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CONGRESS'S OWN HEALTH PLAN AS A MODEL FOR MEDICARE REFORM

INTRODUCTION

As Congress begins work on a reconciliation bill to put into place legislation to flesh out the entitlement spending targets of the recent budget agreement, lawmakers are considering ways to reform Medicare. These reforms not only must achieve the short-term budget targets, but also must begin the task of achieving structural reforms that will bring about long-term savings through efficiency while modernizing and improving the program.

An increasing number of lawmakers, among them Senators John Breaux (D–LA), Connie Mack (R–FL), and Ron Wyden (D–OR), have shown an interest in reforming Medicare by introducing key features of the health care system that covers Members of Congress and over 9 million other federal employees and retirees. This program—the Federal Employees Health Benefits Program (FEHBP)—has been attracting a great deal of attention recently, including a day of hearings before the Senate Finance Committee. Using the FEHBP as the foundation for Medicare reform would be compatible with the outline of reform now being prepared by the leadership in both houses of Congress.

This growing interest is hardly surprising. The FEHBP and Medicare both are large programs run by the federal government, but the similarity ends there. The FEHBP is not experiencing the severe financial problems faced by Medicare. It is run by a very small bureaucracy that, unlike Medicare's, does 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 that blends a formula with negotiations to achieve a remarkable level of cost control while constantly improving benefits and enjoying wide popularity.

The FEHBP experience should convince Congress that, with some modification of the basic FEHBP design, it is possible to design a stable choice system for people on Medicare that would provide constantly upgraded benefits to retirees. As former Congressional

Budget Office (CBO) Director Robert Reischauer recently testified, the "FEHBP shows that it is possible to create a smoothly functioning market system of national scope in which a number of different types of plans compete for enrollment." Reischauer added that the "FEHBP's experience also suggests that an effective competitive market can function without a sophisticated mechanism for risk adjusting payments to plans."[1]

If Congress is to improve Medicare by incorporating features of the FEHBP, however, it is crucial that Members understand the FEHBP's key ingredients, how it really works, and precisely which of its features should be incorporated, not incorporated, or modified if they are incorporated into Medicare.[2]

KEY FEATURES OF THE FEHBP

The FEHBP offers a wide range of plans with a variety of benefits. Although there are some adverse selection pressures in the system, these are surprisingly small considering the fact that the FEHBP by law is community rated (the same premium must be charged to everyone without regard to age and other risk factors) and that there are wide plan variations. The key features are:

1. **A stable premium structure.** Premiums and other enrollee costs have been kept well in check. For much of the FEHBP's recent history, premiums have risen no faster than those in the private sector; in many years, they have fallen below those of private plans and Medicare. As the Congressional Research Service (CRS) noted in 1989, the "rise in private sector premiums in the 1980s exceeds FEHBP's."[3] Later studies have shown similar cost control. In fact, premiums have been quite flat. The average FEHBP plan premium rose 0.4 percent in 1996 and 2.4 percent in 1997. In 1995, the premium actually fell 3.3 percent.

2. **Negotiated premiums in a competitive market.** Unlike Medicare, the FEHBP does not pay fee-for-service providers according to a fee schedule and does not pay managed care plans according to a rigid formula. Instead, it invites plans to submit a package of benefits at a proposed premium, and then negotiates prices and benefits plan by plan. Each approved plan, along with competitors, is offered to federal workers and retirees. The FEHBP pays a percentage of the negotiated premium, up to a dollar limit.

3. **Many competing private plans.** The FEHBP plans include several offered by employee cooperatives and major unions. One reason these plans are popular is that they are organized by groups that actually represent enrollees rather than by health maintenance organizations (HMOs) or insurance companies that often perceive the enrollee as a passive buyer in an individual market. This feature could be particularly attractive in a reformed Medicare system. One might imagine, for example, plans offered through the American Association of Retired Persons, major unions, or even churches.

