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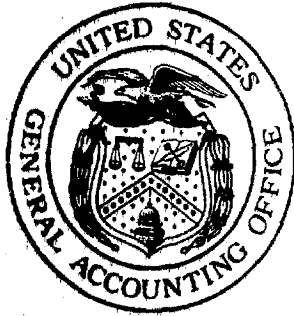

U.S. GENERAL ACCOUNTING OFFICE
STAFF PAPER

# Information On 1976 Health Insurance Premium Rate Increases For Federal Employees Health Benefits Program

Blue Cross/Blue Shield

Aetna

MWD-76-76 7066.0 NOV. 18, 1975

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# Contents


| | | Page |
|---|---|---|
| SUMMARY | | i |
| CHAPTER | | |
| 1 | INTRODUCTION | |
| | Two sets of rates submitted | 1 |
| | Congressional concern | 1 |
| | Scope | 2 |
| 2 | PREMIUM RATE INCREASES FROM 1960 THOUGH 1976 | 3 |
| | Blue Cross/Blue Shield | 3 |
| | Aetna | 7 |
| 3 | SOME FACTORS CONTRIBUTING TO PREMIUM RATE INCREASES | 11 |
| | Physician and hospital data | 11 |
| | Utilization of benefits and inflation | 13 |
| | Psychiatric benefits and costs | 16 |
| | Benefit structures | 16 |
| | Blue Cross/Blue Shield | 16 |
| | Aetna | 17 |
| | Costs | 17 |
| 4 | DETERMINATION OF PREMIUM RATES FOR 1976 | 20 |
| | CSC guidelines for benefit changes | 20 |
| | Blue Cross/Blue Shield | 20 |
| | Initial rate submission | 20 |
| | Civil Service Commission Actuarial Analysis | 21 |
| | Negotiation and final rates | 22 |
| | 1976 rating factors simplified | 22 |
| | Aetna | 23 |
| | Initial rate proposal | 23 |
| | Civil Service Commission Actuarial Analysis | 24 |
| | Aetna response | 24 |
| | Further actuarial analysis by CSC | 24 |
| | Negotiation and final rates | 25 |
| | Other data provided by Aetna | 25 |
| 5 | OBSERVATIONS | 26 |
| | Calculation of the government contribution | 26 |
| | Other health plans available at a lower cost | 30 |
| APPENDIX | | |
| I | Letter from the Chairman, Subcommittee on Retirement and Employee Benefits, House of Representatives to the Comptroller General of the United States dated October 23, 1975 | 35 |
| II | Letter to General Accounting Office from Blue Cross/ Blue Shield dated November 12, 1975 | 36 |

## SUMMARY

This staff paper discusses the 1976 health insurance premium increases by the Blue Cross Association and the National Association of Blue Shield Plans (Blue Cross/Blue Shield) and Aetna Life Insurance Company (Aetna) under the Federal Employees Health Benefits (FEHB) program. Included is a discussion of premium rate increases over the years and some of the factors which have caused them. This paper does not address the question of the reasonableness of premium rate increases; rather it discusses the methodology used by the carriers and CSC in arriving at the final premium rates. It should be recognized that changing any of the assumptions (such as inflation rate or utilization rates) would change the calculation of the premium rates needed.

### INCREASE IN PREMIUM RATES

Premium rates for both Blue Cross/Blue Shield and Aetna have increased substantially since the inception of the FEHB program in 1960. (See p. 3).

Since 1960, Blue Cross/Blue Shield premiums for family high and low options have risen 382.6 percent and 80.1 percent respectively; comparable increases for Aetna have been 377.3 percent and 240.5 percent. Since 1967, Aetna family high and low option premiums and the Blue Cross/Blue Shield family high option premium have generally outpaced the medical care component of the consumer price index. (See pp. 6, 10).

### SOME FACTORS CAUSING THE INCREASES

The average daily service charge (room and board) for a two-bed, semiprivate hospital room rose from $17.90 in 1960 to $70.40 in 1975. Physicians' annual net income increased from $19,517 in 1960 to $49,415 in 1973 (most recent available data), and the average fee for an initial visit to a general practitioner's office rose from $8.46 in 1970 to $10.77 in 1973. (See p. 12).

Other factors which have influenced premium rates include

--increased benefit coverage over the years, and

--increased utilization of benefits (the Civil Service Commission (CSC) has estimated that there will be 5-percent increases in overall utilization in 1975 and 1976).

### DETERMINATION OF PREMIUM RATES FOR 1976

Premium rates for 1976 were established based on judgments and a number of assumptions about events projected to occur in 1976. Through a negotiation process, the differences in judgments and assumptions between CSC and the insurance carriers were resolved in arriving at the final rates.

Blue Cross/Blue Shield initially proposed an overall increase of 38.4 percent, but ultimately agreed to an increase of 35.3 percent.

Aetna requested a 1976 premium increase of 44 percent, while CSC suggested a 26.6-percent increase would be adequate. The final overall negotiated increase was 35 percent. (See p.20.)

OBSERVATIONS

GAO has no basis to question the rate increases agreed upon between CSC and the carriers. However, we have discussed with the Chairman, House Subcommittee on Retirement and Employee Benefits, the desirability of undertaking a comprehensive review directed at identifying areas where CSC and the carriers can act to control costs. For example, congressional concern has been expressed regarding whether (1) the present system stimulates misutilization of health benefits and (2) the carriers and CSC have any incentives to control costs.

We believe that these are important questions which need answering and, until they are answered, little can be done to question the rising costs of health insurance for Federal employees.

In the meantime, there are two potential ways whereby the impact of the premium rate increases on Federal employees could be minimized--one would require legislative action and one would take a careful assessment by Federal employees of the various health insurance plans for which they are eligible. (See p.26.)

1. The Government contribution for health insurance premiums is computed on a simple unweighted average of the six largest Federal Employees Health Benefits plans. This results in the Government paying less than 60 percent of total premiums for the majority of Federal employees. Congress could require CSC to calculate the Government contribution on a weighted basis by giving some recognition to the number of enrollees in each of the six plans, which would reduce the employees contribution in 1976.

2. All Federal employees are eligible for seven health benefit plans. The monthly family high option premium rates for these seven plans range from a high of $93.47 (Blue Cross/Blue Shield) to a low of $57.66 (Government Employees Hospital Association). However, before employees switch plans, they should carefully assess benefits offered by each plan and determine if the plan meets his or her health insurance needs.

# CHAPTER 1

# INTRODUCTION

On October 20, 1975, the Civil Service Commission (CSC) announced changes in 1976 premium rates and benefits for plans participating in the Federal Employees Health Benefits (FEHB) program. CSC stated that premium rates for most of the plans would be significantly higher than 1975 rates because of increases in the cost of health care.

CSC stated that health care costs had risen substantially since price controls were lifted in 1974 and that, in the last year, average hospital charges have increased by 18 percent and average physicians' fees have increased by 11 percent. CSC noted that in addition to normal economic pressures, health care costs reflect (1) a substantial increase in the use of medical care, (2) a doubling and tripling of malpractice insurance premiums, and (3) the high cost of new health care technology.

The Civil Service Commission stated that these cost increases were expected to lead to large operating deficits for most FEHB contracts in 1975. It was estimated that, in total, the two Government-wide plans--Aetna Life Insurance Company (Aetna) and the Blue Cross Association and the National Association of Blue Shield Plans (Blue Cross/Blue Shield)--would have operating deficits, under their FEHB contracts, of more than $100 million by the end of 1975.

Blue Cross/Blue Shield and Aetna requested premium increases of 38 to 54 percent, respectively, but after negotiations with CSC, both plans agreed to aggregate increases of about 35 percent.

## TWO SETS OF RATES SUBMITTED

For 1976 the carriers submitted two sets of rates; one identified as "FEHB Program Primary" and another as "Medicare Program Primary." Currently, if a Federal employee is covered by Medicare, the Medicare program first pays its benefits for claims (Medicare Program Primary) and the FEHB plans pay only for benefits not paid by Medicare. Section 1862(c) of the Social Security Act, as amended (42 U.S.C. 1395), however, provides that no payment may be made under the Medicare program after January 1, 1976, for benefits covered by the FEHB program unless prior to that date Federal employees are provided with coverage which would supplement the Medicare program. This provision would make the FEHB program primary.

According to CSC, if no action is taken by the Congress, the FEHB carriers will pay additional benefits of about $250 million in 1976, which otherwise would have been paid by Medicare. CSC believes, however, that there are strong indications that this problem will be resolved prior to the end of calendar year 1975. We previously reported on this

matter on August 4, 1975.[1/] All information in this staff paper assumes that the relationship of the FEHB program to Medicare will remain the same; that is, with Medicare remaining primary.

## CONGRESSIONAL CONCERN

Congress has expressed a great deal of concern over the proposed increases in health insurance premiums--specifically the proposed increases by Blue Cross/Blue Shield and Aetna under the FEHB program. (See app. I .) The objective of this paper is to provide information to the Congress on the premium increases by these two plans. The paper discusses the following:

--The increase in premium rates since inception of the FEHB program. (See p. 3.)

