United States General Accounting Office

135787

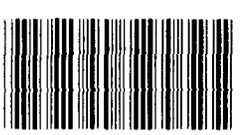
GAO

Report to the Chairman, Legislation and National Security Subcommittee, Committee on Government Operations, House of Representatives

May 1988

GOVERNMENT CONTRACTORS

Criteria Needed for Allowable Employee Health Care Costs



042120/135787

GAO/HRD-88-27

GAO

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

Human Resources Division

B-222052

May 12, 1988

The Honorable Jack Brooks
Chairman, Legislation and
National Security Subcommittee
Committee on Government Operations
House of Representatives

Dear Mr. Chairman:

Because of your expressed interest in the issue, we are sending you our report on the need to ensure that employee health care costs paid by the government under negotiated contracts are reasonable.

Specifically, the report (1) compares the health care costs of the government's 10 largest contractors to those of other manufacturing industries and the government work force, (2) discusses the primary reason for the cost differences found, and (3) evaluates the adequacy of the internal controls over allowable compensation costs established in federal procurement regulations. We are making a recommendation for changes in federal procurement regulations that would improve the government's ability to determine the reasonableness of contractors' health insurance and other compensation costs.

We are sending copies of the report to the Chairmen of the House and Senate Committees on Appropriations and Armed Services and the Senate Committee on Governmental Affairs; the Director, Office of Management and Budget; the Secretary of Defense; the Administrator of the National Aeronautics and Space Administration; the Administrator of the General Services Administration; the 10 contractors reviewed; the Council of Defense and Space Industry Associations; and other interested parties. We will also make copies available to others upon request.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

In fiscal year 1986, the Department of Defense (DOD) awarded about $82 billion in contracts without price competition. Overall, over 90 percent of the dollar value of DOD contracts are negotiated, meaning that health care and other compensation costs can be passed on to the government as long as they are "reasonable." Because many of the government's largest contractors do not compete extensively for private sector sales and face limited price competition for government sales, competitive marketplace forces may not be adequate to contain health care and other compensation costs.

The government reimbursed its 10 largest contractors about $1.2 billion for their employee health care costs in fiscal year 1985. Because of the substantial federal funds involved and limited competitive pressures to contain costs, GAO evaluated the government's efforts to ensure that only reasonable costs are reimbursed under negotiated contracts.

Background

Federal Acquisition Regulations require that negotiated contracts include employee compensation costs—such as salaries, bonuses, and health insurance—only to the extent that they are "reasonable."

DOD, the General Services Administration (GSA), and the National Aeronautics and Space Administration (NASA) are responsible for issuing and administering the regulations under procurement policies established by the Office of Federal Procurement Policy within the Office of Management and Budget (OMB).

Before April 1986, the regulations required that compensation be considered reasonable if total compensation conforms generally to compensation paid by other firms of the same size, in the same industry, or in the same geographic area. Under the total compensation approach, the government had little success in challenging the reasonableness of compensation costs.

The regulations were revised in April 1986 to permit the government to challenge any single element of compensation, such as health benefits, in order to assess compensation from a building block approach. Once an element is challenged, the burden is placed on the contractor to either defend the reasonableness of this element or show that lower costs for other parts of the compensation package offset the "unreasonableness" of one.

Results in Brief

Without consistent quantitative criteria for evaluating the reasonableness of compensation costs on an element-by-element basis, the April 1986 revisions to the procurement regulations will, in GAO's opinion, make it difficult for the government to sustain a challenge to a contractor's costs.

GAO compared the per-employee health care costs of the government's 10 largest contractors to those for government employees, manufacturing industries, and average costs for the 10 contractors.

During the 5-year period 1981-85, the government reimbursed its 10 largest contractors about $4.5 billion for their employee health care costs. The government's costs would have been about $1.2 billion less if the contractors' costs were those of a typical manufacturing firm and up to $2.0 billion less if they were that of the federal employees' health program. Because of the concentration of government business among contractors with higher health care costs, the government's actual costs exceeded the average costs incurred by the 10 contractors by about $524 million.

Principal Findings

Consistent Quantitative Criteria Are Needed

DOD guidance allows auditors to choose from among a variety of available data sources, including the U.S. Chamber of Commerce's annual Employee Benefits survey and contractor-developed surveys, in assessing the reasonableness of an element of compensation. As a result, there is no assurance that similar contractors will be judged using the same criteria or that each element of a contractor's compensation package will be judged using criteria from the same data source. This will make it more difficult to defend the criteria used to challenge the reasonableness of a contractor's compensation costs.

More importantly, without quantitative criteria on an element-by-element basis, the government permits the contractor to choose the criteria it will use to evaluate offsetting elements of compensation. Because it has not established criteria and does not require the contractor to measure offsets using criteria based on a uniform data base of employers, the government is in a weak negotiating position to prove that the contractor's criteria are not reasonable. Thus, in GAO's opinion, it will be

difficult for the government to challenge the offsets claimed by the contractor. GAO believes this constitutes a material internal control weakness in the procurement system. (See pp. 17 to 18.)

Contractors' Health Costs Are Higher

The government paid an average of $2,344 per employee for health care costs in 1985 under contracts with its 10 largest contractors. This exceeded the maximum government contribution to federal nonpostal employees' health care by $1,177. It exceeded the manufacturing industry average, as reported in the Chamber of Commerce's Employee Benefits survey, by $448 per employee and the average of the 10 firms' costs, considering both their government and nongovernment sales, by $199. (See pp. 19 to 22.)

Contractors Have Lower Cost Sharing

The higher health care costs incurred by the 10 contractors can be explained largely by the lower cost sharing required of their employees than employees of other medium and large firms and federal workers. Cost sharing through deductibles and coinsurance is an important part of many federal health financing programs—such as Medicare and the Federal Employees Health Benefits Program—and has been shown to be an effective way to reduce health care costs.

Also, all federal and postal workers have been required since 1959 to pay part of their health insurance premiums. OMB has argued that premium cost sharing helps to restrain the cost of health care for federal employees by encouraging the choice of lower cost health plans; presumably the same argument applies to private sector employees.

There has been a trend toward increased employee cost sharing in the private sector, with 39 percent of employees paying part of their premiums in 1985. However, during that same year only 1 of the 10 contractors required any employees to share in the cost of their individual health insurance premiums. (See pp. 22 to 26.)

Recommendations

GAO recommends that the Director of OMB, through the Administrator of the Office of Federal Procurement Policy, work with DOD, GSA, and NASA to develop, and publish in the Federal Acquisition Regulations, quantitative criteria for determining the reasonableness of the government's reimbursement of contractor health insurance costs. The Director should develop similar criteria for assessing the reasonableness of other elements of compensation and total compensation costs. (See p. 27.)

Agency Comments

DOD, GSA, NASA, OMB, the 10 contractors, and the Council of Defense and Space Industry Associations commented on a draft of this report. (See apps. IV-XVIII.) Although a few contractors said that they agreed in principle with the need for quantitative criteria, most commenters were opposed to the establishment of quantitative criteria for assessing the reasonableness of health care costs or other elements of compensation. Among the concerns expressed were that

- GAO evaluated a single element of compensation without assessing offsets or total compensation,
- the comparisons presented in GAO's report are not appropriate, and
- quantitative criteria should reflect the geographic and demographic differences between contractors.

After analyzing the comments, GAO continues to believe that quantitative criteria are needed for health care costs. The comments convinced GAO of the need to develop quantitative criteria for each element of compensation from a broad cross section of employers in order to enforce the offset provisions of the procurement regulations. GAO does not, however, believe that the government is obligated to reflect all potential variables that could affect health care costs in quantitative criteria because contractors are given the opportunity to present evidence on such factors to justify costs that exceed the criteria. (See pp. 28 to 51.)

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Abbreviations

CODSIA	Council of Defense and Space Industry Associations
DAR	Defense Acquisition Regulation
DCAA	Defense Contract Audit Agency
DOD	Department of Defense
FAR	Federal Acquisition Regulation
FEHBP	Federal Employees Health Benefits Program
GAO	General Accounting Office
GSA	General Services Administration
NASA	National Aeronautics and Space Administration
OMB	Office of Management and Budget
OPM	Office of Personnel Management

Introduction

In fiscal year 1985, the federal government contracted with the private sector to purchase over $200 billion in goods and services. The 10 largest government contractors received over $50 billion in federal contracts. Those 10 contractors were reimbursed about $1.2 billion for their employee health care costs. This report discusses the government's attempts to ensure that contractors' health care costs it reimburses are reasonable.

Procurement Regulations

Federal government procurement is regulated by the Federal Acquisition Regulation (FAR)[1] system, which consists of FAR and agency regulations that implement and supplement it. The Department of Defense (DOD), the General Services Administration (GSA), and the National Aeronautics and Space Administration (NASA) issue and maintain FAR. Two councils, the Defense Acquisition Regulatory Council representing DOD and NASA, and the Civilian Agency Acquisition Council representing other agencies, coordinate the development of FAR changes. The Administrator of the Office of Federal Procurement Policy, within the Office of Management and Budget (OMB), is responsible for overall direction of government procurement policy. Also, within limits, the Administrator may prescribe governmentwide procurement policies that are required to be implemented in FAR. One of the Administrator's principal functions is to provide leadership and ensure action by the executive agencies in establishing, developing, and maintaining a single system of simplified governmentwide procurement regulations.

Procurement regulations have long contained cost principles to determine the allowability of contract costs. One such principle requires that negotiated contracts include employee compensation[2] costs only to the extent that they are reasonable. For negotiated fixed price contracts, cost principles are used to develop a price negotiation position. For negotiated cost reimbursement contracts, cost principles are used to determine the proper amount of reimbursable compensation costs. About 98 percent of DOD procurement during the first half of fiscal year 1986 was through negotiated contracts. DOD contracts amounting to

[1]FAR, a single governmentwide procurement regulation, took effect on April 1, 1984. It essentially consolidated the two previously existing primary procurement regulations: the Defense Acquisition Regulation (DAR), covering defense agencies, and the Federal Procurement Regulations, covering most other agencies. This report uses the term Federal Acquisition Regulations to describe those portions of DAR established before April 1, 1984, but later included in FAR.

[2]Compensation includes, but is not limited to, salaries, bonuses, incentive awards, employee insurance, fringe benefits, and contributions to pension and annuity plans. Health insurance is a commonly offered employee benefit.

about $82 billion were awarded without price competition during fiscal year 1986.

Administration

While OMB is responsible for setting overall procurement policies, the contracting agency is responsible for issuing and administering the regulations. Within DOD, the Defense Contract Audit Agency (DCAA) is responsible for reviewing the reasonableness of contractor compensation. DCAA reviews contractor employee compensation systems and contract cost proposals and audits costs charged against specific contracts. This helps the procurement contracting officer assess the reasonableness of costs in negotiated defense contracts.

Objectives, Scope, and Methodology

The objective of our review was to evaluate the government's efforts to ensure that contractors' health care costs charged against negotiated contracts are reasonable. To do this, we

- evaluated DOD guidance related to assessing the reasonableness of health and other elements of compensation,
- identified the employee health care benefits and costs of the 10 largest federal government contractors, and
- compared the contractors' per-employee health care costs to several available benchmarks.

Adequacy of DOD Guidance

To evaluate the adequacy of DOD guidance for ensuring that health care costs reimbursed under government contracts were reasonable, we

- evaluated FAR, including the April 1986 revision;
- reviewed reports by GAO and the DOD Inspector General relating to the reasonableness of contractor compensation;
- reviewed a December 1983 report by the public accounting firm Coopers & Lybrand on Air Force contractors' health care programs;
- interviewed DCAA officials to obtain their views on efforts to use the reasonableness criteria to review contractor health insurance costs, and problems in enforcing it;
- interviewed members of the DAR Council to discuss recent changes to federal procurement policy; and
- reviewed available DCAA reports relating to contractors' health insurance programs.

Identifying Contractors' Health Care Costs and Benefits

To identify the health care costs paid under government contracts and the benefits provided to contractor employees, we selected the 10 contractors awarded the largest prime contracts by the federal government in 1985. Listed below are the 10 companies, along with the location of their corporate headquarters.

- The Boeing Company, Seattle, Washington.
- General Dynamics Corporation, St. Louis, Missouri.
- General Electric Company, Fairfield, Connecticut.
- Grumman Aerospace Corporation, Bethpage, New York.
- Hughes Aircraft Company, Los Angeles, California.
- Lockheed Corporation, Calabasas, California.
- McDonnell Douglas Corporation, St. Louis, Missouri.
- Raytheon Company, Lexington, Massachusetts.
- Rockwell International Corporation, El Segundo, California.[3]
- United Technologies Corporation, Hartford, Connecticut.

These contractors accounted for about 35 percent of the federal government's 1985 contract awards. We did not attempt to select a statistically projectable sample of contractors because a large sample size would have been required.

At the corporate headquarters of each contractor, we

- obtained information on employee health insurance costs[4] for 1981-85 for both active and retired persons;
- obtained information on total company sales, government sales, and numbers of employees;
- calculated the per-employee health insurance cost under the contracts;
- reviewed health insurance plan benefit brochures;[5] and
- interviewed contractor officials to identify health care cost containment efforts, changes in health benefits, and employee contributions toward health insurance premiums.

We did not attempt to evaluate such factors as location in a high medical cost area or employee demographics that could unavoidably increase a contractor's health care costs.

[3]Rockwell also has corporate offices in Pittsburgh, Pennsylvania, but information on employee health benefits and costs was provided by the El Segundo office.

[4]Employee health insurance costs include medical and dental insurance but not disability insurance.

[5]All contractors provided essentially the same benefits to all employees, whether they worked on government contracts or not.

Comparing Contractors' Health Care Costs to Various Benchmarks

We compared the contractors' per-employee health care costs to maximum Federal Employees Health Benefits Program (FEHBP) postal and nonpostal contributions, the average cost in manufacturing industries as reported by the U.S. Chamber of Commerce, and the per-employee average of the 10 contractors weighted by government sales and by total sales. We

- compared the per-employee health care costs of the 10 contractors for 1981-85 to the per-employee costs[6] under the above benchmarks during the 5-year period;
- estimated the difference between the government's reimbursement of health care costs during the 5-year period and the costs that would have been incurred under the selected benchmarks;[7] and
- compared the health benefits provided by the 10 contractors to those provided by other medium to large firms (50 or more employees) and the government using our December 1986 report Health Insurance: Comparison of Coverage for Federal and Private Sector Employees,[8] which included information from the Bureau of Labor Statistics' 1985 Survey of Employee Benefits in Medium and Large Firms.

Our work was done from April 1986 to April 1987 in accordance with generally accepted government auditing standards. However, we did not independently verify the accuracy of the cost data supplied by the defense contractors or reported to the Chamber of Commerce.

[6]The Chamber of Commerce data allocate retiree medical care costs among active employees.

[7]Our comparisons were based on the share of the company's business that was with the government and the number of employees in each major segment or division of the company.

[8]GAO/HRD-87-32BR, Dec. 31, 1986.

Quantitative Criteria Needed for Assessing Reasonableness of Health Care Costs

The government has had little success in challenging the reasonableness of contractors' compensation costs. Under a 1986 change in FAR, however, the government can challenge an individual element of compensation—such as health care costs—and use criteria other than size, industry, or geographic area to define reasonableness. But the change still does not give the government uniform quantitative criteria to use in determining the reasonableness of contractors' costs. Without such criteria, it will be difficult for the government to sustain a challenge against the reasonableness of a contractor's compensation costs.

We compared the per-employee health care costs reimbursed by the government under contracts with its 10 largest contractors to various benchmarks. Over the 5-year period 1981-85, the government reimbursed those contractors from about $350 million to $2 billion more than it would if their costs were no greater than the selected benchmarks. The higher health care costs incurred by the government resulted primarily because the 10 contractors gave their employees more extensive benefits with lower cost sharing than did other private sector employers and the federal government.

Problems in Assessing the Reasonableness of Compensation Costs

Until April 1986, FAR stated essentially that compensation is reasonable to the extent that the total amount paid or accrued is commensurate with compensation paid under the contractor's established policy and conforms generally to compensation paid by other firms of the same size, in the same industry, or in the same geographic area for similar services.

Using this regulation, DOD had little success in substantiating findings that compensation was unreasonable. When such findings were contested in court or before boards of contract appeal, the government did not fare well. These bodies held that actual compensation costs incurred by contractors are presumed to be reasonable and that the burden is on the government to prove unreasonableness through detailed studies including highly specific information, such as employee qualifications and performance and industry conditions.

These difficulties led the Air Force to conclude that, for all practical purposes, the reasonableness criterion in FAR was unenforceable and should be changed. In March 1984, the Air Force, in coordination with the other services, proposed to the DAR Council—the DOD unit responsible for administering the regulation—that the regulation be revised to (1) give the government greater authority to review and approve

changes in contractor compensation systems, (2) give the government more flexibility in determining the relevant comparative criteria, and (3) put more of the burden on contractors for establishing that their compensation is reasonable.

Also in 1984, we completed a comparative analysis of the pay and benefits at 12 of the nation's largest aerospace contractors.[1] On the average, the contractors paid executives and clerical, technical, and factory employees more than the average pay for similar positions surveyed by the Bureau of Labor Statistics and the American Management Association.

Salaries of professionals (mostly engineers) were slightly below Bureau of Labor Statistics averages. Wide pay variations existed among the contractors and among categories of employees. Some of the contractors' pay was about the same as Bureau of Labor Statistics and American Management Association averages, and some was much higher. Employee earnings increased faster for the contractors than in the general economy, and employee fringe benefit costs were borne more often by the contractors than by the firms surveyed by the Bureau of Labor Statistics.

Based on the salary comparisons alone, however, we were unable to reach a conclusion on the reasonableness of compensation paid by the 12 contractors because the definition of reasonableness embodied in FAR lacked quantitative criteria, and there were no generally accepted pay surveys to which contractors could be compared.

We stated that while the facts by themselves were not sufficient to determine whether the level of compensation was reasonable, they reinforced the importance of DOD contracting officials' carefully examining compensation rates during contract negotiations. We concluded that the fundamental solution rests with developing criteria that are viewed as acceptable and fair to both DOD and the contractors and as usable and enforceable by those charged with overseeing compensation reasonableness.

In considering this matter, the Cost Principles Committee of the DAR Council stated that the reasonableness criteria placed an impossible burden on the government and made it futile to question the reasonableness

[1]Compensation by 12 Aerospace Contractors (GAO/NSIAD-85-1, Oct. 12, 1984).

of contractors' compensation practices. Also, in a May 1985 memorandum to the Secretaries of the Military Departments, the Deputy Secretary of Defense stated that:

"Most companies probably do not know how much they pay in 'total' compensation costs, and certainly none of them account for it in such a way that it would even be identified. Yet, the cost principles states [sic] that 'total compensation' is the criterion that must be applied in the determination of reasonableness. Since no one knows how much 'total' compensation is, and no comparison standards on the 'total' are available, the DOD cannot effectively challenge compensation costs. Accordingly, the Department has no effective restraint on the reasonableness of contractors' compensation programs."

FAR was amended in April 1986 to provide more detailed guidelines for assessing the reasonableness of contractor compensation practices and for dealing with possible government challenges to their reasonableness. However, the new regulations did not include quantitative criteria.

According to the DAR Council, the revised regulations attempt to make three improvements:

1. The previous language implied that the government could challenge particular compensation costs only if the total compensation package—salaries and fringe benefits—was too high. The revised section makes clear that the government can challenge any single element of compensation, such as health benefits. Within certain limits, however, the contractors can still justify the reasonableness of the challenged element or present data showing that other compensation elements offset or compensate for the "unreasonableness" of one.

2. The prior language implied that a contractor's compensation was reasonable if it was in line by either size, industry, or geographic area standards. The revised section states that a contractor's compensation is not inherently reasonable just because it passes one of the specific criteria. The revisions also explicitly allow the government to use criteria other than size, industry, or geographic area.

3. The revisions state that once challenged by the government, a contractor's compensation practices and costs are not presumed to be reasonable.

According to the chairman of the DAR Council's Cost Principles Committee, the intent of the third change is to place the burden of proof to

demonstrate reasonableness on the contractor, instead of the government.

Quantitative Criteria Needed to Enforce FAR Changes

While the April 1986 revision to FAR makes it easier for the government to challenge the reasonableness of an individual element of compensation, it does not give contracting officers and auditors the quantitative criteria they need to support and sustain such challenges. Specifically, it does not (1) specify the criteria to be used in assessing reasonableness, (2) require that criteria developed from a uniform data base be used to evaluate each element of compensation, and (3) specify the factors contractors can introduce to justify challenged costs and the criteria that will be used to evaluate such factors.

The regulation does not require that contractors be told in advance what criteria will be used to evaluate the reasonableness of their compensation costs. Because uniform quantitative criteria have not been established in FAR, contracting officers and auditors can assert criteria from a variety of available data sources, including the U.S. Chamber of Commerce's annual Employee Benefits survey and contractor-developed surveys. As a result, similar contractors could be subjected to different criteria. Because the government cannot demonstrate that contractors have been treated fairly and consistently, in our opinion, it will be difficult to sustain a challenge to the reasonableness of a contractor's compensation costs.

More importantly, FAR does not require that criteria developed from a uniform data base be used to evaluate all elements of a contractor's compensation package. Without such a requirement, the government cannot determine the reasonableness of total compensation or determine the "value" of the offsetting elements introduced by the contractor. We believe that because the government has not specified the criteria to be used in evaluating offsets, it will have difficulty challenging the offsets claimed by the contractor.

Finally, FAR does not place any limit on the factors a contractor can introduce to attempt to justify the reasonableness of a challenged element, allowing the contractor to introduce any number of factors besides the compensation practices of other firms of the same size, in the same industry, and in the same geographic area. Nor does FAR specify the basis for evaluating those factors. Again, this will make it difficult for the government to dispute the factors introduced by the contractor.

Although the intent of the April 1986 revision to FAR was to enable the government to negotiate from a position of strength, without quantitative criteria on an element-by-element basis, the government is left in a weak negotiating position. We do not believe FAR establishes an internal control system that provides reasonable assurance that the health care costs reimbursed under negotiated contracts are reasonable.

Benchmarks for Comparing Health Care Costs

We compared the contractors' per-employee health care costs to two readily available benchmarks:

- FEHBP, the nation's largest employer-sponsored health insurance program.[2]
- The U.S. Chamber of Commerce's annual Employee Benefits survey.

Both sources are updated annually.

FEHBP, established in 1959, offers health insurance to federal and postal employees and annuitants and their dependents. The Office of Personnel Management (OPM) administers the program and contracts annually with various health plans to provide health care coverage. Each health plan varies in its provisions, covered benefits, and premiums. For 1985, about 300 plans participated in FEHBP, covering about 10 million enrollees and collecting premiums of about $6.4 billion.

We selected the maximum government contribution toward federal and postal workers' health insurance under FEHBP as a benchmark rather than calculating the actual federal payments. OPM and the plans negotiate premium rates before the beginning of the year for which the payment applies, and the maximum contribution is set at that time.

The U.S. Chamber of Commerce's Employee Benefits survey represents one of the few studies available for which specific data are collected on employer health insurance costs. For a cross section of American industries, the survey reports how much employers paid to provide health insurance to their employees.

Although the Employee Benefits survey generally is limited to employees who are paid by the hour, we believe it is reasonable to assess both

[2]FEHBP has separate provisions for its postal employees. We used both federal postal and nonpostal rates as benchmarks.

salaried and hourly employees using this survey because all of the contractors selected provide similar health benefits to all employees. Beginning in 1986, the survey includes both hourly and salaried employees.

The Chamber of Commerce data are divided into two principal groups: manufacturing industries and nonmanufacturing industries. We selected the national average for manufacturing industries because the largest government contractors fit into this group. Although we used one overall benchmark, the Chamber of Commerce survey also contains data on health care costs by specific size or type of business or geographic location.

We also calculated the average per-employee health care costs of the 10 largest government contractors weighted by government sales and by combined government and nongovernment business, and used these averages as benchmarks.

