COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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B-164031(5)

May 30, 1980

The Honorable Gladys Spellman
Chairwoman, Subcommittee on
Compensation and Employee Benefits
Committee on Post Office and
Civil Service
House of Representatives

Dear Madam Chairwoman:

Subject: Office of Personnel Management's Comprehensive Medical Plans Network Experiment (HRD-80-89)

At the request of your office, we have reviewed the Office of Personnel Management's (OPM's) administration of the Blue Cross and Blue Shield Comprehensive Medical Plans Network experiment in the Federal Employees Health Benefits (FEHB) program. The Network has been operated by the Blue Cross and Blue Shield Associations (the Associations) since January 1979. It was intended to provide new options for health benefits coverage to Federal employees and to relieve OPM of administrative costs associated with contracting with a number of comprehensive plans. The results of our review are detailed in enclosure I.

The Network provides uniform benefits at a uniform premium rate to over 4,000 Federal employees, annuitants, and their dependents through 18 comprehensive medical plans. 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.

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 has amended its Health Benefits Plans regulations to provide for admission of comprehensive plan networks into the FEHB program. OPM's network regulation requires each

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carrier 1/ 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.

We believe that 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 indicated that two plans did not meet the requirement. The requirements that were not met include the need for a group plan (see enc. I, p. 7) to have physicians representing at least three major medical specialties and for the specialists to receive 75 percent or more of their professional income from prepaid funds.

OPM's General Counsel advised us in January 1980 that these actions were not "waivers" of statutory or regulatory requirements but only OPM's interpretation of undefined legal requirements for comprehensive plans networks.

1/A nongovernmental organization lawfully engaged in providing, paying for, or reimbursing the cost of medical services under group insurance policies or contracts.

OPM's General Counsel further advised us that the legislative requirements for comprehensive plans apply to the Network as a whole rather than the individual participating comprehensive plans. We believe that this interpretation is not proper or logical for either the three physician specialty or the physician specialists substantial prepaid income requirements. In our opinion, participation in the Network by plans that do not individually meet FEHB program statutory requirements is unauthorized, and OPM's failure to apply other plan admission requirements permitted otherwise unqualified plans to participate in the program. The network concept was unknown at the time FEHB legislation was enacted. If it is continued, we believe that the Congress should provide specific legislation detailing financial, admission, and administrative requirements for networks.

OPM did not adequately monitor the Associations' administration of the Network to ensure that individual plans conform with FEHB program requirements. Although the Network contract places primary responsibility for administration of the Network on the Associations and their local plans, the Associations have not effectively monitored comprehensive plans comprising the Network.

During the open season for 1980, one Network plan in Maryland and one in Minnesota expanded service areas or added new medical centers or other service providers after OPM had told the Associations that such expansion would not be permitted. At OPM's direction, the Associations were reviewing enrollment data from these plans and, as of April 1980, had advised 127 Federal enrollees that they would have to select other providers through the FEHB program.

The Associations did not advise OPM that two Network plans in Maryland did not have State certificates of authority required by Maryland to legally operate and thus were not eligible under Federal regulations to participate in the Network. In December 1979, OPM learned about the State certification problems and began inquiring into the situation. As of May 1980, neither plan was certified to operate in Maryland. (See enc. I, p. 19.)

The uniform 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 individually for the FEHB program. Because the uniform premium rate is inconsistent with the community-rating concept (see enc. I, p. 20), Network enrollees in low-cost areas pay higher premiums than they would if the plans had been offered individually through the FEHB program.

This report and the results of the consultant's study should give both OPM and the Congress a basis for determining whether the Network should continue and whether the network concept is a viable alternative for financing health benefits for Federal employees.

RECOMMENDATION TO THE CONGRESS

The Congress should decide whether continuation of a comprehensive medical plans network is appropriate. If it is determined that continuation is appropriate, we recommend that specific legislation be enacted detailing financial, admission, and administrative requirements to be applied to this unique health-care delivery system.

RECOMMENDATIONS TO OPM

We recommend 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.

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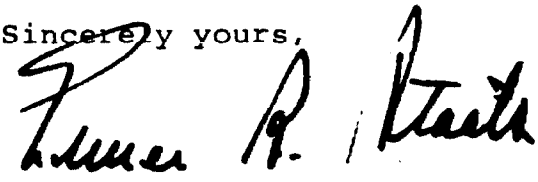
As requested by your office, we have not obtained written comments on this report. We are sending copies of this report to the Chairmen of the Senate Committees on Appropriations and Governmental Affairs and the House Committees on Appropriations and Government Operations. We are also sending copies to the Directors of OPM and the Office of Management and Budget.