--Increases in physician and hospital costs over the years. (See p.12.)

--Inflation and utilization trends for Blue Cross/Blue Shield basic benefit coverage for calendar years 1970-74. (See p. 13 .)

--The growth which has taken place in one major benefit category--psychiatric care. (See p. 16.)

--Rationales used by Blue Cross/Blue Shield, Aetna, and CSC in establishing the proposed 1976 premium increases. (See p.20 .)

--Some general observations by GAO. (See p. 26 .)

## SCOPE

The information in this paper was primarily obtained at CSC headquarters in Washington, D.C. We discussed the contents of the paper with CSC personnel knowledgeable of, and responsible for, administering the FEHB program.

Our actuaries reviewed the rationale and methodology used by CSC and the carriers in arriving at the premium rates for 1976. Because of time limitations, we did not verify the accuracy of the data obtained from CSC or the carriers.

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[1/] "Proposed Coordination Between the Medicare and the Federal Employees Health Benefits Program" (MWD-75-99)

## CHAPTER 2

## PREMIUM RATE INCREASES FROM 1960 THROUGH 1976

Total monthly premiums for the Government-wide Service Benefit plan (Blue Cross/Blue Shield) and the Government-wide Indemnity Benefit plan (Aetna) have risen significantly since 1960.

### BLUE CROSS/BLUE SHIELD

Family high and low option monthly premiums have increased 382.6 percent and 80.1 percent, respectively, since 1960. For the 1976 contract period, monthly premiums have been set at $93.47 and $25.59, respectively, assuming Medicare remains primary to the FEHB program.

The following table shows monthly premiums for Blue Cross/Blue Shield and percentage changes from 1960-76 for family high and low option. The bar graph on page 5 displays similar data and divides total premiums into employee and Government shares. The chart on page 6 compares the price index of Blue Cross/Blue Shield premiums with the medical care component of the consumer price index (CPI) (1967 = 100).

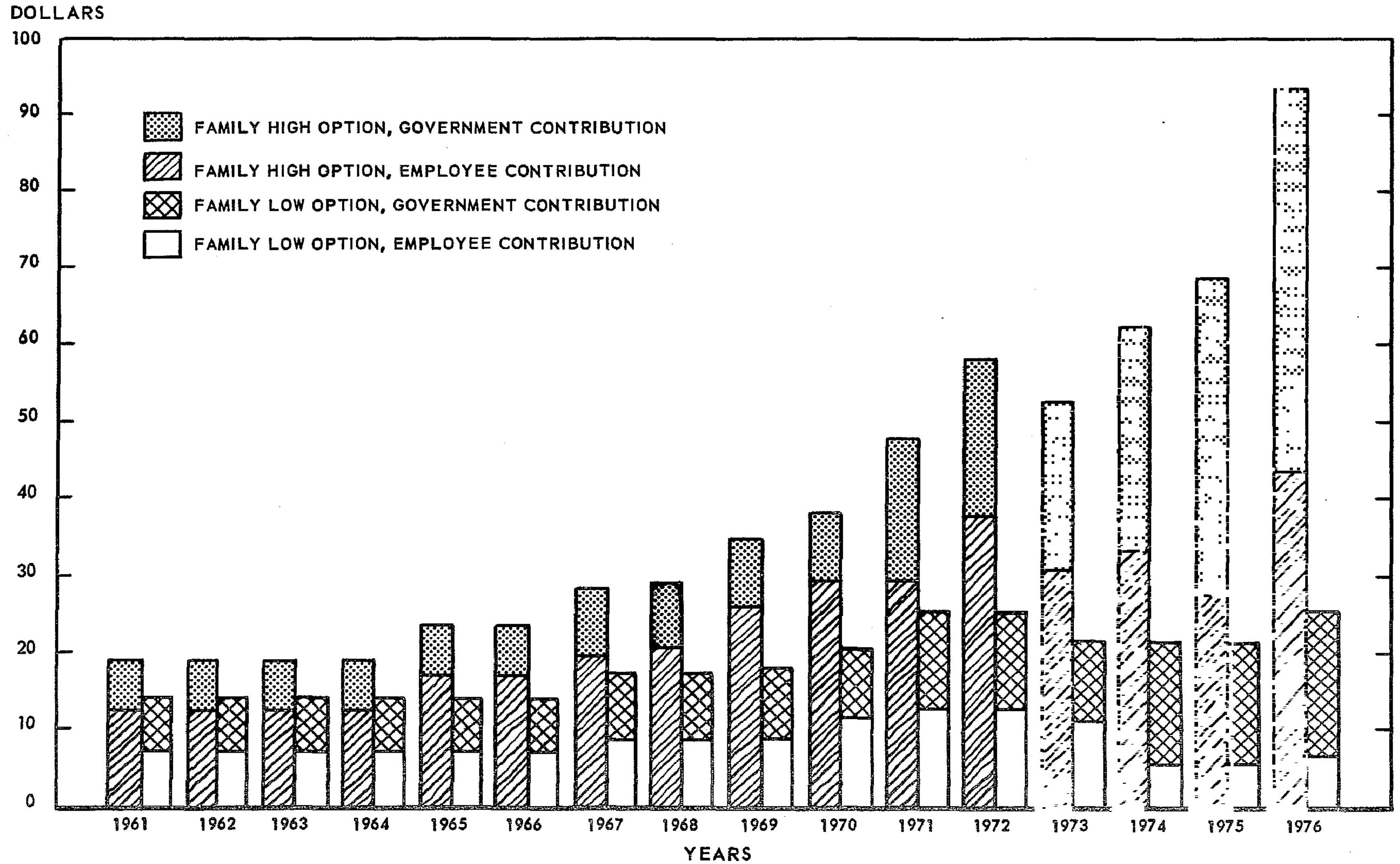
Blue Cross/Blue Shield FEHB Program Monthly Premiums and Percent of Increase

| Year | Family high option Amount | Family high option % Change | Family low option Amount | Family low option % Change |
|---|---|---|---|---|
| [a]1960-61 | $19.37 | - | $14.21 | - |
| 1962 | 19.37 | 0 | 14.21 | 0 |
| 1963 | 19.37 | 0 | 14.21 | 0 |
| 1964 | 19.37 | 0 | 14.21 | 0 |
| 1965 | 23.83 | 23.0 | 14.21 | 0 |
| 1966 | 23.83 | 0 | 14.21 | 0 |
| 1967 | 28.30 | 18.8 | 17.76 | 25.0 |
| 1968 | 29.46 | 4.1 | 17.76 | 0 |
| 1969 | 35.23 | 19.6 | 18.07 | 1.7 |
| 1970 | 38.33 | 8.8 | 20.37 | 12.7 |
| 1971 | 47.91 | 25.0 | 25.48 | 25.1 |
| 1972 | 58.46 | 22.0 | 25.48 | 0 |
| 1973 | 52.61 | [b]-10.1 | 21.65 | [b]-15.0 |
| 1974 | 62.77 | 19.3 | 21.65 | 0 |
| 1975 | 68.92 | 9.8 | 21.65 | 0 |
| 1976 | 93.47 | 35.6 | 25.59 | 18.2 |
| Total percentage increase, 1960-76 | 382.6 | | 80.1 | |