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1 Robert D. Reischauer, *Medicare Reform and the Federal Employees Health Benefits Program*, testimony before Committee on Finance, U.S. Senate, 105th Cong., 2nd Sess., May 21, 1997.

2 Much of the factual information in this study is drawn directly 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), pp. 47–61, and the People-to-People Health Foundation, Project HOPE, *http://www.projhope.org/HA/*.

3 Congressional Research Service, *The Federal Employees Health Benefits Program: Possible Strategies for Reform*, 1989, p. 255.

4. **Information dissemination.** The FEHBP has a comprehensive system of information distribution, complemented by a sophisticated system of information provided through consumer organizations, to help beneficiaries make choices. This could be a model for Medicare, which has been roundly criticized by the U.S. General Accounting Office (GAO) for its relatively poor information system.[4]

5. **Negotiated service contracts.** Negotiations on premiums and benefits are held between the Office of Personnel Management (OPM), which runs the FEHBP, and individual plans. For HMO and point-of-service (POS) plans, the 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 preferred provider organization (PPO) plans, the OPM negotiates a fixed profit per subscriber, usually between 0.5 percent and 0.75 percent of premium. Thus, plans make money through negotiated service contracts rather than traditional profits. Although these plans have to accept market risk, they must lodge revenue surpluses in special reserve accounts that 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.

6. **Low overhead costs.** The FEHBP indicates that a large national program for millions of people, with a wide variety of plans and benefits and careful negotiations between the government and the plans, can be run with a fraction of the staff now running Medicare. As Reischauer notes, the OPM "accomplished the task [of running the FEHBP] in 1996 with a staff of fewer than 150 full-time equivalent employees and a modest administrative budget of around $20 million."[5]

7. **Less regulatory control.** Those who choose plans in the FEHBP are not locked into a comprehensive government-standardized benefits package. There are no premium caps on private insurance plans. There is no Department of Defense–style system of competitive bidding to determine which private plans can or cannot compete for employees' dollars. There are no government boards or panels setting rigid standards for the quality of medical care or specifying the value of a doctor's labor in the delivery of medical services. Private insurance companies, competing for each consumer's dollars, bear the lion's share of administrative costs, and the role of government bureaucracy and regulation is comparatively small.

REFORMING MEDICARE TO INCORPORATE LESSONS FROM THE FEHBP

Many of the these key features of the FEHBP should be incorporated into a reformed Medicare program, in some cases with changes that would improve on the FEHBP. Specifically, Congress should:

1. **Create** a semi-independent congressionally appointed board to operate traditional fee-for-service Medicare in all parts of the country. The board would have power to make

4 *Medicare Managed Care: HCFA Missing Opportunities to Provide Consumer Information*, testimony of William Scanlon, U.S. General Accounting Office, before Special Committee on Aging, U.S. Senate, 105th Cong., 1st Sess., April 10, 1997.

5 Reischauer, *Medicare Reform.*

variations in the benefits, including deductibles and co-payments, subject to an up-or-down vote by Congress without amendment. This would give the traditional program more flexibility to modernize and compete with HMOs now in Medicare.

2. **Require** the traditional fee-for-service plan to include catastrophic protection and offer full Part A and Part B benefits at a stated premium, to be negotiated each year.

3. **Change** the government payment system to an FEHBP-style percentage of premium or health costs, but with the assurance that all the elderly and disabled receive enough assistance in the future to afford good care. The Physician Payment Review Commission (PPRC), which advises Congress on Medicare payments, in its 1997 report examined a variety of ways in which FEHBP-type payment systems could be applied to Medicare.[6] The best structure might be to pay a percentage of the premium above a fixed dollar contribution, with a ceiling placed on the total government contribution linked to the cost of the area's traditional fee-for-service plan. In that way, those choosing a less expensive plan would have most or all of the cost covered, while an enrollee in the traditional program would know that he or she always would be able to afford that plan as well.

