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Reasons for Difference in Premium Rates of Kaiser Plans of Northern and Southern California for the Federal Employees Health Benefits Program. HRD-77-151; B-164562. September 30, 1977. Released October 13, 1977. 2 pp. + 2 appendices (14 pp.).

Report to Rep. Gladys Noon Spellman, Chairman, House Committee on Post Office and Civil Service: Compensation and Employee Benefits Subcommittee; by Robert F. Keller, Acting Comptroller General.

Issue Area: Health Programs (1200); Health Programs: Reimbursement Policies and Utilization Controls (1208).
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Organization Concerned: Civil Service Commission; Kaiser-Permanente Medical Care Program.
Congressional Relevance: House Committee on Post Office and Civil Service: Compensation and Employee Benefits Subcommittee.
Authority: Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901). 5 U.S.C. 8906. H.R. 3795 (94th Cong.).

The Kaiser Foundation Health Plan for Southern California is one of six plans whose rates are used to determine the Government's contribution to the Federal Employees Health Benefits program. Under proposed legislation, the Southern California plan could be one of two plans whose premium rates would be used to compute the Government's contribution. The Kaiser Foundation's 1976 biweekly family premium rate was $7.87 higher for their Southern California plan than for their Northern California plan. Findings/Conclusions: Discussions with Kaiser officials and a review of the assumptions and methodology used in arriving at the premium rates for the two plans indicated that the higher rate for the Southern California plan could be attributed primarily to the following factors: higher property costs, greater benefits, higher inpatient hospital use, higher cost of physician services and nonphysician payroll, higher prescription drug use, and different composition of enrolled families. (Author/SC)

REPORT OF THE COMPTROLLER GENERAL OF THE UNITED STATES

Reasons For Difference In Premium Rates Of Kaiser Plans Of Northern And Southern California For The Federal Employees Health Benefits Program

The Kaiser Foundation Health Plans' 1976 biweekly family premium rate for Federal employees was $7.87 higher for the Southern California plan than for the Northern California plan.

Why were the two 1976 premium rates different? GAO believes that rates were higher for Kaiser's Southern California plan mainly because of

- --higher property costs,
- --greater benefits,
- --higher inpatient hospital use,
- --higher cost of physician services and nonphysician payroll,
- --higher prescription drug use, and
- --different composition of enrolled families.

Under proposed legislation, the Southern California plan could be one of two plans whose premium rates would be used to compute the Government's contribution to the Federal Employees Health Benefits program.

HRD-77-151

SEPTEMBER 30, 1977

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

B-164562

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

Dear Madam Chairwoman:

This report is in response to a request from your Subcommittee that we determine the reasons for the large difference in the 1976 premium rates of the two California Kaiser Foundation Health Plans participating in the Federal Employees Health Benefits program. The biweekly family premium rate was $7.87 higher for Kaiser's Southern California plan than for its Northern California plan. The Subcommittee was concerned about the higher rate for the Southern California plan because, under legislation (H.R. 3795) then being considered by the Subcommittee and reintroduced in the 95th Congress, the Southern California plan would be one of two plans whose premium rates would be used to compute the Government's contribution to the program. Under current legislation, Kaiser's Southern California plan is one of six plans whose rates are used to determine the Government's contribution.

Based on our discussions with Kaiser officials and a review of the assumptions and methodology they used in arriving at the premium rates for their Southern and Northern California plans, we believe that the higher rate for the Southern California plan can be attributed primarily to the following factors:

--Higher property costs.

--Greater benefits.

--Higher inpatient hospital use.

--Higher cost of physician services and nonphysician payroll.

--Higher prescription drug use.

--Different composition of enrolled families.

The effect of each of these factors on the premium rate for the Southern California plan is discussed in appendix I.

We did not obtain written comments from Kaiser or the Civil Service Commission on this report, but the contents were discussed with Kaiser and Commission representatives.

As arranged with your office, we will send copies of this report to the Civil Service Commission and the Kaiser Foundation Health Plan 2 weeks after the date on the cover of the report. We will also make the report available to the public at that time.

