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Medicare Restructuring: THE FEHBP MODEL

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MEDICARE RESTRUCTURING: THE FEHBP MODEL

INTRODUCTION

Although the Balanced Budget Act (BBA) of 1997 included measures to reduce short-term growth in Medicare spending, there remain concerns that the aging of the baby boomers and continuing increases in the cost of medical services will lead to dramatic expenditure growth early in the next century. The National Bipartisan Commission on the Future of Medicare is charged with recommending, by March 1999, measures to assure the long-term solvency of the Medicare program. Among the alternatives it will be considering are incremental changes– such as raising the Medicare eligibility age– as well as some more fundamental restructuring of the program.

One restructuring option that has received considerable discussion is a model based on the Federal Employees Health Benefits Program (FEHBP), which offers multiple managed fee-for-service, point-of-service, and HMO plans to Federal employees and annuitants. Interest in the FEHBP model stems from generally high levels of satisfaction among participants and a perception that the program has been more successful than Medicare in restraining expenditure growth. (As will be seen, this success may have been overstated.) Some proposals would have Medicare adopt specific features of FEHBP, such as its bidding mechanism, while others would replace the traditional Medicare program with a system of private contracts modeled after FEHBP.

Many proponents of an FEHBP approach actually use "FEHBP" as a sort of shorthand to refer to any kind of structured, multiple-choice health insurance program. Some use FEHBP as a model for a defined contribution system, although it does not meet the usual definition of this term. Others treat it as a competitive bidding system, which it also is not. Stuart Butler and Robert Moffitt hold out FEHBP as a model for Medicare reform and then propose a program that differs from FEHBP in crucial ways, including risk-adjusted government contributions that are unrelated to plan prices, and maintenance of a default fee-for-service plan.[1] Similarly, the Physician Payment Review Commission's 1997 examination of competitive models used FEHBP (along with the California Public Employees' Retirement System, CalPERS) as an example of a working competitive system but then moved on to describe Medicare options that were fundamentally different from FEHBP.[2]

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[1] Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, v. 14, no. 4 (winter 1995), p. 47-61.
[2] Physician Payment Review Commission (now Medicare Payment Advisory Commission), *Annual Report to Congress 1997*, Washington, 1997.

Paradoxically, while the FEHBP experience is offered as evidence that a competitive model can work in practice for a large government program, the discussion quickly turns to alternative models that have never been tried anywhere. The actual workings of the program have received little scrutiny, and there has been no systematic examination of what it would really mean to adopt the FEHBP structure for Medicare.

This paper offers a detailed comparison of FEHBP and the Medicare+CHOICE program established under the BBA, which offers Medicare beneficiaries a choice of health plan options other than the original Medicare program. It then reviews the actual success of the FEHBP program, particularly in containing costs and avoiding selection bias. Finally, it considers whether any features of the FEHBP program would provide a useful model for Medicare reforms.

COMPARING MEDICARE+CHOICE AND FEHBP

ELIGIBILITY

Medicare+CHOICE

Medicare is a health insurance program for most elderly and some disabled people. It has two parts: part A (hospital insurance), which covers inpatient hospital and other institutional services, and part B (supplementary medical insurance), which covers physician, outpatient, home health, and other services.

Most people qualify for Medicare part A by paying a payroll tax during their working lives; they then automatically receive Medicare when they turn 65. People aged 65 or older who have not paid into the system may qualify by paying a monthly premium ($309 in 1999). Disabled people who have paid into the system receive Medicare part A after they have received Social Security disability payments for 24 months. Medicare also covers a small number of people with end-stage renal disease.

People who are eligible for part A, along with people aged 65 or older who are not eligible for part A, may voluntarily enroll in part B. All part B enrollees must pay a monthly premium ($45.50 in 1999). As table 1 indicates, most beneficiaries are enrolled under both parts A and B.

Table 1. Medicare Enrollment, July 1997
(hundreds of thousands)

	Aged	Disabled	Total
Both Part A and Part B	31,772	4,296	36,068
Part A only	1,466	519	1,985
Part B only	392	0	392

Source: HCFA, Medicare Enrollment Trends, 1966-1997

FEHBP

Federal employees and annuitants may choose to participate in FEHBP and may also enroll their spouses and children. (In the remainder of this report, the term "enrollees" will be used to refer to employees and annuitants, and not dependents, unless the context indicates otherwise.) About 81 percent of active

employees and 96 percent of annuitants participated in 1995.[3] Table 2 shows the number of participants in March 1998. The exact number of dependents is not available. In 1995 OPM estimated, using health plan data, that there were about 4.6 million dependents enrolled. The total number of persons covered through FEHBP is, then, about 9 million.

Table 2. FEHBP Enrollment, March 1998

	Number (000s)	Percent
Annuitants	1,855	45.0%
Nonpostal employees	1,561	37.9%
Postal employees	704	17.1%
Total	4,119	100.0%

Source: OPM data. Counts exclude dependents.

Note that there are two major groups of annuitants. About 26 percent have retired before turning age 65 and are thus not yet eligible for Medicare (unless they qualify through disability). Most annuitants over age 65 have both FEHBP and Medicare coverage. In this case, Medicare is their primary insurer, and FEHBP provides supplemental coverage. A very small number of annuitants retired before all federal employees were required to pay into Medicare part A; they may buy into part B but must rely solely on FEHBP for hospital coverage. This group is very old and is now negligible.

As noted earlier, some people eligible to participate in FEHBP choose not to do so. They may be eligible for coverage through a spouse's employment or through a public program, they may choose to obtain other private coverage at their own expense, or they may forgo insurance altogether. Table 3 shows the primary source of coverage for active federal workers in 1997. About 6.7 percent were uninsured. (Nationally, about 4.5 percent of workers who were offered insurance through their employment were uninsured in 1996.[4] While the proportion of Federal employees without insurance appears to be slightly higher than the national average, the difference is not significant because of small sample size.)

[3] IHPS calculation based on U.S. Office of Personnel Management, *The Fact Book, 1997 Edition: Federal Civilian Workforce Statistics*, Washington, 1997. (Hereafter cited as OPM 1997.)
[4] IHPS analysis of the 1996 Medical Expenditure Panel Survey (MEPS).

Table 3. Primary Health Insurance Coverage of Active Federal Employees, 1997

	Population (000s)	Percent
Employer plan through own employment*	2,941	79.4%
Employer plan through employment of another household member	326	8.8%
Other private	71	1.9%
Medicare or Medicaid	118	3.2%
Uninsured	249	6.7%
Total	3,706	100.0%

*Presumably FEHBP, but possibly coverage through other employment during the year.

Note: Persons with multiple coverage sources during the year are assigned to a primary source in the sequence shown.

Source: IHPS analysis of March 1998 Current Population Survey (CPS)

STRUCTURE AND FINANCING

Medicare+CHOICE

Medicare pays hospitals, physicians, and other medical care providers directly for covered services furnished to beneficiaries at rates established by law. Beneficiaries may instead choose to obtain their benefits through health plans contracting with Medicare. Medicare's payment rates for these plans are also set by law; the plans negotiate their own rates for participating providers.

Medicare's part A is almost entirely funded by the payroll tax, which is deposited into the Hospital Insurance Trust Fund. Originally, it was expected that workers' contributions to the trust fund would accumulate over their working lives and would be available to finance their part A benefits when they retired. Over time, however, part A expenditures have risen faster than contributions. As a result, the trust fund now pays out more than it takes in. Despite savings measures adopted in the Balanced Budget Act of 1997 (BBA), the trust fund is expected to be exhausted in 2008.[5]

Part B is funded only in part by beneficiary premium payments. For 1999 and later years, the premium is fixed at 25 percent of the expected monthly costs for aged beneficiaries. The remaining costs are paid from federal general revenues.

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[5] "Best estimate," Board of Trustees, Federal Hospital Insurance Trust Fund, *1998 Annual Report,* Washington, 1998.

Both premiums and the government contribution are paid into a Supplementary Medical Insurance Trust Fund. Unlike the Hospital Insurance Trust Fund, this fund was never expected to accumulate a surplus. Although its balance fluctuates, it is essentially financed on a pay-as-you go basis.

Administrative costs of the program are financed by transfers from the trust funds to the administering agency, the Health Care Financing Administration (HCFA) in the Department of Health and Human services. HCFA in turn contracts with private entities for many functions. Claims processing is managed by independent fiscal intermediaries and carriers, while peer review organizations (PROs) perform quality assurance and utilization control activities.[6]

Medicare is an entitlement program. For eligible people, covered services and the amount the government will pay for each service are defined by law. Spending is not limited by annual appropriations; instead, the government must spend whatever is necessary to fund the benefits, and can control spending only by changing the law.

FEHBP

FEHBP purchases coverage from private health insurance plans; it does not pay directly for any medical services or regulate the amounts the plans pay.[7] Active employees receive a contribution from their employing agency and pay the remainder of their premium themselves. The government cost for their coverage is part of the appropriation for each agency; the agency then transfers the required amounts to the administering agency, the Office of Personnel Management (OPM). Annuitants also receive a federal contribution; this amount is not transferred from their former agency, but is part of the appropriation for OPM.

Employee and annuitant premium payments and government contributions are deposited in two trust funds, one for employees and one for annuitants. The premiums charged for health plans include surcharges for program administration and "contingency reserves," discussed below. The funds pay premiums to the health plans and transfer necessary amounts for administration to OPM. Any remaining amounts not paid out to the health plans are retained in the funds.

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[6] For beneficiaries joining contracting health plans, these functions are performed by the plan, except that PROs perform some health plan oversight functions for HCFA.

[7] Except that non-HMO plans with non-Medicare retirees over age 65 must pay for their services at Medicare rates.

FEHBP is not exactly an entitlement program and not exactly an appropriated one: it is an open-ended spending commitment whose size is subject to administrative discretion. The benefits available under FEHBP plans are generally not defined by law. OPM negotiates the benefits, and the premium rates to be charged, with each plan. OPM can thus increase or decrease total program spending without any change in the law. However, once OPM has completed its negotiations for a year, the benefits become an entitlement for employees and annuitants. They are entitled to join the plan of their choice from among the options offered by OPM, and their employing agency or OPM must make a contribution on their behalf in an amount defined by a formula to be discussed below. While costs for employees' benefits are built into each employing agency's annual appropriation, the agency cannot limit its contributions if costs exceed the budgeted amount– as they will probably do in 1999, because of unanticipated rate increases (see below). Instead, the agency must economize in some other way to make up the difference.

CHOICE OF PLANS

Medicare+CHOICE

Medicare beneficiaries are enrolled by default in the Medicare fee-for-service program, now described by HCFA as "original Medicare." They may obtain services from any provider meeting specified standards. Medicare generally pays for services using fixed prices; some services are paid on the basis of providers' actual costs. Beneficiaries are liable for cost-sharing for most services, and there are some services Medicare does not cover, such as outpatient prescription drugs. As a result, most beneficiaries who can afford to do so purchase private supplementary coverage known as Medigap, or obtain comparable coverage as a retirement benefit through their former employers. Very low-income beneficiaries may receive supplementary coverage through the federal-state Medicaid program. Table 4 shows national estimates of sources of coverage for fee-for-service enrollees in 1995.

Table 4. Supplemental Insurance Status Of Beneficiaries In Medicare Fee-For-Service, 1995

Type of Coverage	Percent
Medigap	33%
Employer provided	31%
Medigap and employer provided	6%
Medicaid	15%
Other supplemental	2%
Medicare only	13%

House Committee on Ways and Means, *1998 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*, Washington, 1998.

A beneficiary may instead choose to enroll in a Medicare+CHOICE plan if there is such a plan available in his or her area. (Only beneficiaries who are enrolled under both parts A and B are eligible.) The beneficiary agrees to obtain nearly all Medicare-covered services through the plan, which covers Medicare's basic benefits and usually also provides supplemental benefits. The plan is paid a monthly premium by the Medicare program and may also impose a premium on enrollees (over and above the part B premium paid by most beneficiaries).

There are three types of Medicare+CHOICE plans:

- Coordinated care plans, which may include health maintenance organizations (HMOs), point-of-service (POS) plans, provider-sponsored organizations, and preferred provider organizations (PPOs); all of these plans use provider networks, with varying degrees of restriction on the use of out-of-network providers or financial incentives to use network providers. In general, Medicare does not regulate the amounts these plans pay their affiliated providers.[8]

- MSA plans, which provide high-deductible coverage to beneficiaries choosing to establish medical savings accounts, and which may or may not use restrictive provider networks. (These are available on a limited demonstration basis.)

[8] Payments for urgent out-of-network services are regulated, and there are restrictions on incentive payments to physicians to control the use of services.

- Private fee-for-service plans, which must cover the services of any qualified provider, paying at Medicare rates or rates negotiated with providers.

The Medicare+CHOICE options were created by the BBA and take effect in January 1999. Before its enactment, beneficiaries had the option of enrolling in an HMO under a "risk contract." As under Medicare+CHOICE, an enrollee who takes this option agrees to obtain Medicare benefits through the HMO. The HMO assumes the financial liability for furnishing these benefits in return for a monthly premium.[9] In effect, the new coordinated care option subsumes the former HMO option. To date, no carrier has chosen to offer either of the other two types of Medicare+CHOICE plans. For this reason, the discussion in the remainder of this report will generally be confined to the coordinated care option.

In 1998, about 75 percent of beneficiaries lived in an area with at least one risk HMO available; this total may change for 1999 because of new plans and plan withdrawals (see below). As of October 1998, 16.9 percent of all beneficiaries were enrolled in a risk HMO. HMO penetration varied widely by state, from 0.1 percent in South Dakota to 39.5 percent in California. About 55 percent of enrollees were in five states: California, Florida, New York, Texas, and Pennsylvania. (These states account for 35 percent of all Medicare beneficiaries.)[10]

As table 5 indicates, Medicare HMO enrollment is heavily concentrated in a few health plans. The top six contracting organizations account for more than half of all enrollees.

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[9] About 2 percent of beneficiaries have been enrolled under various types of "cost" contracts; the HMO or other organization receives a monthly premium payment, but receives additional payment if its actual costs exceed this amount. The BBA phases out most of these contracts, except for a few with union or employer health plans.
[10] IHPS computation based on HCFA quarterly penetration data.

Table 5. Percent of Medicare Risk Enrollees In Plans Affiliated with National Firms, June 1997

Name	Percent
PacifiCare-FHP	21%
Kaiser Foundation	11%
Humana	8%
Aetna U.S. Healthcare	7%
United Healthcare	6%
Foundation-HSI	5%
Oxford	3%
Sanus	2%
Prudential	2%
HIP	2%
CIGNA	2%
All other	31%

Note: This table differs from the source in not counting enrollees in individual Blue Cross plans (about 9 percent) as being in a national firm. Blue Cross HMOs are operated by local affiliates with no involvement by the national association.

Source: House Committee on Ways and Means, *1998 Green Book,* based on Physician Payment Review Commission.

FEHBP

FEHBP participants are not, as under Medicare, enrolled by default in any plan. Instead, they must choose from among three different types of plans:

- The government-wide Blue Cross/Blue Shield plan. This fee-for-service plan will pay for services from any provider but offers reduced cost-sharing when services are obtained through the plan's PPO network of contracting providers.

- Fee-for-service plans offered by employee organizations; of these, 6 are open to all employees, while 6 are available only to specific groups, such as the Foreign Service or the Secret Service. Except for a few of the special-group plans, these plans also include a PPO feature.

- Comprehensive medical plans (CMPs). Unlike Blue Cross/Blue Shield and the employee organization plans, CMPs are available only to employees residing in specific service areas. There are about 300 CMPs available in 1999.

Most of these are HMOs, covering non-emergency services only when obtained through providers in the HMO's network. There are 26 POS plans, which will pay for out-of-network services but impose higher cost-sharing for these services. There is one national point-of-service plan, and at least one other CMP in every state except Alaska and Wyoming.

Many of the fee-for-service plans offer two levels of benefits, "high option" and "standard option." The high option plan offers reduced cost-sharing or other enhanced benefits in return for a higher premium.

Table 6 shows March 1998 enrollment by type of participant and type of plan. Overall, 70 percent of participants were in Blue Cross/Blue Shield or one of the fee-for-service plans offered through an employee organization. Annuitants are the least likely to enroll in CMPs, postal employees the most likely. Note that the table is confined to employees and annuitants. Dependents are slightly more likely to be in CMPs; about 34 percent were in CMPs in 1995.

Table 6. FEHBP Enrollment by Type of Plan and Enrollee, March 1998

Type	Annuitants	Nonpostal employees	Postal employees	Total
Blue Cross/Blue Shield	1,014	616	220	1,850
Percent	*54.7%*	*39.5%*	*31.3%*	*44.9%*
Employee organization	536	335	168	1,039
Percent	*28.9%*	*21.5%*	*23.8%*	*25.2%*
CMP	305	610	316	1,230
Percent	*16.4%*	*39.1%*	*44.9%*	*29.9%*
Total	1,855	1,561	704	4,119
Percent	*100.0%*	*100.0%*	*100.0%*	*100.0%*

Source: IHPS, based on OPM data

As under Medicare, FEHBP participants are highly concentrated in a few of the contracting organizations. Over three-quarters of enrollees are covered by just five organizations, only one of which is an HMO.

Table 7. FEHBP Enrollment by Plan or National Chain, March 1998

Name	Employees	Annuitants	Total	Percent
Blue Cross	835,968	1,013,993	1,849,961	44.9%
Standard	*820,548*	*937,422*	*1,757,970*	*42.7%*
High	*15,420*	*76,571*	*91,991*	*2.2%*
Mail Handlers	291,516	161,040	452,556	11.0%
Kaiser Foundation	180,061	98,415	278,476	6.8%
Government Employees Health Association	107,269	142,997	250,266	6.1%
National Association of Letter Carriers	31,016	84,074	115,090	2.8%
Aetna U.S. Healthcare	88,013	14,646	102,659	2.5%
American Postal Workers Union	30,774	66,283	97,057	2.4%
PacifiCare	62,125	15,668	77,793	1.9%
NYLCare	48,461	5,474	53,935	1.3%
Humana	33,812	10,699	44,511	1.1%
Rural Letter Carriers	13,156	29,349	42,505	1.0%
Prudential	34,918	6,889	41,807	1.0%
All other	507,516	205,049	712,565	17.3%
Total	2,264,605	1,854,576	4,119,181	100.0%

Note: The Blue Cross/Blue Shield total represents enrollment in the government-wide plan and does not include enrollment in HMOs offered by individual Blue Cross affiliates.

