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State-Based Health Reform: A Comparison of Health Insurance Exchanges and the Federal Employees Health Benefits Program

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Unwilling to wait still more years for Congress to fix the tax treatment of health insurance, state legislators are now learning that they can take steps to create a new health insurance market in which individuals and families own and control their own health insurance while receiving the generous tax breaks previously available through conventional employer-provided, defined benefits plans. The best way to do this is to create a statewide health insurance exchange (HIE), a new market where individuals and families can purchase affordable and portable health insurance.[1]

In many respects, the HIE concept is broadly similar to the popular and successful Federal Employees Health Benefits Program (FEHBP), the consumer-driven system that covers Members of Congress, federal workers and retirees, and their families—altogether more than 8 million Americans. In key ways that concern governance, health benefits, and consumer choice, however, the FEHBP differs in crucial ways from the HIE concept

Two Systems. The health insurance exchange is still primarily a concept, though a variant of The Heritage Foundation's exchange proposal was enacted and is now being implemented as part of Massachusetts' 2006 health reform plan. Other states are considering replacing the complex rules that govern their health insurance markets, which are often balkanized and dysfunctional, with a statewide health insurance exchange.

The purpose of the HIE is to provide private sector employees with the opportunity to secure a portable health plan of their choice in a competitive environment and to take advantage of the generous tax benefits of employer-based health insurance. Personal ownership and portability of private insurance would stabilize the market, enabling persons to keep their health insurance from job to job without penalty. In the absence of a congressional overhaul of the tax treatment of health insurance, no one has yet devised a better mechanism to accomplish that goal.

The FEHBP, meanwhile, is an institutional reality: It is the largest group health insurance system in the world. The purpose of the FEHBP, established in 1960, was to provide federal employees and retirees with a choice of competitive private health plans through their place of work. It is part of the federal compensation package, designed to attract and retain federal workers.

How Health Insurance Exchanges Are Like the FEHBP:

1. *Broad Choice of Health Plans and Benefits.* Under the FEHBP, federal workers and retirees may

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choose from among a broad range of private health plans, exercising a level of choice that is denied to most other Americans. There is no standardization of health benefits packages in the FEHBP; rather, there are a variety of benefits packages, with different combinations of benefits, payments, co-payments, and deductibles.

Among the choices are health plans offered by traditional carriers, like Blue Cross and Blue Shield, and plans offered by associations, unions, or employee organizations. The plans range from PPOs and HMOs to indemnity plans and consumer-directed plans, such as health savings accounts.[2] In addition to choosing from a wide variety of private plans offering different benefits at different price-points, FEHBP enrollees can pocket the savings from picking and choosing lower cost health plans.

Similarly, in a statewide health insurance exchange, employers and employees can choose from among an even wider array of plans, including health plans sponsored by associations and trade and professional organizations, as well as plans sponsored by unions, employee organizations, and ethnic, fraternal, and religious or faith-based organizations.

Consumer choice is evident in the first state HIE. Early in the implementation of the Massachusetts "Connector" (that state's HIE), six insurance carriers are already participating, and 42 health benefits options are available to employees and their families, with a variety of premiums, deductibles, and co-payments. Outside of the FEHBP, this range of personal choice in health care is rare in the U.S.

2. *Financing Through Defined Contributions.* With the FEHBP, the government, acting as an employer, makes a defined contribution toward the cost of an enrollee's health plan. Under the current government formula, the government contribution is routinely 72 percent of the cost of a health plan; but it can be no more than 75 percent of the cost of any health plan, up to a fixed dollar amount. The government contribution is annually calculated on the weighted average cost of all of the health plans competing in the program. FEHBP enrollees may choose health plans that are more expensive than the capped amount, if they are willing to personally pay the additional cost for a richer combination of benefits.

