Summary BRIEF

# Why FEHBP Isn't a Good Option for Medicare

March 2003

The Federal Employees Health Benefit Program (FEHBP) is again being pointed to as a model for Medicare. Yet, as the attached Families USA analysis shows, FEHBP's structure does not fit Medicare well. Those who believe a FEHBP-style overhaul will produce cost savings while still giving beneficiaries the services they need assume several things, things that likely won't hold true because *Medicare beneficiaries aren't the same as federal employees, and FEHBP's structure is not inherently more efficient.*

- **Getting significant plan participation may be difficult.** Medicare beneficiaries are less attractive to insure than federal employees; experience shows that it is not easy to get—and keep—private plans in a program serving Medicare beneficiaries.
- **Many beneficiaries may not be able to afford plans with the benefits they need.** As in FEHBP, premiums may vary widely and may be high. Medicare beneficiaries are lower-income than federal employees and cannot afford high premiums.
- **Lower-priced plans may not necessarily be the most efficient.** Low premiums may simply mean that a plan has healthier, less costly enrollees.
- **It may be difficult for beneficiaries to make an informed plan selection.** Medicare beneficiaries will confront information barriers that don't affect federal employees, and these will hamper their ability to select a plan.
- **Plan withdrawals may be disruptive.** As Medicare+Choice and FEHBP show, a system depending on private plans is particularly volatile.
- **A FEHBP model may not be more successful in containing cost increases.** Many see cost containment at the key reason to move Medicare to a FEHBP model, but neither FEHBP nor private plans have been consistently more successful than Medicare in containing cost increases.

FEHBP is, at best, a questionable model for Medicare. In fact, it could reduce beneficiaries' access to services and provide no cost savings to the program. It is not a good fit, nor a good option, for Medicare.

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Issue BRIEF

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# Why FEHBP Isn't a Good Option for Medicare

*The Federal Employees Health Benefit Program (FEHBP) has frequently been pointed to as a model for Medicare. Now, as the debate on adding a prescription drug benefit in Medicare and Medicare restructuring begins, a FEHBP-style overhaul is being favored by many and is the Administration's model for the Enhanced Medicare option in the President's Medicare framework. Before FEHBP is seen as a panacea for Medicare, it is worth considering how well FEHBP's basic structure fits Medicare—a fit that is not the best.*

## What is FEHBP?

FEHBP is the health plan for federal employees, retirees, and their dependents and survivors. The Office of Personnel Management (OPM), which administers the program, contracts with private health plans throughout the country. Those eligible for FEHBP coverage choose between nationally available plans, generally traditional fee-for-service plans and locally available HMOs.

FEHBP is a ***premium support system***—the federal government pays a share of the monthly plan premium based on the average cost of participating plans. The federal share is never more than 75 percent of the premium for any plan; the enrollee pays the rest.[1] Although participating plans are expected to offer FEHBP enrollees the same basic benefits they offer to most subscribers, there is not a defined benefit package. Plan premiums, deductibles, and enrollee cost-sharing are not regulated.[2] Participating plans compete for enrollees based on the services they cover, enrollee cost-sharing, and the premium price enrollees must pay.

## How would a FEHBP model work in Medicare?

Under a FEHBP-style system, Medicare beneficiaries would select an insurer from competing plans. The government would pay a portion of plan costs based on the average premium price of all plans available, and the Medicare beneficiary would pay the rest. The government contribution might be capped as it is in FEHBP.

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## How would this be different from the way Medicare operates today?

In traditional Medicare, there is a defined list of covered benefits and cost-sharing is limited. There is no variation in premiums, so all beneficiaries have the same benefits. In Medicare+Choice, basic benefits must also be offered and there are limits on the amount that beneficiaries can be required to contribute toward the cost of their care.[3] This would be different under a FEHBP model. Plans would be free to offer different benefits, have different patient cost-sharing, and set different premium prices for the coverage offered. The beneficiary would be responsible for the portion of the premium that Medicare did not pay. Because beneficiaries would have to pay some of the costs of the plan they choose (the minimum in FEHBP is 25 percent), costs would be one of the key ways plans would compete. Coverage would vary depending on what plans are offered in each area and the amount an individual is able or willing to pay in plan premiums.

