

**UNITED STATES SENATE  
COMMITTEE ON FINANCE**

**Wednesday, May 21, 1997; 10:00 a.m.  
Room SD-215 Dirksen Senate Office Building**

**Hearing on FEHBP As A Model For Medicare Reform**

**WITNESS LIST**

- I. The Honorable Judd Gregg, United States Senator from the State of New Hampshire
- II. The Honorable Ron Wyden, United States Senator from the State of Oregon
- III. A panel consisting of:
  - Stuart M. Butler, Ph. D., Vice President for Domestic Research, The Heritage Foundation; Washington, D. C.
  - Robert D. Reischauer, Ph. D., Senior Fellow, The Brookings Institution; Washington, D. C.
  - Kenneth E. Thorpe, Ph. D., Professor and Director, Institute for Health Services Research, Tulane University School of Public Health and Tropical Medicine; New Orleans, Louisiana
- IV. A panel consisting of:
  - Richard V. Anderson, Vice President, Health Policy, Kaiser Permanente; Oakland, California
  - Edwin C. Hustead, FSA, Senior Vice President, Hay/Huggins, Inc., and Former Chief Actuary, U. S. Office of Personnel Management (1972-1980); Washington, D. C.
  - Peter Wyckoff, Executive Director, Minnesota Senior Federation-Metropolitan Region, and Board Member, National Council on the Aging as Liaison for the National Coalition of Consumer Organizations on Aging; St. Paul, Minnesota

**Nomination Hearing**

**WITNESS LIST**

- I. Robert S. LaRussa, to be an Assistant Secretary for Import Administration at the Department of Commerce



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## Congressional Testimony

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# THE FEHBP AS A MODEL FOR REFORMING MEDICARE

Testimony before  
The Senate Finance Committee  
May 21, 1997

Stuart Butler  
Vice President  
Domestic Policy Studies

My name is Stuart Butler. I am Vice President for Domestic Policy Studies at The Heritage Foundation. I am also a member of the steering committee of the National Academy of Social Insurance's project on long term Medicare reform. I must stress, however, that the views I express are entirely my own, and should not be construed as representing the position of either organization.<sup>1</sup>

It is wise of the Committee to explore the applicability of the Federal Employees Health benefits Program (FEHBP) as a model for reform of the Medicare program. There are a number of working systems in the country, including the California Public Employees' Retirement System (CalPERS), FEHBP, and many systems in the private sector, that contain key features that should be considered in a reformed and modernized Medicare program. These should be explored in Congress' discussion of introducing wider choice with cost control in the Medicare program.

The FEHBP is an interesting contrast to Medicare. Both are large health care programs run by the federal government. But there the similarity ends. The FEHBP is not experiencing the severe financial problems faced by Medicare. It is run by a very small bureaucracy, who, unlike Medicare's staff, do not try to set prices for doctors and hospitals. It offers choices of modern benefits and private plans to federal retirees (and active workers) that are unavailable in Medicare. It provides comprehensive information to enrollees. And it uses a completely different payment system, blending a formula and negotiations.

It is time for Members of Congress to examine the system they are enrolled in and incorporate key features of the program into Medicare.

## **Section I: Summary Points**

Let me summarize the key points that are developed in the body of my testimony.

### Key features and lessons of the FEHBP

- 1) The FEHBP offers a wide range of plans, with a variety of benefits. While there are some adverse selection pressures in the system, these are surprisingly small given the fact that FEHBP is by law community rated (without regard to age and other risk factors) and there are quite wide plan variations. The FEHBP experience thus should make Congress confident that, with modifications to the basic FEHBP design, it is possible to design a stable choice system for Medicare that would provide constantly upgraded benefits to retirees.
- 2) Unlike Medicare, the FEHBP neither pays for specific services according to a fee schedule, nor does it (for HMOs) pay plans according to a flat formula. Instead it

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<sup>1</sup> Much of the material in the main section of this testimony is drawn from Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare program *Health Affairs*, vol. 14, no. 4 (Winter 1995).

invites plans to submit bids and then negotiates prices and benefits, plan by plan. The FEHBP pays a percentage of the negotiated premium, up to a dollar limit.

The FEHBP indicates that there are very different ways in which the Medicare payment system could be altered to address the chronic problems in today's Medicare. The Physician Payment Review Commission, in its 1997 report, examined a variety of ways in which FEHBP-type payment systems could be applied to Medicare (see Chapter 9 of the report).<sup>2</sup>

- 3) The FEHBP plans include several offered by employee co-operatives and major unions. One reason these plans are popular is that they are organized by groups that actually represent the enrollees, rather than by HMOs or insurance companies that often perceive the enrollee as a passive buyer in an individual market. This feature of the FEHBP could be a particularly attractive part of a reformed Medicare system. One might imagine plans offered through the American Associations of Retired Persons (AARP), or major unions, or even churches.
- 4) The FEHBP has a comprehensive system of information distribution to aid beneficiaries making choices, complemented by a sophisticated system of information provided through consumer organizations. This could be a model for Medicare, whose information system has been roundly criticized by the general Accounting Office.<sup>3</sup>
- 5) The negotiations on premiums and benefits are held between the Office of Personnel Management (OPM), which runs the FEHBP, and the individual plans. For HMO and POS plans, OPM typically starts its negotiations based on the local market for these plans (it does not, as in the case of Medicare, apply a formula based on the local fee-for-service market). In the case of fee-for-service and PPO plans, OPM negotiates a fixed profit per subscriber, usually between 0.5 percent and 0.75 percent of premium. Thus the plans make money through negotiated service contracts rather than traditional profits. While these plans must accept market risk, they must lodge revenue surpluses in special reserve accounts which can enable them to bid more competitively in future years. This variation of the normal market answers many of the concerns voiced against allowing competing private plans in Medicare.

### How Medicare could be reformed to incorporate the lessons from the FEHBP

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<sup>2</sup> Physician Payment Review Commission, *Annual report to Congress, 1997* (PPRC, Washington, D.C., 1997).

<sup>3</sup> *Medicare Managed Care: HCFA Missing Opportunities to Provide Consumer Information*, Testimony of William Scanlon (GAO), Special Committee on Aging, US Senate, April 10 1997.

- 1) Create a semi-independent congressionally-appointed board to operate the traditional fee-for-service Medicare in all parts of the country. The board would also have power to make variations in the benefits, including deductibles and copayments, subject to an up-or-down vote by Congress without amendment.
- 2) Shift the payment system for retiree health care to a modified defined contribution system. While many variations are possible, and should be explored, the best structure might be to pay a percentage of the premium above a fixed dollar contribution, with a ceiling to the total government contribution linked to the cost of the traditional fee-for-service plan in the area.
- 3) Invite initial bids from private plans meeting specified minimum requirements (including requirements on information disclosure, underwriting limitations etc.) Then allow HCFA to negotiate premiums and benefit packages with individual plans, prior to a final price and benefits package that is then offered to Medicare enrollees in a particular area. Plans should have a basic core of benefits (as FEHBP requires), but negotiators should be able to develop a variety of plan benefits and prices in any area. The traditional Medicare fee-for-service plan also should be required to offer a bid with the price established through negotiation in conjunction with Congress.
- 4) Operate an annual open season in which retirees can choose a plan for the following year.

## **Section II: Lessons of the FEHBP**

Created by Congress in 1959, the Federal Employees Health Benefits Program (FEHBP) offers over 400 competing private plans to active and retired Members of Congress and Congressional staff, as well as active and retired federal and postal workers and their families -- altogether almost 9 million people.<sup>4</sup> The FEHBP works well despite some aspects of its enrollment and design dealt with in a redesigned Medicare program would significantly improve the program for the nation's elderly and disabled.

The FEHBP population is not an ideal insurance pool. For one thing, the FEHBP population of active employees is older (43.8 years) than employees in the private sector (37.4 years).<sup>5</sup> For another, enrollment is optional and eligibility requirements are quite

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<sup>4</sup>For a detailed discussion of the FEHBP, see Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employees Health Benefits Program," *Heritage Foundation Backgrounder* No. 878, February 6, 1992; see also, Walton Francis, "The Political Economy of the Federal Employee Health Benefits Program," in Robert B. Helms (ed.) *Health Policy Reform: Competition and Controls* (Washington D.C.: The American Enterprise Institute, 1995), pp. 269-307.

<sup>5</sup>Based on a 1989 analysis of private and public sector employee age factors, the difference in age between federal employees and private sector employees means that federal employees would have health care costs

liberal. Also, plans may not impose "waiting periods" or limitations or exclusions from coverage for pre-existing medical conditions.

Further, the proportion of higher-cost federal retirees in the program has steadily grown, meaning the FEHBP has been facing a growing proportion of higher-cost-enrollees. In 1975, 858,000 retirees comprised 27 percent of the FEHBP's policyholders. By 1992, some 1.6 million retirees accounted for 40 percent of the entire FEHBP policyholders.<sup>6</sup> And according to OPM's actuaries, the average age of the covered TK in the program (which includes dependents) also has been increasing.<sup>7</sup> The plans are prevented by law from pricing their coverage differently for this higher-risk group by the program's strict community rating requirement.

### **How the FEHBP Works**

Federal workers and retirees can choose from a variety of health plans, ranging from traditional fee for service plans to insurance plans sponsored by employee organizations or unions, to managed care plans. Approximately, 40 percent of all federal subscribers, and 18 percent of all federal retirees, are now enrolled in HMOs. All HMOs in FEHBP have benefits that are especially attractive to the elderly, including catastrophic coverage and mental health coverage. Almost all cover care in an "extended care facility," some with no dollar or day limits. No federal retiree has a range of choice of fewer than seven plans.<sup>8</sup>

The National Association of Federal Employees (NARFE), the major organization representing federal retirees declares that "All FEHBP plans are good. All cover hospital and physician care, prescriptions, outpatient diagnostic lab tests, treatment of mental illness, home health care, routine mammograms for women over 35, routine prostate cancer tests for men over 40, and stop smoking programs."

And unlike Medicare, most FEHBP plans cover prescription drugs and include a wide range of dental services. Furthermore, the elderly can choose very specialized items, such as diabetic supplies.

**How The Elderly Pick Plans.** Each year, in preparation for the Fall annual "Open Season," when retirees and regular employees pick plans for the following year, the Office of Personnel Management (OPM) sends beneficiaries an *FEHBP Guide*, which includes a health plan comparison chart. Health plans also provide retirees with information on benefits and premiums in a variety of ways, including advertising.

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averaging 22 percent higher than private sector workers. *Focus 89*, Proposed Changes in the FEHBP Program, CNA Insurance Companies, 1989.

<sup>6</sup>Carolyn Pemberton and Deborah Holmes (eds.), *EBRI Databook on Employee Benefits* (Washington, D.C.: Employee Benefit Research Institute, 1995), p. 278.

<sup>7</sup>Information from Nancy Kichak, Director of the Office of Actuaries, Office of Personnel Management.

<sup>8</sup>Smith, *op. cit.*, pp. 14, 62.

Perhaps the most valued consumer resource for federal employees and retirees is *Checkbook's Guide to Health Insurance Plans for Federal Employees*, published by a consumer organization. The popular *Guide* compares plans, gives employees and retirees general advice on how to pick a plan, outlines plan features and special benefits, presents detailed cost tables (including the out-of-pocket limits for catastrophic coverage), and presents "customer satisfaction surveys" on the performance of plans. The *Guide* also provides specialized advice for federal retirees, including retirees with and without Medicare and information on HMO options and Medicare.

The *Guide's* "customer satisfaction surveys" are quite detailed, rating plan performance in such areas as access to care, the quality of care, the availability of doctors, the willingness to provide customer information and advice by phone, the ease of getting appointments for treatments or check-ups, typical waiting times in the doctor's office, access to specialty care, and the follow-through on care. The surveys also review patient experience with such things as explanation of care, the degree to which the patient is involved in decisions relating to care, the degree to which the plans' doctors take a "personal interest" in the patient's case, advice on prevention, the amount of time available with the doctor, the available choice of primary care physicians and access to specialists, and the speed with which the patient can contact the plan's service representative.<sup>9</sup>

Beyond this valuable information, federal retirees receive additional guidance from the National Association of Retired Federal Employees (NARFE), a private organization representing approximately 500,000 current and retired federal employees. With a network of over 1,700 chapters throughout the country, NARFE works closely with the OPM in answering questions and resolving problems related to health insurance and retirement matters. In preparation for "Open Season," NARFE publishes its annual *Federal Health Benefits and Open Season Guide*.<sup>10</sup> Most important of all, NARFE actually rates plans on benefit packages that would be most attractive to the elderly. For example, for prescription drugs, NARFE ranks Alliance and Blue Cross/ Blue Shield as the best choices for the elderly.<sup>11</sup>

**The Role of the Office of Personnel Management** OPM is given authority in the FEHBP statute to: contract with health insurance carriers; prescribe "reasonable minimal standards" for plans; prescribe regulations governing participation by federal employees, retirees and their dependents, as well as to approve or disapprove plan participation in the FEHBP; set government contribution rates in accordance with federal law; make available plan information for enrollees; and administer the FEHBP trust fund, the special

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<sup>9</sup>*Ibid.*, pp. 49-79.

