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How Washington Can Improve Health Care Coverage for Federal Workers and Their Families

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Members of Congress, their staffs, and millions of other federal workers and retirees are now choosing their private health care coverage for 2002 from almost 200 plans available nationwide. These enrollees in the Federal Employees Health Benefits Program (FEHBP) have repeatedly reported satisfaction with their chosen coverage under this 42-year-old consumer-driven health insurance system.[2] Their choices include fee-for-service, preferred provider organization, and managed care plans, including those sponsored by unions and employee organizations.[3] Because of federal tax and regulatory policies, no other Americans enjoy such a wide range of choice.

A Troubled Program. Yet the FEHBP is a troubled program. Next year, continuing a recent trend, it faces a projected premium increase of 13.3 percent. In some respects, the FEHBP's problems reflect its unique character as an insurance program exclusively for the aging federal workforce with a large and growing retiree population. Of the 4.2 million active employees and retirees enrolled in the FEHBP, the average age is 54; in the Blue Cross and Blue Shield Service Benefit Plan, one of the largest competitors in the FEHBP, the average age is 60.[4]

Nor is demographics the only reason the FEHBP is experiencing problems. Its difficulties result primarily from shortsighted, outdated government policies that are inherently incompatible with the free-market principles of choice and

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1. This paper is based in part on testimony before the Subcommittee on Civil Service and Agency Organization, Committee on Government Reform, U.S. House of Representatives, by the author on October 16, 2001. Rachel Goldstein, a student at Brandeis University and a Heritage Foundation intern, contributed to the research for this paper.
2. For an overview of the FEHBP, see Walton J. Francis, "The Political Economy of the Federal Employees Health Benefits Program," in Robert B. Helms, ed., *Health Policy Reform: Competition and Controls* (Washington, D.C.: AEI Press, 1993), pp. 269–307; see also Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employee Benefits Program," Heritage Foundation *Backgrounder* No. 878, November 9, 1992.
3. The American Postal Workers Union, the Mailhandlers, the National Association of Letter Carriers, and the Government Employees Hospital Association are among the groups that will sponsor FEHBP plans next year.

competition that lie at the heart of the program. These contradictory policies reflect the thinking of those who administer the program in the Office of Personnel Management (OPM). Judging from their public comments to the media, they too often appear to have little appreciation for its unique character as a market-based system or the principles upon which it is based.

All of these factors converge so that the FEHBP today is working less effectively and less efficiently than it should. Problems include the following:

- **Artificial restrictions on plan options, including less expensive plans.** The FEHBP is one of the few extant models of a competitive health insurance market, yet it is governed by policies and practices that are inconsistent with the functioning of a normal market. Restrictions imposed on supply include administrative or statutory barriers to such plans and options as high-deductible plans, new fee-for-service plans, medical savings accounts (MSAs), and flexible spending accounts (FSAs). Restricting the supply of services in a market constitutes a deliberate distortion of that market that drives up costs and premiums.
- **A steady growth in benefit mandates and regulation and a decline in plans.** Over the past decade, OPM—sometimes with Congress's authorization—has imposed benefit requirements on the programs while expanding its own regulatory reach. According to OPM, between 1991 and 2001, it made 44 benefit changes in the program, including the introduction of new regulatory initiatives. Moreover, by refusing to exercise its statutory authority to preempt all state-mandated benefit laws and insurance regulations on health maintenance organizations (HMOs), it has forced the families of federal employees enrolled in those plans to absorb the costs of the new mandates and regulations. Meanwhile, the FEHBP today has fewer plans, and the plans it has are more standardized and costly. OPM's approach thwarts opportunities for plans to offer different combinations of benefits and premiums, and discourages such lower-cost options as high-deductible plans.
- **Policymakers' neglect of long-term problems.** Such problems include the aging of the program's health insurance pool; the need to improve how the government contributes to competing plans; and adverse selection, by which older and sicker workers and retirees accumulate in certain plans, driving up their costs. Making serious policy changes to correct these problems would help to restrain costs and improve the functioning of the program.

The Need for New Policy. The Administration and Congress should take steps now to correct the problems plaguing the FEHBP and improve health benefits for federal workers and their families. The Administration should reaffirm the OPM Director's statutory authority to negotiate premium rates and benefits and to preempt all state-mandated benefits.

The President should veto any new benefit mandates passed by Congress and seek an independent evaluation of the effect of recent OPM regulatory initiatives and benefit changes on costs. He should insist that OPM promote cooperative plan negotiations, private-sector flexibility, the use of consumer-friendly emerging information technology, and innovation in benefit design and pricing.

Changes in the philosophy of governance within the Administration, however, will not be enough. Congress, working closely with the Administration, should pass legislation that enhances employee options and eases the entry of new plans into the FEHBP market. It should change insurance underwriting rules and the government contribution formula to enable participants to take full advantage of potential savings from their choices. It should take steps to reduce the problem of adverse selection, the congregation of higher risk and more costly enrollees in certain plans. Finally, to broaden FEHBP's pool, Congress should allow young military families and the fami-

4. Stephen W. Gammarino, Senior Vice President for Federal Employees Program and Integrated Health Resources, "Health Care Inflation and Its Impact on the Federal Employees Health Benefits Program," testimony before the Subcommittee on Civil Service and Agency Organization, Committee on Government Reform, U.S. House of Representatives, October 16, 2001, p. 3.

NOTE: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

lies of reservists called up for active duty to enroll in the program. This would substantially improve health care coverage for these families and help stabilize insurance premiums for federal workers and retirees.

A WASHINGTON PARADOX: A MARKET-BASED FEDERAL PROGRAM

The Federal Employees Health Benefits Program is a paradox. It is market-driven, rather than centrally controlled like the huge and financially troubled Medicare and Medicaid programs. It promotes patient choice and market competition through a system of defined contributions to competing private health care plans. Yet thousands of federal workers who benefit from patient choice and competition in the FEHBP market also administer the highly bureaucratic Medicare and Medicaid programs, governed on the very different principles of centralized planning and price regulation.

Because of its patient-driven character, the FEHBP—the largest group health insurance program in the world—is radically different in structure from almost every other private employment or government-run health insurance arrangement. (See text box, "Administering the FEHBP.") No other insurance-based system of financing and delivery in America provides patients with such a broad range of personal choice of plans and benefits.

Market Driven. Once a year, federal workers and retirees across the country choose their own health plan from a variety of plans in the FEHBP. Unlike conventional employment-based insurance, the FEHBP's plans compete directly for the dollars of the consumer; they must win or maintain a worker's allegiance by delivering quality health care coverage at competitive prices. In recent years, the FEHBP's benefit offerings have become progressively richer, including universal availability of prescription drug coverage.

The FEHBP is virtually the only system in the country in which individuals and families can pick the kinds of benefits and treatments they want at the prices they wish to pay while pocketing any savings from their choices. During the program's annual open season, federal workers can take advantage of consumer information to make comparative shopping easier; the competing plans are rated on performance, for example, by various employee and retiree organizations. Historically, the level of employee satisfaction with a personally chosen plan is very high.[5]

Basically Sound Structure. In terms of controlling costs, the FEHBP's record is superior. The program routinely outperforms both conventional employer-based private health insurance and the financially troubled Medicare program, which covers approximately 40 million elderly and disabled citizens. Although FEHBP health plan premiums, like those for most Americans, will increase in 2002, federal employees and retirees will be able to pocket health care savings (from $500 to $1,000 next year) by carefully choosing a plan.[6]

The Congressional Research Service (CRS) concluded in 1989 that the FEHBP's basic structure is "sound."[7] This assessment still applies, despite subsequent changes in Administrations and turbulence in the health care sector of the economy.

