

The Henry J. Kaiser Family Foundation

**The Federal Employees
Health Benefits Program:
Program Design, Recent
Performance, and
Implications for
Medicare Reform**

Prepared by

Mark Merlis

May 2003



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The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform

The Federal Employees Health Benefits Program (FEHBP) offers a choice of health plans to federal employees and annuitants, using a premium contribution scheme that provides incentives for participants to select less costly plans. FEHBP is often held out as a working model of market-based insurance programs. Proponents of a competitive system for Medicare often cite FEHBP as a prototype, and there have also been proposals to use FEHBP itself or a similar system as a mechanism for extending health plan choice to small employers or individuals.

This paper provides a basic description of FEHBP's structure, benefits, financing, and operations. It then moves on to assess FEHBP's recent performance in a variety of areas, including cost increases, benefit changes, access to providers, and risk selection. It concludes with a brief discussion of the implications of the FEHBP experience for Medicare reform proposals.

Description of FEHBP

Eligibility

Federal employees and annuitants may choose to participate in FEHBP and may also enroll their spouses and children. As of March 2001, there were 4.1 million enrollees, of whom 54 percent were active workers and 46 percent were annuitants. The Office of Personnel Management (OPM), which administers the program, does not maintain records of covered dependents, but estimates that 4.4 million dependents were covered through FEHBP in March 2001. Overall, then, the program serves about 8.5 million people.

There are two major groups of annuitants. The first consists of those who retired before turning age 65, who are not yet eligible for Medicare (unless they qualify through disability) and rely solely on FEHBP; these are likely the most costly FEHBP participants. The other group includes those who are ages 65 and over and who have both FEHBP and Medicare coverage. In this case, Medicare is their primary insurer, and FEHBP provides supplemental coverage that wraps around Medicare.¹

¹A small number of annuitants retired before all federal employees were required to pay into Medicare part A; they may buy into part B but must rely solely on FEHBP for hospital coverage. This group is very old and is now negligible in size.

Structure and financing

FEHBP purchases coverage from private health insurance plans; it does not pay directly for any medical services or regulate the amounts the plans pay. Active employees receive a contribution from their employing agency and pay the remainder of their premium themselves. The government cost for their coverage is part of the appropriation for each agency; the agency then transfers the required amounts to OPM. Annuitants also receive a federal contribution; this amount is not transferred from their former agency, but is part of the appropriation for OPM.

Employee and annuitant premium payments and government contributions are deposited in two trust funds, one for employees and one for annuitants. The premiums charged for health plans include surcharges for program administration and “contingency reserves,” discussed below. The funds pay premiums to the health plans and transfer necessary amounts for administration to OPM. Any remaining amounts not paid out to the health plans are retained in the funds.

Choice of health plans

FEHBP participants choose from among three different types of plans:

- The government-wide Blue Cross/Blue Shield (BCBS) “fee-for-service” plan, actually a PPO, which offers a standard and a basic option. The standard plan will pay for services from any provider but offers reduced cost-sharing when services are obtained through the plan’s PPO network of contracting providers. The basic plan covers non-emergency services only through PPO providers.
- Fee-for-service plans offered by employee organizations. Of these, 6 are available only to specific groups, such as the Foreign Service or the Secret Service; another 6 are open to all employees and annuitants nationally. (Nonmembers of the organization pay an “associate membership” fee to participate.) Except for a few of the special-group plans, these plans also include a PPO feature. (One plan, APWU, now offers a “consumer-driven” option.²)
- HMOs and point-of-service (POS) plans. Unlike BCBS and the employee organization plans, these plans are available only to employees residing in specific service areas. There are 159 plans available in 2003. Most are HMOs, and this report uses the term HMO to cover both HMOs and POS plans. When an organization operates in several different areas, each local operation is counted as a plan. Because the operations may have different names, it is difficult to track ownership or affiliation. It is estimated that the number of distinct organizations serving FEHBP enrollees is in the range of 100.

Many of the fee-for-service plans and a few HMOs offer two levels of benefits, “high option” and “standard option.” The high option plan offers reduced cost-sharing or other enhanced benefits in return for a higher premium.

