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STATEMENT OF

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BEFORE THE

SUBCOMMITTEE ON COMPENSATION AND EMPLOYEE BENEFITS

HOUSE COMMITTEE ON POST OFFICE AND CIVIL SERVICE

ON THE

OFFICE OF PERSONNEL MANAGEMENT'S

COMPREHENSIVE MEDICAL PLANS NETWORK EXPERIMENT

Madam Chair and members of the Subcommittee, we are pleased to be here today to discuss our May 30, 1980 report to you on our review of the Office of Personnel Management's (OPM's) administration of the Blue Cross and Blue Shield Associations' (the Associations') Comprehensive Medical Plans Network experiment in the Federal Employees Health Benefits (FEHB) program. I would like at this time to submit a copy of the report for the record and summarize the report.

The Associations' Network experiment has been in operation since January 1979 and consists of 18 comprehensive medical plans sponsored by 14 Blue Cross/Blue Shield organizations. It was


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intended to provide new options for health benefits coverage to Federal employees and to relieve OPM of the administrative costs associated with contracting with a number of comprehensive plans. The Network provides uniform benefits at a uniform premium rate to over 4,000 Federal employees, annuitants, and their dependents. Based on the results of the experiment, OPM expects to determine if the network concept is a viable alternative for contracting for the delivery of health care for Federal employees. A consultant OPM hired to evaluate the Network experiment is expected to issue a final report in June 1980, after which OPM will decide whether to continue the Network.

## OPM DID NOT APPLY FEHB PROGRAM ENTRY REQUIREMENTS TO INDIVIDUAL PLANS ADMITTED TO THE ASSOCIATIONS' NETWORK

There is no specific reference in the FEHB Act to a "network" of comprehensive plans. OPM has not sought specific legislative guidance for conducting the Network experiment, but amended its Health Benefits Plans regulations to provide for admission of comprehensive plan networks into the FEHB program. OPM's network regulation requires each carrier offering a network to agree for itself and on behalf of each plan to comply with requirements of the FEHB Act and FEHB program regulations that OPM determines are applicable.

The FEHB Act defines comprehensive plans as group-practice prepayment plans (group plans) and individual-practice prepayment plans (individual-practice plans) and the act and OPM regulations provide admission requirements for each type.

A group plan must include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from prepaid funds (5 U.S.C. 8903(4)(A)). The group plan physicians practice in a common center. These requirements were intended to serve as a guarantee of physician commitment to prepaid group practice and to insure the availability of specialty care for plan subscribers.

OPM implements the legislation by requiring that the group plan applicants have the following (primary care) medical specialties represented: Obstetrics-Gynecology, Pediatrics, and Internal Medicine. OPM will permit Board-Certified Family Practice to be substituted for one of these specialties. OPM reviews an applicant's organizational and financial data to ascertain that the group's physician specialists receive 75 percent or more of their professional income from prepaid funds.

An individual-practice plan is described in the act as one that offers health services in whole or in substantial part on a prepaid basis by individual physicians. These physicians accept payments by the plan as full payment for covered services. To be approved for the FEHB program, the individual-practice plan must be offered by an organization that has successfully operated a similar plan in the past. This requirement is intended to give OPM assurance that the organization will be able to provide adequate health benefits and that it will continue to be financially viable.

Under the act either type of plan may be terminated by OPM if it never had 300 or more employee or annuitant enrollees

during the preceding two contract terms. OPM has selectively applied this requirement to terminate plans already in the FEHB program and has discouraged plans seeking admission that do not offer the potential to meet this enrollment minimum.

OPM failed to enforce certain basic statutory and other requirements of the FEHB program to permit new developing comprehensive plans to participate in the Network experiment. When it first began negotiations with the Associations for a network, OPM attempted to apply FEHB Act and other FEHB program admission requirements to individual comprehensive plans being proposed for the Network. In later negotiations, OPM determined that most individual plans being offered by the Associations could not meet these requirements. To facilitate a network offering, OPM program officials decided that certain statutory and program requirements, except for the three physician specialty requirement, would be applied to the Network rather than to its individual plans.

A 1978 OPM preliminary review of the 18 Network comprehensive plans indicated that 10 of them did not meet one or more of the requirements of the FEHB Act, FEHB program regulations, or OPM admission criteria. Although OPM's preliminary review did not identify the three physician specialty requirement as lacking in the Network's group plans, our review of applications furnished by Network plans to OPM at that time indicated two plans did not meet this requirement. Another requirement not met was for specialists

in a group plan to receive 75 percent or more of their professional income from prepaid funds.