Historically, the CRS also observed, OPM's managerial role in the FEHBP has been "passive." OPM has played a crucial role in the past as both an umpire and cooperative partner of private-sector health plans, negotiating with them to secure high-quality benefits for federal employees while

5. For example, 87 percent of fee-for-service enrollees, 84 percent of HMO enrollees, and 85 percent of enrollees in point-of-service (POS) plans rated their health plans as "good," "very good," or "excellent." See Congressional Research Service, "The Medicare Program and the Federal Employees Health Benefits Program: Purpose, Design and Operations," *CRS Report to Congress*, May 26, 1999, p. 11.

6. "Checkbook's Annual Guide to Health Insurance Plans for Federal Employees Launches Online for Upcoming Open Season," press release, Center for the Study of Services, October 15, 2001.

7. See Committee on Post Office and Civil Service, U.S. House of Representatives, *The Federal Employees Health Benefits Program: Possible Strategies for Reform*, a report prepared by the Congressional Research Service, Committee Print 101–5, May 24, 1989, p. 231.

largely leaving the specifics of services to the millions of consumers in the program. That tendency to refrain from micromanaging the prices, plans, and benefits allowed federal workers and their families to capitalize on the flexibility and diversity of program options. It also contributed profoundly to the efficient functioning of the FEHBP as a market-based system.

OPM ROLE REVERSAL: FROM CAUTIOUS UMPIRE TO ACTIVE REGULATOR

Ordinary Americans might assume that a successful, decades-old federal program—one that delivers high-quality health care services in a competitive market governed by personal choice, with a high level of consumer satisfaction and a low level of red tape—would be largely immune to political attacks. But the record shows otherwise.

ADMINISTERING THE FEHBP

The Office of Personnel Management (OPM), as program administrator, has broad authority to negotiate premium rates and benefits on behalf of federal employees and retirees. An estimated 176 federal workers participate in the administration of the FEHBP.[1] Characteristically, benefit changes or modifications are made quickly and painlessly, rarely resulting in major political battles either on Capitol Hill or elsewhere.

There is a high degree of flexibility in program administration at OPM, and the administrative costs and levels of regulation remain relatively low.[2] Beyond its responsibility for confidential and sensitive annual negotiations, OPM is responsible for enforcing basic ground rules for competition among the private insurers and making sure that they meet the fiscal solvency, consumer protection, and basic benefit requirements outlined under Title V, Chapter 89, of the U.S. Code. The *categories* of benefits are prescribed for all plans: catastrophic coverage; physician and hospital services (including ambulatory, surgical, and obstetrical services); prescribed drugs; and prosthetics devices. Otherwise, benefits among the plans may vary.[3]

In sharp contrast, the Medicare and Medicaid programs are administered by thousands of employees at the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, and governed by tens of thousands of detailed rules, regulations, and guidelines. In these programs, virtually every aspect of the financing and delivery of health care to seniors, the disabled, and the poor is subject to increasingly detailed measures of government control. Medicare paperwork burdens on doctors, hospitals, and private plans are immense, inhibiting flexibility and innovation, blocking quick adaptation of medical benefits and technology, and threatening the quality of care. Without fundamental structural changes, these problems, particularly in the Medicare program, will worsen.

For such reasons, the majority of members of the National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux (D–LA) and Representative Bill Thomas (R–CA), have recommended transforming the Medicare program into one that resembles the superior FEHBP.

1. Based on OPM staffing for fiscal year 2000.
2. See Alison Evans , *The Federal Employee Health Benefits Program, Managed Competition and Considerations for Medicare*, National Academy on Aging, September 1995, p. 4.
3. Competing health plans have enjoyed flexibility in designing cost-sharing requirements and imposing specific limitations agreed upon in private negotiations with OPM. Today, nearly all plans offer coverage for prescription drugs, durable medical equipment and supplies, dental care (though often limited), mental health care, alcohol and substance abuse treatment, skilled nursing care, home health care, hospice care, and limited experimental therapies and treatments.

As far back as the first Bush Administration, OPM staff had put forth policy initiatives that would have undermined the structure of the FEHBP and turned it into a version of the heavily centralized Medicare program.[8] Fortunately, these efforts were stymied by intense opposition within the Bush Administration and in Congress.

In 1993, as part of a comprehensive plan to overhaul the entire American health care system, President Bill Clinton sought to abolish the FEHBP and fold its services into other parts of the so-called Clinton health plan. In 1994, congressional variants of the increasingly unpopular Clinton plan attempted much the same thing; they would have maintained the outward appearance of the program while changing its substance.[9] However, federal employee union leaders and organizations fought back vigorously, in effect arguing that whatever merits the Clinton plan might have had for the rest of the nation, it should not apply to them and their program.[10] This approach became a recurrent theme in health care policy.[11]

The Clinton Agenda. With the failure of the Clinton plan, the Clinton Administration adopted an incremental step-by-step approach to increase federal control over the private health care sector of the economy. It initiated a steady increase in federal regulation and control over aspects of private plan operations or the delivery of care.[12]

For FEHBP's management, this meant the market was out; regulation was in. In 1999, for example, former OPM Director Janice LaChance described the projected average premium increase as "unacceptable,"[13] suggesting that market competition failed to control costs and indicating that she would ask for greater authority to control costs administratively. Since then, the FEHBP has been subjected to increasing standardization of benefits, an increase in the equivalent of benefit mandates and regulation, including the administrative implementation of the Clinton Administration's "patients' bill of rights" initiative.

In 1999, pursuant to LaChance's desire to exercise more power to "control" costs, OPM proposed Medicare-style direct contracting for certain health benefits and entertained a proposal for bulk purchase (eventually, government purchase) of prescription drugs under federal pricing guidelines.[14] The idea was to reduce specific benefit costs through economies of scale by making large-scale government or government-sponsored purchases of benefits or services.[15] It was not enacted.

8. OPM staff proposals ran into stiff opposition within the Bush Administration's Office of Management and Budget and thus never surfaced as a legislative proposal. As Harry Cain has written, "The OPM felt that it could 'self insure' (that is, assume the risk for) the government wide health benefit plans, it could use its consolidated purchasing power—as Medicare does—to effectively dictate prices and get a better deal all around." See Harry P. Cain II, "Moving Medicare to the FEHBP Model, or How to Make an Elephant Fly," *Health Affairs*, Vol. 18, No. 4 (July/August 1999), p. 26.

9. See, for example, Robert E. Moffit, "Kennedy's Bait and Switch Health Reform," Heritage Foundation *Executive Memorandum* No. 380, May 16, 1994.

10. See Robert E. Moffit, "Why Members of Congress and Federal Workers Don't Want the Clinton Health Plan," Heritage Foundation *Backgrounder Update* No. 220, March 29, 1994, and "Why Federal Unions Want to Escape the Clinton Health Plan," Heritage Foundation *Backgrounder* No. 953, August 4, 1993.