²Under this plan, a single enrollee receives a \$1,000 personal care account from which to pay for care; any amount not used during the year may be carried over into the following year. If an enrollee’s costs exceed \$1,000, the enrollee is responsible for the next \$600. That is, traditional plan coverage, subject to coinsurance requirements, begins when the enrollee’s expenses exceed \$1,600. Families receive a \$2,000 account, and traditional coverage begins when expenses exceed \$3,200.

Table 1. FEHBP Enrollment, by Type of Plan, March 2001

	Employees		Annuitants		Dependents (est.)		Total	
	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent
Blue Cross/Blue Shield	963	44%	1,031	55%	1,900	43%	3,894	46%
FFS Employee organizations	387	18%	538	29%	1,070	24%	1,995	23%
HMOs	849	39%	308	16%	1,461	33%	2,617	31%
Total, All Plans	2,199	100%	1,876	100%	4,431	100%	8,506	100%

Source: OPM (2002)

Table 1 shows March 2001 enrollment, including estimated counts of dependents, by type of plan.

- Overall, 69 percent of participants were in BCBS or one of the fee-for-service plans offered through an employee organization.
- Annuitants are much less likely than active workers to enroll in HMOs, with 84 percent enrolled in either BCBS (55 percent) or another fee-for-service plan (29 percent) offered through an employee organization in 2001.

Benefits

There is no prescribed minimum benefit package for FEHBP plans.³ From time to time, OPM specifies particular benefit changes it wants from all plans. For example, it has recently moved plans in the direction of greater parity of medical and mental-health benefits. In general, however, the plans themselves develop their benefit packages. Once admitted to FEHBP, each plan may propose annual changes in benefits, which may or may not be accepted by OPM. OPM's current policy is to allow benefit reductions or increases in required cost-sharing, but to disapprove benefit increases unless these are offset by other benefit cuts.

While OPM has moved, since the 1980s, to narrow differences among plans, significant variations remain. Plans impose different levels of cost-sharing, have different annual out-of-pocket limits, and differ in the extent of their coverage of ancillary services such as prescription drugs and dental and vision care. Some measure of the extent of the variation may be derived from the independent guide to FEHBP plans produced annually by the Center for the Study of Services, publishers of the *Washington Consumers' Checkbook*. The guide estimates, for enrollees incurring different levels of hospital, medical, drug, and dental expenses during a year, the amount of out-of-pocket liability they would experience under different plans.

³ 5 USC 8904(a) requires that plans "include benefits both for costs associated with care in a general hospital and for other health services of a catastrophic nature."

⁴ The new APWU Consumer-Driven option is omitted, because its benefit design is not comparable.

Table 2. Estimated Out-of-Pocket Costs for a Single Enrollee under Age 55 with “Average” Mix of Services, FEHBP Plans in the Washington, DC, Area, 2003

FEHBP Plans in the Washington, DC, Area, 2003	Estimated out-of-pocket costs, excluding premiums
HMO	
Aetna Health (high)	\$ 190
Aetna Health (standard)	\$ 200
CareFirst BlueChoice	\$ 270
Kaiser Mid-Atlantic	\$ 150
M.D. IPA	\$ 150
PPO	
Alliance	\$ 500
APWU (high)	\$ 350
Blue Cross (basic)	\$ 360
Blue Cross (standard)	\$ 230
GEHA (high)	\$ 500
GEHA (standard)	\$ 540
Mail Handlers (high)	\$ 640
Mail Handlers (standard)	\$ 670
NALC	\$ 390
PBP (high)	\$ 430
PBP (standard)	\$ 450

Source: Center for the Study of Services (2002).

Table 2 shows estimated out-of-pocket costs in 2003 under the plans available in Washington, DC, for a single enrollee under age 55 who uses an “average” mix of services.⁴ (The estimates assume use of providers within the plan’s network.) The HMOs generally expose enrollees to lower out-of-pocket costs than the PPOs, in exchange for more restricted access to providers. For example, estimated out-of-pocket costs, excluding premiums range from a low of \$150 under HMOs like Kaiser or M.D. IPA to a high of \$670 for Mail Handlers standard. Thus, an enrollee in Mail Handlers standard would have out-of-pocket costs more than four times as large as those for an enrollee in Kaiser or M.D. IPA.

Even among PPOs, there is considerable variation in costs. Out-of-pocket costs under Mail Handlers standard are estimated to be nearly three times larger than costs for an enrollee in Blue Cross Standard (\$670 vs. \$230).