Sincerely yours,



Comptroller General
of the United States

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ABBREVIATIONS

FEHB	Federal Employees Health Benefits
HHS	Department of Health and Human Services
HMO	health maintenance organization
OPM	Office of Personnel Management

ENCLOSURE I

OFFICE OF PERSONNEL MANAGEMENT'S COMPREHENSIVE MEDICAL PLANS EXPERIMENTAL NETWORK

INTRODUCTION

In August 1979, the office of the Chairwoman, Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service, requested that we examine the Office of Personnel Management's (OPM's) offering in the Federal Employees Health Benefits (FEHB) program of a Blue Cross and Blue Shield Comprehensive Medical Plans Network. In November 1979, we agreed to focus our review on the administration of the Network, not on the viability of the network concept. The Network consists of 18 prepaid comprehensive plans sponsored and administered jointly through the Blue Cross and Blue Shield Associations (the Associations).

We examined documents and interviewed persons involved with the Network from OPM headquarters in Washington, D.C.; the Associations' Network headquarters in Chicago, Illinois; and the 18 participating Network plans. We also examined OPM's consultant contract to evaluate the Network experiment. We assessed plan adherence to the requirements of the FEHB law and regulations applicable to participation of comprehensive medical plans in the FEHB program.

BACKGROUND

The FEHB program, established by the Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901 et seq.), provides health insurance coverage for Government employees, annuitants, and their dependents. With the passage of the Civil Service

Reform Act of 1978, the authority for administering the FEHB program, previously held by the Civil Service Commission, was conferred upon OPM. 1/

During 1978, the program covered about 10 million persons. Coverage through the FEHB program is provided by the following types of health benefits plans:

--Government-wide Plans: Composed of two plans open to all Government employees and annuitants which provide benefits through direct payments to doctors and hospitals or by cash reimbursements to enrollees. These plans covered about 2.4 million enrollees and about 4.3 million dependents and paid benefits estimated at $2.1 billion in 1979.

--Employee Organization Plans: Composed of 12 health benefits plans sponsored by employee organizations with enrollment open only to Government employees who are members of the sponsoring organizations. These plans provide benefits by cash reimbursement to enrollees or directly to doctors or hospitals. In 1979 these plans covered about 807,000 enrollees and about 1.7 million dependents and paid benefits estimated at $776.3 million.

--Comprehensive Prepayment Plans: In 1980 there are 85 comprehensive plans individually contracting with OPM and the Associations' Network composed of 18 comprehensive plans. Each comprehensive plan is available only to Federal employees living in the geographic area served by the plan. These plans provide comprehensive (1) medical services by physicians and technicians

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1/The Civil Service Reform Act of 1978 (Public Law 95-454, Oct. 13, 1978) and Reorganization Plan No. 2, both effective in January 1979, divided Civil Service Commission functions between OPM and the Merit Systems Protection Board. Although the Commission was responsible for the FEHB program throughout much of the period covered in our review, we shall refer throughout this report to OPM. Under the Commission, the FEHB program was the responsibility of the Bureau of Retirement, Insurance, and Occupational Health; under OPM, the program is the responsibility of the Associate Director/ Compensation.

practicing in common medical centers or (2) benefits in the form of direct payments to physicians with whom the plans have agreements. The plans also provide hospital benefits. In 1979, the 74 plans in the program covered about 335,000 enrollees and about 532,000 dependents and received premium payments of about $305.5 million. The Network included over 4,000 enrollees and their dependents.

All FEHB program plans offer self-only and self-and-family coverage. The Government contribution 1/ to the health insurance premium charge is based on 60 percent of the average of the premium charges for the highest level of benefits offered by six representative plans with the largest enrollments. No more than 75 percent of the premium for any one plan can be paid by the Government under the FEHB Act (5 U.S.C. 8906).