11. Federal union leaders, for example, making arguments strikingly similar to those put forth by representatives of the business community, now want to escape the onerous liability and regulatory provisions of the patients' bill of rights legislation. The Senate version of the bill (S. 1052) includes a provision that would apply the terms and conditions of the legislation to the FEHBP and other government programs; the House bill (H.R. 2563) does not. See Robert E. Moffit, "Why Federal Unions and Members of Congress Want to Escape the Patients' Bill of Rights," *A Heritage Foundation Supplement*, July 23, 2001, at *http://www.heritage.org/shorts/20010723pbor.html*.

12. For an account of the successes of the Clinton Administration's health care policy agenda since 1994, see Carrie J. Gavora, "A Progress Report on the Clinton Health Plan," Heritage Foundation *Backgrounder* No. 1158, February 25, 1998.

13. The notion that an agreed upon FEHBP premium increase is "unacceptable" to an OPM Director is curious. Under Chapter 89, Title V, the OPM Director has almost unlimited authority to negotiate rates and benefits; in any given year, they are only those agreed to by OPM and the private plans in confidential negotiations over the summer, so there is no need for an OPM Director to accept what the OPM Director thinks is "unacceptable."

Certain federal employee union leaders have urged this same approach for the purchase of prescription drug coverage for federal employees.[16] Of course, the logical extension of such an approach is simply standard government contracting under ordinary federal procurement rules: OPM would establish a single standard for benefits and services, request insurers to bid for the government contract, and select one insurance company to cover all employees and retirees.

Importing Medicare-Style Administration. Often promoted as an efficient cost-cutting measure, the real effect of such government monopoly purchasing would be structural, profoundly transforming the dynamics of the program. Instead of a pluralistic competition among insurers offering health benefits to consumers at competitive prices, the government as purchaser would procure each benefit at a preordained government price. It would control both the price of the benefit and the supply of that benefit, its quantity and its quality, in effect controlling the benefit itself—much as the government now does in Medicare, the huge government-run health program for America's seniors.

In Medicare, the government determines—according to elaborate formulas—the price of each of over 500 hospital services and each of over 7,000 physician services. In the FEHBP, if a similar system were adopted, political pressure would be exerted to maintain the price of any given medical service at an artificially low level, regardless of supply and demand, while lobbyists for the doctors and other health care providers would fight to raise the official reimbursement levels for the benefit or service in question. As with Medicare, the government not only would be concerned with price fixing, but also, in the interests of "appropriate" utilization or the delivery of quality care, would be driven to establish the conditions for the delivery of the benefit or service for which it contracted. It would, in the process, set off a paperwork explosion.

These sorts of administrative decisions are a politically irresistible invitation to congressional micromanagement and ever broader, and more complex, OPM administrative adjustments and counter-adjustments in an expanding body of regulation. In Medicare, congressional intervention has devolved into a low art. Between 1990 and 2000, for example, Congress added 699 sectional changes just by amending Medicare law in the annual budget reconciliation process. During that same period, it made only four changes in the FEHBP statute.[17]

In the FEHBP, the dynamics of Medicare-style purchasing would likely be the same. Artificially low prices set by cost-cutting government officials would guarantee cost shifting[18] and periodic

14. The drug purchasing proposal was initiated as a pilot project to enable the Special Agents Mutual Benefit Association (SAMBA) to purchase prescription drugs under the Federal Supply Schedule (FSS) program, the same government pricing arrangement that governs drug purchasing by the Veterans Administration. According to William E. Flynn III, Associate Director for Retirement and Insurance, Office of Personnel Management, "The goal of the pilot will be to determine if a schedule similar to the FSS should be established to provide pharmacy benefits to the FEHBP community." See William E. Flynn III, "FEHBP: OPM's Policy Guidance for 2001," testimony before the Subcommittee on Civil Service, Committee on Government Reform, U.S. House of Representatives, June 13, 2000, pp. 10–11.

15. This routine campaign for government monopoly purchasing to achieve economies of scale is in effect a campaign to transform OPM into a Medicare-style program in which the federal government, rather than the consumer, would become the customer of the providers. The idea appears to be attractive to certain federal union leaders, as well as OPM staff. See Stephen Barr, "Cost of Drugs, Use of Services, Technology Blamed for Premium Rise," *The Washington Post*, September 25, 2001, p. B2.

16. According to National Treasury Employees Union President Colleen M. Kelley, for example, "There is little question that the patchwork of prescription drug purchase arrangements that exists in the FEHBP contributes to these increases. NTEU believes that OPM should negotiate discount prescription drug rates for the FEHBP similar to those available under the Federal Supply Schedule (FSS), a reduced rate drug schedule used primarily by the Veterans Administration for its hospitals." Colleen M. Kelley, testimony on the Federal Employees Health Benefits Program before the Subcommittee on Civil Service and Agency Organization, Committee on Government Reform, U.S. House of Representatives, October 16, 2001, p. 8.

17. Heritage staff analysis of the Budget Reconciliation Acts from 1990 to 2000, conducted March–April 2001.

reductions in the supply of politically priced commodities or services, such as the devastating Medicare reductions in skilled nursing or home health care services under the Balanced Budget Act of 1997.

OPM's Administrative Bias. In the recent past, the FEHBP has had to operate in an atmosphere that was inimical to the free-market principles on which it is based. Policies were formulated and executed by an OPM that seemed to favor the importation of a Medicare-style regulatory centralization.

Consider, for example, OPM's indifference or hostility to medical savings accounts or high-deductible plans, despite the fact that these options can lower premiums and are popular with those enrolled in them.[19] Taxpayers would also benefit from opening the program to more robust competition from these lower-cost alternatives, since the government's contribution to average premiums is set by a formula based on the weighted average premium of all FEHBP plans.

OPM staff have long been aware of the deficiencies in the government contribution formula, which caps the government's total contribution at 75 percent of any plan's premium. The cap prevents enrollees from realizing the full benefit of any savings they achieve in purchasing a lower-cost plan—a perverse incentive that weakens efficiency and cost control in the program.

Likewise, OPM staff know that the FEHBP has no risk-adjustment mechanism and operates on the basis of very crude underwriting as well as the flawed government contribution formula. No distinction is made in the premiums paid, for example, between higher-cost retirees or older workers and lower-cost active employees. This aggravates the problem of adverse selection, with older and sicker workers and retirees congregating in certain plans, which drives up the utilization of services and thus the costs and premiums in those plans.

This risk segmentation is less of a problem today than it was in the early 1980s, particularly since the extension of Medicare coverage to larger numbers of federal retirees. But it is worth noting that, historically, the plans' inability to vary premiums contributed powerfully to the adverse selection problem. Allowing variation of premiums at least on the basis of age or retirement status, coupled with a variation of the government contribution to benefit older enrollees, would largely ameliorate this problem. OPM staff have shown little interest.