   In a health insurance exchange, employers can make a defined contribution to a health plan of an employee's choice. By designating the exchange as the employer's health plan for purposes of federal law, the defined contribution becomes tax-free to the employer, and the value of the health benefits plan is also tax-free to the employee. Taking advantage of the federal tax treatment of employer-based health insurance through a defined contribution arrangement improves the affordability of health insurance premiums for employers and employees alike. But the key advantage for employees is that they can choose health plans, own their health policies just like they own other insurance policies, and thus take their policies from job to job. If an employer does not make a defined contribution, it can set up a Section 125 flexible spending account that employees can use to make tax-free payments for the plans of their choice. In establishing a statewide health insurance exchange, state legislators can make the establishment of a Section 125 account a condition of joining the exchange. This makes the entire process for employers voluntary, in compliance with the Employee Retirement Income Security Act of 1974 (ERISA).

3. *Centralized Enrollment and Premium Payment.* The U.S. Office of Personnel Management (OPM) directly administers the FEHBP. OPM

1. For a brief description of the concept, see Robert E. Moffit, "The Rationale for a Statewide Health Insurance Exchange," Heritage Foundation *WebMemo* No. 1230, October 5, 2006, at *www.heritage.org/research/healthcare/wm1230.cfm*.
2. In 2007, the FEHBP market contains 14 fee-for-service plans, 209 HMOs, and 61 consumer-directed plans. Government Accountability Office, "The Federal Employees Health Benefits Program: Premiums Continue to Rise, but Rate of Growth Has Recently Slowed," testimony before the Senate Subcommittee on Oversight of Government Management, the Federal Workforce, and The District of Columbia, GAO-07-873T, May 18, 2007, p. 4.

handles enrollment and premium payment directly for federal retirees, while federal agencies handle payroll deductions and payments for the active federal workforce.

In this respect, an HIE fulfills much the same role as OPM. It can enroll individuals and families in coverage, collect insurance premiums from employers and employees, and administer any government subsidies to eligible individuals. At the same time, the exchange could contract with vendors, such as third-party administrators, to perform specialized tasks.

4. *Provision of Consumer Information.* Both OPM and federal agencies, operating as employers, assist federal workers and retirees in making plan choices by offering unbiased information on various plan offerings. This is supplemented by solid information from private sector organizations, unions, and employee associations on the best plans available in terms of value, quality, and price. For example, Checkbook's *Guide to Health Insurance Plans for Federal Employees* is an annual Washington bestseller. The National Association of Retired Federal Employees (NARFE), a major organization representing hundreds of thousands of retired personnel, plays a valuable role in informing federal retirees of the best plans for specialized medical services, treatments, procedures, and benefits. As NARFE has repeatedly affirmed, there are no "bad plans" in the FEHBP—only different plans serving different needs.

   In an HIE, exchange officials could prepare and disseminate descriptions of the coverage available as well as comparative information and enrollment forms. As in the FEHBP, private actors would have the incentive to prepare information on competing plans that aids individuals in choosing the coverage that best meets their needs.

How Health Insurance Exchanges Differ from the FEHBP:

1. *The FEHBP operates as a purchasing agent.* The Office of Personnel Management serves as the agent for federal workers and retirees and negotiates directly with private carriers over rates and benefits. In any given year, the health plans' benefits, premiums, and coverage vary due to that negotiation. These changes depend upon the OPM staff's negotiating skills.

   With a Heritage-style health insurance exchange, there is no reason to have the officials of the exchange act as an intermediary between individuals and health insurance plans. Instead, premiums and benefits would be determined by consumer demand in the market.

2. *The FEHBP regulates health insurance plans.* OPM sets basic administrative, benefit, and financial standards and underwriting rules for health plans in the FEHBP.[3] In addition to a crude system of community rating, OPM enforces rules requiring the "guaranteed issue" of coverage and limiting exclusions for pre-existing conditions. Outside of these underwriting rules, FEHBP regulation has been light.[4] This regulatory authority, laid out in just a few pages of statute and regulation, is focused almost exclusively on issues related to consumer protection, marketing practices (e.g., a plain English requirement), and the financial solvency of health plans.[5] Within these rules, every health plan determines its own contractual and payment relationships with doctors and hospitals and other medical professionals and designs its own benefits package.

