The Heritage Lectures

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Open Season for America?

A Symposium on the Federal Employees Health Benefits Program

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OPEN SEASON FOR AMERICA?

A SYMPOSIUM ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

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The Federal Employees Health Benefits Program

Robert E. Moffit, Ph.D. Today, begins an annual Washington, D.C., ritual. It is called "Open Season." It is that special time of year when Members of Congress, federal employees, and federal retirees and their families pick and choose from a wide variety of health care plans.

In Washington, our federal neighbors can choose among 36 different plans. Indeed, roughly half of all people with health insurance in the Washington, D.C., metropolitan area will be covered by these competing health care options. Nationwide, federal employees and their families will have almost 400 choices, with anywhere from a dozen to two dozen plans in any given geographical area.

So, in 1993, Members of Congress, congressional staffers, federal employees, and federal retirees—roughly nine million people—will enjoy a special privilege practically denied to other Americans. They will be enrolled in a health care plan of their personal choice—a plan they selected for themselves, not a plan selected for them by somebody else, their employer. They alone will have made the personal decision as to whether the plan they selected is a rich plan or a lean plan, a traditional fee-for-service plan or a managed care plan, a conventional plan offered by an insurance company or an innovative plan offered by a union they trust or an employee organization whose goals they support.

For its part, the federal government sets basic ground rules for the companies entering into competition for employees' business and contributes 60 percent to 70 percent of the cost of the federal employee health insurance premiums up to a certain dollar amount.

Beyond that, the decision rests with federal employees and their families. Thus, if a Member of Congress or a federal employee wants a more expensive health care plan, they can have one, but they will pay more directly out of their own pockets. If they want a less expensive plan, they can also choose that option, and the savings from making that decision will likewise go directly into their own pockets. So unlike most of us, who are utterly oblivious to the cost of our health benefits package and who treat health benefits as a kind of "free good" that automatically comes with our job, something "paid for" by our employer, Members of Congress and federal employees tend to be very conscious of the cost of their health benefits package. Unlike the rest of us who have little or no choice in the matter, they personally weigh the price and benefit of alternative health care packages, and seek the best value for their money. Mike Causey, veteran reporter on civil service affairs for the *Washington Post*, reports in today's edition that, through careful shopping federal employees and their families can save anywhere from $750 to $3,000 this year.

Finally, let me call your attention to a paradox. The government program serving federal employees is not drowning in a sea of regulation, unlike so many other government programs designed to "help" the rest of us. Medicare, for example, is one model of a single-payer national health system that some Members of Congress want to impose on the rest of us. But it is governed by a huge body of law, numbering hundreds of pages, with over a thousand pages of regulation, and many more thousands of pages of instructions and guidelines governing doctors and hospitals and the treatment of patients.

While the huge Medicare regulatory regime is becoming an unintelligible monster, the FEHBP is simple. The 32-year-old law creating the Federal Employees program is only 26 pages long, with about 100 pages of regulation, and only 93 pages of instructions in the Federal Personnel Manual. That's it. While Medicare requires thousands of central office staffers to run the program, the central administrative staff at the Office of Personnel Management (OPM) is relatively small, 144 people to be exact. In fact, some of the genuine problems that burden the FEHBP, such as adverse selection, restriction of market entry, OPM's role over the rates and benefits of competing plans, are a direct result of government policies; in other words, the restriction on free market forces.

Joining us today for our discussion of the Washington ritual of Open Season and the Federal Employees Health Benefits Program are two of the nation's leading experts on this unique federal enterprise.

I am honored to introduce a former colleague in federal service, **Jim Morrison**, a veteran of three presidential Administrations. There are two things you should know about Jim Morrison: Jim is a life-long Democrat, and he is serious about it. He is also a native of West Virginia. Jim is also the Principal of Morrison and Associates, a Washington-based business consulting firm. The firm provides government relations services for major corporate clients, including Blue Cross and Blue Shield Association and ARA Services Inc.

While the huge Medicare regulatory regime is becoming an unintelligible monster, the FEHBP is simple.

Jim holds his master's degree in Public Administration from the University of Dayton, and his bachelor's from West Virginia State College.

Jim Morrison has more than an academic interest in the Federal Employees Health Benefits Program. He ran it. From 1981 to 1987, he served as the Associate Director of the United States Office of Personnel Management, and had chief responsibility for managing the government health and retirement benefits programs, plus the federal civilian pay system.

Before his service at OPM, Jim held senior management positions in the White House Office of Management and Budget (OMB), the National Aeronautics and Space Administration (NASA), and the Department of Defense. He is the recipient of numerous awards, including the Presidential Rank Award for Distinguished Executive Service, the highest honor awarded to career executives.

Walton Francis is an economist and a policy analyst. He is the recipient of two master's degrees from Harvard University, one in public administration and the other in public policy. He also has his master's in Government from Yale University, and his bachelor's from Indiana University, where he graduated with highest honors. Walt's professional expertise is concentrated in statistical analysis, managed health care, government regulations, and retirement benefits.

But most residents of Washington know Walt Francis as the author of Washington's best seller, *CHECKBOOK's Guide to Health Insurance Plans for Federal Employees*, published annually by Washington Consumers' CHECKBOOK, a leading consumer organization that advises Washingtonians on everything from household appliances to auto repairs.

In 1979, Walt pioneered a systematic comparison of health insurance plans for federal employees; the rest is history. The *Guide* is now in its 14th edition. As the author of the *Guide*, Walt Francis is widely recognized as a leading expert, if not the leading expert, on the Federal Employees Health Benefits Program. In that capacity, he has provided advice to hundreds of thousands of federal employees and retirees through radio, television, and speaking programs, and "health fairs" for consumers in and around the Washington, D.C., metropolitan area.

On behalf of The Heritage Foundation, I welcome both of these distinguished gentlemen, joining us for a spirited discussion on the Federal Employees Health Benefits Program.

James Morrison. As Dr. Moffit indicated, I am a consultant and a Democrat. Therefore, I should start by saying that all the comments to follow reflect my personal views, not those of any clients of Morrison Associates or of the incoming Clinton Administration.

The Federal Employees Health Benefits Program, with over nine million covered lives, is the world's largest employer-sponsored group health insurance plan. For more than thirty years, it has been characterized by two principal features that are now touted as being vital to any future system of health care for all Americans: first, universal coverage or access; and, second, the absence of waiting periods and of coverage limitations for pre-existing conditions.