Growth and administration of the comprehensive plans

Since 1960, OPM has contracted with comprehensive medical plans to provide health benefits and hospitalization coverage to the plans' members on a prepaid basis through the FEHB program. The number of comprehensive plans has grown from 24 in 1972 to 86 in 1980 largely as the result of the enactment of the Health Maintenance Organization Act of 1973 (42 U.S.C. 300e), which authorized a program through the Department of Health and Human Services (HHS) 2/ to actively assist in the development of new prepaid comprehensive medical plans and the expansion of existing ones. As new plans were developed through the HHS program, many sought OPM's approval for entry into the FEHB program to gain access to Federal employees residing in the plans' respective service areas.

OPM, through its Comprehensive Plans Division and its Office of Audits, is responsible for overseeing the Government's contracts with the comprehensive plans. The Division's

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1/The Postal Service, under an agreement negotiated with its employees, pays a higher percentage of health benefits payments than do Government agencies.

2/On May 4, 1980, a separate Department of Education was created. The part of the Department of Health, Education, and Welfare responsible for the activities discussed in this report became the Department of Health and Human Services.

responsibilities include (1) the formal review and recommendations to top OPM officials on the acceptability of comprehensive plan carriers 1/ applying for FEHB program participation, (2) the negotiation each year of benefits, rates, and contract and brochure provisions with each comprehensive plan carrier, and (3) various administrative responsibilities.

Interest in comprehensive plan network

Beginning in 1972, the Associations conducted informal discussions with OPM officials about developing a network of comprehensive plans. The network would have nationally uniform benefits and premiums, would use the same brochure for all its plans, and would operate in the FEHB program under a single master contract with one carrier. The network concept was attractive to OPM because it offered a potential for (1) easing the burden of administering individual contracts with the growing number of comprehensive plans and (2) helping new and developing plans to gain access to the FEHB program.

In December 1974, OPM published a proposed change in the FEHB program regulations to establish rules and procedures for approval of comprehensive plan networks. In response to the proposed regulations, OPM received negative comments from organizations that directly represented, or were associated with, over 90 percent of the existing comprehensive plans in the country. Some of the criticism focused on OPM's proposed uniform network rate because it would contradict the principle of community rating (see p. 20) and result in Federal employees being treated unequally. For example, the uniform network rate would inflate the premium to Federal enrollees in network plans whose local premium rates would ordinarily fall below that of the uniform network rate.

OPM modified many of the proposed requirements but retained the uniform rate in its final network regulations published in April 1975. The appeal of the network approach to OPM was firmly rooted in uniformity for ease of FEHB program administration--a single rate and benefit package for all plans in a network, and a single point of contact with a network's carrier.

1/A nongovernmental organization lawfully engaged in providing, paying for, or reimbursing the cost of medical services under group insurance policies or contracts.

The Associations and the American Association of Foundations for Medical Care (the Foundations), a California-based carrier, were the only applicants for networks under OPM network regulations. Applications from the prospective network carriers were rejected by OPM during 1975 and 1976. Eventually, the Foundations and the Associations submitted proposals for a network that were accepted by OPM for entry into the FEHB program in January 1978 and 1979, respectively. The Foundations withdrew their network from the FEHB program as of December 31, 1979. The Associations' Network, which is still operational, is discussed in the remainder of this report.

Group Health Foundation study of network concept

As OPM was approving and moving ahead in negotiations with the Associations for a Comprehensive Medical Plans Network contract to begin in January 1979, the Group Health Foundation (Group Health) was conducting a comprehensive study (under contract with HHS) to determine the desirability and feasibility of establishing a single network of prepaid comprehensive plans (health maintenance organizations (HMOs)). The study focused primarily on the value of the network approach to large multisite national employers in the private sector, and addressed several aspects common to the FEHB program's network--a single network offering uniform benefits and premiums and one administrative point of contact.

The December 1978 study report found the network concept to be of questionable value, noting that:

--The effect of a uniform network rate would be to increase employee contributions in low-cost plans and decrease them in more expensive plans.

--In low-cost areas of the country where traditional health insurance coverage is relatively inexpensive, prepaid comprehensive plans may be priced out of the market by the uniform rate requirement.

--The use of a centralized network administrator could result in duplication and not substitution of most administrative functions.

An OPM official advised us that preliminary study results had been furnished in September 1978 for OPM to consider before finalizing arrangements for the Associations' Network.

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

We believe that 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 indicated that two plans did not meet the requirement. The requirements that were not met include the need for a group plan to have physicians representing at least three major medical specialties and for the specialists to receive 75 percent or more of their professional income from prepaid funds. In our opinion, participation in the Network by plans that do not individually meet FEHB statutory requirements is unauthorized, and OPM's failure to apply other plan admission requirements permitted otherwise unqualified plans to participate in the program.