   A health insurance exchange is not a substitute for the state's department of health insurance, nor should it duplicate the responsibilities of the

3. Under Section 8902 of Title V of the U.S. Code, OPM "may prescribe reasonable minimum standards" for health benefits plans and carriers.
4. Under OPM rules, there are no mandatory government fee schedules or price controls and no official formulas governing reimbursement to doctors, hospitals, or medical professionals.
5. Under its statutory authority, OPM is to contract with health plans that are licensed in the states; that are reinsured with other companies; that offer detailed statements of benefits with definitions of limitations and exclusions that OPM considers "necessary or desirable"; that charge rates that "reasonably and equitably" reflect the costs of the benefits; and that agree to provide benefits or services to persons entitled under the terms of its contract.

state's health insurance department. Thus, there is no reason for officials of a health insurance exchange to regulate health insurance by imposing benefit mandates or a comprehensive standard benefits package.

3. *FEHBP plans are not bound by state benefit mandates or state premium taxes.* National health plans in the FEHBP operate under federal law and are thus exempt from state benefit mandates and premium taxes.

   With a health insurance exchange, the state legislature may or may not agree to retain state mandates and premium taxes. It is advisable to exempt plans in the exchange from benefit mandates. In Massachusetts, however, the legislature insisted on retaining the state's 43 benefit mandates. Nonetheless, the legislature did institute a three-year moratorium on new benefit mandates and provided for reduced-mandate insurance policies for people between the ages of 19 and 26. In establishing a statewide HIE, state legislators may wish to start with a clean slate and, thus, reduce or eliminate many of the benefit mandates that undermine the flexibility and affordability of insurance products.

4. *Congress has empowered itself to restrict entry into the FEHBP market.* Fee-for-service health plans need legislative approval to enter the FEHBP. State-based HMOs can compete if they comply with OPM's light regulatory regime, which many already do.

   In a normally functioning market, however, participants should be free to enter and exit without restriction, boosting opportunities for consumer choice, innovation, and efficiency. With a health insurance exchange, state officials should allow any willing health plan to enter or exit the market without restriction. Moreover, any certification required for health plans to enter the exchange should be based only on whether the health plans are licensed to do business in the state.

Common Lessons:

1. *The market principles of consumer choice and competition control costs.* Surprisingly, the FEHBP is not an ideal insurance pool, one in which a large number of younger, healthier workers cross-subsidize a much smaller group of older workers and retirees. The federal workforce is significantly older than the private sector workforce. Moreover, the ratio of retirees to active workers has steadily increased over the past several years, and today the average age of an FEHBP enrollee is 60.

   Meanwhile, the health benefits available to federal workers and retirees have been growing progressively richer and more varied. Nonetheless, the FEHBP has demonstrated remarkable historical success in controlling costs.[6] For 2007, the average premium increase in FEHBP turned out to be 1.8 percent, far less than for conventional insurance markets. Even with its relatively unfavorable mix of employees and retirees, this unusual system of consumer choice and competition performs better than its actuarial profile.

   In a health insurance exchange, where insurance carriers compete directly for the dollars of younger workers, states should see similar performance in cost control. In the first year of its health care reform plan implementation, Massachusetts has already registered a significant decline in the average premium available to single individuals through its HIE. The average uninsured Massachusetts resident can buy a health plan for $175 per month, or $109 per month on a pre-tax basis.[7] This is a dramatic decline from the average monthly premium of $350 per month for a single individual buying in the small group market in 2005.

6. The FEHBP has historically outperformed private, employer-based health insurance. Based on comparative data assembled by Walton Francis, a nationally recognized expert on the FEHBP, from 1992 to 2001, private insurance premiums had an average annual growth rate of 6.6 percent, while FEHBP plans had an average annual growth rate of 5.2 percent. During the 15-year period from 1987 to 2001, private insurance premiums grew at a rate of 9.4 percent, while FEHBP premiums grew by 8.4 percent. A Government Accountability Office analysis confirms FEHBP's recent record of superior cost control. See Government Accountability Office, "The Federal Employees Health Benefits: Premiums Continue To Rise, But Rate of Growth has Recently Slowed."