4. **Invite** initial bids from private plans meeting specified minimum requirements (including, for example, requirements on information disclosure and underwriting limitations). Then allow the Health Care Financing Administration (HCFA) to negotiate premiums and benefit packages, as well as service areas, with individual plans before agreeing on a final price-and-benefits package that is 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 Medicare fee-for-service plan also should be required to offer a bid, with the price established through negotiations in conjunction with Congress.

5. **Operate** an annual open season in which retirees can choose a plan for the following year.

6. **Experiment** with risk adjusters to adjust payments to different plans according to the likely costs associated with the beneficiaries who enroll in them (something the FEHBP does not do). The PPRC indicates in its 1997 report that very simple methods could deal with many of the risk differences experienced by the plans.

Lessons of the FEHBP

Created by Congress in 1959, the Federal Employees Health Benefits Program 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—almost 9 million people.[7] The FEHBP works well despite some problems of enrollment and design, and these problems could be dealt with easily in a redesigned Medicare program that significantly improves coverage for the nation's elderly and disabled.

6 Physician Payment Review Commission, *Annual Report to Congress*, 1997, chapter 9.

7 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.: American Enterprise Institute, 1995), pp. 269–307.

The FEHBP population is not an ideal insurance pool. For one thing, the FEHBP population of active employees is generally older (43.8 years) than employees in the private sector (37.4 years).[8] For another, enrollment is optional and eligibility requirements are quite liberal. Also, plans may not impose waiting periods, limitations, or exclusions from coverage for pre-existing medical conditions.

Further, because the proportion of higher-cost federal retirees in the program has grown steadily, the proportion of higher-cost enrollees in the FEHBP has grown as well. In 1975, 858,000 retirees comprised 27 percent of FEHBP policyholders; by 1992, some 1.6 million retirees accounted for 40 percent of policyholders.[9] The average age of those covered in the program (which includes dependents) also has been increasing, according to OPM actuaries,[10] but the program's strict community rating requirement prevents plans from pricing their coverage differently for this higher-risk group.

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 currently are enrolled in HMOs. All HMOs in the FEHBP offer benefits, including catastrophic coverage and mental health coverage, that are especially attractive to the elderly. Almost all cover the care received in an extended care facility, some with no dollar or day limits. No federal retiree has a range of choice that includes fewer than seven plans.[11]

The National Association of Retired Federal Employees (NARFE), the major private 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 prostrate cancer tests for men over 40, and stop smoking programs." Unlike Medicare, most FEHBP plans cover prescription drugs and include a wide range of dental services; in addition, the elderly can choose very specialized items, such as diabetic supplies.

How the Elderly Pick Plans

Each year, in preparation for the annual fall open season in which retirees and regular employees pick plans for the following year, the 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. Perhaps the most valued consumer resource for federal employees and retirees is *Checkbook's Guide to Health Insurance Plans for Federal Employees*, which is published by a consumer organization. The popular *Guide* compares plans; gives employees and retirees

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

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

10 Information from Nancy Kichak, Director of the Office of Actuaries, U.S. Office of Personnel Management.

11 W. Smith, ed., *Federal Health Benefits Information and Open Season Guide, 1995* (Washington, D.C.: National Association of Retired Federal Employees, 1994), pp. 14, 62.

general advice on how to pick a plan; outlines plan features and special benefits; presents detailed cost tables (including out-of-pocket limits for catastrophic coverage); and provides customer satisfaction surveys on the performance of plans. It also includes 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 and allow workers to rate plan performance in such areas as access to care, quality of care, availability of doctors, willingness to provide customer information and advice by phone, ease of getting appointments for treatments or checkups, typical waiting times in the doctor's office, access to specialty care, and follow-through on care. They 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.[12]

Federal retirees also receive additional guidance from NARFE, which represents 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 to answer questions and resolve problems related to health insurance and retirement. In preparation for open season, NARFE publishes its annual *Federal Health Benefits and Open Season Guide*.[13] Most important of all, it rates plans on benefit packages that would be most attractive to the elderly. NARFE ranks Alliance and Blue Cross/Blue Shield, for example, as the best choices for prescription drugs.[14]