FEHB Act requirements and regulations

There is no specific reference in the FEHB Act to a "network" of comprehensive plans. OPM has not sought specific

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legislative authority for conducting the Network experiment, but has 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 the 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.

An individual-practice plan 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's implementation of the program is discussed below.

Three physician specialty and income requirements for group plans

OPM reviews physician lists submitted by group applicants to ensure that the group has physicians representing at least

three major (primary care) medical specialties. As a minimum, OPM prefers that the group applicant have the following 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.

Sufficient availability of providers and successful operation requirements for individual-practice plans

OPM reviews individual-practice plans' applications to determine that enough physicians and specialists are readily available to provide services and that subscribers have a reasonable choice of physicians. Consideration is given to (1) how large the plan's service area is, (2) whether the area is rural or urban, (3) how many contracts the plan has with area physicians and what the physicians' specialties are, (4) how many new patients the physician will accept, (5) whether services are currently provided in whole or substantial part on a prepaid basis, (6) whether participating physicians have agreed not to seek payment for covered services beyond that provided by the plan, and (7) whether the plan offers a complete range of hospital, ambulatory, and preventive care and certain other services.

OPM also reviews (1) an individual-practice plan's enrollment statistics, financial documents, time in operation, and break-even projections to determine whether its past operations have been successful and (2) its marketing materials.

Minimum enrollment requirement for comprehensive plans

OPM program officials interpret the clause in the FEHB Act authorizing termination of plans having fewer than 300 enrollees to mean that an approved plan must have at least 300 enrollees. OPM's experience with comprehensive plans has shown that an average of about 10 percent of the Federal employees within a given service area will enroll in a comprehensive plan. Accordingly, OPM has advised potential applicants which, in its opinion, do not have the potential to attract 300 enrollees that it applies the 300-enrollee criterion in reviewing applications from new plans, and thus has discouraged those plans from applying. OPM may also

review enrollment levels of plans participating in the FEHB program and reject their applications for continuation if they have not met the 300-enrollee requirement.

Application of OPM regulations to Associations' Network

OPM's decision to not 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 rejected the Associations' requests to establish a network during 1975 and early 1976 because the first proposal contained too few plans to justify the cost of making the proposal operational and the second proposal did not satisfy numerous requirements of FEHB program regulations. OPM records show that the Associations acknowledged that they could not offer an acceptable network of comprehensive plans under the existing FEHB program regulations and requirements.

In October 1976, representatives of OPM and the Associations met to discuss, among other things, the Associations' suggestions for certain changes in OPM's interpretation of the network regulations. The Associations sought to have OPM change its interpretation of the network regulations to permit the certification of new and developing health plans that would not otherwise qualify for FEHB program admission. A key issue was the relaxation of the statutory requirements for physician

specialists prepaid income in group plans. The Associations stated that they could assemble a network of 20 to 30 plans if OPM relaxed its standards for qualification of component plans.

In February 1977, in partial response to this request, OPM advised the Associations that it would relax its past successful experience requirements for approving new, developing plans to permit such plans to participate in a network when the network carrier meets the qualifications set forth in the network regulations. OPM's rationale for its decision was that the relaxation of experience requirements would permit OPM to substitute the network carrier's experience, administrative ability, and financial resources for that of a network's component plans. OPM also believed that it would be serving the stated Federal policy of encouraging the growth and development of prepaid comprehensive medical plans and enable new and developing health plans to offer their services to Federal employees earlier than would otherwise be possible.

OPM also advised the Associations that, although it had not changed its longstanding policy on the question of prepaid income requirements for group plan physician specialists, it was going to review the policy.

In March 1977, the Associations proposed a network of 22 plans, 8 of which were already participants in the FEHB program. However, these eight plans were dropped from the proposal at OPM's insistence because the Network's uniform rate would have either (1) significantly inflated the rates paid by employees in low-cost plans, thus conflicting with OPM's efforts to hold down rate increases, or (2) resulted in an unwarranted subsidy for high-cost plans. The Associations added eight new plans to their proposal. However, two of the new plans and two of the plans remaining from the original proposal were later dropped, leaving 18 plans in the Network.