## Why do some think a FEHBP model would be better for Medicare?

Those who see FEHBP as a model for Medicare argue that having Medicare beneficiaries pay part of their insurance premium would make them more sensitive to the different cost of health plan options. This, in turn, they claim would reduce the rate of Medicare spending growth because beneficiaries would select the least costly plans offering the benefits they need. This argument is based on several assumptions: (1) that there is broad plan participation with real competition between plans offering comprehensive benefits; (2) that the least costly plans are the most efficient; (3) that beneficiaries are able to afford plans offering the benefits they need; and, (4) that beneficiaries have the information and the ability to select the most efficient plan meeting their needs. There are many reasons to believe that these assumptions would not hold true for Medicare.

## What are some reasons a FEHBP model might be bad for Medicare?

FEHBP insures a group that is very different from Medicare—different in ways that may affect insurers' willingness to participate in the program; that may skew the correlation between plan efficiency and low price; that may make it more difficult for enrollees to afford plans offering comprehensive benefits; and that may make it more difficult for participants to make informed plan selections or deal with potential service disruptions due to plan withdrawals.

- **Medicare beneficiaries are less healthy than FEHBP enrollees and less attractive to insurers. Getting significant plan participation may be difficult.**
  The majority of individuals covered through FEHBP are active federal employees, a much younger and healthier group than Medicare beneficiaries.[4] The average age of federal employees is 46.5; only 7 percent have disabilities.[5] In contrast, 42 percent of Medicare beneficiaries are over 75;[6] nearly 15 percent have disabilities;[7] over 65 percent suffer from two or more chronic conditions.[8] Covering healthier individuals is financially advantageous for insurers. Because of their poorer health status, Medicare beneficiaries are less desirable to insure.

Experience shows that getting—and keeping—private plan participation in a program serving Medicare beneficiaries is not easy. A significant number of health plans have withdrawn from the Medicare+Choice program, with plan withdrawals resulting in less geographic coverage, less choice, less expansive benefits, and higher premiums for beneficiaries.[9] A FEHBP-based model may fare no better—plans may be concerned about payment levels; if premiums prove inadequate, plans will withdraw. FEHBP advocates contend that payment rates will be less of an issue than in Medicare+Choice since plans will be able to set premiums at the level needed to cover the cost of the benefits offered. However, because Medicare beneficiaries are a high-risk population, insurers may have difficulty setting premiums properly; plans may be concerned that they will enroll a large number of sicker, high-cost enrollees—experience adverse selection—and that the premiums they set will be insufficient.

- **Because of adverse-selection, low-priced plans may not necessarily be the most efficient.**
  Proponents believe that a FEHBP approach will encourage competition and efficiency, which will translate into lower costs. Since beneficiaries will have to pay a portion of the premium, lower-priced plans will have a competitive edge. However, low-priced plans may not be the most efficient; they may simply have healthier enrollees. Plans with high premiums plans may be equally efficient but cover a less healthy population that uses more services.

  The differences in FEHBP's 2003 monthly plan premiums indicate that factors other than efficiency, or even benefits, contribute to variations in premiums. The range in FEHBP premiums for single coverage is over 200 percent—from $177 for a standard option HMO plan in Missouri to $583 for high-option coverage in a non-HMO plan offered nationwide.[10] The plans' benefits and cost-sharing are different, which would account for some of the price range. And geographic differences could be another factor—one is a local HMO and the other a national plan. But neither seems sufficient to account for such a large variation in premiums; the benefits of the two plans are not hugely dissimilar, and even within a small geographic area, FEHBP premiums vary greatly, sometimes as much as 50 percent.[11] While the lower-priced HMO plan may be more efficient, it might also simply have healthier enrollees and, therefore, lower costs. In fact, it is likely that sicker individuals—those that would cost more to cover—would enroll in the non-HMO plan, which allows greater physician choice.[12]

  If the program is to encourage real competition among plans, the government will need to adjust the amount it pays toward premiums based on a plan's risk—its enrollees' health status.