Sincerely yours,

Acting Comptroller General
of the United States

Contents

ABBREVIATIONS

CSC	Civil Service Commission
FEHB	Federal Employees Health Benefits
Kaiser	Kaiser Permanente Medical Care Program

REASONS FOR DIFFERENCE IN PREMIUM RATES OF KAISER PLANS OF NORTHERN AND SOUTHERN CALIFORNIA FOR THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

INTRODUCTION

The Federal Employees Health Benefits (FEHB) program, established by the Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901), provided health insurance coverage for 3.2 million Government enrollees (employees and annuitants) and 6.3 million dependents in 1976. The Civil Service Commission (CSC) administers the FEHB program and contracts for coverage through the following four types of health plans:

--Service Benefit Plan.

--Indemnity Benefit Plan.

--Employee Organization Plans.

--Comprehensive Medical Plans.

The Comprehensive Medical Plans, available only in certain localities, are either (1) group practice plans providing comprehensive medical services by teams of physicians and technicians practicing in common medical centers or (2) individual practice plans providing benefits in the form of direct payments to physicians with whom the plans have agreements. These plans also provide hospital benefits. Forty-one such plans, including 31 group practice plans such as the Kaiser Permanente Medical Care Program plans (Kaiser), provided benefits to about 760,000 program participants in 1976. The amount of benefits paid in 1976 is not available, but benefits in 1975 amounted to about $147 million. In 1977 there were 46 comprehensive plans, 35 of which were group practice plans.

Both the Government and the Federal enrollees contribute to the program's cost. The Government's contribution to the program is computed as 60 percent of the average high option subscription charges for six of the participating plans. Enrollees contribute the balance of the premium.

The plans used in computing the Government's contribution are the Service Benefit Plan, the Indemnity Benefit Plan, the two employee organization plans with the largest Federal enrollments, and the two prepaid, comprehensive

plans with the largest Federal enrollments. The Kaiser plans of Northern and Southern California are the two comprehensive plans used in the calculation.

The following tables show the results of using the present system to calculate the Government's contribution to the FEHB program compared to the system which would result from passage of H.R. 3795. This bill would amend 5 U.S.C. 8906 to provide that the Federal contribution for Federal employee health benefits coverage be determined based on the average of the two plans having the highest subscription charges.

Two Methods of Computing the 1977 Standard Government Contribution

Plan	Total biweekly family high option premium	
	Present	Proposed (note a)
Service Benefit Plan	$ 46.11	$46.11
Indemnity Benefit Plan	36.54	
National Association of Letter Carriers	39.95	
American Postal Workers Union	41.25	
Kaiser-Northern	37.84	
Kaiser-Southern	44.20	44.20
Total	$245.89	$90.31

1977 Biweekly Standard Government Contributions

Present: Family high option--$245.89 divided by 6 = $40.98 X 60% = $24.59

Proposed: Family high option--$90.31 divided by 2 = $45.16 X 60% = $27.10

a/Under H.R. 3795.

COMPARISON OF GOVERNMENT CONTRIBUTION USING THE PRESENT AND PROPOSED METHODS OF DETERMINING THE GOVERNMENT'S CONTRIBUTION

Plan	Family high option enrollment (6/30/76)	Percent of all family high option enrollment	1977 total biweekly premium	Government contribution as a percent of the total premium	
				Present system (note a)	Proposed system (note b)
Blue Cross/Blue Shield	1,143,730	57.8	$46.11	53.3	58.8
Aetna	212,948	10.8	36.54	67.3	74.2
National Association of Letter Carriers	133,590	6.7	39.95	61.6	67.8
American Postal Workers Union	144,656	7.3	41.25	59.6	65.7
Kaiser-North	39,470	2.0	37.84	65.0	71.6
Kaiser-South	28,492	1.4	44.20	55.6	61.3

a/ These percentages were calculated using the Government contribution for 1977- $24.59 for each biweekly period for each plan.

b/ These percentages were calculated using the proposed method of determining the Government contribution for 1977-- $27.10 for each biweekly period for each plan.

APPENDIX I

For fiscal year 1976, the FEHB program's total cost was $2.2 billion of which the Government's share was $1.4 billion. For fiscal year 1977 program costs are expected to increase to $2.8 billion with a Federal share of $1.7 billion; the program is projected to cost $3.2 billion in fiscal year 1978.