OPM had several discussions with HHS staff about the general concept of a network and the possible consequences of adopting the Associations' proposal. OPM was told that, should it approve the Associations' application, HHS would support such a decision if it were done on the basis of a pilot project or test and OPM was not placing itself or the Government in the position of later "grandfathering" in the participating plans when overall HMO policies and regulations were developed by HHS and put in place.

In March 1978, OPM granted tentative approval to the Associations' network application for FEHB program participation beginning in January 1979. The Associations' Network included 12 group plans and 6 individual-practice plans sponsored by 14 Blue Cross/Blue Shield organizations. Characteristics of the plans are summarized in enclosure II.

In May 1978, key OPM and Associations officials met to discuss the conditions of OPM's tentative approval. According to a memorandum prepared by the chief of OPM's Comprehensive Plans Division, OPM and the Associations agreed that:

> "In general, the minimum enrollment requirement for local plans is waived, the professional [prepaid] income requirements for group practice plans is waived, the past successful experience requirement for * * * [individual-practice plans] is waived; the length of time operational is waived * * *."

The Division chief told us that only the three physician specialty requirement for group plans was to be applied to the Network's plans.

An OPM official made a preliminary review of the network application and the information submitted on the 18 comprehensive medical plans ultimately admitted to the FEHB program. OPM identified nine group plans that could not meet the physician specialist prepaid income requirement for FEHB program participation. Three of the nine were determined to not be financially viable because they could not meet the FEHB program's standards for financial stability. A 10th group plan was questioned because of its weak financial condition. Although the applications for two of the Network group plans indicate that they did not meet the three physician specialty requirement, OPM did not cite this in its preliminary review.

The preliminary review did not consider the individual plans' enrollment potential. OPM's experience with comprehensive plans has shown that about 10 percent of the Federal employees within a given service area will generally enroll in a comprehensive plan. Upon applying OPM's criteria to the Federal population for each of the 16 plans for which data were available on the number of Federal employees in the service area, we found that 7 do not appear to have the potential to enroll 300 members. Representatives of the other two Network plans told us they do not know how many Federal employees

live in their service areas. In contrast to the treatment accorded Network plans, in July 1978 OPM rejected a plan seeking direct admission to the FEHB program on the basis of low enrollment potential, stating that:

> "In enacting the FEHB legislation, Congress intended to assure that maximum health benefits are provided at the lowest possible cost to employees and annuitants, and to the Government. Comprehensive plans with low enrollment potential do not serve the purpose of the FEHB Program as intended by Congress."

OPM's interpretation of legislative authority

In reply to an inquiry from our Office of General Counsel, OPM's General Counsel advised us that OPM does not assert that OPM has authority to waive statutory requirements or that it can waive requirements of its regulations except through appropriate procedures. OPM's General Counsel said that the files her office reviewed "do not demonstrate the existence of attempted 'waivers' of statutory or regulatory requirements by OPM * * *."

OPM's General Counsel indicated that several requirements for comprehensive medical plans that are contained in 5 U.S.C. 8903 are set forth in general terms without specific definitions. She cited as an example that, in a group-practice prepayment plan, the required physician-specialists must receive "all or a substantial part of their professional income from prepaid funds" (5 U.S.C. 8903(4)(A)). She indicated that the term "substantial part" is not defined.

OPM's General Counsel contends that the absence of express definitions in the statute for such terms indicates a legislative intent for implementation through interpretation by OPM, using its understanding of the congressional policy in the statute as its guide. She 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.

We believe that these requirements are specifically made applicable to the individual group plans in the statute, which provides as follows:

> "GROUP-PRACTICE PREPAYMENT PLANS-- * * * The group shall include physicians representing at least three major medical specialties who receive all or a substantial part of their professional income from the prepaid funds."

While the Network contains a number of such group plans, it is not in itself such a group. Moreover, in 1959, when the FEHB program was established, only a few prepaid comprehensive health benefit plans existed and the concept of a comprehensive medical plan network was unknown. We, therefore, believe that the Congress contemplated that OPM would contract for or approve individual group plans, each of which would be required to meet the act's specific requirements. The statutory requirements have not been changed since 1959.

In our opinion, it is illogical to view the Network as the entity to which such requirements should be applied. 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.

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 18 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.