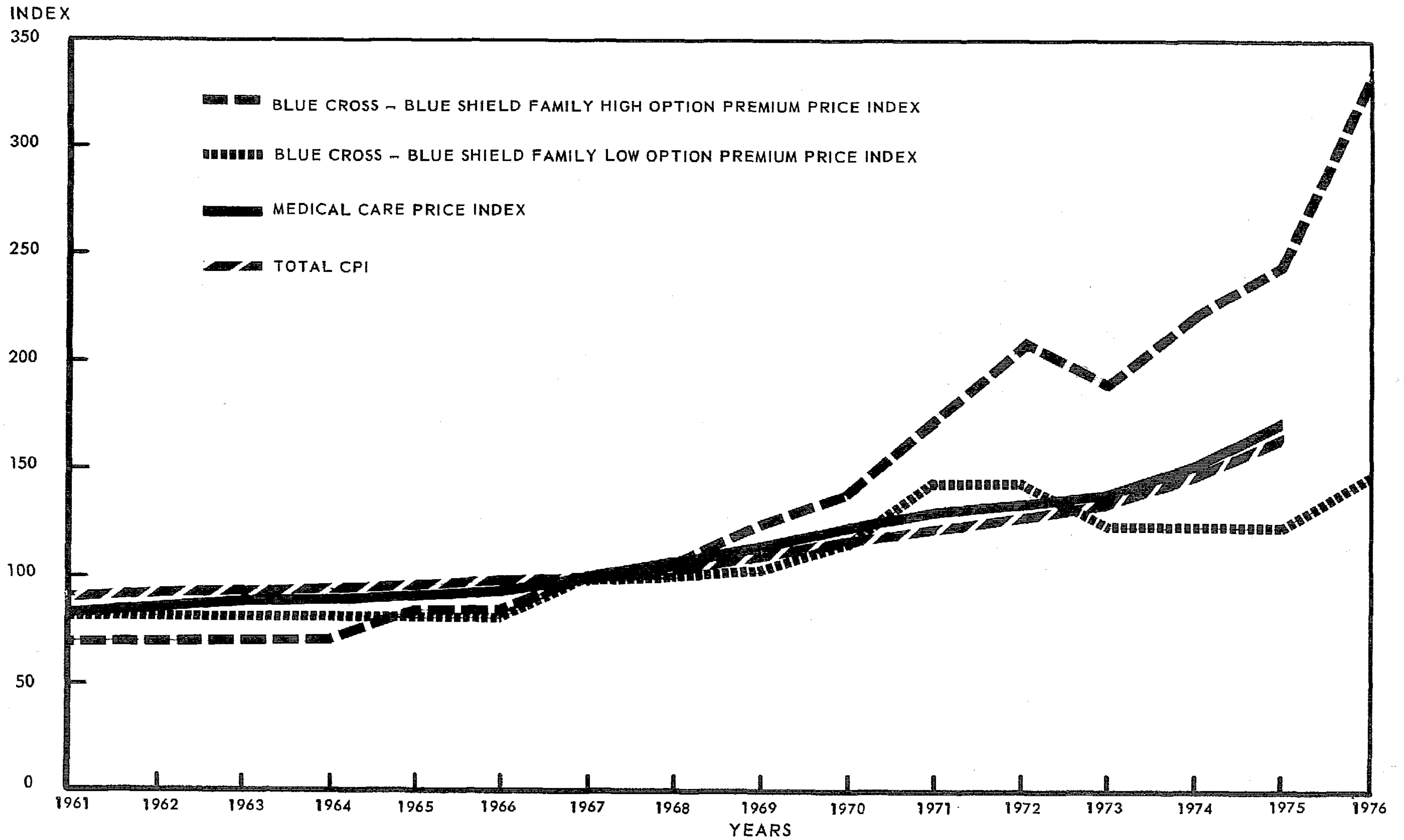
[a]First contract period was from July 1, 1960, to October 31, 1961. Contract periods ran through October 31 of each year until 1966 when the period was changed to a calendar-year basis.

[b]These reduced rates resulted, in part, from price controls which went into effect in August 1971. The carrier realized unanticipated savings as a result of these controls in the last half of 1971 and in 1972.

**FAMILY HIGH AND LOW OPTION, BLUE CROSS – BLUE SHIELD, MONTHLY PREMIUMS, EMPLOYEE AND GOVERNMENT SHARES**



## BLUE CROSS – BLUE SHIELD FAMILY HIGH AND LOW OPTION PREMIUM PRICE INDEXES; CONSUMER PRICE INDEX (CPI) AND MEDICAL CARE INDEX (1967 = 100)



## AETNA

Family high and low option monthly premiums have increased 377.3 percent and 240.5 percent, respectively, since 1960. For the 1976 contract period, monthly premiums have been set at $83.33 and $46.04, respectively, assuming Medicare remains primary to the FEHB program.

The following table shows total monthly premiums for Aetna and the percentage change each year from 1960-76 for family high and low option. The bar graph on page 9 displays similar data and divides total premiums into employee and Government shares. The chart on page 10 compares the price index of Aetna premiums with the medical care component of the CPI (1967 = 100.).

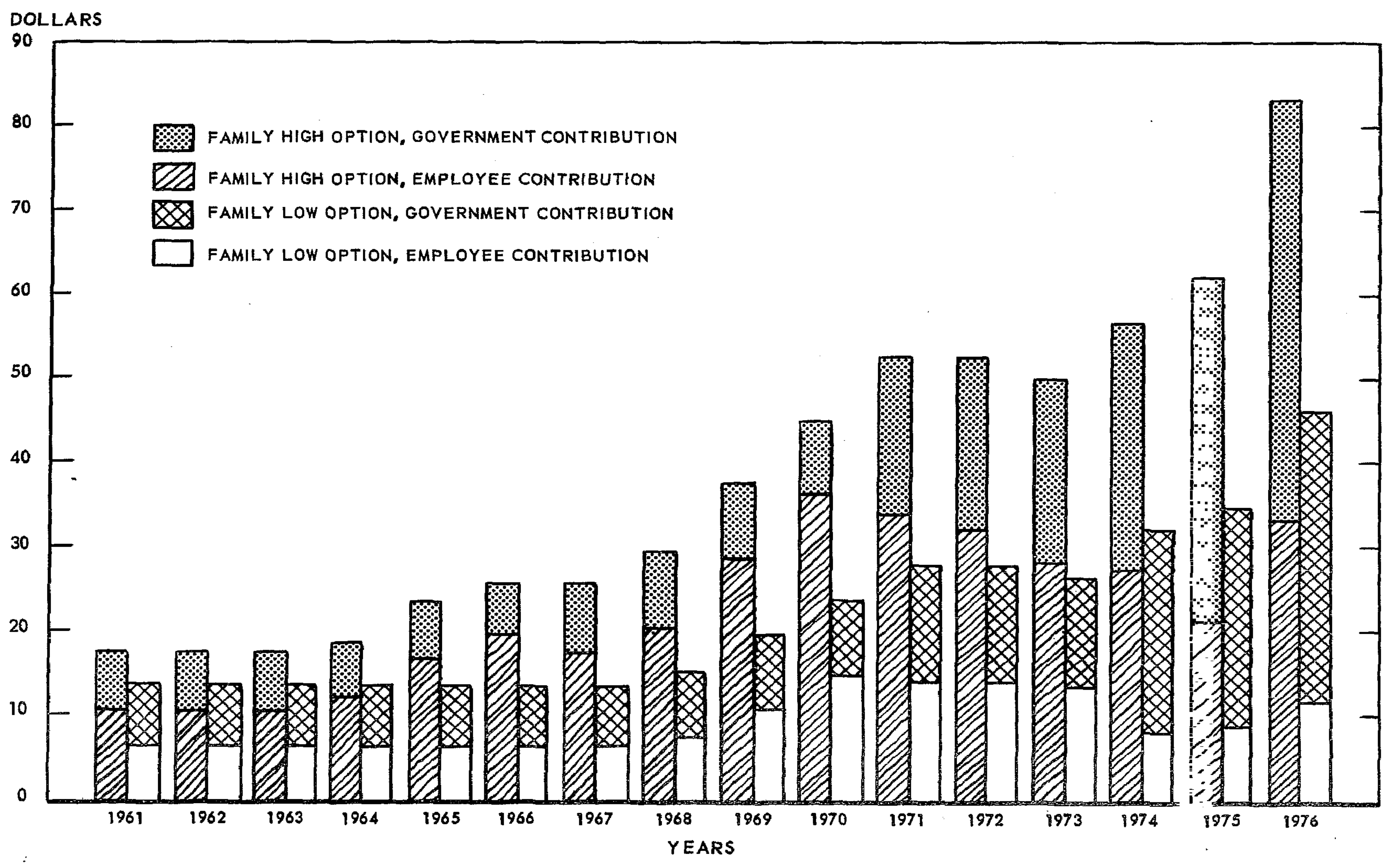
Aetna FEHB Program Monthly Premiums and Percent of Increase

| Year | Family high option Amount | Family high option % Change | Family low option Amount | Family low option % Change |
|---|---|---|---|---|
| [a]1960-61 | $17.46 | - | $13.52 | - |
| 1962 | 17.46 | 0 | 13.52 | 0 |
| 1963 | 17.46 | 0 | 13.52 | 0 |
| 1964 | 18.98 | 8.7 | 13.52 | 0 |
| 1965 | 23.51 | 23.9 | 13.52 | 0 |
| 1966 | 25.91 | 10.2 | 13.52 | 0 |
| 1967 | 25.91 | 0 | 13.52 | 0 |
| 1968 | 29.03 | 12.0 | 15.16 | 12.1 |
| 1969 | 37.72 | 29.9 | 19.70 | 30.0 |
| 1970 | 44.94 | 19.1 | 23.70 | 20.3 |
| 1971 | 52.56 | 17.0 | 27.74 | 17.1 |
| 1972 | 52.56 | 0 | 27.74 | 0 |
| 1973 | 49.94 | [b]-5.0 | 26.35 | [b]-5.0 |
| 1974 | 56.70 | 13.5 | 31.98 | 21.4 |
| 1975 | 62.18 | 9.7 | 34.10 | 6.6 |
| 1976 | 83.33 | 34.0 | 46.04 | 35.0 |
| Total percentage increase, 1960-76 | | 377.3 | | 240.5 |

