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

FOR RELEASE ON DELIVERY
Expected at 10:00 A.M.
Thursday, December 1, 1983

STATEMENT OF

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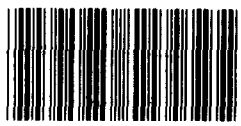
BEFORE THE

SUBCOMMITTEE ON CIVIL SERVICE, POST OFFICE
AND GENERAL SERVICES
OF THE
SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS



ON

LEGISLATION TO AMEND THE FEDERAL EMPLOYEES HEALTH BENEFITS ACT

Mr. Chairman and Members of the Committee:

I appreciate this opportunity to comment on the legislation being considered by the Committee to amend the Federal Employees Health Benefits Act. My statement will highlight our views on the major features of the three bills[1] before the Committee. We will be glad to submit more detailed comments later.

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[1]S. 2027, "Federal Employees' Health Insurance Amendments of 1983";

S. 1685, "Federal Employees Health Plan Improvement Act of 1983"; and

H.R. 3798, "Federal Employees Health Benefits Reform Act of 1983."

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Before discussing these bills, however, I would like to mention our February 1983[2] report to you, which described issues that persons familiar with FEHBP perceived as needing to be addressed to better assure the program's stability. We reported on four major issues:

1. Greater health care cost containment efforts are needed. This is evidenced by the chart attached to my statement which shows the program's cost growth in the last decade in relation to total national health care expenditures. In many ways FEHBP's cost problems are a microcosm of the health care cost issues facing our society and until ways are found to control the general escalation of health care costs, FEHBP's cost will continue to rise and remain a serious problem.
2. The lack of predictability over budgeting for the government's contribution toward health plan premiums was a major reason why the program encountered severe budgetary shortfalls, which led to Office of Personnel Management administrative actions in 1981 and 1982 to reduce benefits. When the annual budget estimates are prepared, there is little way to accurately predict future plan premiums. Further, anticipated enrollment levels for the individual plans are not known at that

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[2]"Financial and Other Problems Facing the Federal Employees Health Insurance Program," GAO/HRD-83-21, February 28, 1983.

time and thus are not factored into the budget estimates. Both premiums and enrollment levels ultimately determine the government's cost. This uncertainty about enrollment levels was illustrated during the past two open seasons (May 1982 and November 1982), when about 20 percent of FEHBP enrollees switched plans.

3. Contrary to congressional intent, FEHBP is not comparable to health programs of large private sector employers in terms of either the level of benefits offered or the employer's contribution--the government's benefits and contributions are lower.

4. Selective enrollment, resulting from consumer choice, is perceived by some participating plans to be a problem. Over time, low and high utilizers of health care are segregated into different plans, causing some plans' enrollment to consist of a disproportionate number of higher than average utilizers. Premiums for such a plan must reflect the cost of insuring these people, which in turn makes the plan's premiums unattractive to low utilizers and causes them to move to less expensive plans, leaving the plan with an even more expensive group of enrollees. This problem may ultimately make comprehensive coverage either unaffordable or unavailable to those who need it most, such as the chronically ill and those in need of a specific benefit, such as treatment for mental disorders.

Our comments on each of the bills as they relate to these issues follow.

Cost Containment

S. 2027 establishes a cost containment program which emphasizes (1) peer review of the utilization and quality of health care delivered, (2) the use of deductibles and copayments, (3) the design and offering of alternative, more cost effective types of medical care, and (4) the adoption of Medicare reimbursement rules. We believe these actions are needed and can contribute to containing health care costs in FEHBP. In particular, we believe that the government should begin to adopt a more uniform approach for reimbursing health care providers that participate in government-financed health programs.

