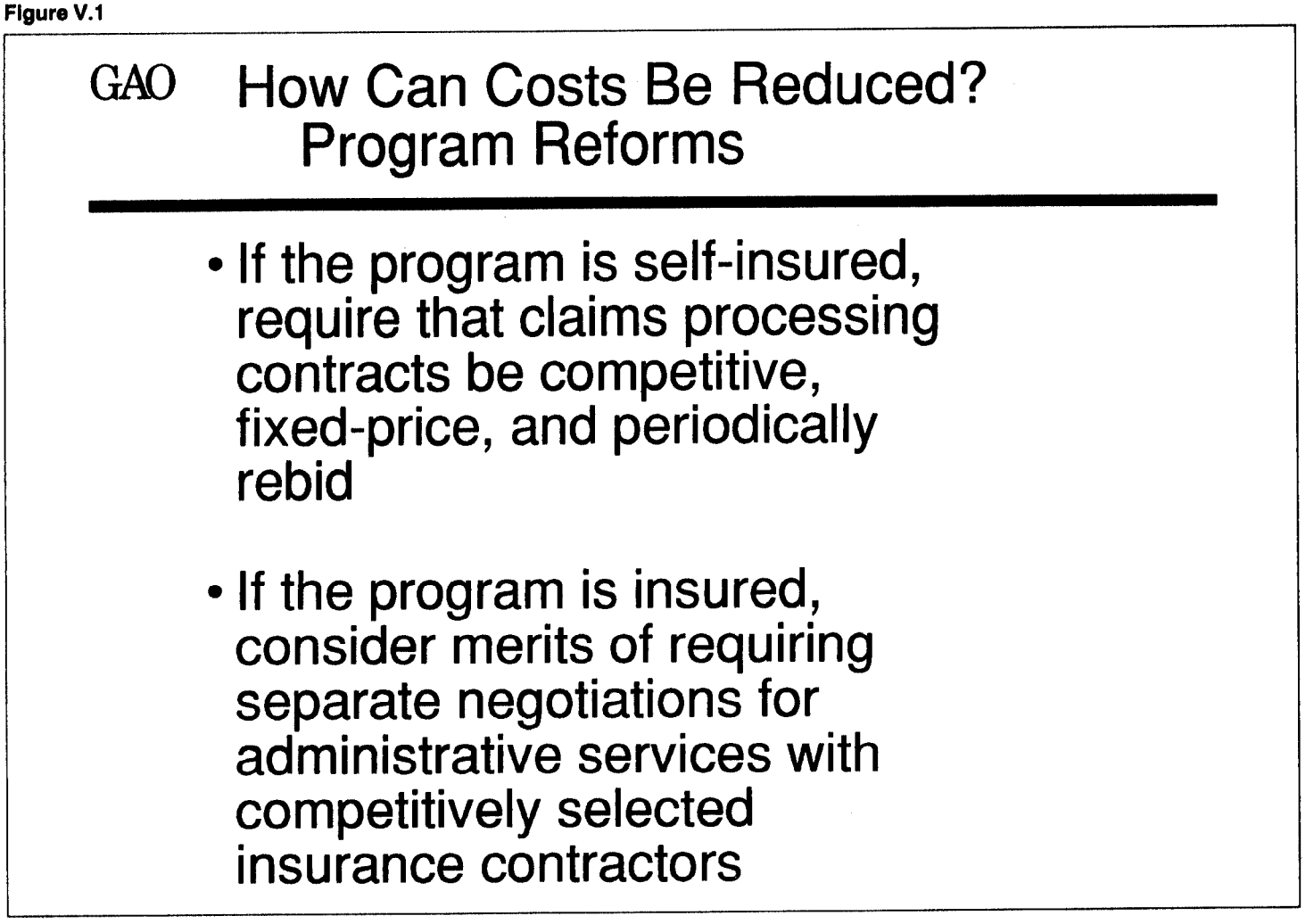
Blue Shield contract in 1988, but it was not negotiated for all of the FFS plans' contracts until 1990.

Nevertheless, we do believe that cost savings could be achieved under the current program structure. To estimate the general magnitude of the range for potential administrative cost reductions, we assumed that the weighted average of the FFS carriers' operational expenses could have been lowered. To determine the lower average, we estimated what FEHBP's costs would have been if the higher cost carriers' operational expenses had been reduced to the program averages of either $149.29 per enrollee or $6.82 per $100 of benefits paid and the lower cost carriers' expenses had remained the same. Using this methodology, we estimated that the program's total operational expenses would have been either $422 million, based on the per enrollee expense, or $406 million, based on the expenses per $100 of benefit payments. The total administrative costs of $507 million (excluding premium taxes) would have been reduced to either $472 million or $455 million. We excluded premium taxes from FEHBP's costs because the program was exempted from those taxes in 1991. If FEHBP's costs had been within this range, between $35 million and $52 million would have been saved, for a reduction in cost of between 7 percent and 10 percent.

This methodology assumes that the expenses of the higher cost plans could all be reduced to the same level, while the expenses of the lower than average cost plans would not be reduced. Because other large insured health benefits programs cost about 34 percent less to administer than FEHBP, we believe that a reduction in the weighted average of the carriers' operational expenses of from 7 to 10 percent is a reasonable goal. However, we believe that the savings should not be achieved through arbitrary expense reductions that could affect the provision of benefits but through objective analyses of what the expenses for the efficient administration of the individual plans should be. Also, the savings would be partially offset by any additional costs incurred by OPM to increase its oversight of carrier expenses, provide incentives for efficiency improvements, and monitor the quality of the carriers' claims processing performance.

How Can FEHBP's Costs Be Reduced?

Figure V.1



Structural Changes Can Be Made to Reduce FEHBP's Administrative Costs

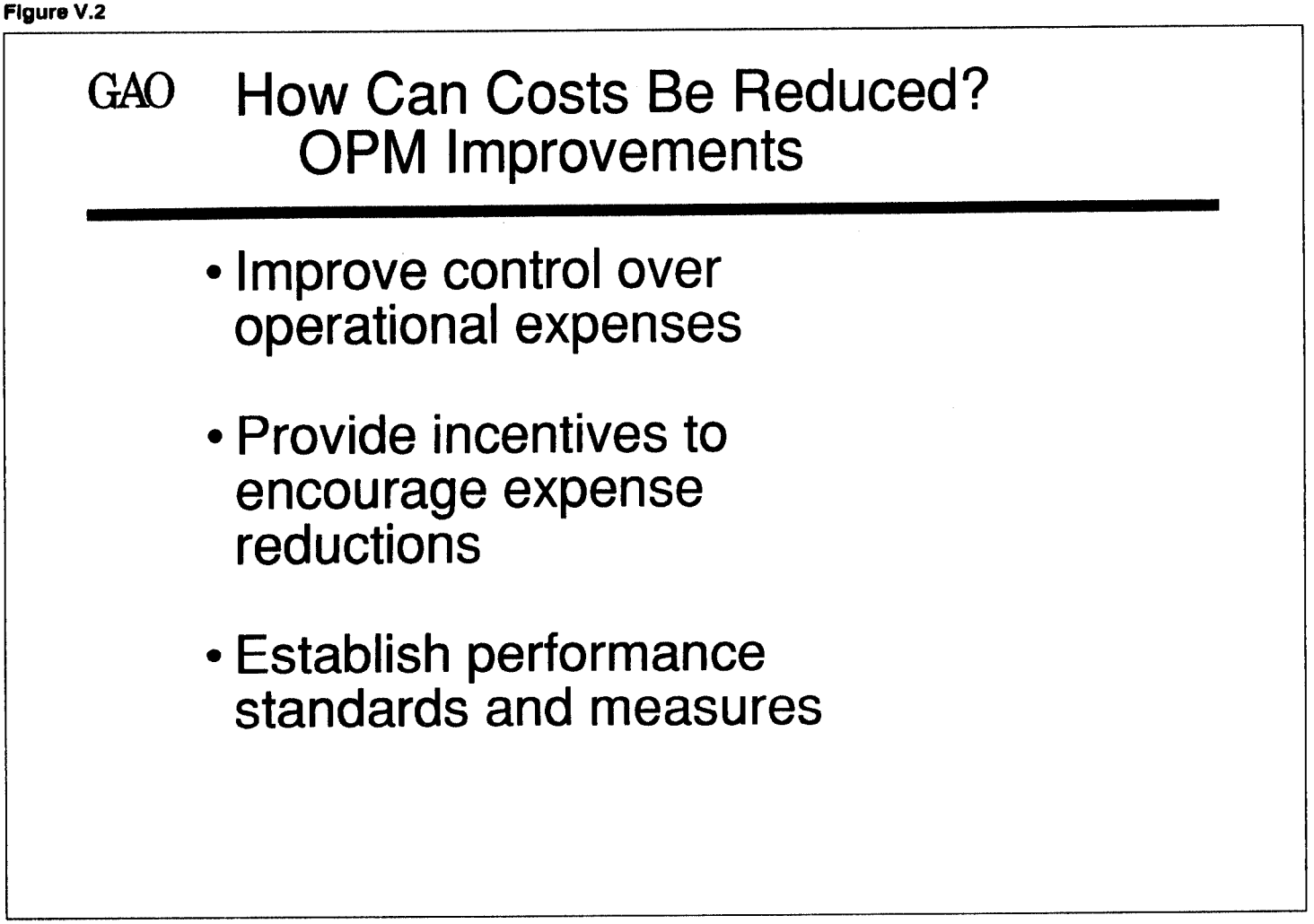
CHAMPUS's costs were substantially reduced when, in 1976, OCHAMPUS stopped reimbursing claims processors for their expenses and converted to a smaller number of periodic, competitive, fixed-price contracts. Currently, CHAMPUS costs about the same to administer as the nonfederal programs in our review. Although most of these programs did not incur some administrative costs incurred by FEHBP because they were self-insured by the employers, Congress may find that the program's benefit costs could be lowered through an insured arrangement, such as the risk-sharing approach proposed by H.R. 1774. Because over 90 percent of the FFS plans' total costs are for benefit payments, we believe that the decision to

insure or self-insure FEHBP should be based primarily on benefits considerations rather than on administrative costs.

Regardless of how FEHBP would be insured under program reform, it should be administered more efficiently. FEHBP is the largest employer-sponsored health benefits program in the United States, and we believe that insurance companies or other claims processors should be able to perform FEHBP's administrative functions at a cost more comparable to the cost of CHAMPUS and nonfederal programs. Our analysis of FEHBP's operational expenses indicated that its costs were high primarily because the carriers were (1) not selected for their administrative efficiency and (2) reimbursed for expenses incurred up to ceilings that allowed generous increases in expenses each year. Reimbursing the carriers for the costs they incur does not encourage them to improve their efficiency and/or otherwise contain their expenses to levels charged by other claims processors.

We believe that FEHBP's administrative costs could be reduced by between $197 million and $201 million if, under program reform, a more uniform benefits structure were established and the services related to claims processing were required to be procured under periodic, competitive, fixed-price contracts. If the reformed program is self-insured, the bidders would be competing solely on the basis of the administrative services to be provided. In this case, OPM should select claims-processing contractors primarily on the basis of the cost-effectiveness of their services. However, if FEHBP is fully or partially insured by insurance underwriters, the bidders would be competing primarily on the basis of the price of underwriting the health benefits that make up the vast majority of the program's cost. Thus, under this type of a structure, OPM should evaluate separately the administrative and benefit costs in negotiating contract bids. To ensure that the program's claims processing services are procured at the lowest possible price, the Committee and Subcommittee may wish to consider the merits of requiring OPM to separately negotiate fixed prices for the program's administrative services with competitively selected insurance contractors.

Figure V.2



Improvements in Current Program Controls Could Reduce Carrier Operational Expenses

We believe that differences in the FEHBP plans' sizes, benefits structures, and enrollee demographics, such as age and family size, could cause some plans to have higher costs than others. However, because (1) the cost per $100 of benefit payments for three of the plans were similar to the other programs reviewed and (2) we did not find any strong relationships between the plans' operational expenses and factors related to the processing of claims that were suggested to us as causes of the wide variation in plan expenses, we also believe that the plans' operational expenses can be substantially reduced.

To reduce FEHBP's operational expenses under the current program structure, we believe that OPM needs to exercise greater control in reimbursing carriers for costs incurred. To do this, it will first need to obtain expense and work-load information from the carriers in uniform formats so that it can analyze and compare their expenses, efficiency, and efforts to control expenses. This information would support OPM's negotiations to establish and adjust ceilings that would set reasonable limitations on the carriers' expenses on the basis of work load and other factors, such as economies of scale, rather than just on historical costs. After OPM has negotiated appropriate ceilings, we believe that it should offer monetary incentives to encourage the carriers to improve efficiency, increase productivity, and/or institute other measures to reduce their expenses below the ceiling amounts.

