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REPORT BY THE U.S.

# General Accounting Office

## Financial And Other Problems Facing The Federal Employees Health Insurance Program


Recognizing that the cost of the Federal employee health program was escalating faster than anticipated, the Office of Personnel Management tried to avert a budget shortfall for fiscal year 1982, primarily by reducing health benefits. The final 1982 rates, determined after the benefit reductions, appear to be reasonable. The increased 1982 rates should improve the program's financial stability.

The report notes that the Federal employee health program appears not to be comparable to private sector employee health programs.

This report also discusses a phenomenon unique to the Federal program--selective enrollment--that is potentially damaging to the program, as well as other perceived problems and various opinions on how to address them.

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-206417

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

Dear Mr. Chairman:

This report is in response to your December 10, 1981, letter and subsequent discussions with your office requesting that we examine and report on a number of topics related to the Federal Employees Health Benefits Program. Among other things, it

--presents the rationale and justification for the 1982 benefit reductions and rate increases in the program,

--compares some Federal health plans to plans offered by some private sector employers, and

--describes suggestions made by various people to address perceived program problems.

At your request, we did not take the additional time needed to obtain agency comments on the matters discussed in this report.

As arranged with your office, we are sending copies of this report to the Director, Office of Management and Budget; the Director, Office of Personnel Management; and other interested parties. Copies will also be available to other parties upon request.

Sincerely yours,

Philip A. Bernstein
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE CHAIRMAN,
SUBCOMMITTEE ON CIVIL SERVICE,
POST OFFICE, AND GENERAL
SERVICES, SENATE COMMITTEE
ON GOVERNMENTAL AFFAIRS

FINANCIAL AND OTHER PROBLEMS
FACING THE FEDERAL EMPLOYEES
HEALTH INSURANCE PROGRAM

## DIGEST

The Office of Personnel Management (OPM) administers a $5 billion health insurance program for about 10 million employees, annuitants, and dependents through contracts with over 100 insurance plans. The program's cost is shared by the Government and the employees and annuitants who elect to participate.

For 1982, the program experienced unprecedented benefit reductions and large rate increases. In addition, enrollees were not allowed to switch plans at the usual time, although benefit and rate changes meant enrollees were paying more for less benefits. In response to a request from the Chairman, Subcommittee on Civil Service, Post Office, and General Services, Senate Committee on Governmental Affairs, GAO reviewed the rationale and justification for these changes as well as other issues related to this program. (See pp. 1 to 7.) At his request, GAO did not take the additional time needed to obtain agency comments on the matters discussed in this report.

### OPM ACTIONS APPROPRIATE, BUT AFFECTED PLANS DIFFERENTLY

During negotiations for the 1982 program, OPM ordered benefit reductions and other program changes in an attempt to keep program costs within budget estimates. Using budget estimates as a spending constraint--although not done in the past--was appropriate.

Based on fiscal year 1982 budget estimates, OPM determined that the initial 1982 rate proposals would have caused a $440 million budget shortfall for the Government share of program costs. Primarily through two rounds of benefit reductions, OPM eliminated part of the shortfall.

However, OPM requested and received a supplemental appropriation of about $300 million for the 1982 program, about half of which was required to eliminate the rest of the shortfall. The other half of the supplemental appropriation was needed to account for a budget error, a prior year shortfall, and increased costs due to anticipated enrollment shifts. (See pp. 8 to 19.)

OPM's administration of benefit reductions and negotiation of service charges or profit allowances affected plans differently. In the first round of reductions, OPM initially required some plans to cut some benefits to specific levels, despite plans' different benefit structures. OPM's intent regarding these cuts was to add more cost containment or, more appropriately, cost-sharing features to the program while still satisfying its other benefit reduction objectives. In the second round, OPM required all but a few plans to reduce benefits by the same percentage, resulting in less varied rate changes. The variance among plans for first-round rate changes due to benefit reductions was about six times greater than that for second-round rate changes. (See pp. 26 to 31.)

OPM also used different methods to compute the 1982 service charges for the two Government-wide plans; consequently, Blue Cross/Blue Shield received a 100-percent increase in its service charge, while Aetna received a 5-percent increase. Had OPM determined Blue Cross/Blue Shield's service charge using the method applied to Aetna, the charge would have increased only 10 percent. OPM is developing a structured approach that it intends to apply uniformly to all plans, including employee organization plans, that have service charges. (See pp. 31 to 36.)

RATE INCREASES WERE REASONABLE

GAO contracted with an actuarial firm to review rate increases for certain plans. The contractor concluded that the 1982 rate increases agreed to by OPM and the program's three largest plans were reasonable according to generally accepted actuarial practices.

In addition, the contractor concluded that, by the end of 1982, these plans should be in better financial condition. If this is representative of what occurred in other health plans, program stability should improve. (See pp. 20 to 25.)

## FEDERAL PROGRAM NOT COMPARABLE TO PRIVATE SECTOR PROGRAMS

Studies of the program from 1979 to 1982 indicate that it was not comparable to private sector health benefit programs. OPM studies in 1979 and 1980 concluded that, while benefits were generally comparable, private sector employers paid a greater proportion of the cost than did the Federal Government. An analysis of fringe benefits concluded that this disparity in employer contribution persisted in 1981. GAO's limited analysis indicated that the 1982 program was still not comparable to private sector programs, both in benefits and in employer contributions. (See pp. 37 to 42.)

## SELECTIVE ENROLLMENT-- A THREAT TO PROGRAM STABILITY

Selective enrollment--allowing Federal employees to enroll in the health plan that best suits their expected health needs--is a unique feature of the Federal program because the Congress intended to give enrollees a choice among different plans with different benefits. Because higher utilizers of benefits tend to join more comprehensive plans while lower utilizers join less comprehensive plans, the cost and related premium rates of the more comprehensive plans increase, thereby encouraging lower utilizers to leave. There is disagreement about whether, and to what extent, selective enrollment adversely affects the program.

Blue Cross/Blue Shield was so concerned with the potential adverse impact of selective enrollment that it threatened to withdraw from the program for 1982. GAO believes that the withdrawal of a plan, like Blue Cross/Blue Shield, with high utilization experience would accelerate rate increases associated with selective enrollment.

Some people associated with the program believe that eventually the issue of selective enrollment will drive the cost of comprehensive coverage out of the reach of those who need it most and, ultimately, reduce greatly the comprehensiveness of benefits. GAO presents and evaluates some suggested solutions to this problem. (See pp. 43 to 54.)

During GAO's review, people associated with the program expressed various opinions about other perceived problems. In addition to selective enrollment, four major problem areas were identified:

--The desirable level of competition.

--The lack of control and predictability associated with the method used to compute the Government cost.

--Poor enrollment data.

--The need to contain or reduce program costs.

In a synopsis of each problem area, GAO lists suggested solutions and some pros and cons. In addition, OPM actions on prior GAO recommendations relating to these problems are discussed. (See pp. 55 to 63.)

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## ABBREVIATIONS

| | |
|---|---|
| APWU | American Postal Workers Union |
| FEHBP | Federal Employees Health Benefits Program |
| GAO | General Accounting Office |
| HMOs | Health Maintenance Organizations |
| LWOP | leave without pay |
| NALC | National Association of Letter Carriers |
| OPM | Office of Personnel Management |

# CHAPTER 1

## INTRODUCTION

The Office of Personnel Management (OPM) reduced benefits for those enrolled in the Federal Employees Health Benefits Program (FEHBP) for 1982. This unilateral reduction of benefits was historically unprecedented but helped constrain the premium rate increases that otherwise would have been needed to finance the program. OPM's action disrupted the normal bilateral negotiations with health plans, resulted in litigation, almost caused the program's largest health plan to withdraw, and postponed the regularly scheduled period during which enrollees could change plans. At the beginning of 1982, enrollees were effectively locked into plans they had chosen for 1981, although benefits and rates had changed considerably. In short, enrollees were generally required to pay more for less benefits.

In December 1981, the Chairman, Subcommittee on Civil Service, Post Office, and General Services, Senate Committee on Governmental Affairs, requested that we examine certain issues related to FEHBP.

### FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

FEHBP, established by the Federal Employees Health Benefits Act of 1959, is the world's largest employer-sponsored, voluntary health program. It provides health insurance to employees, annuitants,[1] and their dependents. In 1982, FEHBP provided health insurance to about 3.7 million enrollees and 6.3 million dependents through 119 health plans. The program's fiscal year 1982 budget was $4.7 billion, of which $2.9 billion was financed by the Government (including the Postal Service) and $1.8 billion by enrollees. Administrative responsibility for FEHBP rests with OPM. Its responsibilities include

--negotiating benefits and premium rates and contracting with qualified health plans;

--conducting open enrollment periods;

--calculating the Government contribution for each enrollment;

--administering the Employees Health Benefits Fund;

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[1]Includes retired and disabled Federal workers and survivors of deceased Federal workers.

--prescribing regulations concerning health plan and enrollee responsibilities, rights, and procedures; and

--reviewing, upon request, claims payments denied by health plans.

FEHBP encompasses three basic types of health plans:

--Government-wide Plans: Two Government-wide plans are available to all eligible employees, annuitants, and dependents, regardless of geographic location. The Service Benefit Plan, administered by Blue Cross/Blue Shield, provides benefits through direct payment to doctors and hospitals. This plan, which is required by law to offer two benefit levels or options, accounts for about 50 percent of all FEHBP enrollees. The Indemnity Benefit Plan, administered by the Aetna Life Insurance Company, also must offer two benefit levels or options. The plan provides benefits through payments either to the enrollee or to doctors or hospitals. It enrolls about 12 percent of all FEHBP enrollees.

--Employee Organization Plans: These plans, of which there were 17 in 1982, are sponsored by employee organizations and are available only to eligible Federal employees and their dependents who are, or become, members of the sponsoring organization. Some plans are also open to annuitants and their dependents. The plans provide benefits by payments either to the enrollee or directly to doctors and hospitals. These plans account for about 28 percent of FEHBP enrollment.

--Comprehensive Medical Plans: These plans, often referred to as Health Maintenance Organizations (HMOs), offer Federal employees, annuitants, and dependents prepaid care from plan doctors and hospitals in particular geographic or service areas. The plans, of which there were 100 in 1982, provide comprehensive medical services through doctors and technicians in medical centers or through direct payments to doctors or hospitals with whom the plans have agreements. HMOs account for about 10 percent of FEHBP enrollment.

Within OPM's Compensation Group, the Office of the Assistant Director for Insurance Programs was responsible for contract negotiations of 1982 rates and benefits with these health plans.

To qualify for participation in FEHBP, a health plan must meet certain OPM standards. These include (1) providing a rate structure with one individual rate and one family rate for each

option, (2) not having more than two options, (3) having the financial resources and experience to fulfill its program obligations, and (4) providing a special reserve, primarily for the Government-wide and employee organization plans. The special reserve is the difference, over time, between premium rate (subscription) income and claims paid; it is used to pay claims when subscription income is insufficient. OPM requires plans to invest this special reserve, and the investment income is to be credited to the reserve account. In the past, OPM policy was that rates be set at a level sufficient to maintain a special reserve level ranging from 2 weeks to 1-1/2 months of subscription income, depending on the type of plan. Each year, these special reserves are considered when OPM negotiates new contracts for health benefits and rates.

OPM conducts the open season--an enrollment period during which any unenrolled eligible employee may join a plan, and any enrolled employee or annuitant may change plans. Timing of the open seasons is left to OPM's discretion; however, since the early 1970s--except for the 1982 contract year--they have been held annually. In conducting open season, OPM is responsible for making available to employees and annuitants information which will aid them in making informed choices among health plans. OPM and each plan jointly prepare a brochure summarizing plan features for the enrollee. The brochure is a statement of plan benefits, limits, and exclusions and serves as a contract between the enrollee and a plan. OPM also provides enrollees with enrollment information, rates, and comparisons of various health plan features.

The cost of FEHBP is shared between the enrollee and the Government. By law, the Government's share for each enrollment is equal to 60 percent of the unweighted average of the high option rates for six plans. These plans--the Big Six--are the two Government-wide plans, the two employee organization plans with the largest enrollment, and the two comprehensive medical plans with the largest enrollment. For 1982 the Big Six were the (1) Blue Cross/Blue Shield Service Benefit Plan, (2) Aetna Indemnity Benefit Plan, (3) National Association of Letter Carriers (NALC) Health Benefit Plan, (4) American Postal Workers Union (APWU) Plan, (5) Kaiser Foundation Health Plan-Northern California Region, and (6) Kaiser Foundation Health Plan-Southern California Region. The Government's share for any enrollee cannot exceed 75 percent of a plan's total rate. For postal employees, the Postal Service pays a larger percent (75 percent of the Big Six average up to 93.75 percent maximum limit for 1982) which is agreed to during contract negotiations with the postal unions.

OPM administers the Employees Health Benefits Fund, the trust fund through which FEHBP is financed. Each agency pays into the trust fund the Government share for each enrolled employee, using funds from its salaries and expenses appropriation account. The Postal Service pays its share for postal employees, and OPM pays the Government share for all annuitants, including postal annuitants. Employees and annuitants pay the trust fund their share of costs through salary or annuity withholdings, respectively. OPM forwards this subscription income to the plans, but retains a small portion in the trust fund for administrative expenses and a contingency reserve. The contingency reserve may be used to defray future rate increases or increase the benefits provided by the plan from which the reserve is derived, as long as the reserve retains at least an amount equivalent to 1 month's subscription income.

## OBJECTIVE, SCOPE, AND METHODOLOGY

Due to the disarray and uncertainty associated with the program at the end of 1981, we were asked to review certain issues related to FEHBP. These issues involved questions that could be grouped into five categories or areas of concern; our objective was to answer these questions.

One area of concern focused on the reasons for the 1982 benefit cuts and rate increases:

--Why were 1982 health benefits reduced when premium rates increased significantly?

--Did a true 1982 FEHBP budget shortfall of the magnitude indicated by OPM exist?

Our responses to these questions are discussed in chapter 2.

A second concern was the justification for the rate increases:

--Were the 1982 rate increases for the three largest health plans reasonable and justified?

This question is answered in chapter 3.

The third area of concern involved equitable treatment of Federal health plans:

--Did OPM fairly and equitably administer the two rounds of benefit cuts?

--What is the justification for increases in service charges or profits for selected health plans?

These questions are discussed in chapter 4.

A fourth area of concern was program comparability:

--Is FEHBP comparable (in terms of benefits and employer/employee contributions) to private sector health plans?

This question is discussed in chapter 5.