But the FEHBP is also characterized by a third feature that more and more health care policy experts consider to be a positive: consumer choice.

Thus, the Federal Employees program is a living example, in many ways, of the currently "red hot" concept of "managed competition."

There are many similarities between "managed competition" and the FEHBP. Both maintain a vibrant role for the private-sector insurance community. Both require tried-and-tested and "approved" health plans. And both ensure subscribers with market competition on the part of providers offering a basic level of benefits.

Historically, the features of competition and private-sector responsibilities, coupled with a light dose of government intervention, have provided a healthy balance between quality, cost, and service.

> **Historically, the features of competition and private-sector responsibilities [in the FEHBP], coupled with a light dose of government intervention, have provided a healthy balance between quality, cost, and service.**

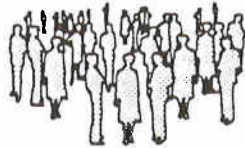
But most important, the FEHBP has outperformed large plans in the private sector in terms of annual cost increases. Much of the FEHBP's good cost performance, relative to private sector plans, is and was due to the basic competition among FEHBP plans and the fact that genuine cost-sharing on the part of employees—that is, deductibles and co-insurance—was introduced into the Federal Employees program in 1982. At that time, first-dollar coverage was still the norm in the private sector. This introduction of cost-sharing improved the cost-consciousness of FEHBP consumers, and made them careful subscribers. While private-plan holders had no reason to be the least bit frugal, the co-payment provisions of the FEHBP caused federal employees and retirees—yes, the program provides the same coverage to retirees as to active workers—to shop around more carefully for their medical services.

By and large, FEHBP subscribers have been quite satisfied with their health care. This is evidenced by the extremely low volume of systemic complaints. Ask at any congressional office. Problems of a systemic or structural nature are simply not high on the list of consistent complaints. This is even more remarkable when one considers the efforts of some federal employee unions to stimulate congressional interest in changing the program, as well as the circulation of several much-publicized studies of the FEHBP.

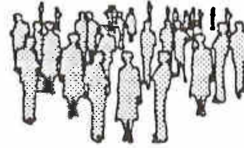
Most of the conventional proposals for reforming the program are driven more by political considerations than by substantial concerns related to health care. In most cases, the standard re-

How the Federal Employees Health Benefit Plan Works

Members of Congress and Hill Staffers



Federal Workers



Federal Retirees

Workers Choose Plan According to Desired Services, Premiums

Each Participant Chooses One of the Competing National Health Plans or Local HMOs

Typically, there are 10-20 FEHB Plans in Any Given Area

Private Plan

Private Plan

Private Plan

Private Plan

Agency or Office Deducts Worker's Share of Premium from Paycheck and Adds Government Contribution

Sends Money to OPM Trust Fund

Office of Personnel Management

OPM Approves Plans and Authorizes Premium Payments According to Plan Enrollment

OPM Trust Fund

Federal Treasury

Appropriation for Federal Government's Share of Retirees Premium Added to Trust Fund

form proposals, favoring a restriction on consumer choice or a less or non-competitive model of health care delivery, are solutions to yesteryear's problems or solutions in search of a problem.

That said, the FEHBP is by no means a perfect health care system. But it has many strengths. The intricacies of the Federal Employees program are well-known only to a very few people. Certainly, public knowledge of the program is obscure compared to the public's awareness of Medicare and Medicaid, the huge public health programs run by the Department of Health and Human Services.

For the benefit of our fellow citizens, we need to remedy this lack of knowledge. Consumer choice and competition work. And consequently, in 1993, health care reformers should examine closely the workings of the FEHBP when formulating proposals for a national health care system that emphasizes universal access, cost controls, consumer choice, and competition.

Walton Francis. Writing about the Federal Employees Health Benefits Program from a consumer's perspective is supremely interesting. Today, however, I want to bring to this discussion a different perspective on this program.

I would like to talk about it as a health insurance program in the context of, and comparing it to, other health insurance programs the federal government already operates. I also want to talk about it with an eye towards national health reform of some kind coming up in the Clinton Administration.

I want to use as a point of comparison the Medicare program and, to a lesser extent, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the health insurance program for civilian dependents and retirees of the military. Both of these programs, I think, are markedly inferior in many respects to the Federal Employees Health Benefits Program. The reasons for that, and the manifestations of that comparative inferiority, are exceedingly important for an understanding of what is likely to happen under various scenarios of future changes in our health care financing system.

. . . the Federal Employees program has tied or bettered the performance of Medicare.

I make these criticisms of these other programs not to malign them in any way, but simply to point out that the American political system does not do all things with equal facility or competence. I am sorry to say that, in general, it does not handle health insurance very well. The Federal Employee program is an extraordinary exception, and the reasons for that will surely amuse you when we get to discussing the causes.

I would like to evaluate these programs from two perspectives—cost control and adequacy as insurance. We could use others, but these two are, I think, the most important in the judgment of most people.

First, cost control. How does the federal employee program do in controlling costs and what can be learned from that? Consider the last decade: the cost of the Federal Employees program has grown, just like the costs in other insurance programs, public and private. By cost, I am using here the total insurance cost, the total premium cost, regardless of the percentage paid by the government or the enrollees. At an annual rate compounded, that cost has grown 9 percent. That number can vary slightly depending on what year you pick as your base period, but the period that I just gave you is 1982 to 1991.

How does that compare to other major programs and to the private sector? First, let me say that I have not seen a good comprehensive time series on the private sector. But the annual press

and data releases of Hay Huggins and Mercer Inc., firms that monitor employee benefits, and other professional surveys of private sector employee benefit programs, keep suggesting double digit increases—10 percent or 15 percent or 20 percent annual cost increases in private health insurance each year. This has certainly been true in recent years. I know that can't be true over a long period stretching back in time, or we would have even higher health care costs than we do. My impression is that private sector insurance costs have probably grown at a compound rate of around 12 percent to 15 percent. This is markedly inferior to the 9 percent achieved in the Federal Employees Health Program over the last ten years and 10 percent over the last fifteen years.