In the benefit negotiations for 1980, several of the Network's comprehensive medical plans requested through the Associations that the benefit brochure be changed and that they be permitted to expand their service areas and/or increase the number of service providers by adding medical centers or physician groups. The chief of OPM's Comprehensive Plans Division advised the chief of the Insurance Operations Branch that:

"The Network represents a wide variety of carriers which differ greatly in organization, operations, finances etc. Only one carrier in the organization is a qualified HMO. Our ability to handle questions such as these raised by the Associations for the 1980 contract year is impaired by the

fact that the trade Associations, for all intents and purposes, administers these plans on behalf of the OPM. As a result, we have little knowledge and information about the carriers, i.e. mode of operation, capability to deliver services or appropriateness or inappropriateness of the carriers in general on the basis of our usual criteria. Several of the carriers would not meet requirements independent of the [Blue Cross/Blue Shield] trade Associations and a few were previously denied by the Commission.

"There are * * * [three] * * * points which should be considered with regard to the changes the Blues have requested.

"1. If the Network is an experiment, any changes during the experimental period represent additional and perhaps significant variables to measuring results.

"2. The Network contract represents a sharp departure from basic agency policy and the treatment of other comprehensive health carriers and HMO's. The differences in treatment (in terms of fairness and equity) are now becoming known to other carriers in the FEHBP who are making verbal complaints.

"3. Recent studies of large employers have shown networks to be of questionable value and possibly disadvantageous to employers in a number of ways. Allowing change now may be viewed as encouraging the expansion of the Network in the face of lack of evidence of its value to the Government."

In July 1979, OPM made clear to the Associations that it would not, during the Network's 2-year experimental period, permit such changes. Although the Associations were responsible for ensuring that OPM's decision was adhered to by the Network's comprehensive medical plans, two Network plans--the South County Health Plan (Maryland) and the Health Maintenance Organization of Minnesota--issued supplemental materials in November and December 1979 indicating that OPM's Network brochure was incorrect and should be disregarded.

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 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. According to OPM staff responsible for monitoring the contract, these situations might not have occurred if the two plans had individual contracts with OPM because such plans know they are required to submit all supplemental marketing materials intended for distribution to Federal employees for advance OPM approval.

In January 1980, OPM emphasized to the Associations that, as the Network administrator, they were responsible for relaying OPM's policy decision on changes in the Network's comprehensive medical plans to the individual plans to ensure that the policy was followed. OPM directed the Associations to identify enrollees admitted to Network plans who do not live in the approved service area or who selected medical care providers that had not been approved by OPM, and to arrange for such enrollees to obtain services from approved FEHB plans.

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 have not complied with that State's certification requirements for HMOs and, according to a State official, have 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 either the Associations or Blue Cross of Maryland.

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 whose application for 1980 admittance to the FEHB program had been disapproved.

In contacting the Insurance Division of the Maryland Department of Licensing and Regulation, OPM indicated that it was told on December 5, 1979, 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 further 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. State

certification, however, was to be contingent upon the results of the State's audit. The State began an audit at the plan around April 11, 1980, targeted for completion at the end of April. A State official told us that, because previous concerns about the plan's financial stability were lessened after the plan's obligation on an $800,000 debt was deferred for 5 years by the creditor, the plan will likely be certified.

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. Free State, if successful in getting a State certificate of authority as an HMO providing prepaid care, would then take over East Baltimore's and Greater Dundalk's prepaid subscribers and contract with them for medical services.

On March 31, 1980, the Maryland Insurance Commissioner ordered Greater Dundalk to a hearing scheduled for April 11, 1980, to show cause why its operations as an HMO should not be terminated. 1/ According to an official from the Insurance Division, the show-cause notice was issued because the Greater Dundalk plan had indicated that it would not pursue State certification as an HMO, but planned instead to be a provider group under the Free State plan. At the time the notice was sent, no application had been filed for the Free State plan. He said that, as long as Free State was also not certified, the Greater Dundalk plan was operating illegally.

On April 9, 1980, 9 days after the show-cause notice was sent, Blue Cross of Maryland submitted an incomplete application to the State seeking certification of its proposed Free State plan.

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

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1/Greater Dundalk was later granted a 30-day extension, and the hearing is now planned for May 1980.

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.

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 either the Associations or Blue Cross of Maryland.

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 1/ 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 (see p. 5) 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 stated:

> "* * * based on the interview and survey responses, the concept of uniform rates is opposed by most HMOs and is not considered important or desirable by most knowledgeable purchasers, with the exception of the Civil Service Commission [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.