The fifth category of issues involved perceptions of needed changes and our past recommendations:

--What program features have been perceived as needing modification to assure FEHBP stability?

--What actions has OPM taken in regard to past GAO recommendations, particularly those of a cost containment nature?

These matters are discussed in chapters 6 and 7.

The scope of our review included visits with representatives from the following 10 plans which have offices in the Washington, D.C., metropolitan area:

Government-wide plans

Aetna Indemnity Benefit Plan
Blue Cross/Blue Shield Service Benefit Plan

Employee Organization plans

Alliance Health Benefit Plan
American Federation of Government Employees Health Benefit Plan
APWU Plan
NALC Health Benefit Plan
Postmasters Benefit Plan

Comprehensive plans

George Washington University Health Plan
Group Health Association
Kaiser-Georgetown Community Health Plan, Inc.

These plans, chosen because of their geographic location and general availability to most Federal employees, represented about 80 percent of FEHBP enrollment at the beginning of 1982.

We visited the Group Health Association of America, a national trade association of HMOs located in Washington, D.C. Sixty-seven of the over 100 organizations represented by the Association contract with OPM to provide health benefits to Federal employees. We also met with a representative of the Kaiser Foundation's California headquarters office to gain a perspective of the eight Kaiser plans, including the two California plans whose rates are used in determining the Government contribution to the program.

During our visits with plan representatives, we discussed various questions related to FEHBP, focusing primarily on those related to benefit reductions, budget shortfalls, and rate increases. Where available, we gathered documentation regarding these questions. We also discussed plan officials' perceptions on questions related to cost containment and program features needing modification.

The Director of OPM responded, in writing, to a detailed list of questions regarding the rationale for benefit cuts, rate increases, the budget shortfall, equitable treatment of health plans, and comparability. We interviewed OPM officials regarding each question, reviewed OPM negotiation files for the 1982 contract year, and gathered documentation concerning OPM estimates of budget shortfalls and savings. We used information from plans and OPM to describe the events occurring during the negotiation cycle for 1982 benefits and to evaluate OPM's use of budget estimates and its administration of benefit cuts. Time constraints did not permit us to evaluate the methodology used by OPM in making estimates of budget shortfalls or savings.

We interviewed OPM program and audit officials, and where necessary, plan officials, to determine what actions had been taken in regard to our past recommendations.

We contracted with the Actuarial Research Corporation, Falls Church, Virginia, to assist us in determining whether the 1982 rate increases for FEHBP's three largest plans were reasonable and justified according to generally accepted actuarial practices. The contractor identified the factors that contributed to rate increases.

To determine congressional intent in regard to comparability, we reviewed the program's legislative history. We analyzed recent studies and data regarding FEHBP comparability to health insurance programs offered by large private sector employers during 1979-81. For 1982, we performed a limited qualitative comparison of FEHBP plans with certain private sector health plans. Specifically, we compared the benefits of 15 FEHBP plans

(the 2 high-option Government-wide plans, the 11 high-option employee organization plans that were open to all current employees, and the 2 comprehensive plans with the largest Federal enrollment) to the benefits of 33 private sector group insurance plans obtained from 4 major insurance companies. For 23 of these plans, the insurance companies provided information on employer-employee health insurance cost sharing which we used to compare the relative contributions of the Federal Government and private sector employers. Because FEHBP and private sector plans we examined were judgmentally selected, the results of our analysis are limited to these plans alone. The results are intended to be an indication of the degree of comparability between current Federal and private sector health insurance programs. We did not examine the characteristics of the population insured by FEHBP versus that of the private sector plans, such as the comparative ages of active employees in the Federal and private sectors.

Our review was performed in accordance with generally accepted government audit standards.

# CHAPTER 2

## BENEFIT REDUCTIONS WERE

## UNPRECEDENTED BUT APPROPRIATE

When OPM reviewed the plans' proposed rates for 1982, it concluded that, if it accepted the rates with the significant increases as proposed, the Government would incur costs exceeding the amount that had been budgeted for 1982. In an attempt to bring program costs within an estimated budget amount, OPM ordered that benefits be cut--a first for FEHBP. Program disruption ensued, and OPM was not entirely successful in eliminating the budget shortfall for the Government contribution. OPM's actions, however, to bring program costs within the budget were appropriate.

### 1982 HEALTH BENEFITS REDUCED AND RATES INCREASED BECAUSE OF POTENTIAL BUDGET SHORTFALL

Plans' unexpectedly high proposed rate increases and OPM's resultant management actions steered the 1982 contract negotiations off their normal course and delayed the 1982 open season. Contract negotiations between OPM and the individual plans proceeded normally until the end of July 1981, when OPM received the plans' proposed rates for 1982. Although OPM had planned for some increase in rates, it estimated that under the plans' proposals, the total contribution to FEHBP would have exceeded the $4.7 billion budgeted amount for the employee and Government contribution by more than $800 million. The potential shortfall for the Government contribution alone changed in size as OPM refined its estimates, but was eventually set at $440 million.

After rejecting suggestions to set rates that were insufficient to recover costs or to request additional appropriations, OPM decided to avert the shortfall in the Government contribution, primarily by taking the unprecedented step of unilaterally requiring plans to reduce benefits. OPM's actions were only partially successful in eliminating the total shortfall, disrupted the normal course of negotiations, and resulted in legal actions and uncertainty. In general, however, the Federal courts found OPM's actions were within its legislative authority.

#### Proposed rates caused potential budget shortfall

Before submission of plans' proposed 1982 rates, negotiations proceeded as usual. By the end of March 1981, OPM

had issued its call letter soliciting 1982 benefit proposals from the plans and outlining OPM policy on benefits that plans could add to their packages. For 1982, OPM encouraged plans to consider adding midwife services, hospice care, and dental packages. Plans were to offset any new benefit, however, by reducing some other benefit so that the overall dollar value of the benefit package would not increase. By the end of April, plans had submitted their 1982 benefit proposals for negotiation with OPM. OPM sent its rate call letter to the plans in early June, requesting their proposed rates and supporting actuarial data for the 1982 benefit package. As requested, plans submitted their proposed rates by the end of July.

The proposed increases over the 1981 rates were larger than OPM had anticipated. OPM had estimated its fiscal year 1982 budget for FEHBP in October 1980 allowing for an 11.5-percent increase in rates. This planned increase was consistent with the rate experience of the previous few years and fell within the inflationary projections of the President's Council of Economic Advisors and the Office of Management and Budget. Using the July 1981 rate proposals for the six plans that determine the Government contribution, however, OPM calculated an average increase in rates of over 30 percent--almost three times larger than the budgeted increase.

OPM estimated that the proposed rates, if accepted, would have resulted in a significant shortfall in the $4.7 billion included in the President's fiscal year 1982 budget. Regarding the Government and enrollee contributions to the program, OPM's original estimates showed a shortfall over $500 million. OPM later revised this estimate to $800 million. OPM's initial estimate of the Government's share of the shortfall was $190 million. OPM later revised this estimate to $370 million and then to $440 million, using updated employee and annuitant population data.

<u>OPM considered several strategies to avert its initial shortfall estimate</u>

Believing that the proposed increases were unacceptable to enrollees and taxpayers and that such increases threatened the integrity of the Federal budget, OPM considered several strategies for addressing its budget problem. According to the Director, OPM staff recommended setting rates at a level insufficient to recover costs and using plan reserves to subsidize the new rates. The Director informed us that he rejected this recommendation because OPM had seriously underpriced most plans in 1980 and 1981 and to do the same for a third consecutive year would have exacerbated the problem and threatened the financial underpinnings of the program.

OPM also considered covering the total shortfall by seeking additional funds from the Congress. This was quickly rejected, according to the Director, due to the overall concern with the Federal budget, OPM's fiduciary responsibility, and the Nation's economic outlook. The Director did not believe that, in good conscience, he could ask the Congress for an additional sum of that magnitude. We believe that an OPM request for funds to cover the total shortfall in the Government contribution would have further complicated the issue since appropriations for active employees are made directly to the employing agencies, not to OPM.

Reducing benefits was another strategy OPM considered to avert the shortfall. According to the Director, three approaches were available for benefit reductions: OPM could (1) mandate increased across-the-board coinsurance features, thus transferring some increased costs to enrollees, (2) instruct plans to choose benefit cuts to meet an established percentage of proposed premium, or (3) direct that specific benefits be cut.

OPM reduced benefits and postponed reserve recovery to address its initial shortfall estimate

OPM unilaterally decided to make up half of its initial shortfall estimate of $190 million by reducing specific benefits and half by deferring the rebuilding of plan reserves. At an emergency meeting on August 21, 1981, OPM informed the two Government-wide plans and all but three employee organization plans that its underestimates of inflation and utilization of benefits had created an immense budget problem. To deal with this problem, OPM required these plans to cut benefits below the level tentatively agreed to. The agreements were tentative because the associated rates were awaiting actuarial verification by OPM.

The general atmosphere resulting from the August 21 meeting seems to have been one of confusion. During the meeting, OPM did not distribute written guidelines for the plans to use in accomplishing the required benefit reductions. Instead, it mailed a copy of the Associate Director for Compensation's statement to the plans after the meeting. This statement briefly explained the specific cuts to be made and OPM's rationale for the reductions. Nevertheless, different plans received different impressions of what OPM was requiring. Some plans thought they were told to reduce benefits by 10 percent; some thought they were told to reduce benefits by whatever was necessary to keep their rate increase from 1981 to 1982 below 20 percent. However, most plans we talked to

[illegible] planned to negotiate these cutbacks within 2 weeks but extended the deadline because of unforeseen complications in implementing the cuts.

Before plans submitted their proposed rate increases, OPM had intended to establish rates at a level that would have partially recovered reserves that had been seriously drawn down. However, the Director changed his position and deferred $95 million in reserve recovery to fiscal year 1983, allowing plans to lower their rates by those amounts which had been added to build up the reserves from their depleted levels.

<u>OPM strategies to address revised shortfall estimate</u>

As OPM estimates of the potential shortfall in the Government contribution increased to $370 million, OPM planned several strategies to address it. For example, as shown in table 1 (see p. 12), in addition to the $190 million benefit reduction and deferred rebuilding of the reserves already undertaken, OPM ended free coverage for employees on leave without pay (LWOP). In the past, since health insurance continued for enrollees on LWOP without the enrollees paying their share, other enrollees subsidized LWOP employees' coverage. By making LWOP employees pay the employee share of the rates, the income needed to pay for benefits would be spread over a greater number of enrollees, thereby reducing the average rate and saving an expected $20 million in the Government contribution. OPM also expected to save $35 million by reducing abortion, mental, and dental coverage beyond the levels already imposed by the August cuts. This latter strategy was blocked, however, by judicial action.

Another strategy to avert the revised shortfall focused on reducing the Government contribution by lowering APWU's rate or by altering the composition of the Big Six by replacing APWU with a lower cost plan. Following the benefit cuts ordered in August, the FEHBP status of the APWU plan was uncertain. OPM maintained that APWU had not submitted an acceptable proposal by the September deadline and, therefore, could be terminated. APWU filed suit against OPM to prevent implementation of the August cuts. Nevertheless, OPM continued to negotiate with APWU and addressed what OPM considered to be APWU's serious financial problem by proposing to APWU that its plan provide less comprehensive coverage and lower rates than APWU had proposed. OPM estimated that a low-option plan it had offered APWU would save FEHBP $230 million. According to OPM, savings of that magnitude would have eliminated the need for further reductions by other plans. OPM

also estimated that a mid-option plan it offered APWU could save $125 million. Removing APWU from the Big Six and repl ing it with another employee organization plan with a lower rate could also save $125 million, according to OPM estimat OPM discussed changing the composition of the Big Six at co gressional hearings held on October 19, 1981, and attended both House and Senate members concerned with FEHBP. Specif ally, OPM testified that removing APWU or NALC, or both, wo reduce the Government contribution to FEHBP, but OPM did no submit a legislative proposal to accomplish this.

Table 1

OPM Strategies to Avert Potential 1982 FEHBP Budget Shortfall in the Government Contribution

| Strategy | Potential shortfall (millions) | | |
|---|---|---|---|
| | $190 | $370 | $44 |
| First-round benefit cuts | 95 | 95 | 9 |
| Deferred reserve recovery | 95 | 95 | 9 |
| LWOP adjustment | - | 20 | 2 |
| Additional mental, dental, and abortion reductions | - | 35 | - |
| APWU removed from Big Six | - | 125 | - |
| Mid-option APWU plan | | | a/12 |
| Second-round benefit cuts | | | a/10 |

a/OPM estimated that APWU acceptance of a low-option plan would have saved $230 million, eliminating the need for further cuts by other plans.

## OPM implemented a second round of benefit cuts to address revised shortfall estimates

In late October 1981, the Director concluded that his only alternative to avert the potential shortfall in the Government contribution--now estimated at $440 million--was second round of benefit cuts. According to the Director, hi discussion with various Congressmen at the hearing gave him the impression that there would be no additional funding for FEHBP. With the status of APWU still undecided, the latest increase in the shortfall estimate, $35 million not realized in mental, dental, and abortion cuts due to pending litigation, and the desire to conclude all negotiations by the end

of October, the Director determined that the second round of benefit reductions would total $105 million--the amount necessary for FEHBP to remain within the budget estimates, assuming the LWOP adjustment was implemented and APWU accepted a modified plan. OPM actuaries calculated that a 6.5-percent cut in the estimated value of benefits across all plans would achieve the desired $105 million in savings. Based on this calculation, the second round was a 6.5-percent reduction in the value of benefits for all plans included in the first round and for the Comprehensive Medical Plans (HMOs).

### Lawsuits challenging OPM actions to avert shortfall added to FEHBP uncertainty and delayed open season

Lawsuits against OPM over benefit reductions and other program changes led to FEHBP uncertainty and delayed open season. With the exception of the abortion decision, however, the courts ultimately upheld OPM's authority to mandate benefit reductions.

OPM decided that plans should not use FEHBP funds to pay for abortion benefits. The American Federation of Government Employees contested this decision in court. Although the court ruled against OPM, the agency applied the ruling only to the plans that were party to the suit. As a result, some 1982 plans covered abortions; others did not.

Although plans sued OPM concerning both rounds of benefit cuts, the courts upheld OPM's authority. At the end of September, APWU and NALC filed suits contesting OPM's authority to impose the first round of benefit reductions. The U.S. District Court for the District of Columbia denied the plans' request for temporary restraining orders. Later, the District Court ruled that OPM had not abused its discretion in implementing the first round of benefit cuts. At the end of October, the National Federation of Federal Employees and the American Federation of Government Employees filed suit challenging the second round of benefit reductions. On November 4, 1981, the District Court ruled in favor of the plans and disallowed the second round of benefit cuts. OPM, however, appealed this decision, and on December 21, 1981, the U.S. Court of Appeals ruled in OPM's favor.