Medicare, I think, is the program of direct interest here. The Medicare program has also achieved a cost growth rate of 9 percent over the 1983 to 1992 period. If you stretch it out to the 1976 to 1992 period, Medicare has grown at a rate of 10.9 percent; 1 percent more than the FEHBP. You may say, "So what? Here we have two federal programs that just about tie each other. Big deal." But, there is a fundamental difference. In the first place, Medicare has achieved its cost-savings, in substantial part, because of the Prospective Payment System (PPS), a by-product of which is the shifting of some hospital costs over to the private sector. For these purposes, the FEHBP is part of the private sector. It is one of the victims of cost-shifting. So, without using

FEHBP and Medicare Performance: 1975-1993

	Medicare Aged					FEHBP		
	Part A	Part B	Total Cost/ Enrollee	Annual Increase	15-Year Increase	Total Cost/ Enrollee	Annual Increase	15-Year Increase
1975	$326	$153	$479	—	—	$557	—	—
1976	*453*	*187*	639	33.4%	—	694	24.6%	—
1977	579	220	799	25.0%	—	789	13.6%	—
1978	*670*	*262*	933	16.7%	—	828	5.0%	—
1979	*762*	*305*	1,066	14.3%	—	902	9.0%	—
1980	853	347	1,200	12.5%	—	1,021	13.1%	—
1981	*995*	*419*	1,414	17.8%	—	1,263	23.7%	—
1982	*1,137*	*490*	1,627	15.1%	—	1,384	9.6%	—
1983	*1,279*	*562*	1,841	13.1%	—	1,485	7.4%	—
1984	*1,421*	*633*	2,054	11.6%	—	1,548	4.2%	—
1985	1,563	705	2,268	10.4%	—	1,543	-0.3%	—
1986	1,564	800	2,364	4.2%	—	1,909	23.7%	—
1987	1,572	937	2,509	6.1%	—	2,029	6.3%	—
1988	1,617	1,040	2,657	5.9%	—	2,284	12.6%	—
1989	1,749	1,130	2,879	8.4%	—	2,472	8.2%	—
1990	1,971	1,250	3,221	11.9%	13.8%	2,801	13.3%	11.6%
1991*	2,007	1,342	3,349	4.0%	11.8%	2,960	5.7%	10.3%
1992*	*2,174*	*1,537*	3,711	10.8%	10.9%	3,197	8.0%	10.0%

Note: FEHB data include costs shifted from Medicare. * Medicare data estimated. Final figures expected to be higher.

Sources: Medicare data from 1987 through 1992 from *Green Book*, data in italics interpolated. Excludes administrative costs. FEHBP data through 1989 from annual Insurance Report. Pre-1981 data from *Federal Fringe Benefit Facts* OPM Press Release used for 1990-92 % increase. Includes adminstative costs.

cost-shifting as a major device, and indeed being a victim of it, the Federal Employees program has tied or bettered the performance of Medicare.

It is even more interesting that over this period there have been essentially no Medicare-style "cost-containment" reforms of the Federal Employees program, whereas Medicare has been the beneficiary of at least one piece of reform legislation virtually every year for the last ten years, several of them very significant—physician payment reform in 1989, for example, as well as Prospective Payment for hospitals in 1983.

So here we have a huge federal program serving 35 million elderly and disabled people, which has preoccupied both the Congress and the executive branch in their attempt to reduce its cost. It has indeed been able to reduce the rate of increase in health care costs, partly because of the monopsony power of government; and yet it has at best tied the performance of a program which has had close to zero management reforms over the same period of time and has not relied on government coercion at all.

Second, let us look at these programs' adequacy as insurance programs.

A little known fact is that CHAMPUS, which is, in most respects, a fairly standard insurance program—modest deductible, 80 percent co-insurance paid by the government—has a $10,000 catastrophic limit. This means that a military family enrolled in CHAMPUS can be exposed to an annual cost of $10,000 before CHAMPUS pays the rest. This is, as we all know, quite a high limit by health insurance standards. And it is a limit, indeed, which many of these families find impossible to live with. So, there has sprung up an industry of CHAMPUS supplemental policies that these people buy, because it is the only way they can actually obtain catastrophic protection.

Medicare, as you know, has had a very interesting history on the subject of catastrophic coverage. We have seen the passage and then repeal of the Medicare Catastrophic Coverage Act of 1988. I won't go through all the politics of that. But suffice it to say that, almost thirty years after the founding of the Medicare program, it still does not protect enrollees against catastrophic cost in any category—hospital or doctor or prescription drugs, which aren't covered at all. And of course, virtually all people enrolled in Medicare, who can afford to do so, feel impelled to buy gap fillers—Medi-gap plans—whose unintended by-products include the virtual elimination of cost-sharing, and hence cost-consciousness, from this government program.

In contrast, the Federal Employees program, though it is comprised of approximately two dozen fee-for-service plans and 300 or more HMOs, has a superb record of catastrophic coverage. All of the fee-for-service plans have an explicit guarantee; it is usually a limit on out-of-pocket expenses of around $2,500 or $3,000. And HMOs do even better.

There is a simple reason for this. It is that people over time have migrated into the plans that offered better catastrophic coverage simply because they wanted better catastrophic coverage. Seeing this, the plans improved their coverage to attract consumers in the future. So, the customers made the choice. There is nothing in the structure of the Federal Employees program that guarantees catastrophic coverage. It is not mandated by law; it is simply a product of the functioning of a market-driven system. (I would add that wise prodding by enlightened executives such as Jim Morrison has played a role as well.)

So we have these three medical programs run by the federal government. Two have done poorly on cost control, and one has done better. Two have done poorly on insurance coverage, and one has done better. And yet, the one that has done better, the Federal Employees Health Benefit Program, is by far the least tightly managed of the three and has not relied on government coercion to regulate provider payments.

In considering the causes of this superior performance, I would like to tell you how the FEHBP has been evaluated by the major studies that have looked at it.

Over a decade ago the consulting firm of Mercer Inc. was hired to look at this program. The evaluation was done from the perspective of benefits consultants to Fortune 500 companies. They concluded that the program was a disaster. They said it needed immediate reform. But get this: They said that the most serious problem with the program was that it allowed competition among health plans.

About five years ago Towers, Perrin, Forster and Crosby, Inc., a Washington, D.C., consulting firm, looked at the program and made essentially the same diagnosis. But the Towers consultants went so far as to say that what the FEHBP presents is not true competition. "True competition," they said, has to do with competitive contracting, the way the government buys pencils or submarines, not consumers making choices among competing providers. They essentially prescribed the same thing: "Let's create a program that looks a lot like Medicare and then have competitive bids for the claims processing."