Contractors' Costs Exceed Selected Benchmarks

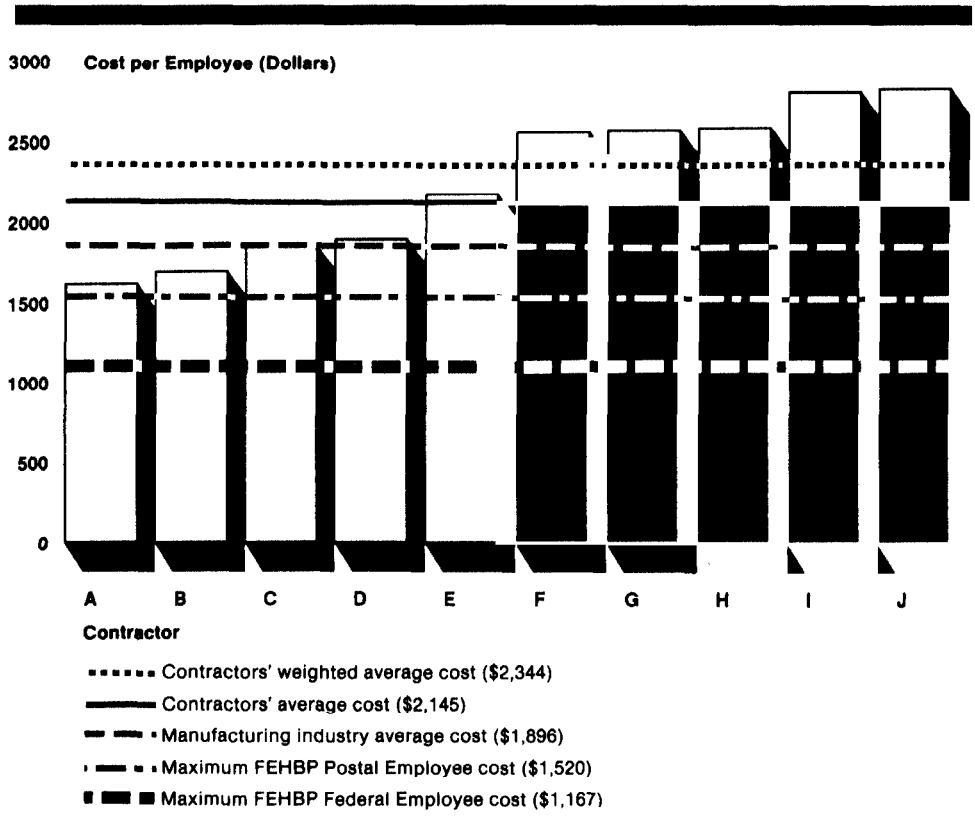
Between 1981 and 1985, the government reimbursed its 10 largest prime contractors about $4.5 billion for the costs they incurred to provide health insurance to their employees. Those costs exceeded the costs under the selected benchmarks—the maximum government contribution for federal workers' health insurance, the manufacturing industry average as reported by the U.S. Chamber of Commerce, and the weighted average per-employee health care costs of the 10 largest government contractors—by about $350 million to $2 billion for the 5-year period.

As shown by figure 2.1, the 10 government contractors had per-employee health care costs in 1985 ranging from $1,613 to $2,830. On the average, the government reimbursed the contractors $2,344 per employee for health care costs. The two companies with the lowest per-employee health care costs had the highest percentages of private sector business.

FEHBP

In 1985, the 10 contractors' costs per employee exceeded the maximum government contribution under FEHBP for federal nonpostal workers ($1,167) by a range of $446 to $1,663 and for federal postal workers ($1,520) by a range of $93 to $1,310. On average, the government reimbursed the contractors $1,177 more ($2,344-$1,167) per employee for health care coverage than the maximum paid toward federal nonpostal workers' health care coverage and $824 more ($2,344-$1,520) than the maximum paid toward federal postal workers' health care coverage.

Figure 2.1: Comparison of Health Care Costs Per Employee for 10 Government Contractors to Various Benchmarks (1985)



Chamber of Commerce

Also, in 1985, the health care costs per employee of 6 of the 10 contractors were higher than the overall average for manufacturing industries as reported by the U.S. Chamber of Commerce.[3] The six firms exceeded the manufacturing industry average—$1,896—by $274 to $934. The remaining four firms' costs were from $6 to $283 below the industry average. On the average, the government reimbursed the contractors $448 ($2,344−$1,896) more per employee than the industry average reported by the Chamber of Commerce.

Contractor Average

The per-employee health care costs of 6 of the 10 contractors were higher than the weighted average per-employee health care costs of the

[3]The Chamber of Commerce data combine health insurance costs for active and retired employees, but calculate the per-employee costs based on the number of active employees. If the 10 contractors' health care costs were similarly calculated, the cost differences shown above would increase.

10 contractors, considering both government and nongovernment business. The six firms exceeded the contractor weighted average—$2,145—by $25 to $685. Overall, the government reimbursed the contractors $199 ($2,344−$2,145) more per employee for health care than the weighted average per-employee cost of the 10 contractors.

The results of our analysis for 1981-84, which showed similar differences in per-employee health insurance costs, are shown in tables I.1 and I.2 of appendix I.

Multi-Year Cost Differences

Using data on the number of employees and government sales as a percentage of total sales for each of the 10 contractors (see app. III), we estimated the effect the higher health care costs had on government reimbursements over the 5-year period 1981-85. (See figure 2.2.) In 1985, government sales as a percentage of total sales ranged from about 21 to about 92 percent and averaged 63 percent.

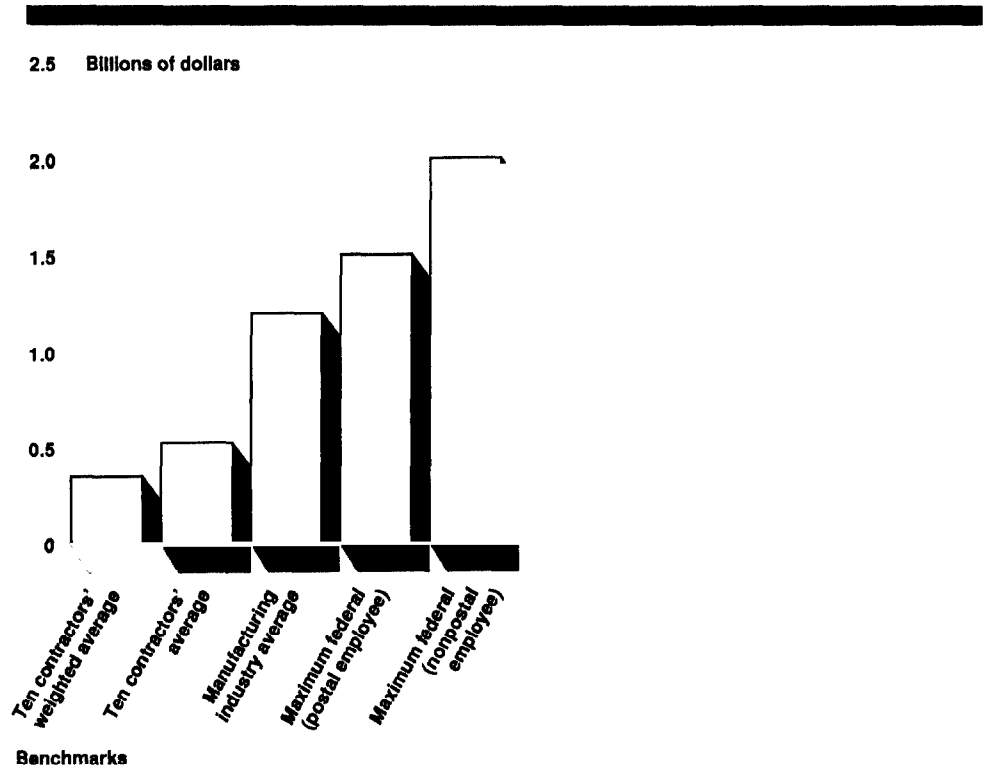
If the 10 contractors' costs had been no greater than the selected benchmarks, the government's reimbursements over the 5-year period would have been reduced by

- $350 million based on the average government payment to the 10 contractors,
- $524 million based on the average per-employee costs incurred by the 10 contractors,
- $1.2 billion based on the average per-employee costs for manufacturing industries;[4]
- $1.5 billion based on the maximum government contribution to federal postal employees' health insurance, and
- $2.0 billion based on the maximum government contribution to federal nonpostal employees' health insurance.

We did not attempt to evaluate factors, such as location in a high medical cost area or an older work force, that could justify higher contractor costs or determine whether lower costs for other elements of compensation would offset the higher health care costs.

[4]In computing the differences under the manufacturing industry average, we allocated the contractors' retiree health care costs among the active employees to provide a consistent basis for comparison with the Chamber of Commerce data, which similarly allocate retiree costs among active employees. However, we did not include retiree costs in computing the other estimates because the benchmarks did not include such costs.

Figure 2.2: Extent to Which Government Reimbursement to 10 Contractors Exceeded Costs Under Selected Benchmarks (1981-85)



Higher Costs Result Primarily From Lower Cost Sharing

The higher costs incurred by the contractors could be explained largely by the lower cost sharing required of their employees compared to employees of other private sector employers and the federal government. The contractors were also more likely to provide coverage of such services as home health care and dental care than other private sector employers or the government.

Cost Sharing

Cost sharing is an important part of the federal health financing programs. For example:

- Medicare[5] beneficiaries pay a $520 deductible for hospital care, and coinsurance of $130 a day for days 61 to 90, $260 a day for days 91 to 150,[6] and all charges for hospital stays beyond 150 days.
- Medicare beneficiaries are required to pay a monthly premium for part B coverage[7] and 20 percent of the approved charges for most services.
- Beneficiaries of the Civilian Health and Medical Program of the Uniformed Services,[8] other than dependents of active duty members,[9] pay 25 percent of total charges for inpatient care.

As shown in figure 2.3, premium cost sharing provisions apply to all federal and postal workers, but do not apply to all private sector employees, particularly those employed by the 10 contractors reviewed.

Federal workers have shared in the cost of their health insurance since FEHBP's inception in 1959. Under FEHBP, the maximum government payment toward federal workers' health insurance premiums is set at 60 percent of the unweighted average of the high-option rates for the six plans with the largest enrollment (the Big Six). The government's payment may be less, however, depending on the cost of the health plan chosen, and the employee must pay at least 25 percent of the total premium. For federal postal workers, the maximum government payment is 75 percent of the Big Six average; the employee must pay at least 6.25 percent of the premium. OMB has argued that premium cost sharing helps to restrain the cost of health care for federal employees by encouraging the choice of lower cost health plans; presumably the same argument applies to private sector employees.

[5]Medicare is a federal program that assists most of the elderly and some disabled people in paying for their health care.

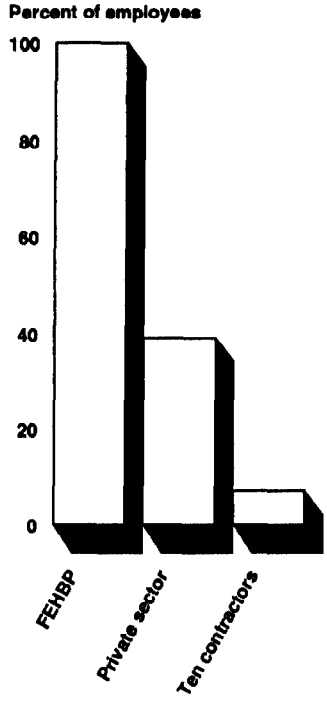
[6]Beneficiaries have 60 lifetime reserve days during which they pay a coinsurance amount equal to about $260 a day. After exhausting their lifetime reserve days, beneficiaries are liable for the entire cost of hospital services.

[7]Part B, Supplementary Medical Insurance, covers physician services and various other health care services, such as laboratory and outpatient hospital services.

[8]This program provides financial assistance for medical care provided by civilian sources to dependents of active duty members, retirees and their dependents, and dependents of deceased members of the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the commissioned corps of the Public Health Service, and the commissioned corps of the National Oceanic and Atmospheric Administration.

[9]Dependents of active duty members pay $25 per visit or $7.55 a day, whichever is greater, for inpatient care.

Figure 2.3: Federal, Private Sector, and Contractor Employees Who Contribute to Their Own Health Insurance Premium (1985)



There has been a trend toward increased employee cost sharing in the private sector. From 1980 to 1985 the percentage of private sector employees contributing to the cost of their own health insurance increased from about 29 to about 39 percent. The corresponding increase in cost sharing for dependent coverage has been from 49 to 58 percent.

In 1985, only 1 of the 10 contractors (representing 7 percent of the contractors' employees) required any employees to share in the cost of their individual health insurance premium. That contractor required cost sharing only for employees living in certain parts of the country. Similarly, only 2 of the 10 contractors (with 36 percent of the employees) required employees to contribute toward the cost of their dependents' health insurance.

Those contractor employees who contributed toward the cost of their premium paid less than federal employees and the average private sector employee. Employees of the one contractor that required employee cost sharing for single coverage contributed $8.80 per month to the cost

of their health insurance premiums, compared to an average of $12 per month for private sector employees and $38 per month for federal employees.

We applied 25- and 40-percent premium cost sharing to the 10 contractors' health care costs. In 1985, 3 of the 10 contractors would have incurred per-employee health care costs that were less than the maximum government contribution for federal nonpostal employees if they had required their employees to pay 40 percent of the cost of their premiums like federal nonpostal employees. Moreover, for the same year, costs for 4 of the 10 contractors would have been less than the maximum contribution per postal employee if 25-percent premium cost sharing had been required. (See tables I.3 and I.4 on page 53 for additional details.)

The 10 government contractors also required lower cost sharing by their employees in terms of deductibles and coinsurance than the government required of its workers and most medium and large firms required of their employees. In 1985:

- About 44 percent of federal employees and 5 percent of private sector employees subject to coinsurance were required to pay 25 percent of their medical bills, whereas none of the contractor employees were subject to this level of coinsurance. Most contractor employees' coinsurance ranged from 10 to 20 percent of their medical bills.
- All federal employees and about 29 percent of private sector employees were subject to deductibles of $150 or more compared to 10 percent of the 10 contractors' employees.

Cost sharing through deductibles and coinsurance has been shown to be an effective way to reduce the utilization of medical services and thus health care costs. According to a study by the Rand Corporation,[10] per capita health care expenditures rise as cost sharing falls. Specifically, the study found that persons with a 50-percent copayment spent about 33 percent less on all medical services than those with full coverage. In addition, full coverage led to more people using services and to more services per user without a commensurate improvement in health status.[11]

[10]Phelps, Health Care Costs: The Consequences of Increased Cost-Sharing, the Rand Corporation, Nov. 1982, pp. 8-9.

[11]Brook, et al., The Effect of Coinsurance on the Health of Adults: Results From the Rand Health Insurance Experiment, Dec. 1984, p. vii.

Services Covered

The contractors also provided more extensive benefits than either the federal government or most private sector employers, although the effect of some of those benefits on health care costs is unclear. In 1985, the 10 contractors' employees were more likely to have coverage for dental care, home health services, and alcohol and drug abuse treatment than employees of other medium to large private sector firms or the federal government. For example:

- Ninety-six percent of the 10 contractors' employees were provided dental benefits, compared to 76 percent of private sector employees and 64 percent of federal employees.
- All employees of the 10 contractors were provided coverage for alcohol and 93 percent for drug abuse care. In contrast, of private sector employees, 68 percent were covered for alcohol and 61 percent for drug abuse treatment; and of federal enrollees, 53 percent were covered for alcohol and drug abuse care.
- Ninety-three percent of the 10 contractors' employees were provided home health benefits, compared to 56 percent of private sector employees and 42 percent of federal employees.

Some benefits, such as home health and extended care, can reduce overall health costs to the extent that they substitute for more costly hospital care. The extent that they increase or decrease costs depends, however, on the scope of the coverage and the effectiveness of utilization controls.

Appendix II contains more detailed comparisons of the benefits provided to, and cost sharing required of, employees of the contractors, medium and large firms, and the federal government.

Conclusions, Recommendations, and Agency/Industry Comments

Conclusions

The government lacks adequate internal controls to help ensure that the health care costs reimbursed under government contracts are reasonable. The health care costs reimbursed under contracts with the government's 10 largest contractors were higher than those incurred by most manufacturing industries included in the Chamber of Commerce survey or the government in providing health insurance for their employees. The higher costs resulted primarily from the lower cost sharing required of contractor employees rather than factors beyond the contractors' control.

Although the April 1986 revision to FAR is an important first step in strengthening the government's position in negotiating allowable compensation costs, weaknesses in the regulation will make it difficult to sustain a challenge against an individual element of compensation. First, the regulation does not specify in advance what criteria are to be used in assessing reasonableness or require that the same criteria be applied to similar contractors. The government will have a difficult time showing that it is treating contractors fairly and consistently.

Second, the regulation does not require that each element of a contractor's compensation package be assessed using criteria developed from a uniform data base. Thus, the government will find it difficult to assess the reasonableness of total compensation or the "value" of any offsets claimed by the contractor. Finally, the regulation does not specify what factors can be used to justify challenged costs or how such factors will be evaluated.

The government should establish uniform quantitative criteria on an element-by-element basis from a consistent and uniform data base of employers in order to strengthen its negotiating position and provide a firm basis for evaluating offsets. In addition, the government should identify the factors that could justify higher health care costs and either (1) reflect such factors in the quantitative criteria developed, which would eliminate the need for the FAR provision that allows contractors to justify challenged costs, or (2) list those factors in FAR along with the criteria that will be used to evaluate them.

Recommendations

We recommend that the Director of OMB, through the Administrator of the Office of Federal Procurement Policy, work with DOD, NASA, and GSA to develop, and publish in FAR, quantitative criteria for determining the reasonableness of the government's reimbursement of contractor health

insurance costs. The Director should develop similar criteria for assessing the reasonableness of other elements of compensation and contractors' total compensation costs.

Agency Comments and Our Evaluation

DOD Comments

DOD disagreed with our recommendation, stating that criteria for assessing the reasonableness of contractor health insurance costs are already available and being used within the Department. According to DOD, no one criterion would be appropriate for judging the reasonableness of every contractor's health insurance costs, and it is impractical to include a comprehensive list of available criteria in FAR.

We were aware that DOD guidance includes references to various sources of data and surveys that contracting officers and auditors can use for determining reasonableness of compensation, but do not believe that mentioning the availability of such sources constitutes explicit or quantitative criteria. The DOD guidance allows contracting officers and auditors to use any of the cited data sources, to develop additional data, or to rely on data supplied by the contractor being reviewed. By allowing contracting officers and auditors to choose from an array of potential criteria, similar contractors could be assessed using widely varying criteria. Further, the guidance does not require the use of criteria based on consistent data sources to evaluate all elements of compensation. Unless consistent criteria are used to evaluate each element, the reasonableness of total compensation cannot be determined from a building block approach.

DOD is opposed to imposing limitations on elements of compensation, stating that such limits would clearly conflict with the cost principle and might be viewed as a form of wage control by industry and the legislative branch. According to DOD, while an evaluation is performed on individual elements of compensation to determine reasonableness, the compensation cost principle also requires that the particular circumstances surrounding the compensation element be considered, along with offsetting elements that may be lower than would be considered reasonable. GSA and NASA similarly commented on FAR's offset provision.

We agree, and have revised the report text to make clear that contractors can, under the April 1986 revision to FAR, introduce data on other elements of compensation to offset or compensate for the "unreasonableness" of one. However, without quantitative criteria on an element-by-element basis developed from the same data base, the offset provisions make the regulations essentially unenforceable. Contractors, who technically have the burden of proving reasonableness once an element has been challenged, are allowed to develop the criteria they use to assess the reasonableness of the offsetting elements. However, the regulations do not require that the contractor use the same base of comparison for determining the reasonableness of each offsetting element.

Because quantitative criteria set a limit on what the government is willing to pay, not on what a contractor can spend, they should not be viewed as wage controls. We believe DOD should view quantitative criteria as an essential internal control in negotiated contracts to ensure that the government is not paying an unreasonable price for the goods purchased.

According to DOD, the April 1986 revision to FAR provides general reasonableness criteria for compensation cost and places the burden on contractors for establishing reasonableness. DOD said that the revision should result in more favorable consideration by the courts or boards of contract appeals in the future. It is, DOD said, too early to determine the effectiveness of the change. GSA and NASA also expressed concern that it is too early to consider further changes to FAR.

We believe that even with the revision to FAR, it will be difficult for the government to sustain a challenge before the courts or boards of contract appeals until the government establishes quantitative criteria for assessing the reasonableness of each element of compensation. As noted earlier in DOD's comments, contracting officers and auditors are given wide latitude in selecting the criteria they use to challenge the reasonableness of a contractor's compensation costs. In addition, contractors are not told in advance what criteria will be used to evaluate their costs. Without uniform quantitative criteria, the government cannot demonstrate that it is treating contractors fairly and consistently. Two similar contractors in the same city could be judged using widely varying criteria.

Further, as discussed above, once an individual element of compensation has been challenged, the contractor is allowed to introduce other elements of compensation to offset or compensate for the unreasonableness

of the challenged element. However, because there are no uniform quantitative criteria for assessing the value of such offsets, the burden is on the government to prove that the offsets claimed are not adequate.

DOD said that no one criterion is appropriate for determining the reasonableness of an element of contractor compensation, pointing to the different levels of reimbursement for federal postal versus nonpostal employees as an example of the role unions can play in the establishment of benefit levels. According to DOD, the process of determining reasonableness is complicated by the recent industry practice of providing a "market basket" of fringe benefits from which employees select the mix and level of benefits that best suit their individual needs. This practice, DOD said, makes it more difficult to establish criteria for individual elements of compensation.

Because the April 1986 revision to FAR allows contractors to submit data to justify the reasonableness of an element of compensation once it has been challenged, the government need not account for every potential variable affecting a contractor's costs before challenging their reasonableness. The government can challenge reasonableness based on some general test and place the burden on the contractor to prove that geographic, demographic, or other factors justify higher costs. We noted on page 19, however, that quantitative criteria could be established to reflect differences in industry, size, or geographic location.

Finally, quantitative criteria would make it easier, not harder, to analyze contractors that offer a "market basket" of fringe benefits. By establishing uniform quantitative criteria on an element-by-element basis based on a consistent group of employers, the higher health costs that result from employees' tendencies to select more extensive health benefits in exchange for less paid time off would automatically be factored into the offsets allowed under the regulation through "lower" than reasonable paid time off costs.

Additional DOD comments are contained in appendix IV.

NASA Comments

NASA said that the development of rigid quantitative limitations on health care and other elements of compensation would be ill advised because it would have a potentially deleterious effect on contractor staffing and performance. According to NASA, it is in the interest of any employer to have a compensation scheme that achieves the maximum level of employee satisfaction and morale for the resources expended

and that rigid schemes are self-defeating. NASA recommended that quantitative criteria be tested on a few selected contractors to determine whether universal implementation is desirable.

We did not intend that the quantitative criteria be viewed as an absolute limit on allowable costs. As discussed on page 16 and under the DOD comments, the April 1986 revision to FAR allows the contractor to submit data to justify the need for costs that exceed the limit or to introduce other elements of compensation to offset the unreasonableness of the challenged item. These provisions would not limit contractors' flexibility to design benefit packages to meet the needs of their employees, but would give the government a means, once criteria were established for each element of compensation, for ensuring that the offsets permitted by the regulations exist and that the total compensation package is reasonable.

While we agree with NASA that quantitative criteria should be tested, we believe such testing should be done to select the most appropriate criteria, not to determine whether to adopt any criteria.

NASA also criticized the potential quantitative criteria used in our report, pointing to the poor health insurance package available to government workers and the government's poor track record in recruiting and retaining staff. According to NASA, it is doubtful that a contractor would be able to negotiate as favorable a health insurance package as could the government because of economies of size. With respect to the Chamber of Commerce data, NASA expressed concern that the data would not have been compiled under government auspices.

We agree that neither federal employee benefits nor the Chamber of Commerce data provide the ideal source for quantitative criteria; we noted on page 19 that another option would be to develop criteria based on a cross section of government contractors. As NASA notes elsewhere in its comments, however, both Chamber of Commerce and FEHBP data can now be used in assessing the reasonableness of a contractor's health care costs. Accordingly, we believe they provide a valid point of comparison.

As General Electric points out in its comments, while the government has lower health care benefits, it has better pension and sick leave benefits than most of the private sector. What is important is that the criteria established for each element of compensation be from the same source. It would be inappropriate, for example, to set criteria for health

benefits based on an industry average and criteria for pensions based on federal employees. To ensure fair and consistent application of the offset provisions of the regulations, the criteria must be based on the same group of employers.

Regarding the economies of size NASA claims the federal program has, we note that the federal program is composed of over 300 individual health plans ranging in size from under 50 to over 1.4 million employees. While the federal government negotiates health plans with commercial insurers, 8 of the 10 contractors, each of which has over 100,000 employees, are self-insured and do not "negotiate" a health insurance package.