⁴The new APWU Consumer-Driven option is omitted, because its benefit design is not comparable.

Premium rates and reserves

Two methods are used to establish plan premiums: experience rating and community rating.

- Experience rating is used for all the PPO plans and 20 of the HMOs in 2003. Rates are based on the individual plan's projected costs for serving FEHBP enrollees in the coming year, plus a "service charge"—in effect, a profit allowance—of from 0.5 percent to 1.0 percent. The cost projection relies on the plan's past cost experience with the FEHBP group, trended forward for inflation, benefit changes, and other factors expected to affect costs. This computation necessarily involves some subjective judgment and thus becomes the subject of negotiation between OPM and plans.
- Community rating is used for the majority of HMOs. The plan reports the rates it charges to the two employer groups whose enrollment is closest in size to the plan's FEHBP enrollment, excluding any group whose rate is established on a retrospective experience basis. The lower of the two quotations is the "community rate," which is then adjusted for "expected use of medical resources of the FEHBP group." This adjustment reflects differences in the benefit package for FEHBP and the particular employer group and *may* reflect demographic differences or other factors expected to affect utilization or costs.⁵
- For both experience-rated and community-rated plans, the agreed-upon rates are increased by 1 percent for administration and 3 percent to provide a contingency reserve for each plan. The reserve is held in the trust funds and may be drawn upon if a plan's costs exceed its premium receipts. The administrative allowance pays OPM's expenses. As these are well below 1 percent of premiums, the excess goes to build up the reserves.

Premiums are not risk-adjusted, meaning that the premiums paid to a plan do not vary by enrollee characteristics, such as age, sex, or health risk. Premiums for the national plans do not vary according to where an enrollee is located either. The absence of these adjustments may affect competition among plans, an issue that is considered below.

The government contribution for employees and annuitants is set at the lesser of (a) 75 percent of the premium for the plan selected; or (b) 72 percent of the average premium, weighted by enrollment, of all participating plans. Thus, even if a plan's premium is so low that the maximum government contribution would cover all of it, the enrollee must still pay 25 percent. Postal employees pay a negotiated lower share of premiums. Enrollees may now deduct their share of premiums from taxable income through a "premium conversion" system comparable to private employers' section 125 plans.⁶

⁵ Note that the demographic adjustment only occurs if the plan's usual method of establishing rates for employer groups includes demographic factors. In addition, the adjustment affects the uniform price quoted by the plan for all enrollees; no particular enrollee is charged more or less because of his or her age or other factors.

⁶ In addition, OPM plans to allow employees, beginning in mid-2003, to establish flexible spending accounts under which pre-tax dollars could be used for cost-sharing and uncovered medical expenses.

The 3 percent reserve surcharge on plan premiums is paid by agencies and enrollees along with the rest of the premium and is deposited in the U.S. Treasury. The FEHBP trust fund and the Retired Employees Health Benefit (REHB) fund consist of these deposits—“special reserve” accounts individually attributable to each plan—as well as general program reserves.

With OPM approval, a plan may draw on its special reserve if its costs exceed its premium revenue. For example, if the prospective rate established for the BCBS plan proves inadequate during the course of a year, the plan may draw on its reserves. The effect, over the long run, is that the plan is not at risk. It cannot actually suffer a financial loss unless its shortfall is so great that the special reserves are inadequate to cover it. (If a plan actually went bankrupt, the general program reserves would cover outstanding medical claims for FEHBP enrollees.)

A second use for the reserves is to dampen year-to-year fluctuation in premium rates. For example, if an HMO projects a large increase in its community rate for the coming year, OPM may agree that reserves may be drawn down to reduce the increase. In recent years, plans have drawn heavily on the reserves for this purpose. The reserve fund balances dropped from \$7.8 billion at the end of fiscal year 1995 to \$5.8 billion at the end of fiscal year 1999. The reserves have since been built up again, with an estimated balance of \$7.6 billion at the start of fiscal year 2003 (OMB, 2003). The drawing down of reserve fund balances in the mid- to late-1990s and the building back up these funds over the last few years help to explain the trends in average FEHBP premiums and per enrollee spending shown below in Table 3.