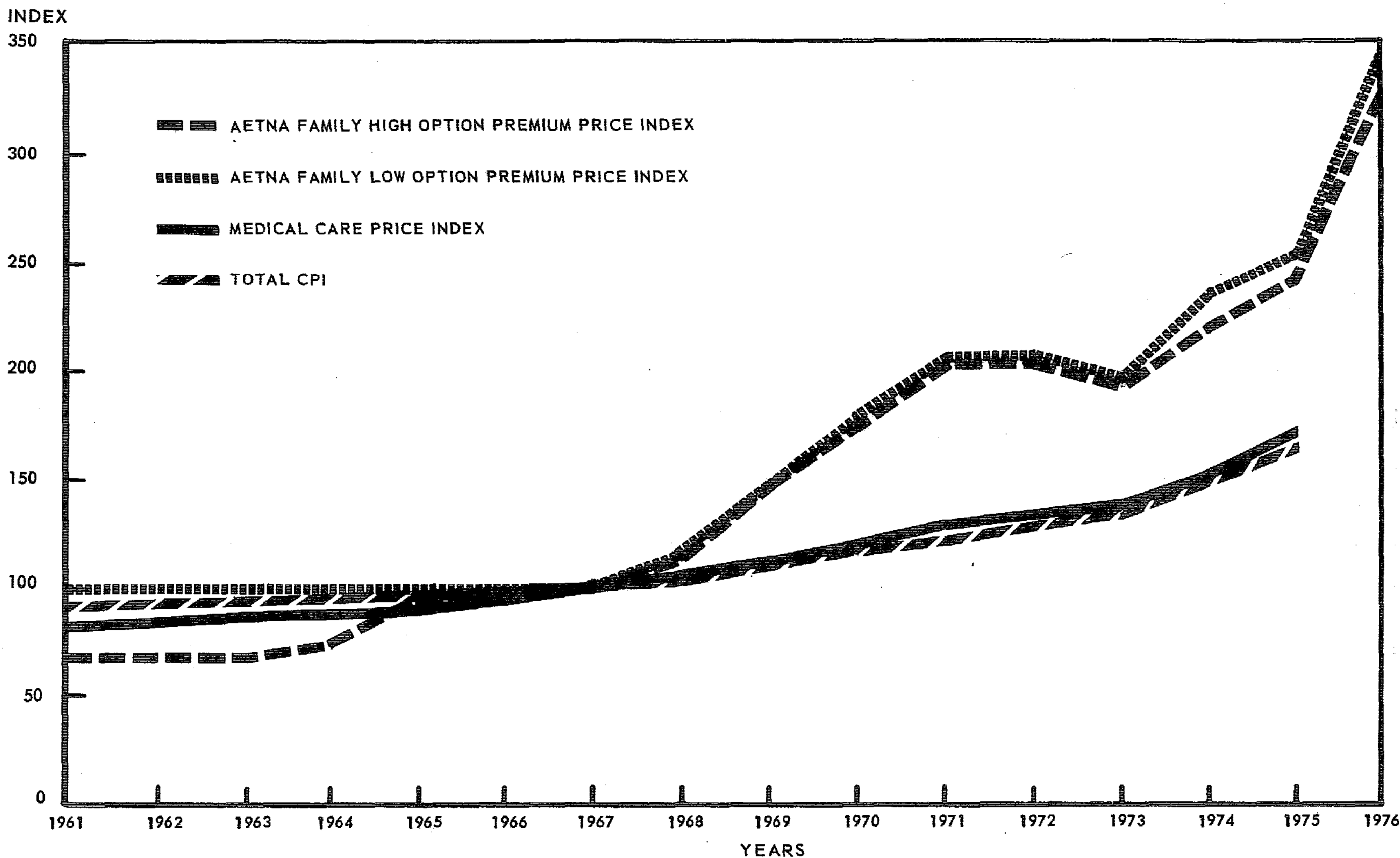
[a]First contract period was from July 1, 1960, to October 31, 1961. Contract periods ran through October 31 of each year until 1966 when the period was changed to a calendar-year basis.

[b]These reduced rates resulted, in part, from price controls which went into effect in August 1971. The carrier realized unanticipated savings as a result of these controls in the last half of 1971 and in 1972.

## FAMILY HIGH AND LOW OPTION, AETNA, MONTHLY PREMIUMS; EMPLOYEE AND GOVERNMENT SHARES



## AETNA FAMILY HIGH AND LOW OPTION PREMIUM PRICE INDEXES; CONSUMER PRICE INDEX (CPI) AND MEDICAL CARE INDEX (1967 = 100)



# CHAPTER 3

## SOME FACTORS CONTRIBUTING TO PREMIUM RATE INCREASES

Some of the factors which have caused health insurance premiums to rise are (1) increased costs for medical and hospital care, (2) increased utilization of benefits, and (3) addition of new benefits. Direct benefit costs comprise a large proportion of health insurance costs. For example, under the FEHB program, Blue Cross/Blue Shield pays out about 95 percent of the funds it receives to cover incurred medical and hospital bills.

CSC was not able to provide us with complete historical data showing the portion of premium increases that was attributable to benefit changes for Aetna and Blue Cross/Blue Shield. Blue Cross/Blue Shield was able to provide estimates made at the time of rate submission to CSC. The estimates, however, are not necessarily the actual cost of providing the new benefits as reflected in Blue Cross/Blue Shield's experience. (See app. II.) However, by directive from CSC, new benefits were not permitted which would add significant costs to 1976 premiums. (See p. 20.)

### PHYSICIAN AND HOSPITAL DATA

The average daily service charge for a two-bed, semiprivate hospital room has risen from $17.90 as of October 1960 to $70.40 as of January 1975, an increase of 293.3 percent.

Based on information obtained from the American Medical Association and the Social Security Administration, average physicians' net income increased from $19,517 in 1960 to an estimated $49,415 in 1973. (More recent data were not available; data concerning the average physician fee for an initial office visit are available for 1970, 1971, and 1973 only.)

The following table displays the above data in more detail.

<u>Hospital and Physician Charge and Fee Data</u>
<u>1960, 1965, 1970-75</u>

| Year | Average daily service charge, semiprivate hospital room, adult in-patients (note a) Charge | Percent Increase | Average physician net income | Average fee for initial office visit General practice | Internal medicine |
|---|---|---|---|---|---|
| 1960 | $17.90 | - | $ [b]19,517 | (c) | (c) |
| 1965 | 23.80 | - | [b]25,442 | (c) | (c) |
| 1970 | 43.50 | - | [d]41,770 | $ 8.46 | $ 17.82 |
| 1971 | 49.15 | 12.99 | [d]45,278 | 9.65 | 24.13 |
| 1972 | 52.99 | 7.81 | [d]47,239 | (c) | (c) |
| 1973 | 56.07 | 5.81 | [d]49,415(est) | 10.77 | 20.68 |
| 1974 | 59.76 | 6.58 | (c) | (c) | (c) |
| 1975 | 70.40 | 17.80 | (c) | (c) | (c) |

a/ The daily service charge includes room accommodations, food service, routine nursing care, and minor medical and surgical supplies. Ancillary services such as X-ray, laboratory, operating room visits, and pharmacy were excluded. Information was gathered from nongovernmental community (short-term general) hospitals registered by the American Hospital Association. Prior experience had shown that certain types of hospitals were atypical in their rate structure. Accordingly, the following types of facilities were excluded: (1) hospital units of such institutions as colleges and universities, prisons and schools for the mentally retarded, (2) children's hospitals, and (3) maternity homes. Charges for intensive care units, cardiac care units, and extended care units have also been excluded.

b/ Calculated using a comparative index compiled by the Social Security Administration.

c/ Not Available.

d/ Obtained from the American Medical Association.

## UTILIZATION OF BENEFITS AND INFLATION

CSC, Blue Cross/Blue Shield, and Aetna have estimated that there would be increases in utilization of benefits and inflation in 1976. CSC estimated that inflation would increase medical costs by about 15 percent in 1975 and at least 10 percent in 1976. CSC also has estimated that utilization of benefits will increase by about 5 percent annually in 1975 and 1976.

Aetna's 1975 paid claims through August 1975 were 24.2 percent higher than its 1974 paid claims through August 1974. Blue Cross/Blue Shield claims data showed cost increases over previous comparable periods of over 20 percent in the fourth quarter of 1974 and over 25 percent in the first quarter of 1975.

Since the projections used by CSC and the carriers were made on aggregate total claims paid, we were not able to determine the specific areas of utilization which had the greatest impact on the 1976 premium rate increases. We were, however, able to obtain specific information on inflation and utilization trends for Blue Cross/Blue Shield basic benefits for calendar years 1970-74. This information was compiled from fourth quarter utilization reports filed each year by Blue Cross/Blue Shield with CSC and represents all hospital benefits and most physician benefits paid under the high-option basic coverage of the plan. Benefits excluded account for 15.7 percent of the total benefits paid by Blue Cross/Blue Shield.