While the concerns NASA voices about relying on the Chamber of Commerce data not generated under government auspices may be valid, the government has traditionally relied on just such data in assessing the reasonableness of compensation costs. For example, the government currently relies partly on surveys conducted by the contractor being reviewed as criteria for assessing reasonableness. The Chamber of Commerce data would provide an independent source of criteria, until a more extensive source of criteria is developed under government auspices.

According to NASA, FAR was revised in April 1986 and again in July 1986 to put the burden of demonstrating the reasonableness of a contractor's costs on the contractor.

As discussed on page 17, we do not believe the burden of proof has been effectively shifted to the contractor because the government lacks consistent, defensible criteria for challenging a contractor's costs and evaluating the offsets permitted by FAR.

NASA also said that in a prior report we indicated that the 1986 FAR changes would significantly improve overhead negotiations and reduce inconsistent treatment of compensation costs. NASA also indicated that establishing quantitative criteria would be a breach of the April 1986 arrangements and piling change upon change would solidify the emerging consensus that chaos is the only consistent rule to which government contractors are subject.

Our 1986 report contains little mention of compensation costs and did not conclude that April 1986 revisions would significantly reduce inconsistent treatment of such costs. Quantitative criteria are not a breach of the arrangements provided in the April 1986 revisions. Rather, they are

the means for enforcing them. Allowing contract negotiators to question an element of compensation using any criteria they choose or, for that matter, to use different criteria in assessing costs under different contracts or for different contractors is, in our view, chaos. The only parties that benefit from this situation are the contractors since the government has no firm basis for challenging any of their costs.

NASA also said that our recommendation is another case of "squeezing just one part of the compensation balloon." According to NASA, the likely result of a definitive limitation on contractor-paid premiums in excess of whatever standard is established is that employees would be paid higher salaries to make up for it.

Comments received from NASA and others convince us of the need for quantitative criteria for each element of compensation. Further, those criteria must be developed from a consistent data base of employers in order that the value of each element can be determined and, following a building block approach, the reasonableness of total compensation assessed. With quantitative criteria for each element, we believe it will be possible to prevent contractors from merely shifting costs to other elements without reducing total compensation.

NASA also questioned whether our overall recommendation is consistent with the broader sense of government policy espoused in Executive Order 12615, "Performance of Commercial Activities" (Nov. 19, 1987). The clear intent of that order, NASA said, is to encourage contracting out of functions presently performed internally by the government, presumably on the premise that efficiency and cost reduction will result. According to NASA, we address that government activity—defense and aerospace procurement—that is most thoroughly contracted out and propose to reform it with personnel rules patterned after those applied to government employees.

We see no inconsistency between our recommendation and Executive Order 12615 because none of the contractors reviewed are primarily performing functions that are, or have been, performed internally by the government. Our recommendation is intended to strengthen internal controls in the contracting process, not to discourage contracting.

Finally, NASA expressed concern that our recommendation is addressed to the Director of OMB rather than through normal FAR system channels and those agencies with statutory responsibility for its maintenance,

namely DOD, NASA, and GSA. NASA said it believes the FAR regulatory councils are in the best position to develop regulations.

We agree that the FAR regulatory councils are in the best position to develop quantitative criteria. Our recommendation is directed at OMB, however, because that agency has the overall responsibility for establishing procurement policies. We recognized the role of the FAR councils by recommending that OMB work with DOD, NASA, and GSA in revising the regulations.

Additional NASA comments are contained in appendix V.

GSA Comments

GSA said that quantitative reasonableness criteria or ceilings would be perceived as wage controls by both industry and employee unions and recommended that we seek a statutory basis for compensation limits before we proceed with our recommendation. The agencies would also need statutory authority, according to GSA, to establish an organization capable of performing compensation surveys and establishing reasonableness criteria. Maintaining a compendium of reasonableness criteria for all possible elements of compensation would be a virtually insurmountable task, GSA said, because of differences between industries, geographic locations, different size firms, and so on.

Quantitative criteria set a limit on what the government is willing to pay (unless higher costs are justified by the contractor), not on what a contractor can spend. Because of this, we believe procuring agencies have adequate legislative authority to establish quantitative criteria without congressional action.

Regarding the need for statutory assistance to establish an organization capable of performing compensation surveys, we believe adequate authority exists, and GSA currently conducts such surveys to establish travel per diem reimbursement rates. Similarly, the Bureau of Labor Statistics conducts annual surveys of medium to large industries and might be able to expand the survey to obtain the additional data needed to develop quantitative criteria.

GSA believes the contractor compensation reviews conducted by the defense agencies can be better tailored to the circumstances of an individual contractor than nationwide quantitative criteria. Such reviews

could, GSA said, use the data sources cited in our report when "considered applicable and appropriate" for challenging health insurance costs within the present framework.

Quantitative criteria would not replace contractor compensation reviews. Rather, they would provide a consistent and enforceable basis for conducting such reviews. Allowing auditors to use the sources we cited when "considered applicable and appropriate" could result in contractors being held to widely varying standards based on the whims of the individual auditor. We do not believe such a practice is fair or enforceable. Contractors have a right to (1) know in advance what criteria will be used to evaluate the reasonableness of their compensation costs and (2) be subject to criteria consistent with those applied to their competitors.

GSA said that the citation of high savings that would result from using government health insurance costs as a standard of reasonableness seems "patently inappropriate," saying that the government is generally out of line with industry practice.

We agree that FEHBP does not provide a sound basis for quantitative criteria, but believe it provides a benchmark for demonstrating the effect of cost sharing on health care costs. We have revised the report to make it clear that we are not advocating the adoption of FEHBP or any of the other benchmarks used for comparative purposes.

According to GSA, if the extended impact of more liberal health insurance benefits for industry employees and retirees is considered, there may actually be a benefit to the government and the nation through a reduction in the need for government health cost supplements and aid.

The primary difference between the 10 contractors' health care costs and those of other private sector firms and the government is the limited employee cost sharing required of contractor employees. Although the contractors' employees had more coverage in some areas—such as home health and dental care—those benefits are not, as GSA suggests, likely to significantly reduce the costs of federal health benefits because (1) there is very limited coverage of dental services under health financing programs and (2) most employees would probably not meet the requirements for Medicaid and Medicare coverage because of income and age restrictions. One important area where health insurance benefits can reduce the need for government health care program assistance is catastrophic coverage. Virtually all federal and postal employees have

catastrophic coverage, decreasing the likelihood that a serious or chronic illness will impoverish them and necessitate coverage under Medicaid. By contrast, 25 percent of contractor employees lacked catastrophic coverage, meaning that a prolonged illness could exhaust company-provided insurance and result in coverage under a federal program.

Additional GSA comments are contained in appendix VI.

OMB Comments

OMB did not specifically comment on our recommendations, but stated that it believes additional information is needed to support our conclusions that a test other than general reasonableness should be used to evaluate government contractors' health insurance reimbursements. Before an assessment could be made of the reasonableness of a contractor's health care costs, OMB said, information would be needed on such things as

- whether the contractor's product market share was expanding or contracting,
- "health outcomes" as a product of contractor plan costs,
- secondary cost effects compared with immediate plan costs,
- productivity of contractor employees as a function of compensation,
- industry supply and demand conditions at a point in time and over time, and
- alternative compensation packages available to the employee.

As the Air Force stated in proposing the April 1986 revision to FAR, the government should be able to negotiate contracts from a position of strength by establishing what it believes to be reasonable and by including only reasonable costs in the prices it negotiates and pays. The intent of the revised regulation was to make it easier for the government to challenge the reasonableness of a contractor's compensation and to place the burden of proof to demonstrate reasonableness on the contractor.

OMB, however, rather than using the regulation to enable the government to negotiate from a position of strength, would require government contracting officers and auditors to perform highly complex studies, frequently using data that may not currently exist, before challenging reasonableness. Clearly, a requirement that such analyses be performed in assessing reasonableness places the burden of proof on the government, not the contractor as intended by the regulation.

We do not believe that the government should have to analyze every potential factor that could cause a contractor's health care costs to exceed some quantitative limit. The revised regulation gives the contractor the opportunity to prove that demographic, geographic, or other factors justify costs that exceed what the government considers reasonable. The contractor can perform any or all of the analyses OMB mentions in support of its costs, but, as intended by the regulation, the burden is on the contractor to justify costs that exceed the norm.

OMB also said that it needed information on the numbers of employees eligible for, and covered by, the sample plans in order to make comparisons among plans and evaluate reasonableness. Employee cost, OMB said, is the major quantitative basis of comparison among plans, but no information was provided on the development of this statistic. OMB also said that it would need to know whether employees have other health insurance coverage and whether the contractor's plan was the primary or secondary plan. According to OMB, employees covered by more than one plan may benefit from both plans, and each may bear only part of the employee's health costs.

In developing per-employee health care costs for the 10 government contractors, we divided total health care costs by the number of employees covered by the plan. Also, in estimating potential savings using FEHBP data, we adjusted for differences in rates between single versus family coverage. We did not make similar adjustments in the Chamber of Commerce data because single/family data were not available. We did not determine the extent to which employees were covered under other health plans because such data were not used in determining costs under FEHBP or the Chamber of Commerce.

OMB said that it needs to know to what extent the corporation or the third-party insurer bears the costs of administering the plan, and whether these costs were included in the per-employee costs by each of the various studies. According to OMB, the costs of administering FEHBP are paid by the government, not the private insurer.

Administrative costs were treated in the same manner as such costs are treated in the Chamber of Commerce's Employee Benefits survey. We included the costs of paying claims but excluded costs of administering the plan. Under FEHBP, the premium includes both the cost of processing claims and OPM's costs for administering the program. Those administrative costs are then included in the premium.

According to OMB, our benefit-by-benefit approach does not reflect modern trends in employee benefits, which allow the employee to select benefits from a so-called "menu" of benefits made available to the employee by the employer. OMB said that "cafeteria" plans are successful because they tend to lower employer costs and increase employee satisfaction. A benefit-by-benefit analysis of reasonableness would discourage government contractors from adopting cafeteria benefit plans even though such plans lower costs, OMB said.

The benefit-by-benefit approach is, in our opinion, consistent with both federal procurement regulations and the trend toward "cafeteria plans." As stated on page 16, FAR was revised in April 1986 to make it clear that the government could challenge a particular element of compensation, such as health benefits. The revised regulation also provides that a contractor can introduce other elements of compensation to offset or compensate for the "unreasonableness" of one. It is such offsets that make the benefit-by-benefit analysis consistent with cafeteria plans. For example, if employees tend to choose more extensive health benefits in exchange for lower pension benefits, then the "unreasonableness" of the contractor's higher health care costs would be offset by lower than "reasonable" pension costs. Accordingly, a benefit-by-benefit analysis of reasonableness should do nothing to discourage cafeteria benefit plans.

According to OMB, one of the benefits that we associated with higher health insurance costs was home health care. The government experience with Medicare suggests, OMB said, that home health care and extended care benefits lower health and health insurance costs, not raise them, because they substitute for more costly hospital care.

While we agree that home health and extended care benefits can, if properly controlled, reduce health insurance costs, the experience with Medicare does not support the assertion that home health care generally substitutes for more costly hospital care. First, there is no longer a prior hospitalization requirement for home health coverage under Medicare. Second, as we discuss in our 1981 and 1986 reports,[1] home health is a difficult program to control, with about a third of the payments going toward noncovered services. We have, however, revised the report to show that these benefits, depending on how they are structured and controlled, could either increase or decrease health care costs.

[1]Medicare Home Health Services: A Difficult Program to Control (GAO/HRD-81-155, Sept. 25, 1981) and Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 2, 1986).

According to OMB, we concluded from a 1984 study of 12 contractors, which showed a faster rate of increase in employee earnings for contractors relative to the average earnings in the general economy, that contractors provide unreasonable compensation. These conclusions are inappropriate if control for other influences has not been provided, OMB said.

Our 1984 study did not conclude that contractors provide unreasonable compensation. We concluded, as we state on page 15, that the reasonableness of the 12 contractors' compensation could not be determined because the definition of reasonableness embodied in FAR lacked quantitative criteria and there were no generally accepted pay surveys to which contractors could be compared.

OMB also said that apart from expectations that employees will remain with the contractor that provides good health insurance, there is the further question as to whether the government ought not to encourage people to seek medical care. According to OMB, preventive health costs less over the long term, although the most efficient point of subsidy has not yet been determined.

We agree that the government ought to encourage people to seek needed health care and that preventive health costs less over the long term. However, if OMB is suggesting that the government not place any controls over health care spending in order to encourage contractor employees to seek needed care, then we disagree. Such a position is inconsistent with the administration's position with respect to cost sharing and the need to give health care beneficiaries incentives to be prudent shoppers. For example, the February 1982 Economic Report of the President states that

". . . Much of the increase . . . [in health care expenditures] has been due to perverse incentives that are built into the medical system. A set of arrangements for buying and selling health services has developed which insulates the participants from the economic consequences of their actions and raises serious questions about the effectiveness of these increased expenditures in buying more 'health.' The major problems are the prevalence of third-party payments and the exclusion of employer contributions from the taxable income of employees."

The report goes on to state that

". . . a system of deductibles and copayments makes the individual share in the costs. It leads to a more efficient use of resources than a plan that covers all medical expenses, beginning with the first dollar of expense. With "first-dollar" coverage,

the individual has no financial incentive not to seek treatment if it has any chance of being beneficial, regardless of its costs . . ."

OMB, in its fiscal year 1985 budget submission, explained the importance of premium cost sharing between employer and employee, stating that

"Since Federal employees pay a share of the cost of the FEHB program and have many plan choices available to them, competitive market forces help to restrain FEHB cost increases.

"In 1983, for example, the average cost of health benefit plans offered by private-sector FEHB carriers increased by over 20 percent. After federal employees made health plan selections for the year, however, the actual increase in costs was only 4 percent."

In both the fiscal year 1987 and 1988 budgets, OMB proposed a change in the way the government share of FEHBP premiums is determined to provide, according to OMB, "more equitable cost sharing between the Government and its employees." The effect of the proposed change would be a decrease in the maximum government contribution. The stated intent of the proposed change is to encourage federal employees to choose low-cost plans.

We believe that premium cost sharing on the part of contractor employees could have a similar moderating effect on their health care demands, making them more prudent shoppers for health benefits. In the end, both the government, through decreased costs under negotiated contracts, and the contractors, through improved competitive position in international markets, would benefit. As OMB states in its fiscal year 1988 budget summary:

"More efficient use of health resources would not diminish the quality of health care, but, as shown by the experience of major international competitors, would free the Nation's resources for other productive efforts."

OMB also said that an analysis of the costs of health care benefits of government contractors should include a floor for health care benefits as well as a ceiling. According to OMB, health insurance encourages medical treatment and early identification of job-related illness. Early treatment would, OMB said, reduce disability payments and adjudicated claims against the government, which could cost the government more than providing health insurance. Federal contractors are not, OMB noted, required to provide health insurance to their employees.

OMB's suggestion that contractors might discontinue their employee health benefits is inconsistent with comments from the contractors that state that extensive health benefits are offered to attract and retain highly skilled employees and are arrived at through collective bargaining agreements.

OMB's suggestion that controls over contractors' health spending would cost the government more through disability payments than the cost of the insurance is inconsistent with findings about the effects of cost sharing. In the August 1987 Health Services Research, Emmett Keeler reported the results of a government-sponsored study by the Rand Corporation to examine the effects of cost sharing on the health status of the nonaged. The study concluded that:

"... For an average, reasonably healthy person, having access to medical care free of charge will not lead to greatly improved health, whether measured in general, physiologic, or health habits terms. Indeed, people receiving free care were more likely to report worry or pain from these conditions."

Additional OMB comments are contained in appendix VII.

Industry Comments and Our Evaluation

We also obtained comments from the 10 contractors reviewed and the Council of Defense and Space Industry Associations (CODSIA). (See apps. VIII-XVIII.) Generally, the commenters were opposed to the establishment of quantitative criteria for determining the reasonableness of health care costs. The following summarizes the primary concerns expressed and our evaluation.

- Contractors generally commented that compensation should be evaluated in terms of total compensation, not on an element-by-element basis. While we agree in principle, experience suggests that this is not realistic in practice. In fact, the April 1986 revision to FAR permits an evaluation of total compensation from an element-by-element building block approach. (See p. 43.)
- Contractors generally commented that they should be allowed to offset higher health care costs with costs for other elements of compensation that are lower than what is considered reasonable. We agree and have revised the report to more clearly recognize the offset provisions. Application of the offset provisions, however, necessitates the development of quantitative criteria on an element-by-element basis. (See p. 44.)

- Five contractors commented that competition for sales is effective in containing health care costs. We agree, but are concerned about contractors that do not compete extensively for private sector business. (See p. 44.)
- Contractors generally stated that competition to attract and retain highly skilled staff requires that they offer extensive benefit packages. We agree that contractors need to be competitive for staff. Quantitative criteria would not, however, give any contractor an advantage in attracting and retaining staff because similar contractors would be judged by the same criteria. (See p. 45.)
- Quantitative criteria should, the contractors said, reflect the geographic and demographic differences between contractors. We would not object to establishing adjustment factors to compensate for location, age, sex, or other factors. However, we believe the regulations should specify what factors can be introduced to justify higher costs and the criteria to be used in evaluating them. (See p. 46.)
- Mandated benefits laws are causing their health care costs to increase, according to several contractors. Increased costs caused by federally mandated benefits laws affect all employers equally and would therefore be reflected in the quantitative criteria. Further, self-funded health plans, such as those operated by 8 of the 10 contractors, are exempt from state-mandated benefits. (See p. 46.)
- The contractors generally stated that benefits are determined through collective bargaining agreements and would be difficult to change. We recognize that quantitative criteria could not be applied to existing collective bargaining agreements and would have to be phased in. Contractors would have to keep the government reimbursement limits in mind when negotiating future contracts. (See p. 48.)
- The asserted criteria used in our report are, the contractors said, inappropriate. We agree that none of the data bases used in our comparisons provide an adequate basis for establishing quantitative criteria. We have revised the report to recommend the development of criteria fair and equitable to both the government and the contractors and to clarify that the points of comparison contained in the report should be viewed as benchmarks, not potential criteria. (See p. 48.)
- Cost containment efforts undertaken by the contractors are not, several said, reflected in the report. To the extent contractors have initiated cost containment efforts since 1985, it should be easier for them to meet any quantitative criteria developed. Cost containment would reduce the effect of quantitative criteria but would not eliminate the need for such criteria. (See p. 49.)

Total Compensation Should Be Evaluated

CODSIA and eight contractors (Boeing, General Dynamics, General Electric, Grumman, Lockheed, Raytheon, Rockwell, and United Technologies) said that compensation should not be evaluated on the basis of individual elements, but in total. CODSIA said that the 1986 change to FAR to allow a stand-alone evaluation of just one element of compensation was a mistake. Similarly, General Dynamics, while agreeing that quantitative criteria would be beneficial, said that it is essential that any such tool consider the total compensation package and not focus on a single element, as we have done in this report. Lockheed said that any judgment of compensation reasonableness should consider (1) the compensation package and not arbitrary comparisons of costs and (2) the overall compensation package rather than selective elements.

While we agree in principle with the comments, FAR was revised in April 1986 because the government had little success in challenging the reasonableness of contractors' compensation using a test of total compensation. As discussed on page 14, the Air Force concluded that, for all practical purposes, FAR's reasonableness criteria pertaining to total compensation were unenforceable. The Air Force noted that the government, even with its specialized compensation reviews, has never been able to scrutinize contractors' total compensation packages because of their complexity.

According to the Air Force, reviews are normally conducted of some element or elements of the compensation package and challenges, if any, are made to individual elements. Further, when challenged on some element of a compensation program, contractors generally respond, not by referring to the total compensation package, but rather by defending the challenged element or by claiming that some other element is lower than would be reasonable if considered in isolation.

In recommending the change that led to the April 1986 revision to FAR, the Air Force concluded that, however superficially appealing the total compensation test is, it is not the way in which judgments are made on the reasonableness of compensation in practice. According to the Air Force, the total cost is judged—if ever—by building it up from the individual elements of compensation.

The April 1986 revision permits contract negotiators and auditors to assess the reasonableness of total compensation from this building block approach. We agree with this approach and believe the quantitative criteria we recommend are essential for effective enforcement of the revision.

Offsets Should Be Allowed

The April 1986 revision to the regulations allows contractors, when defending the reasonableness of specific elements of cost, to introduce other compensation elements to offset or compensate for the "unreasonableness" of one. Contractors generally commented that our report did not consider such offsets. General Electric, for example, said that a compensation package that provides high health benefits will frequently provide low pension or other benefits. Citing federal employees as a specific example, General Electric said that the federal government has developed a compensation program that includes a trade-off between higher pension and sick leave benefits and less costly health benefits. Similarly, General Dynamics said that we did not consider offsets in arriving at our conclusion that health care costs are unreasonable.

As discussed on page 29, we have revised the report to more clearly recognize FAR's offset provisions. In our opinion, however, applying the offset provisions would require developing quantitative criteria on an element-by-element basis from a consistent data base of employers. Currently, the offset provisions render FAR essentially unenforceable because there is no consistent way to evaluate the value of the offsets.

Although the burden of proof is supposedly placed on the contractor to show that total compensation is reasonable, the contractor is allowed to select criteria on an element-by-element basis to evaluate offsetting elements. Because criteria from different data bases can be used to assess each element of compensation, there is no way to assess the reasonableness of total compensation.

An assessment of total compensation requires quantitative criteria on an element-by-element basis developed from a consistent source of data, whether it be federal employees or private sector employees.

Competitive Marketplace Provides Incentive to Contain Costs

Five contractors (Boeing, General Dynamics, General Electric, Raytheon, and United Technologies) stated that the competitive marketplace provides adequate incentives to contain health care and other compensation costs. For example, General Electric said that the company's diverse mix of commercial and defense businesses provides an "internal discipline" that acts to moderate wages and benefits. Similarly, United Technologies said that the forces of competition that result in particular cost levels in the commercial business extend also to the defense contracting business.

We agree that a competitive marketplace provides effective incentives for companies to contain costs. Companies such as General Electric and

United Technologies, which do most of their business with the private sector, must contain their health and other compensation costs in order to remain competitive in private markets. Companies that do not compete extensively in the commercial marketplace, however, do not face the same competitive pressures to contain costs because most government contracts are negotiated with limited price competition. Health care costs under negotiated contracts can be passed on to the government as long as they are "reasonable." Only 4 of the 10 largest contractors relied on the private sector for over 40 percent of their sales.

In a March 25, 1986, memorandum to the director, DAR Council, the Cost Principles Committee stated that competitive pressures by themselves are not strong enough to ensure that costs at defense contractors are kept within reasonable limits. The committee said that the government must have the right to challenge unreasonable costs, including unreasonable compensation costs, lest they simply be passed on to the government because of the special nature of the government marketplace.

For contractors that derive most of their business from the government with limited price competition, we believe it is necessary to establish additional internal controls over allowable costs. Quantitative criteria would provide such controls.

Competition to Attract and Retain Staff

CODSIA and eight contractors (Boeing, General Dynamics, General Electric, Hughes, Lockheed, Raytheon, Rockwell, and United Technologies) commented that defense contractors must offer competitive benefits in order to attract and retain a highly skilled work force. For example, CODSIA said that defense contractors compete for employees possessing high technical skills, such as engineers and scientists, who are able to command a much broader competitive compensation program of which health benefits is only one element. Similarly, Rockwell said that its goal must be a competitive total program of compensation and benefits to attract, retain, and motivate a qualified work force in both its commercial and government marketplaces.

While we agree that contractors need to be competitive for staff, they also need to contain costs to compete in world markets. According to OMB, high health care costs threaten the competitive position of American industries in world markets. OMB noted in the fiscal year 1988 budget that:

"Rising medical costs have been cited as a factor in the declining international competitiveness of many industries. During the last decade, the competitive burden of health care costs on American industry has doubled, widening the gap between the U.S. and its major trade competitors."

Without strong pressures to limit compensation costs in order to compete for sales, those contractors that do not compete extensively in world markets do not, in our opinion, have to worry as much about increasing costs to compete for staff. This, we believe, gives them a competitive advantage over other firms. Quantitative criteria would not give any contractor an advantage in attracting and retaining staff because similar contractors would be judged by the same criteria. In our opinion, this would create competition to design the most attractive compensation package within the limits allowed by the criteria.

