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

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U.S. EMPLOYEES HEALTH BENEFITS

Status of Contractor's Nonlegislative Recommendations to Reduce Costs

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Human Resources Division

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The Honorable David Pryor
Chairman, Subcommittee on
Federal Services, Post Office
and Civil Service
Committee on Governmental Affairs
United States Senate

Dear Mr. Chairman:

This report is in response to your request that we review the status of nonlegislative recommendations to the Office of Personnel Management (OPM), contained in a recent contractor's report on the Federal Employees Health Benefits Program (FEHBP). This program currently provides health insurance to about 3.9 million enrollees (plus dependents), including about 2.4 million active federal civilian employees and 1.5 million annuitants. In fiscal year 1988, the federal government is expected to contribute an estimated $6.2 billion to the program.

The April 1988 contractor's report on FEHBP was prepared by Towers, Perrin, Forster & Crosby, Inc. (TPF&C), for OPM, the federal agency responsible for managing the program. While the report concluded that FEHBP has major problems requiring fundamental legislative restructuring, it also contained several policy changes that, in its opinion, OPM could take under its present legislative authority to alleviate some of the program's problems. TPF&C estimated that these actions could achieve program savings of at least $500 million per year.

Background

FEHBP is the largest employer-sponsored health benefit program in the United States. All active federal civilian employees, federal annuitants with 5 consecutive years of FEHBP coverage immediately preceding retirement, and their dependents are eligible to participate.

The Federal Employees Health Benefits Act of 1959 (5 U.S.C., Chapter 89) established FEHBP, effective July 1, 1960, to provide employer-sponsored health benefits to federal civilian employees and their dependents (including survivors and disabled employees). After passage of this legislation, the Blue Cross and Blue Shield Federal Employee Program and the Aetna Life Insurance Company were authorized to establish governmentwide plans. Each of these insurers was required to establish a high and low option that would be available to all FEHBP participants.

In addition, FEHBP authorized employee organizations to establish plans for members only. Initially, 13 employee organizations offered coverage to their members. In contrast with the statutory requirements of the governmentwide plans, FEHBP did not require employee organization plans to offer both high and low options. The law also required that health maintenance organizations (HMOs) be made available to FEHBP participants. Originally, 21 HMOs participated in FEHBP.

The number of options available under the program has increased dramatically during its 28-year history. By 1988, over 430 different FEHBP plans offered 460 different health benefit options. This increase is attributed to the growth in the number of HMO options offered and to the addition of new employee organization plans. Virtually any HMO may enter FEHBP. However, employee organizations not currently participating in FEHBP may participate only with specific legislative authority.

Currently, the federal government contributes 60 percent of the simple average of the premiums for individual and family coverage (using the high option where more than one option is offered) of what are known as the "Big Six" plans. The "Big Six" are the two high option governmentwide plans, and the two employee organization plans and the two HMOs with the highest enrollment.[1] For any individual plan option, the government's contribution for non-Postal Service employees and all annuitants cannot exceed 75 percent of the total premium.[2]

The Federal Employees Health Benefits Act of 1959 gives OPM the responsibility for operating FEHBP. This legislation authorizes OPM to (1) contract with qualified carriers; (2) develop regulations that enable it to negotiate benefit levels and premium rates and accept or reject a carrier's participation; (3) set minimum plan standards; (4) develop regulations for enrollee participation and termination; (5) develop regulations on open enrollment periods; (6) disseminate information on plans; (7) administer the Employee Health Benefits Fund, through which all FEHBP funds flow; and (8) regularly examine the operation, administration, and experience of FEHBP plans.

[1]Currently, the "Big Six" plans are high option Blue Cross-Blue Shield, high option Aetna, Government Employees Hospital Association, high option Mail Handlers, and the Kaiser Foundation Health Plans of Northern and of Southern California.

[2]The Postal Service contribution for active postal employees is 75 percent of the Big Six average, with a maximum limit of 93.75 percent of the premium for any individual plan option.