Because FEHBP is a government program, we also believe that OPM needs to negotiate performance standards so that enrollees would be assured of a standardized minimum level of service regardless of the plan they chose. To enforce the standards, OPM would also need to establish performance measures, require periodic performance reports, and penalize those carriers that failed to meet the standards.

After OPM has obtained adequate, reliable, and consistent cost and performance data from the carriers, we believe it should be able to negotiate fixed prices for the administrative services performed by the carriers that would be more comparable to the prices charged other large employer-sponsored health benefits programs for similar services.

Objectives, Scope, and Methodology

Our first objective was to determine whether FEHBP was more or less expensive to administer than other large employer-sponsored health benefits programs. If our work indicated that administrative costs were higher for FEHBP than for other programs, our next objectives were to identify opportunities for reducing the costs and estimate how much could be saved. Our objectives were also to (1) analyze and compare administrative costs of individual FEHBP plans; (2) review the experiences of CHAMPUS in converting from cost-reimbursable contracts to competitive, fixed-price contracts; and (3) conduct a limited survey of states to determine whether their health plan claims processors were required to meet performance standards for timeliness, accuracy, and customer service.

We focused our review on the FFS plans in the program and did not review the HMO plans because

- FFS plans accounted for about 80 percent of the program enrollment;
- most HMO plans are paid the same premium rate charged other group programs for similar services in the same geographic area and, thus, are not required to account for their administrative costs; and
- proposals to reform FEHBP would not have a major effect on the administration of HMO plans.

We obtained financial data for 1982 to 1988 for the FFS plans participating in FEHBP from annual accounting statements submitted to OPM by the FFS plan carriers. The reports showed summary information on premium income, health benefit payments, operational expenses charged by the carriers and their underwriters, premium taxes, state statutory reserve payments, and profits. The 1988 data were the latest available at the time we did our review. We did not verify the accuracy of the data reported in the accounting statements, and the data are subject to change upon audit by OPM. We also obtained data from OPM on the FFS plans' enrollment as of September 30 for each of the years from 1982 through 1988 to analyze enrollment trends and compare the FFS plans' 1988 costs per enrollee.

To determine the administrative costs that private sector and other government entities are paying for their health benefits programs, we obtained and analyzed 1988 data from a survey conducted in early 1989 by A. Foster Higgins & Company, a consulting firm. Several of the survey questions concerned administrative costs of health benefits plans.

Survey questionnaires were sent to about 10,000 employers. About 6,000 questionnaires were distributed to Foster Higgins' clients, prospective

clients, and employers that expressed interest in participating in the survey. Another 2,000 questionnaires were distributed by 42 health care coalitions to their members, and 1,400 questionnaires were distributed by the National League of Cities to its members. Questionnaires were also sent to the Fortune 500 companies and 50 state governments. Foster Higgins followed up with a letter to all of the nonresponding Fortune 500 companies and a phone call to all of the nonresponding state governments. Employer coalitions also followed up with their members who did not respond. Because the questionnaires were sent to a judgmental sample of employers, the responses are not statistically representative of all employer-sponsored health benefits programs.

A total of 1,943 questionnaire recipients (about 20 percent) responded, including about one half of the Fortune 500 companies. Because our review focused on FEHBP's FFS plans, we eliminated respondents that indicated the only plans available to employees were HMOs. We also eliminated respondents that did not respond, or responded they did not know, to questions concerning administrative costs and respondents that did not report whether their health benefits programs were self-insured or insured. Finally, we only used responses from firms employing 10,000 or more employees because these firms were more comparable in size to FEHBP plans. Thus, we used 199 of the 1,943 responses for our analysis—163 from private sector firms and 36 from state and local governments. Of the 199 health insurance plans, 164 were self-insured and 35 were insured.

The questionnaire included several questions concerning health plan administration, and the employers were asked to show administrative costs as a percentage of paid claims in one of eight percentage ranges. Foster Higgins manually reviewed and performed a computer logic check of all responses but did not perform a formal verification of them.

To compare CHAMPUS and FEHBP, we interviewed and obtained documents and reports from OCHAMPUS and other Department of Defense officials and reviewed our past reports on CHAMPUS. We limited our review of CHAMPUS to administrative costs, contracting methods, performance standards and monitoring, and conversion from cost-reimbursable to competitive, fixed-price contracts. We did not attempt to evaluate whether the administration of CHAMPUS was economical and efficient.

During the design phase of our review, we asked officials of the sponsoring organizations and underwriters for the Aetna; APWU; Blue Cross and Blue Shield; GEHA; Group Health, Inc.; Mail Handlers; NALC; Postal Supervisors;

Postmasters; and Rural Letter Carriers plans to provide reasons that might explain the variation in operational expenses among the plans. We obtained data on the reasons cited by the plans for calendar year 1988 and used least squares regression analyses to determine if relationships existed between that data and the plans' operational expenses per enrollee and per $100 of benefits paid.

One of the factors cited by the plans was plan size or economies of scale. For this factor, we used each of the 25 FFS plans' enrollment as the size variable. We believe the number of claims processed would have been a better measure of the plan size, but we were not able to use that measure because the 25 plans do not count claims consistently. Although the Blue Cross and Blue Shield plan is the largest plan, its claims are processed by 71 member plans, which vary substantially in the size of their claims work load. To determine if the member plans' expenses were affected by economies of scale, we analyzed the relationship between the numbers of major medical, institutional, and dental claims processed by the member plans and their expenses per claim for processing those types of claims.

Another factor cited by the officials was the percentage of enrollees eligible for Medicare. We obtained the data for that factor from OPM for 16 of the 17 FFS plans with greater than 10,000 enrollees. OPM did not have the data for the Postmasters plan.

To analyze the relationships between plan costs and other factors, we used a written questionnaire to obtain the data, which included the number of claims processors per enrollee, claims processor salaries and turnover rates, and the size of the customer service staff compared to the size of the claims processing staff. The questionnaire was sent to the sponsoring organizations or underwriters for the Association of Civilian Technicians (ACT), Aetna, American Federation of Government Employees (AFGE), APWU, Alliance, Government Employees Benefit Association (GEBA), GEHA, Mail Handlers, National Association of Government Employees (NAGE), NALC, National Association of Postmasters (NAPUS), National Federation of Federal Employees (NFFE), National Treasury Employees Union (NTEU), Rural Letter Carriers, Postmasters, and SAMBA plans and for the Blue Cross and Blue Shield member plans for the National Capital Area and Roanoke, Virginia. We did not verify the data provided in response to the questionnaire. For these analyses, we combined the cost data for the ACT, GEBA, and NFFE plans because the underwriter (CNA Insurance Companies) reported the data for those plans on a combined basis.

We also visited the claims processing locations and met with officials of the Union Labor Life Insurance Company, the underwriter for the AFGE and NAGE plans; CNA, the underwriter for the ACT, GEBA, Mail Handlers, and NFFE plans; and the Blue Cross and Blue Shield member plans for the National Capital Area and Roanoke, Virginia.

To compare OPM's monitoring of plan performance to the monitoring of other large health benefits programs, we obtained information on the use of performance standards from OCHAMPUS. We also conducted a telephone survey on the use of performance standards by 14 state governments that we identified as having large plans that provided health benefits through the payment of claims. The 14 states are listed in table III.1.

We did our review from February 1990 to April 1991 in accordance with generally accepted government auditing standards.

1988 FEHBP Plan Administrative Costs Per Enrollee

Plans with more than 10,000 enrollees	Enrollees (in thousands)	Costs per enrollee[a]
NFFE[b]	18	$241.57
NAGE[b]	18	232.46
Postmasters	31	230.15
NAPUS	15	213.70
AFGE[b]	28	208.81
Postal Supervisors[b]	46	196.52
Blue Cross/Blue Shield	1,372	185.99
NTEU	11	177.75
APWU	121	162.23
Mail Handlers	491	156.41
SAMBA	24	152.42
Panama Canal	16	151.22
NALC	230	142.08
Aetna[b]	237	134.40
Rural Letter Carriers	46	131.00
Alliance	35	112.78
GEHA	304	109.70
Total	**3,043**	**$164.72[c]**

[a]Costs include operational expenses and profits. Premium taxes and state statutory reserves are not included.

[b]Plan no longer in FEHBP.

[c]This figure is the weighted average.

Source: GAO calculations based on data from OPM.

Comments From the Office of Personnel Management

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415

OFFICE OF THE DIRECTOR

October 15, 1991

Mr. Richard L. Fogel
Assistant Comptroller General
United States General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

Thank you for the opportunity to comment on your draft report, Federal Employees Health Benefits Program, Millions Can Be Saved By Reducing Administrative Costs. We are in agreement with many of the observations contained in your report. There is no question that the FEHB Program should be able to operate at reduced administrative expense levels. Indeed, in 1988 OPM commissioned Towers, Perrin, Forster and Crosby to do a study of the FEHB Program which cited $200 million in potential administrative savings. This is essentially the same figure noted as the maximum potential savings in your report, which gave a range of potential savings between $35 and $200 million.

We are also in agreement that the root cause is that carriers in the FEHB Program enter and remain in the Program under non-competitive, self-renewing contracts. In this environment, the real "purchaser" in the Program is not the OPM contracting office, but the individual FEHB enrollee who elects a specific plan. As mentioned in your report, individual plan decisions are driven by the relationship between specific premiums and benefits. This relationship will be but negligibly affected by the potential administrative savings available in a program where over 90 percent of the funds are disbursed as benefits. Therefore, we cannot look to either market forces or the individual's decision-making process to purchase a given plan to effect administrative savings. Clearly, any attainable savings must be realized as a result of explicit OPM actions designed to achieve them.

The structure of the current Program mitigates against success in reducing administrative costs. In a program where over 90 percent of the funds are expended on benefits, our focus to date has been on benefit and cost containment initiatives designed to reduce the rate of cost increases for benefits in the overall Program. In response to the last GAO report on the FEHB Program, Fraud and Abuse: Stronger Control Needed in Federal Employees Health Benefit Program, we are seeking additional resources to better monitor carrier operations in this area. Effective internal controls and cost containment initiatives are rarely achieved without incurring administrative costs, especially in an environment where these initiatives must be negotiated at the

same time that administrative cost ceilings are being set. In short, the real world constraints of the FEHB law and the environment it has created make many worthwhile initiatives virtually impossible.

I think it is useful and instructive to contrast this environment with that of the organizations your report used as benchmarks for estimating potential administrative savings. The vast majority of the state and private sector insurance programs encompassed by your work are self-insured programs where administrative services contracts are competitively let. In such an environment the purchaser is the employer, not the employee. Benefit provisions, cost containment initiatives, and internal controls are designed and implemented to be as effective as possible; they are not negotiated with vendors with self-renewing contracts who are concerned with the potential impact on market share and enrollee behavior. Large purchasers of health services who self-insure and who are free to compete are in a position to take full advantage of the market place and their leverage as large consumers to acquire quality services at the most reasonable price available. Moreover, all of their leverage can be focused on the quality and cost of operations. OPM proposed to be just such a consumer in its outline for a reformed FEHB Program transmitted to Congress in April 1990.

Unfortunately, OPM is not yet such a consumer, as your report makes clear. Nonetheless, your report concludes that some savings may be attainable, perhaps $35 million, less incentive payments to carriers and the costs of an augmented OPM oversight staff. While your analyses did not identify the factors underlying the wide variation in current carriers' operating expenses, your report recommends that OPM undertake an effort to do so and attempt to use the results to set more reasonable expense ceilings and incentives to achieve administrative cost reductions. We will pursue this recommendation. However, we must remain mindful that service levels cannot be disrupted. More importantly, in a program where more than 90 percent of all funds are expended for benefit payments, any administrative savings which lead to a lowering of carrier internal controls and oversight over benefit payments would constitute false economy.

If we are successful in acquiring the additional resources needed to implement the recommendations contained in your Fraud and Abuse report, we will be in a better position to make informed decisions as to the potential savings which could be realized by exerting greater oversight over administrative costs versus internal controls and benefit payments. In the interim, we have requested that carriers provide additional data to us relating to their operating performance, and I will ask our independent Inspector General to begin developing, in the course of ongoing carrier audits, the type of data that you suggest would be useful in setting more realistic administrative expense ceilings. I

hope that your staff and workpapers will be available to assist us in this endeavor. Our focus will be on the largest carriers with the highest expenses.

Thank you for your report. I found it instructive and supportive of the real solution to excessive administrative expenses, which is fundamental reform of the current FEHB Program.

Sincerely,

Constance Berry Newman
Director

Comments From the Blue Cross and Blue Shield Association

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

BlueCross BlueShield Association

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October 16, 1991

Bernard L. Ungar
Director, Federal Human
Resource Management Issues
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ungar:

We appreciate the opportunity to provide comments on the draft of the GAO report entitled "Federal Health Benefits Program: Millions Can Be Saved by Reducing Administrative Costs." We urge GAO not to release the draft report without correcting three major deficiencies which we address in our comments below: (1) The administrative cost issue is not put in proper context; the report ignores the much larger and more critical issue of FEHBP's total costs. (2) The methodological model underlying the study is too simplistic to be able to explain observed differences among carriers. (3) The report's conclusions are weak and unsubstantiated.