Dr. Harry P. Cain II, former Vice President of Blue Cross and Blue Shield Association, who was responsible for the Blues' contracts with the FEHBP, observed that if OPM staff were as committed to and as knowledgeable about the principles and market dynamics of their FEHBP program as the Centers for Medicare and Medicaid Services staff (formerly the Health Care Financing Administration staff) are about Medicare, the large and rapidly growing performance gap between the FEHBP and the Medicare program would widen even further:

> In particular, the OPM could have supported extensive research on the workings of managed competition, including the criteria and processes needed for allowing or encouraging new plans to enter the competition and the mechanisms needed for better risk adjustments. In accordance with their respective charges and histories, however, the OPM has supported no research on managed competition, whereas HCFA has

18. Dr. Scott Nystrom of George Mason University noted that, under OPM's proposed drug pilot program, the likely consequence of allowing FEHBP carriers to purchase prescription drugs at the Federal Supply Schedule price would be to increase prices for non-FEHBP prescription drug purchasers, including Medicare beneficiaries without drug coverage. Such an FEHBP policy change would also increase prescription drug costs for agencies getting prescription drug discounts under the FSS, including the Department of Veterans Affairs. See Scott V. Nystrom, Ph.D., "FEHBP: OPM's Policy Guidance for 2001," testimony before the Subcommittee on Civil Service, Committee on Government Reform, U.S. House of Representatives, June 13, 2000, p. 7.
19. In March 2001, senior OPM staff again stated that medical savings accounts are "not being considered" for the program. See Katy Saldarini, "Budget Hints at Cost Cutting Measures for Federal Health Plans," *Government Executive*, March 2, 2001.

long operated an extensive research program related to Medicare.

Parenthetically, in this HCFA/OPM comparison there is an obvious and disquieting truth about publicly managing a private competitive system. In the absence of some special background or training, public sector managers, like private sector managers, will continually seek ways to augment their control over resources, their power to manage, and their ability to do a "better job" of it. Private competitors' innovations will typically be seen by the public managers as irritants, disruptions, and unanticipated problems that need to be controlled or quashed. There have been many incidents in FEHBP's long history that underscore that danger.[20]

The FEHBP, then, is not only a paradox of Washington policymaking: a government health care program based on the free-market principles of consumer choice and competition. It is also a political paradox: It periodically gets a hostile reception from left-leaning health policy analysts and politicians, and even, in some cases, the federal executives who are responsible for administering the program.

In the broader national health care debate, the existence of the FEHBP—and the fact that, despite its politically engineered imperfections, it still works tolerably well—is a persistent irritant to the ideological opponents of patient choice and free-market competition in health care. The greatest support for the consumer-driven character of the program is registered among health care economists and the broad mass of federal employees and retirees covered by it.

Expanding Regulatory Reach

As noted previously, the Office of Personnel Management has traditionally exercised a deft touch in negotiating with private health plans on behalf of federal workers and retirees. That track record emphasized a give-and-take negotiating process between the federal government and private plans, with deference given to private plans in the development of a combination of benefits and prices to meet changing consumer demands in a tough market.

In recent years, however, OPM has largely broken with this tradition of "passive management." According to its own estimates, it made 44 significant benefit changes between 1990 and 2001. Most of these were benefit additions or, in their effects, the equivalent of benefit mandates on private insurance plans similar to those enacted by state legislatures. These changes, according to OPM, resulted in a net cost increase of $225 million, or only 1.15 percent of total program costs.[21]

These official estimates seem very low. When OPM decided to apply the Clinton Administration's version of the patients' bill of rights to the FEHBP, for example, it testified that the entire panoply of patient protections would amount to less than $10 per year for each FEHBP policyholder.[22]

Some of the benefit mandates have been particularly controversial. In 1994, for example, the Clinton Administration ordered FEHBP plans to cover an expensive and experimental treatment using bone marrow transplants to combat breast cancer within 24 hours or face exclusion from the program, even though the procedure was not widely tested and medical authorities generally favored restricting the treatment to major academic medical centers. FEHBP coverage of bone marrow transplants for the treatment of breast cancer was the product of intense lobbying on Capitol Hill. Years later, the Clinton Administra-

20. Cain, "Moving Medicare to the FEHBP Model, or How to Make an Elephant Fly," p. 34.

21. Office of Personnel Management, "FEHBP–Significant Health Benefit Changes 1990–2001: Overview," *Staff Report*, 2001.

22. See William E. Flynn III, Associate Director for Retirement and Insurance, Office of Personnel Management, "OPM's Policy Guidance for FEHBP Contract Year 2000," statement before the Subcommittee on Civil Service, Committee on Government Reform, U.S. House of Representatives, May 13, 1999, p. 3.

tion still required that it be included in the FEHBP benefits package.[23]

Subsequently, peer-reviewed studies of the procedure found that the transplants appeared to be no better than conventional chemotherapy in treating breast cancer. Nevertheless, in 2000, OPM retained the bone marrow transplant mandate and added an administrative application of the Clinton patients' bill of rights (including government standards for access to emergency care, direct access to specialists, and requirements governing information disclosure, performance, provider network characteristics, and management of care) as well as new standards for health care quality and customer service.

In 1998, OPM had attempted to impose cost accounting standards, developed for defense contractors doing business with the U.S. Department of Defense, to the FEHBP's private plans. It did not seem to make any difference to OPM staff that Defense-style contracting, with firms bidding to supply a particular product, and the dynamic environment of a competitive market in the FEHBP, where private plans compete directly for consumers' dollars and market share, are entirely different institutional arrangements. Remarkably, OPM wanted to take a form of government cost accounting appropriate for the first and simply apply it to the second. Fortunately, OPM's effort—a costly imposition on providers—was blocked by Congress.[24]

The recent OPM trend toward more detailed benefit setting and more aggressive regulatory control has been accompanied by special-interest lobbying for additional benefit mandates. For example, in hearings before the House Subcommittee on Civil Service, various witnesses advocated the annual inclusion of benefits and services, such as audiological services, acupuncture, pastoral counseling, and medically beneficial foods, as necessary health benefits. This type of aggressive political lobbying not only threatens the traditionally sensitive process of negotiations between OPM and private health insurance plans, but also serves to undermine the most basic feature of the program: the provision of health benefits and medical services that patients want. Instead, patients increasingly are forced to pay for benefits and services they do not want.

While patient choice has been a distinguishing feature of the FEHBP, OPM policy in recent years has been driving the program in a different direction, gradually standardizing health plan policies. The difference in the actuarial value of the packages offered in the FEHBP has thus progressively narrowed. The effect has been to deprive federal workers and their families of the more customized options available in the 1980s. Even if one assumes that any given required additional benefit is justified by a nominally small cost, the accumulation of these additions can have a significant effect over time. While any one benefit may be a minimal cost in its first year, increased utilization over subsequent years will drive up overall costs.

Declining Flexibility. OPM's aggressive regulatory campaign increasingly standardized the private plans' benefit packages. Thus, competing plans had fewer opportunities to offer different combinations of premiums and benefits. Moreover, plan officials have had less room to initiate more attractive cost-saving innovations.

For example, in 1999, Blue Cross and Blue Shield, which covers almost half of federal workers and retirees in its two major plans, proposed to OPM the introduction of "cost sharing" in prescription drug coverage to restrain rising drug costs. As the Blues' Senior Vice President Stephen W. Gammarino told Congress,

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23. "We are aware of study results and reports that have resurfaced questions about the appropriateness of this treatment. Nevertheless, clinical trials on the therapy for breast cancer are continuing. Given this, we determined that changing our basic coverage requirement was not necessary. We continue to believe in the effectiveness of the approach we took earlier." Flynn, "FEHBP: OPM's Policy Guidance for 2001," p. 9. Flynn was speaking as Associate Director for Retirement and Insurance at OPM.