Otherwise, plans serving a sicker population will have to set premiums high, making them more expensive for beneficiaries. Those plans will not be able to compete effectively. Conversely, plans that are low-priced because they have healthier enrollees may be overpaid, a current concern with FEHBP. [13]

- **Many Medicare beneficiaries may not be able to afford plans offering more generous benefits, because those will likely have higher premiums.**
  It is not easy to make sure payments to plans adequately reflect differences in risks borne by the plans; this doesn't appear to be done well in FEHBP today.[14] But without such risk adjustment, the plans that attract less healthy individuals—which would most likely be the plans offering the most comprehensive benefits—may be unaffordable. Medicare beneficiaries are generally less able than federal employees to pay high premium rates. The average annual base salary of federal employees was $53,959 in 2001.[15] In contrast, in 2000, only 16 percent of Medicare beneficiaries had annual incomes over $40,000, and nearly 65 percent had incomes below $25,000.[16] Forty percent had less than $12,000 in countable assets.[17]

  If contributions to premium payments are not properly risk-adjusted, there would be little incentive for plans to offer the more generous benefits that would appeal to, and are needed by, sicker beneficiaries. In fact, plans would want to make sure that they didn't attract high-cost beneficiaries, possibly by structuring benefits, copayments, and other cost-sharing to be more attractive to those in better health. Failure to ensure that a range of plans, including those offering more generous benefits, is affordable for all may result in an erosion in benefits, or a two-tiered system in which only wealthier beneficiaries could afford plans with richer benefits and lower-income beneficiaries would be relegated to less generous plans or left unable to afford any private-plan offering a drug benefit.

- **Selecting a plan will be complex: beneficiaries may have difficulty making an informed selection.**
  FEHBP offers non-postal employees a smorgasbord of plans with different benefits at different prices: there are 24 national fee-for-service plans plus two to 10 managed care plans in each state. A Medicare program based on FEHBP's structure would also offer an array of plans. For a beneficiary, selecting the best plan may be difficult. The level of support that federal employees receive during the "open season" when they select a health plan attests to the complexity of plan selection: there are health fairs, work-site presentations by health plans, and considerable Internet information is available. Medicare beneficiaries would not receive a comparable level of support and are less likely to have Internet access, making it even more difficult to evaluate competing plans.[18]

Not only will Medicare beneficiaries receive less direct support choosing a plan than federal employees, but as a group they are not as well equipped to navigate the confusing plan selection processes. Federal employees are, on average, better educated—41 percent of federal employees have a college degree or higher,[19] while fewer than 15 percent of Medicare beneficiaries have attained a comparable level of education.[20] Medicare beneficiaries are also more likely to suffer from health conditions that could diminish their ability to select a plan: nearly 50 percent are unable to perform at least one activity of daily living, 5 percent suffer from Alzheimer's, and 8 percent report suffering from a chronic mental impairment.[21]

Because of the obstacles Medicare beneficiaries will confront when selecting a plan, many may choose based on premium price alone—the easiest way to compare plans—rather than on a careful assessment of benefits, cost-sharing, and quality. As a result, they may not select the best plan for their needs.

- **Plan withdrawals may be disruptive.**
  Because of their health status, Medicare beneficiaries need consistently available health care coverage and are less able than many other groups to weather disruptions in insurance. Yet a FEHBP-like system, with care delivered through private plans, would be particularly susceptible to volatility. Medicare+Choice illustrates how the private health insurance market can fail beneficiaries. A significant number of health plans have withdrawn from Medicare+Choice, with plan withdrawals affecting about 2.2 million beneficiaries between 1999 and 2002. But lack of stability is not just a Medicare+Choice problem that can be corrected by moving to a FEHBP-model. FEHBP has experienced significant market volatility of its own,[22] with over 50 percent of participating HMOs dropping from the program between 1996 and 2002.

## Has FEHBP been much more successful than Medicare in containing costs?

For the reasons outlined above, the FEHBP model does not suit the Medicare population well. But beyond those crucial considerations, a key fiscal rationale for moving to a FEHBP model is cost savings. FEHBP does spend less per person covered than Medicare—not at all surprising given that it serves a much healthier population.[23] But in spite of lower overall spending, FEHBP has not consistently demonstrated that it is more successful than Medicare in containing health care costs or providing services efficiently—and there is no reason to believe that a Medicare program based on FEHBP would do better.

