FAX TRANSMITTAL FROM

THE OFFICE OF THE GENERAL COUNSEL U.S. OFFICE OF PERSONNEL MANAGEMENT

TO: Jennifer Klein

of White House

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OPM/OGC

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DATE: 8/23/96

TOTAL NUMBER OF PAGES (including cover sheet): 4

COMMENTS:

Federal procurement authority

the Civil Service Retirement System or the Federal Employees' Retirement System),

(ii) as to whom a court order or a decree referred to in section 8341(h), 8345(j), 8445, or 8467 of this title (or similar provision of law under any such retirement system other than the Civil Service Retirement System or the Federal Employees' Retirement System) has been issued, or for whom an election has been made under section 8339(j)(3) or 8417(b) of this title (or similar provision of law), or

(iii) who is otherwise entitled to an annuity or any portion of an annuity as a former spouse under a retirement system for Government employees,

except that such term shall not include any such unremarried former spouse of a former employee whose marriage was dissolved after the former employee's separation from the service (other than by retirement); and

(11) "qualified clinical social worker" means an individual—

(A) who is licensed or certified as a clinical social worker by the State in which such individual practices; or

(B) who, if such State does not provide for the licensing or certification of clinical social workers—

(i) is certified by a national professional organization offering certification of clinical social workers; or

(ii) meets equivalent requirements (as prescribed by the Office).

§ 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 5 of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall require the carrier—

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums,

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chapter shall contain a detailed l shall include such maximums,

limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

(k)(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or cer-

tified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this title.

(l) The Office shall contract under this chapter for a plan described in section 8903(4) of this title with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, "qualified health maintenance carrier" means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c–9(d)).

(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.

(2)(A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this title.

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a, shall require the carrier—

(1) to implement hospitalization-cost-containment measures, such as measures—

(A) for verifying the medical necessity of any proposed treatment or surgery;

(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

Strom Thurmond

PROVIDING ACCESS TO FEHBP FOR SMALL EMPLOYERS

If a state does not provide for group purchasing options for small employers, then the state may reques the federal government to make group purchasing available to small employers through the Federal Employees Health Benefits Program (FEHBP).

A state that chooses to provide for a group purchasing option other than FEHBP could require that FEHBP plans participate.

The small employer FEHBP purchasing option would operate generally as follows:

- All carriers participating in FEHBP for federal employees that also provide coverage outside of FEHBP (e.g., not including union plans specific to federal employees) would be required to offer coverage through the small employer FEHBP purchasing option.

- Small employers would obtain coverage through a separate risk pool from federal employees, so premiums paid by federal employees would be unaffected.

- FEHBP would establish rating and access guidelines for carriers generally consistent with a given state's insurance laws (with some adjustment to recognize that individual employees would be choosing plans within FEHBP, while employers usually make that choice under state insurance laws).

  Note: It is unlikely that the small employer FEHBP purchasing option would operate effectively without insurance reforms providing for guaranteed access to coverage and limitations on experience rating. It might, therefore, be appropriate to require that these types of reforms be in place in a state before FEHBP is made available to small employers in that state.

- Administrative costs associated with the small employer FEHBP purchasing option would be supported through membership fees paid by participating small employers.

- After experience with enrolling small employers, FEHBP, in consulation with states and interested parties would prepare a report examining the feasibility of enrolling individual purchasers (e.g., the self-employed and unemployed).

Purchasing Cooperatives
Administration & Kassebaum/Kennedy Proposal

	Administration	Kassebaum/Kennedy
1. Funding	Grants: total of $25 million/year for 5 years --state option --can be for state agency, non-profit, or for-profit if profits are shared on pro-rata basis	No provision
2. Eligibility	For grants: organization must be: --free of conflicts of interest --bear no insurance risk --small employers in coop area must be served on first- come, first-served basis --operating costs of coop based on reasonable fees --demonstrate financially viability in long-run --other criteria defined by Secretary of HHS.	Coops would be certified by state and register with Dept. Of Labor. Must: --not bear insurance risk --not be controlled or affiliated with insurance company --broad-based board of directors --contract with multiple, unaffiliated health plans. --small employers in coop area must be served on first- come, first-served basis --operating costs of coop based on reasonable fees
3. State law overrides	No provision.	1. Overrides state "fictious group laws" (which prevent employers purchasing insurance together) 2. If state allows minimum benefit package (i.e., not all state mandated benefits required) for small employers, coop may also sell the product to small employers.
4. FEHB Option	--Governor must request (but OPM could decline if it considers option not feasible) --"Agents" chosen by OPM would be authorized to use FEHBP name in marketing. Could negotiate but not handle premium funds. --OPM could require FEHBP commercial carriers to sell its products through coop (and could terminate carrier in FEHBP if it did not comply) --This option funded with grant money	No provision