Source: IHPS, based on OPM data.

BENEFITS

Medicare+CHOICE

The basic benefits under original Medicare were established in 1965 and have not been significantly modified since. (A major benefit expansion under the Medicare Catastrophic Coverage Act of 1988 was repealed a year later.) While the package was comparable to standard employer group policies at the time of enactment, it is now considerably less generous than many private plans. It

imposes a heavy inpatient deductible ($768 per benefit period in 1999), requires 20 percent coinsurance for most part B services, and provides no limit on beneficiaries' out-of-pocket liability. As a result, in 1995, original Medicare paid 84.9 percent of costs for covered services for beneficiaries in the fee-for-service program; the remaining 15.1 percent was paid by beneficiaries (or by their supplemental coverage) in the form of required deductibles, coinsurance, and balance billing by providers.[11] In addition, the program omits entirely such important services as outpatient prescription drugs.

Medicare+CHOICE plans must provide nearly all covered Medicare services (the major exception is hospice care). In addition, they *must* provide supplemental services if their monthly payment from Medicare is more than the plan's "adjusted community rate" (ACR) for the Medicare benefit package (the ACR concept and its effect on benefits is discussed further below). They *may* provide additional supplemental services as "basic" benefits for all enrollees. In addition, they may establish a "high option" plan that provides further supplemental benefits for enrollees who choose to purchase them.

The most common supplemental benefit in Medicare HMOs has been waiver or reduction of Medicare's cost-sharing requirements. Commonly, there is no charge for inpatient services, and Medicare's 20 percent coinsurance for outpatient services is replaced by a copayment, such as $10 per physician visit. In 1998, 93 percent of plans imposed at least some copayments.

As table 8 shows, most plans also provide some supplemental benefits in addition to the reduction in cost-sharing. Perhaps the most important of these benefits for most beneficiaries is outpatient drugs, which are covered by about two-thirds of the plans. However, this coverage is often very restricted. For example, of the three HMOs available to beneficiaries in Washington, D.C., in 1999, two limit drug coverage to $1,000 per year, while the third has a limit of just $300 per year.[12]

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[11] U.S. House, Committee on Ways and Means, *1996 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*, Washington, 1996.
[12] 1999 benefit information from "MedicareCompare" on HCFA web site, www.hcfa.gov.

Table 8. Supplemental Benefits in Basic Package, Medicare Risk HMOs and CMPs, October 1998

Benefit	Number of plans	Percent of plans
Routine physicals	327	97%
Immunizations	304	90%
Eye exams	280	83%
Ear exams	243	72%
Outpatient drugs	226	67%
Health education	128	38%
Dental	124	37%
Foot care	101	30%
Lenses	2	1%
Hearing aids	2	1%

Source: HCFA, Managed Care Monthly Report, Oct. 1998.

Some form of high-option package was offered by 51 percent of plans in October 1998; national data on benefits in these plans are not available.

In summary, all Medicare+CHOICE plans are significantly more generous than original Medicare. If a plan imposes no copayments, it is immediately about 18 percent more generous than original Medicare (assuming the 15 percent average cost-sharing in original Medicare cited above). If it imposes copayments, its value may be somewhat lower, but is increased by any supplemental benefits it offers.

FEHBP

There is no prescribed minimum benefit package for FEHBP plans.[13] OPM from time to time specifies particular benefit changes it wants from all plans. For example, it is currently moving plans in the direction of greater equity in medical and mental health benefits. In general, however, the plans themselves develop their benefit packages.

- Fee-for-service plans were expected, at the time of their entry into the program, to offer benefits comparable to those offered to large employer groups.

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[13] 5 USC 8904(a) requires that plans "include benefits both for costs associated with care in a general hospital and for other health services of a catastrophic nature."

- CMPs are generally expected to offer the plan most frequently purchased by their commercial subscribers. The few CMPs that are experience-rated offer the highest level of benefits made available to any employer group, or their current FEHBP package, whichever is higher.

Once admitted to FEHBP, each plan may propose annual changes in benefits, which may or may not be accepted by OPM. OPM's current policy is to seek benefit stability; significant year-to-year changes in benefits are discouraged. Except for changes mandated by OPM, changes are usually expected to be budget neutral. That is, the cost for a new benefit must be offset by a reduction in some other benefit.

All FEHBP plans are more generous than original Medicare. All have lower inpatient deductibles (or none), provide a limit on out-of-pocket spending, and include some amount of coverage for outpatient physician drugs. Those with a PPO option usually impose lower coinsurance than Medicare's 20 percent for physician and ambulatory services. The CMPs, like Medicare HMOs, replace coinsurance with per-visit copayments.

Historically, there has been considerable variation in plan benefits. A study by the Congressional Research Service, looking only at the fee-for-service plans, found that the most generous plan in 1988 had an actuarial value for single enrollees 42 percent higher than that of the least generous plan. For families, the maximum difference in actuarial value was 56 percent.[14] Since that time, OPM has moved to narrow the differences among plans. For example, there are no longer plans that pay a fixed amount for all services regardless of whether any provider will accept that amount; all plans now cover prescription drugs. However, significant variations remain. Plans impose different levels of cost-sharing, have different annual out-of-pocket limits, and differ in the extent of their coverage of ancillary services such as prescription drugs and dental and vision care.

There has been no formal analysis in recent years of the variation in value among FEHBP plans. However, some indication of the variation may be derived from the independent guide to FEHBP plans produced annually by the Center for the Study of Services, publishers of the *Washington Consumers' Checkbook*.[15] The guide estimates, for enrollees incurring different amounts of hospital, medical,

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[14] U.S. Library of Congress, Congressional Research Service, *The Federal Employees Health Benefits Program: Possible Strategies for Reform*, Report prepared for the House Committee on Post Office and Civil Service, Washington, 1989 (Committee Print 101-5).

[15] Center for the Study of Services, *Checkbook's Guide to 1998 Health Insurance Plans for Federal Employees* (by Walton Francis and the Editors of Washington Consumers' Checkbook), Washington, 1997.

drug, and dental bills during a year, the amount of out-of-pocket liability they would experience under different plans. These estimates can in turn be used to estimate overall plan benefit value. (The method is discussed in appendix B.)

Table 9 shows the results for single enrollees in Washington, D.C., area plans in 1998. On average, the HMOs are about 19 percent more valuable than the PPOs; the highest estimated HMO value is 31 percent greater than the lowest estimated PPO value. There is also some variation in value within each type. The Preferred Health HMO has an estimated value about 10 percent higher than that of NYLCare Standard; the GEHA PPO has a value about 12 percent higher than that of the NALC PPO.

These estimates depend, of course, on the validity on the *Consumers' Checkbook* analysis. OPM has reportedly calculated that differences in plan actuarial values are as little as 10 percent.[16] Even if the higher estimates are correct, variation in plan value appears to have narrowed considerably in recent years. However, enrollees choosing the PPO options trade greater flexibility in choice of providers for higher exposure to out-of-pocket costs and reduced benefit value.

[16] Personal communication cited in Physician Payment Review Commission, *1997 Annual Report.*

Table 9. Estimated Benefit Value of Washington, D.C., Area FEHBP Plans for Single Enrollees Using Network Providers, 1998

	Estimated benefit value
HMOs	
NYLCare Standard	$ 2,106
QualChoice	$ 2,118
G. Washington Standard	$ 2,122
United HealthCare	$ 2,215
CapitalCare	$ 2,216
G. Washington High	$ 2,230
M.D. IPA	$ 2,240
Columbia	$ 2,251
Prudential	$ 2,265
CareFirst	$ 2,269
CIGNA	$ 2,272
Free State	$ 2,272
NYLCare High	$ 2,279
Aetna U.S. Healthcare	$ 2,282
Kaiser	$ 2,300
Preferred Health	$ 2,310
Average HMO--	$ 2,234
PPOs	
NALC PPO	$ 1,762
Postmasters Standard PPO	$ 1,809
APWU PPO	$ 1,838
Mail Handlers Standard PPO	$ 1,854
Alliance PPO	$ 1,928
Blue Cross Standard PPO	$ 1,950
Mail Handlers High PPO	$ 1,957
GEHA PPO	$ 1,979
Average PPO--	$ 1,885

Note: Blue Cross High and Postmasters High are omitted, because the source provides no out-of-pocket cost estimate for in-PPO utilization.

Source: IHPS estimates based on Center for the Study of Services, *Checkbook's Guide to 1998 Health Insurance Plans for Federal Employees.* See appendix for discussion.

PLAN RATES AND GOVERNMENT CONTRIBUTIONS

Medicare+CHOICE plans know in advance the average federal contribution they will receive to provide the minimum Medicare benefits for each enrollee. They then establish their supplemental benefits and any required premium to be paid by the enrollee, taking into account any profit they expect to make on the federal payment for the minimum benefits. The process under FEHBP is theoretically more or less the reverse. The plans develop a total benefit package and quote a price for it. The amount of the federal contribution, and hence the amounts enrollees must pay, is dictated by the average of the plans' rate quotations.

Medicare

The federal contribution for an enrollee in a Medicare+CHOICE plan is based on average expected costs for similar beneficiaries remaining in the traditional fee-for-service program. Until 1998, the basic payment rate for each county was set equal to 95 percent of average costs in that county.[17] The county-level rate-setting process meant that there were large disparities in rates, particularly between urban and rural counties but also among neighboring counties in the same metropolitan area. In addition, rates could change markedly from year to year in counties where the computation was based on a small number of fee-for-service beneficiaries. The BBA made changes in the computation intended to reduce the amount of variation in rates for different counties and the degree to which rates for a given county would fluctuate from year to year.[18]

The actual payment for each individual enrollee is the county rate times factors to reflect age, sex, institutional status, and Medicaid eligibility. These factors, intended to reflect differences in expected utilization and cost, have been found to have relatively low predictive value. The BBA requires HCFA to implement a risk-adjustment system by 2000, in order to better reflect the health status and

[17] Separate rates are established for the aged, the disabled, and persons with ESRD. The latter may not enroll in an HMO, but may remain in the plan if they are enrolled before developing ESRD.

[18] Rates for each county are determined on the basis of a blend between costs in that county and national average costs. The actual rate for a county is the greater of this amount or a national minimum amount--$379.84 per month for aged enrollees in 1999. In addition, each county is assured at least a 2 percent rate increase each year. For 1998 and 1999, the result of these two minimums is that every county's rate is either the national minimum or 2 percent above its prior year rate; no county is being paid under the blended rate. HCFA is supposed to adjust the blended rate to assure that total payments are no more than would have been made under the old system. This adjustment has produced blended rates in every county that are below one or the other of the two specified minimums. See the discussion in HCFA's *Federal Register* notice of June 26, 1998 (v. 63, no. 123, p. 35004-5).

expected cost of individuals in each plan. (The issue of risk selection and risk adjustment is discussed further below.)

Medicare+CHOICE plans, in March of each year, learn the federal payment rates that will apply to their enrollees in the following year. They are then expected to compare their average expected federal payments to their adjusted community rate (ACR) for the minimum Medicare benefits. The ACR is supposed to reflect what the plan would charge non-Medicare enrollees for the same set of benefits, with adjustments to take into account differences in demographic characteristics of Medicare and non-Medicare enrollees. If the ACR is less than the expected Medicare payment, the plan must generally provide, at no cost to enrollees, supplemental benefits of a value equal to the difference. (This provision does *not* mean that the HMO must, in effect, turn over its entire profit on the Medicare payment in the form of additional benefits. The ACR already includes the HMO's usual profit margin on its commercial contracts. So additional benefits are required only when the Medicare profit would be greater than the usual commercial profit.)

The plan may choose to provide supplemental benefits beyond the minimum requirement. If its ACR for the total package of basic Medicare and supplemental benefits exceeds the expected Medicare payment, it may charge the difference to enrollees in the form of a supplemental premium. (There will be an additional supplemental premium in plans that distinguish between basic and high-option benefit packages.) The plan may instead fund part of the benefits by accepting a profit margin on the Medicare benefits lower than the margin included in the ACR.

Table 10 shows the monthly premiums charged to enrollees by HMOs for their basic package in 1998. As the table indicates, almost 70 percent of plans charged no premium. This is because their payment from Medicare was sufficient to cover the entire package, including the minimum Medicare benefits and the supplemental benefits.

Table 10. Monthly Premium for Basic Package, Medicare Risk HMOs and CMPs, October 1998

Basic monthly premium	Number of plans	Percent of plans
$0	236	69.8%
$ 0.01 - $19.99	15	4.4%
$20.00 - $39.99	43	12.7%
$40.00 - $59.99	23	6.8%
$60.00 - $79.99	18	5.3%
$110.00	1	0.3%
Average -- $11.39		
Median -- $35.00		

Source: HCFA, Medicare Managed Care Monthly Report, Oct. 1998

Plans are required to notify HCFA of their supplemental benefits and premiums for a year by May 1 of the preceding year. This early lock-in has had an unforeseen effect in 1998. Some plans have determined, relatively late in the year, that they cannot afford to offer coverage at the rates they proposed in May. As a result, some have terminated their Medicare contracts in specific counties or have withdrawn from the program altogether. The issue of plan termination is discussed further below.

FEHBP

The federal contribution for FEHBP, unlike that for Medicare, is not set before the plans establish their benefits and premium rates. Instead the contribution is set on the basis of the plans' rate quotations. This section will therefore describe rate-setting first, and then the method for setting government contributions.

Rating. Two methods are used to establish plan premiums: experience rating and community rating.

- Experience rating is used for all the fee-for-service plans and 22 of the CMPs in 1998. Rates are based on the individual plan's projected costs for serving FEHBP enrollees in the coming year, plus a "service charge"– in effect, a

profit allowance--of from 0.5 percent to 1.0 percent.[19] The cost projection relies on the plan's past cost experience with the FEHBP group. The 1998 rates, for example, are based on actual cost data from 1996, trended forward for inflation, benefit changes, and other factors expected to affect costs. This computation necessarily involves some subjective judgment and thus becomes the subject of negotiation between OPM and plans.

- Community rating is used for the vast majority of CMPs. The plan reports the rates it charges to the two employer groups whose enrollment is closest in size to the plan's FEHBP enrollment, excluding any group whose rate is established on a retrospective experience basis. The lower of the two quotations is the "community rate," which is then adjusted for "expected use of medical resources of the FEHBP group." This adjustment reflects differences in the benefit package for FEHBP and the particular employer group and *may* reflect demographic differences or other factors expected to affect utilization or costs. Note that the demographic adjustment only occurs if the plan's usual method of establishing rates for employer groups includes demographic factors.[20] In addition, the adjustment affects the uniform price quoted by the plan for all enrollees; no particular enrollee is charged more or less because of his or her age or other factors.[21]

- For both experience-rated and community-rated plans, the agreed-upon rates are increased by 1 percent for administration and 3 percent to provide a contingency reserve for each plan. The reserve is held in the trust funds and may be drawn upon if a plan's costs exceed its premium receipts. The administrative allowance pays OPM's expenses. As these are well below 1 percent of premiums, the excess goes to build up the reserves.

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[19] This profit allowance varies by contractor performance (e.g., in timely processing of claims), degree of risk assumed, promotion of federal socioeconomic objectives (such as substance abuse reduction), and other factors.

[20] Beginning in 1999, payments to a CMP may be reduced by as much as 1 percent if the CMP fails to meet "customer service performance standards," such as accuracy of consumer information and timely consideration of disputed claims, and "critical contract compliance requirements," such as timely submission of information to OPM. Note that this reduction does not affect the plan's quoted premium or the amount paid by an enrollee; any withheld amounts go into the contingency reserves.

[21] One recent study erroneously asserts that plans can charge different premiums by age and sex, and even takes Butler and Moffit to task for correctly describing the program. Roger Feldman, Bryan Dowd, and Robert Coulam, *The Federal Employees Health Benefits Plan: Implications for Medicare Reform*, Report prepared for HCFA and the Competitive Pricing Advisory Committee by Abt Associates, Cambridge, MA, June 1998.

In theory, FEHBP's payment rates represent reasonable cost for fee-for-service plans and a market-driven price for CMPs. However, there are two key deficiencies in the system that may have affected competition among plans.

First, rates are established nationally for the fee-for-service plans and locally or regionally for the CMPs. This means that a fee-for-service plan may be more costly than the CMPs in some areas and less costly in others. In 1998, for example, the Blue Cross/Blue Shield standard biweekly rate for single enrollees is $85.75. This compares to an average of $59.74 for five CMPs in New Mexico and an average of $98.22 for the two CMPs in Delaware.

Second, while rates for the fee-for-service plans reflect their actual costs for FEHBP enrollees, those for a CMP are based on its prices for other employer groups, and may or may not reflect differences between FEHBP enrollees and the plan's commercial enrollees. Nor is there any attempt to adjust the rates to reflect any differences in the characteristics of FEHBP enrollees choosing different plans. The potential effects are considered in the discussion of risk selection later in this paper.