Inflation and Utilization Trends
for Blue Cross/Blue Shield High Option Basic Benefits (note a)

| Medical categories | Percent of Blue Cross/Blue Shield 1974 basic benefits | Year 1970 | 1971 | 1972 | 1973 | 1974 |
|---|---|---|---|---|---|---|
| Blue Cross in-hospital | 58.3% | | | | | |
| Cost per day | | $ 79.29 | $ 88.05 | $ 94.90 | $101.85 | $119.42 |
| Inflation increase | | - | 11.0% | 7.8% | 7.3% | 17.3% |
| Utilization increase or decrease (-) | | - | -3.8% | 2.4% | 6.7% | 1.5% |
| Blue Cross outpatient | 5.0% | | | | | |
| Charge per visit | | $ 22.87 | $ 25.16 | $ 27.31 | $ 29.84 | $ 34.91 |
| Inflation increase | | - | 10.0% | 8.5% | 9.3% | 17.0% |
| Utilization increase | | - | 7.8% | 7.8% | 6.1% | 11.6% |
| Blue Cross maternity | 4.2% | | | | | |
| Benefit per claimant | | $377.06 | $402.71 | $434.99 | $458.56 | $534.94 |
| Inflation increase | | - | 6.8% | 8.0% | 5.4% | 16.7% |
| Utilization increase | | - | -4.2% | -6.7% | -7.9% | 6.6% |
| Blue Shield inpatient surgery | 15.2% | | | | | |
| Charge per procedure | | $205.63 | $224.40 | $240.27 | $256.35 | $282.98 |
| Inflation increase | | - | 9.1% | 7.1% | 6.7% | 10.4% |
| Utilization increase | | - | 2.6% | -0.2% | 0.2% | 8.0% |
| Blue Shield inpatient medical Care | 5.4% | | | | | |
| Charge per visit | | (b) | $ 11.16 | $ 12.10 | $ 13.12 | $14.92 |
| Inflation increase | | - | (b) | 8.4% | 8.4% | 13.7% |
| Utilization increase | | - | (b) | 6.0% | -7.8% | 4.9% |

| Medical categories | Percent of Blue Cross/Blue Shield 1974 basic benefits | Year 1970 | 1971 | 1972 | 1973 | 1974 |
|---|---|---|---|---|---|---|
| Blue Shield outpatient surgical | 4.9% | | | | | |
| Charge per procedure | | $ 24.95 | $ 27.57 | $ 28.70 | $ 30.43 | $ 33.84 |
| Inflation increase | | - | 10.5% | 4.1% | 6.0% | 11.2% |
| Utilization increase | | - | 5.6% | 4.1% | 2.3% | 8.0% |
| Blue Shield outpatient X-ray | 3.4% | | | | | |
| Benefit per claim | | (b) | $ 23.72 | $ 24.54 | $ 25.43 | $ 28.32 |
| Inflation increase | | - | (b) | 3.4% | 3.6% | 11.4% |
| Utilization increase | | - | (b) | 4.4% | 2.1% | 11.0% |
| Blue Shield outpatient medical | 1.2% | | | | | |
| Benefit per claim | | (b) | (b) | $ 19.08 | $ 18.74 | $ 20.59 |
| Inflation increase | | - | (b) | (b) | -1.8% | 9.9% |
| Utilization increase | | - | (b) | (b) | -14.9% | 25.7% |
| Blue Shield maternity | 2.4% | | | | | |
| Benefit per claimant | | $174.62 | $190.62 | $201.79 | $207.49 | $225.68 |
| Inflation increase | | - | 9.2% | 5.9% | 2.8% | 8.8% |
| Utilization increase | | - | -0.8% | -4.5% | -4.6% | 7.7% |
| Total inflation (1973-74) | | | | | | 15.2% |
| Total utilization (1973-74) | | | | | | 4.5% |
| Total increase (combined inflation and utilization)[c] | | | | | | 20.3% |

a/ CSC inflation and utilization trends developed from fourth quarter statistics each calendar year.

b/ Information not available at CSC.

c/ Inflation and utilization compound on each other making the total greater than the simple sum of inflation and utilization.

Similar information could not be developed for Aetna because it provides information only on aggregate claims, without specific categories. Aetna has agreed to provide this type of information to CSC beginning in 1976.

## PSYCHIATRIC BENEFITS AND COSTS

To illustrate how increased benefits have affected the FEHB program, we prepared a history of psychiatric benefits.

At the inception of the FEHB program in 1960, benefits for treatment of mental illnesses were very limited. Since that time, the benefit structure has been liberalized, and mental illness benefit payments by Blue Cross/Blue Shield rose from 3.9 percent in 1960-65, to about 7.2 percent of all payments in 1974. CSC estimates that about 11 percent of Aetna FEHB claims payments were attributable to psychiatric charges in 1974.

### Benefit Structures

#### Blue Cross/Blue Shield

Originally, mental or nervous disorder basic benefits were limited to payments for care provided in a hospital, not to exceed 30 days (high option) or 10 days (low option) in any 12 consecutive months. Supplemental benefits were limited

> "to inpatient care (including treatment in a mental institution) and to 50 percent of outpatient and out-of-hospital treatment under the high option; to INPATIENT treatment in a hospital (not a mental institution) under the low option."

For the second contract period (Nov. 1961 to Oct. 1962) low option supplemental benefits were broadened to include payments for treatment in mental hospitals and outpatient and out-of-hospital facilities, subject to the applicable deductible and the percentage of copayment limitation.

In 1963 (Nov. 1963 to Oct. 1964 contract period) Blue Cross/Blue Shield increased mental benefits to provide 30 days of inpatient care for low option and 120 days for high option. The supplemental benefits were increased from 50 percent to 80 and 75 percent, respectively (high and low option), for drugs used in treating nervous or mental disorders.

In the 1967 contract, the plan significantly expanded psychiatric coverage. Supplemental benefits for nervous and mental disorders were increased to provide 80 percent (high option) and 75 percent (low option) coverage, or the same benefits provided for other illnesses. Day-night hospital care, collateral visits with members of a patient's family, group therapy, and services of a "mental health team" were also covered. For 1976 Blue Cross/Blue Shield has added hypnosis and hypnotherapy to mental and nervous benefits.

Aetna

Under the original Government-wide Indemnity Benefit Plan, benefits for mental and nervous disorders for patients not confined to a hospital were limited to 50 percent of covered expenses. Inpatient coverage for mental disorders was the same as for physical illness.

In the 1961-62 contract, Aetna limited annual out-of-hospital psychiatric benefits to 50 percent of allowable expenses or $250, "whichever is less."

In 1967 benefits for nervous and mental disorders were expanded. Under both options the plan provided benefits for hospital expenses for night care for mental or nervous related confinements in a "day-night" hospital and for "other hospital expenses and surgical-medical expenses" for day care, group therapy, and collateral visits with members of the patient's immediate family. Charges by psychologists and psychiatric nurses were also allowable under the condition that services were rendered "in accordance with specific instructions by an M.D. specializing in neurosurgery or psychiatry who diagnosed the disorders."

In 1968 Aetna removed the $250 limitation and the 50 percent limitation for payment for care provided for outpatient nervous and mental disorders, making benefits the same as for other illnesses. Benefits were also to cover expenses of psychiatric social workers. The condition that psychological service be provided on specific instruction of a medical doctor was removed in 1971.

For 1975 Aetna limited each person's outpatient psychiatric benefits to 20 sessions a year, or 40 sessions a year at a qualified community mental health center.

Costs

A CSC analysis shows that mental illness benefits paid by Blue Cross/Blue Shield increased absolutely and relatively from 1960 through 1973. Mental illness benefits as a percent of total benefits declined slightly in 1974 but is projected to rise in 1975. The table on page 18 shows Blue Cross/Blue Shield total benefits as compared to mental illness benefits.

Total Benefits Paid by Blue Cross/Blue Shield FEHB Plan, July 1960 through December 1974--High and Low Option Total (millions)

| Period | Total benefits | Mental illness benefits | Percent mental illness of total |
|---|---|---|---|
| 7/60 to 12/65 | $1040.4 | $ 40.2 | 3.9 |
| 1966 | 277.2 | 13.2 | 4.8 |
| 1967 | 336.8 | 18.1 | 5.4 |
| 1968 | 405.0 | 24.8 | 6.1 |
| 1969 | 480.9 | 30.4 | 6.3 |
| 1970 | 601.9 | 41.1 | 6.8 |
| 1971 | 698.9 | 49.1 | 7.0 |
| 1972 | 760.4 | 54.3 | 7.1 |
| 1973 | 848.2 | 61.8 | 7.3 |
| 1974 | 979.1 | 70.1 | 7.2 |

Aetna and CSC say comparable trend data for the Government-wide Indemnity Benefit Plan are not available. In 1974 Aetna officials estimated mental and nervous benefit percentages as follows:

| Year | Mental and nervous benefits percent of total claims |
|---|---|
| 1969 | 7 |
| 1970 | 8 |
| 1971 | 9 |
| 1972 | 10 |
| 1973 | 12 |

CSC estimates that 1975 claims attributable to mental and nervous disorders will be 8 to 9 percent of total claims, compared with about 11 percent from 1972-74. According to CSC, this decrease will result from Aetna's reduction of outpatient mental benefits. In two recent studies, Aetna estimated that about 8.5 percent of its 1974 open-season cancellations were from persons who had earlier submitted claims for mental and nervous benefits. CSC estimates that enrollee transfers from Aetna to Blue Cross/Blue Shield will increase total Blue Cross/Blue Shield mental and nervous benefits for 1975 by $5 million more than income will be increased. An Aetna study showed that mental and nervous claimants who left Aetna during the November 1974 open season had paid premiums of $721,847 in 1974 while submitting claims of $3,901,894--resulting in a loss ratio of 540.5 percent in this category of claims and claimants.