24. Blue Cross/Blue Shield plans, for example, would have had to restructure the entire cost accounting system to comply with the high cost of the congressionally thwarted OPM requirement. See Stephen W. Gammarino, Senior Vice President, Federal Employee Program, Blue Cross and Blue Shield, "FEHBP: OPM's Policy Guidance for 2000," statement before the Subcommittee on Civil Service, Committee on Government Reform, U.S. House of Representatives, May 13, 1999, p. 10.

> To be precise: our proposals to introduce cost sharing in our mail pharmacy program for members with Medicare have been rejected repeatedly, despite our having provided ample, unprecedented documentation of the need for this change. While we have sought to minimize unnecessary utilization and to assure that necessary cost sharing was spread across our entire covered population, the repeated denials simply maintain the free drug benefit for the Medicare population while increasing the burden on active employees.[25]

At the same time, neither OPM nor federal agencies have taken full advantage of the rapidly emerging information technology that could enhance patient choice of the benefits that patients *do* want and improve the administration of this unique choice-based program.[26] Such information technology makes it much easier for workers and their families to compare, pick, and choose the type and quality of coverage and the benefits, physicians, and specialists that best suit them. Variants of this technology enable workers and their families to enhance their wellness and management of disease and could even help them customize their benefit packages. Moreover, the confidentially protected data from these software transactions would enable OPM to enter negotiations with private plans with a much clearer idea of patient preferences. Although OPM has only limited experience in this area, greater competition and expanded use of information technology holds great promise for federal workers and their families.[27]

Abdicating Responsibility. Paradoxically, while OPM in recent years has been an increasingly active and aggressive regulator of health plan options, centralizing authority over benefit design, it simultaneously has surrendered its authority over the benefits offered to federal workers and retirees by HMOs "domiciled" in the various states. State benefit mandates unquestionably contribute to higher costs for individuals and families purchasing state-based health care plans. Today, state legislative requirements for health insurance plans to cover services, providers, and disease groups total 1,403 nationwide.[28] Not surprisingly, the findings of medical science are often subordinated to political considerations in the adoption of these "body part" mandates.[29]

States are aggressive insurance regulators. In the area of managed care alone, for example, between 1994 and 1999, state legislatures enacted more than 1,000 laws regulating managed care plans.[30] These regulations can have significant transactional costs, just as mandated benefits can have a significant impact on premium costs.

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25. *Ibid.*, p. 11.
26. For a discussion of the status and potential of this information technology, see Walton J. Francis, *Providing Online Consumer Information Through Federal Employee Health Insurance Plans*, a report prepared for the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, 2000, at *www.policynet.com*.
27. In 1998, OPM offered a Web-based application for health plan comparison, *PlanSmartChoice*, and users reported high rates of satisfaction. See, *PlanSmartChoice: Fall 2000 Open Enrollment, A Report to the Office of Personnel Management*, prepared by *PlanSmartChoice Inc*., Research Triangle, N.C., June 25, 2001. The company recently changed its name to Asparity Decision Solutions.
28. The list of legally required state benefits and services is remarkably varied. It includes acupuncturists, alcohol abuse treatment, bone marrow transplants, chiropractors, contraceptives, dieticians, drug abuse treatment, hair prostheses, in vitro fertilization, infertility services, mental health parity, occupational therapists, naturopaths, message therapists, pastoral counselors, physical therapists, physician assistants, psychologists, social workers and speech therapists, and treatment for TMJ disorders. See Susan S. Laudicina, Betsy Losleben, and Katherine Pardo, eds., *State Legislative Health Care and Insurance Issues: 2000 Survey of Plans* (Washington, D.C.: Blue Cross and Blue Shield Association, December 2000).
29. A recent workshop conducted by the Institute of Medicine on politically popular mandates (breast cancer treatment and the 48-hour minimum hospital stay) concluded, "A lesson from this policy case study is that science's traditional methods of communication do not work well in influencing policy when public pressures politicize an issue." Institute of Medicine, *Unintended Consequences of Health Policy Programs and Policies: A Workshop Summary* (Washington, D.C.: National Academy Press, 2001), p. 4.

One would think that OPM would protect federal workers and retirees and their families from these additional costs. It has not. While OPM has used its statutory authority to preempt state-mandated benefits in plans offered on a nationwide basis and HMOs that operate in interstate commerce, it has refused to do so among state-based HMOs,[31] reducing the competitive position of these plans and forcing federal employees in these states to pay higher premiums than they would otherwise because of the additional cost of the mandated benefits. These costs, which are nowhere taken into account in OPM's own cost estimates of regulatory or benefit changes, can be rather substantial in states like California, which has 42 mandates, and Maryland, which has 50.

Beyond OPM's administrative actions, Members of Congress—in a bipartisan break with their traditional policy—recently have begun to intervene in FEHBP benefit setting. They have been proposing legislation to force federal employees and taxpayers to pay for a whole range of currently fashionable benefits, including acupuncture, osteoporosis screening, contraceptive coverage, fertility treatments, Viagra prescriptions, and encouragement of the use of generic drugs, as well as an expansion of FEHBP coverage to the parents of federal workers and same-sex domestic partners.[32] Proposing an unprecedented restriction on the right of federal employees and retirees to spend their own money on medical services of their choice, Senators Bill Nelson (D–FL), Richard Durbin (D–IL), and John Edwards (D–NC) recently introduced a bill (S. 1606) that would deny federal payment to "any health care provider" that charges a "membership fee or any other extraneous or incidental fee to a patient" as a condition for getting a medical service.[33]

Sharply Differing Analyses. As noted, OPM staff have indicated that, taken together, their "benefit changes" have achieved savings and had little overall effect on the real growth of premiums. But the extremely low estimates generated by OPM suggest, at the very least, the need for a comprehensive and independent economic analysis of the cumulative impact of these benefit and regulatory changes over time.

Independent, particularly private-sector, econometric analyses of state benefit mandates and the transactional costs of regulation on health insurance plans show a much greater impact on health care costs and premiums than indicated by the OPM staff analysis. For example, a 1996 study of additional health benefits mandated by state governments, conducted by the U.S. General Accounting Office (GAO), found that state-mandated benefit laws accounted for 12 percent of the claim costs in Virginia, which had 29 benefit and managed care mandates, and up to 22 percent of the costs in Maryland, which then had 36 mandates.[34]

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30. *The Challenge of Managed Care Regulation: Making Markets Work?* a report produced for the Robert Wood Johnson Foundation through Changes in Health Care Financing and Organization (Washington, D.C., 2001), p. 3.
31. See statement of William Flynn III, Associate Director of Retirement and Insurance, "FEHBP Rate Hikes—What's Behind Them," in hearing before the Subcommittee on the Civil Service, Committee on Government Reform and Oversight, U.S. House of Representatives, 105th Cong., 1st Sess., October 8, 1997, p. 73.
32. Stephen Barr, "On Capitol Hill, Lots of Interest in Expanding Health Coverage," *The Washington Post*, March 6, 2001, p. B2.
33. The application to the Federal Employees Health Benefits Program in S. 1606 is made explicit in Sec. 1128G, "Limitation on Payments to Providers Under a Federal Health Care Program." While the FEHBP is not named, it is referenced as a "health insurance program" under Chapter 89 of Title 5, United States Code. The Nelson–Durbin–Edwards legislation would reinforce but also go well beyond existing federal policies restricting the right of Medicare patients to make private agreements with their doctors for wanted medical services, which was enacted as Section 4507 of the Balanced Budget Act of 1997, and would apply them to federal workers and retirees, as well as beneficiaries in other government health programs. For an account of the current status of Section 4507, including litigation in the federal courts, see Robert E. Moffit, "Congress Should End the Confusion Over Medicare Private Contracting," Heritage Foundation *Backgrounder* No. 1347, February 18, 2000.
34. U.S. General Accounting Office, *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance,* GAO/HEHS–96–161, August 19, 1996.