We do agree with two of the assumptions in the report, namely (1) administrative costs are important and are nearly always in need of review, and (2) the level of administrative costs in the FEHBP is probably higher than necessary and could be reduced without harm to the program. Our fundamental concern with the draft GAO report is that it tends to divorce the issue of administrative costs from the purpose of administration.

Our own Federal Employee Program (the "Government-wide Service Benefit Plan") is a case in point. We administer our program through 69 local Blue Cross and Blue Shield Plans. As a consequence of such decentralization our administrative costs are undoubtedly higher than they would be if we operated as one national, centralized company. On the other hand, our localized character gives us a much more powerful ability to manage the cost and quality of our benefits while maintaining a responsive level of service. As a consequence, the total cost of our program is lower, and the satisfaction of our subscribers is higher, than one would find in a "more efficient" centralized program.

The Purpose of Administrative Costs

The major objectives of the report are: (1) to determine whether plans in the FEHBP are more or less expensive to administer compared to other large employer-sponsored health benefits programs and (2) if it is found that administrative costs are higher for FEHBP plans, identify opportunities for reducing costs and estimate how much can be saved. While we feel that the report fails to adequately address either of the two objectives, we are more concerned that the draft report is focused on an issue so narrowly defined as to miss the major issues. Focusing on administrative costs has been a long-time preoccupation for the Medicare program, and a more recent concern for the CHAMPUS program. In our experience in both of these programs, higher total costs have resulted from attempting to arbitrarily reduce administrative costs. As your leader, Mr. Bowsher, testified in June before the Subcommittee on Health of the Committee on Ways and Means (referring to the results of the General Accounting Office's study of the Medicare program) "...spending too little on administration translates into spending too much on the program."

See comment 1.

Though the report's stated objectives refer to FEHBP administrative costs across the board, the report actually limits its focus to fee-for-service plans. We think that an expansion of the report to include HMO FEHBP plans would further illustrate the important interrelationship between administrative costs and benefit costs in achieving program cost-effectiveness. Typically, an HMO spends significantly more of its total income in administrative costs than does the typical fee-for-service carrier. Frequently, the more effective the HMO, the higher the administrative cost ratio. Including HMOs in the study would provide an opportunity to demonstrate that higher administrative cost ratios are not necessarily indicative of program ineffectiveness.

See pp. 16 and 17 and comment 2.

Two of the major strengths of the FEHBP are that (1) it provides a variety of consumer choices and (2) it promotes competition between fee-for-service carriers and HMOs, a competition that has intensified in the last several years. We encourage the GAO to look carefully at the value and cost of choice and at the effect of that competition and its resulting benefits to the government and to the subscribers. If the GAO chooses to look only at the relatively minor issue of administrative cost ratios, then at least look at the whole administrative cost question.

See pp. 14 and 15.

The Methodological Model is Too Simplistic

See comment 3.

In several places the draft GAO report indicates that there may be some variables that affect the level of administrative costs (variables such as benefit management programs, or risk-mix of enrollees), but that because there is not enough data on those variables, they will not or cannot be evaluated. Those variables are then excluded from the analysis. To put that another way, the report seems to assume that if there is insufficient quantitative data available on an issue, the issue must not be important. That brings to mind the old story of the inebriated fellow who, having lost his car keys on the street late at night, was seen down on his hands and knees under the street lamp. He admitted to a policeman that he thought he had lost his keys somewhere else, but he was looking under the street lamp "because the light is better here!"

See pp. 16 and 17.

Administrative costs and benefits costs are interrelated and cannot be separated when considering a program designed to minimize total costs in a health benefits plan. Innovations in holding down benefits costs, such as Managed Care, PPO's and other cost containment activities, which have a direct effect on reducing utilization, require increased administrative effort. Thus, a successful total cost reduction strategy can result in smaller increases in benefit expenses when compared to administrative expenses over time. In other words, the transition from a relatively higher cost fee-for-service product to a lower cost managed care or PPO product requires an investment in administrative costs in order to attain the expected savings in total costs. This has been our experience in recent years.

Now on p. 42.

The GAO report takes a different view of this trend. On page 54, the report states:

> "The FFS plans' benefit costs increased by 64 percent during the six-year period while their operational expenses increased by 86 percent, or at a 34 percent higher rate than the benefits costs. The percentage increase in expenses was greater than the increase in benefit costs because at the beginning of the period, the actual expenses charged to the program were well below the ceiling amount whereas by the end of the period, the expenses charged were close to the maximum allowed."

See comment 4.

The GAO report seems to assume that the higher rate of increase in administrative expenses is an undesirable occurrence explained by the carriers' intent to push administrative costs to the ceilings rather

than as a positive indication that innovative benefit design strategies are working to reduce overall costs.

Now on p. 10.

Another troublesome assumption of the GAO report is its fundamental conclusion on page 16 of the report:

> "We believe that the administrative costs of the FFS portion of FEHBP were higher than the costs of the other large health benefits programs we reviewed primarily because the carriers were not provided incentives to reduce their operational expenses."

See p. 16.

In other words, the report concludes that carriers have substantial operational inefficiencies which can be reduced by simply providing the right incentive to reduce administrative costs. While we agree that FEHBP administrative costs could be reduced that way, we question whether such reductions would translate into program savings. The report assumes that higher levels of FEHBP administrative costs result from operational inefficiencies. In our case, attributing Blue Cross and Blue Shield FEP's higher administrative cost per benefit dollar to inefficient carrier operations is comparable to attributing Alaska's higher home heating costs per month to energy inefficient homes. Just as there are other factors, such as climate, which influence Alaskan heating costs, so too there are other environmental factors which influence administrative expenses in Blue Cross and Blue Shield FEP.

Now on pp. 27 and 28.

One of these factors is the presence of other coverage, such as Medicare, which results in a reduced benefit payout with the increased administrative effort associated with coordination of benefits. This, in turn, contributes to a higher administrative cost ratio. The report indicates, on page 27, that OPM explained this effect to GAO; however, the report goes on to state:

> "Although we agree that FEHBP's administrative costs could have been higher for enrollees covered by Medicare than for other employees, we do not believe that this was the major reason for the large cost differences between FEHBP and the other programs. Contrary to what OPM officials believed, almost 80 percent of the private, state, and local government programs included in our comparison also covered retirees aged 65 and over. We assume that those individuals would also have been eligible for Medicare."

See p. 28.

We are seriously concerned with the offhanded manner in which the report dismisses a very significant factor which impacts the administrative cost ratio. While we understand that other programs

cover retirees, we seriously doubt if any of these programs replicate the enrollment experience of the Blue Cross and Blue Shield Federal Employee Program, where six out of every ten enrollees is an annuitant. And our Medicare-eligible annuitants receive additional benefits not available to our non-Medicare eligible subscribers. This is no small factor. In order to accurately analyze appropriate levels of administrative costs, all relevant factors which influence those costs must be included in the methodological model. A model which first excludes a major component, HMO plans, and then essentially attributes all administrative cost variances of the remaining fee-for-service plans to carrier operational inefficiencies while failing to measure the effect of other relevant cost factors, is at best too simplistic. A more appropriate and comprehensive model might result in the use of measures, such as administrative cost per claim or administrative cost per member, weighted by intensity of utilization, which would better measure the cost-effectiveness of administrative cost behavior.

See pp. 18 and 19.

See pp. 17 and 18.

Furthermore, comparisons of administrative costs between FEHBP carriers and Administrative Services Only (ASO) plans such as CHAMPUS or private sector self-insured plans are misleading. Generally, the administrative costs of the ASO plans do not reflect the costs of benefit design and development, actuarial services, or provider arrangements. While these costs are part of any health benefits program, they are not borne by ASO carriers, whereas these costs are borne by underwriters such as the FEHBP Plans. FEHBP Plans also bear some of the cost of effective employee communications in a competitive market.

Another methodological concern is inferential. The report highlights the fact that the CHAMPUS administrative cost experience changed significantly after converting from cost reimbursement contracts to competitive fixed priced contracts. The clear implication is that the change in contract form is what lowered costs. The report does not mention that during the same time period Medicare contractors reduced their costs per claim even further than did the CHAMPUS contractors, without any change in contract form. Without a more carefully constructed analytic model, which considers factors like electronic technology, many hypotheses could be generated to explain such variances.

See comment 5.

Incidentally, the report also implies that CHAMPUS was delighted by its clear success in reducing administrative costs. One must wonder then why CHAMPUS went on to develop a totally new approach -- one which sought to shift the underwriting risks as well as the total cost

See comment 6.

management challenge -- back to the private sector. Congressional concerns blocked the Defense Department from using the new approach nationwide, so the CHAMPUS reform initiative was confined to an experimental area (California and Hawaii). Evaluations of that experiment are not focused on administrative cost ratios.

The Conclusions Are Weak and Unsubstantiated

See comment 7.

We take strong exception to the conclusion reflected in the title of the report that "millions can be saved by reducing administrative costs." An understanding of the fundamentals of the total cost structure of the health benefits industry could support a different conclusion: the arbitrary reduction of administrative costs is likely to lead to higher health benefits expenses, which will more than exceed any savings from reduced administrative costs. For this reason, we also take exception to all the quantitative estimates contained in the report because these figures do not reflect the true expected cost results that would be produced by a methodological model which reflects the interaction of all the factors that affect administrative costs.

See pp. 16 and 17.

Concluding Comments

We realize that the GAO was asked by the Post Office and Civil Service Committee to assume that FEHBP will be transformed into a self-insured, third-party administrator model for the fee-for-service benefits while keeping the HMOs in the program. As our testimony before that Committee has emphasized, we believe that such a model would be a serious mistake -- for the Federal beneficiaries and for the government. I will not here repeat our arguments on that issue, except in one respect.

See pp. 14 and 15.

As I noted above, FEHBP has evolved to the point of stimulating strong competition between fee-for-service carriers and HMOs, competition which is being waged on issues of cost, benefits, and service. The program's administrative costs are probably higher as a result, but both the government and its employees and annuitants are benefitting -- from lower total premium costs, more choice, and better service. If the GAO is going to focus on administrative costs, then please do look at the benefits derived.

As we have elsewhere argued, FEHBP competition could be made even better, and more cost effective, if the government adjusted its contributions to each Plan to reflect enrolled risk. That would, of

course, require even more administrative expense, but the payoff in total FEHBP efficiency could be terrific. Alternatively, if the GAO must stick with the self-insurance assumption, then please do look at what the government and the beneficiary population will get for it. Look closely at CHAMPUS and Medicare and the consequences of their lower administrative costs. Look at the efficiency of their entire program, and the consistency and quality of their service, and the range of choice available to their beneficiaries, and the total cost impact of there being only one party at risk.

We cannot speak for other carriers, but we who administer the Government-wide Service Benefit Plan are very sensitive to administrative cost questions. Our internal budgeting and performance incentive programs are designed to promote better performance at lower cost. We are doing better; we could do better yet, and we will. Our reasons for that are competitive. We are convinced that our long-run survival and success depend on our being more cost-effective than our competitors. Ultimately, that is the very best dynamic to rely on if you want to see administrative costs and benefit costs that are worth every penny.

See p. 16.

One final point. We do agree with the GAO related to OPM's resources. OPM has a significant and very challenging responsibility to manage the FEHBP to maximize its total cost effectiveness. In our experience, OPM does not have the resources adequate to do that job, and that is yet another reflection of the government's propensity to "control administrative costs" without careful consideration of their relation to total program costs.

We appreciate the opportunity to comment on the draft report, and we hope that our comments will enhance the final report.

Sincerely,

James N. Gillman
Vice President

JNG/dh/swh

The following are GAO's comments on the Blue Cross and Blue Shield Association's October 16, 1991, letter.

GAO Comments

1. The Comptroller General's statement[1] quoted by Blue Cross and Blue Shield pertained to substantial cuts in the Medicare contractors' budgets for activities to prevent fraud, waste, and abuse of program funds. For many years, we have been suggesting that Medicare contractors' payment safeguards be adequately funded. However, we also have recommended a number of actions to improve the efficiency and effectiveness of those safeguards.[2]

2. We believe the exclusion of HMOs from our review was appropriate for the reasons stated on page 70. However, we revised page 1 to clarify that the scope of our review was limited to FFS plans. Additionally, we believe that the analysis of the relationship between administrative costs and program effectiveness suggested by Blue Cross and Blue Shield would require more than the inclusion of HMOs in our comparison of administrative cost ratios. It would also require the determination and comparison of the relative effectiveness of the FFS and HMO plans in providing health benefits.

3. We revised pages 6 and 33 to clarify that variables we were unable to analyze because of insufficient data might have affected the individual plan's costs.

4. We agree that the increase in administrative costs might have been partially attributable to activities to contain benefit costs. However, as of January 1992, Blue Cross and Blue Shield had not responded to our October 1991 request for information on the cost of, and savings from, its activities for the period 1982 through 1988.

