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ISSUE BRIEF



The Federal Employees Health Benefits Program: What Lessons Can It Offer Policymakers?

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A workshop featuring

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The FEHB Program

The Federal Employees Health Benefits (FEHB) program frequently enters health policy discussions. It is often cited as a living example of “managed competition,” in which a multitude of health plans compete for customers. Some analysts have held it up as a model for Medicare and other public programs to emulate. Some legislators view it as a vehicle upon which to piggyback coverage of other populations, such as military retirees or employees of small businesses. Last, but not least, the FEHB program is simply a major purchaser of health insurance. In fact, it is the largest employer health plan in the United States, providing coverage to about 9 million people—federal workers and retirees and their dependents and survivors—at an annual cost of about \$17 billion.

This Forum meeting will examine how the federal employees health program works, what issues its managers face, and what lessons their experience might offer for covering other populations.

HISTORY

Congress did not set out to design a health insurance marketplace when it created the FEHB program in 1959. Rather, it was doing something that most other large employers already had accomplished in simply providing health benefits for employees.

The program began operation in 1960, offering 28 plans, with 15 available in the Washington, D.C., area.¹ The enabling legislation enacting the FEHB program allowed four types of plans to compete: existing employee-sponsored plans, a nationwide service benefit plan, a nationwide indemnity plan, and health maintenance organizations (HMOs). Previously, in the absence of an employer-sponsored plan, some federal government agencies had offered group plans paid for by employees. The legislation allowed those employee organization plans to continue. Under the provisions of the statute authorizing the Civil Service Commission to contract for a government-wide service benefit plan and a government-wide indemnity plan, Blue Cross and Blue Shield and the Aetna Life Insurance Company, respectively, established plans in the program. Each had a high and a standard option.² (Aetna withdrew its indemnity plan several years ago, after its competitive position was damaged by adverse risk selection.) The original law also required the program to offer HMOs, and at the beginning 21 participated. Today, the number of HMOs has grown to more than 300. While the fee-for-service

plans in the FEHB program are limited to those specified in statute, the law allows any HMO to join if it meets federal admission requirements. Seven of the fee-for-service plans are open only to people in select groups.

A MARKETPLACE

The FEHB program is often called the largest managed competition system for offering consumers a large variety of health plan choices in a way that contains costs.³ Over its almost 40-year history, the program has faced several problems, some directly related to the large number of options offered to members. One of the most significant problems is related to risk segmentation—that is, some health plans in the program have attracted or retained a disproportionate number of older and sicker people than others. Attracting a relatively sicker population means that plans must charge higher prices, thereby putting them at a competitive disadvantage compared to plans with healthier enrollees.

Two key architectural features driving competition within the FEHB program are its annual open enrollment period and its method for contributing to members’ health plan costs. In essence, each year the government offers each employee or retiree a sum of money to help cover the cost of health coverage, while asking the person to contribute part of his or her wages or pension toward that cost. About 15 percent of those eligible eschew the program altogether. Some of these people opt to join outside plans, such as those offered by spouses’ employers that may have richer benefits or

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require a lower employee contribution. Others (probably mostly younger people or low-wage workers) opt to have no health insurance.⁴ FEHB program members can choose from between one and three dozen plans in each geographic area.⁵ In 1996, while the vast majority of plans being offered were HMOs, 72 percent of those covered by the program chose fee-for-service or PPO (preferred provider organization) plans.⁶ Almost all of the 2.3 million active employees in the program have chosen either HMOs with limited networks of providers or PPOs in which they face financial incentives to use providers in a network. About 5 percent of enrollees switch among plans each year.

Of the 4.1 million employees and annuitants in the program, about 1.8 million were enrolled in the Blue Cross/Blue Shield high and low options, as of September 1997. Other fee-for-service plans with the highest number of enrollees were the Mail Handlers high and low options (479,000), Government Employees Hospital Association (246,000), National Association of Letter Carriers (166,000), and American Postal Workers Union (115,000). HMOs with the largest FEHB enrollment were Kaiser Permanente-California (139,000), Aetna U.S. Healthcare (92,000), Kaiser Permanente Mid-Atlantic (77,000), NYLCare Mid-Atlantic (41,000), and GHI Health Plan (41,000). About 80 HMOs in the program had fewer than 300 FEHB enrollees. (PruCare of Connecticut had only two FEHB members as of September 1997.)⁷