Using the FEHBP model, Medicare would rely on private plans to control costs. Yet since 1970, traditional Medicare has done better than, or at least as well as, the private sector in holding down rates of spending growth.[24] Administrative costs, often used as a proxy for efficiency, are also lower in traditional Medicare than in the private sector—2 percent compared to an average of 9.5 percent in

private health plans and 11.9 percent for HMOs.[25] Efforts to control spending have also been impressive. Medicare's inflation-adjusted annual increase in per capita spending was 1.8 percent from 1995-1999.[26] In contrast, private plan premiums increased at an average annual rate of 5 percent from 1993 to 1998.[27]

FEHBP's record on cost-containment mirrors that of private plans. Premiums increased at double-digit rates in recent years, increasing cumulatively by about 50 percent between 1998 and 2002.[28] These increases in FEHBP premiums would have been even greater if plans had not shifted costs to employees and reduced benefits,[29] a short-sighted approach to cost containment that would not serve the Medicare population well.

Traditional Medicare is not only a reliable and equitable means of delivering health care to seniors but, because of its low administrative costs and record of holding down spending growth, it may also be the most cost-effective. This would hold true for a drug benefit provided in Medicare. Adding a drug benefit would not change the assessment of comparative reliability, equity, and general cost-effectiveness of traditional Medicare and a FEHBP-like restructuring.

## Conclusion

FEHBP is at best a questionable model for Medicare. At worst, under a FEHBP model, plan participation would be insufficient to provide real choices or real competition; beneficiaries would have difficulty affording more comprehensive plans providing services they need; benefits would erode; service would be disrupted or erratic; there would be a two-tiered system of care, with only the wealthy able to afford high-cost plans with rich benefits and low cost-sharing; and cost savings would be achieved through benefits reductions, not increased efficiency. We should not gamble with the health of Medicare beneficiaries to test a model that seems ill-suited for them.

The Medicare population is very different from federal employees, and the private market has failed them before, which is part of the reason that traditional Medicare is the choice of 87 percent of beneficiaries.[30] There is no reason to believe that the private market will serve Medicare beneficiaries any better under a FEHBP model, and there are numerous reasons to believe that, under a FEHBP model, beneficiaries would be facing significantly higher out-of-pocket costs. With traditional Medicare, all beneficiaries can depend on the same level of care. It is a choice that should not be taken away.

*This issue brief was written by Dee Mahan.*

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[1] The government's contribution is set by law at 72 percent of the weighted average premium of all health plans offered to government employees but not more than 75 percent of the total premium for any plan. United States Office of Personnel Management, "*FEHB Handbook, 2003*," available online at (*http://www.opm.gov/insure/handbook/fehb03.asp).*

[2] The Office of Personnel Management, which oversees FEHBP, expects that the benefit package that HMOs offer FEHBP will provide basically the same coverage that the HMO offers to most enrollees in the same area. General Accounting Office, Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, "*Medicare+Choice: Selected Program Requirements and Other Entities Standards for HMOs,"* October, 2002, available online at (*http://www.gao.gov/new.items/d03180.pdf).*

[3] In Medicare+Choice, cost-sharing cannot exceed the aggregate level imposed under original Medicare. AARP, *Structuring Health Care Benefits: A Comparison of Medicare and the FEHBP*, May 2000, available online at (http://research.aarp.org/health/2000_05_benefits_1.html).

[4] Information is for statistics on federal employees, 2001. Office of Personnel Management, *Federal Civilian Workforce Statistics: The Fact Book, 2002 Edition*, June 2002, available online at (http://www.opm.gov/feddata/02factbk.pdf).

[5] Ibid.

[6] Center for Medicare and Medicaid Services, *Program Information on Medicare, Medicaid and SCHIP, and Other Programs of the Center for Medicare and Medicaid Services,* June 2002, available online at (http://cms.hhs.gov/charts/series/sec3-b1.pdf).

[7] In 2002, 14 percent of beneficiaries had disabilities and 0.6 percent were Medicare-eligible because of a diagnosis of End-Stage Renal Disease (ESRD). Ibid.

[8] Ibid.

[9] Marsha Gold and John McCoy, *Monitoring Medicare+Choice Fast Facts, Choice Continues to Erode in 2002* (Washington: Mathematica, January 2002), available online at (http://www.mathematica-mpr.com/PDFs/fastfacts7.pdf).

[10] Office of Personnel Management, *2003 FEHB Premiums,* available online at (http://www.opm.gov/insure/health/03rates/index.asp).

[11] In Washington, DC, the 2003 monthly premium for single HMO coverage for the highest-priced plan was 50 percent higher than the lowest-priced ($348 compared to $229). Ibid.