After the District Court disallowed the second round of benefit cuts in early November, OPM issued regulations indefinitely postponing the 1982 open season. According to OPM, its decision was based on a need to have full distribution of program information, particularly in a year of substantial benefit changes and rate increases. Such distribution could

not be accomplished in time for the scheduled open season of November 9 to December 11, and OPM believed that holding open season without thorough distribution of information would have been useless. In addition, significant aspects of some 1982 plans were uncertain because lawsuits concerning benefit cuts were still pending. It should be noted that OPM had already agreed to allow Blue Cross/Blue Shield to withdraw from FEHBP if a 1982 open season was held before adverse selection problems were addressed. (See ch. 6.) It is unclear, however, what impact, if any, this agreement had on OPM's decision to indefinitely postpone open season.

The National Federation of Federal Employees and the National Treasury Employees Union, among others, filed suit to force OPM to hold open season. The District Court ordered open season to commence December 7 without the 6.5-percent reductions, but the Court of Appeals stayed this order. In February 1982, the Court of Appeals upheld OPM's authority to postpone open season. OPM eventually held open season in May 1982, allowing changes to take effect in July 1982, fully 6 months after benefit reductions and increased rates went into effect.

## OPM ACTIONS TO ELIMINATE FEHBP SHORTFALL WERE PARTIALLY SUCCESSFUL

According to OPM's estimates of actual savings, its actions to avert its $440 million shortfall in the Government contribution completely eliminated the active employee component of the shortfall, but only partially eliminated the annuitant component. OPM documents identify about $300 million in combined savings from its actions. To fund FEHBP at its reduced benefit level during 1982, OPM requested a supplemental appropriation of over $300 million for its annuitant account. This request included funds for a fiscal year 1981 shortfall, a fiscal year 1982 budget error, anticipated increased costs due to enrollment shifts, and the unliquidated portion of the $440 million shortfall.

OPM estimated its actions eliminated about 44 percent of the annuitant component and all of the active employee component of the $440 million shortfall. According to OPM, about $277 million of the shortfall was attributable to annuitants and about $172 million to active employees.[1] The first round of OPM actions addressed about $190 million of the shortfall--the annuitant component being reduced by $74 million and the active employee component by $114 million (see table 2).

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[1]Figures do not total precisely due to OPM rounding.

## Table 2

### Effect of OPM Actions to Reduce Fiscal Year 1982 FEHBP Shortfall

| Government cost components | (1) Based on President's budget | (2) Based on proposed rates (note a) | (3) Shortfall (2) - (1) | (4) After first-round changes | (5) Shortfall (4) - (1) | (6) After second-round changes | (7) Shortfall (6) - (1) | (8) Total savings (2) - (6) |
|---|---|---|---|---|---|---|---|---|
| | | | | (billions) | | | | |
| FY 82 contribution for annuitants | .824 | 1.101 | .277 | 1.027 | .203 | .980 | .156 | .121 |
| FY 82 contribution for active employees | 1.422 | 1.594 | .172 | 1.480 | .058 | 1.410 | (.012) | .184 |
| | b/2.250 | b/2.690 | c/.440 | b/2.510 | c,d/.260 | b/2.390 | c,e/.140 | c/.300 |
| FY 81 annuitant shortfall | | .058 | .058 | .058 | .058 | .058 | .058 | |
| FY 82 annuitant budget error | | .042 | .042 | .042 | .042 | .042 | .042 | |
| Total | 2.250 | 2.790 | .540 | 2.610 | .360 | 2.490 | .240 | .300 |

a/Includes fiscal year 1981 annuitant shortage transferred to fiscal year 1982 and fiscal year 1982 annuitant error.

b/Figures rounded as OPM rounded.

c/Figures calculated using OPM rounded figures.

d/This shortfall figure based on OPM rounded numbers indicates a $180 million first-round savings. Actual first-round savings without rounding total $188 million and result in about a $250 million shortfall.

e/This shortfall figure based on OPM rounded numbers indicates a $120 million second-round savings. Actual second-round savings without rounding total $117 million; however, in discussing second-round savings OPM excludes $12 million in savings which resulted in an active employee surplus. Thus, according to OPM, second-round savings totaled $105 million.

The second round of benefit reductions saved $105 million of the shortfall. Of this, OPM attributed $47 million to annuitants and $70 million to active employees, leaving a $156 million deficit and $12 million surplus, respectively. Together, both rounds of savings, including the deferral of $95 million in reserve recovery, liquidated about $300 million of the $440 million shortfall. OPM did not completely liquidate the shortfall primarily because it was not successful in getting APWU to accept a mid-option plan.

Although OPM directed its cost saving action at averting a potential $440 million shortfall, it recognized that this action would not fully cover the cost of operating the program even at the reduced level. Specifically, in addition to the $440 million shortfall for fiscal year 1982 due to higher than anticipated rate increases, the total fiscal year 1982 shortfall also included (1) a fiscal year 1981 annuitant account shortfall of $58 million and (2) a fiscal year 1982 budget error in the annuitant account of $42 million. The fiscal year 1981 shortfall was transferred to fiscal year 1982 when the October 1, 1981, continuing resolution (Public Law 97-51) authorized the use of fiscal year 1982 funds to pay prior year obligations without any corresponding increase in OPM's fiscal year 1982 annuitant appropriation. In effect, this authorization simply transferred the fiscal year 1981 problem to fiscal year 1982. The fiscal year 1982 budget error was not related to the higher than expected proposed rate increases. According to an official in the Compensation Group's Office of Financial Control and Management, OPM erroneously estimated that it would begin fiscal year 1982 with a $42 million balance in the annuitant account. Therefore, OPM did not believe that it was proper to include this shortfall caused by OPM error--not proposed rate increases--with a shortfall to be addressed through rate reductions.

OPM requested and eventually received a supplemental appropriation of $30[illegible] million to operate FEHBP during fiscal year 1982. This supplemental was solely for OPM's annuitant account and, according to the Assistant Director for Financial Control and Management, is based on the following figures:

--$156 million unliquidated annuitant component of $440 million shortfall.

--$42 million annuitant account budget error for fiscal year 1982.

--$58 million fiscal year 1981 annuitant account shortfall transferred to fiscal year 1982.

--$47.8 million contingency to cover increased program costs due to delayed open season enrollment shifts.

THE USE OF THE ESTIMATED FEHBP BUDGET SHORTFALL WAS APPROPRIATE

OPM's estimate of the Government contribution for annuitants was directly related to its FEHBP annuitant appropriation. As a result, treating this estimate as a valid spending constraint was appropriate. In addition, OPM elected to treat its estimate of agency contributions for active employees, although not directly related to the amounts in agencies' salaries and expenses accounts, as a similar spending constraint. Such treatment seems reasonable given (1) the prior accuracy of its estimates, (2) that OPM's estimate of aggregate agency contributions is the only such program estimate available, (3) the inseparable nature of the annuitant and active employee components of FEHBP, and (4) OPM's desire to avoid increasing Government and enrollee spending.

Each year, as part of the Federal budget process, OPM estimates FEHBP trust fund revenues and expenditures and updates the fund's Program and Financing Table submitted to the Office of Management and Budget. This table, which later appears in the Appendix to the President's Budget, displays OPM trust fund estimates for the budget year and the current fiscal year, and actual data for the prior fiscal year. Further, the financing portion of the table segregates data for each fiscal year according to funding source. These sources include (1) the Government contribution for annuitants appropriated to OPM, (2) the Government contribution for active employees appropriated to agencies as part of their salaries and expenses accounts, (3) Postal Service contributions for active postal employees, and (4) withholdings from active employees and annuitants.

OPM calculated the Government's fiscal year 1982 budget shortfall by treating FEHBP trust fund income estimates derived early in fiscal year 1981 as a spending constraint and comparing these to later estimates. However, only the specific appropriations from which the Government contribution is made to the trust fund--OPM's annuitant appropriation and agencies' appropriations for salaries and expenses--are true FEHBP spending constraints from a legal standpoint.

More specifically, OPM's appropriation for annuitants is an identifiable item in the President's Budget which the Congress, through an appropriation, authorizes OPM to pay to the FEHBP trust fund. Likewise, the President's Budget includes

an identifiable amount for each agency's salaries and expenses, a small portion of which is for the Government's contribution to FEHBP for active employees. This small portion, however, is not identified as a specific item. Thus, when the Congress approves an agency's request for salaries and expenses through an appropriation, it is authorizing the agency to pay some unidentified amount for its FEHBP contribution. If an agency's actual contribution should exceed the amount anticipated for FEHBP, if indeed a specific amount was anticipated, the agency must absorb the difference through reprogramming or seek a supplemental appropriation.

In contrast, OPM's estimate of agency contributions for active employees is simply the aggregate amount agencies are likely to pay in satisfying their FEHBP obligations. In making this estimate, OPM has no knowledge of the amount individual agencies may be including in their budget requests for their contribution to FEHBP. Also, OPM's aggregate estimate is not broken down on an individual agency basis.

The historical accuracy of OPM's trust fund estimates for active employees supports its use as a spending constraint. OPM calculates the only estimate of expected agency contributions which can be used to control program spending for active employees. Although the methodology used to make this estimate does not use individual agency estimates of the Government contribution, it has proven to be, with the exception of fiscal year 1982, a reasonably accurate approximation, in the aggregate, of actual agency payments. Specifically, for fiscal year 1981, OPM's budget estimate was $1.195 billion while actual contributions totaled $1.184 billion. For fiscal year 1980, OPM's estimate was $1.034 billion, and actual contributions were $1.037 billion.

OPM's use of the trust fund income estimate as a spending constraint for the Government contribution to annuitants is clearly appropriate. Since OPM determines its annuitant estimate in the same manner it generates its annuitant appropriation request, the annuitant trust fund estimate is directly related to the annuitant appropriation request. Because of this direct relationship, OPM, by operating FEHBP within its annuitant estimate, is in effect exercising control over its annuitant account and insuring that the spending authority, a true budget constraint, is not exceeded.

Likewise, OPM's use of its estimate for the Government contribution for active employees as a spending cap is appropriate. According to the Associate Director for Compensation and his staff, OPM is singularly responsible for the annuitant appropriation. As such, OPM must either manage the account within its boundaries or seek additional funding. Given the

administration's fiscal policies concerning reduced Government spending and the political climate at that time, OPM elected to minimize any supplemental funding requests and took management action to live within its budget. Recognizing, however, that it could not achieve budget savings in its annuitant account through benefit reductions without similarly affecting active employees and also feeling responsible as the central program manager for holding down agency and employee costs, OPM decided to exercise control over the whole program and use its trust fund estimates to calculate the budget shortfall on a programwide basis.

According to the Director, OPM's broad, Government-wide view of FEHBP was essential for gaining control of the growing cost of the program. He informed us that the annuitant appropriation issue should not be allowed to obscure the real cost of the program. If he had not acted to reduce the potential Government shortfall for all agencies, they would have had less money for other purposes. He contended that this would have helped drive some agencies to request appropriations to fund essential work. An Office of Management and Budget official we talked to generally supported OPM's view of the trust fund estimates and its rationale. According to this official, other Federal agencies have historically used trust fund budget estimates as spending ceilings for other programs.

## CONCLUSIONS

When OPM concluded that 1982 FEHBP proposed costs for the Government and the enrollee would exceed budget estimates, it initiated action to deal with this situation. By unilaterally requiring that benefits be cut, OPM disrupted the normal bilateral negotiation process and threw the program into a state of uncertainty for its participants. Reducing benefits, however, saved money for the Government and the taxpayer. Reducing benefits also held down the enrollees' increased contribution to health insurance. If OPM had not exercised managerial responsibility for FEHBP and used budget estimates as a management tool to control program expenditures, rate increases would have been even higher.

## CHAPTER 3

## 1982 RATE INCREASES WERE REASONABLE AND SHOULD IMPROVE FEHBP'S FINANCIAL CONDITION

We contracted with the Actuarial Research Corporation of Falls Church, Virginia, to assist us in determining whether the 1982 rate increases, which averaged about 30 percent for all options for FEHBP's three largest plans (representing about 68 percent of total enrollment), were reasonable according to generally accepted actuarial practices. The contractor reviewed supporting documentation supplied by OPM and the Blue Cross/Blue Shield, Aetna, and APWU plans and found the rate increases to be both reasonable and prudent. The increases were necessary to make up for deficiencies in 1981 rates[1] due primarily to underestimates of inflation and utilization of health benefits for 1981 as well as to meet anticipated inflation increases in 1982. Although only a minimal margin was built into the rates, and OPM anticipated little reserve recovery in 1982, our contractor estimated in June 1982 that most plan options examined would conclude calendar year 1982 with significantly improved reserve positions. This improvement indicates a somewhat better financial position than anticipated when 1982 rates were established.

### ASSUMPTIONS USED IN THE ACTUARIAL ANALYSIS

The contractor did not limit the actuarial analysis to information available to OPM and the plans at the time rates were decided in 1981; rather, the contractor also used information that was not available at the time the rates were established and made assumptions based on the more recent information. These assumptions concerned expected inflation and utilization levels, effects of selective enrollment, and administrative costs. For the high options of Blue Cross/Blue Shield and Aetna, as well as the APWU plan, the contractor assumed that 1982 per capita costs would rise 15.7 percent above 1981 costs, based on an estimated increase in hospital prices of 14.9 percent and a residual for utilization derived

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[1]5 U.S.C. 8902 allows for the readjustment of rates based on past experience. Thus, a deficient rate in 1 year can be recouped in the next year by increasing the rate. Likewise, income from excessive rates can be returned by reducing rates in the subsequent year.

from the historical experience of the Blue Cross/Blue Shield low option. The contractor projected Blue Cross/Blue Shield low option per capita costs to rise 15 percent in 1982 and expected the Aetna low option per capita cost to rise 20 percent, based on 1981 Aetna experience. These cost assumptions were applied only to the real benefit costs for 1981, not simply to the 1981 premium rates charged for enrollees.