<sup>10</sup>Smith, *op. cit.*, p. 50.

<sup>11</sup>*Ibid.*, p. 63.

fund containing contributions from the government and enrollees and from which all payments to health plans are made.<sup>12</sup>

Unlike HCFA, OPM does not impose price controls or fee schedules, issue detailed guidelines to doctors or hospitals or standardize benefits. Private plans within the FEHBP must meet "reasonable minimal" standards regarding benefits.<sup>13</sup> But the law creating FEHBP does not specify a comprehensive set of standardized benefits. Congress merely defines the "types" of benefits that "may be" provided.<sup>14</sup>

OPM sends out a "call letter" in the Spring of each year to insurance carriers, inviting them to discuss rates and benefits for the following calendar year.<sup>15</sup> In these confidential discussions, OPM outlines its expectations on rates and benefits to the carriers, and the carriers invariably respond by offering proposals. This is an unusual, and largely successful, mixture of discussion and jawboning. Congress rarely intrudes into this process.

In setting the government contribution to retirees health benefits, OPM must make its calculations according to a formula established by law. OPM determines the government contribution on the basis of the average premium of the government-wide service benefit plan, the indemnity benefit plan, the two largest employee organization plans and the two largest comprehensive. This is commonly called the "Big Six" formula.<sup>16</sup> OPM calculates the average premium of these six largest plans, and multiplies that average by 60 percent. This determines the *maximum* annual government contribution, which is applied to each plan and option. This maximum contribution in contribution was \$1,600 for individuals and \$3,490 for families. The formula has one

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<sup>12</sup>This summary of legal authorities can be found in the *Federal Employees Health Benefits Program* (Washington, D.C.: Congressional Research Service, 1989), p. 238.

<sup>13</sup>For purposes of the FEHBP, a health plan is defined as "a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangements provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services." *Code Federal Regulations* Chapter 16, 1602.170-8. The minimum standards for health benefits carriers includes a requirement that the carrier be lawfully engaged in business of supplying health benefits meet financial solvency standards, including "reasonable financial and statistical records; open access to records by OPM and GAO investigators or auditors; an acceptance of payment in accordance with contract and contingency receive requirements; a requirement to perform the contract in accordance with 'prudent business practices'." See 48 CFR, Chapter 16, Part 1609 "Contractor Qualifications" OPM's other regulatory prohibitions and restrictions deal primarily with consumer protection, including prohibitions against false misleading, deceptive or unfair advertising, and a requirement for retention of financial records.

<sup>14</sup>Title 5, *United States Code*, Section 8904.

<sup>15</sup>In this process, OPM maintains strict confidentiality. OPM staff historically have not even shared the document with the Office of Management and Budget.

<sup>16</sup>In recent years, the government-wide "service benefit plan" has been Blue Cross and Blue Shield, the two largest employee organization plans have been the Mailhandlers and the Government Employee Hospital Association Plan, and the two largest comprehensive medical plans have been the Kaiser Foundation Plan of Northern California and the Kaiser Foundation Health Plan of Southern California. With Aetna dropping out of the program in 1989, OPM staff have used a mathematical formula to calculate the service indemnity component of the Big Six formula.

other crucial adjustment. In no case can the federal government contribute any more than 75 percent of the cost of the premium of any plan. The federal contribution for individuals ranges from about \$1,000 to about \$1,600. According to the PPRC, premiums for individuals range from about \$400 to about \$1,800.

OPM prepares kits outlining rates and benefits for the coming calendar year, disseminating information on the plans. Beneficiaries then pick a plan during open season. OPM maintains an "Open Season Task Force" to help in making decisions, and a hot line that retirees (or regular workers) can call during open season.

Whatever the plan chosen, the government's premium is sent directly to the plan. The enrollee's premium contribution normally is deducted from the enrollee's paycheck (for workers) or annuity (for retirees) and also sent by OPM directly to the chosen plan. OPM also helps retirees and employees settle disputed claims.

**Adverse Selection.** While the FEHBP has been successful, there have been two persistent and interrelated problems associated with its design: adverse selection in the program, and an outdated system of insurance underwriting.

Adverse selection has been an irritant in the FEHBP for many years, and is exacerbated by the strict community rating requirement. Still, it has not undermined the program. To be sure, OPM has taken steps to limit the variation in benefit packages to limit some of the risk selection, and, during the negotiation process, has allowed some plans with particularly generous packages to eliminate some benefits. Even so, in its exhaustive 1989 analysis of the strengths and weaknesses of the FEHBP, the Congressional Research Service concluded that the program at that time was structurally sound. According to the CRS, "That FEHBP has continued to 'work' over the years, despite major changes in the environment in which it has operated, reflects the soundness of its basic design."<sup>17</sup>

### **Section III: Using the FEHBP Model to Reform Medicare**

Transforming Medicare into a program similar to the FEHBP would mean changing fundamentally the role of the federal government, and more specifically the Department of Health and Human Services (HHS) and the Health Care Finance Administration (HCFA). It would mean that instead of setting prices, paying for specific services, and regulating virtually every facet of the system, HHS would -- like OPM in the FEHBP system -- have only two broad functions: calculating and dispensing a payment to Medicare beneficiaries, to be used for the purchase of health care; and overseeing a market of health plans approved for sale to the Medicare population.

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<sup>17</sup>CRS, *op. cit.*, p. 231.

A new Medicare system conforming to this framework might be designed in the following way.

### **Element 1: Change the Government's role**

In a reformed Medicare system based on the FEHBP, HHS would have monitoring and payment clearing house functions similar to those of OPM within the FEHBP program. It would be responsible for making disbursements to the plans selected by Medicare beneficiaries. But it would not regulate the premiums of plans or the prices of services. Nor would it actually run any plans, any more than OPM does. On the other hand it would negotiate directly with competing plans offered to beneficiaries on premiums and benefits. Specifically:

- a) The government would maintain the "traditional" fee-for-service Medicare plan which would be available everywhere. However, it would no longer run that plan. Instead, Congress would establish a federally-sponsored not-for-profit corporation to sponsor a "Medicare Standard Plan." The corporation would be governed by its own government-appointed board and would offer the standard Part A and Part B benefits. However, the board would also recommend to Congress each year changes in the services, premium, deductibles and copayments for the Standard Plan. These changes would have to be ratified by Congress in an up-or-down vote without amendment.
- b) The government would allow private plans meeting certain requirements (see below) to submit bids to offer a set of services to the elderly. HCFA would negotiate with each plan on the benefits, premium, service area etc. After these negotiations, the plan could be offered to Medicare beneficiaries.
- c) Like OPM in the FEHBP system, HHS would conduct the annual Medicare open season in which private plans . During open season, beneficiaries would choose their plan for the following year. Before open season, each Medicare beneficiary would receive an information kit from HHS, including standardized information on prices, benefits and consumer satisfaction for Medicare-approved plans in their area, including the Standard Plan. Beneficiaries would also receive a selection form on which to indicate their choice.
- d) Once the selection had been made, HCFA would send the appropriate contribution to the chosen plan (see below). The beneficiary would be responsible for any difference between the voucher and the premium costs, but could elect to have the government pay that difference and reduce the beneficiaries Social Security check (similar to the part B option today). If no plan were selected, the beneficiary would be assigned to the Standard Plan.

## **Element 2: Change the Medicare payment system**

There has been considerable interest in recent years in refining the way in which the government makes payments for the care of Medicare patients. Among the concerns with the current system is that Medicare appears to be overpaying many HMOs because of the payment formula based on the cost of fee-for-service plans in an area. Another is that the defined benefit nature of Medicare and its payment system necessarily drives up cost. To deal with this second concern, many policymakers and Members of Congress have argued for some form of defined contribution. But a worry with this alternative approach is that an “arbitrary” budgeted contribution could leave seniors carrying an unacceptable degree of risk.

Fortunately, the FEHBP’s payment formula and plan negotiation system appears to be a good model to solve these problems. Some combination of the following options should be considered.

### **Option 1: A market adjusted but government-set contribution to plans**

Although the FEHBP does not use a “voucher” to make payments to plans (it uses a percentage of premium with a limit), a modified voucher system could work in an FEHBP-style Medicare program. Essentially this would be a modification of the Average Area Per Capita Cost (AAPCC) mechanism used today to set capitation amounts for HMOs under the risk contract program. The law sets this fee at 95 percent of the estimated average cost of fee-for-service care for Medicare patients in the area. It then adjusts this rate for certain demographic characteristics such as age, sex, Medicaid eligibility, and institutional status, to determine the capitation amount.

Under this modified system, HCFA would calculate the contribution amount for each Medicare beneficiary, using the primary risk factors and income information, and an adjustment to reflect the total Medicare budget for the year and the estimated average enrollee cost of a weighted local basket of plans (based on plan information supplied for the open season). This basket would comprise “typical” plans, such as the Medicare Standard Plan, a catastrophic/MSA plan, a Blue-Cross standard plan, and a comprehensive HMO plan. This is a refinement of the “big six” formula used by OPM to set the government contribution to the FEHBP. The calculation of the Medicare voucher would be made *after* the plans had filed their price and benefit information for the open season, so that the voucher would reflect the actual market formula encountered by the beneficiary.

The distinction between Part A and Part B would disappear under this reform, and the budgeted net Medicare expenditure for the initial year of the new program would be divided by the number of eligible individuals to determine a base rate for the voucher. In future years the combined cost of the vouchers would be adjusted in line with the Medicare budget to determine the base rate for the year. This base rate would then be adjusted according to three factors:

**Primary risk factors.** The base rate would be adjusted according to the enrollee's age, sex, reason for eligibility (age or disability), institutional status, and ESRD status.

**Local market variance.** The base rate also would be adjusted to reflect a weighted average enrollee cost of a "basket" of plans offering certain categories of benefits (discussed later).

**Income adjustment.** To incorporate the objective of income-adjusting the general revenue subsidy to the current Part B program, the portion of the base rate roughly equivalent to the government's net Part B contribution would be adjusted in this way. The portion equivalent to Part A would not.

This payment system would link payments to the risk and income of the beneficiary, and in that way avoid much of the concern that high risk or poorer beneficiaries would shoulder too much of the cost. Yet the incentive for individuals to seek out the best value for money in plans would be strong.

## **Option 2: A negotiated premium with a formula payment**

A variant to consider is first for HCFA to invite bids and negotiate benefits and premiums, as outlined above. Then a minimum contribution could be made by the government, based on the general criteria discussed in option 1 but based on the lower cost plans. In addition, HCFA would pay a fixed proportion of the premium above that minimum amount, up to a limit linked to the cost of the traditional fee-for-service plan in the area – which would have to submit a bid in the same manner as other plans.

This modification would slightly weaken the incentive to seek the best value for money (since the enrollee would be insulated for part of the cost above the base amount). On the other hand, an individual would still be able to choose the traditional plan with the government ensuring that the individual's net premium payment would be fixed.

## **Element 3: Standards for participation by a plan**

Any private health plan would be eligible to receive an individual's Medicare benefits in part payment for providing health care providing it met certain threshold requirements. The requirements would apply to plans marketed by affinity organizations, such as churches, unions or elderly groups, not merely to plans marketed by insurers or provider organizations. There would be no restrictions on the number of plans available in an area or the types of plan, and plans could operate in different service areas and provide different benefits. A plan could gain approval to market to the Medicare population provided it:

- a) Has a license to issue health insurance in the state, or gains approval directly from HHS.
- b) Will provide services in a service area acceptable to HHS.
- c) Meets solvency requirements.
- d) Includes a core of basic coverage determined by legislation. The basic package would have to cover "medically necessary" acute medical services, including physician services, inpatient, outpatient and emergency hospital services, and inpatient prescription drugs, with a catastrophic stop-loss amount for these services. A plan thus could offer a much leaner package than today's Medicare (although it would have to provide catastrophic protection, unlike Medicare), but it could offer a range of services beyond the base coverage. For example, some plans might offer dental benefits or drug coverage. States would be preempted from mandating additional benefits for plans serving the Medicare population.
- e) Files with HHS a standardized statement of benefits, a table of rates for the same actuarial categories used to determine Medicare benefits (age, institutional status etc.), and consumer information as determined by an advisory board. Plans would not be able to deny coverage or change rates because of health status. The price, benefit and consumer information also would have to be available to any Medicare beneficiary upon request (see *Information, marketing and consumer decision-making*)
- f) Accepts and continues coverage for any Medicare beneficiary applying during the annual open season.

#### **Section IV: Issues Associated With The Proposed New Medicare System**

Under this reformed system, Medicare would operate much like the FEHBP serves retired federal workers and retirees. Medicare beneficiaries would be able to pick a private plan which included the services they wanted (beyond the core package), delivered in the way they wanted, and, if they wished, perhaps through an organization with which they were affiliated (as many FEHBP enrollees do). Or they choose the Medicare Standard Plan. Because beneficiaries would receive a defined contribution (based on the options discussed earlier), they would have a strong economic incentive to pick the plan that best met their objectives of price, quality and services.

The organization of services, the selection of benefits, and payments to providers would be in the hands of the plan managers competing for enrollees. Unlike the federal

officials managing Medicare today, these managers would have the freedom and the financial incentive to experiment with new ways to deliver care at a competitive price.