OPM's decision not to apply certain statutory and FEHB program requirements to the individual plans within the Network could have resulted in the:

--Admission of some group plans that are obligated to refer patients at added costs to outside (primary care) specialists because they do not meet the three physician specialty requirement.

--Lack of commitment to cost containment objectives inherent in the requirements that a substantial portion of group plan physician specialist income be derived from prepaid practice.

--Avoidance of OPM experience and service capability requirements intended to assure that individual practice plans are financially stable and otherwise qualified to provide quality medical services to Federal employees.

--Avoidance of OPM minimum enrollment potential requirements intended to assure that local plans can provide services within reasonable cost limits.

OPM's General Counsel advised us that OPM does not assert that it has authority to waive statutory requirements or that it can waive requirements of its regulations except through appropriate procedures. She indicated that several requirements for comprehensive medical plans that are contained in the

statute are set forth in general terms without specific definitions. She further contends that the absence of express definitions in the statute indicates a legislative intent for implementation through interpretation by OPM, using its understanding of the congressional policy in the statute as its guide.

OPM's General Counsel said that changes in the structure and nomenclature of organizations involved in the delivery of health care require adaptation by OPM in interpreting the statutory terms in order to fully implement the statutory objective to make available to Federal employees a range of options for health benefits. Within this context, she believes that OPM has the authority to evolve its interpretation and modify standards to meet changing circumstances, as long as its interpretation remains consistent with the statute. She said that what appeared to be waivers of statutory requirements could more appropriately be characterized as modified interpretations of those statutory requirements which have no definitions set forth in the statute.

OPM's General Counsel also contends that the comprehensive plans' legislative requirements apply to the Network as a whole, rather than its individual components--the comprehensive plans participating in the Network. She stated that, therefore, it is inappropriate to refer to statutory requirements for the Network's individual components.

We agree with OPM's General Counsel that OPM has the

authority to evolve its interpretation and modify standards to meet changing circumstances, as long as its interpretation remains consistent with the law. We believe, however, that it is not proper or logical to apply the legislative requirements that group plans include three physician specialties and that physician specialists receive all or a substantial part of their income from prepaid funds to the Network as a whole rather than to each of the group plans participating in the Network.

The three physician specialty and physician specialists substantial prepaid income requirements lose all meaning under such an interpretation since the Network consists of both individual-and group-practice plans (these requirements are applicable only to the latter) in different locations throughout the country.

We believe that both requirements apply to each group plan in the Network, rather than the Network as a whole. Since OPM lacks the authority to waive these requirements, we believe that participation in the Network of plans that cannot individually meet these statutory requirements is unauthorized. In our May 30, 1980 report, we recommended that if the network concept is continued specific legislation be enacted detailing financial, admission, and administrative requirements to be applied to this unique health care delivery system.

## OPM NEEDS TO IMPROVE MONITORING OF NETWORK ADMINISTRATION

Placing primary responsibility for administering the Network on the Associations was intended to relieve OPM of many day-to-day administrative duties in dealing directly with the plans. However, OPM has not adequately monitored the Network's administration to insure that individual plans conform with Federal program requirements, and the Associations have not effectively monitored the 18 comprehensive plans comprising the Network. As a result, OPM was not aware that

--two of the Network's comprehensive plans expanded their service areas or added new service providers and

--two comprehensive plans in Maryland were operating in the Network without State certification.

Under the Network contract, OPM delegated principal responsibility to the Associations for Network operations, oversight, and technical advice. OPM would normally perform these or similar functions if it were dealing directly with a comprehensive plan in the FEHB program. The Associations' responsibilities include:

--Exercising Network management and oversight responsibility to assure the adequacy of Network contract performance.

--Maintaining effective two-way communication between OPM and the participating plans and reporting significant developments to OPM.

--Dispensing enrollment information and distributing premiums received appropriately among participating plans.

--Maintaining accurate records of Network enrollment, receipts, and disbursements.