Enrollment and consumer information

Federal employees may enroll in an FEHBP plan at the time of initial employment or during an open season held in November and December of each year. Current enrollees may change their choice of plans during the open season. Once a plan has been selected, the enrollee cannot change plans until the next open season.

Active employees receive information about FEHBP and enroll at their worksite.⁷ Each agency is responsible for processing enrollment forms; transmitting enrollment changes to plans and periodically reconciling its records with those of the plans; deducting required employee contributions from paychecks; and forwarding employee and agency contributions to OPM, which then pays the plans. For annuitants, OPM processes and reconciles enrollment changes, deducts required contributions from annuity checks, and bills annuitants directly if their annuity is insufficient to cover their required contribution.

All employees receive an annual guide produced by OPM; this includes general information about the program and a listing of each participating plan, including service area, premiums, and cost-sharing requirements (but not other benefit information). Each plan listing also includes the plan’s accreditation status and the results of the required surveys of consumer satisfaction in each plan. More detailed information about each plan is made available in individual brochures, produced by each plan using a standardized format and subject to OPM review.

⁷ Annuitants and employees in some agencies can make plan changes through an Employee Express online system.

OPM makes all of this information available on its Web site, along with a feature that lets users compare available plans in their area on a variety of dimensions, including premiums and cost-sharing, how the plans are rated by other participants, and so on. There are also independent sources of comparative plan information, notably the annual guide produced by *Washington Consumers' Checkbook* and often made available to employees by federal agencies. Plans may also market to employees, for example in mailings or public advertising. However, FEHBP plan marketing does not involve face-to-face contact (except at health fairs sponsored by federal agencies), nor do plans have any role in the enrollment process.

Administrative costs

Although a 1 percent surcharge is added to premiums to cover OPM administrative costs, actual OPM costs are much lower—only about one-tenth of 1 percent of total expenditures in 2000. (The unused collections are deposited in the reserve funds.) About 160 OPM employees approve and monitor plans and negotiate benefits and premium rates. As noted above, OPM does enrollment processing and premium collection only for annuitants. Federal agencies carry out these functions for active employees, and there is no information on what they are spending for this purpose.⁸

A full comparison of FEHBP administrative costs with those of other public and private insurance programs would also include the costs that are incurred by the plans themselves—for claims processing, utilization review, and other purposes—and that are included in their premium rates. For the PPOs, these are comparable to those of an administrative services organization serving a large self-insured group plan. OPM estimates that the national plans spend about 7 percent of premiums on administration.⁹ Administrative costs for HMOs tend to be higher. Financial statements of major HMO chains show administrative costs on employer group business in the range of 10 to 12 percent of claims. In addition, for the community-rated plans, premiums implicitly include a profit margin comparable to that realized on their commercial contracts. Given recent experience, this might be zero just now for many plans, but would typically be in the range of 2 to 5 percent.

Adding OPM, agency, and plan costs together, administration might average at least 7 to 10 percent of claims cost for the PPOs and 15 percent or more for the HMOs. In comparison, Medicare's administrative costs in 2002 for beneficiaries in "Original Medicare"—the fee-for-service program—came to about 2.1 percent of claims.¹⁰

⁸ Probably they spend more per active employee than OPM does per annuitant, because there is employee turnover and there may be less plan-switching among annuitants.

⁹ Statement of Abby L. Block, Senior Advisor for Employee and Family Policy, OPM, before the Senate Finance Committee, Apr. 3, 2003.

¹⁰ Based on Boards of Trustees (2003). As under FEHBP, administrative costs for the nearly 5 million beneficiaries enrolled in Medicare+Choice plans are included in premium payments to the plans. Plan rate submissions for 2000 show average administrative costs equal to about 14 percent of claims, roughly the same as for FEHBP HMOs (Merlis, 2001).

These percentage comparisons may be deceptive, because service costs for Medicare beneficiaries are much higher than those for FEHBP enrollees. The two programs might spend the same dollar amounts on administration, but Medicare's spending would appear lower as a percent of claims. Absolute dollar amounts for private insurance administration are difficult to obtain, but one source does produce estimates for Blue Cross Blue Shield plans. For plans operating a PPO on an administrative services-only basis—essentially the way Blue Cross operates under FEHBP—mean administrative costs per member year were \$271 in 2002 (Sherlock Company, 2002). Medicare's costs in 2002, \$4.8 billion for about 36 million fee-for-service beneficiaries, were about \$133 per beneficiary, or about one-half as large.