In stark contrast to today, HCFA would have no role in setting the provider reimbursement rates, deductibles or cost-sharing levels of any private plan, nor any role in requiring benefits beyond the care benefits required by statute. The federal corporation, not HCFA, would be responsible for these decisions in the case of the Medicare Standard Plan.

### **Can a consumer-choice system reduce costs?**

Whether the proposed program “reduces costs” costs depends on how it addresses two distinct aspects of cost. The first of these is the total net outlays of the Medicare trust funds. In other words, would it cut the government’s Medicare budget? The second perspective on cost is how the program would affect the gross costs of serving the elderly. Would a trimming of government outlays merely shift greater costs to the elderly, or would a consumer choice system slow down the growth in service costs? And linked to this second question, could the voucher be designed so that it tracks reasonably accurately the market costs of serving enrollees with certain health conditions in different places?

A defined contribution, in contrast with a defined benefit, controls net government outlays directly because the total contribution is determined by a budget. But, would savings for government merely result in extra enrollee costs? In fact, there are good reasons to expect that this combination of market competition and enrollee incentives would reduce the growth of total medical costs for the elderly and hence the financial exposure of the elderly. The FEHBP’s premium and budget experience suggests strongly that major savings could be achieved in Medicare with a similar market-based design, although conclusions have to be somewhat guarded because so little scientific research has been carried out on the program. In spite of its design shortcomings, the FEHBP has generally outperformed private sector employer-based health insurance and has significantly outperformed Medicare. A comprehensive 1989 study of the FEHBP by the Congressional Research Service concluded that the FEHBP cost increases were lower than those of the private sector.<sup>18</sup> Subsequent analyses have come to similar conclusions.<sup>19</sup> Analyzing the FEHBP’s premiums in the 1980’s, for instance, Lewin-ICF noted that “The available evidence suggests that the FEHBP competitive market dynamics, combined with increased emphasis on cost control, has outperformed the private sector despite increasing benefits in recent years and the impact of an increasing share of retirees.” Most recently, Frank McArdle also concludes that the FEHBP’s rate of premium increases has been lower than the private sector.<sup>20</sup> During the 90’s the premium

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<sup>18</sup>*Ibid.*,

<sup>19</sup>See Walton Francis, “Political Economy of the Federal Employee Health Benefits Program.” See also, Allen Dobson, Rob Mechanic, and Kellie Mitra, *Comparison of Premium Trends for Federal Employees Health Benefits Program to Private Sector Premium Trends and other Market Indicators* (Fairfax, Virginia: Lewin-ICF, 1992).

<sup>20</sup>Frank McArdle. “Opening Up the FEHBP.” *Health Affairs*, Vol. 14, No. 2 (Summer 1995).

performance of the FEHBP has indeed been remarkable. In 1994, the average annual premium increase was only 3 percent, and 40 percent of all enrollees in the program, including retirees, saw decreases in their premiums. In 1995, the entire program experienced an average annual *decrease* in premiums of 3.3 percent.

Another reason to feel confident that converting Medicare into a system of competing and flexible plans is that Medicare is so far behind other sectors in introducing design innovations. Enrollment in HMOs is growing but still small, for instance, while PPOs are heavily restricted and point-of-service plans unavailable. Admittedly, the very elderly now in Medicare may be disinclined to switch to different service arrangements, but more recent retirees, and the disabled, typically are quite familiar with them from their working days. These elderly likely would choose plans containing service innovations if they had the incentive to do so, just as large numbers of FEHBP enrollees do today. With so much ground to make up, giving Medicare beneficiaries the incentive and opportunity to enroll in plans using less costly arrangements could sharply reduce the growth in total costs. One recent study estimates that a 10 percentage point increase in HMO market share within Medicare would be associated with a 1-3 percent decrease in aggregate Medicare spending.<sup>21</sup>

To be sure, the FEHBP does not operate in a market that is completely free of government efforts to regulate prices. Government managers negotiate premiums before they are posted for the open season. Some skeptics of consumer-based approaches suggest that this means the “price maker” power of a government “buyer” actually is holding down costs because plans are afraid of losing access to their market.<sup>22</sup> Nonetheless, the plans still must design and price their product shrewdly in strong competition with each other for enrollees if they are to remain in business. Significantly, OPM devotes most of its negotiating energy with the large plans that undermine the government’s maximum contribution, and largely ignores the pricing of other plans. So it is not clear that the government’s “jawboning” function in the FEHBP is important in holding down costs than this competition for price-sensitive enrollees. But what is clear is that OPM bargaining with competing plans is far more successful at holding down costs than HCFA issuing edicts to hospitals and physicians.

**Enrollee costs in local markets.** The enrollee’s financial exposure is affected by the local market, of course, and not just by the economics of the system as a whole. To keep this exposure reasonable, the voucher amount must closely track the local market for serving an individual with the enrollee’s health care needs.

The closest equivalent to a Medicare voucher today is the adjusted average per capita cost (AAPCC),

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<sup>21</sup>Laurence C Baker, *Can Managed Care Control Health Care Costs: Evidence from the Medicare Experience* (Washington, D.C.: National Institute For Health Care Management, 1995), p. 22.

<sup>22</sup> See Joseph White, “Managing Health Care Costs In The United States,” in *Health Care reform Through Internal Markets: Experiments and Proposals* (Washington, D.C.: The Brookings Institution, 1995), p. 148.

This method of determining the capitation amount has been criticized for a number of shortcomings which blunt potential savings to Medicare and make the market less efficient.<sup>23</sup> For instance, all HMOs in an area are paid the same capitation rate, linked to fee-for-service costs. In some cases this more than Medicare would pay for a particular enrollee in fee-for-service. So, HMOs can often game the system by attracting lower-cost enrollees for any given capitation amount and keeping the difference in cost (subject to profit controls). These and similar problems have led several experts to call for greater flexibility in setting the AAPCC and the incorporation of more sophisticated risk adjustments.<sup>24</sup>

A voucher approach can deal with these deficiencies because it introduces a very different incentive from that in the risk contract system. Because the voucher is not a full payment made to a plan, but a degree of financial support for an enrollee choosing between plans with different prices, it triggers a much stronger price/quality competition between plans seeking the business of enrollees. Plans would not be able to price themselves to take advantage of the shortcomings in a bureaucratic structure of capitation payments. They would instead have to compete to satisfy a customer who is motivated to pick a plan according to the full package of premium, services, quality and anticipated out-of-pocket costs.

#### **Is adverse selection a serious problem?**

Policymakers naturally are concerned about the possibility that adverse selection might destabilize a consumer choice Medicare system, particular a system as proposed here, that allows plans to vary benefits.

We believe that a stable market with acceptable differences in cost would result from the proposed system without any special risk adjustment mechanism in addition to the primary risk factors used for the vouchers and premiums. But it would be wise to establish a review commission to monitor this aspect of the program and to recommend additional risk adjusters if necessary. Still, while there is little research available on how problematic undesirable adverse selection might be in a voucherized Medicare program, there are reasons to suppose it would not be severe.

Perhaps the most persuasive reason for optimism is the experience of the FEHBP. The community-rated FEHBP permits plans to offer a wide range of benefits, yet requires plans to charge exactly the same premium to a perfectly healthy 19 year old as to a chronically sick 89 year old. It also has no special risk adjustment mechanism. This

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<sup>23</sup>See, for instance, *Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs* (General Accounting Office, September 1994), GAO/HEHS-94-119. See also Ratner, *op. cit.*

<sup>24</sup>See Gail Wilensky, "Incremental Health System Reform: Where Medicare Fits In," *Health Affairs* (Spring 1995), pp. 179-180.

would seem to be an open invitation to destructive adverse selection pressures. Yet, although there clearly is some adverse selection in the program, it is remarkably stable.

We incorporate the features of the FEHBP into the proposed Medicare reform which seem to explain its ability to withstand destructive adverse selection, and include other features that improve upon the FEHBP in this regard. Three features are particularly important.

First, limiting plan switching to once a year (in Medicare today, an enrollee in the risk contract sector may switch after just 30 days), using the same open season procedure as the FEHBP. This would make it more difficult for enrollees to destabilize the market by transferring to generous, unrestricted plans just to cover an expensive illness or elective treatment.

Second, allowing plans to vary their premiums according to a range of basic risk factors, which the FEHBP does not. This premium variation would reduce the financial attraction to plans of seeking out enrollees likely to be healthier because of their demographic characteristics. Adjusting the voucher according to the primary risk categories would also insulate enrollees in higher risk categories from their generally higher premium costs.

Third, the central marketing and information-distribution arrangements (an elaboration of the FEHBP open season) would help to limit cherry-picking by plans, as these features appear to do in the FEHBP. Because Medicare enrollees would receive standard information on all plans in their area, it would be impossible for plans to "hide" themselves from applicants they do not desire. And to retain their approval to market to Medicare enrollees, plans could be required to adopt other marketing guidelines to reduce unfair practices.

We do, of course, propose to retain a "traditional" Medicare plan as an option for beneficiaries. Would there be significant adverse selection against the government because only very old and chronically sicker beneficiaries remained with the plan? And would these enrollees face spiraling net costs under the defined contribution system?

While both results are theoretically possible, especially if the government-operated plan remains as inflexible and outdated as today's Medicare, the design of the proposed system reduces this danger. For one thing the premium of every plan is adjusted by the major risk factors, and so a plan attracting a large share of very old enrollees would receive much higher premium income from these enrollees -- who in turn would qualify for a larger voucher. For another thing, the voucher amount would be adjusted in each area according to the weighted costs of a basket of plans, which would include the Medicare Standard Plan, giving a further refinement to the voucher and thus helping to limit the potential for large net costs to enrollees in the Standard Plan.

Further, it is by no means obvious that chronically sicker beneficiaries generally would avoid private plans in favor of the standard plan. The private plans could not turn away any beneficiary during open season, no matter how sick the person was. And unless its structure of coverage were significantly changed from today's Medicare, the Standard Plan would not provide stop-loss protection and would lack coverage for services (such as prescription drugs) that is routine in private plans.

### **Information, marketing and consumer decision-making.**

A final concern is information. For a market to function that is both efficient and that satisfies consumers, those consumers must be armed with the information they need to make good decisions. Health care decisions can be confusing enough for young, well-educated people, so it is reasonable to question whether elderly people -- who in many cases are easily confused -- could make informed decisions in a market of competing plans.

There is little research available on exactly what information the elderly require to make sensible decisions in health care, but several categories suggest themselves. These include premium and likely out-of-pocket costs, benefits, information on customer satisfaction, and some measurements of quality.<sup>25</sup> In the information clearing house function assigned to HHS, standardized consumer information on prices, benefits would be included, as would "consumer information." This latter category might take the form of such things as categorization of plans (similar to the Medigap market); information on typical costs for certain illnesses, perhaps using the "illness episode approach"; and patient evaluations, such as these prepared for FEHBP enrollees by *Washington Consumers' Checkbook*. To make this information as helpful as possible, it would make sense to create a "Consumer Advisory Board", consisting of representatives of Medicare beneficiaries and the health care industry, to recommend to HHS what information should be made available to beneficiaries and how. Plans would be free to supply additional information, and to advertise, as they can in the FEHBP, but they would have to meet certain disclosure criteria to remain Medicare approved.

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<sup>25</sup>For a discussion of this issue, see Shoshanna Sofaer, "Informing And Protecting Consumers Under Managed Competition," *Health Affairs*, (Supplement 1993), pp. 76-86.

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STATEMENT OF  
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MAY 21, 1997

**Introduction**

Mr. Chairman and members of the Senate Finance Committee, I am pleased to be here to examine the potential role of the Federal Employees Health Benefit Program (FEHBP) as a model for the Medicare program. Adopting an FEHBP style approach within the Medicare program would, according to its supporters, increase the number of plans beneficiaries could choose, provide a structural change in the program that would provide the opportunity for on-going cost savings, and would create incentives for continuous improvements in the quality of care. My comments will focus on three areas; first, what transitional steps would be required to move the Medicare program closer to an FEHBP type mode?. Second, if Medicare adopted an FEHBP type model, what changes in policy should be considered, and finally would an FEHBP style approach promote the three policy goals I noted earlier?

Prior to examining these issues, it seems critical to outline briefly the case for and against large-scale structural changes in the Medicare program. As I noted above, the case for structural reforms in the program may, in part, be judged against several criteria including their ability to contain long-term program costs, increase choice of plans and providers for beneficiaries, and to continuously improve the quality of care provided Medicare beneficiaries. These issues are examined briefly below.

Cost Containment

One of the goals of a restructured Medicare program would be to re-align the per enrollee growth in Medicare spending with the growth in private health insurance. At least through 1993, per enrollee growth in Medicare spending has been lower than the private sector. The recent substantial shift of private sector workers and their families from fee-for-service to managed care over the past three years changed this trend. Between 1993 and 1995, private health insurance increased 3.5 percent per enrollee compared to 9.7 percent for the Medicare program (see Figure 1). With respect to the future, the Congressional Budget Office projects that private health insurance will rise at 4.7 percent per enrollee and Medicare at 7.5 percent per enrollee. However, the recent budget agreement between the President and Congress would reduce the per enrollee growth in Medicare spending to 4.4 percent over the next five years--0.3 percentage points below that expected in the private sector. Thus, the case for structural reform, it would appear, seems to

hinge on the ability of the reforms to sustain this rate of growth past the year 2002. Alternatively, it could be argued, the more incremental changes made recently to Medicare payments to HMOs under its risk program could, if coupled with continued savings generated in provider payments, yield a similar rate of growth that the broader structural changes would yield. However, even with Medicare rising at rates slightly below the expected growth in the private sector, the Medicare HI trust fund is still expected to be exhausted before the year 2010. In short, simply re-aligning the growth in Medicare spending with the growth in private health insurance spending will not, by itself, provide a long-term solution to financing problems plaguing the HI trust fund.