## CHAPTER 4

## DETERMINATION OF PREMIUM RATES FOR 1976

It would be easy to calculate premium rates if the exact amount that was needed to pay claims, administrative expenses, and taxes were known. Problems arise, however, because the exact amount of claims and expenses cannot be determined until after all claims and expenses arising during a particular contract year have actually been paid. Therefore, it is necessary to estimate in advance what claims and administrative costs will be.

If (1) there has been no change in benefits, (2) it is known that future claims and expenses will not increase, and (3) there is no change in the number of persons insured, the premium could be determined solely from past experience. These conditions, however, rarely, if ever, are found. Therefore, it becomes necessary to modify data obtained from past experience to represent what it is believed future claims and administrative expenses will be.

The projection or modification of past data into future estimates involves a considerable amount of judgement. Judgemental differences between the carriers and CSC necessitate the negotiation of final rates acceptable to both parties. By comparing the assumptions underlying the rates developed by the carriers and CSC, the differences are narrowed and premium rates are established on which both parties agree.

### CSC GUIDELINES FOR BENEFIT CHANGES

In a March 6, 1975, letter to all the FEHB carriers, the Director, Bureau of Retirement, Insurance, and Occupational Health of CSC, set forth certain guidelines governing proposed benefit changes for 1976. He stated that the Commission was "seeking ways to keep premiums from increasing significantly for the 1976 contract term" and that proposals for benefit changes which would result in significant additional cost would be considered only if most, or all, additional costs could be offset by modest reductions in other benefits.

### BLUE CROSS/BLUE SHIELD

#### Initial Rate Submission

On July 31, 1975, Blue Cross/Blue Shield submitted its preliminary rates for 1976 to CSC. Based on claims incurred and paid after the Economic Stabilization Program controls were lifted, Blue Cross/Blue Shield believed that an overall 38.4 percent rate increase was justified. New

benefits contributed a small portion to the increase--less than 1 percent of the total. The 1975 negotiated rates were underestimated to cover that year's claims. Therefore, 15 percent of the rate increase for 1976 is intended to recoup projected 1975 losses. The other significant portion of the rate increase request was attributable to anticipated inflation and moderate increases in utilization of health services in 1976.

Additional contributory factors to the rate increase that Blue Cross/Blue Shield cited in its preliminary proposal but did not quantify were:

--higher premiums for professional liability insurance for both hospitals and doctors (malpractice insurance);

--defensive medicine practices, such as requiring additional medical procedures to provide a defense should a malpractice suit arise; and

--expanding medical technology which produces more costly new medical procedures and instrumentation.

The 38.4 percent preliminary rate increase represented an overall factor applicable to both high and low options and individual and family contracts. The specific percentages applicable to each option were determined later during the negotiation process.

Civil Service Commission Actuarial Analysis

CSC had its actuarial staff do an independent projection of the 1976 Blue Cross/Blue Shield (and Aetna) rates. The FEHB program is self-sustaining since premiums contributed by the employee and the Government are intended to cover all program expenses, including CSC's administrative cost, which is limited to 1 percent of subscription income. A total of 4 percent of the premium is deposited in CSC's contingency reserve from which the Commission withdraws its administrative expenses. The remaining 96 percent goes directly to the carriers for claims and administrative expenses.

CSC actuaries, using partial 1975 claims experience, projected that (1) 1975 Blue Cross/Blue Shield claims would cost about 20 percent more than those incurred in 1974 and (2) there would be a 15 percent increase in 1976 over 1975. Since the actual 1975 rate had been based on a projected increase of only 10 percent, the 1976 rate had to be adjusted to reflect the 10 percent deficiency. Additionally, rates had to be increased to recoup some, or all, of the carriers' reserves which needed replenishing following the 1975 losses.

## Negotiation and Final Rates

Blue Cross/Blue Shield (and Aetna) negotiate with CSC using their preliminary estimates, until a mutually agreeable rate can be achieved. The basic contract which specifies rates, benefits, and other administrative matters, is amended annually to be effective for a one-calendar-year period.

On November 14, 1975, the 1976 contract between CSC and Blue Cross/Blue Shield had not been signed. Several points remained to be settled, including the amount for the public service charge (previously called a risk charge), set at $3.3 million for 1975. Blue Cross/Blue Shield is requesting 1 percent of total subscription income. This percentage would result in about $16 million in 1976.

In early September, CSC and Blue Cross/Blue Shield reached basic agreement on total income that would be needed to leave Blue Cross/Blue Shield in an improved financial position at the end of 1976. On September 5, Blue Cross/Blue Shield submitted another rate proposal revising its estimate down from a 38.4 percent increase to a 35.3 percent increase. CSC agreed with the aggregate increase but counterproposed on October 2 a distribution of the increase among the options of the contract so that each option would eventually become self-sustaining.1/ On October 8, Blue Cross/Blue Shield accepted the CSC rates as final for 1976.

## 1976 rating factors simplified

To explain the rating factors that produced the 35.3 percent aggregate 1976 rate increases for Blue Cross/Blue Shield, it is necessary to understand that premium charges for 1976 (or for any particular year) are not based simply on amounts needed to pay claims and administrative costs for 1976. Neither is the premium cost entirely related to total payments made during 1976 for claims received during 1976. Instead the premiums have been calculated to produce at the end of 1976 a specific financial goal. The goal includes

--covering the actual health care costs of claims and administration projected for 1976--the actuarially acceptable premium for the year;

--reflecting a break-even position on prior years' experience; i.e., establishing and adjusting reserves so that they will be adequate to cover the projected costs of 1975 and all prior years' claims incurred but not yet paid (liabilities for claim payments for care rendered during prior years);

---

1/Currently the low options have a surplus while the high options have a deficit.

--producing a contingency reserve equal to at least one month's subscription income; and

--moving toward an adequate rate for each option so that each rate is an actuarially acceptable rate for that particular option.

The aggregate rate increase of 35.3 percent can be viewed as moving from the 1975 rates now in effect to a 1976 estimated rate that will satisfy these four objectives.

First, the 1975 premium rate now appears to be inadequate, and a loss of around $127 million is currently projected by CSC (Blue Cross/ Blue Shield estimates the loss will be about $102 million). In other words, the 10 percent premium increase granted in 1975 over 1974 has proven to be too low (see p. 20); it should have been about 20 percent according to CSC calculations.

Second, CSC deems recoupment in 1976 of the 1975 loss necessary because the contracts between CSC and the carriers are for only one year. Therefore, spreading losses over longer periods which are not under contract would be inadvisable.

Third, the increased cost and increased utilization trends CSC has developed show 1975 costs to be 20 percent greater than 1974 costs with the forecast for 1976 being 15 percent greater than 1975. This 15 percent is the increase that would have been necessary had 1975 rates been adequate.

AETNA

Initial rate proposal

On April 15, 1975, Aetna proposed adding a benefit for usual and customary dental charges. The benefit was to apply only to dependent children covered under the high option. The company estimated the benefit would add $3.50 to monthly family, high option premiums. On July 7, 1975, the Commission accepted this proposal on condition the cost increase be offset by increasing the high option deductible.

Aetna submitted its 1976 rate proposal on July 31, 1975. Aetna requested a 41.9 percent rate increase over 1975. Aetna also asked that it be allowed to establish (1) a special reserve equal to 1 month's premiums and (2) a special provision for payments required by certain States for treatment not covered by the FEHB contract.[1/] Aetna stated

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[1/] GAO previously reported on this matter. "Conflicts Between State Health Insurance Requirements and Contracts of the Federal Employees Health Benefits Carriers" (B-164562), October 17, 1975.

that in the absence of this special provision, an additional 5-percent increase should be provided.

Civil Service Commission actuarial analysis

CSC's independent review of the Aetna submission resulted in the Commission's actuaries noting that 1975 claims might be 20 percent higher than the 1974 rate and that 1976 claims might be 10 percent higher than in 1975. CSC also found that Aetna's 1974 claim reserves were slightly higher than necessary at the end of 1974. Certain other differences resulted from using incurred, rather than paid, claims figures. On August 20, 1975, the Commission suggested Aetna revise its calculations and submit additional supporting data.