The Role of the Office of Personnel Management

The FEHBP statute gives the OPM the authority 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 fund that contains contributions from the government and enrollees, and from which all payments to health plans are made.[15]

Unlike the HCFA, the OPM does not impose price controls or fee schedules, or issue detailed guidelines to doctors or hospitals on standardized benefits. Private plans within the FEHBP must meet "reasonable minimal" standards regarding benefits,[16] but the law creating the FEHBP does not specify a comprehensive set of standardized benefits. Congress merely defines the "types" of benefits that "may be" provided.[17]

12 W. Francis, ed., *Checkbook's Guide to 1995 Health Insurance Plans for Federal Employees* (Washington, D.C.: Washington Consumers' Checkbook, 1994), pp. 49–79.

13 *Federal Health Benefits Information and Open Season Guide, 1995,* p. 50.

14 *Ibid.,* p. 63.

15 This summary of legal authorities may be found in CRS, *The Federal Employees Health Benefits Program*, p. 238.

The OPM sends out an annual "call letter" in spring to insurance carriers, inviting them to discuss rates and benefits for the following calendar year.[18] In these confidential discussions, the 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, the OPM must make its calculations according to a formula established by law. The 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 plans. This is commonly called the "Big Six" formula.[19] The 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. This maximum contribution in 1995 was $1,600 for individuals and $3,490 for families. The formula has one other crucial adjustment: In no case can the federal government contribute any more than 75 percent of the cost of any plan's premium. 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.

The 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. The OPM maintains an Open Season Task Force to help in making decisions, as well as a hot line that retirees (or regular workers) can call during open season.

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

Adverse Selection

Even though the FEHBP has been successful, there have been two persistent and interrelated problems associated with its design: adverse selection and an outdated system of insurance underwriting.

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16 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 of Federal Regulations,* Chapter 16, 1602.170–8. The minimum standards for health benefits carriers include a requirement that the carrier be lawfully engaged in the business of supplying health benefits and meets 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." The 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.

17 *United States Code*, Title 5, Section 8904.

18 In this process, the OPM maintains strict confidentiality. OPM staff members historically have not shared the document even with the Office of Management and Budget.

19 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 members have used a mathematical formula to calculate the service indemnity component of the Big Six formula.

Adverse selection, an irritant for many years, is exacerbated by the strict community rating requirement but has not undermined the program. The OPM has taken steps to limit the variation in benefit packages, to limit some of the risk selection, and (during the negotiation process) to allow some plans with particularly generous packages to eliminate some benefits. Even so, however, in its exhaustive 1989 analysis of FEHBP strengths and weaknesses, the CRS concluded that the program was structurally sound: "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."[20]

USING THE FEHBP TO REFORM MEDICARE

Transforming Medicare into a program similar to the FEHBP would mean fundamentally changing the role of the federal government, and more specifically the Department of Health and Human Services (HHS) and the HCFA. It would mean that instead of setting prices, paying for specific services, and regulating virtually every facet of the system, HHS (like the OPM in the FEHBP system) would 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.

A new Medicare system conforming to this framework should be designed to include four elements: (1) changing the government's role, (2) changing the Medicare payment system, (3) implementing a system for negotiating with competing plans, and (4) setting standards for participation by a plan.

Element #1: Changing the Government's Role

In a reformed Medicare system based on the FEHBP, HHS would have monitoring and payment clearinghouse functions similar to those of the 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 run any plans, any more than the 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. It would no longer run that plan, however. Instead, Congress would establish a federally sponsored not-for-profit corporation to administer a Medicare Standard Plan. This corporation would be governed by its own government-appointed board and would offer the standard Part A and Part B Medicare benefits and charge a premium. Each year, however, the board also would present to Congress recommended changes in the services, premium, deductibles, and co-payments 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 (described below) to submit bids to offer a set of services to the elderly. The HCFA, within HHS, would negotiate with each plan on benefits, premium, service area, and other questions, after which the plan could be offered to Medicare beneficiaries.