[12] Review of current and historic plan premium prices, Office of Personnel Management listing of annual FEHBP premiums.

[13] Mark Merlis, *Medicare Restructuring the FEHBP Model,* (Washington: Kaiser Family Foundation, February 1999), available online at (http://www.kff.org/content/archive/1461/fehbp2.html).

[14] Robert Reischauer, "Medicare Reform and the Federal Employees Health Benefits Program," Testimony before the Senate Committee on Finance, May 21, 1997, available online at (http://www.brook.edu/dybdocroot/views/testimony/reischauer/19970521.htm).

[15] Office of Personnel Management, *Federal Civilian Workforce Statistics: The Fact Book, 2002 Edition*, op. cit.

[16] Center for Medicare and Medicaid Services, *Program Information on Medicare, Medicaid and SCHIP, and Other Programs of the Center for Medicare and Medicaid Services*, op cit.

[17] Kaiser Family Foundation, *Medicare Chartbook, 2nd Edition*, Fall 2001, available online at (http://www.kff.org/content/2001/1622/Medicare_Chart_Book.pdf).

[18] Individuals over 50 are less likely than younger Americans to use the Internet. Also, level of education and income are highly correlated to Internet access and use, again indicating that federal employees would have greater access than Medicare beneficiaries. U.S. Department of Commerce, National Telecommunications and Information Administration, *Americans in the Information Age Falling Through the Net,* October 2000, available online at (http://www.ntia.doc.gov/ntiahome/digitaldivide/execsumfttn00.htm).

[19] Office of Personnel Management, *Federal Civilian Workforce Statistics: The Fact Book, 2002 Edition*, op. cit.

[20] Kaiser Family Foundation, *Medicare Chartbook*, op cit.

[21] Center for Medicare and Medicaid Services, *The Characteristics and Perceptions of the Medicare Population*, available online at (http://cms.hhs.gov/mcbs/PublDT.asp).

[22] In 1996, 476 HMOs participated in FEHBP, compared with 200 in 2002. Center for Medicare and Medicaid Services, "Medicare+Choice: Policy Concerns, Implications, and Prescriptions for Change," October, 2002, available online at (http://cms.hhs.gov/healthplans/benpkg/mc00anal.asp).

[23] In 1998, per-enrollee claims expenditures for FEHBP averaged $3,961; for Medicare the average was approximately $5,000. In both programs, however, there is significant variation. General Accounting Office, "Report to the Subcommittee on International Security, Proliferation and Federal Services, Committee on Government Affairs, U.S. Senate, *Federal Employees Health Plans, Premium Growth and OPM's Role in Negotiating Benefits*, December 2002, available online at (http://www.gao.gov/new.items/d03236.pdf); and Kaiser Family Foundation, *Medicare Chartbook*, 2001, op. cit.

[24] In both 1998 and 1999, Medicare's cost increases were below the rate of growth in the private sector. In 1999, Medicare reduced its spending in comparison with the previous year. Marilyn Moon, "An Analysis of Medicare and Private Expenditures," Kaiser Family Foundation, September 1999.

[25] Committee on Ways and Means, U.S. House of Representatives, *Medicare and Health Care Chartbook, 1997*, available online at (http://www.access.gpo.gov/congress/house/ways-and-means/sec3.pdf).

[26] Thomas Bodenheimer, "The Not-So-Sad History of Medicare Cost Containment as Told in One Chart," *Health Affairs* (January 2002), Web exclusive, available online at (http://www.healthaffairs.org/WebExclusives/2101Boden.pdf).

[27] In 1998 and 1999, average annual spending in private plans dwarfed Medicare's rate of growth, with average private plan spending increasing 6 percent in 1998 and 6.2 percent in 1999, compared to Medicare's respective annual increases of 0.1 and 1 percent. Stephen Heffler, et al; "Health Spending Growth Up in 1999; Faster Growth Expected in the Future," *Health Affairs* (March/April 2001): 193-203.

[28] General Accounting Office, "Report to the Subcommittee on International Security, Proliferation and Federal Services, Committee on Government Affairs, U.S. Senate, *Federal Employees Health Plans, Premium Growth and OPM's Role in Negotiating Benefits*, op. cit.

[29] Ibid.

[30] Center for Medicare and Medicaid Services, *Program Information, Medicare, Medicaid and SCHIP,* op. cit.