Kaiser Health Benefit Program

Kaiser consists of a number of organizations which provide health care in six regions of the country. Kaiser is the largest prepaid group practice plan in the United States and has been available to the public since 1945. The program provides prepaid hospital, medical, and related services to its enrollees through 26 hospitals and about 3,000 physicians. During 1975 the program reported revenues of about $750 million and membership of about 2.9 million. The Northern and Southern California plans accounted for 85 percent of these revenues and 84 percent of the enrollees.

In 1976 Kaiser of Northern California covered about 155,000 FEHB program participants and received about $40 million from the FEHB program. FEHB program participants accounted for about 12 percent of the Northern California Plan's membership, and the Federal group was the largest group covered by this plan. Kaiser of Southern California covered about 116,000 FEHB program participants and received about $36.2 million from the FEHB program. FEHB program participants accounted for about 9 percent of Kaiser-Southern's membership, and the Federal group was also the largest group covered by this plan.

The participating organizations in each of Kaiser's two California plans are (1) the Kaiser Foundation Health Plan, Inc. (Health Plan), (2) Kaiser Foundation Hospitals (Hospitals), (3) Permanente Medical Group (Medical Group), and (4) Permanente Services Corporation (Services).

--Health Plan: A nonprofit corporation which contracts with individuals and groups (e.g., Federal employees) to arrange for comprehensive health care benefits. It also contracts with Hospitals and Medical Group to provide the facilities and services required to meet the covered health care needs of members. Health Plan is located in three Kaiser regions--Southern California, northern California, and Hawaii, and has subsidiaries in the three other regions-Colorado, Ohio, and Oregon.

--Hospitals: A nonprofit corporation which owns and operates general community hospitals, which are available to both members and nonmembers.

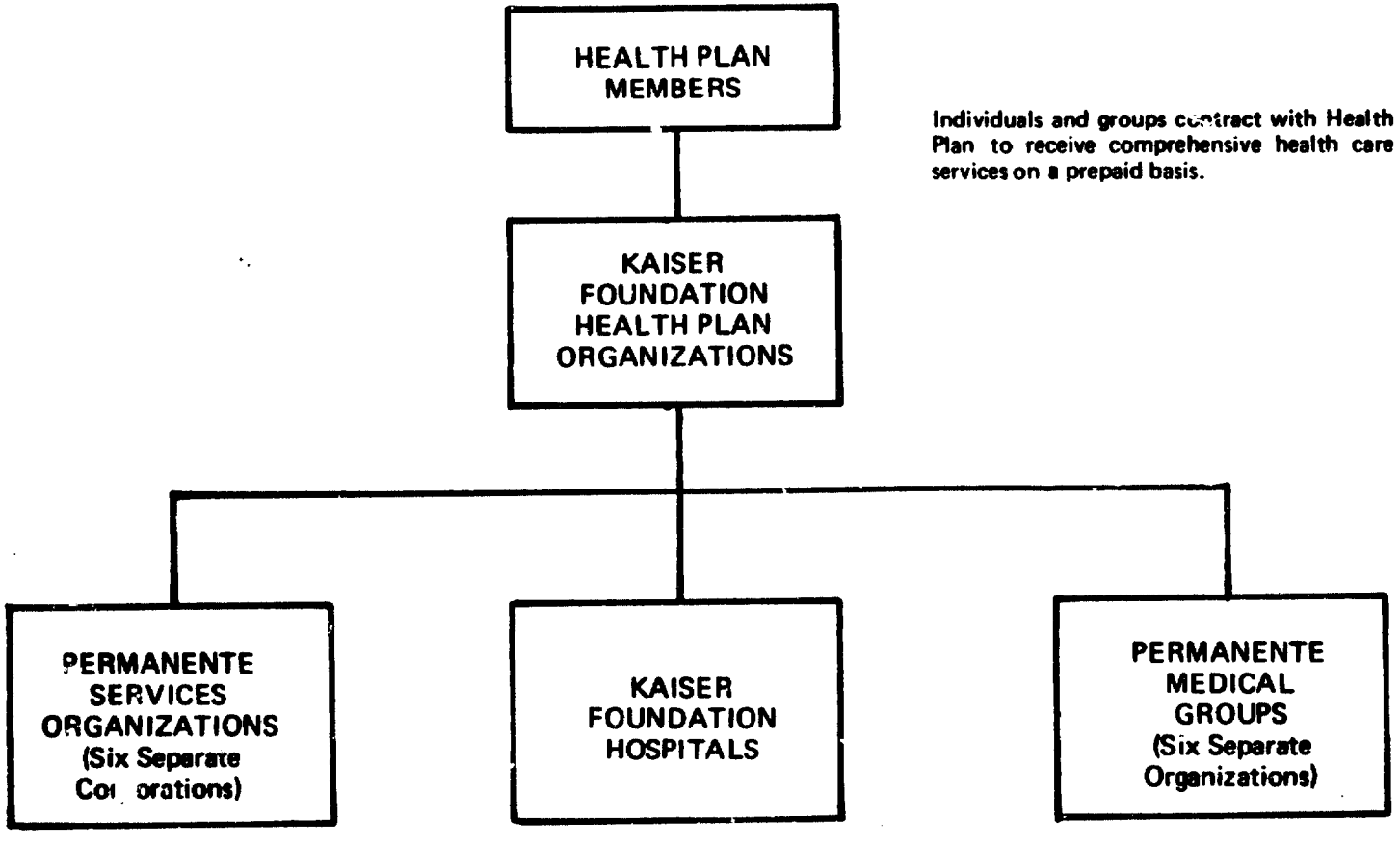
--Medical Group: A for-profit partnership of physicians who provide medical care. The partnership receives payment from Health Plan in the form of a per capita payment--a set amount per member per month--negotiated annually between Health Plan and Medical Group. Individual physicians are not paid on a fee-for-service basis. Instead, income is pooled and distributed according to a prearranged formula that does not relate income to specific services performed. The compensation arrangement between Medical Group and Health Plan also includes incentive and bonus features designed to encourage effective operation of the total Kaiser program.