The Office of Personnel Management (OPM), which runs the program, sets financial, administrative, and benefit terms for each plan. While each plan must offer core medical and hospital benefits, there is considerable variety in benefit structures. OPM publishes a guide to help members make choices but does not attempt to compare the costs of plans for members. The agency also provides extensive information on the OPM Web page on the Internet. At least half of the covered employees and many retirees have access to and use the Web site, according to OPM officials.⁸ The Center for the Study of Services, publisher of *Washington Consumers' CHECKBOOK* magazine, sells a consumer guide for \$8.95 that estimates how much each plan will cost enrollees by subtracting the government contribution from each plan's premium and adding to that amount estimates of how much each plan will cost people as a result of cost-sharing features, such as copayments and deductibles.

The FEHB Program's Payments to Plans

OPM pays health plans under a formula that will change January 1, 1999, under provisions in the Bal-

anced Budget Act of 1997 (BBA). In 1996, the federal contribution ranged from about \$1,100 to \$1,600, constituting 75 percent of the least expensive plan's premium and 47 percent of the costliest plan's premium.⁹ Federal employees and retirees pick up the rest of the tab.

Originally designed to cover 60 percent of premium costs, the federal contribution was set at 60 percent of the average of six plans that Congress thought would be representative of the entire program's population. These "Big Six" plans were specified as the high options under the service benefit and indemnity benefits plans, the two largest employee organization plans, and the two largest HMOs. Over the years, the high-option plans experienced substantial adverse selection, partly because they tended to retain a higher-utilizing population, causing their premiums to rise faster than those of other plans. Linking the government contribution to the premium growth rates of plans that experienced adverse segmentation resulted in the government's spending more than it intended on almost every other plan in the program.

When Aetna withdrew its government-wide indemnity plan from the program in 1990 because the plan's viability was being threatened by adverse risk segmentation, the government contribution would have dropped considerably if it had been based on the remaining five of the "Big Six" plans enumerated in statute. Instead, a contribution methodology was enacted that preserved the "Big Six" formula by calculating a "phantom" Aetna premium based on the actual 1989 premium raised by the average premium increase for the other five plans. The phantom formula was extended through the end of contract year 1996 and a slightly modified version was used for 1997 and 1998. Since the phantom premium is substantially higher than the other five premiums, it artificially inflated the government's contribution, according to OPM. (The 1997 and 1998 modifications were intended to alleviate this problem.)

Barring further amendments of the law, the program would have shifted to a "Big Five" formula to set the government premium contributions after 1998, resulting in the shift of nearly \$27 a month in costs to the average enrollee. Instead, the administration and Congress developed a new "fair share" formula that was enacted as part of the BBA. Beginning in 1999, this formula will set the government's maximum dollar contribution at 72 percent of the weighted average premium of program participants; it will continue the 75 percent ceiling on the contribution to any particular plan.

The current FEHB payment formula encourages but may not maximize competitive premium prices. Setting the government contribution on a percentage basis limits how much consumers will respond. For example, program members who shift among the lower-cost plans keep only 25 percent of the premium savings and must pay only 25 percent of any additional premium. However, those who shift among the highest-cost plans will pay the full marginal cost of any additional premium because of the government contribution ceiling. Finally, price competition based on plan efficiency may be muted because the government does not adjust payment to health plans to compensate those that have attracted or retained higher-risk members.

A payment formula that would send stronger price signals to consumers would have the government pay a fixed amount equal to the entire premium of the least costly plan, with members picking up the additional costs if they opted for other plans. In the absence of a risk-adjusted payment formula, however, stronger price signals might exacerbate the risk segmentation that already has occurred and cause many of the remaining fee-service-plans to become uncompetitive. OPM officials interviewed say that they believe on philosophical grounds that all employees ought to contribute something toward paying for premiums. Furthermore, moving to a contribution formula that required employees to pay nothing for the cheapest plan might raise costs to the government if it induced people who have opted for spouses' plans with greater contribution requirements to shift into the FEHB program.

OPM officials also say that they do not want employees' choice of plan to be based entirely on price and want people to consider the quality of plans as well. To this end, the agency surveys members' satisfaction with plans and publishes the findings and is working to develop quality measures.