Despite this limitation, the question is whether an FEHBP type structure could mirror the expected growth in private sector premiums overall. By the nature of how the FEHBP negotiates premiums with the locally rated managed care plans, the answer is likely "yes". The FEHBP currently uses a version of "most favored customer" status where managed care plan premiums charged the FEHBP have to be substantially similar to those charged in the commercial market. In addition to the bargaining power exerted by the Office of Personnel Management, this process allows the program to piggyback on savings generated more broadly by other private sector purchasers.

The recent experience with the growth in FEHBP premiums has been favorable. Premiums for the Blue Cross standard option plan were virtually the same in 1995 and 1997. Across all plans, the growth in premiums have averaged under 4 percent per year, similar to growth among private sector managed care plans.

Though recently the FEHBP has reduced the growth in health insurance premiums, the methods used to determine both the government's contribution and the fact that the fee-for-service plans must charge a single, national premium have resulted in some anomalies. The national rate charged by the fee-for-service plans creates substantial pricing pressure for the locally rated managed care plans in high health care cost areas while allowing managed care plans in low health care cost areas more pricing flexibility. In high health care cost areas, the national (standard option) fee-for-service plans are generally the lowest priced plan in the market. This places substantial competitive pressure on locally rated managed care plans to lower their premiums, either by reducing the administrative costs, in some cases providing less generous benefits, or simply increasing the efficiency in which they provide services. In contrast, managed care plans in relatively low health care cost markets are able to shadow price the national fee-for-service plan.<sup>1</sup> As a result, the variation in managed care premiums across the country are compressed relative to the variation in premiums observed among managed care plans in the

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<sup>1</sup>In low cost areas, managed care plans have an incentive to increase benefits since consumers pay only 25 percent of each additional dollar in premium costs. In contrast, in high cost areas where premiums are often above the maximum dollar federal contribution, the incentive to add benefits is muted as consumers must pay the full dollar for each dollar of additional benefits added.

private sector as well as the variation in the Medicare AAPCC (see Table 1).<sup>2</sup>

**Table 1. Variation in State Average FEHBP and Private Sector Health Insurance Premiums**

	Low	Average	High
FEHBP	.86	1	1.13
Private Health Plans	.72	1	1.25

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SOURCE: Office of Personnel Management, and survey results from the Health Insurance Association of America, KPMG Peat Marwick and InterStudy.

The results in Table 1 highlight the relative lack of variation in managed care premiums in the FEHBP program relative to premiums quoted in the commercial market. Whether alternative plan rating decisions (for instance, allowing the fee-for-service plans to locally rate) would reduce the growth in FEHBP spending remains an empirical issue.<sup>3</sup>

### Plan Choice

FEHBP eligibles often face several different health plans to select from, including fee-for-service plans, HMOs and point-of-service plans. Several choices are common in less densely populated and more rural areas; for instance FEHBP eligibles living in the Hudson Valley (north of New York City up through Albany) could have 10 to 20 different plans to choose from. The FEHBP experience here contrasts sharply with the experience of the number of plans offered by private employers. As of 1996, 50 percent of private sector employees were offered only 1 health plan.

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<sup>2</sup>Medicare AAPCC payments exhibit substantially greater variation relative to the FEHBP for two reasons; first the FEHBP fee-for-service plans charge a single national rate, whereas the fee-for-service Medicare program pays locally. Second, Medicare uses the county as the unit of payment while the FEHBP relies on a larger unit of plan payment, the plan service area. Use of the larger market area in the FEHBP reduces the variance in premiums. By the same token, there would be less variation in Medicare payments to HMOs if a larger market area were used to determine plan payments.

<sup>3</sup>The impact of the FEHBP contribution formula is one of several institutional features of the program currently part of an on-going two year study at Tulane funded by the Robert Wood Johnson Foundation.

### Plan Satisfaction and Quality

Few direct measures of the quality of care are available within the FEHBP. The OPM does, however, survey members concerning their satisfaction with over 300 health plans. These reports are available widely to FEHBP eligibles during the open enrollment season. Member satisfaction with plans seems relatively high (see Table 2). Only 15 percent of members noted they were dissatisfied with their health plan.

**Table 2. Percent of FEHBP Respondents Satisfied with Fee-for-service and prepaid health plans, 1995**

	<u>Fee for Service</u>	<u>Prepaid</u>
Extremely Satisfied	20%	19%
Very Satisfied	43%	45%
Somewhat Satisfied	22%	22%
Dissatisfied or Neither Satisfied or dissatisfied	15%	14%

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SOURCE: Checkbook Guide

While the brief discussion above suggests an FEHBP type model has, relative to other private sector approaches, performed competitively, adopting this approach within the Medicare program would require several substantial changes in Medicare policy. Indeed, several critical differences exist between the FEHBP and current Medicare policies, including;

- ▶ The FEHBP conducts an annual open enrollment, whereas most HMOs in the Medicare program have continuous open enrollment, allowing beneficiaries to join at anytime. Beneficiaries can also disenroll each month.
- ▶ The methods used by Medicare and the FEHBP to pay plans differ significantly. Medicare payments are set in advance based on the Average Adjusted Per Capita Cost (AAPCC). The AAPCC is based on the experience of the fee-for-service sector. In contrast, the FEHBP pays each plan a fixed dollar amount up to 75 percent of the plan premium. The fixed dollar amount is set at 60 percent of the average premium charged by the "Big Six" plans.
- ▶ Plan rating differs substantially between the FEHBP and Medicare risk HMOs. Under the

FEHBP, fee-for-service plans (for example Blue Cross standard option) charge a single national premium. The FEHBP pays \$134.83 per month for each person enrolling in the Blue Cross standard option plan, with the FEHBP enrollee paying \$44.94 per month for single coverage in New York City, New Orleans or even Indiana, Pennsylvania. In contrast, managed care plans are rated locally. As Medicare payments to hospitals, physicians and other providers in the traditional program vary across and within states, the AAPCC also varies dramatically. As a result, there is substantially greater variation in payments to managed care plans under the Medicare program than exists in the FEHBP.

- ▶ The FEHBP does not make risk adjusted payments to health plans, while Medicare attempts to account for risk using the AAPCC.

With these differences in mind, I turn next to issues concerning a transition from the current Medicare program to one using the FEHBP as a model.

### **Transitional Steps**

As my discussion above illustrates, several important changes are required to move Medicare from its current program structure to an FEHBP like model.

- ▶ *Expand the number and variety of health plans available to Medicare beneficiaries.*

Under current law, HMOs are generally the only choice Medicare beneficiaries seeking alternatives to “traditional” Medicare currently have. In contrast, managed care arrangements in the private sector and the FEHBP include a broader array of plans, including several “hybrid” plans such as point-of-service and preferred provider plans. The majority of private sector employees and their families enrolled in managed care plans are enrolled in these hybrids (41 percent versus 33 percent in HMOs). Efforts should continue to expand the range of plans offered, and their diffusion across currently underserved areas.

- ▶ *Redefine Managed Care Market Areas*

Managed care plans in the private sector negotiate rates with purchasers over an entire plan service area, which often includes entire metropolitan statistical areas or even further. This is also the case with the locally rated managed care plans--the FEHBP negotiates premiums with such plans within a service area. Medicare uses the county as the payment catchment area. This allows health plans to selectively pick their areas of activity; perhaps choosing to offer services in high AAPCC counties and not in lower AAPCC counties within the same general geographic area.

▶ *Risk Adjustment Demonstrations*

The FEHBP does not risk adjust payments to health plans. This has generated substantial self-selection. Selection is exacerbated by the existence of both high and low option plans operating the same market. As the number and variety of plans expand, the next generation of the AAPCC will be needed. Several promising approaches that improve on the current method are in progress, including Ambulatory Care Groups and Hierarchical Co-existing Conditions (HCC). Blended approaches mixing fee-for-service and capitation may also prove promising.

**Key Design Features of an FEHBP Model As Applied to Medicare**

As the discussion above highlights, the adoption of an FEHBP-like model within the Medicare program would require fundamental changes in the program. These changes, and the policy options surrounding them, are outlined briefly below.

- ▶ *Annual Open Enrollment.* The FEHBP provides an opportunity for members to select their health plan each year. Medicare beneficiaries currently enjoy nearly continuous enrollment and disenrollment opportunities. Moving toward an annual enrollment process would represent a major change in policy, and would require fundamental changes in the manner in which beneficiaries interact with the Medicare program.
- ▶ *Submission of Bids By Health Plans.* Health plans develop their “bids” for the Medicare program by estimating their costs of providing Medicare benefits (the adjusted community rate) and comparing it to Medicare’s AAPCC based average payment rate (APR). This is a formula-based approach to determining plan premiums. In contrast, the FEHBP accepts bids from the Big Six plans, and then negotiates rates locally with managed care plans. Movement to an FEHBP style program would change the process of generating plan premiums from a formula based approach to a competitively bid/negotiated one.
- ▶ *Establishing Medicare Payments to Health Plans.* Perhaps the most controversial, and certainly among the most important issues a structural change in Medicare faces is how the program would determine payment rates to health plans. Within a competitive bidding process, the Medicare program would face several policy design options. A common element across each of these options is de-linking Medicare’s payments to health plans from the experience in the fee-for-service sector. In establishing its contribution, Medicare could:
  - Solicit bids from health plans in each area, and base its contribution on the lowest bid in each market. Alternatively, Medicare could base its contribution on the second lowest bid, or some percentile of the bids (e.g. the 50th percentile);
  - Solicit bids from health plans in each area, and bargain multilaterally with each plan over

the premium charged and scope of benefits offered. The bidding process would stop when either the Health Care Financing Administration (HCFA) or the health plan agreed on a counterproposal;

- Solicit bids from health plans, but link their contribution to an external index such as the consumer price index, the projected growth in per capita private health insurance, or changes in gross domestic product;
- Use an approach similar to the current FEHBP model. Here, HCFA could demand that health plans quote (with appropriate adjustments) a rate similar to that offered through the commercial market. This would ensure that the growth in managed care premiums within the Medicare program and the private sector increased at similar rates (this would be similar to the current "most favored customer" approach used by the FEHBP);
- ▶ *The Role of Medicare's Traditional Fee-for-service program.* Another critical design issue facing any reform of the Medicare program is the structure of Medicare's fee-for-service program. Structural changes in the program along the lines of an FEHBP program present at least two choices:
  - Retain the current fee-for-service program as administered by HCFA or;
  - Contract with health plans to provide the fee-for-service benefits;