Specifically, as part of the Social Security Amendments of 1983, the Congress adopted a major reimbursement reform which features a prospective payment method for inpatient hospital care under Medicare. This method, which will be phased in over 3 years beginning in October 1983, discarded Medicare's traditional cost-plus reimbursement methodology and replaced it with a system designed to pay all hospitals relatively fixed amounts per admission based on a patient's diagnosis. If a hospital's costs per admission and diagnosis are less than the prescribed payment rate, it can keep the difference; however, if the costs are more, it will have to either absorb the losses or, more

likely, pass them along to other payors such as FEHBP. Therefore, we believe that the provisions of S. 2027 which are intended to conform FEHBP's reimbursement rules to Medicare with respect to inpatient hospital services represent desirable reforms. However, Medicare has not developed a corresponding prospective payment system for other services and other providers such as physicians. Although there are differences in the mechanics and the resulting amounts allowed, FEHBP uses essentially the same reimbursement approach as Medicare for these providers. Therefore, considering the administrative complexities involved in conforming to Medicare's allowances, we see no reason at this time to extend Medicare's methods to FEHBP for other than inpatient hospital services. At such time as Medicare develops alternative methods, we believe it would then be appropriate to look at these alternatives for possible application to FEHBP.

It should be recognized that such an approach for inpatient hospital services will take several years to implement and should be closely coordinated with the health care industry as well as the Department of Health and Human Services, which is developing the system for Medicare and can provide valuable assistance to FEHBP. In addition and perhaps most importantly, FEHBP should assure that beneficiaries are protected from the cost of hospital services in excess of the allowable amount or identified as unnecessary through the proposed peer review program.

S. 1685 and H.R. 3798, as we interpret them, rely greatly on increased competition among health plans as a means for containing costs. Such health care competition models offer the potential for restraining the growth in health care costs but are virtually untested; therefore, little is known about whether they will succeed in substantially moderating health care cost increases.

Budgeting for Program Costs

S. 2027 provides that the government's contribution toward health plans be based on a weighted average of the premiums charged by all participating plans. In other words, the enrollment level of each plan would be used to determine the government's contribution. If the expected enrollment level of the individual plans can be factored into the budget estimates this should improve their predictability. However, the same difficulties and uncertainties would remain in estimating how much each plan's premiums will change from year to year.

S. 1685 generally would provide that the government's contribution be adjusted annually by the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for All Urban Consumers. This process would improve the predictability of the government's contribution amount because of its independence from plans' premium rates.

H.R. 3798 proposes annual adjustments to the government's contribution in an amount equal to the percentage change in the implicit price deflator of the Gross National Product. This too

would make budget estimates more accurate and predictable than they are now.

Comparability to Private Industry

S. 2027 would increase the government's share of premium payments from 60 to 70 percent for active employees and Medicare-eligible annuitants and to 84 percent for annuitants not eligible for Medicare hospital benefits. Such a change would lessen the disparity between what large private sector employers contribute to health plans and what the government contributes. On the other hand, this provision would add to the government's cost.

Neither S. 1685 nor H.R. 3798 specifically provides for adjustments to narrow the gap between employer contributions for private and federal employee health insurance.

Selective Enrollment

None of the bills would eliminate selective enrollment because consumer choice would remain in the program. S. 1685, however, would mitigate the adverse effects this phenomenon has on plans by adjusting the government payment to plans based on the utilization, age, sex, and geographic location of their enrollees. In other words, the government would provide additional compensation to plans that enroll the sicker and/or more costly beneficiaries. We have concerns, however, regarding the complexity of administering such a system because of the large data collection and analysis efforts that would be required by OPM.