Aetna response

On September 5, 1975, Aetna provided more detailed analyses explaining why it believed 1975 claims would reach $259 million and why it believed the CSC 10 percent factor was too low. The company projected 12 percent for inflation and 5 percent for utilization increases. Aetna agreed with CSC's contention that a portion of the claim reserve for 1974 should be transferred to the special reserves held by Aetna and that CSC's projection of premium income for 1975 should be used.

Further actuarial analysis by CSC

In an internal memorandum of September 12, 1975, CSC's actuary stated that Aetna's original proposal requested a 54.2 percent increase, but after preliminary review and discussion with CSC, Aetna lowered its proposed increase to 44 percent. He then stated that "using our best estimate of claims and a zero special reserve goal suggest an experience rate increase of 26.6 percent would be sufficient.

In explaining the difference between Aetna's 44 percent and his 26.6 percent, CSC's actuary stated,

> "Approximately one-third of the 17.4 percent difference is a result of differences in the projection assumptions. The remaining two-thirds is the difference between the one month special reserve goal set by Aetna and the zero special reserve goal used in the CSC projection."

Part of the differences between CSC's and Aetna's initial projections occurred in estimating 1975 claims. Aetna's 1975 claims paid through August 1975 were 24.2 percent greater than 1974 claims paid through August 1974. Aetna assumed that the 24.2 percent increase would continue through 1975 while CSC estimated that the trend would fall back to a 22 percent increase. Also, CSC's estimate for 1976 claims included an

increase of 10 percent for inflation and 5 percent for increased utilization based on a trend analysis prepared by CSC's actuary. Aetna's estimate for 1976 included an increase of 12 percent for inflation and 5 percent for increased utilization. Aetna used these percentage increases for establishing premium rates for its group health insurance policies.

Negotiation and final rates

Aetna's final rates for 1976 were agreed upon during a September 1975 meeting between officials of CSC and Aetna. The agreement was for rates averaging 35 percent higher than 1975 rates. The high-option self-only premium was increased by 40 percent; the high-option family premium was increased by 34 percent; both low-option premiums were increased by 35 percent. The public service charge was raised from $1.3 million to $1.8 million. CSC's approval of the rates is contained in a letter dated October 2, 1975, to Aetna.

In analyzing the reasons for the increase, Aetna estimated that it will incur an operating loss of $31 million under the FEHB program in 1975. Therefore, the company estimated the 1976 rates would have to be increased 17 percent over 1975 rates to prevent a repetition of this deficit in 1976; therefore, about one half the 1976 proposed rate increase stems from the projection that 1975 rates were inadequate. The remainder of the increase is the result principally of expected increases in cost and utilization.

Other data provided by Aetna

On November 3, 1975, Aetna submitted information to GAO on recent increases in medical costs. The data show increases in the consumer price index for medical care services and semiprivate hospital daily rates of 13 percent and 18 percent, respectively, for July 1975 over July 1974. These increases were higher than for the corresponding previous 12-month period.

The data also show that for Aetna's total group comprehensive medical policies, utilization in the first six months of 1975 by employees was 18 percent above the first six months of 1974 and 15 percent higher by dependents. Both these percentages are higher than those for 1974 compared to 1973. The data also showed that the average charge per claim increased 12 percent for the first six months of 1975 over 1974.

In view of these statistics, Aetna takes the position that the increase factors of 12 percent for inflation and 5 percent for utilization, which it used in its 1976 FEHB program rate calculations, were lower than might be justified if full recognition were given to the data.

# CHAPTER 5

# OBSERVATIONS

This staff paper does not address the question of the reasonableness of premium rate increases; rather it discusses the methodology used by the carriers and CSC in arriving at the final premium rates. It should be recognized that changing any of the assumptions (such as inflation rate or utilization rates) would change the calculation of the premium rates needed.

At this time, we have no basis to question the rate increases agreed upon between CSC and the carriers. However, we have discussed with the Chairman, House Subcommittee on Retirement and Employee Benefits, the desirability of undertaking a comprehensive review directed at identifying areas where CSC and the carriers can act to control costs. For example, Congressional concern has been expressed regarding whether (1) the present system stimulates misutilization of health benefits and (2) the carriers and CSC have any incentives to control costs.

We believe that these are important questions which need answering and, until they are answered, little can be done to question the rising costs of health insurance for Federal employees.

In the meantime, there are two potential ways whereby the impact of the premium rate increases on Federal employees could be minimized--one would require legislative action and one would take a careful assessment by Federal employees of the various health insurance plans for which they are eligible.

## CALCULATION OF THE GOVERNMENT CONTRIBUTION

The Government contribution for health insurance premiums is computed on a simple unweighted average of the six largest Federal Employees Health Benefits Plans. This results in the Government paying less than 60 percent of total premiums for the majority of Federal employees. Congress could require CSC to calculate the Government contribution on a weighted basis by giving some recognition to the number of enrollees in each of the six plans.

Public Law 93-246, dated January 31, 1974 (5 U.S.C. 8906), raised the maximum Government biweekly contribution for health benefits to 50 percent (beginning in 1974) and 60 percent (beginning in 1975) of the "average of the subscription charges in effect on the beginning date of each contract year...for the highest level of benefits offered by

"(1) the service benefit plan;
"(2) the indemnity benefit plan;
"(3) the two employee organization plans with the largest number of enrollments, as determined by the Commission; and
"(4) the two comprehensive medical plans with the largest number of enrollments, as determined by the Commission."

Additionally, the law states the biweekly Government contribution "shall not exceed 75 percent of the subscription charge."

In other words, the maximum Government contribution is 60 percent of the unweighted average of the self-and-family and self-only, high option premiums of the six plans listed above, up to 75 percent of the total premium.

In hearings before the House Subcommittee on Retirement and Employee Benefits on October 21, 1975, there was concern over why the Government's contribution to health insurance premiums was less than the 60 percent stated in the law. The reason this situation exists is because unweighted averages are used in calculating the maximum Government contribution.

To illustrate, the following plans were used for calculating the 1976 Government contribution;

--Service Benefit (Blue Cross/Blue Shield).

--Indemnity Benefit (Aetna).

--American Postal Workers' Union (APWU).

--National Association of Letter Carriers (NALC).

--Kaiser Foundation Health Plan (Southern California).

--Kaiser Foundation Health Plan (Northern California).

Enrollment in the family high option benefit category of the largest plan (Blue Cross/Blue Shield) is over 45 times larger than that in the Kaiser Southern California plan. The law does not recognize enrollment as a weighting factor; therefore, whenever plans with high enrollments (employees and annuitants) have relatively high subscription rates, large numbers of employees receive less than a 60 percent Government contribution.

If the law permitted CSC to use a weighted average (recognizing enrollment in the six plans), more employees would benefit from a Government contribution closer to 60 percent of subscription charges. Using a weighted average would reduce an employee's high option family coverage

biweekly contribution from $21.01 to $18.24 for the Blue Cross/Blue Shield plan and from $15.33 to $13.56 for the Aetna plan.

The following table presents data comparing results of using the present system to calculate the Government share with a system using the results of a weighted average to arrive at the Government contribution.

Comparison of Government Contribution Using a Simple and Weighted Average Calculation

| Plan | Family high option enrollment (6/30/75) | Percent of all family high option enrollment | 1976 total biweekly premium | Percent of Government contribution | |
|---|---|---|---|---|---|
| | | | | Unweighted average (note a) | Weighted average (note b) |
| Blue Cross/ Blue Shield | 1,203,409 | 62.7 | $43.14 | 53.6 | 57.7 |
| Aetna | 216,325 | 11.3 | 38.46 | 60.1 | 64.7 |
| NALC | 120,826 | 6.3 | 36.59 | 63.2 | 68.1 |
| APWU | 96,410 | 5.0 | 36.40 | 63.5 | 68.4 |
| Kaiser-North | 36,632 | 1.9 | 34.42 | 67.2 | 72.3 |
| Kaiser-South | 26,708 | 1.4 | 42.29 | 54.7 | 58.9 |

a/ These percentages were calculated using the Government contribution for 1976--$23.13 for each biweekly period for each of the six plans.

b/ These percentages were calculated using the weighted-average method. The Government contribution under this method is $24.90 for each biweekly period for each of the plans. Each of the six plans was weighted according to family high option enrollment. The calculations represent (1) multiplication of each plan's enrollment by the plan's biweek subscription charge; (2) summing the six totals produced by the operations in (1); and (3) dividing the total produced in (2) by total enrollment in the six plans.

OTHER HEALTH PLANS AVAILABLE AT A LOWER COST

All Federal employees are eligible for seven health benefit plans. The monthly family high option premium rates for these seven plans range from a high of $93.47 (Blue Cross/Blue Shield) to a low of $57.66 (Government Employees Hospital Association).