20 CRS, *Federal Employees Health Benefits Program*, p. 231.

C. Like the OPM in the FEHBP system, the HCFA would conduct the annual Medicare open season in which private plans would compete for consumers' dollars. 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 with standardized information on prices, benefits, and consumer satisfaction for Medicare-approved plans in their area, including the Standard Plan. Beneficiaries also would receive a selection form on which to indicate their choice.

D. Once the selection had been made, the HCFA would send the appropriate contribution to the chosen plan (described below). The beneficiary would be responsible for any difference between that amount and the premium costs, but could elect to have the government pay that difference and reduce the beneficiary's Social Security check (similar to the Part B option today). If no plan was selected, the beneficiary would be assigned to the Standard Plan.

Element #2: Changing the Medicare Payment System

There has been considerable interest in recent years in refining how the government makes payments for the care of Medicare patients. One concern 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; under this approach, however, an arbitrary budgeted contribution could leave seniors with 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 A: A market-adjusted but government-set contribution to plans. Although the FEHBP does not use a fixed contribution to make payments to plans (it uses a percentage of the premium with a limit), a modified contribution 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, the 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). The basket would comprise typical plans, such as the Medicare Standard Plan, a catastrophic/medical savings account (MSA) plan, a Blue Cross standard plan, and a comprehensive HMO plan. This is a refinement of the Big Six formula used by the OPM to set the government contribution to the FEHBP. The calculation of the Medicare contribution would be made *after* the plans had filed their price and benefit information for the open season so that the contribution reflects the 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 new program's initial year would be divided by the number of eligible individuals to determine a base rate for the contribution. In future years, the combined cost of the contribution would be adjusted in line with the Medicare budget to determine the base rate for the year. This base rate then would be adjusted according to three factors:

- **Primary risk.** The base rate would be adjusted according to the enrollee's age, sex, reason for eligibility (age or disability), institutional status, and end stage renal dialysis 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 (see explanation below).
- **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 according to the beneficiary's income. 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 would 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 B: A negotiated premium with a formula payment. A possibly more attractive variant is first for the HCFA to invite bids and negotiate benefits and premiums, as outlined above. Plans would have to contain a core set of benefit categories or types of benefits, determined by statute, including catastrophic protection. It should be noted that such a core benefit requirement is materially different from a comprehensive government-standardized benefit package in which levels of benefits, and even specific treatments and medical procedures and their duration, are set forth in meticulous detail.

A minimum contribution would be determined by the government, based on the average cost of plans in the area. The HCFA then 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 weaken slightly the incentive to seek the best value for money because 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: Implementing a System for Negotiating with Competing Plans

If the HCFA were to negotiate with Medicare plans, as the OPM does under the FEHBP system, ground rules for both private insurers and government negotiators would have to be understood clearly by private insurers and government officials. The OPM's negotiation with a host of private insurance plans is sensitive and unique in the processes of government.[21]

To participate in this negotiating process, interested private insurance plans would be required to submit an application to the HCFA or to the relevant government agency. These applications should disclose qualifying information such as financial solvency, certification by state insurance agencies as plans lawfully engaged in the selling of health insurance coverage, the service areas they cover, the benefit coverage they will offer, a description of their delivery systems, and their premium charges. If plans disclosed this information in a satisfactory fashion, meeting the basic requirements, they would be qualified to enter into the negotiating process with the government. Using the FEHBP-style model, qualified plans would be required by law to offer a core package of benefits, including catastrophic coverage, and these benefits would be identified in terms of category or type (such as hospital and physician services). Specific benefit levels, or copayments, deductibles, or coinsurance, would not be defined by statute or prescribed by the HCFA in regulation. Benefit levels, or the inclusion or duration of medical procedures and treatments, would be left entirely to the negotiating process.