There was then a Congressional Research Service (CRS) study in 1989. But the CRS study did not really seek to reach any overall conclusions as to what ought to be done about the program. So, I will skip over it for now.

And finally, just last year, Chairman William Clay of the House Committee on Post Office and Civil Service hired a group of health benefits consultants—basically, retired insurance executives in the Fortune 500 context—and asked them to look at this program. And what do you know? They looked at it and said, "You are not running this program the way the federal government runs Medicare." They didn't put it in those words, but that is essentially what they meant to say; or, putting it in the private sector context, this is not the way Fortune 500 companies run their programs.

The consultants to the House Post Office and Civil Service Committee thus made the same recommendation: What we need to do is to have a benefits structure set in law, and have competitive contracting for the claims processing. Now, you might ask yourself, "How is it that we have had these major studies recommending essentially abolition of this program and its replacement by something along the lines of CHAMPUS or Medicare when, in fact, the existing program arguably out-performs these other programs?" And why was there—this is the striking thing—no real recognition of the superior performance of the FEHBP in any of the studies I have cited, except for the 1989 Congressional Research Service study?

I think the answer is real simple. The people who were paid to do those studies are people who have spent their entire lives in the game of "living the model." There is a single plan: The wise and beneficent employer decides the details of that plan; he imposes it on all of his employees; they take it or leave it; and the employer will have it administered by professional claims payers —insurance companies, thank you very much—and they will do it just swell. When you hire people who are immersed in that system, it should not be surprising that they recommend more of the same.

Now, think for a moment. It is fairly bizarre. What on earth makes us think that any Fortune 500 company, let alone every one of them, is competent to devise optimal health insurance programs? These companies are in the business of selling automobiles or computers or widgets or whatever; they are not insurance design experts.

Let us leave that aside for a moment. You can speculate on it. However, there is certainly no demonstrated corporate competence in delivering health care and keeping health care costs down over the last decade, to say the least.

Now, let's talk about how the Federal Employees Health Benefits Program has done so well. I must first tell you that it is an accidental program. It was "designed" by a political happenstance. Back in 1959 when this program was enacted, the civil service bureaucrats at what is now called the United States Office of Personnel Management (OPM), did indeed want to have a system that looked a lot like the future Medicare program and the Fortune 500 model. The basic idea was that the federal government would set the benefits in law, and then hire people to process the claims payments. Employees would take what they got, with no choice.

But a funny thing had happened. The federal government was quite a latecomer among large employers to this field, and federal employees had devised alternatives. In particular, during prior decades there were a number of unions which developed plans for their members—group health insurance plans—which their members were quite happy with, and these union plans were competing for federal employee business, and they employed thousands of people processing claims and related services.

A single plan would have abolished all of this existing apparatus, and that was politically untenable. So, a compromise was struck, and a system was devised in which a number of plans would be allowed to compete simultaneously. It was understood that there would be a half dozen or more competing plans. You may occasionally hear propaganda to the contrary, but let me assure you that it was known—from day one—that there would be no fewer than about eight or nine competing plans just among the fee-for-service plans—and there were HMOs then, too, though not many.

As a result of a political deal struck—based on the Washington political principle that you never abolish anything if you can possibly avoid it because people get hurt, and the political system doesn't like to hurt people—we created a competitive system. Every year there is an open seas n, every year federal employees can join any plan they choose. There are no pre-existing conc tions or exclusions, because otherwise the system would not work, and so on.

Now, I don't want to say there is nothing wrong with the program; indeed, there is a significant adverse selection problem. This arises primarily because there are a large number of annuitants aged in the 70s and 80s—hundreds of thousands of them—who are in this program with medical care costs four or five times higher on average than those of active employees. They are in the plans on the same basis as those employees and they tend to concentrate in certain plans. One of the major games played in this program is to flee those with high-cost annuitants and get into the plans that they are not in. And that is an unfortunate dynamic which greatly reduces the cost-containment potential of this program. It is one that can be fixed by a rate redesign, but the political system has not seen fit to propose, let alone enact, such a fix.

Competition certa explains much, if not all of the success of the Federal Employees program. But why hav Medicare and CHAMPUS been able to emulate this success? Can't they even copy it? No me tell you why I think this has not occurred. It has to do quite simply with the peculiar and inexorable workings of the American political system.

Medicare is burdened with all the inherent weaknesses of political planning. I am not blaming the executive branch nor the congressional side, nor Republicans and Democrats; I don't think these partisan divisions are really material. I would contrast our government operations with the parliamentary democracies, such as Great Britain and Canada, where I think outcomes are quite different. In our system of government, certain kinds of "pork barrel" and certain kinds of "micro-management" decisions are certain to result when the government runs programs directly or by contracting. And I don't think they are avoidable, unless you can structurally design government programs where these things cannot occur because the government is not directly

responsible for management. (For example, in the Food Stamp program there is no direct responsibility for either diet details or grocery store management.)

Let me explain what I mean with the example of the Medicare Prospective Payment System (PPS) for hospital reimbursement. I will contrast this with some key features of the Federal Employees Health Benefits Program, and I will also use the Medicare deductible as an example.

Prospective Payment is, in almost everybody's opinion, the single most important reform made in the Medicare program since its inception. The basic idea is to bring a market-like payment approach into the program by paying hospitals an identical amount for each medical procedure, rather than on a cost-plus basis. Thus, instead of paying each hospital what it costs to perform an appendectomy in that hospital, Medicare sets a single rate based on an all-hospital average. If it turns out that an appendectomy costs **X** dollars on average, we pay each hospital **X** dollars; and those which can do it for less make a profit, and those which can't do it for that price are going to lose, but have a substantial incentive to reduce cost. A dynamic, cost-reducing incentive is the theory of PPS, and to a substantial extent, its practice.

But there is a little problem. You can't reasonably take a national average and pay the same rate for an appendectomy in New York City that you would pay in rural Kansas, where health care costs are lower. So, from the beginning the program was designed to include a cost differential across geographic areas, based on a wage rate index calculated city by city. As a result, New York City gets about 20 percent more than the national average and rural Kansas about 20 percent less. So far, so good.

. . . we have in the Federal Employees Health Benefits Program a proven design which performs very well, certainly far better than the alternative program designs for health care reform that are on the table. . . .