--Services: A for-profit corporation that operates outpatient pharmacies. It also provides a variety of support such as data processing, accounting, purchasing, and transportation for the other three Kaiser organizational components. Its stock is owned entirely by the two nonprofit components of Kaiser--Hospitals and Health Plan. Services receives payments on a cost-reimbursable basis, plus a return on capital investment in pharmacy operations, which amounts to about 17.5 percent.

The following chart depicts the basic contractual arrangements among the various components of the Kaiser organization.

KAISER-PERMANENTE MEDICAL CARE PROGRAM

BASIC CONTRACTUAL ARRANGEMENTS



APPENDIX I

SCOPE OF REVIEW

As requested by the Subcommittee on Retirement and Employee Benefits, House Committee on Post Office and Civil Service, our review was to determine why such a large difference existed in the 1976 premium rates charged by the Kaiser Foundation Health Plans of Northern and Southern California under the FEHB program. We evaluated the reasonableness of the assumptions and methodology used by Kaiser in explaining the differences in the premium rates. However, we did not verify the accuracy of the data provided by Kaiser to explain the differences because it would have taken too much time in view of Kaiser's complex organizational structure. Additionally, we reviewed and analyzed pertinent legislation and legislative proposals, reviewed the contracts between Kaiser and the Civil Service Commission, and reviewed applicable Kaiser documents. We made our review of Kaiser plans at Northern and Southern California in the San Francisco and Los Angeles areas, and at the Civil Service Commission in Washington, D.C.

EXPLANATION OF RATE DIFFERENCE

For the 1976 contract year Kaiser of Southern California had a published family high-option biweekly rate of $42.29; the comparable rate for Kaiser of Northern California was $34.42. Although these published rates indicate a difference of $7.87 between the two plans, the actual difference was greater--$9.36--before a $1.1 million transfer from the CSC-held contingency reserve 1/ lowered the Southern California family rate by $1.21. Two other minor, technical adjustments to the rate amounted to 28 cents, bringing the total difference to $9.36.

1/The contingency reserve is the fund resulting from CSC's withholding up to 4 percent of premiums, plus the interest earned on the fund. CSC may make transfers from this fund to the various FEHB plans. According to the FEHB Act, "The contingency reserves [transferred to the plans] may be used to defray increases in future rates, or may be applied to reduce the contributions of employees and the Government to, or to increase the benefits provided by, the plan from which the reserves are derived, as the Commission from time to time shall determine."