Risk Segmentation

The FEHB program enrolls three sets of people: employees, annuitants with Medicare, and annuitants without Medicare, according to Walton Francis, a long-time analyst of the program. In total, more than 40 percent of those enrolled in the program are annuitants. Annuitants with Medicare cost the program slightly less than employees, because Medicare is primary payer for their coverage. The remaining annuitants are more costly to insure. Over the years, employees and annuitants with Medicare gradually fled plans with a disproportionate share of annuitants without Medicare, causing a number of plans to enter "a death spiral from

adverse selection."¹⁰ According to Francis, the main reform needed to offset the effects of risk segmentation is to have the government pay more for higher-cost annuitants.

Risk segmentation has had negative economic consequences for many of the FEHB program's members. A plan that has attracted primarily high health risks can cost several times as much for approximately the same level of benefits as a plan made up of healthier risks. For example, an evaluation of the FEHB program published by OPM in 1988 documented that, while Aetna's high and standard options had virtually the same actuarial value (a three-percentage-point difference was estimated), the high-option premium was more than two times greater and its employee contribution rate was more than four times higher than the corresponding figures for the standard option.¹¹ OPM officials say that risk segmentation is a much smaller problem in the program today than it was a decade ago. They point out that it does not have any impact on government costs and that individuals have freedom to leave a plan they think is overpriced and join another. However, many employees do not understand the cost and benefit differences between plans, despite the information available to them.

The 1988 evaluation by Towers, Perrin, Forster, & Crosby concluded that the FEHB program faced several fundamental problems. It noted that, while plans competed at the consumer level for lower-risk enrollees, the lack of competition among carriers for entry into the program had severe consequences. As noted above, OPM can exercise little or no discretion about which firms compete. The nationwide plans are determined by statute, and any HMO may join that meets certain standards. According to the report:

By legislating that it will do business with certain entities and only with those entities, the Government relinquishes the tremendous leverage it could otherwise exercise in the health care marketplace. By contracting with such a large number of entities (over 400), the Government also multiplies its costs and fragments its buying power. Competition in the FEHB program is at the consumer level, for which the program has often been praised. However, this form of competition does nothing to counteract these inefficiencies, but actually exacerbates them. As noted above, the purpose of this competition is almost exclusively to attract the better risks, not to provide a product in the most cost-effective manner.¹²

The 1988 evaluation also noted that community-rated HMOs, often drawing healthier members of the federal employee program, might be overpaid. To

alleviate this problem, OPM now negotiates rates with HMOs based either on the experience of FEHB members or on an estimation of what private firms are paying. This estimate is based on rates paid by the two employers in the community whose numbers of employees enrolled in the HMO are closest in size to the number from the FEHB program.

In recent years, OPM has taken a number of steps to mitigate the opportunities for risk selection. The program's administrators have limited the variation in benefit packages, requiring some plans to drop benefits and others to add them. The difference in actuarial value of the packages is reported to have narrowed to as little as about 10 percent, down from four or five times that much in 1989.¹³ Despite the narrowing of actuarial value, the costs to employees among plans can vary widely. For example, the enrollees' share of premium for fee-for-service plans ranges from \$39.55 a month to \$248.41 a month. While some of the difference is attributable to benefit differences, how much of the cost variation is due to risk segmentation, plan efficiency, quality of care, and other factors is open to question.

Costs

In recent years, the FEHB program has held up well when compared to other employer programs in its effort to restrain the growth of health insurance premiums. Surveys of employers show that annual premium growth in employer plans dropped from double-digit rates at the beginning of the decade to 2 percent or less during the past three years.¹⁴ While demonstrating a similar trend, FEHB premiums have generally grown at rates lower than those reported by nonfederal employers, with average premiums actually declining in 1995 and 1996, according to the Congressional Budget Office (CBO). Although OPM announced that FEHB premiums would increase by an average of 8.5 percent in 1998, this appears to be consistent with developments in the private market, according to CBO. Premium increases among private employers will be in the 5 to 10 percent range in 1998, according to estimates by the Hay Group, a firm that tracks employer premium costs.

THE FORUM SESSION

The FEHB program is constantly held up as an example to emulate and sometimes seen as a place to put populations needing health insurance. For example, during last year's debate over reforming Medicare, one approach under consideration would have converted Medicare to a defined contribution plan mimicking many features of the FEHB program.¹⁵ More recent

proposals would open the program to military retirees and to members of the general public who do not have access to health insurance.