OPM did not systematically monitor the administration of the Network contract, but relied upon the Associations for identification of any significant developments affecting the experiment or compliance with FEHB program requirements. OPM personnel responsible for the Network contract told us that they were completely out of touch with the Network's comprehensive plans. However, an Associations' official told us that their functions are directed more toward facilitating the member Blue Cross and Blue Shield sponsoring organizations' and comprehensive plans' relations with OPM, rather than acting as the Network administrator or overseer. He indicated that local member organizations would generally oversee the comprehensive plans and that the Associations would be alerted to possible problems by its built-in administrative devices. We found that these devices did not function effectively.

Network 1980 market expansion not coordinated with OPM

During the open season for 1980, two of the Network's comprehensive medical plans expanded their service area or added new medical centers or other service providers without

OPM approval. This contradicted an OPM policy decision to not permit any Network expansion during the first 2 years of experimentation.

The South County Health Plan amended the brochure by adding 41 ZIP codes to those already in its approved service area and by adding two other medical centers--one near the Baltimore city limits and the other in Annapolis. The net effect was to increase the plans' service area from rural Calvert County and the rural, southern third of Anne Arundel County (about 2,500 Federal employees) northward to the edge of the Baltimore city limits, taking in all of Anne Arundel County, including Annapolis (about 14,000 Federal employees).

The HMO of Minnesota distributed an expanded list of health service providers to Federal personnel offices and employees along with a memorandum telling them to disregard the list in OPM's Network brochure. Although this did not increase the plan's service area, it did provide increased access to the plan and enhanced its potential marketability.

OPM became aware of these two comprehensive plans' unauthorized marketing efforts only when Federal employees and personnel offices called for confirmation that the brochure should be disregarded. OPM officials advised the employees and personnel offices that the brochure was correct and that any additional information put out by the two plans was

unauthorized. The Network contract requires the Associations to maintain an effective system of two-way communication between OPM and the plans. The Associations were unaware of the two situations until OPM mentioned them, but agreed to investigate the two cases.

As of April 1980, the Associations were reviewing enrollment data from the plans' open season for 1980 and had notified 60 enrollees in the South County plan and 67 enrollees in the HMO of Minnesota plan that they would have to select other providers through the FEHB program.

Associations did not alert OPM to comprehensive plans' certification problems

Although network regulations require the network carrier to certify to OPM that each plan in the network is "legally operational," two plans in Maryland had not complied with that State's certification requirements for HMOs and, according to a State official, had been operating without a State certificate of authority since the Network began operations. According to an OPM official, a plan is not considered legally operational unless it is in compliance with State requirements. However, OPM did not receive any indication of the State certification problems of the two Maryland plans from the Associations.

Not until December 1979 did OPM find out inadvertently that two of the Network's comprehensive plans in Maryland might be closed by the State because they had not yet received a

State certificate of authority. This information was received from another comprehensive plan in Maryland. Subsequently, OPM contacted a State official in Maryland and was told that the Insurance Commissioner had advised the Greater Dundalk and East Baltimore Medical plans around November 1979 that each plan must be certified within 60 days to operate legally in Maryland or face State actions that would result in closing them. OPM was also advised that substantial debts had placed the East Baltimore plan in bad financial shape and that the State had to terminate site audits four times because the plan's books were not in order. It was especially important that the East Baltimore plan be certified in order that it retain its Medicaid contract, which represented most of the plan's business.

In mid-December 1979, OPM again contacted the State's Insurance Division and was told that the East Baltimore plan's deadline for obtaining a certificate of authority had been deferred because it had applied for a certificate. In April 1980 a State official told us that concerns about the plan's financial stability had lessened since the plan's obligation on an $800,000 debt was deferred until 1983 by the creditor. The State official later told us that the East Baltimore plan was certified on June 6, 1980.

Also in mid-December 1979, an official from the State's Insurance Division advised OPM that the Greater Dundalk plan had neither responded to the Insurance Commissioner's November 1979 letter nor pursued State certification. OPM learned, however, that Blue Cross of Maryland had negotiated an agreement with the Insurance Commissioner to allow the Greater Dundalk plan to continue operating for a few months until Blue Cross could form a wholly owned subsidiary to be called the Free State Health plan to run its prepaid operations.