Quantitative Criteria Should Reflect Geographic, Demographic Differences

CODSIA and all of the contractors criticized the potential criteria presented in the report because they do not reflect differences in costs that occur because of size, geographic location, or demographics of the work force. For example, McDonnell Douglas said that it has concentrations of employees in many geographic areas with high medical costs, making it inappropriate to develop a single set of criteria to gauge all defense contractors or to compare all parts of the country against one common set of criteria. General Electric said that employee demographics also introduce significant variances, citing such variables as age, sex, and dependent coverage. Regarding size, Raytheon said that it is a generally accepted fact that companies as large as the 10 contractors will have more costly benefits than those with 50 or more employees who participate in the Chamber of Commerce's Employee Benefits survey.

We would not object to establishing adjustment factors to compensate for location, age, sex, or other factors. However, as we state on page 27, we believe that if these factors are to be considered, FAR should be altered either to (1) reflect the factors in the quantitative criteria and eliminate the provision allowing contractors to justify challenged costs or (2) list the factors the contractors would be allowed to introduce in FAR along with the criteria that will be used to evaluate them.

Costs Increasing Because of Mandated Benefits

CODSIA and four contractors (General Electric, Hughes, McDonnell Douglas, and Raytheon) said that the contractors' costs are increasing because of state-mandated benefits and congressionally mandated

continuation-of-benefits provisions that do not apply to federal employees' health benefits. For example, CODSIA said that our report does not recognize the number of states that have mandated minimum levels of benefits. These mandates, CODSIA said, have no impact on federal employee health benefit plans, but directly affect private employers equally. Similarly, General Electric commented that the Consolidated Omnibus Budget Reconciliation Act of 1986 requires private sector employers to provide continuation of health coverage for terminated employees, divorced spouses, and children reaching the maximum eligible age, but public entities are exempt.

Because they are self-funded, 8 of the 10 government contractors reviewed are, like the federal government, exempt from state-mandated benefits. Further, although the contractors are subject to the continuation-of-benefits provisions of the Reconciliation Act, the employer is not required to pay for the continued coverage. The employer is allowed to charge the employee up to 102 percent of the cost of the coverage. Although FEHBP plans are not subject to the act, all provide similar continuation-of-benefits provisions. Further, increased costs caused by adverse selection[2] would affect all employers and, therefore, be reflected in the quantitative criteria.

CODSIA also commented that our approach would be at cross-purposes with initiatives being considered by the Congress to further extend health care benefits and costs at the employers' expense, citing pending mandated health benefits and catastrophic protection legislation. According to CODSIA, the government would be increasing contractors' costs through these bills while challenging them as being excessive.

Increased costs caused by the enactment of federally mandated health benefits would affect all employer-provided health benefits and would, therefore, be reflected in the Chamber of Commerce Employee Benefits survey or other quantitative criteria based on a cross section of employers. Medicare beneficiaries, not employers or their employees, would pay for the catastrophic health proposals cited by CODSIA. To the extent that employers provide Medigap[3] coverage to supplement Medicare, the enactment of the catastrophic proposals might reduce their costs.

[2]The tendency of persons with poorer than average health risks to purchase more insurance than persons with average or better health.

[3]Private insurance to cover all or part of the deductible and coinsurance amounts not covered by Medicare.

Benefits Shaped by Collective Bargaining

CODSIA and six contractors (Boeing, General Electric, Lockheed, McDonnell Douglas, Raytheon, and Rockwell) commented that health benefits and other elements of compensation are shaped by collective bargaining agreements. For example, General Electric said that its wages and benefits are the result of such agreements reached with several different unions. According to General Electric, our attempt to set a quantitative standard for health costs ignores the "give and take" that is the heart of collective bargaining. Rockwell similarly stated that it trades off different elements of total compensation during union negotiations. Raytheon said that the effects of unions on health care costs are not identified in the Chamber of Commerce study, and CODSIA said that health benefits are an emotional issue with employees and a strike issue with unions.

We recognize that quantitative criteria would have to be phased in as new collective bargaining agreements are reached. The establishment of quantitative criteria could help ensure that contractors protect the government's interests during collective bargaining. Quantitative criteria, rather than altering the ability of contractors to negotiate pay and benefits during collective bargaining, would give the government, and the contractors, a method for determining the net effect of the trade-offs made.

Finally, regarding comments that health benefits are a strike issue, we note that both General Electric and McDonnell Douglas reported success in negotiating significant changes in their health benefits programs to increase employee cost sharing. Having quantitative criteria should, in our opinion, aid the firms during contract negotiations with the unions.

Criteria Used Are Inappropriate

All of the commenters criticized the potential criteria presented in our report, particularly our use of the FEHBP and Chamber of Commerce data. For example, General Dynamics said that the 10 largest defense contractors are among the nation's largest firms and should be compared with similarly sized and located manufacturing and engineering businesses. Similarly, Boeing said that comparing Boeing to the government work force or medium-sized employers is inappropriate because each draws from a different labor pool.

While we agree that limitations in each of the data sources used in our comparisons limit their usefulness as quantitative criteria, we believe they provide appropriate benchmarks for comparison. As DOD and NASA state in their comments, the data used in our comparisons are available and can be used to assess the reasonableness of contractors' health care

costs. The industry's opposition to criteria based on such data, however, highlights the problems DOD and other contracting agencies are likely to face in attempting to challenge the reasonableness of a contractor's health care costs using available data sources. As stated on page 17, it will be difficult for the government to demonstrate that the criteria upon which it bases its challenge are fair and consistent. To overcome these problems, we believe that it is essential that the government develop quantitative criteria from a more extensive data base, either by expanding surveys currently conducted by the Bureau of Labor Statistics or developing a separate survey.

Contractors' Cost Containment Efforts

CODSIA and several of the contractors also criticized our report for not recognizing the significant cost containment efforts of the contractors, particularly those occurring in 1986, and said that our report deals with cost shifting rather than cost containment. For example, Grumman said that a significant factor overlooked in our study is its timing. According to Grumman, 1986 was a year in which many companies made changes that reduced costs significantly. McDonnell Douglas expressed similar views, stating that most of the defense contractors with labor agreements since 1985 have negotiated new agreements with numerous cost containment provisions, such as preadmission certification programs and preferred provider organizations. According to Hughes, as a result of its ongoing program to control medical costs within southern California and Tucson, where 90 percent of its employees are located, the company's per-employee medical plan cost declined in 1986. Hughes said that most of its savings have been achieved by creating business agreements with medical providers that have resulted in major reductions in hospital costs.

To the extent contractors have initiated cost containment efforts since the period covered by our review, those efforts would reduce the effect of quantitative criteria. Such criteria are still needed, however, as an internal control over government payments.

CODSIA said that our report criticizes cost-effective programs, such as home health care, extended care, hospice care, and utilization reviews. Similar views were expressed by Hughes, Boeing, Raytheon, Grumman, Rockwell, United Technologies, and General Electric.

We did not intend to criticize home health care, extended care, hospice care, or utilization reviews. Although we included home health care in a comparison of contractor and federal employee benefits, we were not

attempting to criticize this benefit any more than we intended to criticize the federal program for offering catastrophic coverage. We have, however, added a statement to the report indicating that home health care can, when used as an alternative to hospitalization, reduce costs. Whether home health care increases or decreases costs, however, depends largely on the coverage provided and the effectiveness of utilization controls. Our report does not discuss the effectiveness of contractors' utilization review efforts or their provision of hospice benefits.

According to Boeing, the primary premise of our report is that costs can be reduced by simply shifting more of the expense to individuals. Boeing said that it has undertaken a different strategy to contain costs, increasing the employee's financial incentives to use cost-effective health care providers, while attempting to reduce system costs through aggressive contracting and discounts with health care providers. Boeing said that it expects this approach to have a more significant effect on controlling overall health care costs. Rockwell expressed similar views.

We agree that the actions Boeing and Rockwell have taken can help contain the growth of health care costs. The same cost containment strategies are being used by the government and many other contractors. These actions, however, attack only one factor affecting health care costs—provider charges. We believe overutilization of health care services is as significant a problem. What is needed is a comprehensive effort to reduce costs, not an effort aimed at one aspect of the problem.

An effective way to reduce overutilization is to make employees more prudent shoppers for health care benefits. We reported in 1982 that:

"... the structure of the third party payment system isolates many consumers from the financial effects of their use of the health care system. Thus, the price of care for many is no longer a significant factor in health care decisions. As a result, consumers desire and health care providers deliver extensive, high quality care even when only marginal value would result."[4]

The 1982 Economic Report of the President stated that "a system of deductibles and copayments makes the individual share in the costs. It leads to a more efficient use of resources than a plan that covers all medical expenses . . . ."

[4]A Primer on Competitive Strategies for Containing Health Care Costs, GAO/HRD-82-92, Sept. 24, 1982.

OMB, in its fiscal year 1985 budget submission, similarly noted the importance of premium cost sharing in encouraging more cost-effective utilization of health care options, stating that

"... Since federal employees pay a share of the cost of the FEHB program and have many plan choices available to them, competitive market forces help to restrain FEHB cost increases.

"In 1983, for example, the average cost of health benefit plans offered by private-sector FEHB carriers increased by over 20 percent. After federal employees made health plan selections for the year, however, the actual increase in costs was only 4 percent."

Accordingly, we view cost sharing as an effective cost management strategy.

Health Cost Comparison of the 10 Contractors and Federal, Postal, and Manufacturing Industry, 1981-85

Table I.1: Employers' Per-Employee Health Insurance Cost for Federal Nonpostal and Postal, Manufacturing Industry, and 10 Largest Government Contractors, 1981-85[a]

	1981	1982	1983	1984	1985
Federal employees	$777	$874	$1,043	$1,145	$1,167
Postal employees	1,008	1,051	1,273	1,490	1,520
Manufacturing	1,302	1,494	1,681	1,752	1,896
Ten contractors	1,404	1,614	1,825	1,986	2,145

[a]Federal employees' and postal employees' costs represent maximum costs, manufacturing industry figures represent average costs, and contractor figures represent average costs weighted by number of employees.

Table I.2: Health Costs Per Employee for 10 Government Contractors, 1981-85

Contractor	1981	1982	1983	1984	1985
A	$1,129	$1,046	$1,275	$1,536	$1,613
B	1,047	1,250	1,418	1,581	1,690
C	1,507	1,856	2,011	1,922	1,852
D	1,402	1,506	1,819	1,896	1,890
E	1,425	1,650	1,803	1,967	2,170
F	1,867	2,135	2,359	2,389	2,559
G	1,701	2,007	2,365	2,629	2,572
H	1,872	2,164	2,413	2,302	2,589
I	1,980	2,158	2,458	2,700	2,809
J	1,580	2,013	2,065	2,396	2,830
Weighted average cost[a]	1,404	1,614	1,825	1,986	2,145
Weighted average reimbursement[b]	1,538	1,725	1,951	2,146	2,344

[a]Average cost of contractors weighted by number of employees.

[b]Average cost weighted by product of number of employees and share of government business.

Table I.3: Difference Between Contractors' Health Costs Per Employee With 40-Percent Cost Sharing and Maximum FEHBP Nonpostal Contribution for 1981-85

Contractor	Cost difference[a] 1981	1982	1983	1984	1985
A	$(155)	$(133)	$(219)	$(235)	$(197)
B	105	217	135	(27)	(93)
C	95	65	94	47	22
D	(69)	(211)	(232)	(169)	(144)
E	109	151	85	89	190
F	292	359	306	214	363
G	275	365	422	486	431
H	377	459	451	290	441
I	368	374	375	410	451
J	154	316	174	265	502

[a]We computed the above differences by multiplying the contractors' actual health costs per employee by 60 percent and then subtracting the potential FEHBP company cost per employee. We calculated the potential FEHBP cost per employee for each contractor by multiplying FEHBP nonpostal individual and family annual rates by the percentages of individual and family enrollees of total company enrollees, then adding the resulting individual amount to the resulting family amount to get the average potential FEHBP nonpostal cost per employee. Numbers in parentheses indicate that the contractor's per-employee health care costs would be below the maximum government contribution under FEHBP for nonpostal workers.

Table I.4: Difference Between Contractors' Per-Employee Health Care Costs With 25-Percent Cost Sharing and the Maximum Government Contribution for Postal Employees, Under FEHBP, 1981-85

Contractor	Cost difference[a] 1981	1982	1983	1984	1985
A	$(159)	$(345)	$(393)	$(333)	$(304)
B	(194)	(167)	(275)	(294)	(246)
C	131	270	168	(34)	(116)
D	46	1	15	(63)	(97)
E	63	109	3	(10)	114
F	398	494	461	242	428
G	278	385	443	507	434
H	365	449	386	268	454
I	460	468	469	512	564
J	193	395	217	351	628

[a]We computed the above differences by multiplying the contractors' actual health costs per employee by 75 percent and then subtracting the potential FEHBP postal company cost per employee. We calculated the potential FEHBP postal cost per employee for each contractor by multiplying FEHBP postal individual and family annual rates by the percentages of individual and family enrollees of total company enrollees, then adding the resulting individual amount to the resulting family amount to get the average potential FEHBP postal cost per employee. Numbers in parentheses indicate that the contractor's per-employee health care costs would have been below the maximum government contribution under FEHBP for postal workers, assuming 25-percent cost sharing.

Comparison of Health Insurance Coverage for Employees of the 10 Largest Government Contractors to Coverage for Federal and Private Sector Employees

The following sections summarize the level of coverage for eight health benefits for FEHBP, private sector, and each of the 10 contractors as of 1985. For each benefit or feature, the report presents a definition and the results of our analysis. Information on federal and private sector benefits was derived from our December 1986 report Health Insurance: Comparison of Coverage for Federal and Private Sector Employees.[1] Information on the 10 contractors' health benefits was obtained by reviewing employee benefit and health plan brochures.

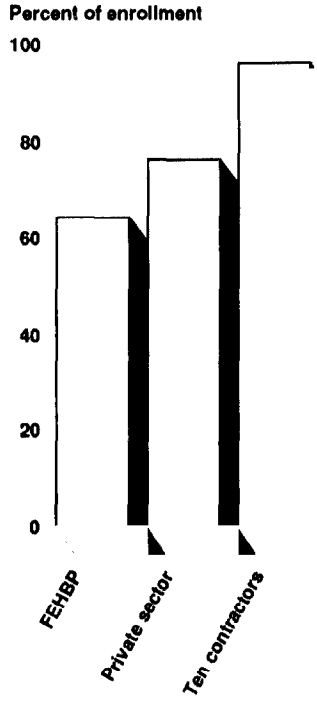
Dental Care

Definition

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

[1]GAO/HRD-87-32BR, Dec. 31, 1986.

Figure II.1: Federal, Private Sector, and Contractor Enrollees Covered by a Dental Care Benefit (1985)



Results

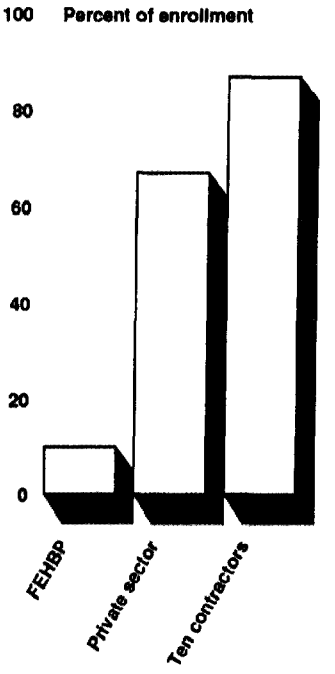
Dental care is offered more extensively among the 10 contractors than among FEHBP plans or other private sector employers. (See figure II.1.) Ninety-six percent of the 10 contractors' employees were offered dental care benefits, compared to 76 percent of enrollees in the private sector and 64 percent of federal and postal workers.

Extended Care

Definition

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

Figure II.2: Federal, Private Sector, and Contractor Enrollees Covered by an Extended Care Benefit (1985)



Results

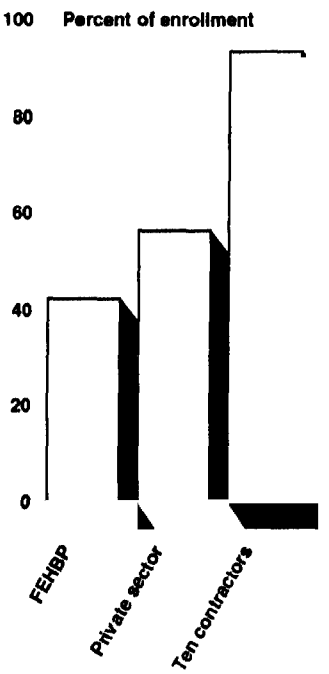
Extended care benefits were covered more extensively by the 10 contractors than by either FEHBP plans or other private sector employers. (See figure II.2.) Eighty-six percent of the contractors' employees were covered compared to 10 percent of federal enrollees and 67 percent of private sector enrollees.

Home Health Care

Definition

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

Figure II.3: Federal, Private Sector, and Contractor Enrollees Covered by a Home Health Care Benefit (1985)



Results

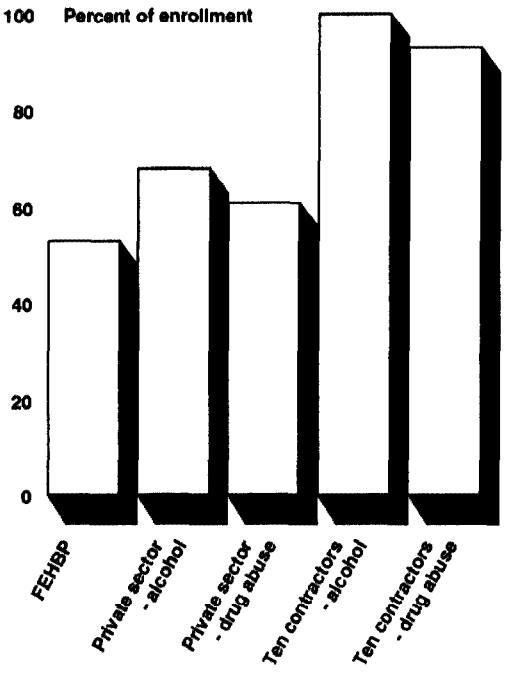
Ninety-three percent of the 10 largest government contractors' employees were provided home health benefits compared to 42 percent of federal enrollees and 56 percent of private sector enrollees. (See figure II.3.)

Alcohol and Drug Abuse Care

Definition

Alcohol and drug abuse care is the treatment of alcoholism, drug addiction, and drug abuse. Included are inpatient and outpatient programs that provide counseling services, educational programs, nutritional and medical therapies, and recreational activities. Inpatient care is generally limited to 20 to 30 days per year. In addition, treatment may include medical and hospital services related to acute care or detoxification. Acute care is treated the same as any other illness or condition. All federal and private sector health plans cover acute care even if they do not cover alcohol or drug abuse treatment.

Figure II.4: Federal, Private Sector, and Contractor Enrollees Covered by an Alcohol and Drug Abuse Care Benefit (1985)



Results

Alcohol and drug abuse care was covered more extensively for employees from the 10 largest contractors than for federal or private sector enrollees. (See figure II.4.) All employees of the 10 largest government contractors were covered for alcohol care, and 9 of the 10 contractors, with 93 percent of enrollees, covered drug abuse care. In contrast, 53 percent of federal enrollees were covered for alcohol and drug abuse care, and of private sector enrollees, 68 percent were covered for alcoholism treatment, and 61 percent for drug abuse treatment.

Coinsurance for Major Medical Benefits

Definition

Coinsurance is the fixed percentage of covered medical charges paid by the enrollee. For example, if a plan offers enrollees a coinsurance rate of 25 percent, the plan would pay 75 percent and the individual would pay

25 percent of covered charges. Major medical benefits cover many categories of expenses, such as hospitalization, physician services, and laboratory fees, some of which are not covered by basic benefits and others for which basic coverage limits have been exhausted. Major medical benefits are characterized by deductibles and coinsurance.

Figure II.5: Federal, Private Sector, and Contractor Enrollees Subject to 25-Percent Coinsurance (1985)

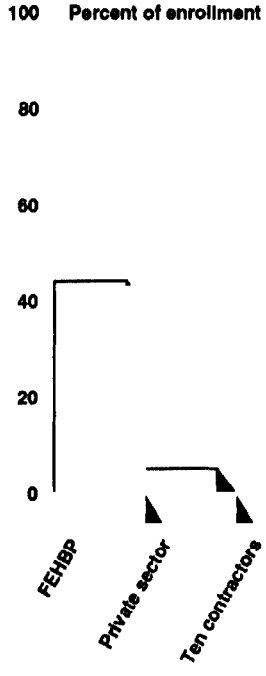
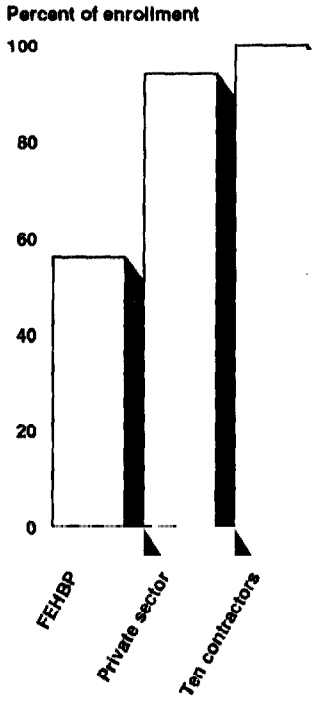


Figure II.6: Federal, Private Sector, and Contractor Enrollees Subject to 10- to 20-Percent Coinsurance (1985)



Results

About 80 to 90 percent of federal and private sector enrollees were subject to coinsurance, compared to 78 percent of the contractor employees. Two contractors, representing 22 percent of the enrollees, paid 100 percent of all covered medical expenses.

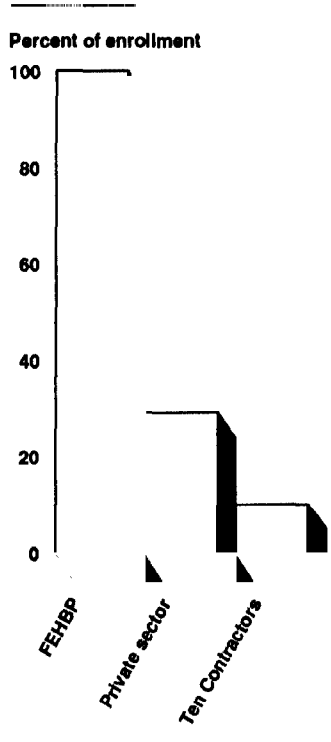
The contractors' employees with coinsurance were required to pay a smaller share of their medical costs than were many federal enrollees and private sector employees. (See figure II.6.) All of the contractors' employees subject to coinsurance paid 10 to 20 percent of their medical bills, as did about 95 percent of private sector enrollees and 56 percent of federal enrollees. (See figure II.6.) The other 44 percent of federal enrollees and 5 percent of private sector enrollees paid 25 percent of their medical bills. (See figure II.5.)

Flat Rate Deductible for Major Medical Benefits

Definition

A flat rate deductible is the amount of covered charges that an enrollee must pay before his or her health plan pays any benefits. Deductibles are usually applied on a calendar year basis.

Figure II.7: Federal, Private Sector, and Contractor Enrollees Subject to Flat Rate Deductibles of $150 or More for Major Medical Benefits (1985)



Results

All employees of the 10 contractors and about 80 to 90 percent of federal and private sector enrollees were in plans that had deductibles for major medical coverage.

As shown in figure II.7, all federal enrollees were subject to deductibles of $150 or more, while about 29 percent of private sector enrollees and 9 percent of contractor employees were subject to this level of deductibles.

The remaining private sector enrollees paid less than $150 in deductibles, and the remaining contractor employees paid deductibles of $100 or less.