In 2000, Democratic Governor Howard Dean of Vermont cited the negative impact of the state's benefit mandates on health insurance costs, saying that they contributed to about 25 percent of 1999 health insurance premiums. He asked the state legislature to stop enacting them.[35]

Private economic analyses of the relationship between health benefit mandates and premium costs show similar effects.[36] In this respect, the Administration and Members of Congress should verify the assumptions, analysis, and conclusions of OPM staff.

A Sharp Decline in Plan Participation. There has been a disturbing drop in the number of plans participating in the FEHPB. In the mid-1990s, almost 400 health plans competed in the program. For 2001, OPM announced that only 245 plans were expected to participate. Between 1998 and 1999, the FEHBP lost 65 plans—a stunning 20 percent of the plans that had participated. For 2002, OPM announced that only 180 plans were expected to participate.

When private firms participating in a government program in accordance with government policies do not behave the way government officials expect them to behave, it is not automatically the fault of the private firms. The large number of dropouts has caused the FEHBP to become less competitive internally, potentially reducing enrollee choice and contributing to higher premiums.[37]

WHY FEHBP PREMIUMS HAVE BEEN RISING

In recent years, the FEHBP's premiums have been rising at a troubling rate.[38] Estimates project that FEHBP premiums will increase an average of 13.3 percent in 2002. While Administration officials and Members of Congress should be concerned, they should also maintain perspective on what these premium increases mean.

First, even with a projected average increase in 2002 of over 13 percent, in the crucial area of cost control, FEHBP is very likely to continue outperforming private employment-based health insurance, which is sure to experience double-digit premium increases next year. Hewitt Associates, a major benefits consulting firm, is now projecting 13 percent to 16 percent cost increases in 2002, and many private companies are planning to pass on substantial cost increases to their employees.[39]

The FEHBP also will likely outperform highly regarded public programs of a competitive character. Indeed, the California Public Employees Retirement System (CalPERS), which often is compared to the FEHBP, has announced premium increases averaging 15.5 percent in 2002; in 2001, the celebrated California program reported an increase of 12.9 percent, while the FEHBP projected an increase of 10.5 percent.[40]

The FEHBP still enjoys a superior record in comparison to Medicare, which, unlike FEHBP, is governed by a complicated and rigid system of price controls. Based on the annual reports of the Medicare trustees, the average cost of Medicare (both Part A and Part B) per enrollee has risen from $3,834 in 1992 to $6,228 in 2001, representing a 10-year increase of 62 percent. Over the same period, the enrollment-weighted average premium in FEHBP, for both single enrollees and families, has risen from $3,440 to $5,322, a 10-year increase of 54 percent.[41]

35. Hon. Howard Dean, State of the State Address, State of Vermont, January 4, 2000.

36. See, for example, Gail A. Jensen and Michael A. Morrisey, "Mandated Benefit Laws and Employer Sponsored Health Insurance," Health Insurance Association of America, Washington D.C., January 1999.

37. Eric Yoder, "Rising Rates," *Government Executive*, December 1999, p. 42.

38. The projected average increase in 2001 was 10.5 percent; in 2000, it was 9.3 percent; in 1999, it was 9.5 percent. "Health Care Marketplace: FEHBP Premiums to Rise 13.3 Percent Next Year," *Daily Health Policy Report*, *Kaisernetwork.org*, September 24, 2001.

39. "Movin' On Up," *National Journal's Daily Briefing*, October 30, 2001, at *www.nationaljournal.com*.

40. Office of Personnel Management, "Industry Trends: Questions and Answers," fact sheet on FEHBP premium increases, September 2001.

Second, projected annual increases in premiums do not automatically translate into actual annual premium increases in the FEHBP. The reason, which does not generally apply to workers who get their insurance through conventional private-sector employer plans: the ability of federal workers "to vote with their feet" and choose lower-cost health plans during the annual open season if they are unhappy with their current health plan. Based on previous experience, it is likely that actual premium increases in 2002 will be less than the 13.3 percent projected by OPM.

In sharp contrast, private-sector workers often have no choice at all of health plan; they get what their employer provides, usually some sort of managed care plan. And among those private-sector workers who do have a choice of plans, choice is often very limited.

Broader Health Care Trends. Premium increases in the FEHBP reflect the cost of benefits; and precisely because of the competitive character of the program, which includes the real possibility of losing market share, there is obviously no economic incentive for a health plan participating in the FEHBP to set rates higher than necessary.

Nonetheless, the FEHBP is not immune to trends in the broader health care system that are driving costs upward: the general aging of the American population, the increase in the demand for hospitalization, a continuing and growing demand for newer and more effective prescription drugs, the recent double digit increases in medical malpractice insurance, the economic impact of a growing body of state and federal regulatory initiatives, and the desire of patients to take advantage of the best and newest medical technology to lengthen or enhance the quality of their lives. These trends apply with equal force to patients enrolled in private employment plans and the FEHBP.

In private employment-based health insurance, benefits are another form of compensation for work. Every dollar increase in health care benefits amounts roughly to a dollar decrease in wages and other compensation. Under current arrangements, persons today are using health insurance to cover small, routine, or purely predictable medical services. This results in huge and unnecessary overpayments into the health insurance system in the form of prepaid health care and a proportional loss of disposable income.

Federal employees are not immune. Ideally, routine medical services should be paid directly out of pocket and given the same favorable tax relief that today is exclusively available for insurance payments. Allowing persons to pay routine medical bills from tax-free flexible spending accounts or medical savings accounts would be the best way to accomplish that end.

Beyond the general increase in health care costs, particularly the demand for and higher utilization of new and more expensive prescription drugs, there are other major reasons why FEHBP is experiencing significant cost increases. Among the most important is the FEHBP population itself.

The Aging FEHBP Insurance Pool. Health care costs rise rapidly with age. Persons over the age of 65 have average health care expenditures more than twice that of the general population, and almost three times more than persons under the age of 65.[42] And the federal workforce is older and aging more rapidly than either the private-sector workforce or the general American population. There are 4.2 million active employees and retirees enrolled in the FEHBP. As noted, the average FEHBP enrollee is 54 years of age, and the average enrollee in the Blue Cross and Blue Shield Service Benefit Plan, one of the largest competitors in the FEHBP, is 60 years of age.[43] Private-sector health insurance pools are considerably younger.