Government officials would have a legal obligation to negotiate with private plans on a confidential basis. Negotiation would cover such topics as the adequacy of coverage levels and alternative combinations of benefits, the accuracy of proposed marketing materials, the ease of consumer access to the plans' customer service representatives, the presence of a dispute resolution process for claims, and the reasonability of proposed premiums. HCFA officials also would make sure that Medicare beneficiaries would be able to contact any approved plan directly to get additional information either on benefits or coverage. Like officials at the OPM, HCFA officials would be expected to be sensitive to changing conditions and opportunities in the health insurance market and to be flexible in their dealings with private insurance companies that must meet consumer demand in a highly competitive environment.

If Members of Congress have serious reservations about the ability of the HCFA—which is primarily a regulatory body—to carry out such sensitive responsibilities, they may wish to detail OPM staff to the task of negotiating rates and benefit levels for the country's retirees, just as the OPM does today for retired Members of Congress and federal workers.

Just as the OPM is responsible for enrolling federal retirees, the HCFA would be responsible for enrolling Medicare beneficiaries. The HCFA would be required to notify all Medicare beneficiaries of approved plans in their areas in advance of a six-week to two-month open season period. Any plan changes, such as disenrollment as a result of death, would be the responsibility of the HCFA. Moreover, new premium payments to health plans would be made by the HCFA and would include both the government's share and the enrollee's share (if any), and would be handled as a deduction from Social Security, just as the Medicare Part B premium is handled today.

Element #4: Setting Standards for Participation by a Plan

Any private health plan would be eligible to take part in the Medicare program, providing it met certain requirements. These requirements would apply to plans marketed by

21 For advice on establishing the conditions of a negotiation process for private plans in a reformed Medicare system, the authors are indebted to James Morrison, formerly Associate Director of Compensation at the OPM. A high-ranking career civil servant who supervised FEHBP negotiations with private health insurance plans, Morrison served at the OPM during the Carter and Reagan Administrations.

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 or types of plans available in an area, and plans could operate in different service areas and provide different benefits. A plan could gain approval to market to the Medicare population if it:

A. Has a license to issue health insurance or operate a health plan 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) while still offering 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 (for example, age and institutional status); 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.

F. Accepts and continues coverage for any Medicare beneficiary applying during the annual open season.

ISSUES ASSOCIATED WITH THE PROPOSED SYSTEM

Under this reformed system, Medicare would operate in much the same way as the FEHBP operates in serving retired federal workers and retirees. Beneficiaries would be able to pick a private plan that included the services they wanted beyond the core package, with these services delivered in the way they wanted—perhaps, if they wished, through an organization with which they were affiliated (as many FEHBP enrollees do). Or they would 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 price, quality, and service objectives.

The organization of services, selection of benefits, and payments to providers would be in the hands of plan managers competing for enrollees. Unlike the federal officials managing Medicare today, these managers would have the freedom and financial incentive to experiment with new ways to deliver care at a competitive price.

In stark contrast to the present situation, the HCFA would have no role in setting the provider reimbursement rates, deductibles, or cost-sharing levels of any private plan and no role in requiring benefits beyond the care benefits required by statute. The federal

corporation, not the HCFA, would be responsible for these decisions in the case of the Medicare Standard Plan.

Issue #1: Can a Consumer-Choice System Reduce Costs?

Whether the proposed program reduces costs depends on how it addresses two distinct aspects of cost. The first is total net outlays of the Medicare trust funds: In other words, would it cut the government's Medicare budget? The second is 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? Linked to this second question is another: Could the government's contribution be designed so that it tracks, in a reasonably accurate way, the market costs of serving enrollees with certain health conditions in different places?