The problem arises because there must be boundaries separating counties, determining which get the higher rate, which get the average rate, and which get the lower rate. And those boundaries are drawn around hundreds of cities throughout the United States. Near each city there is a hospital two miles this side of the county line that gets the high rate—the New York City rate, if you will—and there is a hospital two miles across the county line on the other side which gets the average rate or even the rural Kansas rate. That is a difference that makes one hospital profit and the other fall into great financial peril. And yet, to say that they are in different labor markets is patently ridiculous. In my example they are four miles apart; of course they are in the same labor market. And yet, the government program is forced to, and cannot avoid, paying them a different amount if it is going to have area wage differentials, which it has to have, because otherwise we ultimately get the absurdity of paying Kansas and New York at the same rate. Wherever we set those boundaries, there will be hospitals right at the boundary line which are irrationally and unfairly disadvantaged.

Now, how can our political system respond to claims of an unfair and irrational disadvantage by an organized interest—and a hospital is an organized interest. Answer: It responds by simply re-classifying these hospitals near the boundaries as if they fall into the higher wage area, and pays them the higher rate. Now, this, mind you, is a zero-sum gain. These hospitals get a higher rate out of the same pot of money. So, every other hospital gets a little bit less.

The political responses started fairly early in this program, which has been on the books just about a decade now. Right now, I think we are up to around 500 hospitals which have been re-classified into a higher rate area. But there is another little problem with this. Every time you re-classify a hospital, there is another hospital four miles farther out which is on the border, and thus unfairly disadvantaged. There is no logical stopping point. There is no way to stop.

Congressmen love this. Why? Because they get to do a favor for a constituent who is in deep trouble, who deserves not to be in deep trouble, who is being irrationally deprived of fair payment rates. It helps them get re-elected and it helps them feel good. It does everything fine, except it destroys over time Medicare's Prospective Payment System.

Now, regardless of how this Medicare drama plays out, you might ask what that has got to do with our story. Well, the answer is, that kind of thing does not go on even remotely to the same degree in the Federal Employees Health Benefits Program. It simply does not create specific inequities which the political system can focus on as needing fixing.

I will illustrate the essential argument here with a second example—the Medicare deductible. In Medicare, for outpatient services, there is a $100 deductible. That deductible, until a couple of years ago, was $75—it had been at $75 for many, many years. Early on, the Reagan Administration proposed raising that deductible, which by the way, in real dollars was hundreds of dollars when the Medicare program was created almost thirty years ago.

Well, you have heard the phrase "dead on arrival" budgets? There is no budgetary proposal more "dead on arrival" than a proposal to lift the Medicare deductible, at least to any economically meaningful level. That is a political act, an act which is certain to cost 35 million Americans directly, dollar for dollar, money they don't want to lose. The political system is not about to inflict that harm on them if it can possibly avoid it. Raising the deductible for Medicare becomes a political act, and a political act which our political system really is not going to be able to undertake.

What about FEHBP? Hasn't its deductible been frozen? No. The reason is, there is no one deductible in the FEHBP. There are many deductibles. Each plan sets its own deductible; and not only that, there may be a hospital deductible, an outpatient deductible, and even a prescription drug deductible. Some plans have three different ones, and some have one that covers everything. There is no single number that the political system can seize on and say, "Aha, I can't let that number be changed, because otherwise people will be disadvantaged, they will vote against me."

The FEHBP has hardly anything like that for Congress to fix on. And that is why it is not plagued by the same kinds of problems that afflict Medicare, and that is also why it is dynamically responsive.

Let me expand my explanation by telling you something about the use of managed care in these three programs—CHAMPUS, Medicare, and the FEHBP.

In CHAMPUS, the big deal is they just put a bunch of people—I think it is Southern California, but it may be all of California—into an HMO. Willy-nilly, they have to take it; they only have one choice, but by golly, they are in an HMO. Lo and behold, they are saving a lot of money compared to traditional fee-for-service medicine. This is a revelation.

There is talk in the Department of Defense of having some other HMO in some other area of the country handle civilian dependents. What incredible management dynamism. What understanding. And the political system may actually allow them to do that. A couple of years ago, it didn't allow CHAMPUS to institute any serious HMO effort, so this is real progress—one HMO and moving to two.

Even better, Medicare has gotten up to the magnificent total of 3 percent of its beneficiaries in HMO enrollment. Wow, 3 percent in managed care! This is not so many, but a lot more than CHAMPUS outside of California. And it only took twenty years of effort to get there.

Where is the FEHBP? The FEHBP at the end of this Open Season will have 30 percent of enrollees—both retirees and employees—in HMOs. Virtually all of the rest of the plans have just

started to offer, as a side option which you can slide right into, a preferred provider arrangement. Managed care is thriving in the Federal Employees Health Benefits Program. And of course, that explains why it has kept its costs down. This program automatically generates managed care, because the plans that better compete by controlling costs offer better prices to consumers and thus attract more enrollees. And the HMOs are beating the traditional fee-for-service plans hands down, as we all knew they would.

Let me stop here and leave you with a few thoughts as to what this all means. In the first place we have in the Federal Employees Health Benefits Program a proven design which performs very well, certainly far better than the alternative program designs for health care reform that are on the table, based on the experience of existing federal programs. It is a design which seems to be less vulnerable to the kinds of political infirmities which strike the other programs. And for good reason: Because there is less government management, there is less for government to micro-manage and mess up.

I say this not to disparage the federal government, but just to underscore that, however cumbersome and unwieldy and complex a Fortune 500 bureaucracy is, the federal bureaucracy is far worse. The telephone companies have had terrible problems in recent years with health insurance. They have struggled with issues like instituting deductibles, with the unions going on strike and so on. So, it is not that this is some purely government evil. But it is the natural result, if you will, of politicizing certain decisions, rather than letting people make those decisions for themselves. And any program manager who hasn't yet come to the realization that, rather than slashing deductibles, he could simply offer people a choice of health plans, and they will gravitate towards plans with higher deductibles if those plans are effectively saving them money, is a manager who is out of touch with reality.