Catastrophic Protection

Definition

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

Figure II.8: Federal, Private Sector, and Contractor Enrollees Subject to Coinsurance With No Catastrophic Protection (1985)

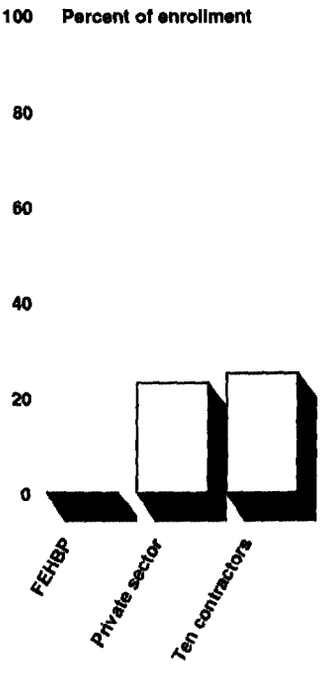


Figure II.9: Federal, Private Sector, and Contractor Enrollees With Catastrophic Protection Limits of $1,200 or Less (1985)

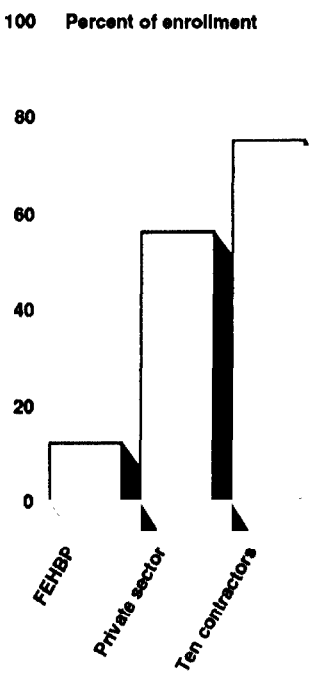
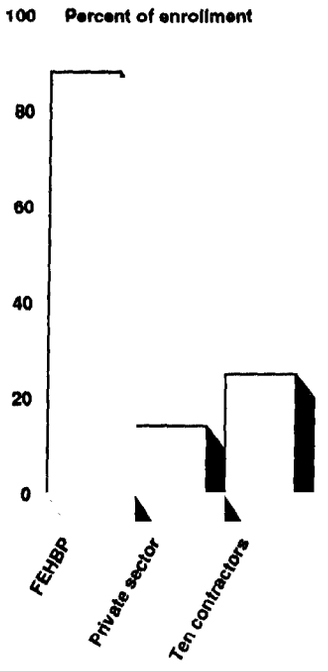


Figure II.10: Federal, Private Sector, and Contractor Enrollees With Catastrophic Protection Limits Over $1,200 (1985)



Results

In 1985, contractor and other private sector employees were less likely than federal enrollees to have catastrophic protection. (See figure II.8.) All FEHBP enrollees had catastrophic protection, whereas 23 percent of private sector enrollees and one contractor representing 24 percent of contractor enrollees lacked such coverage.[2]

When covered by catastrophic protection, contractor and other private sector enrollees had better protection than their federal counterparts. In 1985, of employees with catastrophic protection, 75 percent of contractor employees and 58 percent of private sector employees were protected against out-of-pocket medical costs of $1,200 or less compared to about 12 percent of federal enrollees. (See figure II.9.) About 25 percent of contractor employees (those of two companies) and 14 percent of private sector enrollees would have to pay more than $1,200 in medical expenses before their plan covered the remaining benefit expenses. In contrast, 88 percent of federal enrollees would have to pay more than $1,200 out of pocket. (See figure II.10.)

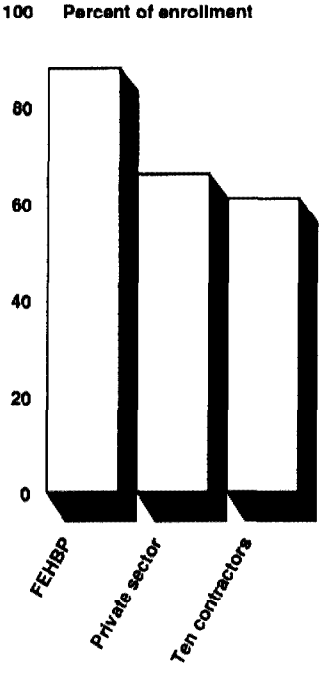
[2]Two contractors representing 22 percent of contractor enrollees provided first dollar coverage of most major medical expenses, making specific catastrophic protection unnecessary.

First Dollar Coverage for Hospital Room and Board

Definition

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

Figure II.11: Federal, Private Sector, and Contractor Enrollees Provided First Dollar Coverage for Hospital Room and Board (1985)



Results

In 1985, federal enrollees were more likely to be covered by this benefit than were the 10 government contractors or other private sector enrollees. (See figure II.11.) Eighty-eight percent of federal enrollees had first dollar coverage of room and board, compared to 66 percent of private sector enrollees and 61 percent of the 10 government contractors' enrollees.

Characteristics of Government Contractors Selected for Review

	1981	1982	1983	1984	1985
Number of employees (in thousands)	970	956	945	979	999
Health care costs (in millions)	$1,348	$1,522	$1,702	$1,916	$2,105
Total sales (in billions)	$85	$85	$92	$100	$109
Government sales (in billions)	$32	$39	$46	$49	$56
Average percentage of government to total sales[a]	54	59	63	62	63

[a]Average of each company's share of government business—not based on overall percentage of government to total sales.

Comments From the Department of Defense

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301-8000

PRODUCTION AND
LOGISTICS

25 JAN 1988

Mr. Frank C. Conahan
Assistant Comptroller General
National Security and International
Affairs Division
United States General Accounting Office
Washington, DC 20548

Dear Mr. Conahan:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) Draft Report, "GOVERNMENT CONTRACTORS: Limits Needed On Employee Health Insurance Reimbursement," dated November 13, 1987 (GAO Code 101111), OSD Case 7461.

The DoD has reviewed the GAO Report and does not concur with the recommendation that the Federal Acquisition Regulation (FAR) be revised to specify quantitative criteria for determining the reasonableness of the Government's reimbursement of contractor health insurance costs. While the quantitative criteria set forth in the GAO report might be useful for assessing reasonableness, no one criterion alone is sufficient for use in determining the reasonableness of every contractor's health insurance costs.

Additionally, the Department is opposed to the establishment of any type of dollar limitation on individual elements of compensation cost. This would undoubtedly be viewed as a form of wage control by industry and the legislative branch. It would also be inconsistent with the current FAR requirement that the particular circumstances surrounding the compensation element must be considered, along with other compensation elements which may be lower than would be considered reasonable.

The Department of Defense has long been concerned about the reasonableness of compensation costs. For a number of years, Defense Agencies have provided guidance to contracting officers, their representatives and auditors for determining the reasonableness of both total compensation cost and individual elements of compensation cost. Included in this guidance are references to various sources of data and surveys (such as the U.S. Chamber of Commerce annual Employee Benefits survey), which can be used as benchmarks for determining reasonableness. For several years, the Joint Logistics Commanders have issued

escalation guidelines to be used by contracting officers in the negotiation of compensation and benefits. In April 1986, the FAR was revised to provide more detailed guidance on the reasonableness of compensation costs. It is still too early to determine how effective that change has been in shifting the burden of proof of reasonableness from the Government to contractors. As more experience is gained with the new cost principle, the DoD, the General Services Administration and the National Aeronautics and Space Administration will evaluate its effectiveness. If necessary, appropriate changes will then be made.

Thank you for providing the Department an opportunity to comment on the GAO draft report. Detailed DoD comments on the report findings and recommendation are enclosed.

Sincerely,

Jack Katzen
Deputy Assistant Secretary of Defense
(Systems)

Enclosure

GAO DRAFT REPORT - DATED NOVEMBER 13, 1987
(GAO CODE 101111) OSD CASE 7461

"GOVERNMENT CONTRACTORS: LIMITS NEEDED ON EMPLOYEE HEALTH INSURANCE REIMBURSEMENT"

DEPARTMENT OF DEFENSE COMMENTS

* * * * *

FINDINGS

- **FINDING A: Background: Contractor Employees Health Care Costs.** The GAO explained that the Office of Federal Procurement Policy, within the Office of Management and Budget (OMB), is responsible for setting overall procurement policies. The GAO pointed out, however, that the Department of Defense (DoD), the General Services Administration (GSA) and the National Aeronautics and Space Administration (NASA) are responsible for issuing and administering the regulations and reviewing the reasonableness of contractor compensation. The GAO reported that the Federal Acquisition Regulations (FAR) have long contained cost principles to determine the allowability of contract costs such as salaries, bonuses, and health insurance to the extent that they are reasonable. Notwithstanding, the GAO concluded that the Government has had little success in challenging the reasonableness of contractor compensation costs. The GAO observed that, under a 1986 change in the FAR, the Government can now challenge an individual element of compensation and criteria, other than size, industry or geographic area, to define reasonableness. The GAO further observed, however, that the changes still do not give the Government explicit or quantitative criteria to use in determining reasonableness of contractor costs. The GAO reported that, in FY 1985, the Federal Government awarded its ten largest contractors over $50 billion in contracts, reimbursing these contractors about $1.2 billion for employees health care expenses. The GAO concluded that the Government needs to establish quantitative criteria for determining the reasonableness of contractor health care costs. (pp. 2-17/GAO Draft Report)

Now on pp. 2-13.

DOD POSITION: Partially concur. While the factual statements are generally accurate, the DoD disagrees with the GAO conclusions. The Government does have explicit or quantitative criteria to use in determining reasonableness of contractors' health insurance costs. For a number of years, the Defense Agencies have provided guidance to

contracting officers, their representatives and auditors for determining the reasonableness of both total compensation cost and individual elements of compensation cost. Included in this guidance are references to various sources of data and surveys (such as the U.S. Chamber of Commerce annual Employee Benefits survey), which can be used as benchmarks for determining reasonableness. It appears that the GAO was not aware that these explicit criteria are already available to and used by the Department to evaluate compensation cost.

If the GAO is advocating that one of these surveys or sources of data be selected for the purpose of establishing a limitation or ceiling on a particular element of compensation cost, the Department would also nonconcur. While an evaluation is performed on individual elements of compensation to determine reasonableness, the compensation cost principle also requires that the particular circumstances surrounding the compensation element must be considered, along with offsetting elements which may be lower than would be considered reasonable. Establishment of any type of limitation on a particular element would clearly conflict with the cost principle and would possibly be viewed as a form of wage control by industry and the legislative branch.

- **FINDING B: Problems in Assessing the Reasonableness Of Compensation Costs**. The GAO found that, until April 1986, the FAR stated, "Compensation is reasonable to the extent that the total amount paid or accrued is commensurate with compensation paid under the contractor's established policy and conforms generally to compensation paid by other firms of the same size, in the industry, or in the same geographic area, for similar services..." (underscoring supplied) The GAO observed, however, that the Defense Contract Administration Service and the Defense Contract Audit Agency efforts to use the regulation had resulted in little success in substantiating findings that compensation was unreasonable. In addition, the GAO found that the courts or boards of contract appeal held actual compensation costs incurred by contractors were presumed to be reasonable, unless proven otherwise by the Government (usually through detailed studies, which include employee qualifications, performance and industry conditions). The GAO reported that the above difficulties led the Air Force to conclude that the reasonableness criteria in the FAR was unenforceable and should be changed. In this regard, the GAO reported that, in March 1984, the Air Force proposed that the regulation be revised, as follows:

- to give the Government greater authority to review and approve changes in contractor compensation systems;

- to give the Government more flexibility in determining the relevant comparative criteria; and

- to put more of the burden on contractors for establishing reasonable compensation. (pp. 17-18/GAO Draft Report)

Now on pp. 14-16.

DOD POSITION: Concur. The revised FAR language, which became effective in April 1986, provides general reasonableness criteria for compensation cost, and places the burden on contractors for establishing reasonableness. This revision should result in more favorable consideration by the courts or boards of contract appeals in the future.

o **FINDING C: April 1986 Change To Federal Acquisition Regulations.** In 1984, the GAO completed a comparative analysis of the pay and benefits at 12 of the nation's largest aerospace contractors and found that, on the average, executives, clerical, technical and factory employees were paid more than the average for similar positions surveyed by the Bureau of Labor Statistics and American Management Association.1/ The GAO reported that, in April 1986, the FAR was amended to provide more detailed guidelines for assessing the reasonableness of contractor compensation practices and for dealing with possible Government challenges to their reasonableness. According to the GAO, the new regulations attempted to make three improvements to the FAR, as follows:

  - to make clear that the Government can challenge any single element of compensation, such as health benefits (although the contractor can still introduce other compensation elements to offset or compensate for the unreasonableness of one);

  - to make clear that a contractor's compensation is not inherently reasonable just because it passes one of the specific criteria of size, industry or geographic area standards (i.e., the revisions explicit allow the Government to use criteria other than size, industry or geographic area); and

  - to make clear that a contractor's compensation practices and costs are not presumed to be reasonable, once challenged by the Government.

1/ GAO/NSIAD-85-1, "Compensation by 12 Aerospace Contractors," October 12, 1984 (OSD Case 6577)

The GAO observed that, according to the Chairman of the Cost Principle Committee of the DAR Council, the intent of the third change is to place the burden of proof to demonstrate reasonableness on the contractor, instead of on the Government. The GAO concluded, however, that the changes to the FAR still do not give the Government explicit or quantitative criteria to use in determining reasonableness of contractor compensation costs and that the fundamental solution rests with developing enforceable criteria acceptable and fair both to the DoD and the contractors. (pp. 18-20/GAO Draft Report)

Now on pp. 16-18

DOD POSITION: Partially concur. The DoD agrees with the facts, as presented, but disagrees with the conclusion, which implies that explicit or quantitative criteria (to use in determining reasonableness of contractor compensation costs) should be included in the FAR. Explicit quantitative criteria are available and are being used within the Department to evaluate the reasonableness of compensation costs. (Also see DoD response to Finding A.)

As the GAO noted, the intent of the April 1986 FAR change is to place the burden of proof to demonstrate reasonableness on the contractor. This is accomplished by requiring the contractor to describe which available surveys or other methods are used to establish compensation levels. The contractor methodology is examined, and available surveys and data, which provide the best comparability to the particular contractor situation, are also examined. This analysis is performed at both the gross compensation level, the gross fringe benefit level, and for the largest areas of fringe benefits.

The change to the FAR was implemented only eighteen months ago. It is, therefore, too soon to determine how effective that change has been in conveying to the Government the right to challenge compensation costs in total or by individual element, and conveying to contractors the responsibility for demonstrating the reasonableness of compensation costs. Until the effectiveness of this revision can be fully evaluated, it is the Department position that no further changes should be made to the compensation cost principle.

- **FINDING D: Potential Quantitative Criteria For Assessing Health Care Costs.** The GAO stated that it sought to identify potential criteria for assessing contractor compensation costs for health insurance because the changes to the FAR still do not give the Government explicit criteria to use in determining reasonableness. The GAO identified two available sources of data that could be used to establish fairness to the contractors, based on the cost of employer provided group health insurance, as follows:

- The Federal Employees Health Benefits Program (FEHBP). The GAO reported that the FEHBP offers health insurance to Federal and postal employees and annuitants and their dependents, is administered by the OPM, and includes about 300 different plans with 10 million enrollees and premiums of $6.4 billion. The GAO observed that it selected the maximum Government contribution toward Federal health insurance under FEHBP as a potential criterion rather that the actual Federal payments. The GAO noted that, since the OPM and the plans negotiate premium rates prior to the beginning of each year, and the maximum contribution is set at that time, administration of the criterion would be relatively easy and more equitable to contractor employees.

- The U.S. Chamber of Commerce Annual Employee Benefits. The GAO reported that the U.S. Chamber of Commerce Employee Benefits study provides, for a cross-section of American industries, how much employers paid to provide health insurance to their employees. The GAO observed that it selected the national average for manufacturing industries because the largest Government contractors fit into that group. The GAO further observed that, although the Employee Benefits study is limited to employees who are paid by the hour, it is still reasonable because all of the contractors selected provided similar benefits to salaried and hourly workers.

The GAO reported that, in addition, as a third quantitative criterion, it calculated the weighted average per employee health care costs of the ten largest Government contractors, factoring in both their Government and nongovernment business. According to the GAO, however, these data are not as readily available as the FEHBP or the Chamber of Commerce data. (pp. 21-23/GAO Draft Report)

Now on pp. 18-19.

DOD POSITION: Nonconcur. The DoD disagrees that any one of the three potential quantitative criteria identified by the GAO would be appropriate for use by the Government in establishing the reasonableness of contractor health insurance costs. It is the Department's position that no one criterion is appropriate for determining the reasonableness of an element of contractor compensation.

The different levels of reimbursement afforded to postal versus nonpostal employees serve as a good example of the role that employee unions can play in the establishment of benefit levels, even within the Federal Government. The FEHBP coverage provided by the Federal Government to postal employees is approximately 36% more expensive than the FEHBP

coverage provided to nonpostal employees. The primary difference between these two groups of Federal employees is the level of union involvement in negotiating fringe benefits. Needless to say, the ten contractors' benefit structure reflects this circumstance.

Of course, while individual elements of compensation are subjected to scrutiny to ensure their reasonableness, consideration must also be given to other offsetting compensation elements, which may be lower than would be considered reasonable. As the FAR states, a number of factors must be considered in determining reasonableness based on the particular circumstances. The whole process of determining the reasonableness of individual elements of compensation is complicated by the recent industry practice of providing a "market basket" of fringe benefits from which employees select the mix and level of benefits that best suit their individual needs. Under this practice, which is rapidly growing in popularity, it becomes even more difficult to establish criteria for individual elements of compensation.

- **FINDING E: Criteria Would Significantly Reduce Contract Costs.** The GAO found that, between 1981 and 1985, the Government reimbursed its ten largest prime contractors about $4.5 billion for the costs they incurred to provide health insurance to their employees. The GAO reported, as follows:

  - in 1985, the cost per active employee of the ten largest contractors exceeded the maximum Government contribution under FEHBP for Federal nonpostal workers by $479 to $1,634 and Federal postal workers by $99 to $1,344.

  - According to industry criteria, six of the ten firms exceeded the manufacturing industry average by $249 to $934, or an overall amount of $448 more per employee for health care coverage provided by the ten largest contractors than it would have if allowable costs had been limited to the industry average reported by the Chamber of Commerce.

  - the per employee health care costs of six of the ten contractors were higher than the weighted average per employee health care costs of all the ten contractors, considering both Government and nongovernment business.

  The GAO estimated that the potential multi-year savings under the weighted average of the ten contractors' costs would have been about $350 million over the 5-year period, 1981 through 1985. The GAO further estimated that, under

the average per employee costs of health insurance for manufacturing industries (Employee Benefits), the Government would have saved about $1.2 billion over the 5-year period. Finally, the GAO estimated that savings could have reached $2 billion, if the allowable contractors' costs had been limited to the maximum Government contribution under the FEHBP. The GAO concluded that, at the ten contractors reviewed, setting a limit on allowable health care costs based on the maximum Government contribution for Federal employee health insurance or the manufacturing industry average (as reported by the U.S. Chamber of Commerce) could have reduced Federal Government costs by about $350 million to $2 billion for the 5-year period 1981 through 1985. (pp. 21-28/GAO Draft Report)

Now on pp. 19-21.

DOD POSITION: Partially concur. Setting an absolute dollar ceiling on the amount the DoD would reimburse contractors for employee health care costs would obviously produce savings. The extent of such savings is debatable, however. In any event, the DoD does not agree that any of these criteria could be used as the single data point for determining reasonableness for all contractors, nor does the DoD agree that a ceiling should be imposed on any element of compensation costs. Any projected savings are, therefore, moot.

- **FINDING F: Lower Cost Sharing by Contractor Employees.** The GAO found that, while significant cost savings could result from imposition of either of the selected criteria discussed above, the higher health care costs could largely be explained by the lower cost sharing required of contractor employees compared to employees of other private sector employers and the Federal Government. The GAO observed that cost sharing is an important part of the Federal health care financing programs such as Medicare and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The GAO further observed that Federal workers have shared in the cost of their health insurance since the FEHBP inception in 1959. The GAO found, however, that in 1985, only one of the ten contractors required any of its employees to share in the cost of their individual health insurance premium. The GAO concluded that these contractor employees paid less than Federal employees and the average private sector employee. The GAO also observed that cost sharing through deductibles and coinsurance has been shown to be an effective way to reduce the utilization of medical services and thus health care costs. The GAO concluded that it would not be unreasonable to expect Government contractors to impose employee cost sharing to the same extent imposed by other medium to large sized companies or the Federal Government. (pp. 29-34/GAO Draft Report)

Now on pp. 22-25.

DOD POSITION: Partially concur. The Department agrees that it would not be unreasonable to expect Government contractors to impose employee cost sharing. However, it is impossible to determine from the Chamber of Commerce survey, for example, exactly how much cost sharing is being imposed on employees since data are collected only on the particular firm's contribution to employee health insurance, and not on the employee contribution. Additionally, any analysis of individual elements of compensation cost must still consider other offsetting elements, and the GAO approach is not consistent with that concept.

- **FINDING G: The Kinds and Extent of Services Covered Contributed To Higher Contractor Costs.** The GAO found that, also contributing to the higher contractor health care costs, were the kinds and extent of the services they covered. The GAO noted, for example, that in 1985, the contractor employees were more likely to have coverage for dental care, home health services, and alcohol and drug abuse treatment than employees of other large sized private sector firms or the Federal Government. The GAO cited that 96 percent of the contractor employees were provided dental benefits, 100 percent of employees were provided coverage for alcohol and 91 percent for drug abuse care, and 93 percent were provided home health benefits. In comparison, the GAO reported that percentage wise, the coverage provided by other private sector firms and the Federal Government was less (see detailed comparisons in Appendix II of the report). (pp. 34-35/GAO Draft Report)

Now on p. 26.

DOD POSITION: Concur. However, the GAO report also indicates that the ten contractors surveyed to not provide some benefits, such as catastrophic protection, to the same degree that it is provided by the FEHBP or industry in general. Analyses of this type serve to demonstrate the complexity of the issues involved when discrete analyses must be made of elements of the elements of compensation cost. These analyses also demonstrate that no useful purpose would be served by the imposition of limitations on the individual elements of compensation cost.

RECOMMENDATION

- **RECOMMENDATION:** The GAO recommended that the Director, OMB, through the Administrator of the Office of Federal Procurement Policy, work with the Department of Defense, the National Aeronautic and Space Administration, and the General Service Administration to revise the Federal Acquisition Regulations to specify quantitative criteria for

Now on p. 27.

determining the reasonableness of Government reimbursement of contractor health insurance costs. (The GAO observed that the Director should determine the need to develop similar quantitative criteria for assessing the reason-ableness of other elements of compensation and contractor total compensation costs.) (p. 35/GAO Draft Report)

DOD POSITION: Nonconcur. The DoD disagrees that quantitative criteria for judging the reasonableness of contractor health insurance costs should be included in the FAR. Criteria are already available and being used within the Department. No one criterion would be appropriate for judging the reasonableness of every contractor's health insurance costs, and it is impractical to include a comprehensive list of available criteria in the FAR. Additionally, the Department is opposed to the imposition of limitations on elements of compensation.

Comments From the National Aeronautics and Space Administration

NASA

National Aeronautics and
Space Administration

Washington, D.C.
20546

Reply to Attn of NPN

DEC 22 1987

Mr. Frank C. Conahan
Assistant Comptroller General
National Security and International
Affairs Division
United States General Accounting Office
Washington, DC 20548

Dear Mr. Conahan:

We appreciate the opportunity to review and comment on the General Accounting Office (GAO) draft report entitled, "Government Contractors, Limits Needed on Employee Health Insurance Reimbursement," GAO/HRD-88-27.

NASA requests a reconsideration of the recommendation made in the report. Recommendations to amend the Federal Acquisition Regulations should be addressed to the agencies with the statutory responsibility to maintain the FAR system of regulations. Specific agency comments are provided in the enclosure.

If you need additional information or have any questions, please call Clarence Milbourn on 453-2122.

Sincerely,

M. Peralta
Acting Associate Administrator
for Management

Enclosure

DRAFT GAO REPORT--GOVERNMENT CONTRACTORS:
LIMITS NEEDED ON EMPLOYEE HEALTH INSURANCE REIMBURSEMENT
(GAO/HRD-88-27)

The draft GAO report alleges that between $350 million and $2 billion could have been saved on those contract costs represented as health costs of the ten largest government contractors between 1981 and 1985 if allowable costs were limited by certain quantitative criteria. GAO recommends that the Commercial Contract Cost Principles be revised to contain a limit on allowable health premiums based upon explicit quantitative criteria. They suggest three possibilities: (i) the government contribution toward civil servant health premiums; (ii) average premiums for hourly manufacturing employees as shown in the U.S. Chamber of Commerce's annual "Employee Benefits" study; or (iii) some average expenditure, such as the ten contractor sample used by GAO.

While the report concerns itself only with health insurance costs, its formal recommendation strongly implies that the development of rigid quantitative limitations on as many elements of compensation as possible would be a step forward. If we accept the rather obvious premise that it is in the interest of any employer to have a compensation scheme that achieves the maximum possible level of employee satisfaction and morale for the resources expended, such rigid schemes are self-defeating. In fact, in recent years more forward thinking organizations have evolved fringe benefit plans in which employees have some control over the makeup of their individual package of fringe benefits. GAO seems headed in the opposite direction.