A second assumption concerned the effects of selective enrollment on plans. During the contractor's rate review, there was no way to predict what changes would occur among enrollment groups during the May 1982 open season. The rate increases and benefit reductions could have resulted in widespread reevaluation of health plans by enrollees because these changes helped emphasize rate differences among plans which exceeded benefit differences, both between high and low options and among different high options. To illustrate the potential effect of one type of selective enrollment--healthy high option enrollees transferring to the low option--the contractor assumed for plans with these options, Blue Cross/Blue Shield and Aetna, that 15 percent of the high option enrollees would transfer to the same plan's low option, and these transferees would use 25 percent fewer benefits than the average high option enrollee. Conversely, the contractor assumed that the enrollees moving to the low options would use more benefits than the average low option enrollee. Finally, the contractor assumed that administrative expenses are proportionately related to benefits.

## COMPONENTS OF RATE INCREASES

In the analysis, the contractor divided the total rate increase for each option into nine components (see table 3, p. 23); some were associated with increased rates and some with decreased rates. The following is a brief explanation of these components:

1. Inflation--expected increase in inflation from 1981 to 1982 based on the cost assumptions explained above.

2. Utilization--expected increase in utilization from 1981 to 1982 based on the cost assumptions explained above.

3. Deficiency in 1981 rates--due to larger than expected increases in inflation and utilization from 1980 to 1981 and, therefore, not included in developing the 1981 rates.

4. Benefit changes--OPM mandated benefit reductions. The contractor reviewed the actuarial estimates of the savings attributable to these reductions and found them to be reasonable.

5. Allowance for selective enrollment--based on the assumption discussed above.

6. Proposed change in LWOP factor--Before 1982, employees on LWOP continued to receive health insurance but were not required to pay the employee share of the rate. OPM set rates for 1982 assuming LWOP employees would pay the employee share of the rate. The change resulted in lower rates as LWOP employees were expected to pay the employee share of the rate just as employees in pay status.

7. Change in interest income--changes in anticipated interest income between 1981 and 1982. Plans expected to experience declines in interest income used to pay claims, and this decline was recovered through the rate.

8. Change in contingency reserve transactions--indicates the extent to which contingency reserves were expected to increase or decrease the rate between 1981 and 1982.

9. Residual to special reserve--the contractor added to the special reserve any portion of the rate increase not already accounted for by one of the other factors.

Table 3

Components of 1982 Rate Increases

| | Total increase | (1) Infla-tion | (2) Utili-zation | (3) Deficiency in 1981 rate | (4) Benefit changes | (5) Allow-ance for selec-tive enroll-ments | (6) Proposed change in LWOP factor | (7) Change in interest income | (8) Change in contingency reserve transactions | (9) Residual to special reserve |
|---|---|---|---|---|---|---|---|---|---|---|
| Blue Cross/Blue Shield: | | | | | | | | | | |
| High option family | $15.55 | $11.10 | $0.65 | $7.98 | $(10.24) | $1.37 | $(1.06) | $0.59 | $(0.38) | $5.54 |
| High option self | 7.06 | 4.61 | 0.27 | 4.94 | (4.30) | 0.63 | (0.58) | 0.27 | (0.18) | 1.40 |
| Low option family | 13.46 | 4.04 | 0.03 | 2.36 | (2.80) | 6.16 | (0.41) | 0.16 | 0.86 | 3.06 |
| Low option self | 4.65 | 1.55 | 0.01 | 2.71 | (1.16) | 2.75 | (0.16) | 0.06 | 0.34 | (1.45) |
| Aetna: | | | | | | | | | | |
| High option family | 4.86 | 7.96 | 0.46 | (3.20) | (6.05) | 1.05 | (0.49) | 0.20 | 5.32 | (0.39) |
| High option self | 4.40 | 4.66 | 0.27 | 2.21 | (3.04) | 0.61 | (0.27) | 0.11 | 3.31 | (3.46) |
| Low option family | 15.29 | 5.99 | 2.00 | 6.00 | (6.32) | 0.37 | (a) | 0.09 | 4.18 | 2.98 |
| Low option self | 6.15 | 2.31 | 0.76 | 0.15 | (2.20) | 1.28 | (a) | 0.04 | 1.51 | 2.30 |
| APWU: | | | | | | | | | | |
| Family | 10.27 | 9.08 | 0.50 | 5.90 | (12.24) | (b) | (a) | 0.59 | 0.13 | 6.31 |
| Self | [illegible] | 4.17 | 0.21 | 4.99 | (4.61) | (b) | (a) | 0.27 | 0.04 | (0.83) |

a/Not applicable--the contractor did not include a change in the LWOP factor because the plans did not include such a calculation in their 1982 rate.

b/Not applicable--[illegible] movement from high to low option does not apply to [illegible]

## ANALYSIS OF RATE INCREASES

As can be seen from table 3, the major components of the rate increases were the expected inflation increase from 1981 to 1982 and the deficiency in the 1981 rate. For example, because the 1981 rates were not sufficient to meet 1981 claims, Blue Cross/Blue Shield incurred a $253 million loss and depleted its special reserve in 1981. An exception was the Blue Cross/Blue Shield low option, where the allowance for selective enrollment was the largest component of the increase, giving effect to the selective enrollment assumption described above. Another exception is the Aetna high option, where the change in contingency reserve transactions is the second largest component of the increase. This resulted because the high option received a large payment from its contingency reserve in 1981 which lowered the 1981 rate that otherwise would have been needed. The Aetna high option, however, was not expected to receive such a payment in 1982. The largest decrease in rates was the OPM-mandated reduction of benefits, which largely offset anticipated inflation for 1982. In addition, most plan options are expected to show improved reserve positions through additions to their special reserves.

Although the 1982 rates appear to be sufficient to meet 1982 claims as well as diminish reserve deficits left at the end of 1981, it should be noted that--unlike previous years--OPM did not set 1982 rates with the goal of meeting reserve targets. Instead, the Director deferred reserve recovery to 1983, and OPM set rates that included a minimal margin of 5 percent of subscription income to give plans a cushion to mitigate the need to further reduce reserves. If the anticipated claims payout was correct, the margin would be used to reduce a reserve deficit in some plans and add to the existing reserve in others. If the anticipated payout was underestimated, the margin would be expected to cover the error in estimating.

If the experience of other plans is similar to those the contractor analyzed, it appeared that most plans would end 1982 with improved reserve positions. In other words, some reserve recovery will result, and it is likely that FEHBP will be in better financial condition than OPM anticipated when setting the rates. Specifically, according to the contractor's analysis, the margin in the Blue Cross/Blue Shield high option will probably eliminate the deficit in that option, and the Blue Cross/Blue Shield high and low options combined

should produce a positive reserve of about $4 million at the end of 1982. The Aetna high option, the only option analyzed with a positive reserve at the end of 1981, will probably maintain a positive reserve position, while Aetna high and low options combined will remain in deficit by about $3 million. The APWU deficit should be about $32 million at the end of 1982, about half the 1981 deficit.

## QUALIFICATIONS OF ANALYSIS

The contractor's analysis is tempered by several qualifications relating to estimates in general and estimates for 1982 in particular, because reserve size is sensitive to even a small error in forecasting annual income or outgo. First, while the contractor found that the rate impact of the imposed benefit changes was actuarially reasonable, this determination was based on limited data and so is subject to imprecision. Further, the effects that cost sharing and other benefit changes will have on utilization are not known with certainty. In addition, there are fluctuations in experience from year to year which will reduce a forecast's accuracy. Finally, the analysis was performed before the May open season, so it was necessary to make an assumption about how enrollment would change; however, neither the number of persons changing, their health status, nor their choice of plan could be accurately predicted.

## CONCLUSIONS

The rate increases for 1982 were reasonable and prudent for the Blue Cross/Blue Shield, Aetna, and APWU plans. If the contractor's findings in regard to these three plans are indicative of increases experienced by other plans, FEHBP should end the 1982 benefit year in better financial condition than OPM had anticipated when it negotiated the rates for 1982. Specifically, improved plan reserve balances should improve FEHBP stability.

# CHAPTER 4

# OPM TREATED PLANS DIFFERENTLY

# IN ADMINISTERING BENEFIT CUTS AND

# NEGOTIATING SERVICE CHARGES

OPM's administration of benefit cuts and negotiation of service charges or profit allowances raise questions of equity among plans because the plans were treated differently. The first round of benefit cuts did not apply to all plans and had a more varied impact on plans to which it did apply than did the second round, resulting in cuts of different relative percentage amounts. In negotiating service charges, OPM used different methods to compute the amount of service charge allowed Blue Cross/Blue Shield and Aetna, resulting in a 100-percent increase in the Blue Cross/Blue Shield service charge and a 5-percent increase in the Aetna service charge.

## OPM'S FIRST-ROUND APPROACH TO CUTTING BENEFITS RAISES THE QUESTION OF INEQUITABLE TREATMENT

OPM's approach to cutting benefits in the first round resulted in more variance in the impact on the plans than its second-round approach. In the first round OPM required plans to cut specific benefits to specific levels despite the plans' different benefit structures. This approach affected participating plans by different relative percentage amounts. OPM's second round was designed to affect all plans by the same percentage amount.

In implementing its decision to reduce benefits, OPM established criteria to guide it in administering the reductions. Briefly, OPM desired to satisfy certain savings goals while treating carriers and enrollees equitably through a proportionate sharing of reductions. With respect to the first round, OPM also wanted to build more cost sharing into FEHBP to curb utilization of services. OPM's first-round approach appears less consistent with its equity criteria than its second-round approach. Additionally, plan officials we interviewed generally perceived the second-round approach as more fair and equitable. OPM officials, while conceding the imposition of benefit reductions was a learning process, do not believe either approach to be more or less equitable given the first round's cost-containment objective.

## OPM conducted two fundamentally different rounds of benefit reductions

Initially, the first round of benefit cuts required the two Government-wide and all but three employee organization plans to reduce specific benefits to specific levels. OPM required plans to

- --increase the deductible on supplemental benefits[1] to $200,
- --increase coinsurance rates for enrollees to 25 percent on supplemental benefits, and
- --treat most nonhospital charges, such as outpatient tests, as supplemental benefits.

Additionally, OPM considered plan proposals for reducing mental and dental benefits on a plan-by-plan basis.

OPM's intent regarding these specified cuts was to add more cost containment or, more appropriately, cost-sharing features to the program while still satisfying its other benefit reduction objectives. According to the Director of OPM, these cuts will help curb future program cost increases by curbing utilization. That is, they will make enrollees conscious of health care costs and thereby discourage less necessary uses of covered services. OPM's rationale for considering mental and dental cuts was that such cuts would affect far fewer enrollees than further reductions in basic benefits.

OPM later modified its first-round approach to cutting benefits. Following plans' objections to the first-round approach as well as OPM's recognition of the approach's limitations, OPM allowed plans to submit equivalency proposals that were equivalent in dollar savings to the originally mandated reductions but which did not necessarily implement the OPM-specified benefit cuts. However, the Associate Director for Compensation told us that, although the equivalency allowance did not require specific reductions, OPM did continue to emphasize its first-round cost-containment sentiments. In short, the equivalency allowance permitted the plans greater discretion in determining what benefits to reduce; however,

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[1]As its name implies, supplemental benefits are in addition to basic benefits. Generally, an individual must pay covered expenses up to a certain amount--the deductible--before a plan starts paying a share of the expenses for supplemental benefits and enrollees pay the remainder (coinsurance).

it did not alter the magnitude of the benefit reductions nor the cost-containment emphasis specified by the initial first-round requirements.

Although OPM required the two Government-wide and all but three employee organization plans to comply with first-round and equivalency allowance requirements, OPM excluded HMOs from the specified first-round cuts and made HMO participation in the equivalency reductions voluntary. Further, unlike the other plans which had to satisfy dollar savings goals during the equivalency reductions, HMOs electing to participate had no such benchmarks. The only requirement was OPM approval of all proposed reductions. The Chief, Comprehensive Plans Division, told us that, of 12 HMOs proposing reductions, OPM approved at least a portion of only 4 of the proposals.

OPM officials responsible for managing FEHBP provided several reasons for excluding HMOs and the three employee organization plans. They told us OPM excluded HMOs because (1) the first-round approach to cutting benefits did not make sense for HMOs which generally require no deductibles and few out-of-pocket expenses, (2) HMO-proposed rates for 1982 reflected relatively minor increases, (3) HMOs were already believed to be containing costs, and (4) the cost savings that would have been derived from HMO inclusion were initially believed to be unnecessary. They also told us that OPM excluded the three employee organization plans--Professional Air Traffic Controllers Organization Health Benefit Plan, Panama Canal Area Benefit Plan, and Government Employees Benefit Association Health Benefit Plan--because of their unique situations and insignificant program impact.

The second-round approach to reducing benefits was markedly different from the first-round approach. OPM required all plans (except the same three employee organization plans) to reduce the estimated cost of their benefit packages by 6.5 percent--a reduction level designed to achieve a $105 million cost-savings goal. This approach did not specify the types and dollar level of cuts desired for each plan. Further, it did not exclude HMOs. According to the OPM officials, OPM included HMOs in the second round because (1) this round did not specify the type of cuts that threatened the structural integrity of an HMO, (2) other plans complained about HMOs' previous exclusion, and (3) OPM desired all plans to be "in it" together.

## Which round of cuts was more fair and equitable?

Information to estimate the relative competitive impact due to benefit reductions is not available and thus precludes any definitive conclusions on fair and equitable treatment. What is fair and equitable is debatable because it can be argued that the only absolute measure of fairness and equity in this case is the affected plans' competitive gain or loss. It appears, however, the second round was more fair and equitable than the first because the second round had a less varied impact on plans.

In administering benefit reductions, OPM defined equity in terms of a proportionate sharing of reductions so that no plan gained a competitive advantage. Specifically, OPM desired to

--attain a specified level of benefit savings to reduce the size of the budget shortfall,

--treat plans equitably by (1) ensuring benefit cuts were spread evenly across plans so no enrollee and no plan bore a disproportionate share of reductions and (2) preventing any plan from gaining an unfair competitive advantage from the reductions, and

--build more cost-containing features into each plan (more explicitly a criterion of the first round than the second).

Although OPM's first-round approach treated all participating plans the same by requiring that specific benefits be cut to specific levels, it ignored the fact that plans had different structural baselines against which to apply reductions. For example, one plan may have had a $50 deductible, while another had a $150 deductible. Requiring both plans to increase deductibles to $200 did not have the same impact. The Assistant Director for Insurance Programs told us that, because of first-round shortcomings, OPM permitted equivalency proposals. We believe, however, that OPM's equivalency proposal allowance, although intended to address first-round limitations, did not alter the greater variance of cuts associated with the first-round approach.