Kaiser explained that the total difference of $9.36 was due, for the most part, to the Southern plan's

--higher property cost,

--greater benefits, and

--higher inpatient utilization rates.

The following table shows the factors which comprise the rate difference and the additional cost to Kaiser of Southern California as a result of these factors.

Factors which account for rate difference	Additional cost to Kaiser Southern	Percent of published rate differences
Property costs	$1.75	22.2
Benefits	1.72	21.9
Inpatient utilization	1.44	18.3
Cost of physician services	.99	12.6
Cost of nonphysician payroll	.67	8.5
Drug use	.64	8.1
Family composition	.54	6.9
Nonquantified (imponderables)	1.61	20.4
Actual rate difference	$9.36	118.9
Adjustments (note a)	-1.49	-18.9
Total published rate difference	$7.87	100.0

a/See explanation of adjustments beginning on page 7 .

Property costs

Forecasted property costs including earnings required to support development and expansion of facilities were about $10.5 million higher for the Southern plan. This difference accounted for about 22 percent of the difference in rates.

The Southern plan's capital investment in health care facilities was higher partly due to facilities being generally newer and therefore more costly to construct. The total investment in land, buildings, and equipment for

the Southern plan was $240 million compared to $204 million for the Northern plan at December 31, 1975. Also, the Southern plan was forecasting a larger requirement for future capital needs because of greater expected membership growth.

Benefits

CSC contracts independently with each Kaiser plan just as it would with any other health plan in the FEHB program. Despite organizational similarities, the Kaiser plans offer different benefits. The Northern plan's benefits under the Federal program are more limited when compared to the Southern plan's, and benefit differences account for about 22 percent of the total premium difference.

There were two major benefit differences: (1) members in the Northern plan paid a $1 copayment for each visit to a doctor's office, while members in the Southern plan did not pay anything for a visit to a doctor's office, and (2) the Northern plan members paid manufacturers' full wholesale prices for prescription drugs, while Southern plan members paid half the wholesale prices.

Inpatient utilization

Greater inpatient hospital utilization forecasted for the Southern plan accounted for 18.3 percent of the rate difference. The Southern plan forecasted 452 days per 1000 members compared to 414 days forecasted in the Northern plan. The additional staffing required as a result of the higher inpatient use, coupled with higher nonpayroll hospital expenses, resulted in a forecast of costs for the Southern plan which were about $8.5 million higher than for the Northern plan. 1/

Cost of physician services

Compensation, taxes, and other benefits charged to the Southern plan by Medical Group for physician services were about $5.7 million higher. This accounted for 12.6 percent

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1/A review of the membership populations by age and sex showed no significant difference between the two plans. We did not attempt to determine whether the Southern plan's higher utilization rate was medically justified.

of the rate difference. Kaiser representatives maintain that climate and other factors make Northern California more attractive than Southern California to physicians as a place to establish their practices. Consequently, the Southern plan has to pay more to attract their physicians. At the time of our fieldwork, the most recent and complete payroll data was for calendar year 1975. On the average, in 1975, a physician in the Southern California plan was paid about $9,500 more than a physician in the Northern California plan.

Cost of nonphysician payroll

The forecasted average payroll cost for nonphysician employees in 1976 was about $400 higher per employee for the Southern plan. This difference resulted in a higher cost to the Southern plan of about $4 million and accounted for 8.5 percent of the rate difference.

Drug use rates

The forecasted use of prescription drugs by Southern California members was higher than for Northern California members and accounted for 8.1 percent of the premium difference.

Kaiser officials told us that while there is no clear explanation for higher drug use by Southern California members, one factor could be the different prescribing habits of the physicians in each area. Also, differences in attitudes toward health care between the residents of the Los Angeles and San Francisco areas could affect drug use rates.

Family composition

Differences in family composition accounted for about 7 percent of the premium difference. The family premium rate is a weighted average of the rate for subscribers with one dependent and the rate for subscribers with more than one dependent. The Southern plan had proportionately more subscribers with more than one dependent than did the Northern plan (46 percent compared to about 43 percent).

Nonquantified factors

Collectively, the quantified items mentioned above accounted for about 80 percent of the rate difference.