Another general point: You cannot assume that any federal program will work as intended. Who would have dreamed that CHAMPUS and Medicare would turn out to be health programs so incomplete, so flawed, that a substantial majority of their participants—at least in Medicare's case and a big minority in CHAMPUS' case—would feel impelled to buy supplementary health insurance? That is ridiculous. By the way, I didn't mention this, but I hope it is clear, that hardly anybody in the FEHBP buys supplementary health insurance—they don't need it.

So, you can't assume that a program is going to work as intended—Prospective Payment reimbursement for hospitals in the Medicare program is another example. All kinds of by-products arise. Some programs are better at controlling those by-products than others.

Now, I don't have any particular message for those designing national health insurance reform proposals, except to say they have an obvious model here. And if it is not high on their list of models to emulate, they are out of their minds. Beyond that, I think it is vital that designers of any future reform of America's health care system deal with the potential for the kinds of political messing-up I have illustrated with the Medicare and CHAMPUS systems.

Now, I will give you, as a horrifying example, something that will make all of the existing examples of pork barrel look like child's play. And yet, I think it is inevitable and inexorable if we move to "global ceilings" set by geographic area. It is embodied in some models for health reform touted in this town. And that is, the suggestion that we should set geographic cost ceilings, so that there will be a health care budget for County X or City Y or State Z. As soon as we are in a situation where there is a budget for Kansas and a budget for New York, adding up to a fixed national total, guess what we have done? We will have instituted a new system of pork barrel politics and congressional logrolling where the key players in the political system will be endlessly competing and dealing and bargaining—dollars for Kansas against dollars for New York—all a

result of a functioning political system, and we can say, "Isn't it marvelous that it accommodates?"

Yes it does accommodate. But the results will have nothing to do with good health care policy, except by purest accident, and they will have everything to do with politics. Consider the many failures to get needed military base closings. Can you imagine accepting hospital closings in a system where the politicians get to decide? So, there is great danger in a system that exposes us to the inexorable workings of the political process, which will seize on the real or imagined injustices it creates or sees and then try to remedy them.

Take another example from a possible future health reform plan: Will there be a national health care benefits structure so carefully specified that a deductible is actually named? Well now, that creates the same situation you have in Medicare; there is "the deductible," and it is a political object, and as such, will be subject to the inexorable pressures of the political system. You can be sure of one thing, whatever that deductible is, it will never get higher, at least in any economically meaningful sense, once it is enacted into law. With great political skill, it might be possible to put a deductible into law which changed over time with inflation, but I wouldn't bet on it.

These are the kinds of issues of political economy that have to be faced in designing a new health care system for the United States. And if they are not faced, the Clinton reforms will ensure that taxpayers will be burdened by the same kind of pork barrel catastrophes you can find in other areas of the American federal system. Put another way, even if the Canadian system were a good model, what makes us think that in our political system we could run it as well as the Canadians? We have a wonderful political system. It is really good at what it does well, superbly good. But unfortunately, what it doesn't do well is run anything like health insurance.

The real lesson of the FEHBP is not just that competition works in delivering cost-effective health insurance, but also that competition helps insure us against the least attractive dynamics of our political system.

Q. There are two broad theories about consumer choice. Theory A says that consumers are simply not competent to make decisions about something like health care insurance, but must rely on professional experts to make these decisions for them. It is thus in the consumer's interest to have the employer, or the company's benefits specialist, or a government official, make such decisions, and thus protect the consumer from himself. Theory B says, to the contrary, that consumers are indeed quite capable of making rational choices about health insurance, weighing price and the value of benefits, and thus satisfying their personal wants and needs. This rationality is not confined to highly paid, well-educated, white collar employees. As a corollary to Theory B, it is posited that indeed the farther one goes down the income scale, the consumer's scrutiny of benefits components, including price and out-of-pocket costs, intensifies, thus enhancing the rationality of his decision. We have heard stories that in the Federal Employees system, for example, certain Senators consult the Capitol Hill cops or their secretaries on the best value for money. From your experience, which theory is more correct?

We just can't say that we can get a few bureaucrats in Washington to make the right decision for everybody on health care.

FRANCIS: You have already indicated it. Stick with Theory B.

Q: For individual hospitals, individual physicians, it may not be practical to treat or take care of patients that aren't enrolled in a consumer choice program. That is what I am worried about. How balanced can you be?

FRANCIS: That could happen. You have to decide which particular scenario we are talking about. But look, there are a thousand problems that would have to be solved before you could take the FEHBP and make it the "model" for the nation. The Heritage Foundation has a plan that is a close cousin, and there are 500 details that I could sit here and critique.

There are a lot of problems. One of the reasons that Medicare only has 3 percent enrolled in HMOs is because none of the big HMOs in the D.C. area—Kaiser, Group Health—are participating in Medicare. They determined that what Medicare is going to pay is bad for them. Besides, Kaiser has limited capacity and it has got other business it wants to attract. So, for whatever reason, they have told Medicare to take a walk. Sure, depending on how the government sets up a payment mechanism, that could happen.

I will give you a different example of a difficulty that is just a monstrous problem for any reform relating to the 35 million uninsured. These people, for the most part, are self-employed or employed in very small businesses. There are administrative problems just of arranging to collect premiums, and making provisions for employees if the business goes bankrupt. Who would hold the bag? Senator Roth, for example, has a bill to allow small businesses to sign up directly with the FEHBP, as if they were federal agencies, so to speak. All of these business employees would be starting right away. The problem is, if you think of the mechanics of this process, OPM now deals with several hundred federal agencies, but they all have computerized payrolls; their systems are in place. The government is not going to be a deadbeat in paying itself. But, suppose a million individuals, small businesses, each had to set up an account with OPM. Your 144 OPM employees now administrating the FEHBP would multiply a hundredfold. I say that not to cast doubt on this option, but just to say that any system of this kind involves a lot of management and administrative decisions, and you can mess them up. There is no doubt about that.

In order to smooth over the administrative process, I think you probably would have to tie it to unemployment insurance or to the W-2/W-4 system, or something. You would have to find something to hook it to, because you couldn't manage it otherwise. Maybe small business conglomerates could be formed to participate in the program.

Q: Isn't there a sort of an individual mandate in FEHBP, in the sense that in every employee for the federal government must sign up?