Holding up a federal government personnel policy as a model requires a blind eye for the government's recruitment and retention track record in recent years. We hope our goal is not similar attainments in contractors' staffing. Recommending such a standard has an aroma of spitefulness. It is doubtful that a contractor would be able to negotiate as favorable a health insurance package as could the federal government in view of the economies of size. Contractor employees would be left with an even poorer package than are government workers. The equity of using the government standard is not likely to be defensible or politically sustainable.

While use of a broader index such as the Chamber of Commerce data would be comparatively fairer than the civil service standard, it would carry its own problems. The index would not have been compiled under government auspices. The government would have no assurance that the data would be generated and presented in the same format from year to year or when it would be available. It is likely that such a standard would generate a requirement for government maintenance of the index similar to the way travel per diem limits are currently set for federal workers and contractor employees. In that case, GSA already had the responsibility for

setting reasonable travel and per diem limits for federal employees. Comparison of health costs to travel costs makes for a very weak analogy. Generally speaking, individuals, be they civil servants or contractor employees, all travel on the same travel economy, but economies of size loom very large in the negotiation of health premiums. It is conceivable that premium limits will have to differ as to the size of contractor organizations.

It is difficult to understand how a limit based upon average costs will work as a cost principle. Such a standard would seem to invite a natural if unspoken collusion whereby all data sources would cluster near the average. While some would come down, others would rise. Additionally, the average employed as limit on allowability would have to come from pre-existing data, presumably the latest previous year available. When the time to cycle a new rule, considering such statutory hurdles as paperwork reduction, regulatory flexibility, and mandatory public comment solicitations is added to the data lag, it becomes apparent that to keep the allowability limitation reasonably current an inflation factor will have to be arbitrarily rather than arithmetically arrived at.

Any of the standards of reasonableness mentioned by GAO can be introduced as evidence regarding a challenge to health insurance costs under existing regulations. It is worth observing that the Federal Acquisition Regulation (FAR) at 31.201.3 was changed on July 30, 1987, to put the burden of demonstrating the reasonableness of any incurred cost upon the contractor. Moreover, the Compensation cost principle in the FAR was also amended as recently as April 7, 1986, partly in response to the requirements of Public Law 99-190, Section 2324, to achieve the proper balance between the evaluation of individual compensation elements as opposed to an evaluation on an overall basis. That change also embodied a shift to the contractor of the burden of demonstrating the reasonableness of an individual compensation element. In a report of October 10, 1986 (GAO/NSIAD-87-11), the GAO reviewed the implementation of Section 2324 and found that "The improved criteria for these costs and the amended resolution procedures prescribed by DOD through the Federal Acquisition Regulation (FAR) should significantly improve overhead negotiations and reduce inconsistent treatment of these costs." The exceptions to that general conclusion noted by GAO were in two relatively minor areas totally unrelated to compensation. A subsequent setting of rigid quantitative limits on health premium costs would be justifiably viewed by the contracting community as a breach of that arrangement supported only by data derived from a period prior to these regulation changes. Piling change upon change only solidifies the emerging consensus that chaos is the only consistent rule to which government contractors are subject in their contracting relationship with their government customer.

This recommendation is another case of squeezing just one part of the compensation balloon. The likely result of a definitive

limitation on contractor-paid premiums in excess of whatever standard is established is that employees would be paid more salary to make up for it. However, if employees are expected to pick up their own health premiums, the amounts added to their salaries for that purpose will have to be inflated so that the after-tax net of the additional pay will be sufficient to pay the additional premiums. This is because salaries are considered taxable income while employer-paid health premiums are not under federal tax law and in most other jurisdictions. The probable effect of such a restructuring would be a loss of contractor direct effort netted against increased tax revenues flowing to general U.S. Treasury funds.

In summary, NASA believes that when issues such as the potential effect upon contractor staffing and performance, and the problems inherent in the responsible maintenance of quantitative criteria within a cost principle context are considered, the GAO recommendation in both its narrow and broad forms becomes ill-advised. We question whether GAO's overall recommendations are consistent with the broader sense of government policy espoused in Executive Order 12615, Performance of Commercial Activities (November 19, 1987). The clear intent of that Executive Order is to encourage contracting out of functions presently performed internally by the Government, presumably on the premise that efficiency and cost reduction will result. GAO addresses that government activity, defense and aerospace procurement, that is most thoroughly contracted out and proposes to reform it with personnel rules patterned after those applied to Government employees. Both approaches cannot be correct.

NASA is also concerned that this recommendation would be routed through the Director, OMB rather than through normal FAR system channels and those agencies with statutory responsibility for its maintenance, namely DOD, NASA, and GSA. We believe that the FAR regulatory councils would be in the best position to assess the potential advantages and disadvantages of reforms in the contractor compensation area and be in the best position to develop regulations resulting from this analysis. In view of our belief that element-by-element quantitative limits on contractor compensation would be stultifying and have a potentially deleterious effect upon contractor performance, we recommend that measures such as GAO suggests be tested on a few selected contractors to determine whether universal implementation is desirable.

S. J. Evans
Assistant Administrator
for Procurement

Comments From the General Services Administration

General Services Administration
Office of Acquisition Policy
Washington, DC 20405

December 22, 1987

Dear Mr. Anderson:

Thank you for the opportunity to review and comment on the draft GAO report titled "Limits Needed on Employee Health Insurance Costs." The report contains an analysis of the health care costs of the nation's 10 largest defense contractors, and a comparison of these costs with the Government's health care costs for its own employees (regular and postal) and a U.S. Chamber of Commerce study of manufacturing industry health care costs. Based on the findings that the average costs of the 10 contractors studied exceed the benchmarks chosen for comparison and the benefits provided are greater, the GAO has concluded that the Government needs to establish quantitative criteria for determining the reasonableness of contractors' health care costs. GAO has suggested use of the two benchmarks noted above or the weighted average per employee health care costs of the 10 largest defense contractors as the basis for possible quantitative criteria to be published in the Federal Acquisition Regulation (FAR). The GAO recommendation is directed to the Director, OMB who is asked to work through OFPP, DOD, NASA, and GSA to accomplish a FAR revision. The Director, OMB is also being asked to determine the need for developing similar quantitative criteria for assessing the reasonableness of other elements of compensation and contractors' total compensation costs.

An analysis of the data presented in Appendix I (Table I.1) of the GAO report shows that for the period 1981-1985, the employer's share of the per employee health insurance costs of the 10 largest Government contractors exceeded the Government costs for regular federal employees by 87.5 percent. For the same period the average per employee health insurance costs of the 10 largest Government contractors exceeded manufacturing industry averages by only 10.4 percent. This fact should indicate that the Government is generally out of line with industry practice. Consequently, the citation of high savings that would result from using Government health insurance costs as a standard of "reasonableness" for contractor costs seems patently inappropriate.

Private industry is frequently cited as a model of efficiency for the Government. Every effort is being made under OMB Circular A-76 to "privatize" Government commercial operations in the interests of economy. If the extended impact of more liberal health insurance benefits for industry employees and retirees is considered, there may actually be a benefit to the

Government and the nation through a reduction in the need for Government health cost supplements and aid. Furthermore, a 10.4 percent variance between ten leading contractors and industry generally does not appear to be cause for particular concern since it should be expected that major firms would be leaders in this area of employee concern.

In any event, it is very difficult to evaluate any particular element of employee compensation in isolation. High health insurance benefits may be offset by lower compensation elements such as salaries or life insurance benefits. The April, 1986, revision to the "Compensation for Personal Services" cost principle in FAR 31.205-6(b) permits the Government to challenge a particular element of cost and requires the contractor to demonstrate the reasonableness of a compensation item in question. However, in doing so, the contractor may introduce and the contracting officer must consider not only any circumstances surrounding the compensation item challenged, but also the magnitude of other compensation elements which may be lower than would be considered reasonable in themselves. The FAR permits such offsets within a limited list of compensation elements.

It is too early to evaluate the efficacy of the new regulations. All of the data presented by GAO predates the revised FAR rules. We believe it is premature to consider the more drastic quantitative criteria for health insurance benefits and other compensation elements being recommended by GAO. The new FAR rules should be given an opportunity to demonstrate their utility before embarking on a more radical course.

Furthermore, because of differences between industries, geographic locations, different size firms, etc. it would be virtually an insurmountable task to develop, publish, and constantly update a compendium of reasonableness criteria for all possible elements of compensation that would be equitable to all Government contractors. Nationwide industry data such as that contained in the GAO report for health insurance costs may not be equitable in all situations, and is not even available, to our knowledge, for all the myriad elements of compensation cost. The FAR regulatory process is simply not equipped to manage such a reasonableness criteria (ceiling) setting operation. Also, it would seem that the contractor compensation reviews being performed by the defense agencies can be better tailored to the circumstances of individual contractors than a nationwide FAR determination. Such reviews could use the sources cited by GAO for challenging health insurance costs within the present framework of the FAR when considered applicable and appropriate.

If quantitative reasonableness criteria or ceilings were imposed on health insurance costs and other elements of compensation as suggested by GAO, we anticipate that they would be perceived as wage controls by both industry and employee unions. Questions concerning the procuring agencies' statutory authority to impose such limits would surely arise. Therefore, if despite our arguments to the contrary, GAO decides to move forward with its recommendations, we recommend that GAO first seek a statutory basis for imposing compensation limits to assist the procuring agencies and give Congress an opportunity to evaluate the proposal and determine the basis for the compensation limits. The agencies would also need statutory assistance to establish an organization capable of performing compensation surveys and establishing quantitative reasonableness criteria (wage limits).

In conclusion, we do not concur with the GAO recommendation for establishing quantitative reasonableness criteria for health insurance costs and the suggestion concerning the development of similar quantitative criteria for other elements of compensation and total compensation costs.

Sincerely,

PATRICIA A. SZERVO
Associate Administrator for
Acquisition Policy

The Honorable
William J. Anderson
Assistant Comptroller General
General Accounting Office
Washington, DC 20548

Comments From the Office of Management and Budget

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D C 20503

OFFICE OF FEDERAL
PROCUREMENT POLICY

JAN 13 1988

Mr. William J. Anderson
Assistant Comptroller General
General Government Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Anderson:

We are in receipt of your proposed report to the Congress on contractor employee health insurance costs. Thank you for the opportunity to comment.

While the draft report represents considerable effort, we believe additional information is necessary to support your conclusions that a test other than general reasonableness should be used to evaluate government contractors' health insurance reimbursements.

We have identified in the enclosure additional information on the contractor sample and the health insurance plans of all government contractors that would, in our view, improve the usefulness of the report.

Should you have questions regarding these comments, please have your staff call Peg Thomson, Deputy Associate Administrator for Procurement Law and Legislation, 395-3300.

Sincerely,

Robert P. Bedell
Administrator

Enclosure

ENCLOSURE

Comments on GAO Draft Report
"Government Contractors: Limits Needed on Employee Health Insurance Reimbursement"

The Federal Acquisition Regulation (FAR) provides general guidelines for assessing the reasonableness of employee compensation, but does not provide specific quantitative measures of the reasonableness of compensation or elements of compensation. Compensation includes salary and taxable and non-taxable employee benefits such as health insurance.

The General Accounting Office (GAO) report states that employee compensation is reasonable if contractor costs meet certain quantitative standards to be determined by the Office of Federal Procurement Policy in consultation with the agencies. GAO concludes that if standards are not quantitative, reasonableness cannot be enforced. GAO recommends that the Office of Management and Budget (OMB) determine the need to develop quantitative criteria for assessing the reasonableness of other elements of compensation and total compensation.

The GAO report compared costs of health insurance for the ten contractors receiving the largest prime contracts with other private sector firms and the government and concluded that contractor costs should not exceed the following:

(1) the weighted average cost for the GAO contractor sample;
(2) the average cost for industries of the same size, geographic area, and manufacturing sector; nor
(3) the costs of health insurance for federal employees.

GAO then compared the types of benefits offered by their sample, other private sector firms and the government and concluded that higher health care costs of government contractors were due to more extensive benefits and less cost sharing. If costs were controlled, the GAO estimated that government savings would be $350 million to $2 billion.

The GAO report does not provide information needed to demonstrate that the sample is representative of all government contractors. The GAO report should have provided information on the following:

(1) Employees
  (a) numbers eligible and covered by plan
  (c) type of employee
    (i) hourly or salaried
    (ii) profit sharing or not

(2) Employer's market share
  (a) of product sales
    (i) government
    (ii) non-government
  (b) product market characteristics
    (i) static or fluctuating
    (ii) expanding or contracting

(3) Insurance
  (a) self-insured employers
  (b) plan administration

(4) Employee benefit plan
  (a) type of plan
    (i) cafeteria
    (ii) conventional
  (b) benefits offered
    (i) cost as compared to value
    (ii) reasonableness

Without such information we cannot determine whether the compensation provided by these contractors is or should be at all comparable to each other, to that provided by other employers of the same size in the same sector, and to federal employee benefit programs. In the absence of such data, relying on GAO's conclusions would lead OFPP and others to erroneous conclusions and policy prescriptions. The consequences of the absence of these data are discussed below.

(1) Employees

Numbers eligible for, and covered by, sample plans. Employee cost is the major quantitative basis of comparison among plans, but no information was provided on the development of this statistic. We need to know, for example, whether cost per employee included costs for dependents, and whether the base was total employees, employees eligible for the plan, or employees in the plan. We also need to know whether employees were covered under employer plans of the spouse, or the employee's dependents as well as the employee, and whether the sample plan was the primary or secondary plan. Employees covered by more than one plan may benefit

from both plans and each may bear only part of the employee's health costs. To the extent that the contractor plan is superior it will be the primary plan and bear a higher cost than the secondary plan.

Hourly or salaried employees. Chamber of Commerce data on hourly employees was used to determine reasonableness of benefits for hourly and salaried employees. The report states that Chamber's study of hourly employees was "reasonable because all of the contractors selected provide similar benefits to salaried and hourly workers." Benefits provided to hourly workers are not comparable to benefits provided to hourly and salaried workers unless these hourly workers are also members of benefit plans covering salaried workers.

Now on p. 12.

GAO states (p. 14 of the report) that it identified no differences in the composition of the contractors' workforce that would account for the difference in health care costs. A description of the workforce composition and the statistical methodology used to assess these differences is needed to support these statements.

(2) Employer's market share

Information on whether the contractor's product market is expanding or contracting would be useful in evaluating a sample plan with respect to other plans provided in the same manufacturing sector and geographic region. If the product market were contracting, we would expect the employee compensation provided by the firm producing the product to be less than the compensation provided by firms in expanding product markets. If the federal demand for goods and services was expanding during the time period of the study by GAO, then compensation costs should also be increasing.

GAO would impose limitations on the payments to contractors whose demand is increasing simply because markets are depressed in other product areas. This is more correctly characterized as cost control and not the application of reasonableness criteria.

(3) Insurance

Self-insured corporations. Other information missing from the study is whether any of the employers self insure. Most major corporations in the Fortune 500 now do so. If these ten contractors all rely on third party insurers, they are not representative of the private sector. Other corporations partially self insure or hire insurance companies to administer the plan.

Administration. Costs of administration are also needed. We need to know to what extent the corporation or the third party insurer bears the costs, and whether these costs were included in the per employee costs by each of the various studies. For example, the cost of administering the Federal Employee Health Benefits Plan is paid by the government not by the private insurer.

(4) Employee benefit plan

Type of plan. The GAO benefit by benefit approach does not reflect modern trends in employee benefits allowing the employee to select benefits from a so-called "menu" of benefits made available to the employee by the employer. These so-called "cafeteria" plans are successful because they tend to lower employer costs and increase employee satisfaction. A benefit by benefit analysis of reasonableness would discourage government contractors from adopting cafeteria benefit plans even though such plans lower costs.

Cost of benefits offered. Quantitative criteria in comparing health insurance costs are not useful without sufficient information on the benefit to determine the value of the benefit purchased. GAO concluded that the higher cost of contractor health insurance was related to lower cost sharing required of contractors' employees and to providing additional benefits.

One of the benefits which was associated with higher health insurance costs was home health care. The government experience with Medicare suggests that home health care and extended care benefits lower health and health insurance costs, not raise them, because they substitute for more costly hospital care. Another example is alcohol and drug abuse care benefits which lower employer costs through reduced time away from work and higher productivity while on the job. The report should include assessment and valuation of health outcomes as a product of contractor plan costs, as well as balancing secondary cost effects with immediate plan costs, particularly for the self-insured corporation.

Reasonableness of benefits offered. The reasonableness of one element of compensation can be determined only after controlling for the other elements in the employee's compensation package as well as industry demand and supply conditions at a point in time and over time. For example, if defense contractors provide a higher level of capital per employee relative to the average level per employee in the rest of private industry, then these employees may be associated with a higher level of productivity and hence will likely receive higher total compensation relative to the average total employee compensation in the private sector.

The GAO concluded from a 1984 study of twelve contractors which showed a faster rate of increase in employee earnings for contractors relative to the average earnings in the general economy, that contractors provide unreasonable compensation. These conclusions are inappropriate if control for other influences has not been provided.

Reasonableness can be assessed only by considering alternative compensation packages available to the employee. Smeeding described this hedonism in the labor market (Timothy M. Smeeding, "Size Distribution of Wage and Nonwage Compensation," in The Measurement of Labor Cost, Edited by Jack E. Triplett, University of Chicago, Press, 1983). Leibowitz similarly described the tradeoff between wage and non-wage benefits among the components of the compensation package and why employers tailor these packages to the needs and desires of the employees it wishes to retain (Arleen Leibowitz, "Fringe Benefits in Employee Compensation," in The Measurement of Labor Cost, Edited by Jack E. Triplett, University of Chicago Press, 1983). Components of these compensation packages will vary depending on the age distribution of employees, marriage status, union status, taxation of employee benefits, availability of profit sharing, demand for the firm's products and employee's skills.

Federal health policy as evidenced by Medicare indicates that cost is not the only consideration. One of the most expensive benefits to provide is catastrophic protection and Medicare is moving quickly to provide this benefit.

Apart from expectations that employees will remain with the contractor that provides good health insurance, there is the further question as to whether the government ought not to encourage people to seek medical care. Preventive health costs less over the long term although the most efficient point of subsidy has not yet been determined.

An analysis of the costs of health care benefits of government contractors should include the floor for health care benefits as well as a ceiling. Federal contractors are currently not required to provide health insurance to their employees. Health insurance encourages medical treatment and early identification of job related illness. Early treatment would reduce disability payments and adjudicated claims against the government which could cost the government more than providing health insurance.

Comments From the General Electric Company

Arthur V. Puccini
Vice President

Corporate Employee Relations
General Electric Company
3135 Easton Turnpike, Fairfield CT 06431
203 373 3374

December 23, 1987

Mr. Richard L. Fogel
Assistant Comptroller General
United States General Accounting Office
Human Resources Division
Washington, D.C. 20548

Subject: Contractor Employee Health Insurance Costs

Dear Mr. Fogel:

Thank you for the opportunity to review and comment on the proposed report to Congress concerning GAO's review of contractor employee health insurance costs. We appreciate the federal government's attempt to assess the reasonableness of contractor costs. However, the potential criteria identified in this draft report for assessing health insurance costs have serious practical and methodological shortcomings. The application of these criteria would ignore the reasonableness of contractor total compensation costs, undermine the collective bargaining process, and reverse the progress being made in providing quality health care services at a competitive cost affordable to the Company and its employees.

We therefore urge the GAO to acknowledge in any published report the practical limitations of separating out any one element of compensation, such as health insurance, and assigning quantitative standards that do not take into account important variables such as industry, geographical region, work force size, and employee demographics that drive contractor costs. What the draft report clearly shows is the need to pursue alternative approaches that offer a greater likelihood of establishing a meaningful standard of reasonableness.

The "Give and Take" Underlying Total Compensation

General Electric has a compensation program in which both commercial and defense businesses participate. The Company provides a balanced "total compensation" package, which is designed to attract and retain a high skilled work force at a cost which is competitive with those of other companies providing similar products and services. The Company's diverse mix of commercial and defense businesses (the latter representing 25% of total revenues) provides an "internal discipline" which acts to moderate the level of wages and benefits. This mix of businesses requires GE to maintain wages and benefits that are cost-competitive with other companies, both defense and non-defense. The frequent movement of employees between businesses within the Company requires that wages and benefits remain compatible company-wide.

A company's ability to compete in the marketplace for labor is based on providing a total compensation package which meets the needs of individuals it seeks to attract and retain as employees. A competitive compensation package which provides a high level of health benefits will frequently provide reduced pension or other benefits. For example, federal employees have (1) high pension benefits (which include retirement at earlier ages, retirement income indexed to increases in consumer prices, and continuation of health benefits for retirees attaining eligibility for Medicare benefits), and (2) high sick pay benefits (accumulation of up to 30 days annually), offset by (3) less costly health benefits for active employees (more cost sharing and fewer covered services). In this way, the federal government has developed a compensation program which includes a trade-off between higher pension and sick pay benefits and less costly health benefits.

The structure and composition of GE's wages and benefits are the result of collectively bargained agreements reached with several different unions at the national level and applied uniformly across businesses. The collective bargaining process involves trade-offs between wages and benefits; and within benefits, trade-offs between pensions, health and life insurance, layoff benefits, and compensable absences. The GAO's attempt to set a quantitative standard for health costs (or any other individual element of employee compensation) ignores the "give and take" that is at the heart of collective bargaining and that determines the balance between wages and benefits as well as the mix of benefits. Furthermore, the unilateral imposition of increased employee health care cost sharing by the Company would be contrary to the National Labor Relations Act, which requires good faith bargaining between management and labor.

The Problems of Isolating Any One Element

Although the Federal Acquisition Regulations (FAR) provide for the review of individual elements of compensation, they recognize the need to evaluate health benefits within the context of the employer's total compensation package. This broader look at total contractor compensation costs is expanded in FAR 31.205.6(b)(1)(ii), which requires the Government to consider offsetting lower costs among other compensation elements. The GAO's draft report very likely exaggerates potential savings by focusing only on health care, a comparatively higher cost element in the overall package, and discounting the offset provision within the FAR.

Other Variables Affecting Health Care Costs

Assigning a quantitative criterion discounts the significant differences in health care costs attributable to geographic, demographic and other variables. For example, a comparison of

medical prices in major cities where GE operates indicates that the prices in "high-cost" cities can be two and a half times greater than in "low-cost" locations. In addition, costs can vary due to regional differences in the utilization of medical services. For example, hospital admissions per 1,000 employees within major GE locations vary by as much as 76%.

Employee demographics also introduce significant variances. For example, the average age of the work force varies widely between GE locations. Our insurance carrier estimates that health care costs increase about 3 1/2% for each year of age. That translates into cost differences of up to 25% at some of our locations. The percentage of employees enrolled for dependent coverage also varies from as low as 57% to as high as 92%, accounting for an additional 30% difference in health costs. Male/female ratios add another layer of complexity. Within GE, health costs for male employees exceed female employees by 29%.

The GAO should also recognize the countervailing trend in recent years by both the federal and state governments to increase the number of mandated benefits applicable to private sector companies (public entities are exempt). The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), for example, requires employers to provide continuation of health coverage for terminated employees, divorced spouses and children reaching the maximum eligible age. In addition, 14 states have minimum health benefit laws which require coverage beyond that provided by GE's plan.

Given the possibility for such wide variations, "average" costs are neither a fair nor enforceable basis for assessing reasonableness. In addition, although the U.S. Chamber of Commerce's Employee Benefits Survey provides a useful indication of general trends in benefits practices, it cannot be regarded as a basis for assigning quantitative criteria, especially considering the voluntary nature of the survey and its 12.8% response rate. Furthermore, the Chamber survey consists principally of small to mid-sized companies, 85% of whom have fewer than 5,000 employees. By contrast, average employment of the top ten defense contractors is about 100,000 employees (GE has 275,000 employees in the U.S.). These larger defense companies draw from a highly competitive national labor market for their management, engineering and other technical talent, while smaller non-defense employers tend to draw from local or regional labor pools.

GE Health Care Cost-Management Efforts

The implication of the GAO draft report is that defense contractors are less concerned about health care cost containment than either the Federal government or other companies. This is

definitely not the case. GE, for example, has identified cost containment as a major challenge and has had a program to manage health costs since 1980. Significant changes in the medical plan were negotiated with our unions and became effective January 1, 1986. At that time, we increased employee cost sharing by doubling deductibles and doubling contributions for dependent coverage. We also introduced utilization review programs which require precertification of hospital admissions, concurrent review of length of stay in hospitals, discharge planning, case management and mandatory second opinions for selected surgical procedures. These changes created savings of $49 million during 1986, and will help reduce costs in 1987 and future years.