However, Kaiser officials believed that there were other factors contributing to the difference in rates which could not be readily quantified. Kaiser referred to these factors as "imponderables" and used them to explain the remaining rate difference of about 20 percent. The factors included

--geographic differences,

--medical practice differences,

--differences in health care attitudes,

--differences in enrolled populations, and

--differences in facilities.

For the most part, the "imponderables" provide possible reasons for why utilization, medical service costs, and property costs were higher for the Southern plan. For example, in addition to greater property costs, the larger number of facilities of the Southern California plan adds to operating costs by affecting, among other things, the number of personnel, transportation costs, and communications. Costs of operating a health care facility could also be affected by such factors as location, design, local regulations, and different approaches to operations.

In addition to affecting measurable utilization and costs, different medical practices, management philosophy, and members' health care attitudes may affect how health care services are organized and managed and could thus account for cost differences.

COST OF LIVING COMPARISON

In asking us to perform this analysis, the Subcommittee expressed the opinion that since the cost of living was higher in Northern California than in Southern California, it might be assumed that Kaiser rates in Southern California would be lower.

The U.S. Department of Labor develops annual estimates for three hypothetical four-person family budgets--low, intermediate, and high income budgets--and publishes indexes that can be used to compare the costs of these budgets in selected urban areas. A component of this study isolates the costs of all medical care. Information on the San Francisco-Oakland and the Los Angeles-Long Beach intermediate

budgets for a four-person family based on a U.S. average index of 100 shows that while San Francisco has a higher cost of living, Los Angeles has higher medical care costs. 1/

	San Francisco-Oakland		Los Angeles-Long Beach	
Year	Cost of living index	Medical care index	Cost of living index	Medical care index
1971	106	113	100	122
1972	108	114	101	122
1973	106	113	99	123
1974	106	111	98	121
1975	107	115	99	122
1976	106	114	99	126

The 1976 Los Angeles-Long Beach medical care index of 126 was highest in the contiguous United States. Anchorage had an index of 160 in 1976. The cost of medical care in the Los Angeles area was about 11 percent higher than in the San Francisco area; whereas Kaiser's Southern plan rates were about 23 percent higher than the Northern plan's rates.

1/The same relationships also held true for the low and high income budget indexes in 1975 and 1976.

APPENDIX II

U.S. House of Representatives

SUBCOMMITTEE ON RETIREMENT AND EMPLOYEE BENEFITS
OF THE
COMMITTEE ON POST OFFICE AND CIVIL SERVICE
B-345-D RAYBURN HOUSE OFFICE BUILDING
Washington, D.C. 20515

June 14, 1976

Honorable Elmer B. Staats
Comptroller General of the United States
General Accounting Office
Washington, D. C. 20548

Dear Mr. Comptroller General:

This Subcommittee recently introduced a bill (H.R. 12275) to change the method of computing the standard Government contribution for the Federal Employees' Health Benefits (FEHB) program. For 1976 this contribution was based on the average of the premium rate for the six largest Federal employees plans. The Subcommittee's bill would change the Government's contribution to the average of the two most expensive of these six plans. Currently, the two most expensive plans are Blue Cross-Blue Shield and the Kaiser Foundation Health Plan in Southern California.

During the past few months the Subcommittee's staff has been looking at certain aspects of the comprehensive health benefit plans under the Federal Employees' Health Benefits program. As part of this work the staff wanted to determine the reason for the large difference in the 1976 premium rates between the Kaiser Foundation Health Plan in Northern California ($34.42 total bi-weekly premium) and the Kaiser Foundation Health Plan in Southern California ($42.29 total bi-weekly premium). This difference is somewhat surprising when one realizes that Northern California is supposedly a higher cost-of-living area than Southern California. The Subcommittee staff received various explanations from the two Kaiser Foundation Health plans, but none fully explained the difference.

Accordingly, since under H.R. 12275 the Kaiser Foundation Health Plan in Southern California would be one of the plans upon which the Government's contribution would be based, the Subcommittee

APPENDIX II

would like for your office to review the two Kaiser Foundation Health plans in California to determine the reasons for the large variations in their 1976 premium rates.

With best wishes, I am

Sincerely yours,

Richard C. White
Chairman

RCW:bjl