Government contribution. Through 1998, the government contribution was tied to the prices of five plans: Blue Cross/Blue Shield, the two largest employee organization plans, and the two largest CMPs.[22] Beginning with 1999, the maximum government contribution will be the lesser of (a) 75 percent of the premium for the plan selected or (b) 72 percent of the average premium, weighted by enrollment, of all participating plans. Thus, even if a plan's premium is so low that the maximum government contribution would cover all of it, the enrollee must still pay 25 percent. As a result, the government will be paying just over 70 percent for the average enrollee in 1999 (assuming enrollees remain in their 1998 plans).[23]

The 75 percent rule was adopted in the view that participants should always contribute something to the cost of their care, presumably on the theory that they would then be less prone to obtain unnecessary services. However, it distorts the price comparisons presented to enrollees and may therefore affect competition. Table 11 shows single premiums for the Washington, D.C., area health plans affected by the rule in 1998. The standard federal contribution for single enrollees of $1,715 per year is greater than 75 percent of the plans' annual single premium, so the federal contribution is reduced, leaving the enrollee shares

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[22] The formula also averaged in a fictitious premium for a sixth, "phantom" plan, replacing the Aetna indemnity plan terminated in 1989. This premium was derived from those of the other five plans.

[23] Postal employees have negotiated separate contribution rates, which may be as high as 89 percent of a plan's premium.

shown. In the absence of the 75 percent rule, the standard contribution would cover the entire cost of the cheapest plans. The rule has two consequences: it reduces the incentives for participants to choose lower-cost plans, and at the same time reduces the incentive for plans to offer lower prices.

Table 11. Effect of 75 Percent Limit on Government Contribution For Single Enrollees in Washington, D.C., Area FEHBP Plans, 1998

Plan	Premium	Enrollee share	Enrollee share without 75 percent rule	Difference
United HealthCare	$ 2,166	$ 541	$ 451	$ 91
QualChoice	$ 2,124	$ 531	$ 409	$ 122
M.D. IPA	$ 2,056	$ 514	$ 341	$ 173
Kaiser	$ 2,055	$ 514	$ 340	$ 173
CapitalCare	$ 1,910	$ 478	$ 196	$ 282
Mail Handlers Standard PPO	$ 1,899	$ 475	$ 184	$ 291
G. Washington Standard	$ 1,775	$ 444	$ 60	$ 384
NYLCare Standard	$ 1,595	$ 399	$ (120)	$ 518
CIGNA	$ 1,502	$ 375	$ (213)	$ 589

Source: IHPS.

Finally, some of the employee organization plans open to all federal employees require payment of an annual membership fee, ranging from $35 to $170 in 1998. Generally, the employee becomes an associate member, whose only privilege is to participate in the health plan. The membership fee may therefore be regarded as a premium surcharge.

Contingency Reserves. The 3 percent reserve surcharge on plan premiums is paid by agencies and enrollees along with the rest of the premium and is deposited in the U.S. Treasury. The FEHB trust fund and the Retired Employees Health Benefit (REHB) fund consist of these deposits--"special reserve" accounts individually attributable to each plan[24]--as well as general program reserves.

With OPM approval, a plan may draw on its special reserve if its costs exceed its premium revenue. For example, if the prospective rate established for the Blue Cross/Blue Shield plan proves inadequate during the course of a year, the plan may draw on its reserves. The effect, over the long run, is that the plan is not at

[24] Formerly the plans held some reserve funds themselves; however, this meant that they, and not the government, benefited from interest earnings.

risk in the way that Medicare risk HMOs are. It cannot actually suffer a financial loss unless its shortfall is so great that the special reserves are inadequate to cover it. (If a plan actually went bankrupt, the general program reserves would cover outstanding medical claims for FEHBP enrollees.)

OPM generally aims to maintain the reserve for each plan at a level equal to two months or more of expected costs. Over time, if a plan does not need to draw on the reserve, the reserve may exceed this level. The plan may then be permitted to quote a premium rate less than its expected revenue needs and draw down the reserves to make up the difference. The use of reserves for this purpose is in fact a major focus of OPM premium negotiations with community-rated plans– whose FEHBP rates are in theory determined by prices charged to other groups and would not otherwise be negotiable.

Reserve fund transactions– build-ups and drawdowns– can be sizable in any given year. As a result, annual changes in FEHBP premiums do not immediately reflect actual trends in benefit costs. Table 12 shows the changes in the combined trust funds since 1987. As of the end of 1997, the combined funds had a balance equal to about 40 percent of annual program costs.

Table 12. Changes in FEHB Trust Fund Balances as of September 30

	Trust fund balance ($ millions)	Increase/ (decrease)
1987	$ 609	
1988	$ 612	$ 3
1989	$ 2,067	$ 1,455
1990	$ 4,014	$ 1,947
1991	$ 5,208	$ 1,194
1992	$ 4,628	$ (580)
1993	$ 5,864	$ 1,236
1994	$ 6,656	$ 792
1995	$ 7,296	$ 640
1996	$ 7,371	$ 75
1997	$ 6,703	$ (668)
1998 (est.)	$ 6,601	$ (102)

Source: OPM (1997) and *Budget of the United States, FY 1999.* The balance combines the FEHB trust fund and the Retired Employees Health Benefit (REHB) fund.

SELECTION AND QUALIFICATION OF PLANS

Medicare+CHOICE

Medicare must contract with any organization that meets statutory and regulatory standards. Under the TEFRA risk contracting program in effect before the BBA, an organization was automatically eligible if it was federally qualified– determined to meet standards set forth under the HMO Act of 1973 (title XIII of the Public Health Service Act). An organization that was not federally qualified was eligible if it met standards determined by HCFA.[25]

Under the BBA, all organizations must meet standards specified by HCFA. State licensure is also generally required, with a temporary exception for certain provider-sponsored organizations. HCFA standards cover such areas as solvency, adequacy of the provider network, marketing, claims processing and service authorization, and internal grievance procedures. Plan compliance is assessed at the time of initial contracting and then at three-year intervals, with more frequent reviews if there is an indication of problems (such as a high level of complaints or disenrollments). External monitoring by a PRO or other quality review and improvement organization (QIO) is also required. The BBA allows HCFA review to be waived, in whole or in part, if the plan has been approved by a private accrediting body whose standards are acceptable to HCFA.

HCFA has lately been placing increased emphasis on monitoring plan access and quality. Plans are required to submit data reflecting their performance on health outcome measures, such as the Health Plan Employer Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance, and are required to report results of member satisfaction surveys using a Medicare version of the Consumer Assessments of Health Plans Study (CAHPS) instrument. As part of its implementation of the BBA requirements, HCFA has promulgated a Quality Improvement System for Managed Care (QISMC). Under this system, plans will have to conduct internal quality assurance projects that lead to demonstrable improvements in health outcomes; in time, they may be required to meet minimum performance thresholds on HEDIS or other outcome measures.

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[25] These organizations are known as competitive medical plans, or CMPs. The term HMO is used in this paper to refer both to Medicare HMOs and Medicare CMPs, to avoid confusion with FEHBP's term "comprehensive medical plans," which encompasses both federally qualified HMOs and other prepaid organizations. Note that, since the 1980s, HCFA has administered both the federal qualification process and the CMP eligibility process. For Medicare purposes, the distinction has therefore not been a significant one.

FEHBP

Under law FEHBP "may" contract with one government-wide service benefit plan (Blue Cross/Blue Shield), one government-wide indemnity plan (formerly Aetna; there is no such plan now), and any number of employee organization plans. FEHBP "shall" contract with any federally qualified HMO and "may" contract with any number of other CMPs. Thus the only plans FEHBP must offer are federally qualified HMOs.[26]

However, while the statute is somewhat unclear on the subject, it appears that once a plan has been admitted to FEHBP, it may not be arbitrarily dropped. OPM may terminate a plan if it ceases to meet "reasonable minimum standards" for health plans or if its enrollment is below 300 in two successive years. Thus OPM can limit new entrants– no new fee-for-service plans are now being admitted– but may not be able to terminate existing plans without cause. FEHBP thus differs from the selective contracting programs that have been adopted by some large employers, employer purchasing groups or coalitions, and Medicaid programs, under which the total number of participating plans is limited by price and sometimes quality criteria.

Like HCFA, OPM has its own basic standards for health plans, and state licensure is required. (National plans must be licensed in every state, but state benefit mandates that conflict with a plan's FEHBP benefits are preempted.) OPM has been considerably less active than HCFA in the areas of access and quality. Plans must show that they have some form of internal quality assurance program. However, there are no detailed standards for evaluating the plans and there is no routine monitoring. Instead OPM relies on state licensure and on the ability of enrollees to "vote with their feet," changing plans at open season if a plan's performance is unsatisfactory.[27]

OPM does require plans to survey a sample of FEHBP members on access and satisfaction issues; results are included in OPM's annual health plan guide for employers. (This survey will be replaced by CAHPS.) OPM plans to implement HEDIS or other performance measures in the future.

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[26] Under the HMO Act, these plans must in turn offer specified basic benefits to all members. It does not appear that OPM could negotiate a benefit package below this minimum. In addition, the HMO Act specifically forbids an HMO to negotiate with OPM rates different from those the HMO charges to other purchasers.
[27] Personal communication, OPM staff.

ENROLLMENT AND CONSUMER INFORMATION

Medicare+CHOICE

As noted earlier, Medicare beneficiaries are enrolled by default in the traditional fee-for-service program and must make an affirmative decision to enroll in a Medicare+CHOICE plan. Until enactment of the BBA, Medicare beneficiaries could enroll in a plan during an open enrollment period established by the plan; some plans had year-round open enrollment. During the open enrollment period a plan was required to accept any applicant, up to the limits of its capacity, without regard to health status or other factors. A beneficiary could disenroll from the plan and return to traditional Medicare (or enroll in a different plan) at any time.

The BBA establishes an annual coordinated open enrollment, beginning in November 1998, during which beneficiaries will have an opportunity to choose from among Medicare+CHOICE plans available in their area for the coming year. After a phase-in period, the BBA will restrict beneficiaries' current right to disenroll at any time; enrollees will generally be allowed to return to fee-for-service or change plans only during fixed annual periods, unless the beneficiary moves out of a plan's service area or can show that the plan committed certain abuses.

Beneficiaries learn about their coverage options through marketing efforts by health plans and through informational efforts by the Health Care Financing Administration (HCFA) itself. They may also receive information from state-level beneficiary counseling programs funded by HCFA, from advocacy groups, or from independent organizations such as the American Association of Retired Persons or the Consumers Union.

HMOs generally market through their own employed representatives and develop their own informational materials for prospective enrollees. Application for enrollment is made to the plan, rather than to HCFA. HCFA places some restrictions on the activities of HMO representatives and requires that brochures, advertisements, and other marketing materials be reviewed in advance. There have been concerns that direct marketing could lead to abuses. For example, plans may target healthier beneficiaries by designing their marketing materials to appeal to younger and more active seniors. In addition, marketing by the individual plan means that an enrollee may learn about only that option, instead of all the choices available.

As a result, there has recently been greater emphasis on providing enrollees with independent information that compares all available options. HCFA has a

number of publications that include information about HMOs and other coverage options. Some of these are furnished to all beneficiaries; others are available on request, through counseling programs, and on the Internet. A new feature on HCFA's Web site, "Medicare Compare," allows beneficiaries to obtain a limited amount of comparative information on all the options available in their particular area. At this point, the information includes only benefits and premium rates and does not include comparisons of quality or satisfaction. HCFA is also planning to test the use of a third-party open enrollment broker as a tool to provide beneficiaries with education about their Medicare coverage options, both fee-for-service and managed care, and to provide assistance in making the coverage choice that best meets their needs.

The BBA directed HCFA to conduct a national educational and publicity campaign before each open enrollment period, with the costs to be defrayed through users' fees to be assessed on Medicare+CHOICE plans. HCFA is supposed to mail the following information to beneficiaries before the start of each annual open enrollment period:

- General information, including a description of benefits under the Medicare fee-for-service program, a discussion of Medigap, an explanation of the Medicare+CHOICE enrollment process, and information on enrollee rights and the possibility and consequences of contract termination by a Medicare+CHOICE plan.
- A comparative listing of Medicare+CHOICE plans available in the area, including service area, premiums, supplemental benefits, cost-sharing and out-of-pocket limits, and network restrictions, including restrictions on the ability to select from among providers within the network.
- "To the extent available," quality and performance indicators for plans, including comparisons with the performance of the Medicare fee-for-service program on the same indicators. Areas to be covered include disenrollment rates, satisfaction information, information on health outcomes, and the plan's record of compliance with Medicare requirements.

HCFA has implemented this requirement only in part for the 1998 open enrollment period. Beneficiaries in most areas will receive a brief description of their Medicare options and of how to think about choosing among plans. However, detailed comparative information about plans will be distributed only to 5.5 million beneficiaries in Ohio, Florida, Arizona, Oregon and Washington.

FEHBP

Federal employees may enroll in an FEHBP plan at the time of initial employment or during an open season held in November and December of each year. Current enrollees may change their choice of plans during the open season. Once a plan has been selected, the enrollee cannot change plans until the next open season.

Federal employees receive information about FEHBP and enroll at their worksite.[28] All employees receive an annual guide produced by OPM; this includes general information about the program and a listing of each participating plan, including service area, premiums, and cost-sharing requirements (but not other benefit information). Each plan listing also includes the plan's accreditation status and the results of the required surveys of consumer satisfaction in each plan. More detailed information about each plan is made available in individual brochures, produced by each plan using a standardized format and subject to OPM review. OPM makes all of this information available on its Web site, along with a Health Profiler that lets users tailor their own comparisons of available plans. As noted earlier, there are also independent sources of comparative plan information, notably the annual guide produced by *Washington Consumers' Checkbook* and often made available to employees by federal agencies.

Plans may also market to employees, for example in mailings or public advertising. Unlike marketing under Medicare, FEHBP plan marketing does not involve face-to-face contact (except at health fairs sponsored by federal agencies), nor do plans have any role in the enrollment process.

In summary, OPM is much farther along than HCFA in making comparative information available to participants, although HCFA is working to improve. In the long run, it may prove much more difficult to educate Medicare beneficiaries about their coverage options and to assure that they make rational choices, for several reasons. First, Medicare beneficiaries enter the market as individual purchasers and are harder to reach than people who obtain coverage in a group environment. It may be difficult to assure that all beneficiaries receive and understand information about their coverage options, and even more difficult to assure that they all actively select from among those options.

In addition, of course, many Medicare beneficiaries are very old or disabled. Some may have cognitive disabilities; even those without such limitations may

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[28] Some employees may be able to make plan changes through Employee Express, a system accessed through a computer or a touch-tine phone.

have had little experience with managed care or in choosing among health plans during their working life. (They are thus different from federal annuitants, who were familiar with FEHBP during their active employment.) Finally, the Medicare system is simply more confusing than FEHBP. Beneficiaries must understand Medicare itself, 12 different Medigap supplemental options, and a bewildering variety of possible Medicare+CHOICE options, including HMOs, POS plans, provider-sponsored plans, and– if these materialize– MSAs, PPOs, and private fee-for-service plans.

PLAN TERMINATIONS AND PLAN CHANGES

Under both Medicare and FEHBP, a plan may terminate its contract at the end of a year; enrollees must then find another source of coverage. While this can be a problem for enrollees under either program, the problems under Medicare are more severe and have recently been highlighted by a wave of non-renewals for the 1999 contract year.

As of October 8, 1998, 43 Medicare plans had ended their contracts and another 52 had reduced their service areas, dropping enrollees in certain counties.[29] The chief reason cited was the early lock-in of benefit and premium proposals for 1999. As noted earlier, plans were required to submit these proposals by May and were not permitted to revise them in the light of their own updated cost projections; some also cited new regulatory requirements, released after their bids, that they said would increase costs.

A total of 414,292 beneficiaries, about 7 percent of risk HMO enrollment, will be dropped from plans at the end of 1998. Most of these have the option of joining another HMO in their area, though this will entail obtaining services from a new provider network. Only about 45,074 current HMO enrollees will have no managed care option. They will be automatically returned to the fee-for-service program; if they desire supplemental coverage, they will need to seek it from a Medigap carrier. Under the BBA, Medigap carriers will have to offer coverage to those of the enrollees who are 65 or older, but not to any younger disabled beneficiaries; in addition, the policies offered need not include prescription drug coverage, an important benefit for many beneficiaries.

Nonrenewals and reductions in service areas can also occur under FEHBP. For 1999, 63 plans have dropped out of FEHBP and 6 others have terminated enrollment in part of their service area.[30] Most of these plans are small; the total number of enrollees affected is only 62,000, or 1.5 percent of FEHBP enrollment.[31]

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[29] HCFA, "Status of Medicare Managed Care Non-Renewals," Oct. 1998 (www.hcfa.gov).
[30] OPM Benefits Administration Letter 98-411, 9/22/98.
[31] IHPS calculation based on March 1998 enrollment data.

All of these enrollees can join one of the national plans; there may or may not be a CMP available to them. Another 30 plans have reduced their service areas but are not automatically terminating enrollments in the areas that have been dropped. Enrollees may remain in the plan but may have to travel farther to obtain care from network providers.

FEHBP enrollees are arguably better protected against plan terminations than Medicare enrollees because there are comprehensive national plans available to them. Medicare beneficiaries with no local managed care option are assured of access only to original Medicare plus minimal supplemental coverage; they may be rejected for more comprehensive plans for health or other reasons.

A related problem that may affect both Medicare and FEHBP enrollees is merger or acquisition of plans. The managed care industry is in a period of consolidation, with plans buying up other plans; enrollees in a given plan may find that they are suddenly enrollees in a different plan and must use a different provider network. This occurred, for example, when Kaiser purchased the Washington, D.C. Humana plan in early 1998. After a limited transition period, the FEHBP enrollees in Humana were expected to use Kaiser providers.[32] Even in the absence of a change of ownership, care of specific enrollees may be disrupted if a plan terminates its contract with a provider. Beginning in 2000, FEHBP will require plans to provide transitional care, allowing the enrollee to continue seeing the provider for up to 90 days. Medicare has no comparable rule (although an enrollee could disenroll and access the provider through original Medicare).

CONSUMER PROTECTION

Medicare and FEHBP regulations and contracts include a variety of protections for health plan enrollees. The following discussion compares compliance with key elements of the Consumer Bill of Rights and Responsibilities promulgated by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry in November 1997.