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41. Comparative estimates for Medicare and FEHBP were calculated by Walton Francis, a prominent Washington health policy analyst and author of *Checkbook's Guide to Health Insurance Plans for Federal Employees.*
42. There are sharp variations among the working population as well. For example, based on 1997 estimates, persons between the ages of 45 and 64 had an average per capita expenditure of $3,226, while persons aged 18 to 44 had an average per capita expenditure of $1,666. See *Health Care Expenses in the U.S. Civilian Non-Institutionalized Population*, Medical Expenditure Panel Survey, U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Research and Quality, at *http://www.meps.ahrq.gov/Printproducts/printProdlookupLIVE.asp*.

Unlike private-employer sponsored insurance, where retiree coverage often has been drastically reduced or discontinued, the FEHBP continues to cover retirees, a large growing group of policyholders that has higher health care costs. As of 1998, 1.85 million federal retirees participated in the program; their average age was 71 years. The range of FEHBP retirees is broad, because federal workers may retire as early as age 55; in certain occupations, some may retire as early as 50 with full health benefits. Even with Medicare coverage, federal retirees are more expensive than active employees in the program.

Complicating the problem has been the downsizing of the active federal workforce. Since 1993, the workforce numbers shrunk by 324,580, disproportionately among full-time workers at the Department of Defense.[44] Moreover, 71 percent of the permanent federal workforce today will be able to take normal or early retirement by 2010, with an estimated 40 percent expected to do so.[45] Thus, the growing imbalance between active employees and retirees will deepen, making retirees the fastest growing group in the FEHBP.

OPM officials have been keenly aware of these disparities, yet neither OPM nor Congress has taken any serious steps to change the demographic dynamics that threaten the program. One might think that OPM and Congress would seek ways to expand the youth of the FEHBP pool. In 1998, however, Congress moved exactly in the opposite direction, enacting a flawed demonstration program to assess FEHBP coverage for military *retirees* in the Defense Authorization Act for Fiscal Year 1999.[46]

HOW TO IMPROVE THE FEHBP

If most of the FEHBP's problems, particularly in terms of cost and efficiency, are traceable to government policy, then most of them can be solved by government policy.

What the President and the Administration Can Do

There is much that the Administration can do to improve the program. Specifically:

- **Veto any congressionally mandated benefits.** Under current law, it is the management responsibility of the OPM Director to negotiate rates and benefits for federal employees and retirees. Historically, Congress has respected the authority of the OPM Director in this area and has refrained from interfering in the sensitive process of negotiations with private plans trying to compete in the program. In recent years, however, there has been a growing inclination among Members of Congress to override the OPM by imposing their own politically driven preferences for benefits, medical services, or treatments and procedures legislatively. The President should back up the authority of the Director of OPM in this area and make it clear he will veto any legislation imposing such mandates on the FEHBP.
- **Seek an independent analysis of the economic impact of the benefit and regulatory changes over the past decade.** The Administration should review the FEHBP's current regulatory regime, including the addition of benefits beyond the core statutory requirements of Title V of Chapter 89 of the U.S. Code, and seek an independent (preferably private-sector) evaluation of the economic impact of these OPM initiatives on claims, costs, or premiums. Premiums reflect costs, and if premiums are to be restrained, costs must be restrained.
- **Instruct OPM to use its legal authority to preempt all state mandated benefits.** The

43. Gammarino, "Health Care Inflation and Its Impact on the Federal Employees Health Benefits Program," p. 3.
44. *The President's Management Agenda: Fiscal Year 2002*, Executive Office of the President, Office of Management and Budget, 2001, p. 11.
45. *Ibid.*, p. 12.
46. For an account of the problems with the military retiree FEHBP demonstration program, see Kristen L. Pugh, "Concerns About Implementation of FEHBP–65 Demonstration Program," testimony before the Subcommittee on Civil Service, Committee on Government Reform, U.S. House of Representatives, April 12, 2000.

Administration should rely on its statutory authority to negotiate benefits for federal workers and retirees and their families to protect them from paying unnecessarily high premiums out of an inappropriate deference to state legislative mandates. OPM, not state legislators driven by special-interest lobbying, has sole responsibility for the rates and benefits in the FEHBP.

- Work cooperatively with private plans to promote innovative cost-saving measures. OPM should return, to the extent practicable, to a tradition of collegial private–public sector negotiations to control costs and improve benefit offerings. For example, plans could be required to offer all of the current benefit packages to all employees and retirees as a high-option plan. They should also offer a variant of the core offerings, a low-option plan, that does not include recent "benefit additions" or mandates and allow consumers to decide for themselves whether they want to pay the higher premiums to purchase those benefits. Consumer choice and competition should be reinforced, not progressively weakened, if the FEHBP is to remain a strong model for broader health care reform.
- Take full advantage of patient-based information technology. Today's emerging software programs[47] enable workers and their families to compare plans more effectively, seek out the best plans, and identify the key features of plans, including access to care, the benefit levels available, and costs and quality measures. Federal workers and their families can thus determine what is most important to them, rate the relative importance of these features, and make detailed personal trade-offs in costs and benefits. Existing technology also enables patients to create a personal profile of their health needs and match that profile with plan offerings, as well as make appointments with physicians and specialists, e-mail their physicians, and maintain their medical records. In effect, emerging information technology introduces a whole new level of personal empowerment and, if fully integrated into the FEHBP, would enable workers and their families to customize their benefit and payment options.

What Congress Can Do

Working closely with the Bush Administration, Congress can make substantial improvements in the efficiency and effectiveness of the FEHBP. For example:

- Ease the restriction on new fee-for-service plans. Current law does not allow the OPM to admit any new fee-for-service plans into the FEHBP. New plans must be HMOs. This legal restriction is outdated and pointless. Normal market efficiency is served when suppliers of services can enter and function in the market freely, responding quickly to changes in consumer demand. A statutory bias in favor of HMOs undermines market competition and consumer choice.
- Create tax-free savings options and allow for rollover of funds into the Thrift Savings Plan. Over 80 percent of large employers and a significant number of small and midsize companies offer their employees benefits through pre-tax cafeteria plans. Among the most popular of these are flexible spending accounts (FSAs, or the so-called Section 125 plans). An employee may pay for unreimbursed or routine medical expenses from funds set aside tax-free in the account.

  Millions of workers in the private sector have access to flexible spending accounts, but not federal employees. They should be allowed this benefit as well, and the amount allowed in these accounts should be increased by allowing the rollover of unused funds from year to year. The tax-free rollover would enable federal employees to build up a reservoir of funds for health care expenses. At the end of their

47. For example, such new software firms include Health Insurance Select, based in Denver, Colorado, at *www.healthinsuranceselect.com*, and Asparity Decision Solutions Inc, based in Research Triangle, North Carolina, at *jjohnston@Asparity.com*. *Checkbook's Guide to 2002 Health Insurance Plans* also has an on-line version for plan comparison at *www.guidetohealthplans.org*.

career, they should be allowed to fold these funds into their accounts in the Thrift Savings Plan (TSP), a component of the Federal Employees Retirement System, or use the funds either to purchase long-term care or to pay for health care expenses in their retirement years.