1/We adjusted the rates submitted by the individual plans to include the fixed percentage for administrative and other costs to reflect what would have been added had they been approved for admission to the FEHB program individually.

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 one of the low-cost Network plans that OPM's preliminary review indicated might have qualified for individual admission to the FEHB program, an enrollee for family plan coverage would have paid $12.27 rather than the network rate of $28.21 per pay period, thereby saving $414.44 during 1979. By contrast, if the plan that had submitted the highest premium rate had been available as a non-Network plan in the FEHB program, an enrollee for family plan coverage would have paid an additional $5.88 per pay period, or a total of $152.88 more during 1979. The Government's share of the total premium charge would not have been affected in either case. A plan official advised us that, because of the uniform rate, as of June 30, 1979, the low-cost plan cited above had attracted only 7 family plan enrollees in an area with about 3,000 Federal employees.

The cost to employees fosters competition among plans in the FEHB program. In the above example, the low-cost plan's chances of enrolling a greater number of persons would have been enhanced if potential enrollees had been offered family plan coverage at a biweekly premium rate of $12.27, rather than $28.21. In addition, this comprehensive plan could have provided more competition to the other FEHB program plans available to employees residing in its service area.

ENCLOSURE I

EVALUATION OF THE NETWORK
BY OPM'S CONSULTANT

On February 11, 1980, OPM contracted with the firm of Coopers and Lybrand to evaluate the Network and develop information to be used in deciding whether it should be continued. During the preceding year, OPM and the Associations had not implemented any special monitoring and reporting systems for evaluating the experiment. The chief of OPM's Comprehensive Plans Division advised us that the Network contract had been administered like any other comprehensive plan contract, except that OPM had not had any direct contact with the Network's comprehensive plans and had dealt only with the Associations.

The Network experiment was to provide OPM with information for evaluating (1) the ability of a network to increase both the availability of and participation in comprehensive plans by Federal employees and their families, (2) the effectiveness of a network in ensuring the quality of care provided and in controlling its cost, and (3) the benefits a network offers a large employer, such as the Federal Government.

The consultant's evaluation of the Network experiment is to include determinations of:

--The Network's actual and potential contribution to expanding the availability of comprehensive medical plans to Federal employees and annuitants, including the reasons for the current level of enrollment.

--The Network's contribution to ensuring a high quality of medical care and service.

--The effects of uniform enrollment rates (rate averaging) on incentives for plans to contain costs and use resources efficiently and the relationship of the uniform rates to HHS community-rating requirements.

--How many of the 18 plans could qualify on their own.

--Whether any differences between Network and non-Network criteria for eligibility of a plan to participate in the FEHB program affect the quality of the program.

--The effects of the Network arrangement on the administrative costs of OPM, the Associations, and the participating plans, compared to the administrative costs of alternative contracting methods.

--The quality and utility of administrative and technical assistance services provided by the Associations to participating plans.

--The Network's contribution to the quality of record-keeping.

--OPM's ability to carry out its oversight responsibilities within the FEHB program under the Network arrangement.

The contractor reported its findings and recommendations orally to OPM on May 13, 1980, and is expected to provide a final written report no later than June 30.

CONCLUSIONS

In our opinion, certain statutory requirements for admission into the FEHB program which should have been applied to each of the group plans participating in the Network experiment were not so applied. OPM failed to apply these and other basic FEHB admission requirements to permit new and developing comprehensive plans to participate in the Network experiment. Participation in the Network by plans that do not meet FEHB statutory requirements is in our opinion unauthorized, and OPM's failure to apply other plan admission requirements permits otherwise unqualified plans to participate in the FEHB program. The network concept was unknown when FEHB legislation was enacted. If it is continued, we believe that the Congress should provide specific legislation detailing financial, admission, and administrative requirements for networks.

The Network contract places primary responsibility for day-to-day administration of the Network on the Associations. However, the Associations have not effectively monitored comprehensive plans comprising the Network or reported substantive developments to OPM as required under the contract. OPM did not systematically monitor the administration of the Network contract, but relied on the Associations to identify any significant developments affecting the experiment or a lack of compliance with FEHB program requirements.