OPM contracted with TPF&C to perform a comprehensive examination of FEHBP and recommend a range of actions to improve the program during the 1990's. The TPF&C report, submitted to OPM in April 1988, identifies major problems in the structure and operation of the program. The report concluded that lack of competition to enter the program results in excessive costs and premiums. Plans are either included by law or excluded without regard to price, quality, or efficiency considerations. The report also noted that the government does not exercise its leverage as a large purchaser to negotiate discounts as large corporations typically do. It also concluded that problems have occurred because of the erosion of the principle of group insurance in FEHBP as people representing the same level of risk have congregated in a given plan or option. This has reduced the cross-subsidies that are possible when young and old and sick and healthy are in the same plan or option.

While TPF&C concluded that a fundamental legislative redesign of the FEHBP program is needed, it also recommended actions that it believed OPM could implement without legislative changes. TPF&C estimated that these actions would save at least $500 million per year (or about 6 percent of estimated 1988 total program costs of $8.8 billion).

Objectives, Scope, and Methodology

The TPF&C study presented seven policy changes to correct some of FEHBP's problems, which, in TPF&C's opinion, would not require a change in existing law. In response to your request we reviewed OPM's plans for addressing these policy changes.

Our review was performed from June through October 1988, primarily at the offices of TPF&C and at OPM headquarters. To determine OPM's plans, we interviewed FEHBP officials at OPM and reviewed relevant material. We also interviewed the principal author of the TPF&C report. We did not verify either the methodology or the data TPF&C used to estimate savings. Further, we did not evaluate the merits of, or the potential costs to implement, either the TPF&C nonlegislative policy recommendations or its suggestions for the legislative overhaul of the program.

TPF&C's Recommendations and OPM's Response

The nonlegislative actions recommended by TPF&C were classified under three headings: (1) benefit plan design, (2) participation and performance standards, and (3) financial arrangements.

As indicated in table 1, TPF&C presented four benefit plan recommendations: (1) to require all plans to implement a uniform set of cost containment measures, (2) to define a minimum standard of benefits for all plans, (3) to require all fee-for-service plans to offer both a high and a low option, and (4) to limit differences between high and low options. TPF&C also included in its discussion of benefit plan changes an alternative of requiring plans to use diagnosis related groups (DRGs)[3] for payment purposes. Two additional recommendations relate to participation and performance standards: (1) to terminate plans with fewer than 300 participants and (2) to require greater emphasis on demonstrated quality of service for HMOs seeking entry into FEHBP. The last recommendation deals with a financial requirement and would mandate the establishment of a letter-of-credit arrangement for fee-for-service plans. (See p. 9.)

[3]DRGs represent a system for classifying each hospital inpatient into a diagnosis category based on the patient's principal diagnosis (and primary operating room procedure for surgical DRGs). The insurer (e.g., Medicare or CHAMPUS) reimburses the hospital at a predetermined payment rate for that DRG.

Table 1: TPF&C's Recommended Nonlegislative Changes to FEHBP and OPM's Response

TPF&C recommended changes	TPF&C estimated annual savings	FEHBP problem being addressed	OPM response	OPM time frame
Benefit plan design:				
(1) Require all plans to implement uniform cost containment measures (see p. 5)	$200 to $240 million	Program inefficiency; lack of mandatory cost containment measures	Planning to retain TPF&C to perform a short-term study to estimate benefits and costs of specific cost containment measures. TPF&C to recommend which measures, if any, OPM should mandate	Apply mandated cost containment measures for 1990 benefit year
(2) Define a minimum standard of benefit for all plans, including HMOs (see p. 7)	$280 to $320 million for recommendations (2), (3), and (4) combined	Risk selection	Should be addressed by the Congress through legislative change	Not applicable
(3) Require all fee-for-service (employee organization) plans to offer high and low options (see p. 7)	See recommendation (2)	Risk selection	Should be addressed by the Congress through legislative change	Not applicable
(4) Limit differences between high and low options (see p. 7)	See recommendation (2)	Risk selection	Should be addressed by the Congress through legislative change	Not applicable
Participation and performance standards:				
(5) Terminate plans with fewer than 300 participants (see p. 8)	Savings not estimated	Program inefficiency	Is enforcing	Calendar years 1988 and 1989
(6) Revise standards for HMO entry into FEHBP, with emphasis on demonstrated quality of service (see p. 8)	Savings not estimated	Program inefficiency	Planning to study but lacks accepted measures of quality	None established
Financial arrangements:				
(7) Letter-of-credit arrangement (see p. 9)	Savings not estimated	Program inefficiency; (reserves) excessive outlays from federal budget	Planning to adopt recommendation	Proposing an effective date of January 1, 1989