Two points regarding OPM's exclusion of HMO participation in the first round of cuts warrant highlighting. First, although the first round initially required that cost-containment features inconsistent with the HMO concept be built into the other plans' benefit structure, these specific

features were not required in the equivalency allowance where HMO participation was optional. Second, by excluding HMOs from the first round, OPM did not apply its criterion to spread benefit cuts evenly across plans. HMO first-round cuts could have reduced the level of cuts other plans experienced.

The second-round approach requiring all but three plans to reduce benefits by 6.5 percent, unlike that of the first round, treated all participating plans the same by affecting each according to the relative richness of its benefit package. Furthermore, this approach affected essentially all FEHBP plans.

The two rounds of cuts had strikingly different effects on the plans' rates. To quantitatively demonstrate the relative effects, we compared the variability of the plans' percentage change in rates for each round caused by benefit cuts.[2] Variability reflects the dispersion of plans' rate changes around the average change for each round. It is statistically measured by the standard deviation computed separately for each round. To compare the effects of the two rounds, we calculated each standard deviation as a percentage of the average rate change; a larger percentage would indicate greater variability among plans in the effect of the benefit reductions on rates. For the first round the standard deviation was 106 percent of the average change, while for the second round it was 18 percent, indicating that the variation among plans in the first round was almost six times greater with respect to the average rate change than that of the second round. Thus, the second round had a less varied impact on FEHBP plans and enrollees than the first.

OPM and the plans did not agree on the more fair and equitable approach to cutting benefits. Of the seven plans we interviewed that participated in both rounds, six felt the second-round approach was more fair and equitable because the same percentage was applied to all plans.[3] OPM officials, however, do not believe that one approach was more equitable than the other. Specifically, the Director of OPM informed us that the first-round approach was reasonably equitable, and Compensation Group officials, citing the first-round objective

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[2]According to GAO and OPM actuaries, an X-percent change in rates does not necessarily equal an X-percent change in benefits; however, the two do roughly approximate each other.

[3]The other plan declined to comment on the relative fairness and equity of the two rounds.

of improved cost containment, noted that confronted with the same situation again, OPM might do nothing differently. While recognizing the first-round approach affected plans differently, the Assistant Director for Insurance Programs stated it was not necessarily inequitable from a program standpoint. Plans that already had cost-containment features did not have to cut as much as those that had fewer cost-containment features.

## CIRCUMSTANCES SURROUNDING NEGOTIATION OF DIFFERENT SERVICE CHARGES

In the 1982 contract negotiations, OPM's method of computing the Government-wide plans' service charges (profit) differed between Blue Cross/Blue Shield and Aetna. Because of this different method, Blue Cross/Blue Shield received a 100-percent increase in its service charge while Aetna received a 5-percent increase. Further, if the same method had been used for Blue Cross/Blue Shield as was used for Aetna, Blue Cross/Blue Shield would have received about a 10-percent increase. There was insufficient documentation in OPM files for us to determine the reasonableness of the large Blue Cross/Blue Shield increase. By June 1982, OPM had not begun negotiating the employee organization plans' 1982 service charges. In addition, because of a recent regulatory requirement regarding the determination of service charges, OPM is developing a structured approach that is supposed to be applied uniformly to all plans with which OPM negotiates a separate service charge.

### OPM's negotiation of the Government-wide plans' 1982 service charges was inconsistent and poorly documented

All FEHBP health plan rates include an amount that is like a "profit" or "fee." For most comprehensive medical plans (HMOs), OPM assumes that the negotiated rate includes an adequate profit amount. For other FEHBP plans, the profit is a negotiated amount, also known in FEHBP as a service charge. Specifically, all FEHBP Government-wide and employee organization plans have service charges.[4]

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[4]Eleven of the comprehensive plans are eligible to receive a separate service charge; however, only three of them have service charges. Because these service charges are small and have not changed since the plans entered FEHBP, we excluded them from our analysis.

In the mid-1970s, the Government-wide plans made a formal agreement with OPM that these plans' service charges would be determined by a specific formula. In this formula, the plan's previous year's service charge was adjusted for changes in the plan's enrollment and the consumer price index to yield the current year's service charge. Each year, OPM's Office of the Actuary reviewed the plans' proposed service charges, but its review was limited to verifying the accuracy of the calculations. Use of this formula approach was continued through contract year 1981. However, for 1982, while Aetna continued to use the formula, Blue Cross/Blue Shield was allowed to negotiate its service charge in a completely new manner, based on OPM's new procurement regulations that were published in October 1981 but not effective until November 1981.

On October 20, 1981, OPM published new procurement regulations regarding FEHBP contracts. The purpose of these regulations was to describe specifically the procurement policies and procedures that applied to FEHBP contracts. In these regulations, OPM generally described six factors that should be considered by the contracting officer in evaluating service charge proposals. These factors were subject to negotiation and no hard and fast formula existed for their application. The factors are as follows.

--Underwriting risk. The degree of risk the carrier assumes should influence the amount of the service charge.

--Conversions. The FEHBP law requires that, if an employee's enrollment is ended, the plan must offer the employee the option to convert to an individual health insurance contract without regard to health status. The potential conversion of persons with preexisting conditions represents a risk that should influence the service charge amount.

--Extent of financial assistance. When, due to losses, the plan must finance FEHBP costs, the service charge should include a factor for financing.

--Plan performance. Plan performance, good or poor, should influence the amount of the service charge.

--Subcontracting. The service charge for each organizational unit of a contract should be evaluated as to its reasonableness.

--Other considerations. The contracting officer may also consider significant changes in the plan's enrollment or in the consumer price index. OPM officials informed us that OPM would also consider the plan's reserve positions; the effects of adverse selection on the plan; the amount of plan expenses, such as advertising expenses, which the procurement regulations prohibit from being charged to the contract; and whether the plan was under the threat of a large disallowance of administrative expenses under audit.

The regulations further stated that the above factors were solely for the purpose of analysis by the contracting officer and did not represent a basis for which a plan might claim a service charge.

On October 23, 1981, Blue Cross/Blue Shield proposed that its 1982 service charge be determined in accordance with OPM's procurement regulations. Although the regulations were not to be effective until November 19, 1981, OPM decided to accept this early opportunity to implement the regulations for the 1982 contract year. Blue Cross/Blue Shield initially requested a service charge of $25 million, a 300-percent increase over its 1981 service charge of $6.4 million.

Through negotiation, OPM and Blue Cross/Blue Shield agreed upon a service charge of $12.7 million. Because these negotiations were conducted orally, there was not sufficient documentation in OPM files for us to determine the reasonableness of the increase. The Director of OPM said that, in negotiating Blue Cross/Blue Shield's service charge, OPM considered the plan's depleted reserves, the unprecedented utilization and inflation in the health care industry, benefit changes, and the risks associated with conversions. Blue Cross/Blue Shield officials informed us that they could have justified about $47 million, mostly because of the risks associated with underwriting and conversions. Blue Cross/Blue Shield proposed $25 million because $47 million represented such a large increase over the 1981 service charge that they believed it would be inappropriate to request the full amount. However, if the service charge formula had been used to calculate Blue Cross/Blue Shield's service charge, as it was for Aetna's, Blue Cross/Blue Shield would have received about $7 million, or a 10-percent increase over its 1981 service charge.

In comparison, Aetna proposed and was granted a $2.9 million service charge based on the service charge formula described on page 32. This amount represented an approximate 5-percent increase over its 1981 service charge of $2.75 million. OPM's General Counsel informed us that Aetna's service

charge was not negotiated under the procurement regulations because Aetna did not request it. Although Aetna initially proposed this service charge on September 14, 1981, before the procurement regulations were published, OPM did not approve this service charge until after the regulations were effective in November.

<u>OPM's approach for negotiating employee organization plans' service charges has varied</u>

Through contract year 1979, the employee organization plan service charges were also generally determined through the service charge formula, although there was no formal agreement between OPM and the plans to do so. Each year, the plans proposed service charges. These proposals were reviewed by OPM's Office of the Actuary which then recommended service charge amounts, based on the service charge formula, to the contracting office. The contracting office was then responsible for negotiating with the plans. Usually, the amounts that the plans and OPM finally agreed upon were close to the amounts recommended by the Office of the Actuary.

In 1980, the Actuary determined that a couple of the employee organization plan service charges were much higher than others, on a per contract (per enrollee) basis. Therefore, in 1980 and 1981, the Office of the Actuary recommended service charge amounts for all employee organization plans that not only reflected changes in enrollment and the consumer price index, but which were also intended to achieve some kind of equity among plans in their service charges per enrollee. Although the contracting office was fairly successful in convincing most plans to accept these recommended amounts, there was resistance from some plans. In fact, because of this type of resistance, 1981 service charges for two employee organization plans had not been settled by mid-1982.

As of June 1982, OPM had not begun negotiating the employee organization plans' 1982 service charges because the enrollment changes from the May 1982 open season were not

yet available.[5] However, some of the plans had proposed figures for their 1982 service charges. Four of the largest employee organization plans (by enrollment) requested increases ranging from 33 to 67 percent over 1981 levels. OPM's Deputy Assistant Director for Insurance Programs informed us that OPM plans to use the amounts resulting from the service charge formula as baseline amounts in negotiating these service charges and require the plans to justify any additional increases.

OPM is developing a structured approach to determining service charges

In December 1980, the Office of Federal Procurement Policy of the Office of Management and Budget published Letter 80-7, which requires that, by January 1982, all agencies must have a structured approach for determining profit in contracts requiring cost analysis. Since all FEHBP contracts are subject to this requirement, OPM is developing a structured approach for determining FEHBP service charges. This structured approach, according to OPM, will be incorporated into its procurement regulations and will supersede the existing sections regarding determination of service charges.

The Deputy Assistant Director for Insurance Programs advised us that the structured approach, when developed, will be applied uniformly to the determination of all FEHBP service charges. However, according to Policy Letter 80-7, the structured approach was to be in place by January 1982. In mid-1982, OPM was still in the initial stages of developing this approach. Therefore, it is unclear when OPM's structured approach will actually be ready for implementation. Until that time, OPM's existing procurement regulations regarding service charges will continue to be in effect.

CONCLUSIONS

In administering benefit cuts, OPM did treat plans differently in the first round by not requiring all plans to participate and by allowing cuts of different percentage amounts. However, the extent that these differences affected the relative competitiveness of the plans is not known. Although the second round appears to have been more equitable because the same percentage requirements were imposed on all but three of

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[5]The Government-wide plans negotiate their service charges before the contract year begins and, therefore, use pre-open season enrollment data. In comparison, the employee organization plans wait until open season enrollment changes are available before negotiating their service charge.

the plans, OPM's first round successfully introduced more cost-sharing features into FEHBP. While another approach to cutting benefits during the first round may have been available to OPM, such as requiring all plans to cut benefits by the same percentage as was done in the second round and specifying that such cuts be cost sharing in nature, this approach might have unfairly affected plans that already had more extensive cost-sharing features. The impact that increased cost sharing will have on the utilization of benefits remains to be seen.

OPM also treated plans differently in negotiating service charges. OPM, however, was under no obligation to use the same method for computing Aetna's service charge as it did for Blue Cross/Blue Shield's. Although a concern for equity could have led OPM to offer the same terms to Aetna, particularly since Aetna's service charge proposal--not OPM's acceptance of it--predated publication of the final regulations, such a concern would have cost the Government and the taxpayers more money. It appears that Blue Cross/Blue Shield benefited by submitting its proposal at the later date.

# CHAPTER 5

# FEHBP PLANS NOT COMPARABLE

# TO PRIVATE SECTOR PLANS

The Congress intended that FEHBP be comparable to health programs of large private sector employers, both in terms of the level of benefits offered and the extent of the employer's contribution toward health benefit costs. However, FEHBP plans do not appear to be comparable to private sector plans in either regard. According to OPM, in 1979 and 1980, private sector and Federal health program benefit levels were generally comparable; however, private sector employers contributed a greater share of health insurance costs than did the Federal Government. In 1982, this disparity in employer contributions still existed. In addition, indications are that, although Federal and private sector plans offered similar types of benefits, Federal plans covered these benefits at a somewhat lower level.

## OPM STUDIES SHOW THAT FEDERAL PLANS WERE NOT COMPARABLE TO THE PRIVATE SECTOR

In passing the Federal Employees Health Benefits Act of 1959, the Congress intended that FEHBP be comparable to the health benefit programs offered by large private sector employers. Further, the Congress intended that this comparability to private sector programs extend to the level of benefits offered and the employer's share of health insurance costs. The Congress wanted equivalent health benefits for Federal employees so the Federal Government could compete in the recruitment and retention of competent personnel. In fact, many of the subsequent amendments to the act also reflect the Congress' goal of making FEHBP comparable to health programs offered by other large employers. For example, the act was amended in 1974, in part, due to the Congress' recognition that the Government's share of program costs was lagging behind not only the private sector but also State and local governments.

In 1981, OPM conducted the Total Compensation Comparability Study to develop a methodology for incorporating all fringe benefits as well as pay rates into a pay comparability system that would set Federal compensation at a level comparable to private sector compensation. As part of this study, OPM used a standardized cost method to calculate dollar values for both private sector and Federal health benefit programs effective in 1979. In this method of analysis, the employer cost of providing FEHBP benefits to the Federal work force is compared with what it would cost the Federal Government to provide private sector benefits to the Federal work force. According to the

OPM study, the 1979 value for Federal health benefits was $760 while the private sector value was $1,045. Stated another way, in 1979 it would have cost the Federal Government 37 percent more to provide Federal employees with comparable health insurance, including a comparable employer contribution, to that offered by the private sector. OPM concluded that private sector and Federal health insurance coverage was generally comparable, but private sector employers paid a greater share of the health insurance premium rate than did the Federal Government.

OPM repeated the comparability study using 1980 data; the results were similar to 1979. The Federal value was $903; the private sector value was $1,242. Again, in 1980 it would have cost the Federal Government about 37 percent more to provide Federal employees with comparable health insurance.

## FEDERAL GOVERNMENT CONTRIBUTES LESS FOR HEALTH INSURANCE THAN PRIVATE SECTOR EMPLOYERS

To examine employer/employee contributions for 1981, we compared data from all FEHBP plans to data from an analysis[1] of fringe benefits, including health insurance, offered in the spring of 1981 by 727 private sector employers. For 1982, we compared data from all FEHBP plans to data from 23 private sector health plans.