MORRISON: They are not required at all. In fact, about 15 percent of the federal employees do not participate in the Federal Employees Health Benefit Program. I don't know that they are necessarily uninsured. They may have spousal coverage elsewhere, or I suspect some of them are uninsured. I don't know why an eighteen-year-old federal employee would be any different than an eighteen-year-old working in a retail situation who says, "I am healthy and I don't want to spend any portion of my money for health insurance." So, I suspect there are some of both there, some spousal coverage and parental coverage. But certainly they know that, "Wow, if I get sick I can come in next open season." I think this is certainly true of some of the lower-level employees who are very young—clerical, secretarial ranks. It is the same syndrome and same kind of situation that you see reflected in the papers, where one of these eighteen-year-olds without a helmet crashes his motorcycle into a tree and then there is all of this lamenting about the fact that they aren't covered. So, we do have those situations, even in the federal work force.

MOFFIT: The Congressional Research Service did an analysis of this back in 1989, and they indicated that the bulk of that 15 percent were covered by other private plans of their spouse. So the number of federal employees who actually are uninsured probably is very small.

FRANCIS: That is one of the neat things about this program, entirely unintended. But it saves the federal government a ton of money. This is because the payment towards the cost of a family policy is typically in the 60 percent to 70 percent range, and that is just low enough that there are many private-sector employers around who offer a slightly better deal. So, the spouses elect to get their family coverage through the private employer plan and the taxpayer gets a free ride.

Q: If both of you were advising me, or President-elect Clinton, could you list two or three "dos" and "don'ts" based on the experience of the Federal Employees system to a national program?

MORRISON: One "don't" would be to make sure that you do not have the federal government be any more heavy-handed than OPM has been in running the FEHBP. I said before, it is a light, deft touch in terms of the governmental involvement. I think that would be key. You need to let the market forces work. And I think any new Administration should adopt the notion of running it efficiently, without controlling every jot and tittle. Micromanagement always catches with the bureaucracy. Probably one of the main reasons we have had the light touches over the years, and some time during my tenure, is that it simply didn't get constant congressional attention. If you are getting a lot of congressional pounding on you every day, the natural tendency is to tighten up. So, I think it would be a big, big mistake to overregulate this program. Whatever President Clinton does for his "managed competition" or his national health care reform plan, he has got to make sure that the government has a light touch, that the private markets have a very active role and are allowed to continue to innovate. Because the innovation is going to come from the people who are out there in

competition; it is not going to come, with all due respect to my former colleagues in the civil service (I did 29 years in government myself), from a government agency. In fact, if a health care reform were designed solely by the people in OPM or HHS, it would be like a car designed solely by the Department of Transportation. It would have five wheels, windshield wipers on the side, and it would have all of those things that are politically necessary for balancing these good and great competing needs.

FRANCIS: There actually is one government-designed car. It was really quite successful in its day. It is called the Jeep. You should one day read the story of how the Jeep was designed; it will blow your mind. But it actually worked very well in doing what it did. But the thought that we would buy a Jeep for all of our future transportation needs, and that we would all have to commute in a Jeep as opposed to whatever car we had, is a frightening thought. You cannot overemphasize the importance of allowing innovation and evolution and the need not only to have a light regulating hand, but also to look for ways, within the category of having a light hand, that will maximize opportunities, rather than constrain them. Unfortunately, this is very difficult for the government to do.

MORRISON: And if it is a consumer choice model, I think you have got to allow people to make a mistake. I don't see any outcry from anyone when they see someone who only makes $14,000 a year driving a Mercedes. That is their choice. If they want to spend their money there, they do that. But we have a lot of people upset about the fact that some 200,000 people enrolled in the Federal Employees system who have chosen Blue Cross High, and the value of that program is perhaps not much greater than Blue Cross Standard. But if they get comfort out of having that Blue Cross High Option card, and they want to pay, in the face of annual information that says you are paying more than you need to, it is still their business. This is America. This is something we have got to keep in perspective. We just can't say that we can get a few bureaucrats in Washington to make the right decision for everybody on health care.

FRANCIS: Let me just comment on that example, because I think it illustrates the potential of this program in a sort of a marvelous way.

I used to be one of those people who said, "It is outrageous that OPM lets the Blue Cross High Option plan stay in existence, because it costs an extra $1,800 a year in premiums to join this particular plan, as compared to the regular Blue Cross plan, and it has almost no benefits that are better. It is outrageous that we are letting these retirees (maybe they are senile) buy this plan."

I still have some of that outrage in me, and I think OPM could have done better than it has. But there is also a reality here that is very straightforward. Point one: that high option plan does happen to offer better home health nursing services than any other plan, and it doesn't take a whole lot of nursing services at home to make up for that extra cost. Point two: its other benefit, far more generous than in other plans, is its outpatient mental health care benefit. And there is no doubt in my mind that people join that plan and pay the extra $1,800 in premium so they can go to the shrink once a week. They see it is a way to budget for it. And they can actually can make a little bit of money if they go every week. These people are budgeting for their health care in a different way. The cost experience of that plan is reflecting the people who enroll in it. They are getting something, because the premium is not paying for a Mercedes for the Blue Cross executives, it is paying for health care costs. We don't know very much. No one has actually sat down and looked real hard at who is enrolled in that plan and why. Again, I could fault the Office of Personnel Management for not

doing a little more than it does. But nonetheless, the system has created a special little risk pool in which the people in that risk pool voluntarily bear their own cost. And yet, you will look at these screeds written by outside consultants and insurance executives, and their first example of reform is that we must right away foreclose the possibility that someone can ever again join a plan with premiums twice as high as some other plan.

MOFFIT: I will just simply add an historical note. When I served as an Assistant Director of OPM, I remember Jim's staff used to come up to see us all the time, complaining about the Blue Cross/Blue Shield High Option, and similar high option plans, and the problem that so many older people were in that group. And we did everything. We sent out mailings to these folks. But the problem was not easily resolved: these enrollees were often very, very old federal employees and a lot of them simply did not want to leave something they were comfortable with. The whole question of change, and moving into an unknown health care plan, was terrifying to them.

FRANCIS: They have left that plan now. The overwhelming majority of people in that plan are younger people, and I am sure they are there for the mental health benefit. So, it took about a ten-year period, but this plan, which used to be the largest plan in the federal government, has now got a stable enrollment of around 200,000 contracts. They are obviously happy; it gained enrollment last year.

Q: Doesn't that kind of suggest—and I will describe it two ways—that really what the federal government is doing is deciding on health care contribution and giving it to the employee? The federal government is really not negotiating and purchasing a plan to offer; it is just saying, "We have reviewed these things, they look like they are well run, and you use the money we gave you as you see fit."