Benefit Plan Design Recommendations

Require Plans to Implement Uniform Cost Containment Measures

TPF&C recommended that OPM require all plans to implement uniform measures that have proven to be effective in containing health care costs. TPF&C estimates that uniform, programwide enforcement of cost containment measures could produce a 3-percent reduction in claims cost, for an annual savings of $200 to $240 million. According to OPM

officials, each FEHBP plan may voluntarily employ cost containment measures, such as precertification[4] and case management. Although OPM encourages the FEHBP carriers to consider using additional cost containment measures, some plan administrators fear that the use of various cost containment measures may result in the loss of enrollees to other plans that use less stringent measures.

OPM plans to retain TPF&C to perform a short-term study that would estimate the benefits and costs of specific cost containment measures. Shortly thereafter TPF&C would recommend which measures are the most promising and whether OPM should mandate each FEHBP plan to adopt them. OPM officials estimate that the earliest mandated cost containment measures would apply to FEHBP would be for the 1990 benefits year.

TPF&C noted that the Congressional Budget Office (CBO) reported on the alternative of using DRGS in FEHBP as a cost containment measure. CBO estimates that if DRGS are implemented in calendar year 1990, the first-year saving would be $230 million. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) has recently adopted DRGS, following their adoption in the Medicare program in 1983.

OPM plans to retain a consultant in fiscal year 1989 to study the feasibility of applying DRGS to FEHBP. The study will review literature on the effectiveness of DRGS in CHAMPUS as well as in the state of New Jersey. It will examine issues that would need to be resolved before applying DRGS to FEHBP, including identifying data sources OPM could use to establish DRG payment rates.

Other Benefit Plan Design Recommendations

TPF&C made three other benefit plan design recommendations (see table 1), all of which address enrollees' ability to switch plans during the annual open season. The lack of a standard level of benefits, coupled with the method of determining the government's contribution, according to OPM officials, has resulted in many low health risk individuals switching from the original Blue Cross-Blue Shield and Aetna plans into other plans. These other plans generally provide coverage at lower rates and, therefore, lower employee contributions.

[4]Precertification for inpatient hospital admissions refers to actions taken by an insurer to determine whether an enrollee should be admitted to a hospital as an inpatient. The primary purpose of this screening is to eliminate unnecessary hospitalizations and to shift patients to a lower cost outpatient setting when appropriate. One example of precertification is obtaining a second opinion before surgery.

As FEHBP is currently structured, enrollees can move from plan to plan without regard to preexisting health conditions. For example, an enrollee anticipating the need for inpatient hospital care over the next year may switch into a more expensive plan providing the most complete hospitalization insurance. The same enrollee may then switch back to a lower cost plan for the following year. This is called risk selection and refers to enrollees in one level of risk clustering in a specific plan.

Risk selection can increase the total costs of FEHBP to the federal government. If enrollees who expect to need extensive medical services switch into health plans that pay a higher percentage of the costs of providing these services, the aggregate costs of all plans will increase. These increased costs will result in higher premiums the following year to both the government and enrollees. In addition, by switching plans, the lifetime maximum benefits for each plan can be circumvented, since the ceiling is not cumulative across plans.

TPF&C made three nonlegislative benefit plan design recommendations to address risk selection:

- Define a minimum standard of benefits for all plans, including HMOs.
- Require all fee-for-service (employee organization) plans to offer high and low options.
- Limit the differences in benefits between high and low options to differences in deductibles, copayments, and perhaps covered services.

These recommendations are intended to reduce risk selection by reducing differences in the overall benefit package across plans. This reduction in the differences across plans would, in turn, reduce the incentive for enrollees to switch plans during the annual open season. The TPF&C report estimates that risk selection is resulting in additional FEHBP annual costs of between $280 and $320 million, or up to 4 percent of total program costs. OPM officials agreed that savings of this magnitude could be expected to result from these actions.