5. We agree with Blue Cross and Blue Shield that the Health Care Financing Administration (HCFA) and its contractors have kept Medicare's administrative costs relatively low without changing to fixed-price contracts. We also agree with Blue Cross and Blue Shield's preceding statement that efforts to control Medicare's administrative costs resulted in an increase in the program's total costs. In 1986, we reported that HCFA had not set its contractors' "cost caps" on the basis of efficiency standards that would have enabled it to consider individual contractor circumstances and

[1]Medicare: Further Changes Needed to Reduce Program Costs (GAO/T-HRD-91-34, June 13, 1991).

[2]Medicare: Cutting Payment Safeguards Will Increase Program Costs (GAO/T-HRD-89-06, Feb. 28, 1989).

use the caps to control payments to inefficient contractors.[3] We believe the application of efficiency standards is appropriate regardless of whether costs are low—as in Medicare—or high—as in FEHBP. Although we agree with Blue Cross and Blue Shield that FEHBP's administrative costs could be controlled without using fixed-price contracts, in our opinion, the payment of a fixed price would be a more efficient way to procure the program's administrative services. Fixed-price payments would eliminate the oversight needed to assure the effectiveness of the cost controls. Also, the carriers would not have to account for their expenses, and the government would not have to audit those expenses.

6. The CHAMPUS Reform Initiative is a "managed care" demonstration project to test a major change in the way health care is provided to military beneficiaries. As Blue Cross and Blue Shield noted, the project shifts some of the financial risk of providing health care from the government to private insurers, which is similar to a change proposed for FEHBP in H.R. 1774. However, OCHAMPUS has continued to use competitive, fixed-price contracts and establish quality assurance standards that the contractors must adhere to.

7. We revised the title to more accurately represent the report's contents.

[3]Funding of Contractors for Medicare Claims Processing (Statement of Michael Zimmerman, Associate Director, Human Resources Division Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives; Apr. 22, 1986).

Comments From the Mail Handlers Benefit Plan

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

Mail Handlers Health Benefit Plan

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September 30, 1991

Mr. Larry H. Endy
Assistant Director
U.S. General Accounting Office
Room 3150
441 G Street, N.W.
Washington, D.C. 20548

BY HAND

Re: Comments on GAO Draft Report on FEHBP Administrative Costs

Dear Mr. Endy:

The Mail Handlers Benefit Plan ("MHBP" or "Plan") and the CNA Insurance Companies, its underwriter and administrator, appreciate this opportunity to comment on the U.S. General Accounting Office's ("GAO") draft report on Federal Employees Health Benefits ("FEHB") Program administrative costs.

GAO studied the administrative costs incurred by the twenty-five fee for service ("FFS") plans that participated in the FEHB program in 1988. GAO found that its task was complicated (if not, in our view, rendered infeasible) because

> "little analysis [previously] had been done of the [FFS plan] carriers' expenses and workload information reported by the carriers was too limited and inconsistent to use for determining the reasons for variations in plan costs, [or for] determining whether an individual carrier's expenses were reasonable or excessive. . . ."

Now on pp. 7 and 8.

(Draft Report, p. 12; see also id., p. 35). Nevertheless, because GAO found an apparently large discrepancy between the administrative costs of FEHBP FFS plans and those of other large employer sponsored programs, as reported in an unscientific survey,[1/] it has concluded, at least preliminarily, that FEHBP

See comment 1.

1/ GAO derived its administrative cost ratios for private sector and state and local government employers from a 1988 A. Foster

(continued...)

Now on pp. 3-4. and 10-11.

FFS plan administrative expenses can be reduced through the establishment of appropriate incentives, such as the CHAMPUS program's method of compensating claims processors on a firm fixed price basis (Id., pp. 5-6, 16-18).

See p. 19.

In our view, GAO's findings are based on inaccurate assumptions about the FEHB program and on irrelevant and incomparable administrative cost ratios derived from obsolete information. Its conclusions, as a result, are essentially erroneous. We agree with GAO that further economies can be achieved in the administration of the FEHB program. As we have stated repeatedly since 1980, many antiquated enrollment, eligibility, payroll office reconciliation, OPM data directives, and audit management practices that add enormous administrative burdens and costs for FEHB FFS plan carriers and underwriters require modernization. GAO, however, has focused its attention on other matters that, as we discuss below, offer the unpleasant prospect of false economies for the generally well managed and successful FEHB program.

Now on p. 40.

See comment 2.

See comment 3.

To begin with, GAO makes much ado about the fact that FFS plan carriers are reimbursed for their actual administrative expenses up to a ceiling (see, e.g., pp. 47-48 (quoting Federal Acquisition Regulation ("FAR") provisions for cost reimbursement contracts)). GAO encourages OPM to begin paying a fixed fee for FEHB FFS plan administrative services. However, due to its limited focus on administrative expenses, GAO has lost sight of the fact that FEHB FFS plan contracts are fixed price contracts with annual price redetermination through experience rating (48 C.F.R. § 1616.102).

GAO also tends to ignore the fact that FEHB FFS carriers and underwriters are not reimbursed for their actual costs. They are reimbursed for their actual allowable costs as determined under

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Now on pp. 70-71.

1/(...continued)
Higgins survey. GAO states in its draft report (pp. 103-04) that the survey's sampling method was not statistically valid and that the survey responses were not verified. We suggest that a great deal of uncertainty associated with this draft report (see pp. 10-11 below) would have been avoided if GAO had obtained the annual financial reports (Form 5500) that these private sector plans file with the Internal Revenue Service and which are available for public inspection at the U.S. Department of Labor. We expect that similar reports also are available from the state and local governments.

the FAR/FEHB Acquisition Regulation ("FEHBAR") cost principles (48 C.F.R. Chap. 1-31 & Part 1631). Those cost principles are not accounting principles or standards; they are Government policies that establish what kinds of costs the Government, as a business, will accept and reject (notwithstanding the fact that the costs that the FAR cost principles address, with few exceptions, are considered legitimate business expenses for all other purposes, including federal income taxation). See M. Rishe, Government Contract Costs, p. 1-4 (1983).

Thus, FEHB FFS carriers and underwriters cannot receive Government reimbursement for various substantial and legitimate administrative costs that the FAR cost principles limit or exclude, e.g., necessary travel costs that exceed Federal Travel Regulation per diem restrictions (see 48 C.F.R. § 1-31.205-46), and must comply with onerous cost reimbursement contractor record keeping requirements. Fixed price contractors usually are not subject to such limitations and obligations. See 48 C.F.R. § 31.102 (FAR cost principles are to be used as guidelines for pricing fixed price contracts; negotiating agreements on individual cost elements is not required); see also M. Rishe, supra, p. 3-16: "[R]eimbursement [under fixed price contracts usually] is not based upon the extent of allowable costs incurred by the contractor during performance." Therefore, GAO should recognize that reimbursing FEHB FFS plan carriers and underwriters for their allowable administrative expenses up to a ceiling is a limitation specially imposed upon -- and not a blessing for -- these carriers and underwriters.

The fixed price nature of the entire FEHB FFS plan contract transfers a substantial and, from CNA's perspective, all too real economic risk from the Government to the contractor. The U.S. Office of Personnel Management ("OPM") and the FFS plan carrier/underwriter annually negotiate a fixed price (or premium rate) for plan coverage. Following the timetable established by OPM regulations , the 1992 negotiations began in late March 1991 with the OPM call letter for benefit and rate proposals due on May 31, 1991, and concluded in August 1991. Carriers and their underwriters are obliged to conduct the 1992 price negotiations without adequately developed claims experience data for 1991. This is a peculiarly risky underwriting practice that FEHB FFS plan carriers and underwriters must accept every year.

If the negotiated fixed price produces subscription income that is inadequate to fund plan benefits and administrative expenses, then the carrier or the underwriter, if the plan is insured, must step in to fund the deficit. This is not merely a theoretical point as GAO's report repeatedly and erroneously suggests (see

See comment 4.

Now on pp. 3 and 35.

See comment 5.

See comment 6.

Draft Report, pp. 4 ("The carriers have a limited insurance risk...."), 38 (describing the underwriters as "middlemen").

CNA has furnished me with the attached Table I showing that in 1988, CNA underwrote three other FEHB FFS plans -- the NFFE, GEBA, and ACT Plans. Those plans had a combined deficit that year of over $10,000,000. In 1989, those plans plus the Postal Supervisors Plan which CNA began to underwrite that year suffered a combined deficit of $25,000,000. No doubt GAO assumes that through experience rating CNA was able to recoup these losses in 1990. See GAO Report GGD-89-102, "Federal Compensation: Premium Taxes Paid by the Health Benefits Program," pp. 3-4 (August 1989). That assumption is, however, plainly invalid.

Experience rating is not a cure-all for insurers. Experience rating can work when the plan has the financial resources to survive the deficit year and it has insureds who are willing to compensate the insurer for its loss by accepting higher premiums/reduced benefits in the following year. Underwritten plans, because of the financial strength of their commercial underwriters, do have the financial resources to endure deficit years.[2/] FEHB enrollees, however, do not have to accept the higher premiums/benefit reductions necessary to recoup such deficits in the following year(s) and instead may opt out of the plan during Open Season. Excessive rate increases, as shown by the history of the FEHB program since 1980, produce enrollment shifts that result in increased, rather than recouped, losses for the carrier or underwriter.

This very predicament caused CNA to terminate the ACT, GEBA, and NFFE plan underwriting contracts in deficit positions that were not covered fully by plan contingency reserves. CNA informs me that it suffered a financial loss of over $28,000,000 on the NFFE underwriting account alone. As Table I shows, this loss incurred by CNA, standing alone, eclipsed the service charges totalling $2,027,000 earned from these four plans throughout the period that CNA underwrote them.[3/]

2/ We wish to stress that the FEHB program has enjoyed the underwriting support of strong insurers such as CNA, Mutual of Omaha, Prudential, Metropolitan, and Blue Cross/Blue Shield of the National Capital Area.

3/ Ironically, OPM's weighted guideline approach to negotiating service charges (48 C.R.R. § 1615.905(a)(2)) prohibits OPM from awarding FEHB FFS plans any more than .2% of incurred claims and administrative expenses to compensate them for their underwriting risk.

See comment 7.

GAO also should be aware that CNA is not the only FEHB FFS plan underwriter that found itself in this unenviable position. Indeed, we understand that every commercial insurer that has participated in the FEHB program since 1980, except for Aetna, has shared this fate at one time or another. In 1988, Mutual of Omaha testified before Congress that five of the nine FEHB FFS plans that it underwrote had incurred a combined loss to Mutual of $34 million in 1987 and that this loss was continuing to mount in 1988. Mutual's representative stated that "Business prudence dictates that we disengage from this loss environment even though we may be foregoing a possibility of future recovery opportunities." Federal Employees' Health Benefits Program: Hearings Before the Subcomm. on Compensation and Employee Benefits of the House Comm. on Post Office and Civil Service, 100th Cong., 2d Sess., pp. 412-13 (1988)(statement of Robert S. Murphy). Mutual later announced that it lost $50 million from underwriting these FEHB FFS plans. The gravity of this risk is further evidenced by the fact that the number of FFS plans has decreased from twenty-five in 1988 to fifteen today due to the financial risks for underwriters inherent under the present contracting system.

See p. 15.

Now on p. 35.

This underwriting risk, which is not present in the administrative services only arrangements that typify the CHAMPUS and large private sector plan settings (see Draft Report, p. 39), creates certain imperatives for FEHB FFS plan carriers and underwriters -- (1) to build and maintain a solid enrollee base and steady subscription income stream by holding rates down and improving benefits to the maximum feasible extent and (2) to pay claims timely and accurately and provide excellent customer service. FEHB FFS plans such as the MHBP accomplish these goals by spending money on, for example, state of the art computerized claims processing systems, extensive employee training, and large customer service and claims processing staffs. Indeed, as shown on the attached Table II, over the period 1984 through 1991, CNA's staffing and workload for the MHBP have more than doubled. Yet CNA's operating expenses per unit of MHBP work have decreased over the same period by 10% unadjusted for inflation, and by 30% when viewed in constant 1984 dollars.

Table II also discloses that 1988 was the year in which MHBP enrollment reached a plateau after a period of rapid growth. To keep pace with this growth, CNA constantly was expanding its facilities, placing new data processing systems on line, and upgrading existing systems. Moreover, 1988 was a particularly high cost year for CNA in which it, among other things, moved its entire MHBP operation to a new facility and developed a more cost efficient, data entry based dental claims examining process known as DESC. In fact, CNA's 1988 administrative expenses for the

See comment 8.

See comment 9.

Now on p. 48.

MHBP exceeded the allowable expense ceiling by $8,000,000 (see also Attachment A hereto). Thus, CNA spent more of its own money on unreimbursed administrative expenses for the MHBP than it earned as an MHBP service charge in 1988 (see Draft Report, p. 61).