Based on a limited analysis, we found that, as in the past, the private sector employer paid a greater share of the health insurance premium rate than did the Federal Government. In 1981, the Federal Government contributed an average of 64 percent of the total cost of individual employee coverage and an average of 58 percent of the cost of dependent coverage. In contrast, most private sector employers contributed more than the Federal Government for both employee and dependent coverage. (See table 4.) For employee coverage, at least 90 percent of the private sector employers contributed more than the Federal Government, and 68 percent paid the entire cost. For dependent coverage, at least 78 percent contributed more than the Federal Government, and 40 percent paid the entire cost. Based on a very limited sample for 1982, about 71 percent of the private sector employers studied contributed a greater percentage of the health insurance rate for individual and dependent coverage combined.

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[1]Hay-Huggins, "Noncash Compensation Comparison," 1981.

Table 4

1981 Private Sector Employers
Health Plan Contributions (note a)

| Contribution level (percent) | Percent of employers contributing for employee coverage | Percent of employers contributing for dependent coverage |
|---|---|---|
| 100 | 68 | 40 |
| 75 - 99 | 22 | 30 |
| 61 - 74 | 4 | 8 |
| 1 - 60 | 4 | 15 |
| 0 | 0 | 4 |
| Other (note b) | 2 | 3 |
| | 100 | 100 |

a/Source: Hay-Huggins, "Noncash Compensation Comparison," 1981, pp. IV-5, IV-6.

b/These employers used a varying contribution level.

## FEDERAL HEALTH BENEFITS ARE FALLING BEHIND THOSE OFFERED BY THE PRIVATE SECTOR

In addition to the fact that the Federal Government contributes less toward health insurance than the private sector, indications are that, for 1982, Federal health plans offered somewhat less, in terms of benefits. We compared the coverage of 33 private sector plans with 15 FEHBP plans for four major benefit categories: inpatient hospital, surgical, major medical, and mental health.

### Inpatient hospital benefits

Our analysis indicates that FEHBP plans offered better benefits for longer hospital stays, and private sector plans offered better benefits for shorter stays. Hospital benefits pay for hospital room and board and other hospital services, such as operating and recovery rooms, drugs, and diagnostic tests, when furnished to a hospital inpatient.

The majority of FEHBP and private sector plans studied paid 100 percent of hospital benefits. Most of these plans, however, limited this 100-percent coverage to a specific number of days. (Days in excess of the specific number were usually covered

under major medical benefits. See below.) On a percentage basis, the Federal plans studied offered more days of hospital coverage than the private sector plans. On the other hand, the Federal plans also more frequently required the enrollee to pay a deductible or copayment before hospital benefits could begin. Most private sector plans studied provided at least 120 days of coverage and seldom required a deductible or copayment. In contrast, even though Federal plans more frequently required a deductible or copayment, a higher percentage of these plans offered a greater number of days of 100-percent coverage and, therefore, provided better benefits for hospital stays of over 120 days.

Surgical benefits

Federal and private sector surgical benefits appear to be fairly comparable. Surgical benefits cover the surgeon's charges for (1) inpatient surgery, (2) outpatient surgery, and (3) hospital charges for outpatient surgery. Hospital charges associated with inpatient surgery are covered under hospital benefits. For inpatient surgery, most of both types of plans cover the surgeon's charges at 80 to 100 percent of the reasonable and customary charge. For outpatient surgery, most Federal and private sector plans cover at least 80 percent of surgeon's charges, sometimes after the enrollee pays a deductible. A minor difference is that private sector plan deductibles are lower than Federal deductibles. (This will be discussed in greater detail under major medical benefits. See below.) For hospital services for outpatient surgery, private sector plans seemed to provide slightly better benefits. The majority of Federal plans covered at least 80 percent of the charges, sometimes after the enrollee pays a deductible, but most private sector plans covered them at 100 percent without the enrollee having to satisfy a deductible.

Major medical benefits

For the plans studied, private sector major medical benefits are somewhat better than those offered by FEHBP. Major medical benefits cover such charges as: physician services, hospital charges in excess of the basic hospital benefit maximum, prescription drugs, ambulance service, anesthetics, prosthetics, diagnostic X-rays and laboratory tests, and durable medical equipment. Specific items covered and level of deductibles, coinsurance, and catastrophic protection vary among plans.

Before a plan begins paying major medical benefits, the enrollee must incur a specific amount of covered expenses, called the deductible. Private sector major medical deductibles

tend to be lower than FEHBP deductibles. Most of the Federal plan deductibles ranged from $150 to $200. In comparison, most private sector plan deductibles ranged from $50 to $125.

In many cases, the plan and enrollee share major medical expenses. After the deductible is met, the plan pays a fixed percent of the reasonable and customary charges for covered services, and the enrollee pays the balance (coinsurance). A plan may or may not have a maximum dollar amount that it will pay. Private sector plan major medical payment rates tended to be somewhat higher than FEHBP payment rates. While all the private sector plans studied had coinsurance rates of no more than 20 percent, none of the FEHBP plans had less than 20 percent. Some had 25-percent coinsurance rates. FEHBP plans are superior in one area: plan maximums. While none of the FEHBP plans studied had plan maximums, 73 percent of the private plans had maximums. Forty-three percent of the private plans had plan maximums of either $500,000 or $1,000,000.

Another feature of major medical benefits is catastrophic protection. This provision stipulates that, when an enrollee's share of covered major medical expenses reaches a specific dollar amount, the plan's payment rate increases to 100 percent. This catastrophic protection is, of course, subject to any plan maximum. Private sector plans appeared to provide better coverage than the Federal plans, although the majority of both types of plans offered some kind of catastrophic protection to limit enrollee out-of-pocket cost. Most Federal plans limited the enrollee's share of covered major medical expenses to between $1,000 and $2,000. In comparison, most private sector plans limited the enrollee's share to between $200 and $1,000. However, most of both types of plans partially or totally excluded mental health benefits from catastrophic protection coverage.

Mental health benefits

The private sector plans studied appeared to provide better coverage of inpatient mental health expenses than FEHBP. Most (87 percent) of the Federal plans offered between 30 and 90 days of inpatient mental health care at 100 percent. About 31 percent of these Federal plans offered additional days of care under major medical benefits. In comparison, about one-third of the private plans covered inpatient mental health expenses at 100 percent for 30 to 70 days, usually with additional days covered under major medical benefits. Another third covered inpatient mental health expenses at 100 percent for 120 days or more, usually with additional days covered under major medical benefits. The remaining third of the private plans covered

these expenses at 80 to 100 percent for an unlimited number of days, subject to a dollar maximum. In addition, about 56 percent of the private plans offered some kind of catastrophic protection for inpatient mental health expenses; however, none of the Federal plans offered this benefit.

Private sector outpatient mental health benefits also appear slightly better than those offered by Federal plans. Outpatient mental health expenses were generally covered under major medical benefits by both private and Federal plans. Although the copayment factor was generally reduced to 50 percent by both types of plans, the private sector plan deductibles tended to be lower, as previously discussed. In addition, over half of the Federal plans had a limit on the number of outpatient mental health visits that the plan would cover, while only 3 percent of the private sector plans had a visit maximum. Finally, 28 percent of the private sector plans offered catastrophic protection for outpatient mental health benefits. None of the Federal plans studied offered this benefit.

## CONCLUSIONS

Although the Congress intended FEHBP to be comparable to private sector insurance plans both in terms of benefits and employer contribution, FEHBP does not appear to meet this goal. OPM studies indicate that the program was comparable in benefits in 1979 and 1980, but the same studies indicate that the program was not comparable in terms of the employer contributions. Our analysis of a study of 1981 private sector benefits indicated that FEHBP still was not comparable in terms of the employer contribution. Based on our limited analysis of private sector plans and FEHBP for 1982, it appears that the program was still not comparable not only in terms of the employer contribution, but also the benefits provided.

## CHAPTER 6

## SELECTIVE ENROLLMENT PERCEIVED

## AS A THREAT TO FEHBP STABILITY

Because Federal employees are allowed to choose among competing health plans, selective enrollment is an inherent part of FEHBP. There is disagreement, however, about the degree of adverse impact it has on the program. As enrollees choose health plans based on expected health needs, individual plans can be affected in different ways. The overall impact of selection on FEHBP, however, is unclear. The program is frequently cited as one in which selection has occurred but has not had an adverse impact. However, some believe that it is only a question of time before the adverse effects of selective enrollment become evident, driving the cost of comprehensive coverage out of the reach of those who need it the most. Over time, some predict, the phenomenon can lead to a decline in the comprehensiveness of benefit packages--ultimately, insurance benefits may not be available to those who need them most, such as the chronically ill, or those in need of a particular, expensive benefit.

Although little data are available, at least one FEHBP plan, Blue Cross/Blue Shield, maintains that selective enrollment has an adverse impact on it. As a result of the benefit cuts and the projected adverse selective enrollment that would result from these cuts, Blue Cross/Blue Shield considered withdrawing from FEHBP at the end of 1981 to minimize financial losses anticipated for 1982 if the regularly scheduled open season were held.

Suggestions for dealing with the adverse impact of selective enrollment are varied and controversial, primarily because selective enrollment is essentially a by-product of the competitive features of FEHBP, and competition among health care insurers is perceived by many authorities to be the key to controlling increases in health care costs.

### CONSUMER CHOICE ALLOWS SELECTIVE ENROLLMENT

Selective enrollment is a by-product of the competitive structure of FEHBP--a structure that features enrollee choice among competing health plans. Most non-Federal employees who receive health insurance have no choice in the level of coverage they receive. Consequently, some people may have more comprehensive coverage than they would prefer. However, the Congress designed FEHBP to give Federal employees the opportunity to choose among different insurance plans with different levels of

coverage through the open enrollment period. Therefore, enrollees who anticipate large medical expenses can select more comprehensive plans, while those anticipating little use of health services can select less comprehensive plans.

A May 1982 Congressional Budget Office study, "Containing Medical Care Costs Through Market Forces," illustrated this effect in a comparison of Blue Cross/Blue Shield's high option to the three other Government-wide options. The study reported that utilization in the Blue Cross/Blue Shield high option was higher than in its low option, as well as in Aetna's high and low options, but it did not report the statistical significance of these data. The study concluded that the differences were due, at least in part, to selective enrollment. In 1979, according to the study, 9.4 percent of Blue Cross/Blue Shield high option enrollees made hospital claims compared to 7.6 percent of the low option enrollees and 7.8 percent and 7.2 percent of the Aetna high and low options, respectively. For maternity care, 1.6 percent of Blue Cross/Blue Shield high option enrollees made claims compared to 1.0 percent of the low option and 0.6 percent and 0.5 percent of the Aetna high and low options, respectively.

## FOUR SCENARIOS FOR SELECTIVE ENROLLMENT

The overall impact of selective enrollment on FEHBP, combining the effects on all plans of all enrollment changes, is difficult to assess because of a lack of data. Likewise, it is difficult to determine which of the possible selection scenarios presented below is most prevalent or which has the largest financial impact on FEHBP. The effect of selection on any particular plan depends on the utilization experience of the enrollee relative to the average utilization of the plans that the enrollee leaves and joins. This relationship is important because plan rates are based on plan experience--higher average utilization means a higher rate for the same benefit package.

Selection may affect a plan in a positive or adverse fashion, and since an enrollee leaves one plan and enters another, the two effects can combine in one of four scenarios.

1. Both the plan losing the enrollee (Plan A) and the plan gaining (Plan B) are adversely affected.

2. Both plans are positively affected.

3. Plan A is adversely affected, but Plan B is positively affected.

4. Plan A is positively affected, but Plan B is adversely affected.

In the first case, Plan A is adversely affected when the enrollee was a lower-than-average utilizer in that plan; Plan B is adversely affected when this enrollee becomes a higher-than-average utilizer in that plan. The enrollee's presence in Plan A held the rate down; other enrollees, particularly higher-than-average utilizers, in Plan A benefited directly from this enrollee's presence. Leaving Plan A will cause its average utilization to increase; joining Plan B will cause its average utilization to increase. In this case, both plans must raise rates to reflect new, higher average utilization. In doing so, each plan runs the risk of driving out low utilizers who do not want to pay the higher rate. Such a loss of enrollment will force each plan to raise its rate again.

Both plans may be positively affected if the enrollee is a higher-than-average utilizer in Plan A but a lower-than-average utilizer in Plan B. Plan A may lower its rate because the loss of this enrollee lowers the average utilization. Similarly, Plan B may lower its rate because gain of this enrollee lowers the average utilization.

The logic of the last two scenarios is similar. For Plan A to be adversely affected while Plan B is positively affected, the enrollee is a lower-than-average utilizer in both plans. For Plan A to be positively affected while Plan B is adversely affected, the enrollee is a higher-than-average utilizer to both plans.

## THE POTENTIAL ADVERSE EFFECTS OF SELECTIVE ENROLLMENT

Although FEHBP is often cited as a program in which selection has occurred but has not had an adverse impact, some people familiar with FEHBP, as well as some participating plans, believe that selective enrollment, over time, contributes to the instability of FEHBP by increasing rates, segregating high and low utilizers, and reducing the comprehensiveness of benefits. Each FEHBP plan sets a rate for its benefit package that should fully cover all claims of a specific population. However, an FEHBP insurer does not know what portion of the FEHBP population will choose its plan. Consequently, the insurer does not know with certainty what sort of risks (higher than average, lower than average) will enroll in its plan and, therefore, cannot be certain that the plan rate will fully cover all claims. According to this scenario of adverse impact, if people who represent a higher-than-anticipated risk choose a particular plan, it is likely that the plan's rate, based on claims experience of the previous year, will not be self-supporting.

Anticipating or failing to anticipate such enrollment patterns results in a no-win situation, according to this scenario. Failure to anticipate an increase in average utilization can result in cash flow problems for a plan since the rate will be based on an underestimate of needed income. Anticipating selective enrollment through increased rates, however, could lead to more movement of low utilizers to less expensive plans, which in time would require a still higher rate adjustment. This spiraling pattern may continue until there is no rate at which the plan would be solvent--any rate increase would cause a selection effect which would outweigh the increase in per-enrollee rate.

If over time, as high utilizers concentrate in particular plans and this scenario continues, plans that vary only slightly in actuarial value (assuming a "typical" cross-section of enrollees) will vary significantly in rates, increasing the cost to enrollees in particular plans and to the Government. (Actuarial value is the claims cost of a benefit package for a fixed population. Differences in actuarial value among plans are due only to differences in benefits; utilization experience does not change because a fixed or typical population is used for the computation.) For example, a July 1982 study[1] reported that, while the actuarial value of the 1982 Blue Cross/Blue Shield high option was 110 percent of the low option, the high option's rate was 194 percent of the low option. Likewise, while the actuarial value of the 1982 Aetna high option was about 110 percent of the low option, the high option family rate was 122 percent of the low option family rate and the high option self only rate was 151 percent of the low option self only rate. In addition, while the actuarial value of the Blue Cross/Blue Shield high option plan for 1982 was only 106 percent of the average value of the four experience-rated plans in the Big Six (Blue Cross/Blue Shield high option, Aetna high option, NALC, and APWU), the rate was 118 percent of the average of these same four plans. According to those who see selective enrollment as a problem, rate differences like these can increase the incidence of selection and increase the segregation of high and low utilizers within FEHBP. In this manner, selection by even a small percentage of enrollees can result in higher costs for enrollees and the Government, particularly when any of the Big Six plans experience adverse selection.