A variation of this idea is to allow federal employees to use personal medical savings accounts (MSAs), now restricted to employees in small firms. Private health insurance plans competing in the FEHBP should be allowed to offer tax-free MSAs. Such accounts free the doctor–patient relationship from third-party interference and end the federal tax penalty on personal payment for routine medical services. MSAs can also significantly reduce employer health care costs compared with traditional health insurance.[48]

As with FSAs, federal workers should be able to roll over the funds in these accounts from year to year tax-free, and use them later to pay for health care expenses in retirement or long-term care, or fold them into their TSP accounts. At the very least, Congress and the Bush Administration should work together to authorize an MSA demonstration project within the FEHBP and evaluate its impact on costs and employee satisfaction.

- **Address lingering problems of risk segmentation and adverse selection.** A persistent irritant in the FEHBP has been a tendency toward adverse selection. While this problem has not been as acute in recent years and competing plans have found ways to adjust, it is still a lingering problem. Any time one has a choice of plans, even if there are only two plans from which to choose, one will experience adverse selection. In the FEHBP, the problem is aggravated by the underwriting rules and the formula governing the government contribution.

Under current law, active workers and retired workers pay the same premium for health insurance despite dramatic differences in both risk and health care costs. FEHBP plans may not charge different rates based on these risks or costs. In this narrow sense, the program operates under what can only be described as a crude form of "community rating"; 22-year-old joggers and 82-year-old smokers pay the same insurance premiums despite the radically different costs and risks. Obviously, when a larger number of older and sicker retirees congregate in a health plan, its costs and premiums soar, encouraging younger and healthier enrollees to drop out. These higher-cost plans find it difficult to compete with lower-cost plans with younger enrollees, and sometimes drop out of the program altogether.

A large infusion of younger workers or enrollees would alleviate the problem. But if plans could charge OPM more for older workers or retirees in a way that reflected their actuarial cost, without raising the costs for these older workers or retirees, not only would one have a more rational insurance market, but the decision of older workers or retirees to pick a particular plan would not necessarily mean sharply higher premiums for younger workers and their families. Much of the adverse selection problem would disappear.

The best way to accomplish this would be to allow plans to charge different premiums, reflecting the real actuarial value of differing age groups in the market, and simultaneously adjust the government contribution to the plan premiums of older and higher-cost enrollees. In other words, older and retired workers would get a larger government contribution. Since age is the most significant risk factor, the government could adjust government contributions in a limited number of categories: active workers, early retirees, retirees with Medicare, and the progressively smaller num-

48. See Victoria Craig Bunce, "Medical Savings Accounts; Progress and Problems under HIPAA," Cato Institute *Policy Analysis* No. 411, August 8, 2001; see also Michael Bond, Mary Hrivank, and Brian Heshizer, "Medical Savings Accounts: Why Do They Work?" *Benefits Quarterly*, Vol. 12, No. 2 (1996), p. 83.

ber of retirees without Medicare. Since there is no risk adjustment mechanism at all in the FEHBP today, this would be a substantial improvement in the functioning program.

- **Remove the cap on the government contribution to a plan.** Under the current financing formula, the government, regardless of how much it contributes in any given year, may not contribute more than 75 percent of the cost of any health plan's premium. A real consumer choice system should give individuals and families the full benefit of any savings that accrue from wise purchasing decisions. In calendar year 2000, for example, the maximum government contribution for family coverage was $4,580. Under this proposed change, workers who purchase a plan with an annual premium of $4,000 would get a $580 rebate from the government. The family, in other words, would realize the full financial benefit of picking the lower-cost plan.

  Although the government's contribution, using the market-based formula, would vary every year and reflect changes in the market, the removal of the cap on the government contribution would give the competing plans in the FEHBP new incentives to offer benefit packages at a premium level equal to or below the government's defined contribution and thereby increase price competition. More intensive price competition would help stabilize the overall premium increases on which the total government contribution is based. Federal employees would have an incentive to purchase lower-cost plans to reduce out-of-pocket costs and to pocket any savings. Those who choose more expensive plans with richer benefit packages would, of course, pay more in premiums and out-of-pocket costs.

- **Create a younger, healthier insurance pool.** The FEHBP needs young blood. One prominent option: Enroll military families and their dependents under the age of 65 under the same terms and conditions that apply to federal employees, retirees, and their families. Representatives of military families have testified that they *want* to be enrolled in the FEHBP.[49] They realize it would give them a much wider range of plans and benefit packages and a far superior medical system. Because health care benefits, like wages, are normally counted as compensation, Congress could enroll military families in the program in a budget-neutral fashion and pass on any savings to these families as rebates or pay increases.[50]

  Representative Eleanor Holmes Norton (D–DC), a member of the House Subcommittee on the Civil Service and Agency Organization, recently suggested a variation of this author's proposal: enrollment of the families of reservists called up for active duty. Like regular military families, reservists and the families of reservists retain a direct connection with the federal government. They are young and would enhance the actuarial profile of the FEHBP pool,[51] since the average age of members of the federal workforce has increased in recent years and is likely to continue, while the number of workers eligible for retirement is expected to soar.

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49. See testimony of Sydney T. Hickey, Associate Director, Government Relations, National Military Families Association, before the Subcommittee on Civil Service, Committee on Government Reform and Oversight, U.S. House of Representatives, 106th Cong., 1st Sess., June 30, 1999.
50. The potential savings to the taxpayer of enrolling this population in the FEHBP could be enormous. According to a recent Congressional Budget Office estimate, the option would result in an accumulated savings of $28 billion over a period of 10 years. For further discussion of this option, see Angela M. Antonelli and Peter B. Sperry, eds., *A Budget for America* (Washington, D.C.: The Heritage Foundation, 2001), pp. 121–122. See also Congressional Budget Office, *Budget Options*, March 2000, p. 86.
51. Delegate Norton offered the proposal during an October 16, 2001, oversight hearing on the Federal Employees Health Benefits Program conducted by the House Subcommittee on Civil Service and Agency Organization.

CONCLUSION

The FEHBP is structurally sound but still troubled. Its problems are rooted in shortsighted government policies that are incompatible with its structure as a system based on consumer choice and competition. The solutions to its problems are also rooted in government policies, but ones that are compatible with its structural advantages and that enhance consumer choice and competition.

In recent years, OPM has become a more aggressive regulatory agency, imposing the equivalent of benefit mandates, promoting plan standardization, and reducing the capacity of private plans to make innovative changes. OPM policies have neither reduced health care costs nor attracted more plans and benefit offerings. Today, there is less variation in plans and benefits in the FEHBP, and federal workers and their families therefore are paying higher prices in a program with less real choice.

Nonetheless, in spite of its recent troubles, the FEHBP has many strengths. It has a level of consumer choice that is unmatched in the private sector. Federal workers and their families enjoy a richness and variety of options that are unavailable to workers in private employer-based health insurance plans. And they are able to pocket the savings generated by their health care decisions.

Working together, the Bush Administration and Congress can significantly improve the FEHBP for federal workers and their families. They can improve it by enriching benefit options, such as offering tax-free accounts from which to pay routine medical expenses; reforming the underwriting and the government contribution formula to sharply reduce the problem of adverse selection; and broadening the insurance pool by including younger families, particularly the families of military personnel and reservists called up for duty, which would stabilize premium increases.

There is no reason why such improvements cannot be made in a program that has become a showcase of personal choice and model of solid health care financing and delivery. Improving the FEHBP can be the first step in the creation of a new health care system for all Americans—one in which individuals and families, rather than corporate or government officials, make their own key health care decisions.

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