A bill introduced recently by Reps. Bill Archer (R-Tex.) and Dan Burton (R-Ind.) would allow federal workers to opt for high-deductible policies coupled with medical savings accounts (MSAs). Proposals to establish MSAs as an option in Medicare and the private sector drew opposition from those arguing that the high-deductible policies would exacerbate risk segmentation problems because they would appeal mainly to relatively younger, healthier people. Proponents often argue that the high-deductible policy provides a helpful incentive for individuals to restrain healthcare spending while the MSA provides a vehicle for savings to help pay for future medical needs.

This Forum meeting will examine how the FEHB program works, what issues its managers face, and what lessons it might hold for covering other populations. **William E. Flynn III**, associate director for retirement and insurance at OPM, will lead off with an overview of the program and key issues facing its managers. **Walton Francis**, a leading expert on the FEHB program, and **Michael J. O'Grady, Ph.D.**, senior analyst at the Medicare Payment Advisory Commission, will analyze important features of the program as well as what lessons it may hold for outside populations.

Issue Questions

The questions to be addressed include the following:

- On what basis do health plans compete within the FEHB program?
- Does the statutory requirement to have particular plans compete in the program detract from the government's ability to contain the growth of costs? How much leverage could OPM exert if it were mandated to be more selective about which carriers competed?
- Given the contribution formula and other features of the program, to what degree do plans compete to attract healthier members and to what degree do they compete on the basis of administrative efficiency and quality of care?
- How are various players—individuals, health plans, and taxpayers—affected by the risk segmentation that has occurred in the program and to what degree?
- Should the government consider implementing a risk adjustment system for paying FEHB health

- plans? What other measures might be taken to mitigate the effects of risk segmentation?
- Should the benefit packages of plans competing in the program be more standardized?
 - How would the introduction of catastrophic plans coupled with medical savings accounts affect the program?
 - How are low-wage federal workers impacted by the FEHB contribution formula?
 - What issues arise when considering the FEHB model for outside populations? Is it a feasible option for covering the uninsured or other groups? If so, to what degree would federal employees be segregated from the new groups? Is OPM an appropriate administrator for a program covering people outside of federal employment?
9. PPRC, *1997 Report to Congress*, 181.
 10. Francis, "Political Economy," 289.
 11. OPM, "Study of the Federal Employees Health Benefits Program," 72.
 12. OPM, "Study of the Federal Employees Health Benefits Program," 7.
 13. PPRC, *1997 Report to Congress*, 184.
 14. Statement of Joseph R. Antos, assistant director for health and human resources, Congressional Budget Office, on premium increases in the Federal Employees Health Benefits Program, before the U.S. House of Representatives Committee on Government Reform and Oversight, Subcommittee on Civil Service, October 8, 1997.
 15. "Medicare: FEHBP Could Be Adopted As Basis For Program Changes, Sen. Wyden Says," *Bureau of National Affairs Pension & Benefits Reporter*, 24 (June 2, 1997), no. 22:1296.

ENDNOTES

1. Walton Francis, "The Political Economy of the Federal Employees Health Benefits Program," in *Health Policy Reform: Competition and Controls*, ed. Robert B. Helms, (Washington, D.C.: AEI Press, 1993), 273.
2. Office of Personnel Management, "Study of the Federal Employees Health Benefits Program," submitted by Towers, Perrin, Forster & Crosby, Inc., Washington, D.C., April 22, 1988, 22-23.
3. For example, see Robert Moffitt, "Consumer Choice in Health: Learning from the Federal Employee Health Benefit Program," Heritage Foundation Backgrounder no. 878, Heritage Foundation, Washington, D.C., November 9, 1992.
4. Francis, "Political Economy."
5. Walton Francis and the Editors of *Washington Consumers' CHECKBOOK, Checkbook's Guide to 1998 Health Insurance Plans for Federal Employees*, (Washington, D.C.: Center for the Study of Services, 1997), 4.
6. Physician Payment Review Commission, *1997 Annual Report to Congress* (Washington, D.C.: Physician Payment Review Commission, 1997), 180.
7. Although the law and regulations allow the Office of Personnel Management (OPM) to terminate plans with less than 300 FEHB members, OPM usually does not do so, partly to make sure that employees have a wide range of choice and access to coverage in less populated areas, according to OPM officials.
8. The Web site also provides links to many other sources of information including evaluations of plan performance.