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[1]William M. Mercer, Inc., "Review of the Federal Employees Health Benefits Program," U.S. House of Representatives, Committee on Post Office and Civil Service, 97th Congress, 2nd Session, Committee Print No. 97-8, July 13, 1982.

According to this scenario, if this disparity between actuarial values and rates based on claims experience persists, enrollment in more comprehensive plans will decline as more enrollees recognize the relatively small differences in benefits payable among plans that vary greatly in premium rates because of differing utilization patterns of the enrolled groups. Enrollees leaving the plan will tend to be those who have least to gain from more comprehensive coverage: the lower-than-average utilizers. In addition, those who are higher-than-average utilizers will tend to remain in that plan. The result of this switch is an increase in the average cost for those remaining in the more expensive comprehensive plan. This selective enrollment effect leads to rates being increased even more, in order to account for the selection effect of a rising average utilization.

To avoid or lessen these rate increases, plans may resort to preferred risk selection by reducing benefits which attract poorer risks and increasing those that attract better risks. For example, Blue Cross/Blue Shield reduced mental health benefits in its 1982 plan in large part, according to plan officials, to reduce the attractiveness of their plan to high utilizers. On the other hand, Aetna enhanced its 1982 dental package in order to attract younger enrollees.

As plans engage in preferred risk selection, this scenario concludes, selective enrollment could result in a gradual homogenization of benefits toward relatively uniform, less comprehensive plans with minimal coverage of high cost conditions. Insurance benefits may not be available for those who need them most, such as the chronically ill or those who need a particularly expensive benefit like outpatient mental health.

## BLUE CROSS/BLUE SHIELD EXPERIENCE MAY DEMONSTRATE ADVERSE IMPACT OF SELECTIVE ENROLLMENT

Blue Cross/Blue Shield was so concerned about the adverse impact of selective enrollment on its plan that it almost withdrew from FEHBP at the end of 1981. While available evidence seems to indicate Blue Cross/Blue Shield is experiencing adverse selection, the programwide effects of adverse selection remain unclear.

The Board of Managers of Blue Cross/Blue Shield, in considering how to implement the second round of benefit reductions, was concerned about the cumulative selective enrollment effect of two rounds of benefit cuts and, consequently, about its ability to continue offering the Service Benefit Plan in FEHBP. The Board faced a dilemma. If it raised rates only

increase could lead to a major exodus from the plan, [illegible] serious financial loss. However, rates could not be raised high enough to offset this risk of adverse selection because higher rates would make the problem worse, not better, by driving out more good risks. In addition, because of a $253 million loss in 1981, Blue Cross/Blue Shield did not have special reserves to protect the plan if it experienced a loss in 198[illegible]. Consequently, any 1982 losses would have to be paid from reserves held for non-Federal subscribers by the individual Blue Cross/ Blue Shield plans that underwrite the Service Benefit Plan.

The Board initially decided to withdraw from FEHBP rather than face open season losses which Blue Cross/Blue Shield's actuary estimated to be about several hundred million dollars, although the costs of withdrawal were not small. Blue Cross/ Blue Shield estimated that termination of the Service Benefit Plan would result in substantial losses: (1) a permanent underwriting loss of $14 million, (2) a $38 million loss through liquidating the plan's investment account, (3) $94 million in wind down costs that the already exhausted contingency reserve would not cover, and (4) additional employee severance pay and lease cancellation expenses. In addition, termination would mean greater allocation of fixed costs for other contracts held by Blue Cross/Blue Shield plans. Finally, the plans would experience damages to good will and reputation which, Blue Cross/Blue Shield believed, would have a significant deleterious effect.

While seeking a delay of the November 1981 open season until corrections for adverse selection were implemented, Blue Cross/Blue Shield negotiated a clause in its contract permitting it to withdraw the Service Benefit Plan during the 1982 contract year. In the Board's judgment, this would permit them to contain the anticipated losses if open season produced the expected severe adverse selection.

Available evidence seems to indicate Blue Cross/Blue Shield's high option is experiencing adverse selection. In addition to utilization data and comparisons of actuarial values and rates cited above, Blue Cross/Blue Shield data suggest that both plan options are hurt by the kind of people joining. Furthermore, the kind of people leaving the high option are contributing to increasing high option rates. However, those leaving the low option contribute to minimizing increases in low option rates.

Based on 1976-79 utilization data, Blue Cross/Blue Shield found expenditures for people joining either option from other plans in open season were about 140 percent of the average of

both options combined. Expenditures for those leaving the high option were about 65 percent below the high option average. Expenditures for those transferring out of the low option were about 145 percent of the low option average. However, Blue Cross/Blue Shield did not report whether these differences were statistically significant. The average annual effect of this selection from 1976 to 1979, Blue Cross/Blue Shield found, was to increase single and family high option claims costs about 2.5 percent while low option single and family claims costs dropped 3.5 percent and 1.0 percent, respectively. In addition, analysis by the Congressional Budget Office indicated that those leaving the Blue Cross/Blue Shield high option during the November 1977 open season (2 percent of plan enrollees) had 1977 claims that were 39 percent below average. This difference was statistically significant. However, those joining the high option at this time had 1978 claims experience close to the average for the plan.

While available data seem to indicate Blue Cross/Blue Shield is being adversely selected, it is difficult to determine the effect of the Blue Cross/Blue Shield enrollment changes on other plans or the program as a whole. Data on the utilization experience of people before they entered or after they left Blue Cross/Blue Shield have not been gathered and analyzed. Blue Cross/Blue Shield officials maintain that people leaving their high option will adversely affect plans they join because they will be higher-than-average utilizers in the new plan.

## SUGGESTIONS FOR DEALING WITH THE ADVERSE IMPACT OF SELECTIVE ENROLLMENT

During our review, we discussed (1) selective enrollment with plan representatives and program officials and (2) suggestions that have been made to address selective enrollment. A brief synopsis of the suggestions, along with some observations, follows:

1. Reduce the number of FEHBP plans dramatically: Because selective enrollment is a by-product of FEHBP's consumer choice feature, eliminating this choice either in total or to a great extent could significantly reduce the impact of selective enrollment. In addition, this solution would reduce OPM's administrative burdens caused by the large number of contracts currently negotiated and administered under FEHBP. The opposition from enrollees, employee unions, or others resulting from such a radical program change, however, limits its

feasibility. Further, except for the competitive bidding that might occur in selecting the participating plan(s), we believe the program's competitive framework would be eliminated.

As an alternative to reducing the number of plans, reducing the number of plans available to any particular enrollee may help address the selective enrollment problem. For example, in administering their plans, some employee organizations have effectively allowed any Federal employees to enroll in their health plan, regardless of whether they are regular members of the organization, if the employees agree to become associate members by paying associate member dues. If enrollees had to become bona fide regular members of the organization (and pay regular member dues) or enroll in a Government-wide plan or HMO, the degree of adverse impact due to selective enrollment would probably be less. Such a provision, however, would severely limit enrollee choice.

2. Link the Government contribution to the enrollee's risk level: There are different approaches to this proposal. One approach is to separate FEHBP enrollees into active employees and annuitants and set the plan rate and the Government contribution higher for annuitants (all annuitants or only nonmedicare eligible annuitants) than for actives. A second approach is to divide FEHBP enrollees according to actuarial categories (e.g., age, sex, geographic area, and disability status) and vary the plan rate and the Government contribution according to degree of risk so that a higher risk category (which costs more to insure) has a higher rate and a higher Government contribution. This solution monetarily compensates plans experiencing selective enrollment, lessening the adverse financial effects. It mitigates the occurrence of the phenomenon, although it does not totally eliminate it. However, it could increase administrative costs for both OPM and the plans. In addition, depending on the source of the additional compensation going to adversely selected plans, it could increase the amount of the Government contribution to FEHBP.

3. Implement less frequent open seasons: By (1) reducing the opportunities to selectively enroll, (2) lengthening the time over which employees and annuitants must project their health care needs, and (3) requiring enrollees to pay into a plan for a longer period of time, the occurrence and adverse effects of selective

enrollment should decline. In addition, OPM would probably realize administrative savings from less frequent open seasons. On the other hand, implementing less frequent open seasons would significantly reduce program competition, and some enrollees could suffer financial hardships should their health status change drastically.

The Aetna Manager for the Government Relations and Employee Benefits Division suggested a less drastic program change that includes one of the fundamental principles of less frequent open seasons. Specifically, he suggested an earlier open season, perhaps 1 month or so, but retaining the January 1 effective date for enrollment changes. The intent is to lengthen the time between selecting a plan to use specific benefits and being able to use such benefits. Although conceptually true, the practical effects of such a minor change on selective enrollment may be minimal. Additionally, such a change would affect the entire negotiation process and thus require rates to be set even earlier. It would, however, permit additional time for carrier notification of enrollment changes and thus improve the reconciliation problem. (See p. 58.)

4. Implement a voucher system: Although the specifics of how a voucher system would operate can vary, the concept is that Federal employees and annuitants receive a specified, annually adjusted payment (i.e., voucher payment) from the Government for health insurance coverage. These employees and annuitants are then free to enroll directly in whatever plan they elect. Whether the Government would limit the number of health plans available or regulate those participating and whether the voucher payment or any part of it could be retained by individuals electing no or low-cost health coverage are examples of specifics which would have to be worked out.

   A voucher system could be used to compensate plans adversely affected by selective enrollment if voucher payments were based on actuarial categories. Competition would continue because consumer choice would remain. Some people associated with FEHBP do not support a voucher system, however, because it sacrifices the group health concept and thus could make health insurance potentially unaffordable to some. In addition, some noted that even with a voucher system, a payroll deduction for the difference between the total rate and the voucher payment would have to be maintained to

assure that plans are paid in full. A voucher system may also require increased administrative costs for agency payroll offices if they have to administer the individual policies.

5. Require all plans to accept annuitants: Only the 2 Government-wide plans and 7 of the 11 employee organization plans open to all Government employees accepted annuitants in 1982. Because annuitants are relatively high utilizers of health services, some people familiar with FEHBP believe this enrollment restriction concentrates the potential adverse effects of selective enrollment in a specific group of plans rather than spreading this risk over all plans. This is perceived as unfair. OPM notified plans, through its 1983 call letter, that it would no longer permit plans which offer associate memberships to restrict or exclude annuitants. In response, one employee organization plan decided to no longer offer associate memberships, while the other plans extended associate memberships to all annuitants. If annuitants are generally reluctant to change plans, however, the real impact lifting the restriction will have on plans with large annuitant populations may be minimal.

6. Implement waiting periods for preexisting conditions: Under FEHBP, an employee or annuitant may change health plans during open season with few restrictions as to preexisting health conditions. Some people believe such a situation acts to encourage selective enrollment. That is, because there is no preexisting enrollment restriction, enrollees with an existing or expected medical condition can temporarily change plans to have coverage for that condition. Once treated, those enrollees can selectively enroll in another, possibly lower cost, plan. The effect is to increase the exploited plan's utilization experience without having adequately contributed to its costs. While not disputing that the absence of a preexisting condition restriction contributes to adverse selection, opponents of any type of waiting period point to the potential financial hardships some enrollees could face if such a restriction was implemented.

7. Link the Government contribution to the plan's past utilization experience: This solution, as offered by Blue Cross/Blue Shield, sets an employee contribution as a fixed percent of the actuarial value of each

plan. The difference between this basic employee contribution and the total rate is paid by the Government. In essence, the Government contribution is a combination of the remaining actuarial value of the plan plus any additional expense due to the plan's actual utilization experience. This solution, like the solution linking the Government contribution to the enrollee risk level, compensates plans adversely affected by selective enrollment. It does not lessen the occurrence of such enrollment. OPM's Assistant Director for Insurance Programs termed this solution as unacceptable because it would decrease program competition, but added that it may serve as a basis for more sophisticated proposals.

8. Do not impose special benefit requirements on select plans: In the past certain FEHBP plans have been required to provide benefit coverage not required of all plans. For example, OPM required Blue Cross/Blue Shield for many years to offer much more comprehensive mental health benefits than any other plan. Those opposing this practice believe that such requirements are competitively unfair and can cause plans to be adversely affected by selective enrollment. They generally advocate that any OPM requirement imposed on one plan should extend to all FEHBP plans.

In discussing possible changes to FEHBP to mitigate the adverse impacts of selective enrollment, all the people we talked to agreed that selective enrollment had occurred, but they did not all agree that it was a problem that required changes to FEHBP.

## CONCLUSIONS

As long as FEHBP is designed to allow Federal employees a choice among competing health plans, selective enrollment will take place, although varying the degree of choice could vary the extent of its occurrence. While data on the impact of this issue up to the present are limited, selective enrollment could have a potentially disruptive impact on FEHBP in the future. If selective enrollment continues unchecked, rate increases, the segregation of high and low utilizers, and ultimately a reduction in the comprehensiveness of benefit packages could occur.

The withdrawal of a plan with high utilization experience because of the adverse impact of selective enrollment could accelerate this process. In particular, remaining plans that provide relatively comprehensive coverage would probably gain many new enrollees with high utilization experience. If these plans

did not adjust their rates in anticipation, such an influx could cause serious cash flow problems, or even bankruptcy, in some plans. In this manner, withdrawal of one plan could precipitate the withdrawal of others. Even if plans adjusted their rates, cash flow could be a problem because measuring selection effects is not an exact science. Plans would have to anticipate what portion of the terminating plan's enrollees would choose their plan and what their experience would be relative to the plan members. Even if a new plan or plans replaced the terminated major carrier, the selective enrollment phenomenon of rate spirals would persist as high utilizers and low utilizers continued to choose that plan best suited to their needs. In addition, enrollees in remaining plans could be faced with large rate increases for the same benefit packages. As these more comprehensive plans come under the pressure of adverse selection, such plans might gradually reduce benefits that are especially attractive to high utilizers to the point where all plans offer similar minimal benefit packages. As a result, people needing plans providing more expensive benefits may not have access to them.