Information Disclosure. As noted earlier, OPM has made greater progress than HCFA in disseminating information about plans and covered benefits to participants. A major gap under both programs is dissemination of comparative quality information. HCFA collects extensive information, such as HEDIS measures and results of CAHPS surveys, but has yet to make it available to

[32] OPM Benefits Administration Letter 98-401, 1/14/98.

beneficiaries. OPM disseminates consumer satisfaction information, but has not yet required any standardized measurement of clinical quality.

Choice of Providers and Plans. HCFA has formal network adequacy standards and routinely monitors compliance with these standards. OPM collects network information on new plans or plans applying for a new service area, but has no standards for evaluating this information. Both programs have implemented specific access requirements of the Bill of Rights, including access to qualified specialists for women's health services and direct access to specialists for persons with complex or serious medical conditions. OPM, but not HCFA, requires plans to provide transitional care when a plan's contract with a provider is terminated, allowing the enrollee to continue seeing the provider for up to 90 days.

Access to Emergency Services. Both Medicare and FEHBP have adopted the "prudent layperson" standard for payment of out-of-plan emergency services.

Participation in Treatment Decisions. Medicare has standards on informed participation, advance directives, disclosure of compensation arrangements, and "gag" clauses in provider contracts. FEHBP has instructed contractors to come into compliance with the Bill of Rights provisions and will be proposing a regulation on gag rules.

Respect and Nondiscrimination. Plans under both programs are subject to federal law in this area.

Confidentiality of Health Information. Both programs have confidentiality standards in contracts or other plan guidance.

Complaints and Appeals. Medicare requires plans to have an internal appeals system for service or payment denials and a separate grievance system for resolving other kinds of complaints. Plans must resolve service appeals within 60 days and must have an expedited procedure for services an enrollee believes are urgent. Enrollee's can appeal plan decisions through a HCFA contractor, the Center for Health Dispute Resolution. Further appeal within DHHS is allowed for claims of over $100; judicial review is permitted for claims over $1,000. In a suit against the federal government, the beneficiary may not obtain punitive damages. However, a beneficiary injured by a health plan decision might have a cause of action in a state court, subject to state law.

FEHBP requires contractors to have an internal appeal process and has instructed them to come into compliance with specific requirements of the Bill of Rights, including expedited review of urgent appeals. Service or payment

denials may be appealed to OPM;[33] an enrollee dissatisfied with OPM's decision may obtain judicial review. A court may award only the amount of benefits in dispute and may not impose punitive damages on a plan.

ADMINISTRATION

HCFA administrative costs were $2.7 billion in 1997. This is equal to about 1.3 percent of Medicare spending. HCFA personnel totaled about 4,000. OPM's costs for administering FEHBP are about $20 million a year, or only about 0.1 percent of FEHBP spending; personnel directly involved with FEHBP number about 160.

This comparison is highly deceptive, however. Most of HCFA's costs are for contracts with fiscal intermediaries and carriers and PROs. The administrative functions they perform are comparable to those performed by FEHBP carriers, but the administrative costs under FEHBP are hidden in plan premiums. In addition, HCFA carries out health services research, which OPM does not, and funds state certification of nursing homes. After accounting for these differences, net HCFA administrative costs were $334 million in 1997, or about 0.2 percent of Medicare spending.[34] Even this figure includes costs for non-Medicare HCFA functions, including oversight of Medicaid and the new state Child Health Insurance Programs, the federal qualification process for HMOs, and enforcement of the Clinical Laboratory Improvement Amendments of 1988 and the Health Insurance Portability and Accountability Act of 1996. Costs and staffing for Medicare alone cannot be precisely identified.

Some analysts have also remarked that HCFA is much more bureaucratic than OPM. For example, one study estimated that Medicare has 677 pages of statute and regulation for every million covered lives, compared to 23 pages for FEHBP;[35] in addition, HCFA issues thousands of pages of guidelines and other policy instructions. Here again, the comparison fails to take into account that HCFA directly administers an insurance program for the 32 million beneficiaries not enrolled under risk or cost contracts, while OPM does not. An appropriate comparison would consider whatever guidelines or other policy documents are issued by FEHBP carriers in performing similar functions.

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[33]OPM has reported that only 50 percent of enrollees seeking OPM review were satisfied with OPM's decision and believed they had received a fair review. OPM upheld the carriers' decision 59 percent of the time. *Budget of the United States, FY 1998*, Appendix.
[34] *Budget of the United States, FY 1999.*
[35] Will Marshall and Martin Schram, *Mandate for Change*, New York, Berkley Books, 1993; cited in David B. Kendall, *President Clinton's Medicare Buy-In: Right Goal, Wrong Program*, Washington, Progressive Policy Institute, 1998.

Nevertheless--while it is difficult to compare HCFA and OPM performance in the one function they have in common, oversight of health plan contracts– it is clear that Medicare has been "micromanaged" by Congress and the executive branch, while FEHBP is operated less bureaucratically and with greater administrative discretion. As a practical matter, however, it is unlikely that Medicare would be free of micromanagement if it operated solely as a health plan contracting program. Medicare funded 22 percent of all personal health care spending in 1996, compared to less than 2 percent for FEHBP. In some sectors it is even more dominant; for example, it paid 33 percent of all hospital costs.[36] Medicare's policies affect the operations of nearly every health care provider and the economy of every community. Because Medicare affects so many more stakeholders than FEHBP, it will inevitably continue to involve political judgments and some degree of bureaucracy, no matter what its basic purchasing strategy.

[36] HCFA, National Health Expenditures series.

FEHBP PERFORMANCE

COST INCREASES

Much of the interest in the FEHBP as a possible model for Medicare stems from its apparent success in restraining costs during much of this decade. Particular attention has been drawn to the fact that average premiums for FEHBP enrollees actually declined by 3.8 percent in 1995 and by another 0.3 percent in 1996, while Medicare per beneficiary costs in these years grew by 7.7 percent per year.

Comparisons of this kind are deceptive, because year-to-year changes in FEHBP premiums are not necessarily related to actual expenses. As noted earlier, premiums are sometimes above cost and lead to a build-up in reserve funds; in other years, the reserve funds are drawn on to meet costs not covered by premiums. Thus, as Feldman, Dowd, and Coulam have noted, growth in actual cost per FEHBP enrollee is a better measure of program performance.

Table 13 compares Medicare spending growth per beneficiary with per enrollee increases in FEHBP premiums and spending.[37] As the table shows, per capita spending did rise somewhat more rapidly under Medicare than under FEHBP between 1988 and 1997, and much more rapidly between 1992 and 1997.

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[37]It should be noted that the two programs are covering different types of services. Much of the growth in Medicare spending in recent years has been driven by increased use of skilled nursing facility and home health services. Coverage of these services is sharply limited under FEHBP plans, and most FEHBP enrollees likely to use these services are also Medicare beneficiaries and would draw on their Medicare benefit first. On the other hand, Medicare does not cover most prescription drugs, while FEHBP plans do. Prescription drugs have been one of the fastest growing components of private insurance spending in recent years; OPM reports that prescription drug spending under FEHBP rose 22 percent in 1998 alone ("Frequently Asked Questions," www.opm.gov\insure). An appropriate comparison of FEHBP and Medicare growth would therefore be restricted to expenditures for services covered under both programs.

Table 13. Annual Growth in Medicare Per Beneficiary and FEHBP Per Enrollee Spending, 1988-1997

		FEHBP	
	Medicare	Premiums	Expenses
1988	5.6%	25.8%	12.6%
1989	8.2%	20.3%	9.9%
1990	11.5%	8.8%	8.4%
1991	4.3%	4.7%	11.8%
1992	11.2%	7.4%	11.8%
1993	8.1%	8.3%	5.3%
1994	9.5%	2.9%	5.3%
1995	9.1%	-3.8%	1.5%
1996	6.4%	-0.3%	1.5%
1997	7.0%	1.6%	3.2%
Average annual increase:			
1987-1997	8.1%	7.2%	7.1%
1992-1997	8.0%	1.7%	3.4%

Source: Medicare spending figures, U.S. Budget; enrollment figures, HCFA; FEHBP premiums and spending from Feldman, Dowd, and Coulam (1996 and 1997 spending figures from U.S. Budget).

More recently, however, there have been significant increases in FEHBP premiums: 8.5 percent in 1998 and 10.2 percent in 1999. The experience under FEHBP thus parallels that recently reported for private employers, sizable premium increases after a brief period of rate stability. At the same time, growth in Medicare spending has slowed. Total spending rose just 1.5 percent in 1998, while growth in spending per beneficiary was near zero.[38]

The 1999 premium increases do not vary significantly according to type of plan or type of enrollee. Table 14 shows 1998 and 1999 monthly premiums weighted by March 1998 single and family enrollment. (The table is confined to plans available in both years.)

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[38] "Medicare Growth in '98 Was Slowest Since Plan's Start," *New York Times*, Jan. 12, 1999, p. 1.

Table 14. Change in FEHBP Premiums by Type of Plan and Type of Enrollee, 1998-1999

	1998	1999	% change
Blue Cross/Blue Shield	$ 325.83	$ 363.54	11.6%
Employee organizations	$ 369.00	$ 400.77	8.6%
CMPs	$ 321.35	$ 350.61	9.1%
Employees	$ 353.33	$ 389.23	10.2%
Annuitants	$ 314.40	$ 345.61	9.9%
Total	$ 335.61	$ 369.38	10.1%

Note: The overall average increase is slightly different from the 10.2 percent announced by OPM, possibly because this analysis does not take into account plans that have split their service areas in 1999 and imposed differential rate increases in different areas. Mergers of service areas to produce a unified rate are considered.

Source: IHPS analysis of OPM data.

It should also be noted that that overall average rate increases mask extraordinary volatility in the rates for individual plans. Premium changes for single enrollees in 1999 range from an increase of 61 percent (for Foundation Health in southern Florida) to a reduction of 22 percent (for ConnectiCare). Table 15 shows rate increases by quintile. The top fifth of plans had increases averaging almost 25 percent.

Table 15. 1999 Rate increases for Single Enrollees in FEHBP Plans by Quintile

Quintile	Average increase
1	-3.6%
2	4.5%
3	8.5%
4	12.9%
5	24.7%
Median increase	8.4%

Source: IHPS analysis of OPM data.

Various causes have been suggested for these increases in the private sector, including the growth of less tightly structured managed care plans or an inability on the part of such plans to control the use of new pharmaceuticals and other medical technologies. It is also possible that the recent increases reflect a phase in an "underwriting cycle." It was long the case under indemnity health insurance that several years of rate restraint, stemming from insurers' desire to attract business, would be followed by several years of rate increases intended to make up for past losses. A similar phenomenon may now be occurring in the managed care industry.

Another explanation is that slow overall FEHBP premium growth in the early 1990s reflected a one-time shift of participants from more costly to less costly plans, and this shift is no longer occurring. As table 16 shows, there was a significant migration from the employee organization fee-for-service plans to the CMPs between 1989 and 1995. Since then, while enrollment in the employee organization plans has continued to drop, the enrollees have been moving to Blue Cross/Blue Shield rather than to CMPs.

Table 16. FEHBP Enrollment by Type of Plan, 1989-1998

	1989	1995	1998
National plans[1]	41.2%	42.5%	44.9%
Employee organizations	37.0%	28.4%	25.2%
CMPs	21.8%	29.6%	29.9%

Source: 1989, Congressional Research Service, *The Federal Employees Health Benefits Program: Possible Strategies for Reform*; 1995 and 1998, OPM data.

[1]In 1989 there were two national plans, Blue Cross/Blue Shield and Aetna.

Whatever the reason, it is clear that FEHBP's favorable experience in the mid-1990s is not necessarily an indicator of its likely success in controlling costs in the future. As will be discussed below, no feature of the FEHBP structure automatically restrains growth in costs. While improved competition under Medicare might generate savings over the long term, the extent of these savings may not be predictable on the basis of short-term experience.

RISK SELECTION

Participants in both Medicare+CHOICE and FEHBP choose from among widely varying benefit packages and different delivery systems. If sicker or more costly participants tend to favor certain health plans, those plans' premiums will reflect the characteristics of their enrollees, rather than the generosity of their benefits or their relative efficiency in providing services. Other plans, attracting healthier enrollees, can offer lower prices and still make a significant profit. This phenomenon, known as risk selection, distorts price competition. The plans unlucky enough to have attracted high-risk participants are penalized, while others are overpaid.

There has long been evidence of risk selection under the Medicare HMO risk contracting program. The Physician Payment Review Commission found that HMO enrollees had lower costs than the average beneficiary before joining the HMO. Those who disenrolled had higher costs than the average beneficiary after returning to the fee-for-service sector.[39] These findings suggest that, while Medicare's HMO payment rates assume that the HMOs will enroll a typical mix of beneficiaries, the HMOs have actually enrolled healthier beneficiaries. As a result, the HMOs have been overpaid, while cost increases in the fee-for-service program have been driven in part by the fact that it retained the most costly segment of the Medicare population.

The extent of risk selection has been disputed by the industry,[40] and may have been reduced somewhat by the rapid growth in Medicare HMO enrollment in recent years. Nevertheless, it is clear that the demographic factors currently used in establishing HMO payments cannot accurately predict the degree of risk presented by a particular plan's enrolled population. Congress has therefore instructed HCFA to adopt a system of risk adjustment, under which payment rates will reflect individual beneficiaries' health status or other factors likely to affect costs. HCFA is in the process of implementing a system that will use adjusters based on the diagnoses of beneficiaries who have used inpatient hospital services. A system that uses diagnoses for beneficiaries receiving ambulatory care is also planned, although this will require much more information than is currently collected by health plans.

As noted earlier, FEHBP's payment rates do not include even the basic geographic and demographic adjusters used under Medicare. As a result, if risk selection occurs, there is a greater potential for distortion in plan prices. For example, if annuitants without Medicare– the costliest group of FEHBP

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[39] Physician Payment Review Commission, *1996 Annual Report*, Washington, 1996.
[40] See, for example, Health Policy Economics Group, PricewaterhouseCoopers, *Is There Biased Selection in Medicare HMOs?*, Washington, American Association of Health Plans, May 1996.

participants– cluster in a few plans, those plans will have higher prices regardless of how efficiently they operate.

Selection under FEHBP has not been formally studied in many years. The Congressional Research Service study cited earlier found that in 1988, while the actuarial values of fee-for-service plans for single enrollees varied by 42 percent, premiums varied by 264 percent. This variance was largely attributable to risk selection. In particular, non-Medicare annuitants drove up the costs of the plans in which they enrolled. Other studies of FEHBP, also dating from the 1980s, found similar selection effects.[41]

Have these problems persisted? While this report will not attempt to replicate the earlier studies, a comparison of the estimated plan benefit values for the Washington, D.C., area presented in table 9, above, with actual plan premiums suggests that selection may still be an important factor in determining plan prices.

Table 17 compares annual single enrollee premiums with the estimated benefit value of the Washington area options. While the estimated benefit value of the plans varies by 31 percent, single premiums range from $1,502 to $3,883, a difference of 159 percent. Some plans charge less than their estimated value, while the most costly plan's premium is more than twice its estimated value.

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[41] James R. Price and James W. Mays, "Biased Selection in the Federal Employees Health Benefits Program," *Inquiry*, v. 22, n. 1 (spring 1985), p. 67-77; James R. Price and James W. Mays, "Selection and the Competitive Standing of Health Plans in a Multiple Choice, Multiple Insurer Market," in R.M. Scheffler and L.F. Rossiter, eds., *Advances in Health Economics and Health Services Research*, v. 6, Greenwich, CT, JAI Press, 1985; both cited in Feldman, Dowd, and Coulam.

Table 17. Cost and Estimated Average Value of Washington, D.C. Area FEHBP Plans for Single Enrollees, 1998

	Estimated value	Premium	Ratio of premium to value
HMOs			
CIGNA	$ 2,272	$ 1,502	0.66
NYLCare Standard	$ 2,106	$ 1,595	0.76
G. Washington Standard	$ 2,122	$ 1,775	0.84
CapitalCare	$ 2,216	$ 1,910	0.86
Kaiser	$ 2,300	$ 2,055	0.89
M.D. IPA	$ 2,240	$ 2,056	0.92
United HealthCare	$ 2,215	$ 2,166	0.98
QualChoice	$ 2,118	$ 2,124	1.00
NYLCare High	$ 2,279	$ 2,342	1.03
Free State	$ 2,272	$ 2,375	1.05
Prudential	$ 2,265	$ 2,386	1.05
Preferred Health	$ 2,310	$ 2,500	1.08
Aetna U.S. Healthcare	$ 2,282	$ 2,483	1.09
CareFirst	$ 2,269	$ 2,491	1.10
G. Washington High	$ 2,230	$ 2,717	1.22
Columbia	$ 2,251	$ 2,831	1.26
Average HMO			0.99
PPOs			
Mail Handlers Standard PPO	$ 1,854	$ 1,899	1.02
Blue Cross Standard PPO	$ 1,950	$ 2,319	1.19
GEHA PPO	$ 1,979	$ 2,548	1.29
Mail Handlers High PPO	$ 1,957	$ 2,599	1.33
Postmasters Standard PPO	$ 1,809	$ 2,621	1.45
APWU PPO	$ 1,838	$ 2,687	1.46
NALC PPO	$ 1,762	$ 2,936	1.67
Alliance PPO	$ 1,928	$ 3,883	2.01
Average PPO			1.43

Source: IHPS analysis based on Center for the Study of Services and OPM data; see appendix B.

Again, the estimated benefit values of the plans, derived from the *Washington Consumer's Checkbook* analysis, are open to question. As noted earlier, OPM has contended that the actuarial difference among plans may be actually be as little as 10 percent. However this makes the premium differentials even less

explicable. If the benefit differences among plans were zero, what would account for a 159 percent premium difference?

- Geography. The PPOs set rates on a national basis, while the HMO rates are set for a particular geographic area. If the Washington area were lower-cost than the national average, the HMOs would be expected to quote lower premiums than the PPOs. However, the weighted average single HMO price under FEHBP in Washington is $2,119, compared to a national weighted average of $2,099. Geography does not appear to be an important factor (although it could be that PPOs are disproportionately drawing their enrollment from higher-cost areas).