Recent FEHBP Experience

Spending growth

Average FEHBP premiums have been growing faster in recent years than private employer premiums or per capita spending under Medicare (Table 3)¹¹. However, annual changes in FEHBP premiums can be deceptive, because of the way OPM uses the trust funds. In some years, premiums increase less than costs, because OPM has drawn on the funds. In other years, premiums rise faster than cost, because OPM is trying to increase the fund balances. Instead, a better measure may be annual change in actual spending per FEHBP enrollee.¹² By this measure, FEHBP has done slightly better than other employer plans and worse than Medicare, on average, since 1996.

Note that FEHBP's use of reserve funds has led to more moderate fluctuation in premium increases than has been experienced by other employer plans. To some extent, the reserves correct for the “underwriting cycle,” periods of low increases followed by periods of high increases. The Medicare+Choice program has a system of stabilization funds meant to prevent large year-to-year changes in supplemental benefits or premiums. However, unlike FEHBP's mandatory reserves, the funds are voluntary, and few Medicare+Choice plans have ever made use of them.

Differences in spending growth are partially affected by the time period selected for review. For example, in the mid 1990s, FEHBP and other employers experienced very slow growth in spending relative to Medicare, partly because many participants shifted to managed care. But spending growth has since accelerated, driven in part by rising drug costs and by broader increases in utilization and prices. Meanwhile, the 1997 Balanced Budget Act cut Medicare payments to providers and plans, thereby reducing Medicare spending during the late 1990s (subsequent legislation relaxed some of the tight controls put into place).

¹¹ The Medicare Payment Advisory Commission (2003) finds similar trends, looking only at FEHBP premiums and not at per enrollee spending.

¹² This is not quite equivalent to change in per capita spending, because the ratio of dependents to enrollees might fluctuate from year to year.

Table 3. Annual Change in Premiums and Spending, FEHBP, Private Employer Plans, and Medicare, 1996–2003

	Average FEHBP premiums	FEHBP per participant spending	All employer premiums	Medicare per capita spending
1996	-0.3%	-0.9%	0.8%	7.2%
1997	1.7%	3.3%	0.8%	5.5%
1998	7.1%	3.8%	3.7%	-0.9%
1999	9.4%	7.5%	4.8%	-0.8%
2000	8.9%	7.0%	8.3%	3.1%
2001	10.8%	6.4%	11.0%	9.5%
2002	13.3%	10.1%	12.7%	6.5%
2003 (est.)	11.1%	15.0%		4.1%
Average annual change, 1996–2002	7.2%	5.3%	5.9%	4.2%

Source: FEHBP premiums, OPM (2001, 2002, and 2002a); FEHBP per participant spending, calculated from OMB (1995-2003); employer premiums, Kaiser/HRET (2002); Medicare per capita spending, Boards of Trustees (2003).

One major difference between Medicare and FEHBP or other employer plans is that Medicare does not cover most outpatient prescription drugs. Cost increases for pharmaceuticals have been a major contributor to private-sector spending growth. If FEHBP did not cover prescription drugs, or if Medicare did, would their growth rates be more similar? One recent study compares growth in Medicare and private insurance spending over 30 years and finds that factoring out services not usually covered under both programs—drugs in the case of private plans, home health and nursing home in the case of Medicare—does indeed narrow the cumulative difference in growth rates (Boccuti and Moon, 2003). Still, Medicare’s cumulative growth rate is far below that of private insurance for comparable benefits.

Table 4 shows OPM’s calculation of the factors leading to FEHBP rate increases in 2002 and 2003. Increased drug costs were an important component, although utilization, technology, and medical inflation comprised the largest component of the increase. Even if increases in drug costs were excluded, FEHBP premium rates would still have increased considerably faster than Medicare per capita costs (7.6 percent vs. 4.1 percent).¹³

¹³ The exact increases with drugs omitted cannot be calculated from the figures released by OPM.