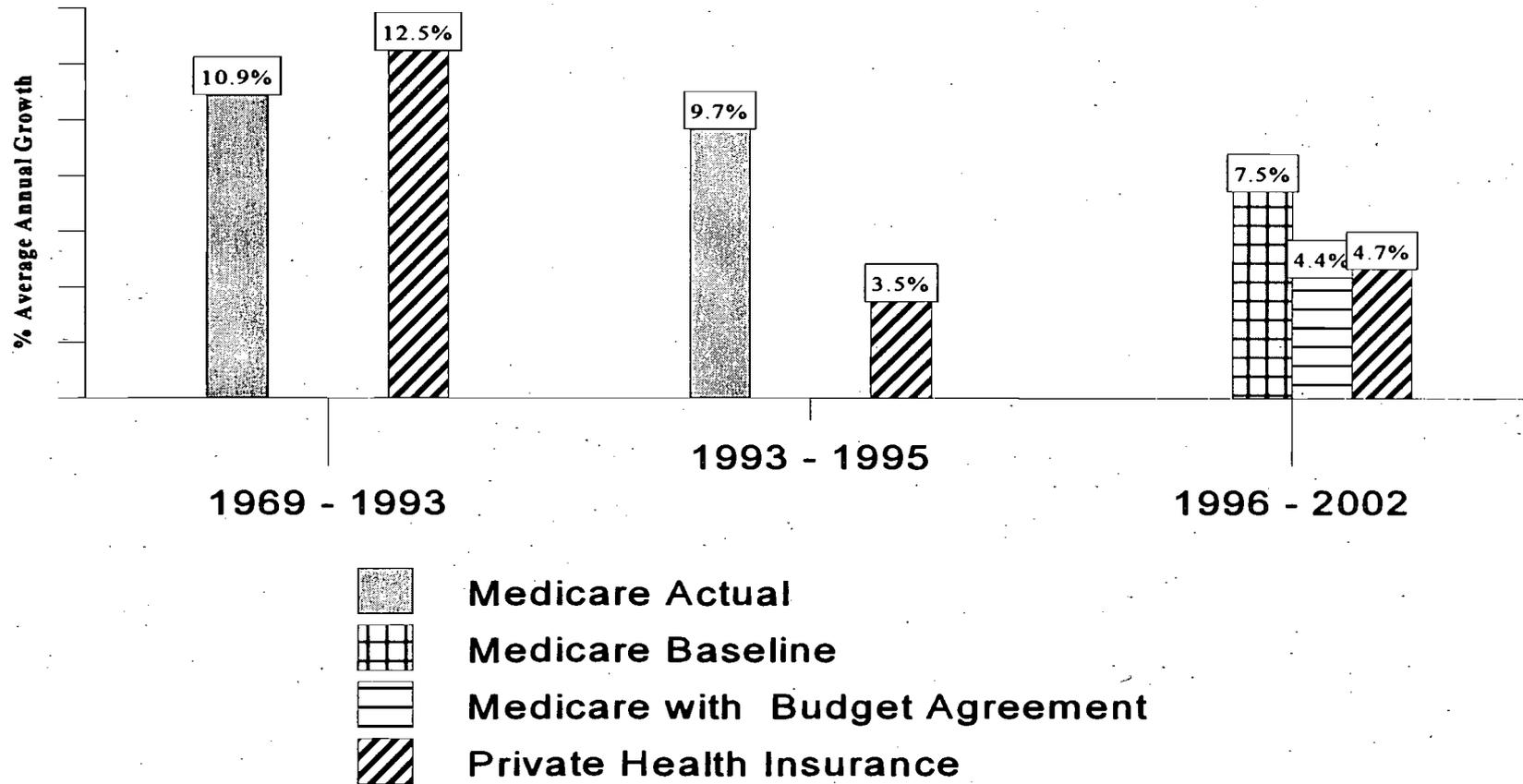
The second option is how fee-for-service benefits are provided within the FEHBP. These are the most popular plans in the program (approximately 30 percent of enrollees select one of the managed care options). A key issue if Medicare adopted this approach for providing fee-for-service benefits is whether the plans would face substantial adverse selection, undermining their ability to compete effectively with the managed care plans. If this approach were selected, it should be accompanied by an improvement in Medicare's current approach for risk adjustment (thus it seems key to include some form of risk adjustment demonstrations as part of any transitional step toward competitive bidding).

- ▶ *Beneficiary Protections.* Under current law, Medicare beneficiaries are provided information on plan benefits, premiums, cost-sharing, lock-in requirements, protection against balanced billing as well as grievance mechanisms. Improvements in these protections, many of which are in the planning and early stages of implementation in the Department of Health and Human Service (HHS), will be required. These include methods for distributing information to Medicare beneficiaries, as well as guidelines providing clear, consistent and accurate information concerning plan marketing during the open enrollment season.

## **Conclusions**

As I mentioned at the beginning of my testimony, the recent budget agreement between the Congress and the President would re-align the expected growth in per enrollee Medicare and private health insurance expenditures. If desired, this should provide an opportunity for the Congress and the Administration to study, design and implement changes in the structure of the Medicare program for the next century. These structural changes will alter substantially how Medicare pays health plans, the role of HCFA, how health plans interact with Medicare and how beneficiaries interact with the program. In light of magnitude of these changes, a substantial transition period will be required to design relevant changes in the program, evaluate their performance within the Medicare program, and make appropriate changes. While creating an approach that will re-align the growth in Medicare with the private sector is a desirable policy objective, great care should be paid to assure that beneficiaries do not face higher disproportionately high out-of-pocket costs and that the quality of care they receive continually improves.

**Figure 1: Historic and Projected Growth In Per Capita Private Insurance and Medicare Spending**



Source: HCFA and CBO Projections



## FEHBP AS A MODEL FOR MEDICARE REFORM

TESTIMONY OF DICK ANDERSON  
VICE PRESIDENT, HEALTH POLICY  
KAISER PERMANENTE MEDICAL CARE PROGRAM

BEFORE THE SENATE FINANCE COMMITTEE  
MAY 21, 1997

Mr. Chairman and members of the Committee, I thank you for the opportunity to present my views on "FEHBP As a Model for Medicare Reform". I am here today representing the Kaiser Permanente Medical Care Program, a non-profit integrated medical care program that provides predominantly prepaid comprehensive health benefits and serves 7.9 million members in 18 states and the District of Columbia. It is the largest private health care delivery program in the United States with 90,000 employees and 9,400 full-time equivalent contracting physicians.

Kaiser Permanente has participated effectively in the Federal Employees Health Benefits Program (FEHBP) from its inception. Today, we serve 633,000 Federal members, including both employees and dependents. Of that total, 480,000 are active Federal members and 153,000 are annuitants. Most of the annuitants are entitled to Medicare benefits. The FEHBP has been very important to Kaiser Permanente, not only because of the responsibility we have undertaken to provide integrated health care to this many members but also because it has been an effective model that many others have emulated for providing multiple choice of competing health plans. We have partnered with FEHBP to develop new benefits and services that have positively affected many others. The predictable and steady growth in our federal enrollment has contributed materially to our stability and success as an organization. There are features of FEHBP that should be seriously considered for inclusion in Medicare reform proposals. I will examine these with you and discuss related issues.

Before I do that, I will first lay a framework by articulating some general principles which, I believe, should guide the design of an effective Medicare competition model and explore what Medicare could look like in the future under this design. Then I will describe how FEHBP currently fits within this framework—where it matches and where it doesn't. Finally, I will elaborate on issues and implications of the FEHBP model for Medicare.

## Some Principles to Guide Effective Competition Between Health Plans

### Competition should encourage efficiency in the marketplace.

- Prices in a competitive market should reflect efficient costs of providing care.
- Competition should be structured to provide incentives for plans to establish prices that reflect efficient costs.

### Competition should be based on “value”—a combination of “price” and quality

- Beneficiaries should be rewarded if they join efficient, high quality plans.
- There should be disincentives for them to join inefficient, low quality plans.
- Rewards should be in the form of lower cost sharing, richer benefits, superior quality of care, and/or better access to care.

### Competition should not be based on risk selection, “gaming”, “buying the business”, or other factors which cause markets to fail.

- The prices faced by beneficiaries should reflect differences in plan efficiencies, not risk selection.
- Rules should be designed to minimize “gaming” and manipulation, including disincentives against bidding excessively high to “pad” the Medicare contribution and requirements that premiums be actuarially sound.

### Competition should be structured to allow flexibility in responding to needs of enrollees and group purchasers.

- Plans should have some latitude in designing benefits and structuring premiums to meet varying requirements.

### Competition should be structured to achieve and maintain marketplace stability.

- Short-term savings should not be achieved at the expense of long-term savings.
- Disruptive changes and volatility should be minimized for beneficiaries, providers, and plans.
- There should not be barriers to entry or to continued participation by efficient, high quality plans.

Given this as a general framework, the following is a picture of what a reformed Medicare could look like in the future if it were to evolve into a program with more effective competition between health plans based on price and quality.

### Choice of Health Plans

- Beneficiaries would participate in Medicare by enrolling in a health plan.
- Health plan choices in an area would include comprehensive plans and at least one fee-for-service plan option.

- All Medicare options would be “full replacement” plans with premiums, that is, all would be required to offer at least a minimum, standard level of coverage that would be specified in law. Traditional Medicare fee-for-service would be converted into one or more plans with premiums.
- Beneficiaries would periodically be given the opportunity to choose among available health plan options and would have timely opportunities to change plans if they were dissatisfied with their choices.

#### Basis for competition

- Beneficiaries would make choices based on quality, service, price, and other dimensions of value. They would pay more if they joined inefficient plans and vice versa. Price competition would take different forms, including reduced premiums, reduced cost sharing at the point of service, or increased benefits.
- Competition based on “risk selection”, “gaming”, or misinformation would be effectively precluded by structuring appropriate payment incentives, providing informed choice for beneficiaries, imposing marketing restrictions that would limit abuses, standardizing benefit options, and limiting opportunities for plans to disenroll higher risks.

#### Informed Choice and Accountability

- Beneficiaries would make informed choices, based on uniform, accessible, comprehensible, and fairly presented information. Information would include valid comparisons of the performance of each health plan option (including measures of quality, health outcomes, access, and satisfaction). Such information would be in a form that is relevant to beneficiaries. Performance data on health plans and providers would be risk adjusted to ensure fair comparisons.
- There would be appropriate beneficiary and provider protections, embodied in standards that would be comparable for all health plans. All plans that met Medicare standards would be allowed to participate in Medicare.

#### Payment

- The basic payment made by Medicare (the Medicare contribution) in a given area would be the same for all beneficiaries. This payment would be based on premiums charged by plans in a local area and would be determined in a manner that is consistent with Medicare budget objectives.
- Medicare payments to individual plans would only vary based on adjustments for differences in the risk of their members. There would be “state of the art” applications of risk assessment and risk adjustment to remove the effects of risk selection from “prices” faced by beneficiaries.

- There would be appropriate incentives for plans to charge premiums that reflect costs of providing efficient, high quality services to Medicare beneficiaries. There would be disincentives for plans to engage in strategies (e.g., “low balling” premiums, targeting favorable risks, or misinforming beneficiaries) that would undermine fair competition.
- There would be appropriate mechanisms to protect plans against catastrophic, unpredictable losses.
- Payments would be structured to preserve stability in benefits and cost sharing for beneficiaries.
- There would be appropriate incentives for plans to enroll “vulnerable” (e.g., chronically ill and disabled) beneficiaries and provide appropriate service to them.

### FEHBP Features

Many, but not all, of the features described above are embodied in the FEHBP model. Federal employees and annuitants have significant choices which include competing comprehensive plans and government-wide fee-for-service plans. All plans that meet FEHBP standards are allowed to participate in the program. Enrollees are annually given the opportunity to change plans during an open enrollment period which is designed to inform choice through the provision of standardized information about plans.

FEHBP makes fixed contributions toward the costs of plans’ premiums.<sup>1</sup> All FEHBP enrollees must share in meeting these premium costs. They must pay the difference between a fixed government contribution amount and their plan’s premium. The higher a plan’s premium, the more that enrollees must pay. Premiums vary based on differences between plans in efficiencies, generosity of benefits, and to some unknown extent risk selection. These factors are the primary basis for competition.

This model has been effective. FEHBP has been popular with Federal employees. They have experienced stability in coverage and costs over long periods of time. While there have been some prominent casualties due in part to risk selection problems (for example, the elimination of the nation-wide Aetna high option plan), choices of comprehensive plans have generally broadened and the other nation-

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<sup>1</sup> For most of the plans, the government contribution is set at 60% of the unweighted average of premiums for the “Big 6”: the nation-wide Blue Cross/Blue Shield high option plan, the two largest employee organization plans, the two largest HMOs (Kaiser Permanente Northern and Southern California), and a “composite” of these five plans that serves as a place holder for the former nation-wide Aetna plan. For any plan, the government-wide contribution is limited to a maximum of 75% of the plan’s premium.

wide options appear to be healthy. It is noteworthy that annual rates of increases in premiums and the government contribution have been low and relatively stable from year to year. During the five year period ending in 1997, annual average compounded rates of premium increases were as follows:

	<u>Employee Only</u>	<u>Employee + Family</u>
BC/BS high option plan	-1.44%	-1.04%
GEHA	1.07%	1.07%
Mail Handlers	4.37%	4.34%
Kaiser-Northern California	-0.28%	0.23%
Kaiser-Southern California	0.07%	-1.14%
"Big 6" average	0.41%	0.35%
Gov't-wide. contribution (60%)	0.41%	0.35%

These data reflect remarkable success in containing increases in FEHBP costs during the past five years. Medicare has not enjoyed similar success.

#### Some Features not Included in FEHBP

Some of the features of the competitive model described above for Medicare reform are not included in the FEHBP design.

- There is no standardized benefit design, even for basic FEHBP coverage options. FEHBP permits significant variation in benefits, including the offering of both high and low option coverages by some plans.
- The FEHBP government-wide contribution is not directly based on local premiums of plans. The amount of the contribution varies with local premiums only to the extent that the 75% limit in the contribution is applicable.
- There is no FEHBP mechanism for risk adjusting payments to compensate for differences between plans in the health risk of enrollees. There are not strong deterrents against plans competing on the basis of risk selection.
- There is no FEHBP mechanism to protect plans against catastrophic, unpredictable losses. (However, plans may reinsure through their own devices.)
- The FEHBP coordinated annual open enrollment period limits opportunities for enrollees who are highly dissatisfied with their plans to disenroll in a timely manner.
- FEHBP has not aggressively encouraged competition based on quality. While FEHBP has periodically measured attitudes of enrollees, it has been somewhat slow to adopt more definitive measures of quality and access and to communicate findings. There is little information currently available to

enrollees that enables them to fairly compare performance of plans in these areas.

### Key Issues in Applying the FEHBP Model to Medicare

Let us return to the subject at hand. What issues need to be addressed when considering the applicability of the FEHBP model to Medicare?