OPM agrees that these recommendations could be implemented without changing the law but believes that instead they should be considered as part of a major legislative overhaul of FEHBP. For example, the TPF&C recommendation to define a minimum standard of benefit for all plans (standardized benefit package) is likely to raise coverage at the low end and, therefore, raise total costs to FEHBP unless benefits are reduced at the top end. But the latter would be difficult to implement because of the expected opposition from enrollees. However, OPM officials believe

that through legislation it would be possible to design a new hospital/ medical core package with add-on options for additional coverage. The agency is studying this issue in the context of an overall reform of FEHBP.

Participation and Performance Standards

Terminate Plans With Fewer Than 300 Participants

TPF&C recommends that OPM terminate plans with fewer than 300 participants (table 1). Currently, each FEHBP plan, after being in the program for 3 years, is required to enroll at least 300 participants. Strict enforcement of this rule should reduce OPM's administrative burden by reducing the number of plans that OPM would need to monitor, negotiate with, and collect information on during annual open enrollment periods.

OPM expects to terminate four HMOs from participation in FEHBP at the end of calendar year 1988 because of their failure to enroll at least 300 participants. OPM estimates that about 20 additional HMOs will be terminated for the same reason by the end of calendar year 1989 (after they have been in the program for 3 years).

Revise Standards for HMO Entry to Assure Quality of Care

In 1988, out of 460 options offered through FEHBP, 427 were HMO options. The number of HMO options has increased substantially from the 21 offered at the inception of FEHBP in 1960. TPF&C recommends that OPM revise standards for HMO entry into FEHBP, with emphasis on demonstrated quality of service. OPM officials pointed out a problem with this recommendation, since there is a lack of accepted measures of quality. OPM began examining this issue in September 1988, within the context of overall system reform.

Financial Arrangements

Establish a Letter-of-Credit Arrangement

TPF&C believes that FEHBP reserve levels are unnecessarily large since, rather than having one aggregate reserve pool for all plans, OPM maintains a separate reserve account earmarked for each plan in the program and each of the FEHBP plans maintains its own additional reserves. TPF&C recommends the establishment of a letter-of-credit (LOC) arrangement for all fee-for-service plans under which LOCs would substitute for plan-held reserves (table 1). This LOC would represent a promise to remit to the FEHBP plan funds as needed to pay claims.

TPF&C recommended that OPM pay enrollment premiums to the health plans through a LOC. This LOC payment method would allow carriers to receive recurring premium payments by drawing against a LOC and, according to OPM officials, would improve the government's cash management practices. The Department of the Treasury would establish the LOC at a financial institution designated by each carrier.

OPM is planning to adopt this recommendation, having published proposed rules in September 1988. This LOC arrangement, which would become effective on January 1, 1989, is designed to minimize the potential for misuse of these funds and reduce OPM's policing responsibility.

Summary

TPF&C estimates that savings of about $500 million per year should be attainable if its recommendations to OPM for nonlegislative changes to FEHBP were adopted. The recommendation for a uniform programwide enforcement of cost containment measures (estimated annual savings of $200 to $240 million) will be studied further by OPM and TPF&C. If implemented, the earliest that mandated cost containment measures would apply to FEHBP would be for the 1990 benefits year.

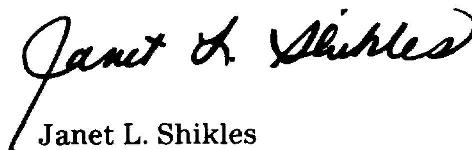
The CBO cost containment measure, discussed by TPF&C, to implement a DRG-based payment system will also be studied. OPM is planning to retain a consultant to study the feasibility of such a change.

Finally, while OPM agrees that TPF&C's recommendations to reduce risk selection (estimated annual savings of $280 to $320 million per year) could be addressed administratively, it believes that the Congress

should consider this issue as part of a major legislative overhaul of FEHBP.

As requested by your office, we did not obtain written agency comments on a draft of this report. However, we discussed its contents with OPM officials and incorporated their comments where appropriate. As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to the Director of OPM and other interested parties and will make copies available to others on request. The major contributors to this report are listed in appendix I.

Sincerely yours,



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