Table 4. Components of Average FEHBP Rate Increase, 2001–02 and 2002–03

	2001–2002	2002–2003
Increased drug costs	4.9%	3.5%
Utilization, technology & medical inflation	9.5%	8.1%
Demographics (age, sex, etc.)	0.7%	1.0%
Benefit changes	-1.6%	-0.6%
Enrollee choice (plan movement)	-0.6%	-1.2%
Other (reserves, financing, etc.)	0.4%	0.3%
Total change	13.3%	11.1%

Source: OPM estimates, www.opm.gov/pressrel/2002/fehbp/2003_FEHB_Premiums.asp, accessed Apr. 8, 2003.

Note that the FEHBP rate increases would have been even higher if plans had not changed their benefits. While Medicare benefits have remained essentially constant in recent years, FEHBP and other employer plans have been cutting back, chiefly by increasing deductibles, coinsurance, and copayments for covered services. These changes are discussed below.

Finally, average premium increases mask notable variations across plans. For example, while the 2003 average premium increase was 11.1 percent, changes varied by plan, from a 16 percent rate reduction in one plan to a 59 percent increase in another. Table 5 shows the distribution of FEHBP participants by the change in their premiums for 2003. If all participants in 2002 had stayed in the same plan in 2003:

- 71 percent of active employees and 82 percent of annuitants would have seen premium increases between 10 and 15 percent;
- 20 percent of active workers and 9 percent of annuitants would have faced rate increases of 15 percent or more.

Table 5. FEHBP Participants, by Change in Premium Rate for 2003

	Employees		Annuitants		Total	
	Enrollees (000s)	Percent	Enrollees (000s)	Percent	Enrollees (000s)	Percent
Rate reduction	51	2%	21	1%	72	2%
No change	4	0%	1	0%	5	0%
Under 10% increase	156	7%	140	8%	295	7%
10%–14.9% increase	1,538	71%	1,520	82%	3,057	76%
15%–24.9% increase	315	15%	112	6%	427	11%
25% increase or more	103	5%	58	3%	161	4%
Total	2,166	100%	1,851	100%	4,017	100%

Note: Based on March 2002 enrollment and assuming no change in plan; omits enrollees in plans withdrawing or reducing service area for 2003.

Benefit changes

The OPM estimates in table 4 show slight reductions in plan benefits in both 2002 and 2003. Data are not available to show the extent to which overall FEHBP benefits may have changed over a longer period. Even measuring change for individual plans is difficult, because plans may improve coverage for some services while reducing benefits for others. Table 6 compares benefits in 1998 and 2003 under the most popular plan, the government-wide Blue Cross Blue Shield standard option, showing improvements in some benefits and reductions in other benefits. For example, mental-health benefits have improved substantially as a result of OPM's move toward parity. Likewise, the separate deductible has been eliminated for prescription drugs. However, cost-sharing for drugs and other health-care services including physician office visits and inpatient and outpatient charges have all increased; the annual deductible for single and family coverage have both risen; and the out-of-pocket limit has doubled over the five-year period. These changes in cost-sharing disproportionately affect those who are sick and higher utilizers of health-care services.

Table 6. Cost-Sharing Provisions under FEHBP Blue Cross Blue Shield Standard Plan, 1998 and 2003

	1998	2003
Deductible (single/family)	\$200/\$400	\$250/\$500
Out-of-pocket limit	\$2,000	\$4,000
Physician office visits	\$10	\$15
Other medical services ^a	5%	10%
Inpatient	0	\$100 per admission
Outpatient facility charges	\$25	10%
Mental health and substance abuse		
Inpatient	\$150 per day, 100-day limit	Same as other inpatient
Outpatient therapy	40%, 25-visit limit	Same as other office visits
Prescription drugs		
Deductible (single/family)	\$50/\$100	None
Coinsurance (retail)	20%	25%
Copayment (mail order)	\$12	\$10 generic, \$35 brand-name

^aIncludes physician in-hospital services, surgery, laboratory, x-ray, and other diagnostic services.

Choice and access

The number of choices available to FEHBP participants depends on where they live. All employees have access to BCBS and the six national employee organization plans. HMOs are available in all or part of 41 states and the District of Columbia, with multiple plans available in some larger metropolitan areas.¹⁴ Nationally, the number of HMOs has dropped from 428 in 1998 to 159 in 2003. This partly reflects OPM's decisions to treat organizations with several regional plans as one plan; in addition, OPM may have terminated some plans with very small enrollments. Still, it appears that enrollees may have fewer choices than in earlier years. For example, employees in Washington, DC, have access to 4 different HMOs and the 7 national plans. In 1998, there were 14 HMOs serving the Washington metropolitan area.