The Associations' 1981 Network proposal sent to OPM on March 28, 1980, states that Blue Cross of Maryland expects to have Free State operational by July 1, 1980. However, on May 5, 1980, an official of Maryland's Insurance Division told us that Blue Cross of Maryland had not submitted a complete application for Free State; therefore, the State has not begun the lengthy review, inspection, and audit process upon which the issuance of a certificate of authority to Free State is contingent. The official said that it was unlikely that Free State will be certified by July 1. Because of this, Greater Dundalk officials advised us that they submitted application material to Maryland on May 7, 1980, in order to pursue certification. As of June 11, 1980, Greater Dundalk was still not certified and Free State's application was still incomplete.

OPM personnel responsible for administering the Network contract were unaware of the incomplete certification application for Free State or of the renewed threat by the State to close down the Network's Greater Dundalk plan until we told them on April 24, 1980. OPM had not received any indication of the continuing certification problems from the Associations.

## UNIFORM PREMIUM RATE UNFAIR TO LOW-COST PLANS AND THEIR ENROLLEES

The uniform Network premium rate has resulted in marketing problems for low-cost Network plans, subsidization of high-cost Network plans, and an expressed desire by some plans to disengage from the Network and apply for individual FEHB participation. Because the uniform rate is inconsistent with the community-rating concept, Network enrollees in low-cost areas pay higher premiums than they would if plans had been offered directly through the FEHB program.

The Associations opposed the uniform rate because it would limit the number of plans willing to participate in the Network and the number of enrollees willing to subscribe. However, OPM considered the uniform rate essential for ease of program administration and insisted on its use.

The Associations' uniform Network rates were developed by calculating the weighted average of the respective single and family rates of the 18 participating plans based on expected

enrollment and adding a fixed percentage for administrative and other costs. The uniform rates are the basis used by OPM to reimburse the Associations, who in turn reimburse plans based on their individual rates developed for the Network benefit package. We did not determine the total subsidy occurring in the Network, but found that 12 of the 18 Network plans submitted biweekly family plan rates that were less than the Network biweekly family plan rate of $55.73 during 1979. These rates ranged from $1.39 to $15.94 less than the Network rate. The rates submitted for the other six plans ranged from $0.44 to $5.88 more than the Network rate.

The 1978 Group Health study included an analysis of the potential for network subsidy. The study found that applying a uniform rate to 31 prepaid group practice plans offered in 1976 under the FEHB program would have resulted in about $8.9 million in premium revenues being reallocated from plans whose actual 1976 premiums were lower than the uniform rate to plans whose actual 1976 premiums were higher than the uniform rate. In effect, the low-cost plans would subsidize the high-cost plans. The study also found that the concept of uniform rates was opposed by most comprehensive plans and was not considered important or desirable by most knowledgeable employers with the exception of OPM.

Network enrollees and potential enrollees are also affected by the uniform rate in that it contradicts the community-rating concept and results in Federal employees and plans' other participants being treated unequally. A community-rated group practice prepayment plan establishes a community premium rate that reflects costs and other characteristics unique to its members and the geographic area in which it operates.

Imposing the Network rate, however, prevents Federal employees enrolled in a Network plan from paying a rate based on the community rate of the group practice plan in which they enroll. Family plan enrollees in six of the Network's nine community-rated group practice plans paid more than the community rate of the plan in which they enrolled. Enrollees in the other three plans paid less than the community rate.

Representatives of eight Network plans in low-cost areas told us that their marketing efforts to enroll Federal employees were adversely affected by the uniform rate. They believed that, had they been afforded the opportunity to charge a premium rate for the same health benefit package that they could charge if they were recognized as a separate plan in the FEHB program, they would have increased enrollment and been more competitive in their area. The two lowest cost plans indicated that, if the uniform rate is continued, they would like to drop out of the Network and apply for individual participation in the FEHB program. A representative of another plan told

us that they would prefer to apply on their own and not be part of the Network, citing differences with OPM over the uniform rate and expansion of the plan's service area.

Although the marketing efforts of Network plans from high-cost areas would appear to benefit from the uniform rate, none of these plans cited the uniform rate as an advantage of being in the Network.

In our May 30 report we recommended that, pending congressional action, the Director of OPM

--improve monitoring to insure that FEHB program requirements are applied to all comprehensive plans in networks,

--develop an alternative to the present uniform rate system that is more closely tied to prevailing local costs in individual plans' service areas,

--terminate from the Network plans that do not individually qualify for admission to the FEHB program, and

--arrange for the orderly transfer of enrollees in terminated plans to other FEHB program plans.

Madam Chair this concludes my statement. We will be happy to answer any questions you or other members of the Subcommittee may have. . .