- Administrative costs, provider reimbursement rates, and overall "efficiency." The HMOs could obtain more favorable prices and do a better job of controlling utilization of services than the PPOs. The potential savings are usually thought to be offset in part by higher administrative costs. Data from surveys of other employers suggests that PPOs have been 6 to 7 percent more costly than HMOs in recent years.[42] These figures do not reflect population or benefit differences and may understate potential HMO savings. Even much higher savings, however, would be insufficient to explain more than a fraction of the premium differences under FEHBP.

The remaining explanation is population characteristics. Detailed data on the characteristics of enrollees of the Washington area plans are not available; however, the mix of active employees and annuitants (with or without Medicare) is known. Table 18 first adjusts the plans' premiums to correct for differences in their estimated value. The adjusted premium is the estimated amount each plan would charge if its benefits were those of the least generous plan.[43] (The adjustment actually increases the variation in premiums, because the least generous plans cost the most, and the most generous the least.) The plans with the highest single rates are those with the highest proportion of single annuitants. The proportion of annuitants is a highly significant predictor of adjusted plan prices.[44]

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[42] The Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans for 1997 found that large employers paid an average of $3,518 for PPO plans and $3,307 for HMOs, a difference of 6.4 percent. KPMG Peat Marwick found that firms with more than 25 employees paid a family rate of $5,388 for PPOs and $5,028 for HMOs in 1996, a difference of 7.2 percent. Thomas Rice et al., *Trends in Job-Based Health Insurance Coverage*, Los Angeles, UCLA Center for Health Policy Research, 1998.

[43] That is, the plan's actual premium times (the minimum value divided by the plan value).

[44] The adjusted r^2 is 0.701, significant at the .0001 level.

Table 18. Adjusted Premiums for Single Enrollees and Proportion of Annuitants in Washington Area FEHBP Plans, 1998

	Estimated benefit value	Premium	Adjusted premium	Percent annuitants
HMOs				
CIGNA	$ 2,272	$ 1,502	$ 1,165	4.0%
NYLCare Standard	$ 2,106	$ 1,595	$ 1,335	9.9%
G. Washington Standard	$ 2,122	$ 1,775	$ 1,474	8.0%
CapitalCare	$ 2,216	$ 1,910	$ 1,519	15.0%
Kaiser	$ 2,300	$ 2,055	$ 1,575	30.1%
M.D. IPA	$ 2,240	$ 2,056	$ 1,618	18.4%
United HealthCare	$ 2,215	$ 2,166	$ 1,723	14.2%
QualChoice	$ 2,118	$ 2,124	$ 1,767	33.3%
NYLCare High	$ 2,279	$ 2,342	$ 1,811	15.0%
Free State	$ 2,272	$ 2,375	$ 1,842	24.4%
Prudential	$ 2,265	$ 2,386	$ 1,857	15.6%
Preferred Health	$ 2,310	$ 2,500	$ 1,907	9.6%
Aetna U.S. Healthcare	$ 2,282	$ 2,483	$ 1,918	9.2%
CareFirst	$ 2,269	$ 2,491	$ 1,935	22.4%
G. Washington High	$ 2,230	$ 2,717	$ 2,148	20.9%
Columbia	$ 2,251	$ 2,831	$ 2,216	29.9%
PPOs				
Mail Handlers Standard PPO	$ 1,854	$ 1,899	$ 1,805	40.2%
Blue Cross Standard PPO	$ 1,950	$ 2,319	$ 2,096	66.6%
GEHA PPO	$ 1,979	$ 2,548	$ 2,269	67.0%
Mail Handlers High PPO	$ 1,957	$ 2,599	$ 2,341	44.5%
Postmasters Standard PPO	$ 1,809	$ 2,621	$ 2,553	83.2%
APWU PPO	$ 1,838	$ 2,687	$ 2,576	80.5%
NALC PPO	$ 1,762	$ 2,936	$ 2,936	82.0%
Alliance PPO	$ 1,928	$ 3,883	$ 3,550	87.8%

Source: IHPS analysis based on Center for the Study of Services and OPM data; see appendix B and discussion in text.

It is usually assumed that annuitants with Medicare are less costly than either active workers or non-Medicare annuitants, because they rely on FEHBP only as a supplement to their Medicare benefits. If this is so, there are three possible

explanations for the strong relationship between prices and annuitant population.

1. The high-cost plans could be enrolling non-Medicare annuitants, chiefly early retirees, and their costs could be driving premiums.

2. High proportions of annuitants *with* Medicare could be foolishly selecting plans that are poor values. But the plans with the highest proportion of annuitants are generally the PPO plans, which are experience rated: their premiums reflect actual costs. So, if the presence of Medicare annuitants drives down costs, there must be an extraordinary degree of offsetting selection bias in the enrollment of active employees and non-Medicare annuitants.

3. The lowest-cost plans could be undercharging. The premiums for the community-rated plans are based on their rates for other employer groups and are not necessarily adjusted for population characteristics. So the HMO premiums might understate costs for the FEHBP group. But the plans presumably would not continue to participate in FEHBP if the price were inadequate. While there are exceptions, it is usually reasonable to assume that their prices are at or above actual costs for FEHBP enrollees.

Whatever the explanation, there is clearly a concentration of higher-cost enrollees in the PPO plans. This concentration may have occurred for at least two reasons. First, it has long been supposed that high utilizers of services have existing ties to particular providers and are reluctant to join restrictive network arrangements that could disrupt those ties. Second, many annuitants may have aged into their current plans; that is, they have simply continued enrollment in the plan they chose during their working years. Most of the HMO options are fairly new; at least in the Washington area, those with the highest proportions of annuitants generally have the longest history of FEHBP participation.

Some analysts have suggested that, whatever the degree of selection bias under FEHBP, it is not an important problem because the overall program is “stable.” That is, in recent years, the program has not experienced a selection spiral– a trend of steadily increasing segregation of high and low-cost enrollees that leads to a continuous widening of the gaps in plan prices. (Such a spiral led to rapid price increases for high option fee-for-service plans in the late 1980s and precipitated the withdrawal of the Aetna indemnity plan.) But, if the estimates shown here reflect the situation nationally, FEHBP’s stability may amount to stable biased selection.

Why is selection a problem? First, the government may be overpaying the HMOs. Again, while the HMO prices are theoretically market-driven, they are not necessarily adjusted for characteristics of the FEHBP participants. If the plans are enrolling healthier FEHBP participants, they– or their capitated subcontractors– may be profiting disproportionately from the FEHBP group. This is especially likely because other participating employers may no longer offer a choice of HMO and fee-for-service options, a practice which has long been thought to encourage favorable selection in HMOs. If other groups are now more heterogeneous, including both healthy and sick enrollees, their rates may be inappropriately high for an FEHBP group biased toward healthier enrollees.

Second, and more important, the price differences that FEHBP enrollees see when they are selecting a plan may not reflect differences in benefits, quality, or efficiency– the factors on which plans should ideally be competing. Instead, some plans appear more costly because of the populations they have attracted.

ENROLLEE SATISFACTION

FEHBP participants are generally satisfied with the program. OPM surveys have found that "95 percent of the FEHBP customers agreed that their health plan compares favorably for value and selection with the private sector, and more than 85 percent rated their overall satisfaction with their plan as being excellent, very good, or good. Over 90 percent believe that the plan guide and brochures that OPM publishes for the FEHBP are clear, factual, and useful."[45]

Medicare beneficiaries are satisfied with some aspects of the program and not others. A 1994 survey recently released by HCFA found that 95 percent of beneficiaries were "satisfied" or "very satisfied" with the overall quality of their care. HMO enrollees were significantly more likely than nonenrollees to be "very satisfied" with the costs of care, although the percentage is unimpressive for either group, 28.8 percent of HMO enrollees and 19.0 percent of fee-for-service enrollees. Fee-for-service enrollees reported higher levels of satisfaction with their interactions with physicians than HMO enrollees.[46]

[45] *Budget of the United States, FY 1998*, Appendix.
[46] Cynthia G. Tudor, Gerald Riley, and Melvin Ingber, "Satisfaction With Care: Do Medicare HMOs Make A Difference?," *Health Affairs,* Mar./Apr. 1998.

FEHBP AS A MODEL FOR MEDICARE

SUMMARIZING THE KEY DIFFERENCES IN THE PROGRAMS

Analysts attempting to characterize the basic differences between Medicare and FEHBP sometimes describe Medicare as a "defined benefit" program and FEHBP as a "defined contribution" program. These terms, drawn from a distinction between two types of pension plans, themselves need to be defined.

- Under a defined benefit plan, the participant is promised specified benefits (a certain dollar amount of pension income, or coverage of specified health services) regardless of how much the cost to the plan sponsor of furnishing those benefits may change over time.

- Under a defined contribution plan, the participant is promised that the plan sponsor will contribute a fixed dollar amount toward benefits. Depending on inflation and other factors, this amount may or may not be sufficient to maintain any given level of benefits over time.[47]

Medicare clearly fits the definition of a "defined benefit" program: the government guarantees that beneficiaries will receive the statutory benefit package at a fixed price to the beneficiary (usually no cost for part A and 25 percent of projected cost for part B). It also guarantees that beneficiaries will have access to a fee-for-service delivery system with an unrestricted choice of providers.

FEHBP is not a defined benefit program, but is not exactly a defined contribution program, either. What the government contributes is not fixed in advance, but is determined by a formula that takes into account participant choices from among options with different benefits, delivery systems, and prices. OPM can indirectly affect government costs by negotiating different benefits with plans and, with some restrictions, by deciding which plans may participate.[48] But it does not operate under any form of per-enrollee budget and could, in the absence of congressional intervention, allow government costs to rise freely with the costs of current benefits.

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[47] Inflation is the obvious factor leading to benefit uncertainty in health care. In pension plans, the key variables are rate of return on the amount contributed and the lifespan during which the participant expects to draw on the accumulated funds.

[48] As noted earlier, OPM must contract with any federally qualified HMO, must buy the basic benefits specified under the HMO Act, and must pay the HMO's community rate for those benefits. To this extent, FEHBP is in part a defined benefit program.

Table 19 shows what would have happened under FEHBP between 1986 and 1996 if growth in the government contribution had been held to inflation, as measured by the medical component of the consumer price index for all urban consumers (CPI-U). The effect, if no enrollees had changed plans, would have been a dramatic cost-shift to enrollees. The difference between the actual 1996 government share and the share under a growth limit, nearly 43 percent, indicates just how far FEHBP is from operating as a defined contribution system.

Table 19. Changes in Monthly Average Government FEHBP Contributions under a CPI-Based Limit

	Government contribution	Enrollee share
1986	$85.28	$47.35
1996	$227.35	$80.92
1996 if government contribution held to medical care CPI	$159.35	$166.17

An alternative way of characterizing FEHBP is as a "competitive bidding" program. Here again, the term is imprecise. "Bidding" ordinarily implies quoting a price for a specified good or service. While it is true that the plans quote prices, those prices are for different commodities– different benefits and also, because of risk selection, different covered populations. It is as if a homeowner were to solicit bids for a kitchen remodeling without specifying any features of the desired kitchen.

There is a competition occurring under FEHBP. Plans are competing for enrollees– not only with each other, but also with other coverage sources available to some eligible persons– and the enrollees' choices ultimately affect government costs. But the plans are competing on multiple dimensions, including price, benefits, quality, and access. The absence of standardized benefits for competing plans makes it difficult for participants to compare prices and values. In addition, plans may manipulate benefits in order to attract more desirable enrollees. Even the price competition is distorted by risk selection and, to some extent, by the contribution methodology.

At the same time, Medicare+CHOICE has some features of a competitive system. While everyone is guaranteed original Medicare for a fixed price, the trade-off is that beneficiaries receive limited benefits that expose them to high– and, in catastrophic cases, unlimited– out-of-pocket spending. As a result, most beneficiaries seek supplementary coverage. In effect, beneficiaries face the following plan choices:

Plan	Benefits	Provider choice	Cost
"Original" Medicare	Medicare package	Unrestricted	$43.80/month part B premium in 1998
Medicare + Medigap	Medicare package plus reduced cost-sharing and possible additional benefits	Unrestricted; may have PPO feature	$43.80/month plus Medigap premium (from $33.50 to $600 per month in one 1996 survey, depending on benefits and enrollee characteristics)[49]
Medicare+ CHOICE coordinated care plan	Medicare package plus possible reduced cost-sharing and/or additional benefits	HMO, POS, or PPO	$43.80/month plus plan premium, if any (from $0 to $110 per month in 1998)

This table does not differ in its basic structure from the table in OPM's annual guidebook comparing available plans. In effect, original Medicare is the low-priced plan in its area (along with any HMO that offers a zero premium). Original Medicare and the other available plans compete on the same dimensions of price, benefits, quality, and access as FEHBP plans. As under FEHBP, the absence of standardized benefits (beyond the minimum under original Medicare) makes comparison of plans difficult, and the price competition is affected by risk selection and contribution methodology.

Assuming that HCFA successfully implements the Medicare+CHOICE program, Medicare will more closely resemble FEHBP in certain respects thought to be important to a successful competitive system. A wider variety of delivery systems will be made available (if organizations come forward to offer the new types of plans). Plan selection will occur during an annual open enrollment period, and plan-switching will eventually also be confined to this period. Beneficiaries will be given clearer and more comprehensive information on the

[49] Lisa Maria B. Alexcih, Steven Lutzky, Purvi Sevak, and Gary Claxton, *Key Issues Affecting Accessibility to Medigap Insurance*, The Lewin Group, Aug. 1997.

options available to them, including information on quality as this becomes available.

Overall, then, the difference between the two programs has been much exaggerated. There are really only three key differences in the two programs:

1. Under Medicare, the most popular plan is a national fee-for-service plan operated by the government (with most routine functions performed by private contractors). Under FEHBP, the most popular plan is a national fee-for-service plan with a PPO option operated by a private insurer.
2. The benefits of original Medicare can only be modified by an act of Congress, and other plans (except MSA plans) must offer at least these minimum benefits. Benefit changes for all FEHBP plans can be negotiated by OPM; no minimum is guaranteed.
3. The government contribution for Medicare options is based on the historic cost of original Medicare, adjusted for geographic cost differences and enrollee characteristics. The maximum contribution for FEHBP reflects the weighted average cost or price of all available plans, with no geographic or demographic adjustments.

The following discussion will consider the implications of modifying Medicare to more closely resemble FEHBP in each of these key areas.

ISSUES IN IMPLEMENTING AN FEHBP MODEL

If Medicare were to adopt the FEHBP model, the system might work roughly as follows:

1. Medicare would make available a single national fee-for-service plan. This might be publicly or privately operated, and it might offer the current Medicare benefits or some other package of benefits. The plan would establish a premium sufficient to cover its anticipated costs; this premium might be adjusted to some extent for local area costs.
2. Other plans, including alternate fee-for-service or PPO plans (like the FEHBP employee organizations) and HMO plans could participate if they met minimum standards. Each of these plans would offer its own benefit package and set its own premium. Plans might or might not be required to offer benefits at least equal to the basic Medicare benefits. Benefit packages might or might not be subject to some degree of standardization.
3. The maximum government contribution would be a fixed percentage of the average premium for participating plans, weighted by enrollment. The program might or might not follow FEHBP in establishing a separate ceiling on the contribution to any specific plan.

This description leaves open a number of key policy decisions; these will now be briefly reviewed.

Operation of the National Plan

The nearest equivalent to original Medicare under FEHBP is the government-wide Blue Cross/Blue Shield (BCBS) plan. How are these plans similar, and how do they differ? To what extent might original Medicare be modified to more closely resemble BCBS? (The following discussion assumes that Medicare benefits would remain fixed by law; this issue is discussed separately in the next section.)

Neither plan is at risk. The federal government covers the entire cost of operating original Medicare, with a fixed contribution from beneficiaries. The federal government covers the entire cost of operating the FEHBP BCBS plan, with a fixed contribution from beneficiaries. Although a premium for BCBS is established at the start of each year, unexpected cost overruns can be compensated through the contingency reserves; profits are limited to a nominal amount. In essence, BCBS is functioning as the third-party administrator of a self-insured plan. A shift to the FEHBP model would, then, have little real effect on Medicare financial operations.

Both plans are operated by local intermediaries. OPM contracts with the national BCBS association; it in turn contracts with local BCBS affiliates to offer coverage to FEHBP enrollees in their area. Conceptually, this is not very different from HCFA's contracts with local fiscal intermediaries and carriers (often, though not always, BCBS organizations) to process Medicare claims. However, HCFA contracts separately with QIOs for quality and utilization review. There might be some case for merging these functions with the claims processing function, as occurs under BCBS.

Medicare provider payment rates are set by law, while BCBS payment rates are negotiated with providers. This distinction may be less important than it seems. While Medicare exercises monopsonistic buying power, its rates are established through a political process in which federal budgetary constraints are balanced against the need to assure access and quality for beneficiaries. BCBS may have less leverage than Medicare, although it is still the dominant private carrier in many markets; like Medicare, it is often a price-giver rather than a price-taker. Still, it, too, must balance cost concerns against the need to maintain access for enrollees. It is improbable that shifting to private rate negotiation would produce any savings for Medicare. Medicare already obtains steep discounts

from providers. For hospitals, for example, Medicare paid 2 percent above cost in 1996, compared to 21 percent for private payers.[50]

BCBS offers a PPO option, while original Medicare does not.[51] BCBS enrollees who use PPO network providers pay reduced cost-sharing and are exempted from balance billing (provider charges above the approved payment amount). BCBS negotiates discounts with PPO providers and may limit participation on other grounds– for example, it could exclude providers thought to be inefficient.