The investment represented by these administrative expenditures has produced considerable successes that GAO should weigh in its analysis. In 1990 and 1991, the MHBP substantially improved its High Option benefits (where 94% of its enrollees are concentrated), and it will do so again in 1992. See 1990, 1991, and 1992 MHBP brochures sections describing how the Plan changes each year (Attachment B hereto). Such across the board benefit increases currently are unknown in the private sector where self insured employers are furiously shifting health benefit costs from themselves to their employees. See 1990 Foster Higgins Health Care Benefits Survey Report 1: Indemnity Plans, pp. 11-13 (Attachment C hereto).

Most significantly in terms of program cost savings, over the same period -- 1990 to 1992 -- the MHBP's High Option premiums have increased at an average annual rate of only 8.33%. (The benefit improvements account for at least 50% of such annual increases.) See Table III accompanying this letter. This is well below the national trend of over 20% for medical indemnity plans. See 1990 Foster Higgins Health Care Benefits Survey Report 1, supra, p. 2 ("1991 marks the fourth year running that the trend applied to traditional medical indemnity benefit plans has exceeded 20 percent.") (Attachment C hereto). Moreover, because the MHBP High Option is factored in the "Big Six" Government contribution formula (5 U.S.C. § 8906), this low rate of premium increases could very well produce a savings for the Government greater than any GAO projected savings to be generated by its proposed administrative cost reductions that, in our view, are not capable of producing benefit cost savings (see Draft Report, pp. 89-93).

See comment 10.

Now on pp. 63-65.

See p. 15.

It therefore comes as no surprise to us that FEHB FFS plan administrative costs exceed other programs such as CHAMPUS and self insured private sector plans that utilize claim processors which have no stake in the plan's financial success. FEHB FFS plans, such as the MHBP, must sustain higher spending levels in order to satisfy the imperatives of paying valuable benefits timely and accurately and providing excellent customer

service.4/ Those FEHB FFS plans that do not spend prudently can and will drop out of the FEHB program. Unquestionably, the administrative cost cutting devices proposed by GAO that would turn FEHB FFS carriers and underwriters into mere claims processors are shortsighted and, at best, will produce false economies that will increase overall FEHB program cost and cause employee dissatisfaction (see p. 13 below discussing the CHAMPUS program). However, we will now show that GAO has grossly overestimated the differential between the MHBP's administrative cost ratio and those of other FEHB FFS plans and of other large employer sponsored plans.

See comment 11.

GAO has computed the MHBP's 1988 administrative cost ratio to be $8.69 per $100 of benefits (Draft Report, p. 31). GAO maintains that this ratio compares unfavorably with the weighted average cost ratio of $7.53 for the seventeen largest FEHB FFS plans (id.) and significantly exceeds the administrative cost ratios for large private sector employer plans -- $4.74 -- large state and local government plans -- $4.65 -- and CHAMPUS -- $4.66 (id., p. 25). In GAO's view, this comparison illustrates inefficiencies in the FEHB program. GAO, however, is comparing apples to oranges.

Now on p. 31

See comment 12.

Now on pp. 26 and 27.

We submit at the outset that ratioing administrative costs to each $100 of benefits paid is not a valid measure of the cost efficiency of a particular plan or of the FEHB program. Administrative expenses are driven by the amount of work performed and, as we have shown, the incentive to invest in the Plan's success. GAO has not been able to account for either

See pp. 18 and 19.

4/ The Draft Report states on page 65 that

> [E]nrollees are not provided information concerning the percentage of their premiums spent for administrative costs.

and adds the following example:

> [E]nrollees may choose the Mail Handlers because its premiums are among the lowest of the FFS plans even though the percentage of its premium spent for operational expenses is among the highest of the plans.

Now on p. 51.

See comment 13.

GAO gives too little credit to the intelligence of federal and postal employees. They can see the forest for the trees and recognize that administrative expense statistics are meaningless in the abstract. It is value for the premium dollar that counts, and value is defined in terms of benefits and customer service.

factor. Even though the MHBP's claim volume annually grows by leaps and bounds due to the addition of new benefits such as its prescription drug benefit, Table II shows that CNA's administrative cost per unit of work has decreased steadily over the past seven years. GAO should acknowledge such efficiency.

See pp. 17 and 18.

In any event, GAO must recognize that the MHBP's cost ratio is increased over other plans by the inclusion of substantial benefit cost containment expenses.[5/] In 1988, CNA incurred benefit cost containment charges for the MHBP that totalled $8,230,769 or over 10% of the MHBP's "administrative expenses" (see Attachment A hereto). Private sector plans customarily account for such charges as benefit expenses, and in 1988 CHAMPUS was paying for its benefit cost containment services, e.g., Peer Review Organizations ("PROs"), through an interagency agreement with the Health Care Financing Administration ("HCFA") (see Draft Report, p. 83). By subtracting this $8 million dollar sum from the MHBP's $77 million dollar administrative expense total for 1988, and then recalculating the MHBP's administrative expense ratio with the MHBP's correct administrative expense total, the MHBP's ratio decreases from $8.69 to $7.75 per $100 of benefits.

See comment 14.

Now on pp. 59 and 60.

MHBP administrative costs are further increased by structural factors that elevate CNA's workload over those of most other

See p. 18.

5/ For purposes of computing this ratio, GAO properly excluded premium taxes that CNA paid on MHBP business because CHAMPUS and large private sector employer sponsored, self insured plans are not subject to such taxes. (CNA paid no state statutory reserves.) GAO similarly should adjust the combined FEHB FFS plan cost ratio of $8.57 that it recites at several points in the Draft Report (p. 5), particularly in light of the fact that in 1990 Congress preempted the application of state premium tax laws to FEHB plans. Backing out premium taxes and state statutory reserves from that calculation produces a cost ratio of $7.70.

See comment 15.

Now on p. 3.

It is worth adding that underwritten FEHB FFS plans were paying state premium taxes and funding state statutory reserves in 1988 at Congress' direction. In 1978, when Congress amended the FEHB Act to preempt state law (5 U.S.C. §8902(m)(1)), it expressly placed premium taxes and state statutory reserves outside of the scope of the new preemption provision. See Blue Cross & Blue Shield v. Department of Banking, 613 F. Supp. 188, 192 (M.D. Fla. 1985) ("It is clear from both the House and Senate reports that Congress . . . intended to preempt all state insurance laws except those regulating premium taxes and mandatory reserves."). OPM and the carriers should not be tarred for their compliance with Congressionally established policy.

plans. The MHBP offers both a High Option and a Standard Option. Its High Option includes dental benefits coverage that reimburses virtually all dental service charges without any deductible (see, e.g., 1988 MHBP Brochure, pp. 15-16 (Attachment D hereto)). Both options provide first dollar coverage for most outpatient services, including surgery, home and office visits, and diagnostic x-ray and laboratory procedures, without a large annual deductible (see id., pp. 7, 12, 13). These structural factors permit MHBP enrollees to submit a separate claim on every medical and dental charge that they and their family members incur. As a result, CNA processes a large volume of low dollar claims for the MHBP.

The resulting administrative cost impact is illustrated by comparing the administrative cost ratios for the MHBP's High and Standard Options in 1988. We calculate that the Standard Option's cost ratio was two dollars or 25% less than the High Option's.[6/] The only difference between the MHBP's High and Standard options in 1988 was that High Option offered dental benefits.

Most other plans avoid the administrative cost burden associated with this claims avalanche. Those plans either limit their dental benefits and/or impose high dollar, front end deductibles on medical benefits. Such deductibles encourage plan participants to hold, or "shoebox," their bills until that deductible is satisfied and then send their plan one large claim. The MHBP necessarily processes more claims than these high deductible plans to pay $100 of benefits on average. The MHBP nevertheless prefers to shoulder the administrative burden and, as a service to its enrollees, pay them benefits as soon as possible after they incur health care debts. Moreover, the incremental administrative costs associated with the MHBP's benefit design do not materially affect Plan premium rates which, as we have shown, are exceptionally reasonable and stable (see pp. 6-7 above and Table III accompanying this letter).

GAO admittedly lacked the information necessary to account for the effects of these structural factors.[7/] Instead it adjusted

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6/ The Standard Option's ratio was $5.94 (exclusive of premium taxes and benefit cost containment expenses), and the High Option's ratio was $7.84.

7/ We cannot comprehend GAO's failure to find a strong relationship between a plan's operational expenses and such factors as the number of claims examiners per enrollee, claims

(continued...)

Now on p. 27.
See comment 16.

the ratios for such effects on an estimated basis by increasing the FEHB FFS plan benefit dollar denominator by 15% (Draft Report, p. 26.) In our view, such adjustment is inadequate and belies the validity of the ratio based analytical approach. Nevertheless, GAO should recognize that making this adjustment reduces the MHBP's ratio from $7.75 to $6.74 per $100 of benefits paid.

Our analysis of GAO's ratio comparison process becomes complicated at this point because we cannot determine, from reading either GAO's draft report or the 1988 Foster Higgins Survey, whether the various ratios compared by GAO are calculated based on equivalent administrative cost pools. We know that the MHBP's cost ratio is inclusive of all operating expenses and the service charge. We are confident, however, that those pools for the comparison private sector and state and local government groups are far from all inclusive.

The 1988 Foster Higgins Survey on which GAO relied disavows any knowledge of which costs compose the administrative cost pools for its survey respondents (p. 25):

> Employers using Blue Cross organizations to pay claims experienced, on average, higher administrative costs (6.7 per cent of paid claims) than employers using commercial carriers (6.0 percent of paid claims).
>
> * * *
>
> Employers using TPAs report significantly lower administrative costs (4.7 percent of paid claims) than those using commercial carriers or Blue Cross plans.
>
> * * *
>
> Employers who paid claims in-house exhibited the lowest administrative expense, averaging 4.5 percent of paid claims. It should be noted, however, that services generally included in the administrative expense of the commercial carriers and Blue Cross plans -- actuarial forecasting, medical consultation, [plan consultants such as Foster Higgins itself, legal fees,] etc.-- must often be purchased separately by clients who are self-administered or use TPAs. The cost for

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1/(...continued)
examiners' salaries and turnover rates and the size of the customer service staff compared to the size of the claims examination staff (Draft Report, p. 35). Staffing size and compensation levels necessarily impact the operating expenses of personnel intensive operations such as benefit plan administration.

Now on p. 33.

Mr. Larry H. Endy
September 30, 1991
Page 11

these services may or may not have been included in their administrative cost data.

Now on p. 35.

See comment 17.

Now on pp. 70 and 71.

GAO and Foster Higgins both report that most large employers are self insured (Draft Report, p. 39; 1988 Foster Higgins Survey, p. 23) and often use third party administrators or self administer their plans (1988 Foster Higgins Survey, p. 24). Consequently, we can conclude that the aggregate data on the 10,000+ employee groups of public and private employers that GAO extracted from this survey to make its calculation (see Draft Report, pp. 102-04) surely understates their administrative expenses by failing to include substantial professional consultant and in-house benefit department expenses.

See comment 18.

See p. 19.

We also know that FEHB plan underwriting and administration is much more onerous than private sector group underwriting and administration. As GAO is aware, private sector employers generally self insure to reduce the burdens of government regulation. In contrast, FEHB FFS plan carriers and underwriters are federal government contractors. Thus, virtually all facets of the FEHB program -- accounting guidelines, procurement regulations, eligibility and enrollment regulations, OPM and GAO data requests auditing practices and premium and claims reconciliation -- are far more costly and complex than in the private sector.[8/] For example, CNA requires a 200 person staff to handle eligibility and enrollment for the MHBP, a costly function that it would not confront in the private sector or CHAMPUS settings. Under these circumstances, we were pleased to discover that the MHBP's cost ratio is consistent with the range for insured plans stated in the 1988 Foster Higgins survey, and we reiterate that our cost per unit of work ratio steadily has been improving since CNA assumed MHBP administration responsibilities. This demonstrates the Plan's administrative efficiency.

See comment 19.

See p. 19.

GAO also stresses the apparent gap between the cost ratios of the MHBP and two other large FEHB FFS plans -- the GEHA and NALC plans. In our view, such gap proves nothing because GAO again is comparing apples to oranges. To begin with, neither the NALC nor

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See comment 20.

Now on pp. 52 and 53.

8/ In fact, GAO would have OPM impose a new recordkeeping requirement -- that FEHB FFS plan carriers and underwriters maintain administrative cost data by function performed as well as by object class (Draft Report, pp. 68-70). No FEHB FFS plan carrier or underwriter maintains an accounting system set up to capture cost data by function performed. Indeed, retention or dividend formulas that insurers use to underwrite private sector plans do not break out costs even by object class.