It has come to our attention, during a survey we have in process, that most employees are aware they are eligible to join Blue Cross/Blue Shield and Aetna. However, very few are aware that they are also eligible to join any one of five employee organization health plans.

In order to join these employee organization health plans, an individual must join the organization as an associate or full member. Four plans require annual dues ranging from $27 to $45; one charges no annual dues. The following schedules compare the seven plans' biweekly rates for high and low option.

1975 and 1976 Premium Rates for Health Plans
Available to all Federal Employees

Family High Option

| Health Plan | Total biweekly premium | | | Employee share of total biweekly premium | | | Approximate biweekly 1976 dues |
|---|---|---|---|---|---|---|---|
| | 1975 | 1976 | Percent increase | 1975 | 1976 | Percent increase | |
| Blue Cross/ Blue Shield | $31.81 | $43.14 | 35.6 | $12.88 | $20.01 | 55.4 | - |
| Aetna | 28.70 | 38.46 | 34.0 | 9.77 | 15.33 | 56.9 | - |
| AFGE | 27.86 | 32.74 | 17.5 | 8.93 | 9.61 | 7.6 | $ 1.75 |
| GEHA | 22.65 | 26.61 | 17.5 | 5.66 | 6.65 | 17.5 | 0.00 |
| MHBP | 31.57 | 32.74 | 3.7 | 12.64 | 9.61 | -24.0 | 1.15 |
| AHBP | 25.67 | 29.20 | 13.8 | 6.74 | 7.30 | 8.3 | 1.05 |
| APWU | 36.40 | 36.40 | - | 17.47 | 13.27 | -24.0 | 1.15 |

Note: Benefits vary among plans.

## 1975 and 1976 Premium Rates for Health Plans Available to All Federal Employees

### Family Low Option

| Health Plan | Total biweekly health premium | | | Employee share of total biweekly premium | | | Approximate biweekly 1976 dues |
|---|---|---|---|---|---|---|---|
| | 1975 | 1976 | Percent increase | 1975 | 1976 | Percent increase | |
| Blue Cross/ Blue Shield | $ 9.99 | $11.81 | 18.2 | $2.50 | $2.95 | 18.0 | - |
| Aetna | 15.74 | 21.25 | 35.0 | 3.93 | 5.31 | 35.1 | - |
| AFGE | 10.91 | 10.91 | - | 2.73 | 2.73 | - | 1.75 |
| GEHA | 14.80 | 14.80 | - | 3.70 | 3.70 | - | 0.00 |
| MHBP | 20.81 | 21.59 | 3.8 | 5.20 | 5.40 | 3.9 | 1.15 |
| AHBP | 7.63 | 7.63 | - | 1.91 | 1.91 | - | 1.05 |
| APWU | (No low option available in 1976) | | | - | - | - | - |

Note: Benefits vary among plans.

Each individual employee must make an individual decision on the cost and benefits provided under each plan and each option. Before employees switch plans, they should carefully assess benefits offered by each plan and determine if the plan meets their health insurance needs.

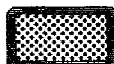
## 1976 MONTHLY PREMIUM FOR 7 HEALTH BENEFIT PLANS AVAILABLE TO ALL FEDERAL EMPLOYEES – FAMILY HIGH OPTION

DOLLARS

100
90
80
70
60
50
40
30
20
10
0

EMPLOYEE CONTRIBUTION

DUES FOR MEMBERSHIP REQUIRED FOR PLAN ELIGIBILITY


GOVERNMENT CONTRIBUTION

BLUE CROSS – BLUE SHIELD
AETNA
GEHA
AHBP
APWU
MHBP
AFGE

NINETY-FOURTH CONGRESS

RICHARD C. WHITE, TEX., CHAIRMAN
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GENE TAYLOR, MO.
ROBIN L. BEARD, TENN.

EX OFFICIO:
DAVID N. HENDERSON, N.C.
EDWARD J. DERWINSKI, ILL.

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

October 23, 1975

B-164562

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

Dear Mr. Comptroller General:

In view of the significant premium rate increases recently announced by some of the Federal employee health benefits carriers, we would like your office to provide us with some information regarding the rate increases of the two Government-wide carriers. We would like the General Accounting Office to provide the Subcommittee with:

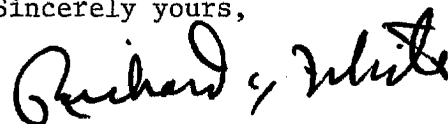
(1) a schedule of the total premium costs of the two Government-wide carriers from 1960 to the present, with the percentage increase each year, the amount of increase attributable to the benefit increase, the average doctor's charge for an office visit, as well as the average annual salary, and the average hospital charges for the following specific years: 1960, 1965, 1970, and 1975;

(2) a chart of the total outlay for psychiatric benefits for these two carriers from the time these benefits were included to the present as a percentage of total benefits paid; and

(3) a schedule of six areas of utilization which have had the greatest impact in the premium rate increases announced for 1976.

The Subcommittee would like to take some action on the premium rate increases by December 1, therefore, we would like for your office to present this information informally to the Subcommittee Members by November 20, 1975.

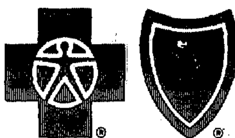
Sincerely yours,



BEST DOCUMENT AVAILABLE

Richard C. White
Chairman

**Blue Cross.**
**Blue Shield.**
Federal Employee Program



Robert J. Laur,
Vice President

1800 M Street, N.W.
Washington, D.C. 20036
(202) 785-7959

12 November 1975

Mr. Michael Speer
General Accounting Office
1000 Independence Avenue, S.W.
Room GE 120
Washington, D. C. 20024

Dear Mr. Speer:

Shown on the attached table are the data you requested regarding the rate impact of benefit changes in the Government-wide Service Benefit Plan for the years 1971-1976.

The rate changes are shown for each option and an overall, or aggregate change, is shown as well. The aggregate has been weighted to reflect the exposure of each option. The cost figures are estimates made at the time of rate submission to the Civil Service Commission, not necessarily the actual cost of providing the new benefits as reflected in our experience.

If you have any questions, please feel free to give us a call.

Sincerely,

Robert J. Laur

Robert J. Laur

RJL/sd
Attachment

Blue Cross and Blue Shield
Federal Employee Program

ANALYSIS OF PROSPECTIVE COST OF BENEFIT
CHANGES BY TYPE OF ENROLLMENT AND YEAR
1971 THROUGH 1976

| Year | High Option Single | | | High Option Family | | | Low Option Single | | | Low Option Family | | | Composite Cost of Benefit Changes as a Percent of Prior Year Subscription Rates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Prior Year Monthly Subscription Rate | Prospective Cost Estimates of Benefit Changes: Amount Per Month | Prospective Cost Estimates of Benefit Changes: Percent of Prior Year Rate | Prior Year Monthly Subscription Rate | Prospective Cost Estimates of Benefit Changes: Amount Per Month | Prospective Cost Estimates of Benefit Changes: Percent of Prior Year Rate | Prior Year Monthly Subscription Rate | Prospective Cost Estimates of Benefit Changes: Amount Per Month | Prospective Cost Estimates of Benefit Changes: Percent of Prior Year Rate | Prior Year Monthly Subscription Rate | Prospective Cost Estimates of Benefit Changes: Amount Per Month | Prospective Cost Estimates of Benefit Changes: Percent of Prior Year Rate | |
| 1971 | $15.71 | $.10 | .6% | $38.33 | $.17 | .4% | $ 8.32 | $.05 | .6% | $20.37 | $ .40 | 2.0% | .6% |
| 1972 | 19.63 | -0- | -0- | 47.91 | -0- | -0- | 10.40 | -0- | -0- | 25.48 | -0- | -0- | -0- |
| 1973 | 23.96 | .70 | 2.9 | 58.46 | * | | 10.40 | .39 | 3.8 | 25.48 | .28 | 1.1 | .5 |
| 1974 | 21.56 | .15 | .7 | 52.61 | .25 | .5 | 8.84 | .11 | 1.2 | 21.65 | .44 | 2.0 | .6 |
| 1975 | 25.74 | .03 | .1 | 62.77 | .15 | .2 | 8.84 | .20 | 2.3 | 21.65 | 1.13 | 5.2 | .4 |
| 1976 | 28.25 | .13 | .5 | 68.92 | .44 | .6 | 8.84 | .14 | 1.6 | 21.65 | .27 | 1.2 | .6 |

* No determinable actuarial effect.

11/12/75

BEST DOCUMENT AVAILABLE

## ABBREVIATIONS

| | |
|---|---|
| AFGE | American Federation of Government Employees |
| AHBP | Alliance Health Benefit Plan |
| APWU | American Postal Workers Union |
| CSC | Civil Service Commission |
| FEHB | Federal Employees Health Benefit |
| GAO | General Accounting Office |
| GEHA | Government Employees Hospital Association |
| MHBP | Mail Handlers Benefit Plan |
| NALC | National Association of Letter Carriers |