It would not be an enormous leap for original Medicare to operate in the same way as the FEHBP BCBS plan. Possibly local intermediaries and carriers could form PPOs, and beneficiaries using in-network services could pay reduced cost-sharing; those going out of network would pay the usual Medicare deductibles and coinsurance. Whether savings could actually be realized from this approach is uncertain. Again, Medicare pays rock-bottom prices. Unless a carrier could negotiate even lower payments with a provider network, it could not offer reduced cost-sharing for in-network services without imposing higher cost-sharing for out-of-network care than currently applies under Medicare. (It could, of course, steer patients away from higher-cost facilities, such as teaching hospitals and safety net providers. This redirection of Medicare funds would have important implications for the ancillary social goals served by the program.)

BCBS is priced nationally, while Medicare is priced locally. Under the Medicare+CHOICE payment system, payment rates are based on local area costs for fee-for-service Medicare; prices and benefits of competing reflect the extent to which they are able to operate more efficiently than Medicare *in that area*. BCBS quotes a single national price. As was noted earlier, this is higher than HMO prices in some areas and lower in others, distorting price comparisons. Changes in the BBA are moving the payment system for Medicare+CHOICE plans toward a blend of local and national costs, and there is a long-standing debate about whether a pricing system should reflect local cost variation that is attributable to practice patterns rather than to input costs.

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[50] Medicare Payment Advisory Committee, *Report to Congress: Context for a Changing Medicare Program*, Washington, June 1998.

[51] Medicare actually operates a sort of rudimentary PPO in its "participating physician" program. Participating physicians agree to accept Medicare's allowable payments as payment in full and are paid slightly more than nonparticipating physicians. Nonparticipating physicians are paid less but may bill a patient up to 15 percent above the Medicare allowed amount. This system reduces costs for beneficiaries who use participating physicians but provides no savings for Medicare.

The wisdom of local pricing will not be assessed here. It is sufficient to say that, to avoid distortion in competition, it is appropriate that all plans in an area be priced in the same way. If the fee-for-service plan is priced nationally, its competitors should be priced nationally. As a practical matter, because no HMO or even chain operates nationally, local pricing will continue for these plans. For this reason, it makes sense to continue local pricing of the fee-for-service plan. A second argument for local pricing is that the national plan is likely to have a larger market share in rural areas or other areas less likely to be served by managed care plans. Because costs may be lower for enrollees in these areas, national rating would mean that rural beneficiaries cross-subsidized urban ones.

In sum, the only significant improvement that might be derived from shifting original Medicare to the private BCBS model would appear to be the ability to develop contractual arrangements with "efficient" providers. A shift to selective contracting under Medicare could, of course, be adopted in isolation from any broader program restructuring. However, it is unclear that available data could support a methodology for identification of preferred providers that would be sufficiently objective and defensible for a government program that must operate under due process requirements. In effect, the major benefit of privatization might be the ability to select providers in a more arbitrary way. Whether this is politically feasible is an open question. Again, Medicare is the most important payment source for many providers– covering, for example, one-third of all hospital bills. Even a privatized Medicare might have difficulty in selectively excluding providers who were prepared to accept its payments.

Benefits

Minimum benefits. Medicare requires all participating plans (except MSA plans) to offer at least the basic Medicare benefits, and further requires plans whose ACR is below the Medicare payment rate to offer supplemental benefits with a value equal to the difference. FEHBP has no minimum benefits.

Assuming that a government-operated original Medicare continued to exist, this plan would necessarily have government-determined benefits. If original Medicare were contracted out, as FEHBP's BCBS plan is, benefits might in theory be negotiated between HCFA and the carrier. However, it is difficult to conceive of how this negotiation would occur. In the absence of a firm budgetary limit (the existence of which would turn Medicare into a defined contribution program, not an FEHBP-like program)[52], what is the negotiating position of the government?

[52] The Butler/Moffit proposal, which is a defined contribution scheme, allows the benefits of its national plan to be modified to meet budgetary limits.

OPM staff may operate under an informal principle of attempting to restrain growth in program expenditures. But they did not, for example, respond to the prospect of an 11.6 percent increase in BCBS rates for 1999 by requiring a significant reduction in benefits. If they had sought to restrain growth to, say, 5 percent, the necessary benefit changes would presumably have led to an outcry from employees, unions, and retiree groups. HCFA would face even greater resistance if it attempted to meet a vague goal of fiscal restraint by negotiating benefit reductions: benefit changes would affect not only millions of beneficiaries but a health care industry heavily dependent on Medicare payment. It is improbable that agency administrators would be given the authority to make substantive benefit changes outside the political process.

Let us assume, then, that the benefits of original Medicare would continue to be determined by Congress. The issue, then, is what its competitors would be required to offer under an FEHBP-like model. There are at least two options other than the current system:

- competing plans could be permitted to offer benefits less generous than original Medicare, or
- plans would be required to offer the Medicare benefits, but would not be required, as at present, to offer supplements if the plan's costs were less than Medicare payments.

These options would, of course, be meaningful only if the competitors could offer a lower price to beneficiaries. This might occur in either of two ways. First, if the government contribution were no longer tied to the full price of original Medicare, but was based on some sort of average of plan premiums, beneficiaries might face some cost greater than the current part B premium to remain in original Medicare. Competitors might be able to offer coverage at a lower cost to beneficiaries, or at no cost. Second, even if the current contribution system were maintained, enrollees in plans that cost less than the contribution amount might receive some sort of rebate.[53]

The two options– less generous benefits or no mandatory supplements– have very different consequences. The first would place financial pressure on beneficiaries with modest incomes to accept some plan with coverage even less adequate than current Medicare. It would almost certainly promote biased selection, with the less generous plans attracting the healthiest beneficiaries. If

[53] This could take the form of a deposit into an MSA account that could be used for cost-sharing or other uncovered expenses. This option is discussed in Physician Payment Review Commission, *1997 Annual Report*.

government contributions were based, as under FEHBP, on average premiums for participating plans, the shift of beneficiaries to sub-Medicare options would reduce the contribution, further pressing lower-income beneficiaries to shift. The result would be a sort of race to the bottom, which might stabilize at a level well below current benefits.

These effects could be mitigated if lower-income beneficiaries received a higher subsidy, so that they could remain in original Medicare at little or no cost. However, if this subsidy in turn were potentially rebatable, the beneficiaries would still face financial pressure to accept substandard coverage. If the subsidy were not rebatable, but could only be used to purchase original Medicare, there would be no reason for the less generous plans to exist– unless they were attractive to healthy high-income beneficiaries, again raising selection issues. Alternatively, plans could be allowed to offer something less than original Medicare but might be subject to some sort of benefit floor. However, this would amount only to a redefinition of the government-mandated benefits; it is not clear why this floor should be something other than the package Congress has already established.

Under the second option, plans would be required to cover Medicare benefits but could– if they were more efficient than fee-for-service Medicare--share savings with beneficiaries in the form of money, instead of in the form of supplemental benefits.[54] How different would this be from the current system? Obviously, it would lead larger numbers of lower-income beneficiaries to prefer HMOs to Medicare. However, this already occurs under the current system, because the HMOs offer supplemental benefits at a lower cost than Medigap plans do. Table 20 shows 1993 Medicare HMO penetration by beneficiary income. Many of the lowest-income beneficiaries receive supplemental coverage at no cost through Medicaid. HMO enrollment peaks among beneficiaries with income above Medicaid levels, and then drops sharply for the highest-income beneficiaries.

[54] It should be noted that, as a practical matter, it is difficult for a managed care plan to offer a benefit package that is precisely equal to but not superior to Medicare. Medicare's cost-sharing, which involves a 20 percent coinsurance payment for physician services, cannot readily be administered by plans that pay their providers on a capitated basis; for this reason, nearly all plans charge fixed dollar copayments for ambulatory services. The average value of these copayments is less than the average value of Medicare's cost-sharing.

Table 20. Medicare Risk/Cost HMO Penetration by Beneficiary Income, 1993

Annual income (in thousands)	Percent HMO enrollment
5 or less	9%
5-10	8%
10-15	12%
15-25	14%
25-50	12%
50+	7%
Total	11%

Source: IHPS estimates based on HCFA 1996.

A similar pattern would be expected if HMO enrollees received cash instead of benefits, although it is likely that selection bias would be increased. At present, Medicare HMOs appear to be experiencing favorable selection (again, this has been debated), even though they are offering more generous benefits that would be expected to attract high users. Presumably this occurs because, for higher-risk people, aversion to managed care outweighs the perceived value of the benefits. If HMOs offered no additional benefits, but simply a lower price, they would be most attractive to healthier low-income people.

The existence of plans with a price below that for original Medicare would, again, gradually affect the government contribution if this contribution were set under an FEHBP-like average-price system. However, this is the entire point of considering a premium competition system. If all plans are priced at or above the cost of original Medicare, the government can achieve savings only if it arbitrarily sets its contribution percentage somewhere below the current level. If some plans are allowed to offer lower prices for the same coverage, the government could gradually share in the savings resulting from beneficiary choices. As will be discussed below, the critical question is whether risk measures are sufficient to assure that these savings do not simply amount to a cost-shift to sicker beneficiaries.

Finally, if there existed plans that offered the Medicare benefits alone for a price lower than Medicare's, there would arise the question of whether enrollees in these plans could obtain supplemental coverage from a Medigap carrier. If so, the result would probably be risk segmentation within the Medigap market. Carriers might offer reduced prices to enrollees of non-Medicare basic plans than

to enrollees in original Medicare, on the grounds that the enrollees in the competing plans were lower risk.

Standardization. Medicare+CHOICE plans offer a "basic" package that includes any supplemental benefits approved by HCFA, and may also offer a high option package with further benefits. The more or less unlimited variation in possible benefit packages makes it difficult for beneficiaries to assess the relative value of different plans. In addition, because certain benefits may be more attractive to certain groups of beneficiaries, variation may promote risk selection. For these reasons, advocates of competition often advocate standardized benefits.

Full standardization of Medicare plans– including original Medicare and all competitors– is probably impossible. It would mean either (a) requiring all plans to offer the basic Medicare benefits with no supplements or (b) expanding the basic Medicare package to include the most common supplements, including reduced cost-sharing, an out-of-pocket limit, prescription drug coverage, and so on. While it may be advisable, in the context of a competitive structure, to consider expansions of Medicare benefits, it is likely that competing plans would still be permitted to offer more generous benefits than original Medicare.

Plans might be required to offer only one or more defined supplemental packages from a limited menu of possible packages, as is the case for Medigap coverage. Of course, the more different packages made available– Medigap now has twelve– the less standardization does to promote informed decision-making by beneficiaries and reduce selection. On the other hand, limiting the possible packages that could be offered may prevent beneficiaries from obtaining coverage that meets their own perceived needs. There are at least two possible compromise options:

1. Standardize individual benefits rather than entire packages. For example, a plan might or might not include prescription drug coverage, but a plan that included such coverage would have to provide a defined benefit. This would facilitate comparison of plans but would still leave room for risk selection.[55]

2. Define a set of permissible supplemental packages and require every carrier to offer every authorized package. There might then be self-selection of enrollees in each type of package, but each carrier would be equally likely to attract enrollees interested in particular benefits.

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[55] It is in any event uncertain that standardized benefit plan designs can completely eliminate this kind of risk segmentation. For example, a plan might still be free to determine which specific prescription drugs would be included in its formulary. Even if such details of coverage were standardized, a plan could restrict access to some services by offering a very limited network of providers or putting in place burdensome administrative requirements.

Plan Premium Quotations and Government Contributions

Under an FEHBP-like system, each plan would quote a premium for its benefit package, the government would set a contribution based on a fixed percentage of weighted average premiums, and enrollees in a given plan would pay the difference (if any) between that plan's premium and the government contribution.

Interplay of price quotation and contributions. In order to consider the implications of moving Medicare into such a system, it is essential to understand that Medicare plans (including original Medicare) are already quoting a total premium for a plan-established package of benefits, and enrollees are paying a share of that premium. It is the contribution mechanism, and not the price quotation process, that is fundamentally different under Medicare and FEHBP. The similarity of price quotation has been obscured because Medicare has a complex process for determining the fairness of the quoted price.

Table 21, based on an analysis by the Physician Payment Review Commission, illustrates the process of Medicare rate quotation. The 1995 Medicare payment for risk HMOs in each area was set equal to 95 percent of expected average costs for comparable fee-for-service Medicare beneficiaries in that area. The "required benefit value" is the difference between this payment and each plan's ACR– its expected cost for furnishing the basic Medicare services to its enrollees. As the table shows, plans in the Minneapolis area had an ACR at least equal to their expected Medicare payment and were not required to furnish any additional benefits. Plans in the Miami area, on the other hand, expected to be able to provide basic Medicare benefits for $106.27 per month less than the Medicare payment. This might have been because Medicare benefits were provided so inefficiently in that area that an HMO could save almost 22 percent by managing care. Or it might have been because the HMOs enrolled healthier beneficiaries, and the risk levels of enrollees were not adequately measured by the demographic factors used to set the Medicare payment.

Table 21. Risk-Plan Benefits And Monthly Premiums Based On Adjusted Community Rate Proposals By Market, 1995

(Dollars per month)

	Miami	Minneapolis	New York
Medicare payment	$488.65	$333.93	$465.95
Required benefit value	$ 106.27	$ -	$ 53.37
Optional benefit value	$ 20.75	$ 75.89	$ 46.77
Supplemental premium	$ -	$ 60.97	$ 8.80
Total premium (Medicare payment plus supplemental premium)	$ 488.65	$ 394.90	$ 474.75
Enrollee share (supplemental premium plus part B premium of $46.10)	$ 46.10	$ 107.07	$ 54.90
Percent paid by enrollee	9.4%	27.1%	11.6%

Note: Required benefit value is equal to Medicare savings in the adjusted community rate proposal; optional benefit value is equal to the maximum monthly premium. Values are unweighted averages of all Medicare risk plans.

Source: House Committee on Ways and Means, *1998 Green Book*, based on Physician Payment Review Commission analysis of 1995 adjusted community rate proposal data from HCFA.

Over and above the required benefits, plans may furnish "optional" supplemental benefits. (Note that these may only be optional for the plan; beneficiaries must accept any supplements defined as part of the HMO's basic benefits.) It may charge a premium for these benefits. This premium may not exceed the plan's ACR for the supplements– that is, what it would charge comparable non-Medicare enrollees for the same benefits. It must be remembered, however, that the plan's ACR– both for basic Medicare coverage and for supplements– includes the plan's usual profit margin for commercial enrollees. In order to compete for Medicare enrollees, a plan may choose to accept a reduced profit margin. For this reason, plans in all the areas shown charged an average supplemental premium less than the expected costs for the optional services.

Overall, the plan is quoting a premium equal to the sum of the Medicare payment and its supplemental charge to enrollees. The enrollee is paying a share of the total premium equal to the sum of the supplemental premium and the part B premium. Beneficiaries who remain in original Medicare may similarly be thought of as paying a share (the part B premium) of a "premium" equal to total per capita cost for the fee-for-service program. In New York, for example, if the "premium" for original Medicare was $490.47 ($465.95 divided by 0.95) in 1995, the beneficiary was contributing $46.10, or 9.4 percent.

Table 22 presents the basic price comparison visible to beneficiaries in New York.

Table 22. Prices for Medicare Options, New York, 1995

	Benefits	Premium	Government share	Enrollee contribution
Original Medicare	Medicare	$490.47	$444.37	$46.10
Risk plan	Medicare plus supplements	$474.75	$419.85	$54.90

Source: based on table 21; see discussion in text.

Under an FEHBP-like system, the premium column of this table would go unchanged. It is the government share that would be modified. Suppose that, in the base year used for establishing government contributions, 60 percent of beneficiaries were in original Medicare and 40 percent in the risk plan. Suppose further that the government intends to set its contribution equal to 90 percent of the weighted average premiums for the two plans. (The 90 percent figure is approximately the current Medicare contribution; the problem of developing this percentage will be considered further below.) Table 23 shows the resulting change in government and enrollee contributions.

Table 23. Changes in Government and Enrollee Shares For Medicare Options under FEHBP Model, New York, 1995

	Enrollment	Premium	Government share	Enrollee contribution
Original Medicare	60%	$ 490.47	$ 435.77	$ 54.71
Risk plan	40%	$ 474.75	$ 435.77	$ 38.98
Weighted average		$ 484.18		

Under the old system, the risk plan was never less costly to the enrollee than original Medicare. Under the new system, it may be less costly and at the same time offer wider benefits– just as, under FEHBP, HMOs are less costly to the enrollees and offer broader benefits than the fee-for-service plans. (Whether this would actually occur under either program if premiums were corrected for enrollee risk is uncertain.) The hope of proponents of a competitive model is, of course, that beneficiaries presented with table 23 will shift in greater numbers to the risk plan. In theory, this would over time reduce the weighted average and hence the government contribution.

What is missing from table 23 is the substantial proportion of beneficiaries who have chosen to obtain their supplemental coverage through Medigap– even though there may be risk HMOs in their area offering comparable coverage at lower cost. These beneficiaries are paying the part B premium plus a Medigap premium of, say, $125 per month, for a total of $171.10 in 1995. While they apparently prefer not to join an HMO, they might be attracted to a private fee-for-service or PPO plan. As was noted earlier, no carrier has yet applied to offer a fee-for-service plan under Medicare+CHOICE, and there are reportedly only a handful of PPO applications. However, the incentives for carriers to offer, and for enrollees to choose, such a plan would change under the new contribution mechanism.

Let us suppose that a private PPO plan in New York would cost about 20 percent more than Medicare for the basic benefits and would offer supplemental benefits comparable than those of the HMO plan. It might, then, have a premium of about $650. Under the current Medicare contribution system, the price table would be that shown in table 24. The government share is the same as for the HMO, and the enrollee pays the entire excess cost of the fee-for-service plan. The resulting price to the enrollee is considerably more than he or she was paying for original Medicare plus Medigap.

Table 24. High-cost PPO Option Added to Medicare Choices, Current Medicare Reimbursement System

	Benefits	Premium	Government share	Enrollee contribution
Original Medicare	Medicare	$490.47	$444.37	$46.10
HMO plan	Medicare plus supplements	$474.75	$419.85	$54.90
PPO plan	Medicare plus supplements	$650.00	$419.85	$230.15

Under the FEHBP system, however, the cost of the PPO plan is averaged in when determining the government contribution. What if a substantial number of beneficiaries who are now paying high Medigap premiums were willing to shift to the PPO? The computation of the government share might look like table 25.