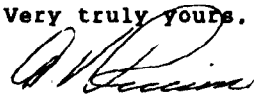
Placing the Emphasis on Quality

It should be pointed out that the challenge is not to provide health benefits as cheaply as possible, but to provide quality health care in the most cost-efficient manner. Comparisons of per-employee costs oversimplify the issue by making it appear that the solution lies in the shifting of costs to employees rather than in the management of total health care delivery cost. Furthermore, the Company's ability to shift costs is limited by the contractual obligation to negotiate plan changes with our unions.

In summary, the GAO's attempt to isolate a single element of compensation, such as health, is overly simplistic. It disregards GE's total compensation approach which is an integral part of our strategy to be competitive in both commercial and defense businesses. Furthermore, it ignores the reality of the trade-offs which occur in collective bargaining, although the FAR provide for such offsets. Finally, the proposed quantitative criteria for assessing the reasonableness of health care costs are seriously flawed because they fail to recognize differences in regional medical prices, utilization of health services, employee demographics, mandated health benefits, and the type of labor force we seek to attract and retain.

In light of both the practical and methodological weaknesses of separating out any one element of total compensation, we urge the GAO to acknowledge in any published report the serious limitations of this approach. However unwieldy and complex, total compensation remains the only fair and enforceable basis for assessing the reasonableness of contractor costs. We look forward to discussing these issues further with you.

Very truly yours,



A. V. Puccini

cc: L. G. Cook
J. R. Finnecy
J. Linz

Comments From the General Dynamics Corporation

GENERAL DYNAMICS CORPORATION
Pierre Laclede Center
St. Louis, Missouri 63105

December 22, 1987

314-889-8200

Mr. Richard L. Fogel
Assistant Comptroller General
Human Resources Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Fogel:

Thank you for the opportunity to comment on GAO's draft report GAO/HRD-88-27, "Contractors' Health Care Costs."

As you correctly state, employee health care has become a major expense, not only among Government contractors, but among most public and private sector entities. We are continually searching for innovative ways to reduce costs and, in fact, are proud of our accomplishments in the area of employee health care. We welcome the GAO's review of this important subject and hope you will consider the comments contain herein.

As I am sure you understand, remaining competitive in today's marketplace requires contractors to find a balance between somewhat conflicting impulses. On one hand, costs must be contained so that prices may be kept low. On the other hand, employers must offer their employees a total compensation package (including health care) sufficient to attract and retain highly qualified individuals. We are concerned that your study does not give adequate consideration to this latter requirement while ignoring the effect competition is already having on the former.

Your study concluded that, whether compared with (1) the Federal Employees' Health Benefits Program, (2) the U. S. Chamber of Commerce's annual Employee Benefits Study, or (3) the weighted average of the ten largest contractors' average health care costs, major Government contractors' health care costs should be reduced.

Our concerns with this conclusion can be summarized as follows:

1. The reasonableness of any single element of compensation, including health care, can not be determined in isolation from other elements of compensation;

2. The quantitative criteria used for assessing the reasonableness of contractors' health insurance costs are not suitable for this purpose; and,

3. In the area of health care, less is not necessarily better.

An expanded discussion of each of these concerns follows.

1. THE REASONABLENESS OF ANY SINGLE ELEMENT OF COMPENSATION, INCLUDING HEALTH CARE, CAN NOT BE DETERMINED IN ISOLATION FROM OTHER ELEMENTS OF COMPENSATION.

Chapter 2 of your report discusses "Problems in Assessing the Reasonableness of Compensation Costs." We agree that this is a complex subject and that the establishment of quantitative criteria for determining reasonableness would be beneficial, both from a management perspective and from a contract administration perspective. It is essential, however, that any such tool consider the total compensation package and not focus on a single element of compensation, as you have done in this draft report.

Your report states that FAR permits contractors, when defending the reasonableness of specific elements of cost, to introduce other compensation elements to offset or compensate for the "unreasonableness" of one. Unfortunately, you have not considered this same offset in arriving at your conclusion that health care costs are unreasonable.

2. THE QUANTITATIVE CRITERIA USED FOR ASSESSING THE REASONABLENESS OF CONTRACTORS' HEALTH INSURANCE COSTS ARE NOT SUITABLE FOR THIS PURPOSE.

As mentioned above, your study compared the health care costs of the ten largest government contractors against three "control groups" and determined that, in each case, the average costs of the Government contractors were greater. In selecting the control groups, adequate consideration has not been given to the requirement for contractors to offer benefit packages which are competitive with their peers.

Assuming for a moment that it is reasonable to examine health care costs in isolation from other elements of compensation, the only logical basis of comparison for large Government contractors is those firms with which these contractors compete for personnel. The ten largest defense contractors are among the nation's largest firms and should be compared with similarly sized and located manufacturing and engineering businesses.

Comparison of the private sector with the public sector rarily makes sense as the motivations to choose one sector over the other as a source of employment are far more varied than simply compensation issues.

The Chamber of Commerce survey is far too broad to permit a reasonable comparison. The Chamber survey includes literally thousands of employers ranging from the very small to the very large. The Government contractors in your study represent a small cross-section of very large firms.

Using the weighted average of the ten firms to assess reasonableness addresses the two concerns just raised, but does little to satisfy your basic objective of creating a quantitative criteria for measuring costs. Further, use of this average fails to address the need for contractors to compete for personnel within certain geographic areas. Assuming that your hypothesis is correct (that Government contractors, as a group, do pay unreasonably high health care costs), comparing the contractors among themselves will neither prove nor disprove this assertion.

3. IN THE AREA OF HEALTH CARE COSTS, LESS IS NOT NECESSARILY BETTER.

Your study concludes that, because Government contractors may pay more in health care costs than the control groups used for comparison, their costs are unreasonable. There is no apparent attempt made in your study to determine what the level of health care should be. Furthermore, recent years have seen a nation-wide movement towards expanded health coverage (catastrophic coverage, for example), as well as a trend towards shifting the burden of health care from the public to the private sector.

We believe your conclusion that less is necessarily better has not been substantiated. We reiterate our position that health care benefits cannot be assessed in isolation from other elements of compensation. If, however, you conclude that you must establish parameters for individual elements of compensation, your review should attempt to determine what level of health care benefits a responsible employer should provide. Only then will you be in a position to assess whether a particular group of employers is paying too much or too little for this element of compensation.

CONCLUSION

The above concerns notwithstanding, we applaud your ambitious efforts to examine a complex subject. We would like to suggest, however, that the review needs to be broadened. Before determining that a particular group of employers are paying for unreasonable levels of health care, a study should be undertaken to determine what level of care should be provided by the private sector.

While objective, quantitative criteria in such areas as health care would certainly be "nice-to-have," we question whether such a goal is realistic considering the complexity of the total compensation issue. At a minimum, such criteria must encompass the entire scope of compensation. Secondly, the need for employers to develop compensation packages that will attract qualified employees cannot be ignored.

We suggest that the best criteria available for determining the reasonableness of compensation is already in place and operating effectively, namely, competition. Competition forces contractors to find the appropriate balance between costly fringe benefit packages and the need to remain within a competitive price range. The emphasis on competition among Government contractors has never been greater than it is today. These competitive forces will do far more to constrain unreasonable costs than the "criteria" which this draft report attempts to define.

Again, thank you for the opportunity to comment. We hope the preceeding will be considered within the constructive manner in which it is intended.

Sincerely,

Robert J. Behr
Corporate Manager,
Government Finance

Comments From the Boeing Company

THE BOEING COMPANY

Mail Stop:
P.O. Box 3707
Seattle, Washington 98124-2207

January 4, 1988
1-9130-12-207

Mr. Richard L. Fogel
Assistant Comptroller General
United States General Accounting Office
Human Resources Division
Washington, D.C. 20548

Subject: Government Contractors' Health Care Costs

Dear Mr. Fogel:

Thank you for the opportunity to review GAO's draft report to Congress on the above subject. The following comments address the major issues that are raised in the draft.

First, the report points out that until recently, Federal Acquisition Regulations (FAR) have required the government to look at a contractor's total compensation costs when evaluating whether costs are reasonable. This is similar to the approach we use when attempting to compare our costs to our competitors' costs. We recognize that because different employee groups have different compensation and benefit needs, it can be misleading to focus on only one segment of the compensation package when considering costs.

Although the report implies that contractors may not have adequate incentives to restrain our compensation costs, it is important to recognize that many of us also compete in the commercial marketplace. It should be noted that per FAR 31.201-3(a) competitiveness is one of the tests for the reasonableness of a cost:

> A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business.

At Boeing, where over 60 percent of our 1986 sales were derived from our commercial business, we provide employees in our commercial operations with the same benefit coverages provided to our employees working on defense projects. Given the intense international competition that we face in the commercial marketplace, it is in our best interest to aggressively manage all of our costs.

At the same time, we must offer a competitive compensation and benefits package in order to attract and retain a qualified workforce. As with many of our competitors, our compensation and benefits packages are often shaped by collective bargaining with unions representing our employees. Our competitive business environment requires us to maintain a delicate balance between costs and employee relations.

BOEING

To: R. L. Fogel
General Accounting Office

This policy satisfies another FAR reasonableness test as FAR 31.205-6(m) states:

> Except as provided elsewhere in Subpart 31.2, the costs of fringe benefit are allowable to the extent that they are reasonable and are required by law, employer-employee agreement, or an established policy of the contractor.

Focusing solely on health care benefits, we offer a different view than that presented in the GAO draft. In reviewing 1987 industry surveys, we note that Boeing's employee benefit costs for pension, profit sharing, health and insurance plans are about average for large manufacturing firms. Our surveys include not only other aerospace firms, but also large firms in the following industries: metals and mining, tobacco, textiles and apparel, machinery, personal care products, food, chemicals, photo and optical, electrical, auto, office equipment and computers, oil, steel, drugs, building materials, and appliances. Comparing Boeing or any other large manufacturer to the government workforce, Medicare or medium-sized employers is an inappropriate comparison since each draws from different labor pools.

I would like to also point out that our philosophy related to controlling health care costs is different than that proposed by the GAO. The primary premise of the GAO draft is that costs can be reduced by simply shifting more of the expense to individuals. Unfortunately, as Medicare and CHAMPUS have discovered, this approach does nothing to actually reduce the overall costs in the system.

As part of our ongoing efforts to manage our costs, we have undertaken a different strategy. We have elected to increase the employee's financial incentives to use cost effective health care providers, while at the same time we are attempting to reduce system costs through aggressive contracting and discounts with health care providers. We expect this approach to have a more significant effect on controlling overall health care costs.

I would like to also address the portion of the GAO draft that compares specific benefits offered by defense contractors with the benefits of federal workers and other companies under the U.S. Chamber of Commerce survey. It is interesting to note that the report suggests that contractors are more generous by offering coverage of skilled nursing facilities and home health care. At Boeing, we have extended coverage of these particular items, in lieu of more expensive hospital inpatient care. As a result, rather than costing us more, they are in fact saving us money since our patients can be moved to less costly settings for their continued care. Similarly, we have included special coverage of

BOEING

To: R. L. Fogel
General Accounting Office

substance abuse treatment since it (1) permits us to directly manage these costs, and (2) encourages early treatment of conditions that can lead to more costly long term health problems if left untreated.

Finally, I find it interesting that the GAO draft report implicitly criticizes contractors for such generous plan provisions as coverage of skilled nursing facilities, home health care and substance abuse treatment, when as recently as June 1986, the Defense Contract Audit Agency was recommending that we: (1) decrease the employee's share of the costs for outpatient mental illness treatment and (2) increase plan payments for home health and hospice care.

In closing, I would like to assure you that at Boeing, we have always taken an aggressive approach to trying to control rising health care costs. From our perspective, this simply represents good business judgment.

Sincerely,

J. A. Batschi
Assistant Controller

BOEING

Comments From Grumman Corporate Services

Grumman Corporate Services
The Services Division of Grumman Corporation
Bethpage, New York 11714-3586

December 21, 1987
PERS-L-87-130

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

Dear Mr. Fogel:

Thank you for the opportunity to comment on the draft report to the Congress on your review of contractor health care costs.

While your intention to provide objective criteria for establishing the reasonableness of contractor health care costs is laudable, your attempt to do so through this study is questionable. First of all, there is no definition of "health care", so we can't be sure that we are all talking about the same thing. Further, since no basic data is reported, there is no way for us to test your conclusions. Although we provided specific data to you, we can't tell which contractor is Grumman. Without access to the specific data used in the study, we can't determine the validity of the conclusions.

In reviewing the methodology which you followed, it appears that at least two criteria were ignored. One is the location of the contractor. The second is the size. The Chamber of Commerce study reports data by region of the country and by size of the firm. There is no indication whether these factors were considered in the GAO study, although they have a significant impact on costs. Nor is there any indication that the data on federal employees takes these factors into account.

We understand that the FAR allows the government to examine individual elements of compensation in order to determine their reasonableness. In reality, however, it can be easily documented that contractors, and most other companies and organizations, do not approach or evaluate their benefit structures by examining individual elements of compensation without regard to others. In some companies, one or another element is more important. Emphasis is placed in that particular area as opposed to others. But the overall level of compensation is most important. It is used to measure competitiveness with other firms in that firm's industry and in the firm's local recruiting area. We believe that the human resources people in government service also take the same approach to benefit planning. For example, the fact that federal employees in your study may pay more for their health care is offset, to some degree, by the greater levels of paid time off they receive and in the level of early and normal retirement benefits for

which they qualify. This would indicate that the government itself is addressing the total compensation level of its employees, rather than taking an individual element approach.

A significant factor overlooked in the study, is its timing. 1986 was a year in which many companies, including Grumman, put in place changes and programs which reduced costs significantly and which will assist in the overall control of costs in the future. At Grumman, we raised our major medical deduction from $100 an individual, $300 per family per year to $250 per individual and $500 per family per year. We have since established a managed care program, using the patient advocate approach, and have added provisions to further encourage the use of out-patient services for surgery to help contain costs.

Furthermore, some elements of health care costs reported unfavorably in the study are really cost savers, but not recognized as such. Extended care and home health care are directed at getting people out of hospitals earlier, while continuing to provide needed care. Without the possibility for specialized care at a lower-cost facility or at home, employees and dependents would be forced into longer stays in the hospital at considerably higher costs. Likewise, company payment for treatment for alcoholism and drug abuse is directed at helping employees to overcome these problems and remain active, productive members of the workforce. This is much more cost effective than allowing an employee's health to deteriorate and therefore incur added health care costs. Untreated alcohol and drug abuse problems generally result in termination, thereby incurring added recruiting and training costs.

Now on p. 52.

Lastly, the Table on page 36 shows that the cost of federal employee health care rose by 49.2% between 1981 and 1985, and that cost of contractor employee health care rose by 52.8% during the same period. This would seem to indicate that the government, in spite of greater cost shifting to employees, has been only marginally more successful in stemming the rise in health care costs than have the ten contractors who have been attempting to manage costs through other methods. If we were to add data from 1986, which was the first year of further initiatives in cost containment by Grumman and I suspect some other contractors as well, the percent increase in costs would probably be lower than the government increases.

Grumman recognizes that the cost of health care is a significant problem in the overall compensation of contract employees. We are committed to continue to search for ways to further contain these costs while providing reasonable but competitive benefits to employees.

Very truly yours,

Robert E. Foster
Director of Personnel

REF:mgc

Comments From the Raytheon Company

Raytheon Company
Executive Offices
141 Spring Street
Lexington MA 02173

617 862 6600
Telex 92 3455
Cable Raytheonex

Raytheon

December 31, 1987

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

Re: GAO Proposed Report on Contractor Employee Health Insurance Costs

Dear Mr. Fogel:

We appreciate the opportunity to comment on your draft report to Congress.

A major concern to us is your method of singling out one element of compensation. Since we, and I am sure other contractors, balance the cost of one element against any planned improvement to another and reflect total compensation and benefits costs in our pricing, we believe competition and not benefit by benefit comparisons will single out those that are too high.

Of equal concern is that you compare our costs to those for government employees and the Chamber of Commerce survey participants. We feel these are not relevant comparisons for the following reasons:

- The insurance costs do not reflect those in the geographic localities of the contractors. This is a major factor in Massachusetts where two-thirds of our parent company employees work and where medical costs have exceeded the national average by as much as 30 percent.
- The companies in the Chamber of Commerce study vary too widely in size. It is a generally accepted fact that companies as large as the ten contractors which average over 100,000 employees will have more costly benefits than those with 50 or more who participate in the study.

Mr. Richard L. Fogel
December 31, 1987
Page 2

- Neither source deals with the differences inherent with the vastly dissimilar demographics of the employee groups. Consider, for example, that high tech contractors must have total compensation packages, including first rate medical plans, in order to attract and retain a workforce comprised largely of scientists, engineers, technical employees and skilled labor.

- While unions exist in some of the groups you cite, the effects of their presence are not identified in the Chamber of Commerce study. Your federal employee analysis does take this into account however, by showing that the postal workers' health plan costs exceed non-postal workers' costs by approximately 30 percent. This impact is made despite the fact that the federal union lacks the power to strike such as exists with our unions.

- Federal employee plans are not subject to the cost increases originating from state and federal mandated benefits. COBRA, with its attendant adverse selection, is a classic example of increasing private sector liability when otherwise no ongoing relationship would exist. Other examples whereby significant costs are imposed on or shifted to the private sector include Medicare becoming the secondary carrier for older employees and Massachusetts mandated coverage for social workers, inpatient psychiatric care, infertility studies and alcoholism treatment.

Perhaps our greatest concern arises from your statement (on page 29) that..."We do not believe it would be unreasonable to expect government contractors to impose employee cost sharing to the same extent imposed by other medium to large sized companies or the federal government."

With approximately 30 percent of our workforce represented by unions, we simply cannot "impose" such radical benefit reductions and we are virtually certain that negotiating the 40 percent employee sharing of insurance premiums you suggest would be a strike issue. Moreover, our experience has shown that such an imposition on our nonunion workforce would result in very serious labor organizing drives which could very well result in salaried employee unions.

Our view is that the union issues we cite are sufficient to make your proposed concepts unworkable but want you to know that we have worked hard within the constraints of the negotiating and work stoppage strength of our unions to control our costs. Specifically, we have negotiated higher deductibles and have implemented Benefit Management features which stress pre-admission certification and mandatory second surgical opinions. Also, through Benefit

Management we seek less costly alternatives, and with the same objective we cover home health care and outpatient treatment programs for appropriate cases such as substance abuse. Unfortunately, your report highlights these latter alternatives in a negative perspective when, in fact, they should be considered proactive cost saving measures.

In summary, the highly technical nature of our business dictates that we must be compared to companies of like size, industry, union content and geographic locations. Total compensation must be the test of reasonableness because altering one element is certain to have an offsetting effect on another. We cannot be compared to dissimilar groups such as federal employees where unions are a lesser factor and for whom costly benefits are not mandated.

We appreciate your efforts but disagree with your approach. We recognize that health care costs are high and increasing at unacceptable rates but feel they are reasonable at Raytheon when you consider the medical community and economy in which we purchase them. Lastly, we will continue our efforts to reduce costs through business and legislative means, such as in Massachusetts where we were instrumental in the preparation and passage of hospital cost controlling legislation.

Sincerely,

M. Silberberg

Marvin Silberberg, Director
Government Accounting Controls

Comments From the Lockheed Corporation

Lockheed Corporation
4500 Park Granada Boulevard
Calabasas, California 91399

January 7, 1988

Mr. Richard L. Fogel
Assistant Comptroller General
U. S. General Accounting Office
Washington, D. C. 20548

Dear Mr. Fogel:

Thank you for the opportunity to comment on your draft report on government contractor employee health insurance costs. Lockheed, along with other major defense contractors, has for a number of years been concerned over the rising cost of health care that is being experienced nationwide, and has implemented a number of actions designed to avoid and contain health care costs.

We are therefore concerned with the conclusions of this draft report, since they concentrate not on ways to contain health care costs, but on ways the government can "save" by not allowing contractors to recover, on U. S. Government contracts, costs that they incur. The draft report attempts to take an overly narrow approach in its conclusions that is inappropriate for a much more complex issue.

We believe that any judgement of compensation reasonableness must consider the compensation package, and not arbitrary comparisons of costs. Moreover, even if reasonableness of compensation could be appropriately assessed on the overall cost to the taxpayer compared to similar types of costs for other industries or for government employees, the assessment should be based on the total, overall compensation of the employees rather than selective elements of a compensation package.

We have a number of areas of concern with this draft report. We take exception to the GAO's conclusion that "the higher health care costs incurred by the ten contractors can largely be explained by the lower cost sharing required of their employees compared to employees of other medium and large firms and federal workers." This conclusion appears to be contradicted by Table I.3 in the draft report, which shows that even if the contractor employees paid an additional forty percent of the contractor's health care costs (which already reflect employee cost sharing presently required by some contractors), per-employee health care costs would still be substantially above that of Federal non-postal employees for most of the contractors. This is in spite of the fact that an additional forty percent cost sharing by contractor employees would substantially exceed cost sharing required under Federal non-postal health care plans.

There are numerous factors that affect health care costs, and which therefore produce "apples to oranges" comparisons of per-employee health care costs. For example, the contractors included in the GAO review have sizeable numbers of employees on the West Coast, which is known to have comparatively high costs of health care. Age distribution of plan participants is also a major factor in health care costs. Health care costs for individual plans can also be influenced by two working family members, either because the family uses only one health insurance plan, or because of coordination of benefits between plans.

We believe that imposition of any reasonableness limitations on health care costs must recognize realistic costs that are incurred by contractors, that cannot be made to disappear simply by limitation on reimbursement of costs under Government contracts. The GAO report, in calling for "reasonableness" criteria that can "save" the Government money, ignores the effect that such indiscriminate "reasonableness" limitations will cause. It is evident from Table I.1 in the draft report that for each set of comparative data used by the GAO, health care costs have risen by approximately 50% from 1981 to 1985. Contractors cannot, and should not be expected to absorb increased unallowable costs merely to limit the costs of Government contracts. Reasonableness criteria for any element of compensation, in order to be fair and equitable, must reflect achievable goals for contractors and not be merely broad-brush limits on the allowability of individual elements of compensation.

We recognize the objectives behind the current procurement regulations; however, such regulations must be implemented judiciously and with restraint since they are at odds with the total compensation approach used by most companies on assessing their compensation and benefits structures. Obviously, Government contractors are affected by collective bargaining negotiations, and any improvements attained in health care costs by increased employee cost sharing, if and when attainable, will most likely result in increased costs in other compensation areas. Furthermore, contractors must realistically be expected to offer compensation packages, including health care benefits, that will allow them to attract and retain the skilled personnel needed in the defense industry, rather than "bare bones" compensation approaches that may only serve to dissipate defense industrial capabilities.

The realities of unavoidable quantitative differences in health care costs among plans are clearly evident in the GAO's own data, showing a 36% difference between per-employee health care costs for Federal postal employees versus Federal non-postal employees. We therefore find it difficult to envision any quantitative reasonableness criteria, and particularly those suggested by the GAO, resulting in fair and equitable solutions to rising health care costs.

We sincerely believe that quantitative limits on reasonableness of health care costs can only result in arbitrary, inequitable and unfair decisions. A more practical solution is to reestablish joint Government-contractor coalitions to develop specific action plans in which contractors could be incentivized to participate.

We urge the GAO to reconsider its conclusions. The report in its present form may result in misguided actions that would prove to be harmful, and will add little toward containing nationwide health care cost growth.

Sincerely,

Robert C. Johnson
Vice President,
Contracts & Pricing

RCJ:srg

Comments From McDonnell Douglas

MCDONNELL DOUGLAS

12 January 1988

Richard L. Fogel
Assistant Comptroller General
United States
General Accounting Office
Human Resource Division
Washington, D. C. 20548

Re: Draft Report - Government Contractors: Limits Needed on Employee Health Insurance Reimbursement

Dear Mr. Fogel:

On behalf of McDonnell Douglas Corporation (MDC) I have as Corporate Director of Health Care Benefits been asked to respond to your letter directed to Mr. Jim Troy, dated November 12, 1987.