As under Medicare+Choice, HMOs are often not available to participants in rural areas. These participants have a choice among the national plans, but some of these plans have much less extensive PPO networks than others.

¹⁴ The states with no HMO in 2003 are Alaska, Arkansas, Delaware, Maine, Mississippi, Nebraska, New Hampshire, North Carolina, and South Carolina. HMOs are available in Guam and Puerto Rico.

Table 7 shows the availability of network primary care physicians for residents of Lebanon, KS, the geographic center of the lower 48 states. In this market, the Blue Cross Blue Shield network has 50 primary care physicians within 50 miles driving distance, while five of the six other national PPO plans have only one primary care physician within a 50-mile radius. Thus, all five of these plans would require an enrollee to drive over an hour for in-network care, compared to 20 minutes for a Blue Cross enrollee and 26 minutes for a GEHA enrollee.

Table 7. Access to In-Network Primary Care for Resident of Lebanon, KS, FEHBP National Plans, 2003

Plan	Number of in-network primary care physicians within:				Minimum distance for in-network primary care	
	15 miles	16-25 miles	26-35 miles	36-50 miles	Mileage	Driving time
Alliance	0	0	0	1	42.8	1 hr., 3 min.
APWU	0	0	0	1	42.8	1 hr., 3 min.
Blue Cross	7	15	3	25	14.8	20 min.
GEHA	0	2	1	5	20.6	26 min.
Mail Handlers ^a	0	0	0	1	42.8	1 hr., 3 min.
NALCa	0	0	0	1	42.8	1 hr., 3 min.
Postmasters	0	0	0	1	46.4	1 hr., 10 min.

^aUse same PPO network.

Note: Primary care physicians include family and general practitioners, internists, pediatricians, and obstetricians/gynecologists. Source: Based on online provider directories accessed April 8, 2003. Mileage and travel times estimated using *Microsoft Streets & Trips, 2001*.

PPO enrollees are permitted to receive services from a non-network provider, but have to pay higher cost-sharing when they go out of network and may also be subject to balance billing, under which providers charge in excess of the plan’s allowed amount for the service.

As a practical matter, then, unless participants in more isolated areas are willing to travel long distances or pay extra amounts for care, they may find that only one or two plans offer meaningful access to services. They may have to choose these plans even if other options might offer lower premiums or have benefit features they might prefer.

Pricing and competition

FEHBP’s premium contribution formula is designed to give enrollees financial incentives to choose less costly plans. In theory, enrollees choosing more comprehensive benefits or less tightly managed plans pay higher premiums. However, there are several problems with the way premiums are established that may lead to imperfect competition.

First, the PPO plans are rated nationally, while the HMOs (even when operated by a national chain) set premiums for a limited area. Because costs vary widely in different regions, PPOs may be more expensive than HMOs in some regions and less expensive in others. There are 20 states where even the highest-priced HMO is less costly than the Blue Cross standard plan. On the other hand, there are 5 states where even the cheapest HMO costs more than Blue Cross.

Second, two plans in a single area may have different premiums in part because of the populations they serve, rather than because of differences in comprehensiveness and efficiency. Competitive systems may be subject to “biased selection”: the tendency of high-cost enrollees to prefer certain plans and low-cost enrollees to prefer others.

Several studies of FEHBP in the 1980s found evidence of selection problems. A new study of FEHBP by Florence and Thorpe (2003), using data from 1996, concludes that there is little evidence of biased selection. The study found that people who chose the most costly plans were only a little over one year older, on average, than those individuals who selected the least expensive plans. However, this study had no data on health risk and had to use age and sex as a proxy; these factors are not very good predictors of utilization or cost.¹⁵

Table 8. Annual Premium for a Single Enrollee, FEHBP HMOs in the Washington, DC, Area, 2003

HMO	Annual premium
Aetna Health (standard)	\$ 2,749
Kaiser Mid-Atlantic	\$ 3,204
M.D. IPA	\$ 3,609
Aetna Health (high)	\$ 3,677
CareFirst BlueChoice	\$ 4,178