See comment 21.

the GEHA plans offered benefit cost containment programs in 1988 on the scale of the MHBP's. The MHBP benefit structure also generates a proportionately higher claims volume than the NALC or GEHA plans because it pays first dollar benefits on virtually all outpatient charges and it offers the most comprehensive dental benefits package in the FEHB program. (The GEHA plan does not offer a comprehensive dental benefits package at all.) However, the most significant differentiating factor, in our view, is that the Mail Handlers Union took the prudent step of insuring its plan. GEHA and the NALC have not and instead rest the financial security of their plans on their own limited financial resources.

See comment 5.

Now on pp. 35 and 36.

There is undoubtedly a substantial cost associated with insuring the MHBP that GEHA and NALC have avoided. We recognize that GAO is enamored with self insurance and ruefully refers to insurers as middlemen (Draft Report, pp. 39-40).[9/] However, GAO fails to recognize the difference between the self insured plans included in the Foster Higgins study that have the strong financial backing of substantial, Fortune 500 business corporations and plans such as NALC and GEHA that, at best, have the backing of a labor union with limited financial resources. Indeed, GEHA, which once was sponsored by the now defunct railway postal workers union, lacks even that support. Where would organizations such as GEHA and NALC obtain funding for a $17,000,000 deficit such as that funded by CNA for the NFFE Plan in 1989 (see Table I)?[10/] The short answer is that they could not, and neither could the Mail Handlers Union alone. That is the reason the Mail Handlers chose to retain an underwriter, and why

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Now on p. 36.

9/ The Draft Report (p. 41) states that

> Another example [of the middleman] is the Mail Handlers' union which charged the program more than $300,000 for its expenses. We recognize that all of these organizations' expenses would not have been eliminated because some of their functions would have had to have been performed by OPM or other claims processing contractors.

See p. 36.

Although we disagree strongly with GAO's characterization, we wish to make GAO aware that since 1988, the Mail Handlers' Union annual expenses charged to the FEHB Program have been reduced to $150,000 as the Union and CNA strive to achieve maximum coordination and efficiency.

10/ GAO should not consider this to be a hypothetical scenario. OPM nearly terminated the NALC's contract for the 1991 calendar year due to the plan's financial instability.

in 1985 when Congress reopened the window for new employee organization plans to join the FEHB program, it saw fit to require that those plans be underwritten (5 U.S.C. § 8903a).

See p. 15.

We also question why GAO chooses to hold CHAMPUS out as a model for others to follow. CHAMPUS has been in utter turmoil over the past several years as U.S. Department of Defense ("DOD") officials have been forced repeatedly to obtain huge supplemental CHAMPUS appropriations from Congress. See Washington Post article captioned "Military Health Costs Rupture as Doctors Deploy to Gulf," p. A21 (Jan. 1, 1991) (Attachment E hereto). If the FEHB program were self insured, Congress would face the annual lengthy funding struggles in the FEHB program which currently occur in the CHAMPUS and Medicare programs, and federal and postal employees and annuitants would wind up with a uniform, but constantly changing, medical plan filled with reduced benefits that anger them and cost shifting approaches utilized in Medicare and CHAMPUS that enrage the medical community. See Washington Post article captioned "The Pentagon Hill 'Policy Shootout,'" p. A17 (June 1, 1990)(Attachment F hereto). Moreover, GAO recognizes in its report that the CHAMPUS method for selecting claims processors has resulted in an oligopoly, not a free marketplace, that produces problems for DOD officials and CHAMPUS beneficiaries whenever a claims processor change occurs (see Draft Report, pp. 43-45). In our view, given the MHBP's and the FEHB program's many recent successes, GAO and DOD should consider modelling CHAMPUS after thriving FEHB plans such as the MHBP, and in fact CHAMPUS through its Reform Initiative has been starting to insure its program.

Now on pp. 37 and 38.

Finally, we address the most fundamental flaw with the GAO's draft report -- its fixation on administrative costs incurred in 1988. We suggest that GAO give thought to withholding this draft report from publication until it reviews up to date information that will permit it to analyze FEHB plan administrative costs in the context of the FEHB Program's successful progress over the past few years. As GAO knows, the Congress and OPM have implemented many FEHB Program modifications proposed by Towers, Perrin, Foster & Crosby in their 1986 report, by the Congressional Research Service in its 1988 report, and by GAO in several reports. Such modifications are too numerous to catalogue in this letter but include mandatory benefit cost containment, preemption of state premium taxes, implementation of letter of credit arrangements, enhanced coordination of benefits with Medicare, new OPM regulations on involuntary plan terminations and improved OPM regulations on minimum standards

See comment 22.

for FFS plans and carriers (55 Fed. Reg. 9109, 22,891), and OPM/carrier progress toward standardizing certain benefits.[11]

The success of this evolutionary FEHB Program reform process should not be discounted. OPM recently announced that "[h]ealth insurance benefits for federal employees have been expanded [for 1992] to meet today's health needs while continuing for the second year in a row a reversal of runaway [premium] increases." See OPM press release captioned "Increased Enrollee Benefits, Low Rate Increases Highlight 1992 [FEHB] Program Changes, dated September 15, 1991 (Attachment G hereto). GAO's proposals if adopted would impair this progress by discouraging carrier/underwriter creativity and energy in adapting to the rapidly changing health insurance environment.

See comment 23.

The evolutionary FEHB reform process has finetuned the workings of the most competitive health insurance marketplace in the world. Competition, as it should, is now producing enhanced benefits and stable premiums that are the envy of CHAMPUS, the private sector and the state and local government sector. We know that Foster Higgins could survey every health plan in this country and not find another like the Mail Handlers Benefit Plan that from 1990 to 1992 has substantially increased benefits across the board while holding premium increases to an average of under 10% annually. GAO should credit Congress, OPM, and the FEHB FFS plans and underwriters for these accomplishments.

Thank you for your consideration of these comments.

Sincerely,

Jerome J. Palermino
Executive Director

cc: Richard E. Ruddick, VP, CNA FEHB Plans Division

11/ This point ties back into the administrative cost inflation issue. Carriers and underwriters are obliged to expend many hours of personnel and computer processing time to implement certain measures mandated by Congress and OPM under the FEHB reform banner -- e.g., requiring FEHB FFS plans to pay Medicare benefits on certain hospitalizations and to offer a smoking cessation benefit. Unilaterally imposed administrative cost burdens on this large scale are unheard of in the private sector setting. We suggest that Congress and OPM more carefully consider administrative cost impact before they issue such mandates.

TABLE I

HOW SERVICE CHARGE COMPENSATES CNA FOR INSURANCE RISK
($000's)

	ACT	NFFE	GEBA	PSHBP
1987				
SERVICE CHARGE	1	215		
GAIN (LOSS)	(87)	(4,918)		
1988				
SERVICE CHARGE	2	301	52	
GAIN (LOSS)	(28)	(8,146)	(1,786)	
1989				
SERVICE CHARGE	4	283	67	600
GAIN (LOSS)	24	(17,180)	(1,449)	(6,405)
1990				
SERVICE CHARGE		97 *	53	352
GAIN (LOSS)		(361)*	514	6,109

* - STANDARD OPTION ONLY; HIGH OPTION TERMINATED 12/31/89

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TABLE II

MAILHANDLERS BENEFIT PLAN
SELECTED DATA

25-Sep-91 MH GAO1
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	1984	1985	1986	1987	1988	1989	1990 *	1991 FORECAST *
AVERAGE ENROLLEES	400,667	445,876	482,646	503,267	516,094	507,012	518,904	513,000
MAIL RECEIPTS	3,161,326	3,766,420	4,731,902	5,367,835	6,033,856	6,224,532	7,481,237	8,469,000
CLAIM SUBMISSIONS	3,047,836	3,659,133	4,572,931	5,161,641	5,816,105	5,957,728	7,822,279	9,588,000
DCN'S PROCESSED	3,157,336	3,776,116	4,730,644	5,370,474	6,035,953	6,162,097	7,301,515	8,950,000
CLAIMS PROCESSED	3,068,019	3,665,446	4,423,934	5,048,803	5,741,028	5,842,156	7,558,603	9,265,000
CLAIMS PAID	2,551,270	2,915,118	3,455,003	3,849,951	4,234,131	4,391,187	5,084,091	6,232,000
CHECKS ISSUED	2,597,193	2,894,801	3,460,382	3,920,359	4,380,051	4,493,833	5,002,485	6,132,000
TELEPHONE INQUIRIES	350,480	450,543	617,612	738,526	907,199	861,896	1,145,345	1,118,000
CORRESPONDENCE	127,416	135,445	194,054	268,228	283,178	287,225	279,189	343,000
UNITS OF WORK:								
DCN'S PROCESSED	3,157,336	3,776,116	4,730,644	5,370,474	6,035,953	6,162,097	7,301,515	8,950,000
TELEPHONE INQUIRIES	350,480	450,543	617,612	738,526	907,199	861,896	1,145,345	1,118,000
TOTAL	3,507,816	4,226,659	5,348,256	6,109,000	6,943,152	7,023,993	8,446,860	10,068,000
STAFFING								
CLAIMS DEPARTMENT	254	316	333	434	463	402	394	471
ALL OTHER	322	386	495	547	715	702	782	982
TOTAL	576	702	828	981	1,178	1,104	1,176	1,453
CONSUMER PRICE INDEX (AVG)	103.9	107.6	109.6	113.9	118.3	124.0	130.6	137.2

* 1990 AND 1991 FORECAST INCLUDE PRESCRIPTION DRUGS.

MAILHANDLERS BENEFIT PLAN 25-Sep-91 MH_GA01
SELECTED DATA 02:28 PM

	1984	1985	1986	1987	1988	1989	1990 *	1991 FORECAST *
**ACTUAL ADMINISTRATIVE EXPENSES (000'S):								
OPERATING EXPENSES	$35,709	$39,863	$49,166	$60,513	$71,995	$69,421	77,382	94,663
COST CONTAINMENT	0	3,725	4,173	4,982	8,231	2,717	3,228	15,724
TOTAL	$35,709	$43,588	$53,339	$65,495	$80,226	$72,138	$80,610	$110,387
OPERATING EXPENSE DOLLARS PER:								
MAIL RECEIPT	$11.30	$10.58	$10.39	$11.27	$11.93	$11.15	$10.34	$11.18
CLAIM SUBMISSION	11.72	10.89	10.75	11.72	12.38	11.65	9.89	9.87
DCN PROCESSED	11.31	10.56	10.39	11.27	11.93	11.27	10.60	10.58
CLAIM PROCESSED	11.64	10.88	11.11	11.99	12.54	12.30	10.24	10.22
CLAIM PAID	14.00	13.67	14.23	15.72	17.00	15.81	15.22	15.19
CHECK ISSUED	13.75	13.77	14.21	15.44	16.44	15.45	15.47	15.44
TELEPHONE INQUIRY	101.89	88.48	79.61	81.94	79.36	80.54	67.56	84.67
CORRESPONDENCE	280.26	294.31	253.36	225.60	254.24	259.78	277.17	275.99
ENROLLEE	89.12	89.40	101.87	120.24	139.50	136.92	149.70	184.53
OPERATING EXPENSE (1984 DOLLARS) PER:								
MAIL RECEIPT	$11.30	$10.22	$9.85	$10.28	$10.48	$9.34	$8.23	$8.46
CLAIM SUBMISSION	11.72	10.52	10.19	10.69	10.87	9.76	7.87	7.48
DCN PROCESSED	11.31	10.19	9.85	10.28	10.48	9.44	8.43	8.01
CLAIM PROCESSED	11.64	10.50	10.54	10.93	11.01	10.31	8.14	7.74
CLAIM PAID	14.00	13.20	13.49	14.34	14.93	13.25	12.11	11.50
CHECK ISSUED	13.75	13.30	13.47	14.08	14.44	12.94	12.31	11.69
TELEPHONE INQUIRY	101.89	85.44	75.47	74.74	69.70	67.49	53.75	64.12
CORRESPONDENCE	280.26	284.19	240.19	205.80	223.29	217.67	220.50	209.00
ENROLLEE	89.12	86.33	96.57	109.68	122.52	114.73	119.10	139.74
OPERATING EXPENSE PER UNIT OF WORK	$10.18	$9.43	$9.19	$9.91	$10.37	$9.88	$9.16	$9.40
OPERATING EXPENSE (1984 DOLLARS) PER UNIT OF WORK	$10.18	$9.11	$8.71	$9.04	$9.11	$8.28	$7.29	$7.12

* 1990 AND 1991 FORECAST INCLUDE PRESCRIPTION DRUGS.

** INCLUDES THOSE EXPENSES CHARGED TO THE CONTRACT AS WELL AS THOSE EXCEEDING THE EXPENSE LIMITATION, AND INCLUDES THE ORGANIZATION AND UNDERWRITER COMBINED.