#### How much benefit standardization should there be?

As indicated above, there may be significant variations in benefits offered by FEHBP plans. Some competition advocates believe that all plans should only offer a standard benefit package to enrollees. In their view, this is necessary to reduce confusion about cost differences between plans and limit opportunities for plans to achieve favorable risk selection. Importantly, a standard benefit package would offer a common denominator upon which plans would establish premiums. Others argue that there would be greater value for beneficiaries if plans were given significant flexibility to compete on the basis of benefits as well as price. They suggest, moreover, that some types of benefits are more appropriate for some options than for others (e.g., coverage of preventive health care services for HMOs but not for fee-for-service options). In my view, some flexibility should be permitted. It would be preferable if all plans were required to cover at least a standard package that included all services currently covered by Medicare (with no or low levels of cost sharing) and preventive care. However, plans should be free to offer a few additional benefit options such as coverage for prescription drugs and/or eyeglasses.

#### What about the FEHBP method for determining payments?

The FEHBP method results in a fixed contribution that is quite stable and predictable from year to year. Basing the payment on the "Big 6" formula ensures that the contribution is essentially unaffected by fluctuations in prices that may occur for rapidly growing plans, for plans that are inherently unstable, or for plans that deliberately engage in strategies to undermine fair competition. Moreover, the FEHBP model discourages plans from bidding excessively high (the fixed government-wide contribution is a ceiling and excess plan premium amounts must be borne fully by federal enrollees) or bidding excessively low (payment to any plan is limited to 75% of the government-wide contribution amount).

Basing the Medicare contribution only on the premiums for selected large plans would provide stability. However, this could create other problems. It would

probably focus an inordinate amount of Medicare's attention on the appropriateness of premiums for the few selected plans. (This raises a question about equity in oversight.) And, this approach would tend to preserve the status quo if the selected plans were large, stable, and dictated market conditions. I believe it would be preferable to base the Medicare contribution on an average of the plans' premiums (weighted by the number of enrollees in each plan).

It is critically important to design the Medicare contribution method so that it discourages inappropriate bidding, including "low-balling" or other gaming that could significantly disrupt the market. This could lead to significant problems for beneficiaries, including abrupt changes in benefits and out-of-pocket costs. A more effective means than the 75% rule to discourage excessively high or low bidding could be to impose "penalties" (for example, to reduce payments by some fixed percentage for increments of premiums which fall either above or below a range that falls around the average weighted premium amount).

To help preserve stability of payments and benefits, Medicare also could adopt an approach similar to the way FEHBP plans use their "contingency reserve funds". The Medicare "Benefit Stabilization Fund" for risk contracting plans is seldom used for this purpose because of the severe restrictions placed on its use.

As noted earlier, the FEHBP government-wide contribution is not directly based on local premiums of plans. There is no variation in the contribution to reflect geographic differences in costs. This may result in excessive payments in some areas and inadequate payments in others. An alternative to the FEHBP formula would be to establish the Medicare contribution for a local area based on premiums quoted by plans for statutory Medicare benefits or for a standard Medicare coverage that is offered by all plans.

#### How much should be passed on to beneficiaries?

The FEHBP model requires enrollees to pay the full amount of the difference between the federal contribution and a plan's premium. This provides a strong incentive for plans to offer low premiums in order to increase enrollment. However, this approach precludes plans from waiving premiums to attract enrollment, as is now permitted under Medicare risk contracting. A combination of these two approaches may be appropriate. (For example, there could be some reduction in Medicare payment that is proportional to the amount of premium waived.) If so, care should be taken to ensure that incentives to create cross subsidies between Medicare and non-Medicare enrollees in a plan would be minimized.

### What about risk adjustment of payments?

As described above, the FEHBP model makes no provision for risk adjustment of either the government-wide contribution or beneficiaries' shares of premiums. There is growing support for implementing proper risk adjustment of Medicare payments, based on state-of-the-art methods. Methods that incorporate diagnostic information (e.g., the "HCC" methodology) and take into account variations in functional health status (e.g., based on self-report) show great promise. Adjustments to account for differences in risk between newer members and older members in a plan (e.g., to account for "regression to the mean") also may be appropriate.

An important objective is to remove the differing effects of risk selection from the prices faced by Medicare beneficiaries. One way to achieve this is to have all plans submit prices for a fixed level of benefits, assuming that they will enroll a standard Medicare population. Resulting premiums for beneficiaries (reflecting differences between the premiums submitted by plans and the Medicare contribution) would, by definition, be adjusted for differences in risk. Under this approach, the actual payment from Medicare to plans would have to be adjusted to reflect differences in risk between the standard population and beneficiaries who ultimately enroll in a plan.

### What about highly unpredictable costs?

Risk adjustment of payments will not completely compensate for risk selection problems, especially those associated with extremely unpredictable, catastrophic costs. The FEHBP does not address such problems. To ameliorate them, some form of "outlier" payment should be considered, in addition to the risk adjustment system. Models include reinsurance for costs which fall above certain thresholds (aggregate or per case), the approach used in New York state to pay plans fixed amounts per occurrence of selected conditions, or a similar approach adopted for the California Health Insurance Purchasing Cooperative.

### What about an annual coordinated open enrollment?

Some believe that the FEHBP approach to annual coordinated open enrollment period with annual "lock-in" should be adopted by Medicare. They argue this would provide for more informed choice for beneficiaries and would reduce opportunities for plans to "dump" higher risk beneficiaries or to "cherry pick" lower risks.

I believe the current Medicare continuous enrollment and disenrollment provisions for risk contracting plans should be retained. Maintaining existing rules would:

- provide important protection to beneficiaries, by ensuring that there would be a timely “escape valve” in the event that a plan would prove to be unsuitable.
- allow plans to be more responsive to the needs of many group purchasers who help to organize and finance Medicare coverage for their retirees,
- allow plans to ensure that the timing of enrollment would be consistent with the orderly development of the capacity to serve new members, and
- provide maximum opportunities for beneficiaries to enroll in efficient, high quality Medicare plan options,

An annual coordinated informational and enrollment period could be adopted to supplement the continuous enrollment and disenrollment provisions. This would help to inform choice and reduce confusion. Opportunities for new beneficiaries to disenroll at anytime during a fixed period following their initial enrollment in a plan could be a compromise between annual “lock-in” and current risk contracting rules.

#### What about competition based on quality and access?

We applaud the leadership role that Medicare is taking to better understand dimensions of quality and access, to develop related measures of performance, and to effectively and fairly communicate findings to beneficiaries. As mentioned, FEHBP has been less active in this area. We support continued evolution of comparable measures (such as the HEDIS indicators), improved processes for assuring quality, and efforts to personalize findings so they have meaning to beneficiaries. We hope the Medicare will continue to partner with others to achieve greater standardization and efficiency in measurement.

A difficult issue is how to operationalize rewards and incentives for beneficiaries who choose efficient, high quality plans, especially those who are vulnerable and have the greatest needs for health care. We urge that the federal government support research in this area, including approaches to adjusting payments for plans that improve health or reduce the rate of decline for those who are chronically ill.

Mr. Chairman and members, this concludes my remarks. Thank you for the opportunity to appear before you. I welcome your questions.

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**FEHBP AS A MODEL FOR MEDICARE REFORM**

**STATEMENT**

**BEFORE THE**

**UNITED STATES SENATE  
COMMITTEE ON FINANCE**

**MAY 21, 1997**

**PREPARED STATEMENT OF  
EDWIN C. HUSTEAD  
SENIOR VICE PRESIDENT  
HAY GROUP**

Thank you for the opportunity to address the Senate Finance Committee on the issue of FEHBP as a model for Medicare reform. I am a Senior Vice President with the Hay/Huggins division of the Hay Group. We are an international benefits and compensation consulting firm. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

As a former Chief Actuary of the Office of Personnel Management, I conducted the premium negotiations for the Federal Employees Health Benefits Program (FEHBP). At the Hay Group, I have worked on a number of analyses of FEHBP, health care reform, and Medicare for the Congressional Research Service (CRS). We assisted CRS in producing their 1989 study on Possible Strategies for Reform in FEHBP. The Hay Group maintains extensive survey data on private-sector health plans in the annual Hay/Huggins Benefits Report (HHBR).

### **The Federal Employees Health Benefits Program**

The Federal Employees Health Benefits Program offers 374 health plan options to Federal employees and annuitants. These include seven plans that are available to all employees and some plans, like BACE, that are only offered to specific groups. Most plans are *Health Maintenance Organizations* (HMOs) that are available to enrollees in the service area of the plan. Depending on the number of HMOs in an area an enrollee can choose from 10 to over 20 plans.

The Office of Personnel Management (OPM) annually conducts intensive negotiations with the FEHBP health plans beginning early in the year, and culminating in the open season in November and December. Key phases in the year are benefit design, premium setting, and communication.

OPM begins the negotiation process with a call letter to the health plans. This call letter specifies the design changes that OPM will consider as part of the annual plan redesign. Similar to the PAYGO restraints in the Budget Enforcement Act, OPM requires that any revised benefit package should not be more expensive than the current package. That means that any substantial benefit increase has to be offset by a benefit reduction.

After the benefits are set, OPM and the plans negotiate the premiums. This negotiation is a careful detailed process that examines all aspects of the plan's operations. The non-HMO plans are, in effect, totally "experience rated". That means that, over time, the premiums paid for each plan equal the benefits paid for the Federal enrollees in that plan plus related administrative costs and profit.

The premium-sharing formula set in the FEHBP law is applied to determine the share of each premium to be paid by the government and the enrollee. The government pays 60 percent of the average premium for six of the largest plans, but no more than 75 percent of the cost of any individual plan. As a result of collective bargaining, the Postal Service pays a greater share of the cost for its employees.

The six plans used in the determination of the government share include the Aetna plan, which is no longer an option. A temporary provision in the law uses a "phantom" premium, based on an estimate of the rate Aetna would be charging if they were in the program. That provision is due to expire. If there is no legislative change, the government contribution will be based on the remaining five plans. Since the phantom Aetna rate is greater than that of the other five plans, default to the permanent provision will lower the government contribution and raise many of the enrollee contributions.

The benefits and premium information is announced in September and distributed to employees and annuitants before the open season. The enrollees can change, add, or drop coverage to be effective in January of the following year.

OPM asks *The Gallup Organization* to conduct an annual survey of plan satisfaction. These results are published with the open season information and provide the enrollees with a qualitative guide to the benefits and services being offered by each plan. Ratings for the nationwide plans range from 74 to 92 percent satisfaction.

Before proceeding to FEHBP as a model for Medicare reform, I would like to discuss three aspects of FEHBP in more detail. These are the process and effect of competition in the program, use of health-care cost management, and a brief comparison of FEHBP and the private sector.

#### *Process and Effect of Competition in FEHBP*

How does FEHBP differ from the theoretical competition approach that was developed by health economists, including Dr. Alain Enthoven, and adopted as a major feature of President Clinton's health care reform proposal?

The theoretical approach would have enrollees choose among identical benefit designs. The employer would pay the same premium for each plan, so the enrollee would pay the cost of any difference between the premiums for any two plans.

There are two very important differences between the theoretical competition approach and the reality of FEHBP. First, while OPM has made standardized terminology and presentation and narrowed the range in the total value of the different plans, there remain complex differences in the scope and level of reimbursement of health care expenses. It is very difficult for an enrollee to quantify the overall difference in benefits between two plans and compare that difference to the premium difference.

Second, many enrollees only pay 25 percent of the difference in cost between plans as a result of the 75 percent limit on government contribution to any plan. The theoretical competition approach would require the enrollee to pay the full difference in cost.

For these and other reasons, such as adverse selection, FEHBP only presents an approximation to the theoretical model. There has been extensive discussion over the years as to whether FEHBP competition results in higher or lower costs than the typical private-sector approach of limited choice. The May 1989 CRS study demonstrated that choice in FEHBP has little impact on cost and, over time, mirrors the cost impact of the limited choice private-sector model.

### *Health Care Management in FEHBP*

As shown in Table 1, annual premium increases have dropped from double digits in the late 1980s, to below the rate of inflation in the last four years. The most important factor in this sharp reduction in trend, in both FEHBP and the private sector, has been the substantial growth of and changes in health care management techniques. Ten years ago, the two models of health care were the Fee-for-Service (FFS) plans, which largely reimbursed any treatment requested by physicians and hospitals; and the HMOs, which monitor the patient treatment from the point that service is first needed.

During the last decade, two other models have become popular. The *Preferred Provider Organization* (PPO) design requires the patient to choose between in-network and higher cost out-of-network providers for each service. The *Point-of-Service* (POS) design also requires the patient to clear any use of in-network services with a gatekeeper. The POS choice is similar to the choice between FFS and HMO plans, but at the point-of-service rather than during the open season. Even the FFS plans have adopted extensive management controls. As a result, there are very few health plans that now permit the complete freedom of choice granted by traditional FFS plans.

OPM and the health plan options have gradually added the PPO and POS features to many of the plans. For example, an enrollee in the Blue Cross/Blue Shield Standard option can choose a \$10 visit to an in-network physician, or opt for an out-of-network physician and pay 25 percent of a scheduled charge plus all charges above the usual and customary fee. The POS approach is being tested in five areas in the Blue Cross/Blue Shield plan, and will undoubtedly be proposed by other plans in the program.

Much of the health care debate in the last few years has been about whether the adoption of these much stronger management approaches has sacrificed the quality of care. Introduction of greater efficiency in the delivery of health care should not sacrifice the quality of needed health care.