A defined contribution, in contrast to 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? There are good reasons to expect that this combination of market competition and enrollee incentives would reduce the growth of total medical costs for, 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 there has been so little scientific research on the program. In spite of its design shortcomings, the FEHBP generally has outperformed both private-sector employer-based health insurance and Medicare; in fact, it has outperformed Medicare by a significant margin. In a comprehensive 1989 study, the CRS concluded that cost increases were lower in the FEHBP than in the private sector.[22] Subsequent analyses have come to similar conclusions.[23] Analyzing the FEHBP's premiums in the 1980s, for example, the health care econometrics firm 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."[24] In 1995, health benefits expert Frank McArdle concluded that the rate of premium increase had been lower for the FEHBP than for the private sector.[25]

During the 1990s, the FEHBP's premium performance has been remarkable. In 1994, the average annual premium increase was only 3 percent, and 40 percent of all enrollees, including retirees, saw decreases in their premiums. In 1995, the entire program experienced an average annual *decrease* in premiums of 3.3 percent. More recently, premiums have risen by an average of 0.4 percent in 1996 and 2.4 percent in 1997.

Another reason to feel confident about converting Medicare into a system of competing and flexible plans is that the current system is so far behind other sectors in introducing design innovations. Enrollment in HMOs is growing but still small, for example, while PPOs are heavily restricted and point-of-service plans have become available only

22 CRS, *Federal Employees Health Benefits Program*, p. 231.

23 See 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, Va.: Lewin–ICF, 1992).

24 Dobson et al., *Comparison of Premium Trends*.

25 Frank McArdle. "Opening Up the FEHBP," *Health Affairs*, Vol. 14, No. 2 (Summer 1995).

recently. Even though the very elderly currently enrolled in Medicare might be disinclined to switch to different service arrangements, more recent retirees and the disabled typically are quite familiar with new kinds of health plans because of their experience during their working years. 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 reduce the growth in total costs sharply. One recent study estimates that an increase of 10 percentage points in HMO market share within Medicare would be associated with a decrease of 1 percent to 3 percent in aggregate Medicare spending.[26]

The FEHBP obviously does not operate in a market devoid of government efforts to regulate prices. Government managers negotiate premiums before they are posted for the open season, and some who view consumer-based approaches with skepticism suggest that this means the "price maker" power of a government buyer actually holds down costs because plans are afraid of losing access to their market.[27] Nonetheless, the plans still must design and price their product shrewdly, competing strongly with each other for enrollees, if they are to remain in business. Significantly, the OPM devotes most of its negotiating energy to the large plans that undermine the government's maximum contribution, and generally ignores the pricing of other plans, so it is not clear that the government's jawboning function is more important than this competition for price-sensitive enrollees in holding down costs. What is clear is that the OPM's bargaining with competing plans is far more successful at holding down costs than is the HCFA's issuing of edicts to hospitals and physicians.

Enrollee Costs in Local Markets. The enrollee's financial exposure is affected by the local market, not just by the economics of the system as a whole. To keep this exposure reasonable, the contribution amount must closely track the local market cost of serving an individual with the enrollee's health care needs.

The closest equivalent to this in Medicare today is the AAPCC that is used to pay HMOs in the system. 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.[28] For example, all HMOs in an area are paid the same capitation rate linked to fee-for-service costs. In some cases, this is more than Medicare would pay for a particular enrollee in fee-for-service, so HMOs frequently can 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, as well as for incorporation of more sophisticated risk adjustments.[29]

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26 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.

27 See Joseph White, "Managing Health Care Costs in the United States," in *Health Care Reform through Internal Markets: Experiments and Proposals* (Washington, D.C.: Brookings Institution, 1995), p. 148.

28 See, for example, U.S. General Accounting Office, *Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs,* GAO/HEHS–94–119, September 1994. See also Jonathan Ratner, GAO, testimony before Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 104th Cong., 1st Sess., May 24, 1995.

29 See Gail Wilensky, "Incremental Health System Reform: Where Medicare Fits In," *Health Affairs,* Vol. 14, No. 1 (Spring 1995), pp. 179–180.

A defined contribution approach can deal with these deficiencies because it introduces an incentive that is very different from that of the risk contract system. Because it represents a degree of financial support for an enrollee choosing between plans with different prices, not a full payment made to a plan, it triggers a much stronger price/quality competition between plans seeking enrollees. Plans would not be able to price themselves to take advantage of the shortcomings in a bureaucratic structure of capitation payments; instead, they would 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.