# CHAPTER 7

## OPINIONS DIFFER ON POSSIBLE SOLUTIONS

## TO PERCEIVED FEHBP PROBLEMS

In addition to the selective enrollment issue discussed in chapter 6, people familiar with FEHBP identified other program issues requiring remedial action. As with selective enrollment, opinions vary, however, as to whether all these program issues are problematic and, if so, what program changes should be implemented to address each perceived problem. Despite the varying opinions, we identified four program issues, besides selective enrollment, that were frequently raised and various suggested program changes to address each. This chapter discusses these issues and the suggested changes.

Based on our discussions with FEHBP health plan officials, OPM officials, and others knowledgeable about FEHBP, four program issues requiring attention were frequently mentioned. These include (1) the desirable level of competition, (2) the lack of control and predictability associated with the contribution formula, (3) poor enrollment data, and (4) the need to contain or reduce program costs. Opinions on how to address each issue differ in terms of degree of change. In addition, because of the highly interrelated nature of these areas, certain suggested actions addressing one issue could affect another. For example, suggestions for addressing selective enrollment may also affect program competition and vice versa. Thus, viewing the issues and the related program actions to address each in isolation may be unrealistic.

### COMPETITION

FEHBP is characterized by a large number of health plans with varied rates and benefit levels. Because of this high degree of consumer choice, the program has been described as a competitive model for health insurance programs. Despite its aforementioned contribution to selective enrollment, this characteristic coupled with periodic open seasons is generally perceived as positive.

The desirable level of competition is the area where people knowledgeable about FEHBP disagree. Those concerned with selective enrollment, although supporting the competitive nature of the program, believe certain actions that would reduce enrollee choice are warranted (see ch. 6, p. 49). Others believe program competition should be strengthened and suggest the following means of emphasizing this program feature.

1. Maintain annual open seasons: Open seasons are a major contributor to FEHBP competition. These periods provide program enrollees the opportunity to choose among plans and select the one, in their opinion, offering the best product for the cost. Most FEHBP principals favor annual open seasons and believe that maintaining annual open seasons and permitting enrollees to change plans as benefits and rates change would continue an established level of competition and be beneficial for the program. Accompanying such an open season frequency, however, would be a sustained risk of selective enrollment occurring as well as the annually incurred administrative costs of conducting an open season.

2. Eliminate the 75-percent cap on the Government's contribution: The amount the Government contributes to any plan is 60 percent of the unweighted average of the Big Six rates, not to exceed 75 percent of the plan's rate. As a result of this 75-percent cap, the Government pays a larger dollar amount for high-cost plans, which, according to some FEHBP experts, creates a disincentive to enroll in and thus to offer low-cost plans. This disincentive can lessen the number and/or types of low-cost plans offered, thus deterring competition. By removing this 75-percent cap, enrollee choice and, theoretically, competition would be increased. Further, although eliminating the cap would increase the Government contribution to lower cost plans, it could also increase the attractiveness of less costly plans and thus lessen the total Government contribution to FEHBP. Such increased attractiveness, however, could simultaneously magnify the adverse selection problem of high option plans.

3. Allow plan advertising to be factored into rates: FEHBP regulations allow plans to advertise, but Government-wide and Employee Organization plans cannot charge this expense to their contract with OPM. Some believe that allowing advertising costs to be included in the rates for these plans would increase the level of program competition, particularly with HMOs, which are not prohibited from including advertising in their rates. Such an allowance, however, could also raise the cost of the program for enrollees and the Government, even though advertising costs are currently considered in setting plans' service charges or profit.

4. Require plans to set rates by geographical areas: With the exception of HMOs, the rates for FEHBP health plans do not reflect costs by geographical area. Instead, plans offer one national rate. According to one hospital industry official, this practice distorts the market and results in unfair competition for low-cost plans because national rates are artificially low in high-cost areas like Washington, D.C. Conversely, these national rates are artificially high in the low-cost areas.

5. Increase consumer awareness and knowledge of plan differences: The buyer's knowledge of product differences in terms of quality and price directly influence the level of competition in any market, including FEHBP. In an earlier review regarding FEHBP,[1] we reported that enrollees who want to make an informed choice would have difficulty understanding and comparing health plans. Although OPM has markedly improved the quality of open season information, some shortcomings are still cited. For example, carriers identified enrollees' limited access to some brochures and the potentially misleading abbreviated language in comparison charts. Additionally, enrollee difficulty understanding the complex contract language used in brochures could also hinder consumer awareness of plan differences.

CONTRIBUTION FORMULA

As explained in chapter 1, the level of the Government and enrollee contributions to FEHBP depends on the rates charged by the Big Six plans for the applicable contract year. OPM officials believe this program feature is a problem because it makes program costs unpredictable and uncontrollable. Some people suggest that OPM's fiscal year 1982 budget shortfall for FEHBP was a direct consequence of the contribution formula's unpredictability. Those advocating the modification of the contribution formula suggest the following changes.

1. Fix the Government contribution and annually adjust it by some pricing index: Fixing the Government contribution refers to establishing a standard dollar amount the Government would contribute toward all plans regardless of plans' rates. According to many, such an

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[1]U.S. General Accounting Office, "Federal Employees Need Better Information for Selecting a Health Plan" (MWD-76-83, Jan. 26, 1976).

amount, because of its independence from plans' rates, would provide predictability to the level of the Government's contribution. This amount could be adjusted annually as rates increase by an appropriate price index (e.g., health care component of the consumer price index) and controlled by capping the index. Opponents of a fixed contribution cite its worsening effect on the adverse selection problem for high option plans.

2. Fix Government's contribution and annually redetermine this level: This approach differs from the above only in how subsequent year contribution levels are determined. Rather than adjust the original contribution level by some index, this approach requires the amount of Government contribution to be determined each year by the Congress or the administration. Although potentially subject to political considerations, proponents of this approach advocate it because of its greater controllability.

## ENROLLMENT RECONCILIATION

OPM, along with other Federal agencies, is responsible for the accuracy of FEHBP enrollment data used by agencies and plans. Accuracy of these data is important because it is used to determine (1) the coverage provided the enrollee, (2) the employee's payroll deduction, and (3) the payment to plans.

Those associated with FEHBP generally agree that reconciliation of plan enrollment data with that of Federal agencies is a problem. Estimates of time needed for agencies to notify plans of enrollment changes ranged from 3 to 5 months to as much as 2 years. Because of this untimely notification, plans may erroneously pay claims of or provide services to ineligible individuals. Conversely, plans could also incorrectly refuse to cover eligible individuals for whom enrollment notification has not been received. According to George Washington University Health Plan officials, the plan covers ineligible enrollees with such frequency that the plan is considering adding a bad debt factor into its rate to cover such losses. Generally, plans cannot understand why agencies have difficulty notifying them promptly of enrollment changes.

In addition to the above, the reconciliation problem causes plans to question the accuracy of the payments to them. OPM sends each plan a semimonthly check to cover its respective enrollment. However, because of untimely notification of enrollment changes and a lack of any enrollment information accompanying the check, plan officials told us they have no way of

verifying the accuracy of the payment received. George Washington University Health Plan officials told us that, based on their enrollment records, payments run between 8 and 10 percent short. Similarly, a Postmasters Benefits Plan official told us that in 1980 the plan received $3 million less than its enrollment records indicated was due.

Officials in OPM's Insurance Program Office agree that enrollment reconciliation is a significant problem. As a consequence, OPM has initiated the following efforts based on prior recommendations we made to address it. Additionally, an office within OPM had proposed a long-term solution that was rejected as too costly.

1. Convert to a common enrollment identification number: According to the Insurance Program officials, OPM requested all plans to convert from enrollment document numbers to enrollee social security numbers by December 31, 1981. This conversion, based on a prior recommendation we made, is intended to facilitate data transmittal. While the Deputy Assistant Director for Insurance Programs told us that most Government-wide and employee organization plans had converted, he did not know how many comprehensive medical plans had.

2. Improve enrollment data exchange and reconciliation in the short run: The Special Assistant to the Assistant Director for Insurance Programs told us OPM established a task force to implement, on an experimental basis, the following recommendations we previously made using Blue Cross/Blue Shield, Aetna, and OPM's annuitant enrollment data. Our recommendations were to

   --have agencies and plans develop a standard format for exchanging enrollment data,

   --require plans to provide payroll offices with verification of enrollment data in computer readable form, and

   --prepare agency instructions on automated reporting and reconciliation of enrollment data.

   According to the OPM official, Blue Cross/Blue Shield and Aetna are currently exchanging enrollment data with OPM's annuitant payroll office through computer tape.

3. Centralize enrollment data at OPM on an automated data base: The Special Assistant told us an OPM centralized and automated enrollment system would be an ideal, long-term solution to the reconciliation problem. OPM's Office of Automated Systems Development proposed such a system in the fiscal year 1981 and 1982 OPM budgets, but the proposal was rejected internally as too costly.

COST MANAGEMENT

Cost management within FEHBP refers to efforts to contain or reduce current and future program costs. These efforts range from improving claim processing procedures (e.g., screening claims for medically unnecessary services and charges in excess of reasonable and customary amounts) to modifying plan benefit structures (e.g., offering midwife delivery coverage and using copayments and deductibles). Given the past and continued trends in health care costs, we have long recognized the importance of cost management in FEHBP.

OPM draws an important distinction between two types of cost management efforts. That is, it segregates (1) cost control achieved through cost transference to enrollees and (2) traditional cost containment achieved through administrative improvements or benefit changes that save program costs without a corresponding loss in necessary patient care or increase in enrollee out-of-pocket costs. We believe this distinction is important because, although both types produce the same short-run effects, the potential long-range effects of increased cost sharing could result in increased costs. Specifically, the intent of cost transference is to make enrollees conscious of health care expenses and thereby discourage the less necessary utilization of benefits. Such cost sharing, however, may also discourage utilization to the point where delayed treatment aggravates the medical condition and ultimately drives up medical costs. The preliminary results of a January 1982 Rand study "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," indicate that cost transference through increased deductibles and copayments does reduce benefit utilization; however, it presents no conclusive evidence as to how the reduced utilization affects enrollee health.

Prior GAO recommendations
to OPM for cost management

Over the last decade, we have made a number of recommendations[2] to contain FEHBP costs through improved claims processing by plans. In general, OPM has failed to implement these recommendations. The recommendations and comments by officials of OPM's Insurance Programs Office follow.

1. Revise health insurance contracts to include incentives for compliance with contract requirements (HRD-76-174): OPM has not implemented this recommendation that is designed to provide plans with incentives to control health benefit costs by denying payment of claims not covered by the contract between OPM and the plan. In commenting on this recommendation, OPM stated that it does not believe that health insurance contracts lend themselves to incentive provisions. In addition, such provisions must be developed bilaterally, and a sole source contractor would be reluctant to agree to such provisions.

   The Deputy Assistant Director for Insurance Programs told us OPM has been unable to determine how to provide adequate incentives in plan contracts to encourage cost containment. Similarly, the Acting Chief of the former Government-wide Plans Division stated that no incentives had been included in plan contracts, although she added that OPM can reduce a plan's service charge if its cost containment efforts are inadequate.

2. Include specific cost control programs in plan contracts (HRD-76-174): OPM has not implemented this recommendation. In commenting on this recommendation, OPM stated that it does not believe that specific cost control programs should be addressed contractually. It believes that plans should be encouraged in the area of cost control, but since the art of health benefits cost control is an ever-changing area, it should not be limited by specific contractual requirements.

   According to the Deputy Assistant Director for Insurance Programs, FEHBP contracts require general cost control measures, such as screening for charges in excess of those which are reasonable and customary and

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[2]See appendix I for titles of reports.

for medically unnecessary services. The official believed that little good would result from more specific contract provisions unless OPM devoted sufficient staff to conduct onsite monitoring of plans.

3. Provide definitive guidance to Employee Organization Plans on the contractual provisions on (1) medical necessity and (2) customary and reasonable payments (HRD-79-87): OPM has not implemented this recommendation, which is designed to contain costs by assuring that benefit payments are made only for covered services, and only for reasonable charges. In commenting on this recommendation, OPM stated that it had worked with the plans to develop a uniform definition of customary and reasonable. Our review, however, showed that additional guidance was needed. The Deputy Assistant Director for Insurance Programs stated that, while OPM has not provided the recommended guidance, he believes that union plans have made substantial improvement in this area. However, because of insufficient staff to monitor these plans, he had no evidence to support his belief.

4. Require adherence to medical necessity and customary and reasonable payment provisions of the contracts as conditions of plans' continued participation in FEHBP (HRD-79-87): To comply with their contracts, plans must have a way to determine that a claim represents a medically necessary service and that claim payments are limited to customary and reasonable amounts. Although OPM is responsible for monitoring plans to assure contract compliance, it has allowed plans to make payments without determining that the services were medically necessary and without developing sound, comprehensive systems to determine the reasonableness of charges. Insurance program officials told us that OPM has not implemented this recommendation because it already has the authority to refuse renewal of a plan's contract if performance is not satisfactory. Further, with respect to employee organization plans, we were told that all six plans recently entering into FEHBP have satisfactorily demonstrated their ability to effectively execute these provisions and all but one of the underwriters of these six also underwrite other plans in FEHBP. In general, however, Insurance Program officials were unaware of the success of its medical necessity and customary and reasonable payment provisions. Furthermore, based on our discussion with plans, little information on either provision was readily available.

5. Monitor and evaluate medical necessity programs in the private and public sectors and require FEHBP plans to use any beneficial aspects (HRD-80-79): OPM has not fully implemented this recommendation which could result in improved care and reduced costs. The Deputy Assistant Director for Insurance Programs stated that OPM has monitored such programs and recommended certain elements found beneficial to FEHBP plans. He added, however, that, because of a lack of staff to monitor FEHBP plans, the effectiveness of the recommended elements has not been determined. The Acting Chief of the former Government-wide Plans Division told us that the division requests plans to report on cost management efforts and encourages use of those found cost effective.

## PRIOR GAO REPORTS INCLUDING RECOMMENDATIONS

## ON CONTAINING FEHBP COSTS

The following GAO reports included recommendations on containing FEHBP costs which are discussed in chapter 7.

--More Civil Service Commission Supervision Needed to Control Health Insurance Costs for Federal Employees (Jan. 14, 1977, HRD-76-174).

--Stronger Management Needed to Improve Employee Organization Plans' Health Payment Practices (Sept. 7, 1979, HRD-79-87).

--OPM Should Promote Medical Necessity Programs for Federal Employees' Health Insurance (July 29, 1980, HRD-80-79).

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