## Comparison of FEHBP and the Private Sector

### Premium Trends

Table 1 compares the average premium changes from 1970 through 1997 of FEHBP and the private sector. The first line is the trend for private-sector plans drawn from the Hay/Huggins Benefits Report, and measured by dividing the average premium for all employers for the current year by the average premium for the prior year. The FEHBP increases are the weighted average for all plans, as reported by OPM, before considering changes in enrollment in the open season. The National Health Expenditures, as reported by the Health Care Financing Administration, Office of the Actuary, consist of spending for health care services and products throughout the United States.

<b>Table 1 - Health Care Trends</b>									
<b>Increase in Health Expenses from Prior Year to Indicated Year</b>									
<b>Selected Calendar Years From 1970 to 1996</b>									
	1970	1980	1981	1982	1983	1984	1985	1986	1987
Private Sector*						17.1%	3.7%	2.6%	8.5%
FEHBP			15.4%	17.3%	17.6%	9.9%	(1.1)%	(11.4)%	17.5%
National Health Expenditures	7.8%	8.6%					8.5%		
	1988	1989	1990	1991	1992	1993	1994	1995	1996
Private Sector*	16.7%	20.8%	16.8%	12.9%	11.5%	8.3%	2.7%	1.2%	(2.5)%
FEHBP	25.8%	20.7%	10.8%	4.7%	7.5%	9%	3%	(3)%	0%
National Health Expenditures			9.9%	11.6%	12.9%	10.6%			

\* From the Hay/Huggins Benefits Report. If an employer offers more than one plan, then the most prevalent plan is used for the trend.

Two important patterns shown in the table are the double-digit increases in the late 1980s and the very low increases in 1994 through 1996. The FEHBP increase for 1997 was 2.4 percent. The low increases in both FEHBP and the private sector are primarily attributable to the move to tighter management controls.

While FEHBP and private-sector premium increases can be significantly different in any given year, the overall patterns of increases are similar. Year-to-year differences between FEHBP and the private sector are attributable to factors such as differences in the adoption of changes and unexpected reserve increases or decreases.

### *Benefits Design*

The broad design of private-sector plans is similar to that of the FEHBP options. Enrollees in traditional FFS plans typically pay 20 percent of the covered health care costs after a deductible of \$200 to \$300. Total annual out-of-pocket expenditures by the patient are normally limited to \$1,000 to \$2,000. Enrollees in PPO and POS plans, who choose in-network providers, often pay less of the total cost. Many private-sector plans charge those who use out-of-network providers a higher percentage of the cost. The HMO plans offer similar or identical provisions to FEHBP and private-sector enrollees.

The major design difference between the typical private-sector and FEHBP plans is the dental plan. The typical private-sector dental plan reimburses 50 to 80 percent of most expenses, and fully pays for preventive care. The typical FEHBP plan only pays a small fixed fee for each procedure. For example, the Blue Cross/Blue Shield Standard option only pays \$8 of the fee for an oral evaluation for adults. This difference is a result of the OPM requirement that design changes that increase cost must be accompanied by a change with an offsetting cost decrease. The policy was in place before dental benefits became common in employer-sponsored health plans. As a result, the FEHBP plans were not able to add substantive dental plans in line with the private sector.

Hay conducts annual evaluations of the relative value of Federal and private-sector compensation. We find that the value of the FEHBP plans is about ten percent lower than the average value of private-sector health plans. The lower value of the FEHBP plan is primarily a result of the difference in the dental provisions.

### *Health Care Management*

The most important trend in private-sector health plans has been the move from FFS to the managed-care approaches in the last decade. In the last four years alone, HHBR reports that managed care has increased from 38 to 76 percent of all plans.

The usual approach in the private sector is to replace the FFS plan with the PPO or POS plan. FEHBP has maintained the choice of plans and that would probably be a necessity in any redesign of Medicare.

## **Important Differences Between FEHBP and Medicare**

There are important differences between Medicare and FEHBP that make many of the design, premium setting, and management aspects of FEHBP inappropriate as models for Medicare. Medicare is a uniform national program that applies to almost all individuals over age 65. FEHBP is an employer-sponsored program that applies to Federal employees and annuitants. FEHBP coverage of annuitants over age 65 is limited to paying a portion of the benefits costs that are not reimbursed by Medicare.

Medicare, as it is now structured, cannot respond quickly to changes in the health care environment. FEHBP can respond to developments in health care design and financing much more rapidly than Medicare, because control of most aspects of the design, management, and pricing rests with OPM. Major changes in Medicare can only be achieved through an extensive legislative process that necessarily requires input from all affected segments of the economy. For example, further restrictions on Medigap policies would be strongly opposed by the insurance industry and many Medicare enrollees.

The population covered by Medicare has many different health needs, and a much higher cost, than the FEHBP population that spans all age groups. The average per capita cost of Medicare, at around \$5,500, is almost triple the cost of the FEHBP population. This difference is magnified by the fact that the average income for Medicare enrollees is much lower than for the FEHBP population.

Differing health care needs, and political and budgetary considerations, have resulted in important benefit design differences between the two programs. For example Medicare does not have a maximum out-of-pocket limit, and does not cover out-patient prescription drugs or dental care. On the other hand, Medicare has extensive provisions for skilled nursing facilities, home health, and hospice care benefits that are not duplicated in FEHBP and private-sector plans.

Another difference between Medicare and FEHBP that limits introduction of major nationwide changes is the ability to communicate quickly and effectively with the enrollees. The workplace is a critical channel of information for FEHBP and other employer plans to convey information on plan changes and address questions and concerns about the health plans. Medicare enrollees, with their extensive health needs, would find the choice to be much more complex and important than most enrollees in FEHBP. It is also much more difficult for Medicare to provide extensive information and quickly address questions than it is for an employer. This limits the number and complexity of options that can reasonably be offered to Medicare enrollees.

A final very important difference is the existence of Medigap policies. These will limit the potential effectiveness of PPO and POS approaches if they are allowed to reduce the financial incentive to use the network providers. If, for instance, Medicare charged the

patient \$100 more for use of an out-of-network physician but Medigap paid the \$100 then there would be no incentive for the patient to use the in-network physician.

### **Lessons of FEHBP for Medicare**

The important differences between FEHBP and Medicare limit the direct application of some concepts from one program to the other. However many of the principles of cost control and negotiation of FEHBP can be transferred to Medicare.

Medicare already offers HMOs, and it is expected that the popularity of HMOs will continue to grow. Now that Medicare HMOs have passed beyond the experimental stage and are predicted to enroll an increasing number, the Federal government could apply the negotiation and communication procedures developed in FEHBP to the Medicare HMOs. These include working with the HMOs to design the most appropriate benefit package, negotiate a fair premium, and communicate the options to the population.

As in FEHBP and the private sector, substantial savings could be achieved by careful application of the PPO and POS design to Medicare. Medicare is initiating demonstration POS contracts, but substantial savings will only come with nationwide availability of such options. The role of Medigap plans will have to be carefully considered in the design of a such options. The government will also have to balance the health care needs of the patients with the controls of the PPO and POS plans.

Choice in FEHBP is far from the theoretical competition approach, and does not have a significant cost impact on the cost of FEHBP. The differences between FEHBP and Medicare make choice in the latter program even less amenable to the theoretical competition approach. It is unlikely that competition among plans of identical design can ever be achieved in Medicare. Instead potential savings can best be achieved by providing choice among health management approaches.

A reasonable goal for competition in Medicare would be to provide three nationwide options with one each of the FFS, PPO and POS designs. Medicare enrollees could choose among the three nationwide plans and the local HMOs. Key questions in designing PPO and POS options in Medicare are:

- How to keep the Medigap plans from defeating the PPO and POS designs?
- How to determine an equitable government and enrollee contribution?
- How to continue availability of the current FFS plan at a reasonable price for those who prefer not to participate in the PPO or POS options?

Thank you for the opportunity to present this testimony to the Committee. I would be happy to address any questions you may have on the application of FEHBP concepts to Medicare.

## Medicare Reform and the Federal Employees Health Benefits Program

Statement of Robert D. Reischauer\*

Committee on Finance  
United States Senate  
May 21, 1996

Mr. Chairman and members of the Committee, I appreciate this opportunity to discuss with you the relevance of the Federal Employees Health Benefits Program (FEHBP) to the future of Medicare. My statement addresses three questions:

- What insights for Medicare reform can be drawn from the FEHBP experience?
- To what extent might FEHBP serve as a model for a restructured Medicare program?
- How important is it to begin restructuring the Medicare program soon?

Congressional leaders and the President have just concluded a bipartisan budget agreement that, we all hope, will keep the Hospital Insurance (HI) Trust Fund solvent through 2007 and lead to a balanced budget by 2002. The agreement calls for \$115 billion in net reductions in Medicare spending over the fiscal 1998 to 2002 period and \$319 billion over the following five years. These savings are expected to be generated primarily by reducing the growth of payments to providers and secondarily by increasing Part B premiums. If the agreement's goals are realized, Medicare spending will be some 13.9 percent below baseline levels by fiscal 2002.

These reductions are significant and will be difficult to realize. Nevertheless,

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\* Senior Fellow, The Brookings Institution. The views expressed in this statement are those of the author and should not be attributed to the staff, officers or trustees of the Brookings Institution.

everyone knows that they are not sufficient to deal with the challenge Medicare will face after 2010 when the first of the baby boom generation turns 65 and becomes eligible for benefits. The Congressional Budget Office (CBO) has projected that baseline Medicare spending will rise by 3.5 percentage points of GDP between 2010 and 2035, while Social Security outlays are projected to increase by only 1.5 percent of GDP over the same time period.

The challenge posed by the baby boomers' retirement and the continued unrestrained increase in utilization in fee-for-service Medicare will have to be met by structural reforms because the traditional ways of holding down Medicare's budgetary impact—raising payroll taxes, increasing Part B premiums, and slowing the growth of payments to providers—probably are not capable of doing the job over the long haul. But what type of restructuring would be most appropriate and when should the effort get underway?

Growing numbers of policymakers and analysts have concluded that, to meet the challenge of the next century, Medicare should be transformed into a system that provides participants with the opportunity and incentives to choose cost-effective health care delivery systems. This could be accomplished if participants were allowed to choose among a number of competing health plans, each offering a more adequate package of benefits than Medicare's current coverage, which close to 90 percent of participants choose to supplement. In such a system, participants who selected more expensive plans would be required to pay higher premiums out of their own pockets while those who joined inexpensive plans would pay lower amounts. Plans would compete to deliver cost-effective care.

The Federal Employees Health Benefits Program (FEHBP) is a system that, in many respects, resembles this structure of competing health plans. It provides coverage to some 9 million people including 2.3 million active federal workers, 1.8 million annuitants, and the dependents and survivors of active and retired workers. Some of the annuitants are covered by Medicare, others are not. While 388 separate plans are available under the program this year, the vast majority are HMOs that are offered only in a particular geographic area and a few are open only to workers in particular agencies (for example, the plans for employees of the FBI and for foreign service officers). Most participants, therefore, can choose among ten to twenty plans. The federal government pays 75 percent of the plan's premium up to a maximum which is set at 60 percent of the average premium for six plans with large enrollments (\$1,599 in 1996 for single coverage)."

FEHBP has had performance that is similar to that of large private employer-sponsored plans with respect to both participant satisfaction and cost growth. Some 95 percent of the participants feel that the options they are provided compare favorably with those offered by private sector employers and over 85 percent are satisfied with their own plan. Over the 1983-96 period, the average participant premium rose by less than 4 percent a year. Federal costs grew at a faster pace--over 8 percent a year--because the shift in enrollment from the more expensive to the less expensive plans held down the growth of employee premiums but not the government's contribution. Since 1992, the growth rates of both the government's and the participants' premiums have slowed to a crawl--around 2 percent a year--as has been the case for large private sector plans as well.

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" Aetna, which was one of these plans, dropped out of the program in 1989 and, ever since, a synthetic or "phantom" Aetna-like premium has been used in the formula.

The general, but not unreserved, success of FEHBP has led some analysts to suggest that this program could serve as a model for a restructured Medicare program. While the FEHBP experience does offer a number of useful lessons and insights for Medicare reform, there are several reasons why FEHBP would be an inappropriate structure for the Medicare program of the future. The problems that FEHBP has muddled along with over the years would be exacerbated if it served only the aged and disabled and did not have its participants concentrated in a limited number of geographic areas.

*Some insights from FEHBP for Medicare reform*

FEHBP offers a number of positive lessons or insights for those who seek to transform Medicare into a more competitive system with broader consumer choice. First, FEHBP shows that it is possible to create a smoothly functioning market system of national scope in which a number of different types of health plans compete for enrollment. While many large employers offer their employees a choice of two or three or even five plans, there are not a lot of examples where participants can choose among two or three dozen alternatives as is often the case for FEHBP participants. The range of options is also broader under FEHBP than under most private and public sector systems. Traditional fee-for-service, preferred provider organization (PPO), independent practice association (IPA), health maintenance organizations with point of service options (HMO-POS) and HMO plans are offered to most participants. Moreover, participants are usually given a choice of more than one plan for each type of insurance, which is rarely the case with private employer-sponsored systems. Furthermore, the system works with a more heterogeneous pool of participants than most private sector systems encounter. FEHBP covers not only the core

clientele of the typical employer-sponsored health plan—active workers and their dependents—but also large numbers of annuitants between the ages of 55 and 64 and their dependents. It also provides primary insurance for federal retirees who are 65 and older but not eligible for Medicare because they spent their entire careers in federal employment before federal workers were brought into the HI program in 1984.