McDonnell Douglas is proud of the leadership role it has taken over the last several years to control health care cost. As pointed out in your report MDC was the only one out of the 10 largest defense contractors to require employee contributions. It should be noted that MDC was willing to take a strike at Douglas Aircraft Company, in 1983/84 in an attempt to require health care contributions. Unfortunately, we were unable to win that concession from the bargaining units at that time. Again in 1986/87 the Company was committed to instituting employee contributions which caused MDC to absorb further significant operating costs due to a work slowdown. These actions required MDC to unilaterally implement employee contributions along with the other elements of a totally new comprehensive health care plan in March 1987 and it was not until December 21, 1987 that MDC gained acceptance of the plan by the major bargaining unit.

During this same period of time MDC elected to take a positive role in health care cost containment programs. In St. Louis MDC was one of the founding members, and continues to be an active participant of the St. Louis Area Business Coalition for health care cost containment efforts. Second, MDC was instrumental in encouraging the growth of HMOs in St. Louis by inviting Kaiser, Maxicare, CIGNA and Prudential to establish HMO operations in St. Louis to help control health care costs and bring managed health care to St. Louis. MDC then took direct action to control costs by establishing it's own HMO/PPO in St. Louis. IN 1987 we established a PPO in Southern California and Tulsa, Oklahoma.

P.O. Box 516, Saint Louis, MO 63166-0516 (314) 232-0232 TELEX 44-857

MDC has been and continues to be on the forefront of health care cost containment efforts. Since the study, MDC has instituted numerous cost containment programs while being asked by the Federal government and state legislators to shoulder more and more of the costs for our country's health care needs. MDC has developed managed care programs, negotiated preferred provider contracts with providers to the tune of 20 - 35% discounts from retail costs, eliminated first dollar coverages, instituted mandatory preadmission hospital certification and second surgery opinion. We recently offered a case management program for large medical expenses, and have begun to develop Wellness Programs such as a total smoke free work environment.

It appears to MDC that the GAO is attempting to compound the cost of health care that the Federal government is asking defense contractors to assume. It was only a few short years ago that employers were asked to assume the cost of over age 65 employees to reduce the cost to Medicare. Then the Federal government asked employers to provide health care continuation to terminated employees and dependents. Now the GAO wants to limit those very same costs that can be charged to defense contracts based on some "similar quantitative criteria;" while at the same time congress is proposing various forms of legislation to increase the cost of health care to all employers. Representative Fortney Stark-Chairman of the House Ways and Means Health Subcommittee has proposed two different bills, both of which would raise the cost of providing health care to employers. Senator Kennedy's health care proposals would increase the level of health care coverage provided to all americans and again increase the cost to employers. The labor movement in this country has declared access, quality and costs to be the major issues in health care. According to an article in Business Insurance, dated November 2, Bert Seidman - Director of the AFL-CIO Department of Occupational Safety, Health and Social Security, ... "Organized Labor will vigorously support legislation to require all employers to provide minimum health care benefits along the lines of the bill recently introduced by Senator Edward Kennedy and will press for retiree health protection, inclusion of long-term care in Medicare and improved standards in nursing homes. All of which would raise the cost of health care to employers."

In Appendix II of your report you compared a number of health care benefits between government contractors and either Federal or private sector employees. This study was based on data from the years 1984/85. Most of the defense contractors with labor agreements since those years have negotiated new agreements and have obtained numerous cost containment provisions. For example Rockwell and Boeing have instituted Preadmission Certification Programs; while Boeing, Lockheed and Rockwell have also established Preferred Provider Organizations.

Some of the specific benefits mentioned in your report are now major issues in the national health picture. Benefits like extended care, home health care, and alcohol and drug abuse are being mandated through state legislative efforts to provide increased coverages to employees, all of which add to employers health care costs. Plus the increased cost of sophisticated technology and the rising price tag of insuring high-cost diseases like AIDS and organ transplants is also forcing employers' costs to increase.

Finally, your report indicates there should be a "similar quantitative criteria" for assessing the reasonableness of health care costs. I have enclosed a recent survey released by Equicor on 1987 hospital costs. The survey ranks hospital costs by states indicating a range from a low of $425 per day to a high of $1,204 per day. MDC has major concentrations of employees working in the second highest cost area, the sixth, the ninth, the sixteenth, the nineteenth and the fortieth state. The average charge per day per patient day ranges from a low of $586 to a high of $1,109. These wide spreads in costs alone make it inappropriate to develop a single set of criteria to gauge all defense contractors or to compare all parts of the country against one common set of health cost criteria."

MDC will continue it's endeavors to control health care costs and to assume it's social obligations to provide quality health care at reasonable prices. MDC believes it should continue to be judged on it's own circumstances and merits rather than against an arbitrary measure which to date cannot be developed to accommodate all the variables contained in the cost of delivering health care to the american public.

Very truly yours,

A. J. Proffitt
Director - Health Care

AJP:njr
Enclosure

Daily Cost In Hospital Up 16 Pct.

NASHVILLE, Tenn. (AP) — Patients spent nearly the same amount of time in hospitals last year as in 1986, but the daily cost jumped an average of 16 percent nationwide, according to a survey of 1,863 hospitals.

The survey was made public Tuesday by Equicor, which is based in Nashville, Tenn. The survey shows that the increase in rates was due largely to a 20 percent increase in hospital charges for services other than room and board.

The study found that the average overall cost of a stay in the hospital increased by 19 percent. The difference in the cost increase for the overall stay and for each day was attributed largely to a 2 percent increase in the average length of stays in the hospital.

William T. Hjorth, Equicor's president, said, "While the stabilization of hospital lengths of stay is very good news, a 19 percent increase in the overall cost of that stay is disturbing, especially in light of a general economic inflation rate of less than 5 percent."

The average daily cost of hospitalization ranged from $353 in Danville, Va., to $1,487 in San Jose, Calif., according to the survey. The average in Missouri and Illinois was $732, ranking behind 14 states and the District of Columbia.

Equicor is a joint venture of Hospital Corporation of America and the Equitable Group and Health Insurance Co. Equicor sells benefit packages to employers.

Hospitals in 46 states showed an increase in their daily charge; those in 17 states reported increases of 20 percent or more, Equicor found.

The American Hospital Association said Equicor should have studied what hospitals collect rather than what they charge, because of the big difference between the figures.

Equicor's study "doesn't reflect the true rates that are paid by Medicare, for example, or other third-party payers," said Clay Mickel, director of communications for the association. With 5,400 members, the association is the nation's largest health-industry group.

The study found that hospital beds in 31 states were empty as often as they were occupied.

The average length of stay ranged from 8.3 days in the District of Columbia to 3.8 days in Alaska, according to the study.

1987 HOSPITAL COSTS

(Average Charge Per Patient Day)	
1. Nevada	$1,204
2. California	1,109
3. District of Columbia	924
4. Hawaii	906
5. Oregon	853
6. Arizona	848
7. Pennsylvania	845
8. Colorado	844
9. Florida	823
10. Louisiana	791
11. Utah	770
12. Alabama	754
13. New Mexico	754
14. Washington	746
15. Illinois	732
16. Missouri	732
17. Nebraska	724
18. Michigan	720
19. Oklahoma	706
20. Texas	702
21. New Hampshire	685
22. Alaska	680
23. Georgia	672
24. Idaho	666
25. North Dakota	665
26. Tennessee	649
27. Indiana	649
28. Ohio	646
29. Montana	631
30. Connecticut	624
31. South Carolina	623
32. West Virginia	621
33. Kansas	616
34. Vermont	607
35. Massachusetts	606
36. Virginia	601
37. Minnesota	594
38. Kentucky	591
39. Maryland	589
40. Arkansas	586
41. Wyoming	584
42. Iowa	584
43. South Dakota	571
44. Wisconsin	552
45. Maine	547
46. Mississippi	527
47. North Carolina	512
48. New York	512
49. New Jersey	476
50. Delaware	474
51. Rhode Island	425

SOURCE: Equicor

Comments From United Technologies

UNITED TECHNOLOGIES

United Technologies Building
Hartford, Connecticut 06101
203/728-7000

January 25, 1988

Mr. Richard L. Fogel
Assistant Comptroller General
United States General Accounting Office
Human Resources Division
Washington, D. C. 20548

Dear Mr. Fogel:

Re: GAO Proposed Report - Contractor Employee Health Insurance Costs

We appreciate the opportunity to comment on GAO's proposed report to Congress on the results of your review of contractor employee health care costs.

While we understand GAO's objective of attempting to define criteria to measure reasonableness of employee health care costs, we do not believe that the criteria suggested by GAO in the proposed report are appropriate.

The reasonableness of health care benefit costs cannot be fairly evaluated other than in the context of total compensation paid. Companies and institutions in different sectors of the economy have adopted different mixes of the various components of compensation. Some classes or groups of employers have adopted compensation structures containing high proportions of retirement pay and paid leave, with lower base compensation, while other employers emphasize base compensation. Similarly, different employers have adopted varying levels of employee health care coverage as part of their total compensation packages.

Thus, we do not believe the reasonableness of employee health care programs can be judged in isolation from other elements of compensation. Further, the averaging of national cost levels, which forms the basis for your suggested criteria, ignores geographical, industry and demographic differences which can be significant. We have experienced significant differences in health care cost levels among the various geographical areas in which we operate, even where substantially equivalent plans apply in the different geographical areas and some units with an older work force have experienced much higher costs.

One reasonableness criteria suggested in your report is the annual U. S. Chamber of Commerce Employee Benefits survey. We do not believe this survey represents an appropriate measure of reasonableness since it consists of much smaller companies than those in the defense contracting community, which do not compete in the same employment marketplace. UTC designs, produces and markets high-technology products such as jet engines, helicopters, engine fuel controls, and other aircraft and space products. Consequently, we must attract and retain employees who have high skills in diverse fields. The costs of attracting and retaining such a workforce are not comparable to those represented in the Chamber survey.

Mr. Richard L. Fogel
Page Two

It is troubling that GAO concludes that defense contract costs are higher than the commercial sector costs and that some special means are required to contain them. There is an implication that defense contractors do not take appropriate steps to control health care costs, and this is similarly troubling.

Taking these points in turn, we point out that UTC's health care plans that were reviewed by GAO are uniform among our government contracting operating units. These units, taken as a whole, have significant non-defense business relating to commercial aircraft, as well as defense business. We cannot establish or bargain compensation cost levels at any of these operating units without taking into account our need to remain competitive in the commercial marketplace as well as in the defense contracting business, since both types of businesses are done by these operating units. Thus the forces of competition which result in particular cost levels in the commercial business extend also to the defense contracting business.

We have taken steps to contain health care costs. We have supported HMO's and similar groups who offer managed care and wellness programs, which hopefully lead to lower overall operating costs, by setting up procedures to facilitate and encourage participation by our employees in cost effective health care decisions. We require second surgical opinions before certain procedures are reimbursed. We also require precertification prior to hospital admission and continuing stay reviews are required during hospitalization. We serve and have served on civic organizations whose objectives are to reduce hospital costs. We have also made challenge grants to hospitals to provide incentives for them to become more cost effective.

The foregoing and similar areas are those which should be focused in order to lower costs.

In summary, we believe that the average cost criterion suggested in the GAO report is inappropriate and cannot produce reasonable results. Such an approach disregards other elements of compensation which must be taken into account in assessing reasonableness. The criteria do not take into account regional and demographic cost differences, and do not recognize the particular labor marketplace circumstances of the defense contracting community. Consequently, we urge you to make these points clear in your final report.

If you wish to explore other avenues of establishing reasonableness criteria, we will be pleased to meet with you and discuss such approaches.

Yours very truly,

Daniel P. O'Connell

Daniel P. O'Connell
Corporate Director,
Executive and Human Resources Programs

Comments From Rockwell International Corporation

Rockwell International Corporation
2230 East Imperial Highway
El Segundo, California 90245

Rockwell International

December 18, 1987

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

Attn: Richard L. Fogel, Assistant Comptroller General

Dear Mr. Fogel:

Thank you for the opportunity to review and comment on the United States General Accounting Offices draft report entitled, Government Contractors: Limits Needed On Employee Health Insurance Reimbursement.

The draft report makes the following points:

- Historically the government has been required to examine a contractor's total compensation costs when evaluating their reasonableness.
- Recent changes in regulation allow the government to challenge any single element of compensation.
- The government especially needs to establish quantitive criteria for determining the reasonableness of contractors' health care costs.
- Three criteria are proposed: the Federal Employees Health Benefits Program, the U.S. Chamber of Commerce's Employee Benefits Survey, and the 10 largest contractors' weighted average per employee.
- Using these criteria the draft report's analysis indicates that contractors' costs are "higher" and then concludes that this is because contractors' have less cost-sharing features in their health-care benefit designs.

We believe that it can be very misleading to focus on only one element of a total compensation program.

- Our compensation philosophy and strategy is based on a total program approach.

December 18, 1987
Mr. Richard L. Fogel
Page 2

- We compare ourselves to other companies based on the costs of total compensation.
- We believe that different types of employees have different compensation and benefit needs (i.e. government employees vs. postal workers).
- We trade off different elements of total compensation during union negotiations to achieve an overall economic package.
- Our goal must be a competitive total program of compensation and benefits to attract, retain, and motivate a qualified work force in both our commercial and government marketplaces.

The proposed quantitative criteria are clearly not appropriate.

- There are vastly different labor pool requirements between a major technology-oriented manufacturing concern and those of a government workforce.
- Small to medium-size manufacturing companies should not be used as a criterion measure for 100,000 + employee organizations.
- There is no treatment of potential differences in terms of geographic location, varying workforce demographics, and the need to recruit scarce labor talent.

Our own cost-surveys include a sample of major corporations in a wide variety of industry groups.

We believe that the proper goal is cost-management rather than cost shifting; because, while we have recently increased deductibles and total out-of-pocket expense for most of our employees (and added monthly contributions for many) our main emphasis is to control increasing costs by encouraging more cost-effective utilization of health care options.

- Many of the design features criticized in the draft report actually reduce costs by allowing the utilization of less expensive service options.

Finally it is the goal of our total compensation program not only to be competitive in the way described earlier--competitive to attract and retain qualified employees, but also, and equally as important, to remain competitive in our quest for additional government contracts. Therefore, continual focus on maintaining a competitive compensation and benefits program just makes good business sense.

C. R. Vennel
Vice President - Human Resources

Comments From the Council of Defense and Space Industry Associations

COUNCIL OF DEFENSE AND SPACE INDUSTRY ASSOCIATIONS (CODSIA)

1620 Eye Street, N.W., Suite 1000
WASHINGTON, D.C. 20006

(202) 659-5013

CODSIA Case 26-87
January 5, 1988

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

Dear Mr. Fogel:

On behalf of the undersigned member Associations of the Council of Defense and Space Industry Associations (CODSIA), we would like to make the following comments and observations in response to your request of November 12, 1987.

As you point out in both your 1984 report, and this draft, "The government needs to establish quantitative criteria for assessing the reasonableness of contractors' compensation costs that are both fair to the government and the contractors and easy to administer." We feel quite strongly that your proposed solution is unfair and costly to both parties albeit easy to administer. "Fairness" rather than "ease of administration" must be our principal guiding criterion.

We believe that changing the FAR in 1986 to allow a stand alone evaluation of just one element of compensation was a mistake. Compensation costs cannot be evaluated on the basis of individual elements, but must be viewed in total. The FAR recognizes this fact by allowing offsets among compensation elements.

The comparative data used in this report are not relevant to major defense contractors. The personnel market place represented by these data is not the same as defense contractors face in competing for talent among themselves and other large commercial employers. For instance, the definition of large manufacturers in the Chamber's Report is 50 or more employees, while the average of all of the 10 defense contractors in your study is in excess of 100,000 employees. Defense contractors also compete for employees possessing high technical skills such as engineers and scientists, who are able to command a much broader competitive compensation program of which health benefits is only one element.

Health care costs are influenced by both regional and demographic differences neither of which are addressed in the GAO analysis. The 1986 EQUICOR Report on Hospital Daily Service Charges clearly point out these geographic differences. For example, in that report the highest average

charge per day is $1,504, found in Canoga Park, CA. The lowest is $141 per day, found in McMinnville, TN. In looking to average charges per stay, Ann Arbor, MI heads the list with $10,744 while Wakita, OK trails the low end at $422. We also understand that the Health Care Financing Administration recently conducted its own study of regional differences in health care costs and arrived at a similar conclusion. It must be pointed out that the 10 defense contractors used in the GAO survey, as well as the rest of the industry, have a preponderance of their employees concentrated in high health care cost areas.

Any fair comparison of health care costs must recognize all influences that drive such costs. The plethora of states which have mandated minimum levels of benefits is not recognized in your report. These mandates have no impact on Federal employee health benefit plans, while they directly affect private employers equally. Furthermore, Congress has mandated additional forms of coverage e.g. COBRA continuation, with such health care coverage producing adverse selection which has a direct impact on employers' health care costs. And once again these mandates have no impact on Federal health care program costs.

One needs only look to the Medicare program to see how cost shifting is being placed on the employer. Your proposed approach would be at cross-purposes with many initiatives currently being considered by the Congress to further extend health care benefits and costs at the employers' expense, e.g., Mandated Health Benefits: S. 1265/H.R. 2508; Catastrophic Health: S. 1127/H.R. 2470. Thus contractors find themselves in between the government, who on one hand is increasing our costs, while on the other is challenging them as being excessive.

Good-faith and contractual relationships with employees will not allow employers unilaterally to change health care plans. Similar to Social Security and Medicare, health care benefits are an emotional issue with employees and are a strike issue with unions. The draft report recognizes this point indirectly by segregating the unionized postal workers benefit costs from that of other Federal employees. In view of the inherent problems associated with the Federal employee compensation and benefits systems, it makes no sense for the private sector to emulate those systems for its employees.

Some additional concerns about the GAO report:

- It does not consider extremely effective cost containment initiatives by defense contractors and criticizes cost effective containment programs such as Home Health Care, Hospice Care and Utilization Reviews.

- Defense contractors in many instances are a mix of commercial and defense businesses with the same programs covering all employees. It would be next to impossible for such dual commercial/defense employers to uncouple these programs.

Now on p. 52.

- The chart on page 36 of your draft report indicates that the trend factor for the different plans cited is the same, illustrating that cost shifting to the employee is not the remedy for the issue of rising health care costs.

- Cost sharing, through higher co-payments and deductibles, is a much more effective cost containment device than having employees pay a higher share of the premium costs.

Neither time nor space has permitted us to present a detailed and thorough analysis of the draft report. We feel that many of the details require further comment in order to meet your established fairness criteria. We would be happy to meet with you for further discussion of these concerns. Mr. Daniel J. Nauer, CODSIA's coordinator on this project will call you in early January to arrange for a meeting to discuss our concerns at greater length.

Very truly yours,

Wallace H. Robinson, Jr.
President
National Security Industrial Association

Jean A. Caffiaux
Senior Vice President
Electronic Industries Association

Don Fuqua
President
Aerospace Industries Association

Comments From the Hughes Aircraft Company

HUGHES

Subsidiary of GM Hughes Electronics

February 12, 1988

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

Dear Mr. Fogel:

This letter is in response to your November 12, 1987 request for comments on the draft GAO report on Contractors Health Care Costs (GAO/HRD-88-27).

Hughes Aircraft Company has developed an on-going program to control medical costs within Southern California and Tucson, Arizona where 90% of the Company's employees are located. As a result of this effort the Company's medical plan cost per employee declined in 1986. During 1987 Company medical costs have increased, but at a low rate when compared to overall medical costs. This cost reduction and cost containment have been accomplished in one of the highest medical cost areas of the country. The majority of the savings have been achieved by creating business agreements with medical providers which have resulted in major reductions in hospital costs. Hughes feels that it is better for its employees and for the community to work with the health care industry to reduce medical costs rather than merely pass medical cost increases on to employees.

The Company has increased employee awareness of medical costs by providing incentives for employees to use preferred medical providers who offer quality care at a reasonable price. If employees use the preferred providers they receive normal medical coverage; however, if they do not use a preferred provider their coverage is reduced by 50%.

Hughes believes that providing 100% reimbursement for medical costs reduces the chance that employees will take the time to look for reasonably priced medical care. Therefore, in January 1986, the Company instituted a program which requires employees to share in the payment of in-hospital treatment up to 1% of their annual salary. Hughes employees have always paid for

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20% of most outpatient services in addition to paying an annual medical deductible expense. The Company has made several other changes which have made the medical plan more cost effective. These cost containment measures include; mandatory second opinions for elective surgery, in-hospital peer reviews to further reduce inpatient charges, mandatory health maintenance organization (HMO) enrollment for one year for new hires to expose employees to cost effective managed health care, a mail order pharmaceutical program to reduce prescription drug costs, and communication/education programs to help employees stop smoking and become more aware of good health habits. Hughes is also proud of its Employee Assistance Program which can help employees overcome alcohol and other dependencies which, if not corrected, have the effect of increasing health care costs or removing a valuable person from the work force.

It is because of these programs and their success in controlling medical costs that Hughes feels qualified to respond to the draft GAO report. The following comments are offered for your consideration:

1. Hughes agrees that it would be helpful to develop medical cost .."criteria which are viewed as acceptable and fair both to DOD and the contractors." This would save innumerable unproductive hours of discussion between government and contractor professionals. Unfortunately, the criteria suggested in the draft report will not accomplish this objective. Some of the reasons the draft report criteria will lead to inaccurate and/or unreliable results are:

    a). Medical costs vary substantially by geographic area. Hughes is located in one of the highest medical cost areas in the country and it is unreasonable to compare Hughes medical costs to costs which represent all areas of the country.

    b) In order to support the national defense effort, Hughes and other defense contractors must attract and retain some of the most technically talented and well educated people in the country. The draft report indicates that there are "no differences in the composition of the work force at the 10 contractors that would account for differences in health care costs." While this may be true when comparing the work forces of the 10 contractors, it is probably not true when comparing the defense contractor employees to either federal employees or to the Chamber of Commerce data. Unfortunately, no data was provided in the draft report to make this comparison.

    In addition, it is important to remember that the commercial high technology and energy companies that are prone to raid the defense industry for talent have overall benefit and compensation plans that are equal to or better than defense contractors.

c) The cost of federal employee medical coverage is not generally impacted by state-mandated minimum health care benefits or federal programs, such as COBRA, which drive up contractors' medical costs.

2. There are several references to Medicare in the draft report, especially in the section on cost sharing. Considering that Medicare is offered by the government, primarily as a supplement to other coverage, it is irrelevant to the discussion of employer-provided benefits. Similarly, the reference to CHAMPUS is not relevant as this program only covers dependents.

3. The draft report emphasizes that defense contractors offer coverage for dental care, home-health care, and alcoholic dependency that is not offered to all government employees. Hughes is convinced that these programs help control overall health care costs. It might be useful for the GAO to study the difference in overall medical costs for federal employees who receive this coverage with those who do not receive the coverage.

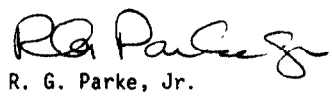
4. Based on the data provided in the draft report, government employees are offered vastly different levels of medical coverage. For instance, 64 percent of federal workers are offered dental coverage, 42 percent are offered home health care, 53 percent are offered alcohol and drug abuse coverage and 88 percent are offered first dollar coverage for hospital room and board. The opportunity to vary the level of benefit coverage for federal employees without causing severe employee morale and labor relations problems is undoubtedly due to the wide range of work performed and the geographic dispersion of federal workers. As a general rule, the defense contractors studied do not have this advantage. It must be noted that Hughes has opened five subsidiaries in lower health care cost areas of the country and has tailored the benefits for employees in these plants after the local labor market. This has resulted in health care costs per employee which are 25 percent to 40 percent lower than the Company's California plants. This fact is not included in the draft report.

In summary, Hughes agrees that the spiraling cost of medical care in the United States is a problem of national significance. The problem must be addressed by using innovative and compassionate methods to lower the cost of quality medical care, rather than simply passing cost increases on to the people who need health care.

Hughes also agrees that employees should pay their fair share of medical costs, because this will help them become smarter consumers of health care and will help to exert market pressure to reduce health care costs. However, it is unreasonable to implement a control system such as the one suggested in the draft report that will force defense contractors to absorb unallowable costs in order to retain the caliber of employees necessary to meet their contractual commitments to the government.

Finally, it is clear from this study that a universally equitable set of simple quantitative criteria for determining the reasonableness of contractors' health care costs does not exist. Therefore, it is recommended that the GAO evaluate the possibility of developing general guidelines and survey analysis techniques that can be used by defense contractors, the DOD, the GSA and NASA to judge the reasonableness of contractor health care costs. It is strongly recommended that these guidelines include an analysis of defense contractors efforts to reduce or contain the cost of medical care in the communities where they operate.

Very truly yours,



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