While measuring risk selection with available data may not be possible, the degree of price variation among plans within geographic areas suggests that selection may be occurring. Table 8 shows the premiums for Washington-area HMOs. CareFirst, one of the few experience-rated HMOs, costs 52 percent more than Aetna standard and 30 percent more than Kaiser (\$4,178 vs. \$3,677 vs. \$3,204). The difference between CareFirst and Aetna standard may be partly attributable to benefit packages, but CareFirst and Kaiser offer benefits of practically equal value. The *Consumer Checkbook* benefit analysis suggests that Kaiser may actually be slightly more comprehensive. Care under Kaiser may be more intensively managed; the plan is a restrictive group-model HMO, while CareFirst offers a broader provider network. Still, it is unlikely that efficiency differences account for a 30 percent price difference. Population characteristics almost certainly play a role.

¹⁵ For a review of the evidence, see Newhouse (1994).

The self-selection of higher-cost beneficiaries into particular plans would not matter so much if FEHBP were paying all plans on the same basis. However, payments to the experience-rated plans reflect actual costs for their enrollees. Payments to the community-rated plans for FEHBP enrollees are based on rates offered to other large employer groups. Plans may adjust these rates for population differences if they do so for other groups. Still, if a plan's FEHBP participants are higher- or lower-risk than its other large-group enrollees, and if adjustments fail to correct for this, then the plan may be over- or under-paid.¹⁶

Even if the total premium amounts paid to plans are appropriate, the system for computing government contributions means that people joining higher-cost plans pay a surcharge. While the aim is to encourage participants to choose cost-effective plans, the effect may be to penalize people who join plans with older or sicker enrollees.

Conclusions

FEHBP has often been an attractive model for policymakers who wish to increase the roles of competition and private plans in the Medicare program. FEHBP has succeeded in offering varying degrees of health plan choice to a large and diverse population of employees and annuitants, at costs comparable to those for other large employer plans. The program is more flexible and less bureaucratic than Medicare and relies chiefly on the market, rather than regulation, to control costs and assure quality.

Still, the program is not without its shortcomings, some of which have been notable for many years. FEHBP has faced many of the same problems as the Medicare+Choice program:

- FEHBP per capita costs have risen faster than Medicare costs in recent years, though somewhat less rapidly than spending by other employer plans. Only part of the FEHBP spending growth is attributable to rising drug expenditures, and costs would have risen even faster if plans had not reduced benefits. As the OPM Director has acknowledged: "Despite its size, the FEHB Program is not immune to the inflationary pressures that have driven up costs in the health-care industry in recent years."¹⁷
- Competition under FEHBP, as under the Medicare+Choice program, has been distorted by pricing problems. Because government contributions to FEHBP plans are not adjusted for demographic factors, health risk, or geography, the net prices offered to participants may reflect enrollee characteristics or plan location, rather than the value of benefits or plan efficiency.
- While many Medicare beneficiaries have no access to Medicare+Choice plans, FEHBP nominally offers enrollees multiple health plan choices everywhere in the country. However, participants in less populous areas may have access only to the national PPO plans, and some of these plans may not always provide meaningful choices among providers. PPOs generally

¹⁶ Plans may elect to adjust these rates for population differences if they use similar adjustments for other groups. Presumably, plans that are underpaid would be more likely to pursue this option.

¹⁷ OPM (2002).

achieve savings by negotiating discounted rates with providers; providers in isolated areas who face limited competition may have little incentive to grant these discounts.

- FEHBP administrative costs, including OPM, agency, and plan costs, can only be estimated, but are probably in the range of 7 to 15 percent of claims, depending on the type of plan. Medicare administrative costs for the fee-for-service program are only about 2 percent of claims. Costs for the Medicare+Choice program are probably comparable to those for similar FEHBP plans.

FEHBP is a model that policymakers are examining as they consider ways of introducing more choice under Medicare or of developing new mechanisms for extending coverage to the uninsured. The FEHBP experience highlights the difficulties in developing a competitive system that operates efficiently and equitably for a nationwide program. And FEHBP's recent performance suggests that competition alone may not resolve the ongoing dilemma of maintaining comprehensive benefits while controlling spending growth.

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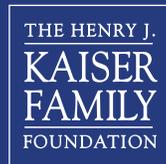
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