A second lesson from FEHBP relevant for Medicare reform is that it does not take a huge complex bureaucracy to operate a competitive system. The Office of Personnel Management (OPM), which is responsible for administering the program, accomplished the task in 1996 with a staff of fewer than 150 full-time equivalent employees and a modest administrative budget of around \$20 million. It should be noted that these figures significantly understate the total resources devoted to running the program for several reasons. For example, information dissemination, enrollment, disenrollment, and initial handling of questions and complaints are performed by the human resource staffs of the various federal agencies. Nevertheless, the FEHBP experience does indicate that the job of administering a competitive system can be handled well without high administrative costs or a large bureaucracy.

A third insight that can be drawn from FEHBP's operations is that it is possible to develop and disseminate comparative information that participants find both intelligible and useful as they decide which health plan to join. This is important because a competitive market will not work efficiently unless consumers are informed. Health plans are complex entities and it is difficult to compare their various dimensions, let alone the quality of the service they provide. Yet over 90 percent of FEHBP's participants were satisfied with OPM's annual *FEHBP Guide* which provides comparative information on the benefits and

costs of the various plans. In addition, several non-profit organizations publish information that describes, evaluates, and grades the choices available to participants. These include *Checkbook's Guide to Health Insurance Plans for Federal Employees* and the *Federal Health Benefits Information and Open Season Guide* published by the National Association of Retired Federal Employees (NARFE). The FEHBP experience suggests that if Medicare were transformed into a program offering more choice, clear and informative material comparing plans could be provided by both HCFA. In addition, private and non-profit organizations would undertake the task of ranking and evaluating the quality of the services provided by plans.

A fourth insight that can be drawn from the FEHBP experience is that competitive markets are likely to be fairly stable. Some analysts have expressed concern that differences in premium increases, performance, or consumer ratings might cause large swings in plan enrollment in a competitive Medicare market. This could cause capacity problems for plans that gained participants and consumer dissatisfaction if participants could not join the plan of their choice or if a surge in enrollment caused a degradation in their plan's service quality. The FEHBP experience suggests that, in an established system, these are not significant problems because few participants switch plans when they have the opportunity. Each year, only about 5 percent of participants choose to switch from one plan to another. While sudden disenrollment might significantly affect a plan with limited enrollment, the balance of the market can easily absorb its members.

FEHBP's experience also suggests that an effective competitive market can function without a sophisticated mechanism for risk adjusting payments to plans. OPM does not adjust its premium payments to plans despite the considerable variation in the expected cost

of the various classes of participants. In other words, for any given plan, the total premium payment for a single 25 year old male federal worker is the same as for the 75 year old annuitant who lacks Medicare coverage. This policy has caused some problems and inequities. The premiums paid by the participants in plans that have attracted less healthy enrollees are unfairly high because federal premium payments are not risk adjusted. In extreme cases, efficient plans whose benefits have been particularly attractive to those with health problems or to high-cost annuitants have been forced to drop out of FEHBP. This has occurred when a plan's adverse risk pool has caused participant premiums to rise and healthier enrollees to drop out of the plan. What is noteworthy is not these problems but rather that the FEHBP system has functioned as well as it has without any explicit risk adjustment. This suggests that the imperfect risk adjustment mechanisms that are presently available should be sufficient for developing a more competitive Medicare system. As more accurate and sophisticated tools are developed, they can be used to improve that system.

Finally, FEHBP's experience has reenforced the conclusions of many private employers that it is neither necessary nor efficient to allow participants to change health plans more than once a year. Medicare currently allows participants who have selected an HMO to disenroll from that plan and choose another HMO or return to the traditional fee-for-service system with 30 days notice at any time during the year. FEHBP, and most private employers that offer more than one plan, restrict this freedom to a fixed "open season" period that occurs once a year. There is no indication that this has caused problems for federal annuitants who most resemble Medicare participants. This is not surprising considering that these retirees can simply choose to remain in the health plan they were enrolled in during their working years and hence are most familiar with. A

similar set of circumstances should develop under a competitive Medicare system where participants might be expected to have a choice of plans, some of which would be similar or even identical to the ones that covered them during their final years on the job.

*Can FEHBP serve as a model for a restructured Medicare program?*

While the FEHBP experience offers encouraging evidence that an efficient, high-quality system of competing health plans can be developed, FEHBP does not provide an appropriate model for a restructured Medicare system for several reasons. Some relate to differences in the populations served by Medicare and FEHBP, some to specific design characteristics of the FEHBP system, and some to the interaction between the two.

Covering the Medicare population is a much more complex undertaking than providing health insurance to federal workers, retirees, and their survivors and dependents. While the participants covered by the FEHBP plans are a diverse lot, they are nowhere near as diverse as the Medicare population. For the most part, FEHBP participants are fairly well educated and overwhelmingly middle- or upper-middle class. They are, presumably, fairly sophisticated consumers. They are largely workers in secure, safe, white or pink collar jobs or retirees whose needs are relatively well met because of the generosity of the federal pension system. They are disproportionately concentrated in relatively few metropolitan areas. In contrast, Medicare participants are older and more likely to be disabled or infirm. They are less educated than the FEHBP population and many have very modest incomes. Medicare beneficiaries are spread throughout the cities, suburbs, and rural areas of the nation.

In a competitive Medicare structure, some entity would have to be established to

perform the functions that the employing agencies fulfill in the FEHBP system. This entity, which could be a government or non-profit organization, would be responsible for enrollment, disenrollment, and developing and disseminating to participants comparative plan information. It would also help participants handle problems that they might encounter with their plans. The task of informing Medicare consumers about their choices would be significantly more challenging than it is under the FEHBP system, in part because of the differences between the two populations. But in addition, one valuable source of comparative information about health plans would not be available to Medicare participants. This source is the informal office discussions that workers have with their colleagues about the performance of various health plans. While many Medicare participants do share such information with retired friends some lead relatively isolated lives.

Several design characteristics of FEHBP make it an inappropriate model for a restructured Medicare system. First and foremost among these is the lack of a mechanism to adjust the government's premium payments for the differential risk or health status of each plan's participants. While this has caused some problems for FEHBP, the consequences for a competitive Medicare system are likely to be far more serious. Foremost among these is the inequity that is created when participants must pay higher premiums not because their plan provides more generous benefits or is less efficient but because its enrollees are less healthy. The lack of a risk adjustment mechanism also increases the incentive that plans have to enroll healthy participants, a response that public policy should seek to discourage, not encourage. Furthermore, if government payments to plans are not risk adjusted, the market will be less stable and there will be less plan

continuity. For the elderly and disabled population, market stability is undoubtedly more important than it is for those of working age.

A second design characteristic of FEHBP that makes it an inappropriate model for a restructured Medicare program is its lack of a common benefit package. While all plans are required by law and regulation to meet certain minimal standards of coverage, plans are free to vary their benefit packages. Over time, the benefits offered by the various plans have become quite similar as plans have attempted to avoid the adverse selection that might result if they offered a comparatively rich package of benefits. Nevertheless, subtle differences in benefit packages, if they were allowed, could be used by plans to attract the healthier participants in a restructured Medicare program. In addition, it is more difficult for consumers to make meaningful comparisons of plans when each offers a different benefit package. For these reasons, it would be best to require that all plans operating in a restructured Medicare program provide the same core package of benefits. Supplemental benefits could be permitted, but they would have to be sold separately and priced to cover any indirect impact they might have on the utilization of core benefits.

The lack of fixed market areas is another aspect of FEHBP that would not be appropriate for a restructured competitive Medicare system. For the most part, FEHBP plans are free to specify the geographic area in which they will provide services. This has not caused significant problems because the FEHBP population is relatively homogeneous. But that is not the case with respect to Medicare population as the large variations in Adjusted Average Per Capita Cost (AAPCC) rates within many metropolitan areas demonstrate. Gerrymandering of service areas can be used to avoid participants with higher-than-average expected costs. Unique plan service areas also can complicate both

comparisons of plan performance and the choices facing Medicare beneficiaries. For these reasons, a restructured competitive Medicare program should establish defined multi-county service areas and require participating plans to offer their services to any Medicare participants in the area.

Finally, the way in which FEHBP has structured and determined plan premiums is probably not appropriate for a restructured Medicare program, at least in the long-run. FEHBP is a relatively passive buyer when it comes to determining the premiums it pays to local HMOs. OPM requires that these plans charge FEHBP no more than they charge their large private sector customers. Adjustments are permitted to reflect differences in the characteristics of the private sector and FEHBP enrollees and in the various benefit packages. This procedure makes a great deal of sense considering that FEHBP enrollment constitutes a relatively small share of most participating HMOs' business. Furthermore, it would be a significant burden on OPM to negotiate actively with hundreds of HMOs scattered throughout the nation. But Medicare's market position would be quite different from that of FEHBP. It would represent a very large purchaser in almost every market. Furthermore, premiums for private employer-sponsored coverage have little relevance for the costs of covering the Medicare population.

Under FEHBP, premiums for the nation-wide fee-for-service and PPO plans are negotiated by OPM. They are uniform across the nation. Thus, plans must lose money on participants in high cost areas such as New York City and make healthy margins on enrollees in low-cost markets in rural areas and in such metropolitan regions as Minneapolis-St. Paul and Portland, Oregon. Under this structure, these plans have an incentive to market more aggressively in low-cost areas. In addition, a system of uniform

national premiums is inequitable because a portion of the premiums paid by participants in low-cost areas is used to subsidize services provided to those in high-cost areas.

Rather than adopting the FEHBP method of setting premiums, a restructured competitive Medicare program should establish premiums through competitive bidding. Medicare's payment level for each market area could be set at the median bid as long as the plans submitting lower bids were capable of serving at least half of the market's Medicare population. The Medicare payment level should incorporate the participant's contribution which would subsume the Part B premium and an amount equal to the average cost of Medigap insurance as long as the required benefit package under the new system was enriched to cover the benefits currently provided by supplementary insurance in addition to the core Medicare services. Those who chose plans with premiums below the Medicare payment level would receive rebates while those who joined more expensive plans would be required to pay additional premiums. Such a system would balance equity and efficiency and use market forces to restrain the growth of federal costs.

#### *When Should Structural Reform Begin?*

Once the bipartisan budget agreement of 1997 has been turned into law, there will be a great temptation to celebrate the accomplishment with a period of legislative rest, particularly in those areas which have been cut the most to balance the budget and pay for tax relief. Few will have the stomach to revisit these policy areas for fear of reopening old wounds. In no area will this reaction be stronger than in Medicare which, under the budget agreement, has been asked to bear 42 percent of the net reduction in non-debt service spending that will occur over the next 5 years.

It would be a major mistake, however, to delay dealing with the long-term challenge facing Medicare. The sooner the nation begins the task of restructuring Medicare, the more options policymakers will have to choose among and the less wrenching the changes will be.

In a number of respects, current conditions are relatively salutary for beginning the restructuring process. But these conditions may not last long. The economy is strong and lacks any significant structural imbalances. Under such circumstances, the dislocations which are an unavoidable part of any major restructuring effort should be accommodated relatively painlessly.

Demographic conditions are also favorable. The next decade will see a lull before the demographic storm breaks. The population aged 65 and over is projected to grow only 0.9 percent a year during the next decade—less than it did during the previous decade and much less than it will in the decade after 2007. The 65 and over group will edge up from 12.7 percent of the population in 1997 to 12.8 percent in 2007. This period of benign demographics means that any new institutional structures that are created over the next few years as part of Medicare reforms will have time to become established and be fine-tuned before the first of the babyboomers begin to turn 65 in 2011. If the new structures are put in place later, they may be overwhelmed by the explosion in the number of new participants. Over the next 14 years, Medicare will have to cope with an average increase in elderly enrollment of only 395 thousand a year; during the 14 years following 2010 the comparable figure will be 1.5 million.

Health market conditions too are conducive for Medicare restructuring. Providers, particularly hospitals and physicians, are in excess supply. As employer-sponsored plans

have constrained their payments to providers, Medicare's payment levels have become relatively generous. Medicare hospital margins--estimated at 12.7 percent for 1997--are higher than they have been in over a decade. Introducing structural reforms, even with the inevitable slips and stumbles, will be unlikely to restrict access or compromise the quality of care received by Medicare participants. This may not be the case a decade from now if private plans successfully wring some of the excess capacity out of the health sector.

From a political standpoint, there is never an easy or good time to restructure a program as popular and successful as Medicare. But the present is as good as it is likely to get because the political environment is likely to become increasingly inhospitable to reform efforts as the years pass. By 2004, when the next President will be up for reelection, about 45 percent of the voters will be 50 and older and justifiably concerned about the adequacy of their retirement benefits. Equity considerations require that structural change be implemented gradually to give those nearing retirement an ample opportunity to adjust to a new system. For these reasons it is important that Congress turn to the long-run problem facing Medicare as soon as its work on the balanced budget agreement is completed.