MORRISON: Basically, that is what they are saying. In terms of the personal choice, it is clearly the individual's discretion.

Q: Blue Cross/Blue Shield does a lot of risk-rating. If a high-risk employee comes into the work force, that is obviously reflected in the rating of the plan.

MORRISON: There are no waiting periods, no risk-rating or personal underwriting, if you will, in the Federal Employees Health Benefits Plan.

Q: Are you sure the insurance industry is going to be real eager to cover 37 million uninsured people?

MORRISON: Well, that is one of the hallmarks of everybody's program. It has got to have universal coverage. Some people are even going beyond that and saying that even in an employer-based system you should have portability, the ability to take your health benefits package wherever you go. I think that the industry has got to look at some kind of reform.

Q: I think, looking to a possible reform plan, one could almost take the Heritage plan, using its credits and vouchers, basing them on a sliding scale and melting it with a managed competition system that looks like the FEHBP. You kind of say everybody can have a spending account, the government will subsidize it up to a certain level. You could combine the two. You can answer it with the Heritage plan, but you couldn't control the specific consumer purchases. You have to buy something to get the federal health tax break, either a tax sub-

sidy or credits and vouchers for low-income people. It is like a partnership, where it meets the minimum standard benefit package.

MORRISON: It is certainly worth looking at. I would hope that the Clinton Administration will take a good look at this program and how it has worked, and not fall victim to the ever-growing stack of reports that the FEHBP has got to be totally redone and made over into a single model.

MOFFIT: I don't have a crystal ball. But consider the dynamics of the debate on health care. Think about what has happened in the health care debate over the past three years. Three years ago if you talked about national health care reform, virtually everybody "in the know," all the health care policy nerds and wonks for sure, were talking about a Canadian-style system. It was inevitable that we were going to have some kind of national health insurance. Right now, I think it is fair to say that a Canadian or British style system is simply not on the agenda of the major players on Capitol Hill. If you were talking reform about a year ago, if you talked about national health care reform, you talked about "play or pay." It said, basically, that there should be a legal requirement that employers either pay a payroll tax or provide private health insurance for their employees. That option has started to slip slowly beneath the waves, largely because of the payroll tax on small business, even more so because of the damage that has been done to "play or pay" by the work of my Heritage colleague, Dr. Stuart Butler, including his congressional testimony, and by the work of Urban Institute. Their scholars made the point that a 7 percent payroll tax would throw 51 million Americans out of their private insurance. That was a scary proposition. Senator George Mitchell, who has been running around the Hill for the past eighteen months trying to get support for that option—has gotten only ten co-sponsors. Now, we see Bill Clinton moving from the "play or pay" option to something that looks simply like mandatory insurance or employer-based insurance. Bill Clinton's idea, in all its essentials—a flat employer mandate—was on the ballot in California. But as of 8:30 on Wednesday morning, the day after the 1992 election, it was going down 68 percent to 32 percent. That was also the plan backed by organized medicine. For advocates of that approach, the debate was lost.

So, what we have seen really over the past several months is a dramatic change in the terms of the debate. When you have the Democratic standard-bearer using the language—the very user-friendly language—of "managed competition," as something he repeats in the debates and repeats on the stump, we are not debating the merits of socialized medicine.

The bigger question facing us all, of course, is whether in fact Bill Clinton is going to retain a Canadian or British-style "global budget" with the rack of price controls modelled after the Medicare system. That is a critical element in the political equation in the next few months. My guess is, he won't be able to sell it to the folks, once they understand its implications.

So, I think the debate is moving in the right direction. The fact that we are actually looking at the emergence of "managed competition," plus the Hatch Bill in the Senate embodying the reforms proposed by the Heritage Foundation, plus the growth of the popularity of medical savings accounts, augurs well for the coming debate.

Q: I am interested in perhaps how Medicare might respond to the FEHBP. I have heard more primary care physicians complain about Medicare. Is there any way that perhaps Medicare could be funded the way the FEHBP is, and get some of that cost under control?

FRANCIS: That is a very interesting question. It is not a new question. It is not one that is discussed openly, I'll tell you that. But there are a lot of people who help run the Medicare program who would like to see some radical reform. They know better than anybody the weaknesses of their own program. It is very hard for me to predict. If I were the President, being a prudent man, I would probably not mess very much with Medicare until I had this other system in place. Then, maybe over the long haul, I might push Medicare in that direction. Consider, the managed care initiative within Medicare. I mentioned they only have 3 percent of their people in HMOs. The people running the program would like to have a lot more. They haven't yet found the right combination of incentives.

Then there are other problems on the Hill. There are a lot of people on the Hill who are very distrustful of managed care in general and HMOs in particular. Some of those people chair the relevant committees in the Congress. They are afraid that old folks will be taken advantage of, and there have been some scandals in Florida and in California. There is a whole raft of considerations. I just don't know how to predict it. Another problem with Medicare, as Bob just suggested, is that because the federal government buys so much medical care through Medicare, it has immense monopoly power. The temptation to use price controls to save money, rather than competition to save money, is a siren song. The cost-shifting that now occurs, once the federal government assumes a greater responsibility for health insurance for everybody, becomes a zero-sum game. If you shift it out of Medicare, it is popping up in the other pot. That is going to be a factor.

Payment in the Medicare system is generally problematic. Let me give you one small example: Medicare has been trying to reform its payment for durable medical equipment. In the last five or six years, Congress has rewritten the statute about how much we pay for wheelchairs and walkers and canes four times in a five-year period, each time undoing what it did the previous time. We wound up paying more for walkers, wheelchairs, and canes than if we had never touched the damn thing at all. As I was saying, the government can use price controls. Actually, it is not always so easy to come up with a system that works. I really wouldn't predict early Medicare reform, particularly as it relates to managing high-tech costs.

Another example is case management, an easy evolution in the FEHBP. You offer the enrollee an extra benefit if he will put himself in your hands. "We will give you more home health care and get you out of the hospital, Mr. Jones, and so on." That is a deal that an independent health plan can offer. An extra benefit in Medicare? No way. You can't offer a benefit to one person that all 35 million of them don't get. The political system can't tolerate that, so it is really constrained. I don't know how a breakthrough will be made. My guess is not right away, but sooner or later it will happen.