MAILHANDLERS BENEFIT PLAN
SELECTED DATA

25-Sep-91
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	1984	1985	1986	1987	1988	1989	1990 *	1991 FORECAST *
ACTUAL UNDERWRITER DIRECT ADMINISTRATIVE EXPENSES (000'S) :								
CNA DIRECT	$24,066	$27,882	$34,698	$42,695	$53,737	$53,261	60,760	72,465
COST CONTAINMENT	0	3,725	4,173	4,982	8,231	2,717	3,228	15,724
TOTAL DIRECT	$24,066	$31,607	$38,871	$47,677	$61,968	$55,978	$63,988	$88,189
CNA DIRECT EXPENSE DOLLARS PER:								
MAIL RECEIPT	$7.61	$7.40	$7.33	$7.95	$8.91	$8.56	$8.12	$8.56
CLAIM SUBMISSION	7.90	7.62	7.59	8.27	9.24	8.94	7.77	7.56
DCN PROCESSED	7.62	7.38	7.33	7.95	8.90	8.64	8.32	8.10
CLAIM PROCESSED	7.84	7.61	7.84	8.46	9.36	9.44	9.04	7.82
CLAIM PAID	9.43	9.56	10.04	11.09	12.69	12.13	11.95	11.63
CHECK ISSUED	9.27	9.63	10.03	10.89	12.27	11.85	12.15	11.82
TELEPHONE INQUIRY	68.67	61.89	56.18	57.81	59.23	61.80	53.05	64.82
CORRESPONDENCE	188.88	205.85	178.81	159.17	189.76	199.31	217.63	211.27
ENROLLEE	60.06	62.53	71.89	84.84	104.12	105.05	117.55	141.26
CNA DIRECT EXPENSE (1984 DOLLARS) PER:								
MAIL RECEIPT	$7.61	$7.15	$6.95	$7.26	$7.82	$7.17	$6.46	$6.48
CLAIM SUBMISSION	7.90	7.36	7.19	7.55	8.11	7.49	6.18	5.72
DCN PROCESSED	7.62	7.13	6.95	7.25	7.82	7.24	6.62	6.13
CLAIM PROCESSED	7.84	7.35	7.44	7.71	8.22	7.91	6.40	5.92
CLAIM PAID	9.43	9.24	9.52	10.12	11.15	10.16	9.51	8.81
CHECK ISSUED	9.27	9.30	9.51	9.93	10.78	9.93	9.66	8.95
TELEPHONE INQUIRY	68.67	59.76	53.26	52.74	52.02	51.78	42.20	49.08
CORRESPONDENCE	188.88	198.78	169.51	145.20	166.67	167.00	173.14	159.99
ENROLLEE	60.06	60.38	68.15	77.39	91.45	88.02	93.51	106.97
CNA DIRECT EXPENSES PER UNIT OF WORK	$6.86	$6.60	$6.49	$6.99	$7.74	$7.58	$7.19	$7.20
CNA DIRECT EXPENSE (1984 DOLLARS) PER UNIT OF WORK	$6.86	$6.37	$6.15	$6.38	$6.80	$6.35	$5.72	$5.45

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MAILHANDLERS BENEFIT PLAN
SELECTED DATA

25-Sep-91 02:28 PM MH_GA01

	1984	1985	1986	1987	1988	1989	1990 *	1991 FORECAST *
PER ENROLLEE:								
MAIL RECEIPT	7.89	8.45	9.80	10.67	11.69	12.28	14.47	16.51
CLAIM SUBMISSION	7.61	8.21	9.47	10.26	11.27	11.75	15.13	18.69
DCN PROCESSED	7.88	8.47	9.80	10.67	11.70	12.15	14.13	17.45
CLAIM PROCESSED	7.66	8.22	9.17	10.03	11.12	11.13	14.62	18.06
CLAIM PAID	6.37	6.54	7.16	7.65	8.20	8.66	9.84	12.15
CHECK ISSUED	6.48	6.49	7.17	7.79	8.49	8.86	9.68	11.95
TELEPHONE INQUIRY	0.87	1.01	1.28	1.47	1.76	1.70	2.22	2.18
CORRESPONDENCE	0.32	0.30	0.40	0.53	0.55	0.53	0.54	0.67
PER EMPLOYEE:								
MAIL RECEIPT	5,488	5,365	5,715	5,472	5,122	5,638	6,362	5,829
CLAIM SUBMISSION	5,291	5,212	5,523	5,262	4,937	5,396	6,652	6,599
DCN PROCESSED	5,481	5,379	5,713	5,474	5,124	5,582	6,209	6,160
CLAIM PROCESSED	5,326	5,221	5,343	5,147	4,874	5,111	6,427	6,376
CLAIM PAID	4,429	4,153	4,173	3,925	3,594	3,978	4,323	4,289
CHECK ISSUED	4,509	4,124	4,179	3,996	3,718	4,071	4,254	4,220
TELEPHONE INQUIRY	608	642	746	753	770	781	974	769
CORRESPONDENCE	221	193	234	273	240	242	237	236
PER CLAIMS DEPT. EMPLOYEE:								
MAIL RECEIPT	12,446	11,919	14,210	12,368	13,032	15,484	18,988	17,981
CLAIM SUBMISSION	11,999	11,580	13,733	11,893	12,562	14,820	19,854	20,357
DCN PROCESSED	12,430	11,950	14,206	12,374	13,037	15,329	18,532	19,002
CLAIM PROCESSED	12,079	11,600	13,285	11,633	12,400	14,035	19,184	19,671
CLAIM PAID	10,044	9,225	10,375	8,871	9,145	10,923	12,904	13,231
CHECK ISSUED	10,225	9,161	10,392	9,033	9,460	11,179	12,697	13,019
PER CLAIMS DEPT. EMPLOYEE PER DAY:								
MAIL RECEIPT	50	48	57	50	52	62	76	72
CLAIM SUBMISSION	48	46	55	48	50	59	79	81
DCN PROCESSED	50	48	57	50	52	61	74	76
CLAIM PROCESSED	48	46	53	47	50	56	77	79
CLAIM PAID	40	37	41	36	37	44	52	53
CHECK ISSUED	41	37	41	37	38	45	51	52

The following are GAO's comments on the Mail Handlers Health Benefit Plan's September 30, 1991, letter.

GAO Comments

1. During the design phase of our review, we determined that it would not be feasible to use the administrative cost information reported on Form 5500, which allowed employers to report the cost information for multiple benefits plans, such as health, life, and disability insurance, on a combined basis. And, although we did not attempt to contact states for cost information on health benefits programs under their individual jurisdictions, we contacted several other sources that we believed might have compiled that information on a nationwide basis, such as the Health Insurance Association of America. In our judgement, the data we obtained from Foster Higgins was the most comprehensive and reliable data available.

2. We believe that the fixed-price characteristics of the FFS plan contracts are adequately discussed on page 40. Although we agree the contracts are considered fixed-price from an overall standpoint, this characterization does not alter the fact that the contracts provide for reimbursement of the carriers' actual and allowable operational expenses.

3. We recognized on page 40 that the reimbursement of carrier operational expenses is limited to allowable costs. However, we modified references to the reimbursement of expenses throughout the report to clarify that the expenses had to be both actual and allowable. While the Mail Handlers plan did not specifically support or oppose our recommendation that OPM consider paying the carriers operational expenses on a fixed-price rather than a cost-reimbursable basis, it pointed out that under a fixed-price reimbursement, the carriers would not have to comply with government cost principles that exclude or limit costs or record-keeping requirements. We modified page 41 to incorporate this point.

4. In our opinion, the risk of loss is limited as long as the insurer continues to underwrite the plan. However, we revised the text on page 3 to clarify that insurers of employee organization plans that were in deficit positions when the insurance contracts were terminated have incurred losses. We also deleted the reference to the carriers' limited risk on page 34 and 35.

5. Page 36 was revised to clarify that "middleman" referred to the sponsoring organizations, not the underwriters.

6. The 1988 and 1989 CNA deficits referred to by Mail Handlers were annual operating losses that affected the plans' year-end financial positions, which reflect cumulative net operating gains and losses and other factors, such as income on investments. Because the financial statements for the terminated plans had not been finalized, we were unable to determine the actual underwriting losses incurred by CNA for those plans. However, our review of earlier statements filed for those plans and the plans' contingency reserves indicated that when CNA terminated the underwriting contracts, it lost money on the ACT, GEBA, and NFFE plans but not the Postal Supervisors plan.

7. We recognize that some employee organization plan underwriters have experienced losses when they or the plan sponsors terminated the underwriting contracts. However, contract terminations have not always resulted in losses for the underwriters.

8. The text on page 43 was revised to state the amount of expenses not reimbursed under the negotiated ceilings.

9. Attachments A through G and table III are not reproduced in this report because they were voluminous and generally contained publicly available information.

10. The potential savings discussed in this report could be used to reduce the total premium rates charged for the plans whereas the potential savings referred to by the Mail Handlers plan would not affect total premiums. Any savings from a reduction in the government's share of premium costs because of the inclusion of Mail Handlers in the "Big Six" formula would be offset by a corresponding increase in the share of premium costs paid by enrollees.

11. We disagree with Mail Handlers that our recommendations to the OPM Director would result in false economies and enrollee dissatisfaction. On the contrary, we believe the available evidence indicated that our recommendations will better ensure that the administrative funds paid to carriers are used efficiently and that the quality of the services provided is maintained.

12. The administrative cost ratios shown in the report for the nonfederal programs were revised. The average cost ratios for private sector and for state and local government programs were replaced by the average cost ratios for private, state, and local government programs that were insured

and self-insured to show the cost differences between the two types of administrative structures.

13. We did not intend to imply that enrollment decisions should be based on administrative cost levels rather than premium values. The text on page 51 was modified to clarify that enrollees are not likely to be aware of the cost levels when they choose their health benefits plans.

14. The cost of the cost-containment services performed for CHAMPUS under the interagency agreement with HCFA was included in CHAMPUS' cost ratio.

15. Although we agree with Mail Handlers that CHAMPUS and the self-insured nonfederal programs were not subject to premium taxes, we believe it is appropriate to include those expenses in FEHBP's cost ratio because the insured nonfederal programs would have been subject to them. Also, if FEHBP is restructured, Congress may have to reconsider whether it would be appropriate for FEHBP to pay, or be exempted from paying, premium taxes.

16. We adjusted the FFS plans' total benefit costs by 15 percent to illustrate a weakness associated with the ratio of administrative costs to benefit payments. However, we did not measure the benefit values of the various FFS plans and therefore believe it would be inappropriate to adjust the ratios for the individual plans by that percentage.

17. The draft of this report was revised to show separate cost ratios for the nonfederal programs that were insured and self-insured. The Foster Higgins statement referred to by the Mail Handlers plan only applies to the self-insured programs administered by the employers or third-party administrators. It does not apply to the self-insured programs administered by commercial insurers and Blue Cross and Blue Shield or the insured programs in our review. Because only 43 (26 percent) of the 164 self-insured programs in our review were administered by the employers or third-party administrators, who may or may not have reported their total costs, we do not believe that the cost ratio for the self-insured programs could have been substantially understated.

18. The "government burden" generally cited as a major reason for self-insuring a health benefits program is state-mandated health benefits, which FEHBP plans are not required to provide.

19. Foster Higgins reported that the insured programs, which responded to its survey, had administrative costs of 6.6 percent of benefits paid. Most of those programs were much smaller than the Mail Handlers plan. The average cost for programs with more than 10,000 enrollees was 5.7 percent of benefits paid. In contrast, Mail Handlers cost percentage of 11.2 percent (including operational expenses, profits, and premium taxes) was 96 percent higher than the percentage for other large insured programs.

20. In our opinion, if OPM continues to reimburse FEHBP carriers for expenses incurred, the carriers should be required to account for those expenses in a manner that would enable OPM to evaluate the carriers' administrative efficiency.

21. Our review did not address whether FEHBP should be restructured as a self-insured program or evaluate the financial soundness of having some employee organization plans underwritten by the sponsoring organizations while others are required to be underwritten by third-party insurers.

22. We reviewed the plans' 1988 administrative costs because that was the latest cost information available at the time. A discussion of the change in the way the plans' benefit cost-containment activities are funded has been added to page 17. In our opinion, the preemption of premium taxes is adequately recognized in appropriate places throughout the report. We do not believe the other changes mentioned, such as the minimum standards of conduct that require carriers to follow prudent business practices, have had a major impact on plan administrative costs.

23. The administrative services provided by the carriers include benefit and premium determinations as well as claims processing and other functions related to the provision of health benefits by FFS plans. Thus, we disagree with Mail Handlers' assertion that our recommendations for ensuring that funds made available to the carriers for providing administrative services are used efficiently would discourage them from striving to expand the health costs covered and/or keep premium rate increases low.

Comments From the American Postal Workers Union, AFL-CIO

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

American Postal Workers Union, AFL-CIO
HEALTH PLAN DEPARTMENT
P. O. Box 3279, Silver Spring, Maryland 20901
WILLIAM J. KACZOR, JR.
Director

September 30, 1991

Mr. Bernard L. Ungar
Director, Federal Human Resource Management Issues
GAO United States General Accounting Office
700 4th Street, NW - Room 3858
Washington, DC 20548

Dear Mr. Ungar:

The APWU Health Plan **(APWU HP)** welcomes the opportunity to comment on the GAO report "Federal Health Benefits Program."