Table 25. Contributions under FEHBP Model with High-Cost PPO Added

	Enrollment	Premium	Government share	Enrollee contribution
Original Medicare	40%	$ 490.47	$ 464.48	$ 25.99
HMO plan	40%	$ 474.75	$ 464.48	$ 10.27
PPO plan	20%	$ 650.00	$ 464.48	$ 185.52
Weighted average		$ 516.09		

The PPO enrollees are still paying slightly more than the $171.10 they were previously paying for Medicare plus Medigap. The government is paying more for everyone than under the old system. If this outcome seems unlikely, one need only look at the FEHBP experience, under which 70 percent of all enrollees– and 84 percent of annuitants– remain in fee-for-service plans that are much more costly and offer less generous benefits than the CMPs.

One possible fix under Medicare would be to base the government contribution, not on the average entire premium, but on the average of the component of the premium attributable to the core Medicare benefits. This would require that each plan quote one price for the Medicare benefits and a distinct price for any supplements. The results might be those shown in table 26.

Table 26. Pricing under FEHBP Model with Prices for Supplemental Packages Quoted Separately

	Enrollment	Premium for core benefits only	Government share	Enrollee contribution	Plus supplements	Final enrollee contribution
Original Medicare	40%	$ 490.47	$ 430.94	$ 59.53	$ -	$ 59.53
HMO	40%	$ 412.58	$ 430.94	$ (18.36)	$ 62.00	$ 43.64
PPO	20%	$ 588.00	$ 430.94	$ 157.06	$ 36.00	$ 219.06
Weighted average		$ 478.82				

Although the PPO is still driving up the average and thus the government contribution, the effect is much less pronounced. There are several other advantages to isolating the premium for the core benefits.

First, if the aim of adopting a competitive system is to restrain the growth in Medicare spending, the government presumably does not want its contribution to increase if beneficiaries choose plans with more generous benefits. (Provision of supplements to low-income beneficiaries will be considered separately below.)

Second, it would facilitate risk adjustment. "Risk" means the likelihood that individuals will use specific services: one person has a 10 percent chance of being hospitalized next year, while another has a 50 percent chance, and so on. If one wishes to index in some way the overall risk presented by different individuals, that index must reflect their likely costs for a uniform package of services.

Setting the government contribution. The new maximum FEHBP contribution, 72 percent of the weighted average premium for all plans, was set to approximately equal the average percent FEHBP was contributing under the old "Big 6" (actually 5) formula. If a Medicare contribution were computed on the same principle, as a percentage of average premiums, this percentage might also be set to maintain approximately the current government share of Medicare spending. (Use of a lower percentage would simply constitute a benefit reduction unrelated to the shift to a competitive mechanism.)

Enrollees in original Medicare generally pay nothing for part A, though a few pay a premium; most pay a part B premium approximately equal to 25 percent of expected program costs for elderly beneficiaries. Overall, the government paid 90.3 percent of Medicare costs in 1997, with premiums covering the remaining 9.7 percent. Leaving aside for the moment the risk adjustment issue, an initially budget-neutral FEHBP-like system would then pay 90.3 percent of average premiums for the basic Medicare benefits, weighted by plan enrollment.

Assuming that both the national plan and competing plans will quote different prices for different geographic areas, this computation would properly be performed locally, leading to a different dollar amount in each locality. A key decision would be whether the percentage used in the computation should also be set locally. The part B premium, $43.80 in 1997 and 1998, is uniform nationally, although per capita part B spending in the most costly counties can be nearly seven times as high as in the least costly counties. As a result, the government contribution to total Medicare spending (part A and part B) for aged beneficiaries in different counties in 1997 ranged from 84.1 percent to 94.6 percent.[56] Use of a national percentage to determine the government share of locally weighted average prices would immediately increase costs for beneficiaries in some areas and lower them for beneficiaries in others. On the other hand, use of a local percentage would perpetuate existing inequities.

[56] Based on 1997 AAPCCs divided by 0.95, and omitting any part A premium payments.

There is also a question of whether an FEHBP-like system for Medicare should adopt the FEHBP rule that limits the government contribution for a low-cost plan to a fixed maximum percentage of the plan's premium (75 percent under FEHBP). As was suggested above, this rule distorts price competition, and there is no clear rationale for retaining it.

Risk Adjustment

The price of a health plan is a function of its benefits, its population's needs, its efficiency, and various other factors that are sometimes termed "amenities."[57] Under the FEHBP system, the prices quoted by competing plans reflect all of these factors. Thus, a more efficient plan covering broader benefits may quote the same price as a less efficient plan providing fewer benefits. Two plans equal in efficiency and benefits may quote different prices because they have enrolled different populations, and so on.

If each plan instead quoted a price only for the basic benefits, this price would still reflect the risk level of plans' current populations, as well as the relative efficiency and "amenities" of plans. Ideally, beneficiaries who chose less efficient plans or ones with more amenities should pay the excess cost themselves, but beneficiaries and plans should not be penalized because a given plan has attracted sicker enrollees.

Butler and Moffit address the risk problem by requiring each plan to quote, not one price, but prices for each of a set of rate "cells"– that is one price for each of a set of defined subpopulations of Medicare beneficiaries. They would use only demographic factors to establish the rate cells: that is, plans might quote one premium for females aged 65 to 69, a different premium for males aged 70 to 74, and so on. The government contribution would similarly be established for each rate cell; there would be a higher government contribution for 85 year-olds than for 65 year-olds, and so on.

One problem with this system is that demographic factors alone do relatively poorly in predicting utilization and costs. This could presumably be addressed

[57]Although the term is meant to apply to such things as private hospital rooms or more polite staff, a residual "amenities" factor necessarily embraces access and quality as well. While it is at least arguable that there is little correlation between price and quality in the current health care system, there is no reason to suppose that such a correlation would not exist in a fully competitive market. In a society in which income is not equally distributed, superior goods, better housing, finer automobiles, are available to persons who are able to pay for them. If health care evolves in the same direction as other markets, the development of objective quality measures would improve rather than reduce the ability of higher-quality plans to command higher prices.

by further subdividing rate cells: there could be a cell for healthy 65 year-olds and one for sick 65 year-olds, or fixed price adjusters for beneficiaries with a given chronic condition. The validity of available adjusters will be considered below; let us assume that adequate adjusters exist and are reflected in the cells.

The more serious problem is that, under the Butler/Moffit proposal, older and sicker beneficiaries will pay more than younger and healthier ones in the same plan. If the government contribution were, say, 80 percent of the average price for each rate cell, older beneficiaries will pay 20 percent of a high price and younger beneficiaries 20 percent of a lower price. It is not clear that this outcome would be unacceptable to Butler and Moffit. But the price differentials based on risk factors would be dramatic– the 1999 demographic factors for aged enrollees differ by a ratio of as much as 7 to 1 for part A, and 5 to 1 for part B. The ratios might be greater if adjusters more accurately pinpointed risk. For example, the adjusters based on inpatient diagnoses that HCFA is planning to implement in 2000 might have ratios of 12 to 1 or more.[58]

This problem is less severe under the current Medicare payment system. The government payment to a plan amounts to payment in full for the Medicare basic benefits, along with any additional benefits the plan may be required to offer because of the ACR mechanism. This payment is risk-adjusted (at this point, still using the inadequate demographic factors). Any plan-imposed premium charge to beneficiaries is for supplemental benefits beyond the minimum the plan is required to offer. This charge is not risk-adjusted; all beneficiaries pay the same amount. In effect--assuming the government's risk adjustment factors can be improved– the plan is correctly compensated for basic benefits, but beneficiaries may pay more for supplemental benefits (including waivers of cost-sharing) in plans that have attracted higher users of those benefits.

Under an FEHBP-like system, however, in which the government contribution would pay only a part of a plan's premium for both core and supplemental benefits, adjusting the government's contribution and not the beneficiary's share may still mean that enrollees in plans with a higher-risk population will be penalized. Somehow a risk adjustment system must assure that the price faced by enrollees for plans reflects efficiency differences but not population differences. At the same time, the sum of the government contribution and the enrollee share must meet the revenue needs– that is, the bid price– of the plan. This is probably achievable; one possible system is detailed in appendix A.

This technical problem aside, a much greater concern is that available indicators of risk still do rather poorly in reflecting probable costs for different individuals.

[58] Presentation by Leslie Greenwald, HCFA Office of Strategic Planning, May 8, 1998.

Table 27 compares the explanatory power of three different systems for assessing the risk presented by different Medicare beneficiaries. "AAPCC-like" refers to demographic factors such as those currently used in Medicare HMO payment. PIP-DCGs, principal inpatient diagnostic cost groups, uses diagnoses from hospital admissions as well as demographics; this is the system to be implemented in 2000. HCCs, hierarchical co-existing conditions diagnostic cost groups, uses data from ambulatory services as well, and allows multiple conditions to be considered; use of this system will require collection of data many health plans are not now able to furnish.

Table 27. Explanatory Power for Groups: Predictive Ratios of Alternate Sets of Risk Adjustment Factors

Groups	AAPCC-like	PIP-DCG	HCC
Beneficiaries ranked by cost			
Lowest 20%	2.49	1.92	1.21
Middle 20%	1.31	1.01	1.11
Highest 20%	0.48	0.85	0.88
Disease groups			
Diabetes without complications	0.63	0.75	1.02
Diabetes with complications	0.45	0.69	0.96
Breast cancer	0.68	0.78	1.07
Hip fracture	0.59	0.85	0.99

Source: Presentation by Leslie Greenwald, HCFA Office of Strategic Planning, May 8, 1998.

The predictive ratio is the ratio of the cost predicted by the adjustment factors to the actual cost experience of beneficiaries in each group. For example, for the beneficiaries whose actual costs placed them in the lowest 20 percent of all beneficiaries, AAPCCs predicted costs 2.49 times their actual costs. For the most costly 20 percent of beneficiaries, AAPCCs predicted only 48 percent of their actual cost. While PIP-DCGs do better, and HCCs better still, there is still a substantial possibility of over- or underpayment if particular plans happen to attract healthier or sicker enrollees.

This problem is at least as important under an FEHBP-like system as under current Medicare+CHOICE. If risk HMOs under the current program are attracting healthier enrollees, they will be overpaid under all three risk adjustment mechanisms. This increases total government spending, because the government must pay higher costs for the sicker beneficiaries remaining in fee-

for-service at the same time that it overpays the HMOs. Beneficiaries, however, are held harmless.

An FEHBP-like system will shift the problem from the government to the beneficiaries. If the idea is that beneficiaries will pay for efficiency differences and not for risk differences, an adjustment system that underestimates risk for the most costly individuals penalizes those individuals. If they are concentrated in certain plans (such as original Medicare), they will pay inappropriately high premiums because the level of risk assumed by those plans has been understated. This could lead over time to a selection spiral, a steadily widening gap between the apparent prices to enrollees of favorably and adversely selected plans.

Areas with Limited Competition

In the illustration provided by table 26, shifting to an FEHBP-like contribution mechanism significantly increased the enrollee share of costs for beneficiaries remaining in original Medicare. This occurred because the HMO's price for the core Medicare benefits was below original Medicare's cost, and because the HMO had a market share sizable enough to bring down the weighted average premium. (Again, a risk adjustment might have affected the results.) If the competition– for example, a relatively inefficient PPO--were more costly than original Medicare, it would raise the weighted average, and beneficiaries remaining in original Medicare might pay less than under the current system. If the competition's market share were negligible– or if there were no competing plans in the area, as is now true for about 25 percent of beneficiaries– the shift to the new system would have no effect on beneficiaries at all. The weighted average for the area would be the per enrollee cost of original Medicare, and a government contribution set at about 90 percent of this cost would leave enrollees paying the same amount as the current part B premium.[59]

Obviously, the hope that the government would realize savings through this system depends on the assumption that enrollees would, over time, shift from more to less costly plans– thus reducing the weighted average premium (or at least slowing its growth), and hence slowing the increase in the government's contribution. However, the system imposes the greatest cost increases on fee-for-service beneficiaries in areas where there is already the highest HMO penetration. It creates the least incentive for change in areas with the lowest HMO penetration.

[59] This leaves aside the problem noted earlier, that the current part B premium reflects a different percentage of program costs in different areas.

This paradoxical effect could be addressed by using some blend of local and national HMO penetration data to set the government contribution. However, this would simply reduce contributions for beneficiaries in areas with low HMO penetration, even if there were no HMO in their area. The FEHBP contribution scheme, which uses national averages, has precisely this effect for participants in areas with no CMPs. They pay higher premiums to join fee-for-service plans, but have no alternative available.

Is this merely a transitional problem, one that will go away if incentives are so structured as to promote development of alternative plans? The BBA, in order to encourage development of Medicare+CHOICE plans, adopted a strategy of deliberately overpaying these plans (relative to fee-for-service) in areas with low fee-for-service costs, and underpaying plans in areas with high fee-for-service costs.

As a long-term approach, of course, this strategy is fundamentally incompatible with a competitive purchasing policy. If other plans cannot beat original Medicare's price in a given area, special subsidies to promote their development would make sense only if there were some strong reason to believe that they could eventually operate at a lower cost than original Medicare, at which point the subsidies could be withdrawn and real competition would occur.[60] This supposes, however, that competition will somehow become more profitable over time in areas that, for good reasons, did not attract private plans in the past. There remain questions about the sustainability of managed care in rural areas. PPOs or less structured arrangements might be possible, but they would be negotiating with the same limited set of providers who are already accepting low prices from original Medicare; the possibility of further savings is doubtful.

Probably there are areas in which it will never be practical or fair to adopt a competitive purchasing strategy. One possibility would be to adopt the competitive strategy in areas that can sustain it and not in others. But how would this line be drawn? If the strategy is adopted only in areas that already have high levels of competition, it doesn't gain anything. So it must somehow be extended to areas where there is limited competition now, but it is thought that further competitive incentives will ultimately work. Sorting these areas from those where competition is impracticable will require some type of regulatory formula, and one which will inevitably substitute political judgments for those rendered by the market.

[60] This was the approach of the HMO Act of 1973, which provided time-limited subsidies for new HMOs. The extent to which these subsidies (as opposed to such factors as employer response to rising costs) promoted HMO expansion has never been seriously evaluated.

Protection of Low-Income Beneficiaries[61]

Under current law, Medicaid pays part B premiums for "specified low-income Medicare beneficiaries" (SLMBs), those with incomes below 135 percent of the poverty level, and also pays required cost-sharing for "qualified Medicare beneficiaries" (QMBs), those with incomes below 100 percent of poverty. Very low-income beneficiaries, such as those receiving Supplemental Security Income (SSI), may qualify for full Medicaid coverage. Medicaid then pays for services not covered by Medicare, such as prescription drugs. Costs for all three populations are shared by the federal and state governments. (This is an extremely simplified description of a program whose complexities need not be explored here.) How would similar protections be extended under an FEHBP-like model?

To preserve current benefit levels for the three populations, subsidies in addition to the basic government contribution would be needed as follows:

- For SLMBs, a subsidy sufficient to assure that they paid nothing for a plan providing at least the minimum Medicare benefits.
- For QMBs, a subsidy sufficient to assure that they paid nothing for a plan that waived Medicare cost-sharing requirements, or some other arrangement for indemnifying them for cost-sharing (for example, direct payment of copayments required under a plan).
- For full Medicaid beneficiaries, a subsidy sufficient to assure that they paid nothing for a plan covering the full range of both Medicare and Medicaid benefits, or some form of wrap-around coverage of Medicaid-covered services not available through the health plan.

The mechanics of these arrangements might be similar to those already developed in states that are enrolling "dual eligibles"– beneficiaries with both Medicare and Medicaid– in managed care programs.[62]

Assuming the subsidy systems can be developed, there are at least two key issues. The first is capacity: whether there will in fact be plans available to all low-income beneficiaries at the subsidized price. The second is "income tiering": the likelihood that low-income persons will be concentrated in health plans whose full cost is covered by the subsidy, while higher-income persons are in other plans.

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[61] This section draws on Mark Merlis, *Health Care Reform: Managed Competition in the Inner City*, Washington, Congressional Research Service, Apr. 1994.

[62] For an overview of technical concerns in these arrangements, see Robert L. Mollica, Maureen Booth, Paul Saucier, and Trish Riley, *Protecting Low-Income Beneficiaries of Medicare and Medicaid in Managed Care*, (2 volumes), Portland, ME, National Academy for State Health Policy, Aug. 1997.

Capacity. The general assumption of a competitive approach is that the most efficient, and hence least costly, plans will be those with the most tightly organized systems, such as staff or group model HMOs. However, because these plans provide care in their own facilities, they may be unable to expand their capacity as rapidly as plans that contract with networks of existing independent providers. This means that the number of enrollment slots available in the lowest-cost plans may be very limited, particularly in the period immediately following program implementation. This problem might be addressed by increasing subsidies when no free enrollment slot is available (a provision of this kind was included in President Clinton's health care proposal).

Even if the lowest cost plans have sufficient capacity, they may not be physically accessible to low-income beneficiaries. This could be addressed either by more aggressive regulation of health plans– to assure that every plan, for example, had sufficient providers in low-income areas– or by increasing the subsidies, to assure that they were reasonably related to the costs of serving beneficiaries in low-income areas.

Even if these problems can be overcome, some available plans may still be more attractive than others. Not every enrollee will be able to join the plan of his or her choice. This problem is not, of course, confined to subsidized enrollees. Even enrollees able to pay more for the plan of their choice may find that the plan is oversubscribed. Some form of waiting list or lottery is likely to be necessary. Even with such an arrangement, some enrollees would have to accept a plan that was not their first choice. One possible consequence would be disruption of existing provider/patient relationships: what if an enrollee were unable to win a place in the health plan with which her usual physician was affiliated?[63] In addition, limitations on the choice of plans might reduce the incentives for plans to provide high quality care, because enrollees might not be able to "vote with their feet."