ENCLOSURE I

During the 1980 open season, two of the Network plans expanded service areas or added new medical centers or other service providers after OPM had told the Associations that such expansion would not be permitted. At OPM's direction, the Associations were reviewing enrollment data from these plans and as of April 1980 had advised 127 Federal enrollees that they would have to select other providers through the FEHB program.

The Associations did not advise OPM that two Network plans in Maryland did not have State certificates of authority required by the State of Maryland. These plans were not legally operational and thus were not eligible under Federal regulations to participate in the Network. In December 1979, OPM found out about these State certification problems and began inquiring into the situation. As of May 1980, neither plan was certified to operate legally in Maryland.

The uniform 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 individually for the FEHB program. Because the uniform premium 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. If the Network is continued, the uniform premium rate should be modified in favor of a system that ties premiums paid to prevailing local costs in the individual plans' service areas.

Information in this report and the results of the consultant's study should give both OPM and the Congress a basis for determining whether the current Network should continue and whether the network concept is a viable alternative for financing health benefits for Federal employees.

RECOMMENDATION TO THE CONGRESS

The Congress should decide whether continuation of a comprehensive medical plans network is appropriate. If it is determined that continuation is appropriate, we recommend that specific legislation be enacted detailing financial, admission, and administrative requirements to be applied to this unique health-care delivery system.

ENCLOSURE I

RECOMMENDATIONS TO OPM

We recommend 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.

CHARACTERISTICS OF COMPREHENSIVE PLANS (note a)

IN OPM'S NETWORK EXPERIMENT DURING 1979

	Location	Date operations began	Date HHS qualified as HMO	Plan physicians: Full time	Plan physicians: Part time	Plan physicians: Percentage of total income prepaid	Approximate plan enrollments: Network	Approximate plan enrollments: Non-Federal	Approximate plan enrollments: Total	Federal target population
Group-practice plans (note b):										
Health Maintenance Group of Birmingham	Birmingham, Ala.	1977	No	0	55	3	9	1,119	1,128	8,545
Baton Rouge Health Maintenance Plan	Baton Rouge, La.	1975	No	23	9	c/100	38	4,881	4,919	1,617
South County Health Care Plan	West River, Md.	1972	No	19	2	95-100	84	707	791	2,500
East Baltimore Medical Plan	Baltimore, Md.	1972	No	7	12	98	82	690	772	(d)
Greater Dundalk Medical Plan	Baltimore, Md.	1972	No	3	29	20	59	243	302	(d)
Fallon Community Health Plan	Worcester, Mass.	1977	11/78	54	0	40	28	7,600	7,628	2,225
HMO Minnesota	St. Paul, Minn.	1974	No	(d)	(d)	10	189	14,042	14,231	8,337
Cumberland Medigroup	Vineland, N.J.	1975	No	9	11	c/100	9	2,200	2,209	408
Mercer Medigroup	Trenton, N.J.	1973	No	9	43	c/100	9	7,556	7,565	3,007
Prepaid Health Plan	Baldwinsville, N.Y.	1977	No	10	6	25	10	2,310	2,320	4,823
Aquidneck Medigroup	Newport, R.I.	1975	No	13	1	9	33	562	595	3,507
Bristol Medigroup	Bristol, R.I.	1971	No	15	5	7	6	380	386	101

	Location	Date operations began	Date HHS qualified as HMO	Plan physicians	Approximate plan enrollments: Network	Approximate plan enrollments: Non-Federal	Approximate plan enrollments: Total	Federal target population
Individual-practice plans (note b):								
Takecare	Oakland, Calif.	1970	6/79	240	83	5,077	5,160	16,927
Health Net	Woodland Hills, Calif.	1973	1/79	311	153	15,347	15,500	108,414
Medical Foundation Program	Chicago, Ill.	1973	No	300	145	14,793	14,938	2,114
Health Maintenance Oregon, Inc.	Portland, Oreg.	1977	6/78	1,000	88	8,912	9,000	15,053
Capitol Health Care	Salem, Oreg.	1977	3/78	190	59	3,941	4,000	1,412
Alamo Health Care Plan	San Antonio, Tex.	1974	No	560	630	3,654	4,284	36,435

a/Each comprehensive plan is sponsored by the Blue Cross and/or Blue Shield organization in its area. Information on the schedule was obtained from the associations or through interviews with officials from the participating plans.

b/OPM categorization of plans.

c/Full-time physicians only.

d/Not available.

ENCLOSURE II