1. **ADMINISTRATIVE EXPENDITURES ARE NOT IN THEMSELVES A MEASURE OF EFFICIENCY OR EFFECTIVENESS**

See comment 1.

First, if FEHB Reform is seriously being considered at this time, we are troubled that the report emphasizes administrative costs, which comprise only 7% of total FEHB program costs, rather than focusing on plan design considerations that account for 93% of FEHB program costs.

See pp. 16 and 17.

Furthermore, experts are now finding that to save health care dollars you must spend additional administrative dollars to better manage costs. It would be a mistake to drive down administrative costs without regard to the need to emphasize cost containment. We are concerned that the emphasis in the report on containing administrative costs may be short-sighted. If administrative costs are severely constrained an administrator will be forced to cut programs that are not solely for the purpose of paying claims. There are many administrative programs that yield a dramatic return on investment.

The **APWU HP** has discovered that spending administrative dollars saves premium dollars. We have developed managed care activities where the return on investment has been as great as $10 for every dollar spent. Examples of these programs are detecting possible provider fraud, developing

provider networks and discounts, and providing member educational programs that emphasize wellness. The **APWU HP** could further reduce administrative costs by eliminating managed care programs, but for every administrative dollar saved, premiums would increase by more than a dollar.

We share the concern that FEHB plans should operate cost efficiently. We are very aware of our administrative costs. During the last several years we have implemented many efficiencies that have resulted in the reduction of **APWU HP** administrative costs. The **APWU HP's** administrative costs per $100 of paid claims is estimated to be $5.93 ($435,000,000 paid claims $25,800,000 service and administrative costs) in 1991. This is an 18% drop from the **APWU HP's** 1988 costs, and a 29.8% drop when factoring in inflation over the past three years.

2. **CONCERN OVER THE ACCURACY AND COMPARABILITY OF THE DATA IN THE STUDY**

See pp. 17 and 18.

While available data indicates that administrative costs may be higher in FEHB than in other public and private sector health plans, we are concerned whether there is data available to make accurate comparisons. Any effort to set target administrative cost levels for FEHB plans should begin with a careful analysis of the relationship of administrative costs to necessary or desirable programs and services.

See comment 2.

FEHB plans perform many functions that are not performed by other insurance programs, or if performed by other programs, are cost accounted for in other ways. For example, the **APWU HP** performs administrative activities that include: enrollment, managed care, employee education, claims administration, and actuarial services. For example, the **APWU HP**, like many other FEHB plans must interact with more than 750 federal agencies to enroll members. Many non-FEHB insurance programs obtain their membership eligibility information from only one source. Other programs, such as Medicare, fund hospital review from a separate administrative budget; however, this is part of a FEHB plan's administrative budget.

See comment 3.

See pp. 19 and 27-28.

There are several factors mentioned in this study that do account for higher administrative cost in the FEHB program. One example is the need to

coordinate with Medicare. The **APWU HP** spends considerable administrative dollars determining a retiree's Medicare eligibility and then coordinating benefits with Medicare. If we calculate the administrative costs based on dollars claimed rather than dollars paid the **APWU HP's** administrative costs would have been $3.93 in 1988. If we did not pay secondary to Medicare, our claims payments would have increased by $159,000,000 in 1988. This is an example of how administrative dollars are used to contain **APWU HP** expenditures.

See pp. 18, 19, and 72.

Based on analyses performed, cost comparisons should focus on the administrative cost per claim rather than the cost for administering each $100 of benefits. The age/sex mix of the insureds and the benefit design can significantly effect administrative costs. For example, a $10,000 claims expense could include one $10,000 hospital claim or eighty $125 prescription drug claims. The volume of claims and mix of claim type significantly influences administrative costs.

See comment 4.

Analysis of CHAMPUS data provides important information; however, there are many differences between CHAMPUS and the FEHB plans. It is our understanding that CHAMPUS administrators do not have any of the benefit setting, rate setting, and premium reconciliation responsibilities that FEHB plans have. These are costly administrative duties. Furthermore, we understand that CHAMPUS plan administrators are supported by a central administrative staff with a budget that is four times larger than OPM's, on a paid claims base that is 2.7 times smaller. For the FEHB program to be supported in a similar manner their administrative budget would need to increase by $100,000,000.

See comment 5.

See comment 6.

We also understand that CHAMPUS claims administrators are reimbursed on a per claim cost and can receive additional funding to make required system changes. FEHB plans receive a single administrative budget for performing all administrative functions. It is not clear whether this report took into account all funding used for administering the CHAMPUS program.

3. **PUBLIC POLICY REQUIREMENT THAT FEDERAL EMPLOYEES SHOULD HAVE AN EFFICIENTLY RUN HEALTH PROGRAM**

See p. 15.

Administrative costs may be higher in FEHB than in CHAMPUS or other insurance programs as a higher service level is demanded by Federal employees. Today it is difficult to attract individuals to public service. One way to attract and retain employees to federal service is by maintaining an attractive health benefit package. Some publicly sponsored programs, such as Medicaid, may provide inadequate service levels. This causes health care providers to become unwilling to provide care. The FEHB program must be administered in a manner that provides service levels that are satisfactory to federal employees.

If the program were competitively bid each year, and the least expensive plan were selected, federal employees could face a wide range of unacceptable service problems.

See pp. 15 and 16.

The **APWU HP** endorses the study recommendations to analyze carriers' costs, to establish baseline costs, and to adjust baseline costs in subsequent years if sufficient accurate and comparable data are available to do so. But the baseline costs must include activities that manage health care costs. This report looks at an important problem, but we hope that before action is taken that there will be a clear direction that will not result in sacrificing the quality of service to federal employees and an increase to the benefit payout.

Very truly yours,

APWU HEALTH PLAN

Carroll E. Midgett

Carroll E. Midgett
Chief Operating Manager

CEM/lw

The following are GAO's comments on the American Postal Workers Union Plan's September 30, 1991, letter.

GAO Comments

1. The Committee and Subcommittee asked us to review FEHBP's administrative costs as part of their in-depth, systematic analysis of the program and its need for reform. In our opinion, the efficient use of administrative funds is important even though those funds are only a small portion of the program's total cost.

2. We revised pages 6 and 33 to better recognize the program differences that could cause FEHBP's administrative costs to be higher than those of other large health benefits programs.

3. We did not have data to determine whether the self-insured nonfederal programs in our review funded some activities related to their benefits programs under separate budgets or whether the costs of those activities were included in the administrative cost ratios they reported. However, the funds spent for hospital reviews, which APWU mentioned as an example of a FEHBP plan function that may not have been included in the cost of the other programs, were included in CHAMPUS' administrative cost ratio.

4. Although we recognize that CHAMPUS contractors do not have the benefits and rate setting responsibilities mentioned by APWU per se, we believe that those responsibilities would entail work similar to that performed by OCHAMPUS in defining covered medical services and supplies and estimating benefit costs in conjunction with the budget process. The cost effect of the decentralization within FEHBP of those types of responsibilities is discussed on page 36.

5. As discussed on pages 59 and 60, over one-half of OCHAMPUS' administrative costs were for functions not performed by OPM, including services related to the processing of claims that were performed by the carriers under FEHBP's current structure. Although the amount of additional resources being sought by OPM in response to our recommendations was not available for publication in time to be included in this report (see p. 76), we believe that increase is substantially less than the $100 million estimated by APWU.

6. The cost of amounts paid to CHAMPUS' contractors for changes required by OCHAMPUS during the contract period and OCHAMPUS' administrative costs were included in CHAMPUS' administrative cost ratio.

Comments From the Group Insurance Board Panama Canal Area Benefit Plan

GROUP INSURANCE BOARD
(Panama Canal Area)
APO Miami, FL 34011

PANAMA CANAL AREA BENEFIT PLAN — W. C. BOTTIN, PRESIDENT

September 25, 1991

Mr. Larry H. Endy
Assistant Director
General Accounting Office
Room 3150
441 G Street, N.W.
Washington, DC 20548

Dear Mr. Endy:

Reference is made to your September 16, 1991 letter in which you requested comments on the GAO Draft Report covering a review of the administrative cost of the FEHBP.

Enclosed is a copy of the revised 1988 Summary Statement of FEHBP Financial Operations for the Panama Canal Area Benefit Plan filed with the Office of Insurance Programs of OPM. The revised report indicates that our 1988 ratio of administrative costs per $100 of benefits is $7.09 after an adjustment in the underwriter's administrative expenses is taken into account.

See p. 20.

The subject raised in the report is very interesting. However, it is only a small part of the problem confronting the FEHBP. I seriously doubt that implementation of the recommendations will begin to solve the high cost of health care in the Federal sector. Nor will the long awaited comprehensive reform of the FEHBP. The problem is a national one with too many special interest groups battling each other.

Should you need further information regarding our revised accounting statement, I can be reached by calling 1-800-622-2625, extension 52-7831.

Sincerely,

W. C. Bottin

Enclosure

CARRIER NAME: PANAMA CANAL AREA BENEFIT PLAN (GHG-D184) CODE: 43

SUMMARY STATEMENT OF FEHBP FINANCIAL OPERATIONS
FOR THE TWELVE MONTH PERIOD ENDING
DECEMBER 31, 1988

REVISED

	TOTAL	OPM USE ONLY
1. SUBSCRIPTION INCOME: (INCL A)		
A. RECEIVED:		
(1) SEMI-MONTHLY	34,727,390	
(2) FROM CONTINGENCY RESERVE	0	
B. ACCRUED BUT UNPAID:		
(1) BEGINNING	(2,865,000)	
(2) ENDING	3,436,000	
C. TOTAL	35,298,390	
2. HEALTH BENEFITS CHARGES:		
A. PAID (SCHEDULE 1 - PART D)	28,922,387	
B. ACCRUED BUT UNPAID:		
(1) BEGINNING	(2,623,000)	
(2) ENDING (SCHEDULE 2)	7,000,000	
C. TOTAL	33,299,387	
3. EXPENSES AND RETENTIONS:		
A. ADMINISTRATIVE EXPENSES:		
(1) ORGANIZATION (SCHEDULE 3)	0	
(2) UNDERWRITER (SCHEDULE 3)	2,119,000	
B. REFUND EXPENSES	0	
C. PREMIUM TAXES PAID & ACCRUED	1,178,608	
D. STATE STATUTORY RESERVE	0	
E. REINSURANCE EXPENSES	0	
F. SERVICE CHARGE	240,916	
G. TOTAL	3,538,524	
4. CHANGES TO SPECIAL RESERVE:		
A. GAIN (LOSS) ON SUBSCRIPTIONS	(1,539,521)	
B. INVESTMENT INCOME	411,072	
C. PRIOR PERIOD ADJ (SCHEDULE 4)	322,479	
D. REFUND OF EXCESS RESERVES	(1,158,344)	
E. SPECIAL RESERVE - BEGINNING	7,825,051	
F. SPECIAL RESERVE - ENDING	5,860,737	
G. EXCESS RESERVES (SCHEDULE 5)	1,368,277	

NOV 27 19

Major Contributors to This Report

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John A. Leitch, Assistant Director, Federal Human Resource Management Issues
Marjorie A. Hrouda, Evaluator-in-Charge
J. Chris Farley, Senior Evaluator
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Related GAO Products

Analysis of Variations in Claims Processing Costs of Fiscal Agents for the Civilian Health and Medical Program of the Uniformed Services (GAO/HRD-77-93, June 8, 1977).

Information on the Performance of Health Applications Systems, Inc. and California Physicians' Service in Processing Claims for the Civilian Health and Medical Program of the Uniformed Services (GAO/HRD-77-142, Aug. 25, 1977).

Performance of CHAMPUS Fiscal Intermediaries Needs Improvement (GAO/HRD-81-38, Feb. 2, 1981).

CHAMPUS Has Improved its Methods for Procuring and Monitoring Fiscal Intermediary Services to Process Medical Claims (GAO/HRD-85-56, Aug. 23, 1985).

Funding of Contractors for Medicare Claims Processing (Statement of Michael Zimmerman, Associate Director, Human Resources Division, Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives; Apr. 22, 1986).

Federal Compensation: Recovery of Improper Health Benefits Charges Needed (GAO/GGD-89-27, Dec. 13, 1988).

Medicare: Cutting Payment Safeguards Will Increase Program Costs (GAO/T-HRD-89-06, Feb. 28, 1989).

Federal Employees Health Benefits Program (GAO/T-GGD-89-26, May 24, 1989).

Federal Compensation: Premium Taxes Paid by the Health Benefits Program (GAO/GGD-89-102, Aug. 8, 1989).

Office of Personnel Management: Better Performance Information Needed (GAO/GGD-90-44, Feb. 7, 1990).

Medicare: Further Changes Needed to Reduce Program Costs (GAO/T-HRD-91-34, June 13, 1991).

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