Issue #2: Is Adverse Selection a Serious Problem?

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

The proposed system, without any special risk-adjustment mechanism in addition to the primary risk factors used for the contribution and premiums, would result in a stable market with acceptable differences in cost. Nevertheless, it would be wise to establish a review commission to monitor this aspect of the program and to recommend additional risk adjusters if necessary. There is little research available on how problematic undesirable adverse selection might be in a reformed Medicare program, but 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 a perfectly healthy 19-year-old exactly the same premium as someone who is chronically sick at 89 years of age. The FEHBP also has no special risk-adjustment mechanism. This would seem to be an open invitation to destructive adverse selection pressures; but even though there clearly is some adverse selection in the program, it is remarkably stable.

The proposed Medicare reform incorporates the features of the FEHBP that help to withstand destructive adverse selection and includes other features that improve on the FEHBP in this regard. Three features are particularly important.

- **First,** it limits plan switching to once a year, using the same open season procedure as the FEHBP (in today's Medicare, an enrollee in the risk contract sector may switch after just 30 days). 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,** it allows 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 of seeking out enrollees who are likely to be healthier because of their demographic characteristics. Adjusting the contribution according to the primary risk categories also would insulate enrollees in higher risk categories from their generally higher premium costs.
- **Third,** it incorporates central marketing and information distribution arrangements (an elaboration of the FEHBP open season) to help limit cherry picking by plans. Because Medicare enrollees would receive standard information on

all plans in their area, it would be impossible for plans to "hide" from applicants they do not desire; to retain their approved status and continue marketing to Medicare enrollees, plans also could be required to adopt other marketing guidelines to reduce unfair practices.

But if traditional Medicare continues as an option for beneficiaries, as it should, 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?

Although both results are theoretically possible, especially if the government-operated plan remains as inflexible and outdated as today's Medicare system, the design of the proposed system reduces this danger. For one thing, because every plan's premium would be adjusted by the major risk factors, 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 contribution. For another, the contribution 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 contribution and thus helping to limit the potential for large net costs to enrollees in the Standard Plan. Moreover, there could be a percentage contribution to premiums in addition to a basic level of contribution, as suggested earlier (and like the FEHBP system), so that enrollees who feel they need more elaborate care would receive a larger contribution—one large enough to afford the traditional fee-for-service plan in any area.

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 was 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 efficiently and satisfy consumers, those consumers must be armed with the information they need to make good decisions. Because health care decisions can be confusing enough for young, well-educated people, it is certainly reasonable to ask whether elderly people—who often 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 health care decisions, but several categories are suggested. These include premium and likely out-of-pocket costs, benefits, information on customer satisfaction, and some measurements of quality.[30] In the information clearinghouse function assigned to HHS, standardized consumer information on prices and benefits would be included, as would such information as categorization of plans (similar to the Medigap market); typical costs for certain illnesses, perhaps using the "illness episode approach"; and patient evaluations such as those prepared for FEHBP enrollees by Washington Consumers' Checkbook. To make this information as helpful as possible, it would make sense to create

30 For a discussion of this issue, see Shoshanna Sofaer, "Informing and Protecting Consumers Under Managed Competition," *Health Affairs*, Supplement 1993, pp. 76–86.

a consumer advisory board, consisting of representatives of Medicare beneficiaries and the health care industry, to recommend to the 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.

CONCLUSION

Congress's own health plan, the FEHBP, is one of Washington's unsung success stories. For many years, it has given Members of Congress, as well as millions of active and retired federal employees, a range of modern plans and benefits unavailable to Medicare beneficiaries. And it has done so while keeping costs firmly under control. The FEHBP also includes tools for operating a choice system that could be the model for long-term reform of Medicare.

It is time to reform Medicare to make the same advantages available to America's seniors.

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