2. *A defined contribution is superior to a defined benefits program, especially for a highly mobile workforce.* Today, the federal government makes a contribution to the cost of each private plan chosen by federal workers and retirees. The maximum dollar amount of this contribution is set by a formula.

   Likewise, a health insurance exchange operates on the principle of defined contributions. Establishing a new system of defined employer contributions would give workers and their families the opportunity to take full advantage of changes in a potentially far more dynamic market for health insurance, leading to potentially hundreds of dollars of savings per family annually. In contrast, in a defined-benefit arrangement, workers cannot take advantage of such changes. This sacrifices cost savings and prevents workers from enjoying the fruits of their smart shopping, such as receiving a better mix of benefits, higher wages, or tax-free account contributions.

   Moving from a defined-benefit to a defined-contribution system makes sense for employers and employees. Employees should be able to secure the full economic benefit of choosing less expensive insurance coverage, if they wish to do so, in return for higher wages or other compensation. A free market rewards rational choices and lets consumers get the best value for their money.

3. *Regulation should be light.* One of the oddest features of the FEHBP is that, despite its millions of enrollees and the fact that it is a government program, it is managed by a staff of less than 200 employees and governed by light and rational government regulation. OPM's own administrative cost is small, comprising less than 1 percent of the "aggregate cost" of health plan premiums.

   Building on this lesson, a health insurance exchange is not and should not be a regulatory agency or a substitute for a state's department of insurance. It is nothing more than an administrative agency for facilitating access and choice for employers and employees. And, in fact, it is preferable for many of its functions to be simply contracted out to private parties or entities.

   In this respect, the function of an exchange is twofold: to enable individuals to purchase portable health insurance without abandoning the advantages of the federal tax code and to facilitate the premium payments and related transactions of employees and employers—especially small employers, who are in desperate need of a simpler system.

   Recent controversies over the implementation of the Massachusetts plan have been rooted not in the inability or unwillingness of private sector players to respond, but in the Connector board's role in setting benefits, determining the standard for "minimal creditable coverage," and granting a seal of approval (in addition to other state certifications) for participation.[8] As Massachusetts' experience suggests, these functions are not well suited to a health insurance exchange.

Conclusion. The FEHBP is the only large group insurance system in the nation in which individuals can choose the plans and benefits that they want at prices they wish to pay. While the FEHBP is not perfect, it has a solid record of performance in expanded consumer choice, cost control, and patient satisfaction.[9] This year's premium increase of 1.8 percent is another milestone in the program's long record of cost control coupled with high levels of consumer satisfaction.

As state officials work to reform their health insurance markets, they should take the best features of the FEHBP and apply them to their own markets: broad choice, competition among plans, defined-contribution financing, and the provision of solid consumer information. A health insurance exchange, properly designed, accomplishes this.

7. Executive Department of the Commonwealth of Massachusetts, "New Health Insurance Plans Will Be Available for Under $200," Press Release, March 3, 2007.
8. Robert E. Moffit, Ph.D., "The Massachusetts Health Plan: An Update and Lessons for Other States," Heritage Foundation *WebMemo* No. 1414, April 4, 2007, at *www.heritage.org/research/healthcare/wm1414.cfm*.
9. According to a 2003 OPM report on FEHBP enrollees, 78.9 percent of enrollees in fee-for-service plans and 62.7 percent of those in HMOs were "satisfied, compared to the insurance industry average of 61.8 percent.

But transforming a health insurance exchange into a regulatory agency, another bureaucracy for setting benefits, or a purchasing agency on behalf of individuals and families, undermines the goals of market-based reform. Instead, state officials crafting reform plans should rely on consumer choice and competition to take care of the details. If they do, they can control costs, improve value, and boost their constituents' satisfaction with their health coverage.

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