The quality issue is the core of the second key concern, income tiering.

Income tiering. Some analysts, such as Uwe Reinhardt, have argued that a certain amount of income tiering is inevitable in our health care system.[64] Just as some people pay more to enroll their children in private schools, some will pay more for a better health plan. Even in countries with universal public programs, higher-income people generally have some option to buy their way out of the

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[63]This would also be a concern if a low-income enrollee's usual source of care happened to affiliate with a plan whose premium was above the maximum subsidy amount.
[64]Uwe E. Reinhardt, "An 'All-American' Health Reform Proposal," *Journal of American Health Policy*, v. 3, no. 3 (May/June 1993), p. 11-17.

system. In this view, the key concern is that the plan or plans available to the lowest-income persons be of satisfactory quality.

This concern could in theory be addressed through stringent minimum quality standards for all participating plans. However, a fundamental assumption of the competitive approach is that the market, rather than regulators, will assure quality. Because consumers would be voting with their dollars, plans would have to provide satisfactory care to attract enrollees. If the lowest-cost plan or plans had a captive enrollment base consisting of the lowest-income enrollees, they would have no incentive to pursue quality goals beyond the absolute minimum required by regulators. As a result, it may be appropriate to limit the amount of income tiering in the system.

There would be several ways to do so:

- Every plan could be required to accept some number of low-income enrollees at the subsidized price.

Each plan would have a fixed number of slots for publicly subsidized enrollees, perhaps set on the basis of some percentage of its total enrollment. The plan would accept the public subsidy for these enrollees as payment in full, even if its ordinary premium was considerably higher. Losses on these enrollees would have to be shifted to the plan's private enrollment in the form of higher premiums.

- There could be a limit, either in dollar or percentage terms, on the amount by which any plan's premium could exceed the benchmark rate.

This approach was included in the competition proposal advanced in 1992 by John Garamendi, the California Insurance Commissioner. Limits on excess premiums would not give low-income groups access to the higher-priced plans; they would merely restrict the revenues available to those plans and thus limit the extent to which their amenities (or quality) could exceed those of the benchmark plan. Income tiering would still be likely, and there would still be no market-based guarantee of the quality of the benchmark plan.

- Premium subsidies could be set at a level sufficient to allow low-income enrollees a choice among several plans.

Under this approach, the sum of the basic government contribution and additional subsidies might be set equal, not to the lowest-bid premium, but to some higher figure, such as the area-wide average premium. This solution obviously raises subsidy costs.

CONCLUSION

Adoption of an FEHBP-like model for Medicare would require solutions to formidable policy and technical questions that FEHBP itself has never addressed. Some of these have already been discussed: risk adjustment of premiums and government contributions, managing the competition of national and local plans in local markets, and protecting low-income beneficiaries. There are others that have been passed over here and may be even more difficult– such as how to integrate the millions of beneficiaries now receiving supplemental coverage through retiree health plans into a competitive structure.

Even if all these issues can be resolved, there is no evidence that adoption of an FEHBP-like approach would necessarily save money over the long term. The price increases under FEHBP in the last two years, and similar experiences under other competitive models such as CalPERS,[65] suggest that the competitive approach is not a formula for meeting a particular budget target. The only way to guarantee savings under a competitive structure would be for the government to arbitrarily limit growth in its contributions--as FEHBP has not done– leaving beneficiaries at risk of steadily eroding benefits or rising costs.

It is true that FEHBP is itself an imperfect model of competition, because its contribution structure largely shields employees from cost differences among plans, or because OPM has been insufficiently aggressive in negotiating with plans. But FEHBP, whatever its imperfections, is an example of what can actually be implemented under a large federal program serving millions of beneficiaries. Its evolution suggests the gap between "perfect" competition and political possibility.

This is not to say that the structure of the Medicare+CHOICE system cannot be improved upon. Certainly more must be done to help beneficiaries make appropriate choices from an increasingly complex menu of health plan options. Possibly some change in the contribution formula to make participants more sensitive to the costs of different options might be considered– *if* adequate risk adjustment systems can be developed and appropriate protections are provided to low and middle-income beneficiaries.

As the nation considers improvements in Medicare, there will undoubtedly be lessons to be learned from FEHBP, as well as from other public and private efforts to develop competitive systems. But Medicare is unique, in the huge and

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[65] Average CalPERS premium increases for 1999 are 7.3 percent. "Employees Facing Steep Increases in Health Costs," *New York Times*, Nov. 27, 1998, p. 1 and 26.

highly vulnerable population it serves and in its impact on the national health care system. There can be no single off-the-shelf model for Medicare restructuring. Instead FEHBP should be regarded as one of many models– successful in some respects, unsuccessful in others– from which policymakers may draw as they work to assure that promise of Medicare is kept for future generations.

APPENDIX A: USING RISK ADJUSTERS IN AN FEHBP-LIKE SYSTEM

The aim of a risk adjustment system is to assure that beneficiaries who choose less efficient plans or ones with more amenities will pay the excess cost themselves, but beneficiaries and plans will not be penalized because a given plan has attracted sicker enrollees. Assuming that risk adjustment factors of acceptable predictive value are available– an heroic assumption--how would they be applied in an FEHBP-like system?

Table A-1 shows one possible method for establishing a risk-adjusted government contribution.

Table A-1. Risk Adjustment of Government Contribution, Method A

	Bid	Risk factor	Base government contribution	Risk adjusted contribution	Enrollee share
Plan A	$ 150.00	1.2	$ 96.00	$ 115.20	$ 34.80
Plan B	$ 100.00	1.0	$ 96.00	$ 96.00	$ 4.00
Plan C	$ 70.00	0.8	$ 96.00	$ 76.80	$ (6.80)
Average	$ 106.67	1.0			

Plans A, B, and C each have 100 enrollees in Year 1. Plan A's enrollees are determined, using available risk factors, to have expected costs 20 percent above the average for all enrollees; plan B has an average mix of enrollees, and plan C's enrollees have expected costs 20 percent below the average. These differences are reflected in the risk factor.

The plans submit bids for year 2 based on their expected revenue needs for their current enrollees. The government sets its basic contribution equal to a fixed percentage– say, 90 percent– of the weighted average of the plans' bids. It then adjusts its contribution by the risk factor for each plan. The enrollee pays the remainder of the plan premium. The government is, in the aggregate, paying 90 percent of plan costs, and enrollees in the aggregate are paying 10 percent. However, enrollees in plan A are paying nearly 9 times as much as enrollees in plan B, and enrollees in plan C would pay a negative amount--which, again, might somehow be rebated. The differences in enrollee share are wholly out of proportion to the real differences in efficiency of the plans. (Assuming plan A is original Medicare, this disproportion amounts to a heavy penalty for remaining in the fee-for-service program.)

Table A-2 shows an alternate method of risk adjustment that leaves aggregate government and enrollee contributions unchanged but that sets the enrollee share more fairly.

Table A-2. Alternate Method for Risk Adjustment

	Year 1 enrollment	Year 2 bid	Risk factor	Standardized bid	Efficiency ratio	Enrollee share	Government contribution
Plan A	100	$ 150.00	1.2	$ 125.00	1.20	$ 12.80	$ 137.20
Plan B	100	$ 100.00	1.0	$ 100.00	0.96	$ 10.24	$ 89.76
Plan C	100	$ 70.00	0.8	$ 87.50	0.84	$ 8.96	$ 61.04
Average		$ 106.67	1.0	$ 104.17	1.00		

Plans can submit bids for year 2 in either of two ways. First, the plans could bid their expected per member revenue need for their current population; this is the "initial bid." The government could then adjust each bid, based on the risk factor for the plan's current enrollees, to get a bid for a typical enrollee, one with a risk factor of 1.0; the result is the "standardized bid." Alternatively, each plan could be required to submit a bid for the typical enrollee. It would then take into account its own revenue needs and known differences between its enrollees and the typical enrollee; presumably it would arrive at a bid equal to the standardized bid shown.

Plan A's standardized bid of $125 is 20 percent above the weighted average standardized bid for all plans, presumably because it is less efficient than plans B and C. The standardized bids for plans B and C are below the weighted average. These differences are reflected in the "efficiency ratio" (more properly, the inefficiency ratio).

In fixing the government and enrollee shares for each plan, there are two constraints:

- We want the enrollees in plan A to pay 20 percent more than the average enrollee, while the enrollees in plans B and C should pay 4 percent and 16 percent less than the average, respectively.

- We want the sum of the government's contributions to all plans to equal 90 percent of the total premium requirements of all plans. (This is equivalent to saying that we want the government to pay 90 percent of the weighted average premium.) The sum of the plans' bids times their current enrollees is

$32,000. The total government contribution will, then, be $28,800, leaving $3,200 to be paid by enrollees.

Given these two constraints, we arrive at the enrollee share amounts shown, which correctly vary by efficiency. The government's share is the remainder of each plan's premium.

This system assures that each plan receives its revenue requirements for its current enrollees, that the government's aggregate contributions are held to the desired level, and that what each enrollee pays reflects the relative efficiency of the plan that enrollee has selected.

One problem with such a system is that enrollee shares must be computed before the open season for each year. Shifts of enrollees among plans during the open season may affect the risk profile of each plan and hence its required revenues, as table A-3 illustrates.

Table A-3. Effects of Enrollment Shifts on Government Contributions under Alternate Method of Risk Adjustment

	Year 2 enrollees	Revised risk factor	Revised revenue need	Enrollee share	Revised government contribution
Plan A	90	1.3	$ 162.50	$ 12.80	$ 149.70
Plan B	90	1.1	$ 110.00	$ 10.24	$ 99.76
Plan C	120	0.7	$ 61.25	$ 8.96	$ 52.29

In the open season held just before the start of year 2, enrollees receive a comparative chart that shows the three plans and the enrollee share of basic benefit costs under each plan (with any additional cost for supplemental benefits shown separately). Enrollees then make their plan choices. Some low-risk enrollees shift from plans A and B to plan C. As a result, the risk factors for plans A and B go up, while the risk factor for plan C goes down. The plans' true revenue needs change accordingly. Plan A needs $162.50 per enrollee to serve its new population, rather than the $150 per enrollee projected at the time of its year 2 bid. Plan C only needs $61.25, rather than the $70 it bid. As a result of the shift, the total revenue requirement of the plans is now $31,875, rather than $32,000.

The enrollee shares must presumably stay the same as those quoted during the open season. If plans are not to gain or lose inappropriately, the government contribution to each plan must be revised to reflect the plan's revised revenue requirements. The sum of the government contributions is now $28,726, or a little more than 90 percent of the revised total plan premiums; this excess would grow if selection were more profound. However, the government will in theory save money in future years because more enrollees are now in the more efficient plan.

APPENDIX B: ESTIMATED PLAN BENEFIT VALUES

The estimated benefit values used in the discussion of benefit variation among FEHBP plans are derived from estimates provided in the independent guide to FEHBP plans produced annually by the Center for the Study of Services, publishers of the *Washington Consumers' Checkbook.*[66] The guide estimates, for enrollees incurring different amounts of hospital, medical, drug, and dental bills during a year, the amount of out-of-pocket liability they would experience under different plans. Table B-1 shows the estimates for single enrollees.

For each class of enrollee, this figure can be subtracted from the assumed total bill amount to produce an estimated plan benefit payment, as shown in table B-2. For each plan, a weighted average is then computed assuming the following share of enrollees in each utilization class. This weighted average is the estimated benefit value shown in table 9 of the report.

Incurred bills	Percent of enrollees
None	20%
$ 500	50%
$ 1,500	10%
$ 3,000	8%
$ 6,000	8%
$ 20,000	3%
$ 70,000	1%

[66] Center for the Study of Services, *Checkbook's Guide to 1998 Health Insurance Plans for Federal Employees* (by Walton Francis and the Editors of Washington Consumers' Checkbook), Washington, 1997.

Table B-1. Washington Consumers' Checkbook Estimates Of Single Enrollee Out-of-Pocket Costs under Washington Area FEHBP Plans, 1998

	Estimated out-of-pocket costs for enrollee incurring bills totaling:					
	$ 500	$ 1,500	$ 3,000	$ 6,000	$ 20,000	$ 70,000
Aetna U.S. Healthcare	$ 30	$ 150	$ 250	$ 330	$ 1,380	$ 2,060
Alliance PPO	$ 210	$ 550	$ 930	$ 1,290	$ 3,710	$ 4,340
APWU PPO	$ 290	$ 770	$ 1,010	$ 1,390	$ 3,930	$ 4,970
Blue Cross Standard PPO	$ 300	$ 590	$ 760	$ 910	$ 2,860	$ 4,200
CapitalCare	$ 50	$ 240	$ 390	$ 490	$ 1,880	$ 2,820
CareFirst	$ 40	$ 170	$ 270	$ 350	$ 1,450	$ 2,120
CIGNA	$ 40	$ 180	$ 280	$ 350	$ 1,330	$ 2,010
Columbia	$ 40	$ 200	$ 320	$ 400	$ 1,590	$ 2,360
Free State	$ 30	$ 160	$ 280	$ 360	$ 1,460	$ 2,180
G. Washington High	$ 60	$ 190	$ 360	$ 480	$ 1,650	$ 2,460
G. Washington Standard	$ 110	$ 330	$ 620	$ 760	$ 2,220	$ 3,320
GEHA PPO	$ 240	$ 480	$ 690	$ 940	$ 3,060	$ 5,110
Kaiser	$ 20	$ 120	$ 210	$ 290	$ 1,310	$ 1,920
M.D. IPA	$ 50	$ 210	$ 320	$ 440	$ 1,640	$ 2,410
Mail Handlers High PPO	$ 230	$ 660	$ 890	$ 1,080	$ 2,770	$ 4,150
Mail Handlers Standard PPO	$ 260	$ 630	$ 1,110	$ 1,610	$ 3,510	$ 5,000
NALC PPO	$ 470	$ 850	$ 1,000	$ 1,260	$ 3,340	$ 5,660
NYLCare High	$ 40	$ 160	$ 260	$ 330	$ 1,280	$ 1,900
NYLCare Standard	$ 100	$ 310	$ 730	$ 850	$ 2,380	$ 3,500
Postmasters Standard PPO	$ 310	$ 630	$ 1,200	$ 1,430	$ 3,990	$ 6,250
Preferred Health	$ 40	$ 160	$ 230	$ 270	$ 730	$ 1,190
Prudential	$ 30	$ 180	$ 300	$ 390	$ 1,480	$ 2,260
QualChoice	$ 100	$ 370	$ 550	$ 690	$ 2,590	$ 3,790
United HealthCare	$ 30	$ 220	$ 380	$ 510	$ 2,150	$ 3,190

Source: Based on Center for the Study of Services, *Checkbook's Guide to 1998 Health Insurance Plans for Federal Employees* (by Walton Francis and the Editors of Washington Consumers' Checkbook), Washington, 1997, p. 28. Out-of-pocket costs exclude premiums and membership fees.

Table B-2. Estimated Benefit Payments for Single Enrollees under Washington Area FEHBP Plans, 1998

	Estimated plan benefit payment for enrollee incurring bills totaling:					
	$ 500	$ 1,500	$ 3,000	$ 6,000	$ 20,000	$ 70,000
Aetna U.S. Healthcare	$ 470	$ 1,350	$ 2,750	$ 5,670	$ 18,620	$ 67,940
Alliance PPO	$ 290	$ 950	$ 2,070	$ 4,710	$ 16,290	$ 65,660
APWU PPO	$ 210	$ 730	$ 1,990	$ 4,610	$ 16,070	$ 65,030
Blue Cross Standard PPO	$ 200	$ 910	$ 2,240	$ 5,090	$ 17,140	$ 65,800
CapitalCare	$ 450	$ 1,260	$ 2,610	$ 5,510	$ 18,120	$ 67,180
CareFirst	$ 460	$ 1,330	$ 2,730	$ 5,650	$ 18,550	$ 67,880
CIGNA	$ 460	$ 1,320	$ 2,720	$ 5,650	$ 18,670	$ 67,990
Columbia	$ 460	$ 1,300	$ 2,680	$ 5,600	$ 18,410	$ 67,640
Free State	$ 470	$ 1,340	$ 2,720	$ 5,640	$ 18,540	$ 67,820
G. Washington High	$ 440	$ 1,310	$ 2,640	$ 5,520	$ 18,350	$ 67,540
G. Washington Standard	$ 390	$ 1,170	$ 2,380	$ 5,240	$ 17,780	$ 66,680
GEHA PPO	$ 260	$ 1,020	$ 2,310	$ 5,060	$ 16,940	$ 64,890
Kaiser	$ 480	$ 1,380	$ 2,790	$ 5,710	$ 18,690	$ 68,080
M.D. IPA	$ 450	$ 1,290	$ 2,680	$ 5,560	$ 18,360	$ 67,590
Mail Handlers High PPO	$ 270	$ 840	$ 2,110	$ 4,920	$ 17,230	$ 65,850
Mail Handlers Standard PPO	$ 240	$ 870	$ 1,890	$ 4,390	$ 16,490	$ 65,000
NALC PPO	$ 30	$ 650	$ 2,000	$ 4,740	$ 16,660	$ 64,340
NYLCare High	$ 460	$ 1,340	$ 2,740	$ 5,670	$ 18,720	$ 68,100
NYLCare Standard	$ 400	$ 1,190	$ 2,270	$ 5,150	$ 17,620	$ 66,500
Postmasters Standard PPO	$ 190	$ 870	$ 1,800	$ 4,570	$ 16,010	$ 63,750
Preferred Health	$ 460	$ 1,340	$ 2,770	$ 5,730	$ 19,270	$ 68,810
Prudential	$ 470	$ 1,320	$ 2,700	$ 5,610	$ 18,520	$ 67,740
QualChoice	$ 400	$ 1,130	$ 2,450	$ 5,310	$ 17,410	$ 66,210
United HealthCare	$ 470	$ 1,280	$ 2,620	$ 5,490	$ 17,850	$ 66,810