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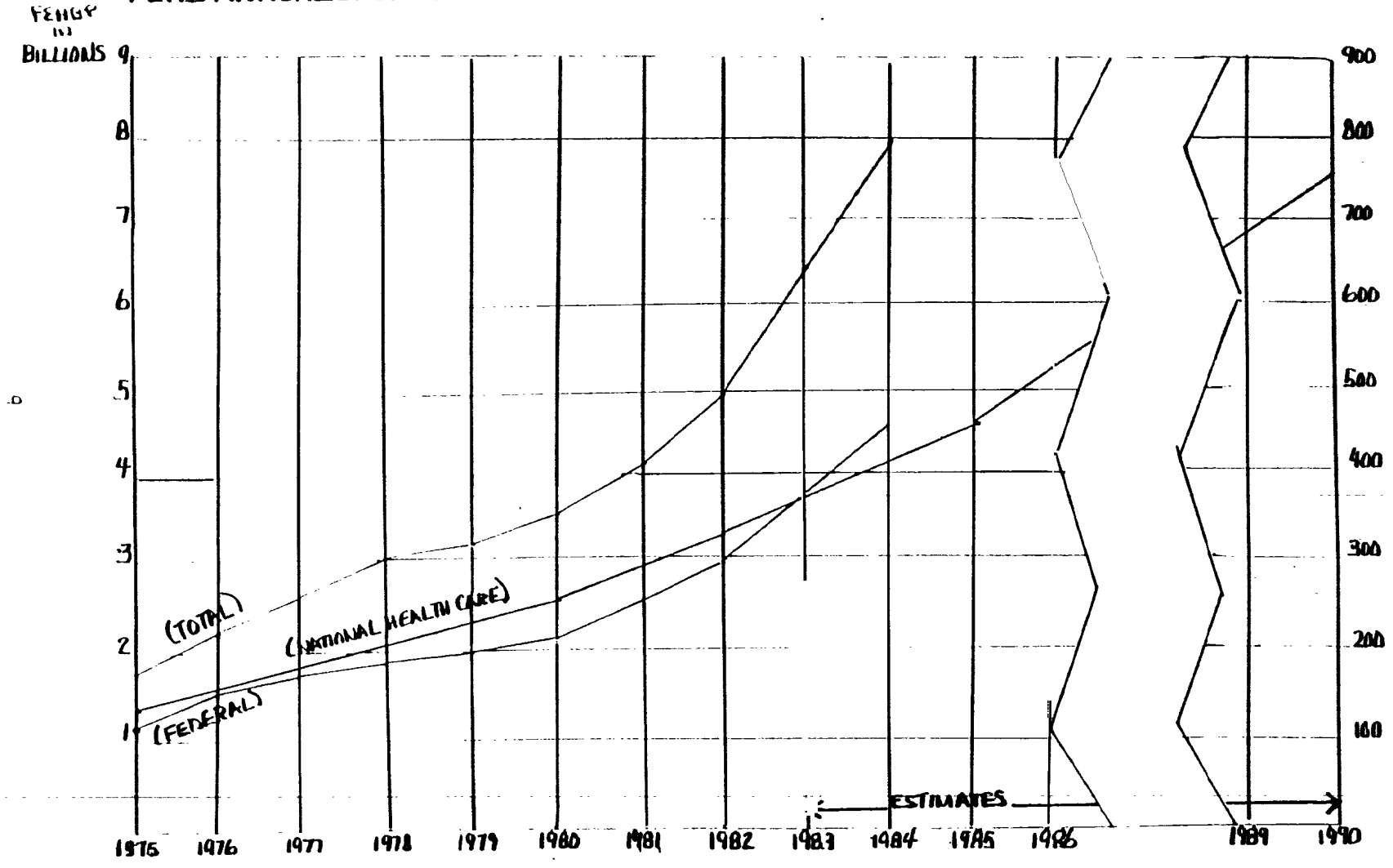
I would like to address one additional matter. S.2027 requires that every 2 years the Comptroller General review and report to the Congress on the activities carried out by utilization and peer review organizations created by the amendments. Under section 204 of the Legislative Reorganization Act of 1970, as amended, our Office is required to perform any reviews requested by committees of jurisdiction. We believe such an arrangement would be more mutually advantageous than a specific legislative requirement because it would allow us, through discussions with the committee, to focus our audit efforts on the matters of greatest concern to the committee. Accordingly, we recommend that the requirement for periodic Comptroller General reviews and reports on the activities of the utilization and peer review organizations be deleted from the bill.

That concludes my prepared statement Mr. Chairman. We would be glad to answer any questions you may have.

FEHB ANNUAL COSTS IN RELATION TO INCREASES IN NATIONAL HEALTH CARE EXPENDITURES



SOURCES: FEHB COSTS OBTAINED FROM U.S. GOVERNMENT ANNUAL BUDGET, FY 1977-1984
NATIONAL HEALTH CARE EXPENDITURES OBTAINED FROM HEALTH CARE FINANCING ADMINISTRATION

ATTACHMENT

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