c:coopskk

COMPARISON OF APPROACHES

Major Features	ACCESS TO FEHB PLANS TO FORM A PURCHASING COOPERATIVE FOR SMALL EMPLOYERS	FEHB ACCESS PLUS RATE NEGOTIATION BY OPM	STATE BASED FEHB APPROXIMATION; OPM SETS UP AND ADMINISTERS
Benefits	Negotiated between carrier and State cooperative or small employer with OPM assistance as requested.	The same as FEHB benefits, modified only by State requirements that exceed FEHB requirements.	
Rates		Based on the benefits offered and the characteristics of the group. Negotiated by OPM and carriers. There would be a surcharge for OPM's administrative costs.	Based on the benefits offered and the characteristics of the group. Negotiated by OPM and carriers. OPM's administrative surcharge would reflect the greater administrative effort involved
Informational requirements		FEHB literature modified for State enrollees.	
Enrollment and premium collection		Determined jointly by carrier and State cooperative.	Determined by carrier, State cooperative, and OPM.
Risk and reserves		OPM would incorporate State requirements into rate setting process.	OPM would incorporate State requirements into rate setting process. OPM could establish additional requirements if deemed necessary.
Disputed claims and court review		Carrier and State cooperative would determine review process. OPM would not be involved.	OPM could act as a consultant for the State or employer. Litigation would be against the carrier, not OPM.

Pros	• Minimizes Federal involvement and maximizes State and small business flexibility. • Access need not be restricted to FEHB plans. • Would not require extensive legislative and administrative changes.		
Cons	• Some States may want more assistance and less flexibility.	• More Federal intrusion. • More restrictive. • Problem of setting rates without experience. • Unknown risk pool. • Only FEHB plans would be available through this Program. Other plans could not participate, but could compete with this Program.	• More Federal intrusion. • More restrictive. • Problem of setting rates without experience. • Unknown risk pool. • Only FEHB plans would be available through this Program. Other plans could not participate, but could compete with this Program. • OPM would have to work with as many as 39 different States in setting up cooperatives. • OPM would need to develop expertise in the laws and regulations of each State.

ACCESS TO FEHB PLANS TO FORM A PURCHASING COOPERATIVE FOR SMALL EMPLOYERS

Description

States would request access to FEHB plans for purposes of establishing a purchasing cooperative. HHS would certify State-organized purchasing cooperatives. OPM would then provide a list of FEHB participating carriers, and small employers could contact them directly. If the State desired a larger role in the formation of the purchasing cooperative, it could do so at its option.

Comments

It is likely that not all HMO's in the FEHB Program would have the capacity to absorb a large influx of new enrollees and their families. In areas without FEHB HMO's, only the Service Benefit Plan would be available.

This approach would require few, if any, legislative and administrative changes. It might be possible to accomplish this through an Executive Order and regulatory changes. FEHB contracts would need to be amended to require FEHB carriers to accept the employees of small businesses for coverage. The State cooperative and the carrier could work out the terms of that coverage and the details for collecting premiums. The employees would not be covered under OPM's contract with the carrier. State roles could be active or passive, depending on State interests.

Benefits could duplicate those offered to Federal enrollees, except for modifications necessary to meet the requirements of State law, or greater variation of the FEHB package could be offered if desired by the State. Small employers who currently pay some portion of a premium for minimal (typically high deductible) catastrophic coverage would find FEHB-type coverage more costly. The advantages associated with establishment of a purchasing cooperative would largely result from the role played by the State, the size of the group, the percentage of each employer's workforce that participates, and the demographic characteristics of the covered population.

The participating carriers would be Blue Cross/Blue Shield and HMO's doing business in the State. All other FEHB carriers have selective memberships and do not provide coverage on an unrestricted basis.

FEHB ACCESS PLUS RATE NEGOTIATION BY OPM

Description

Same as before except that OPM would negotiate the rates for small employers for the FEHB benefits package modified if necessary to accommodate State requirements.

Comments

It is likely that not all HMO's in the FEHB Program would have the capacity to absorb a large influx of new enrollees and their families. In areas without FEHB HMO's, only the Service Benefit Plan would be available.

Rates would be set on a State-wide basis. Small employers would constitute a separate risk pool from the FEHB for rate setting purposes. Further, the composition of the risk pool would be uncertain since there would be no requirements regarding employee participation or employee contributions.

This approach would require OPM to work with as many as 39 different States to administer the program. OPM would develop expertise in the laws and regulations of each State. Differences in governing provisions from State to State would be difficult to administer.

In the case of HMO's, we would negotiate a rate for small employers at the same time we negotiate a rate for Federal employees. In the case of the Service Benefit Plan, we would negotiate a rate for each participating State. Only one contract with each plan would be necessary, with the possible exception of the Service Benefit Plan.Small employers would constitute a separate risk pool from the FEHB on a State-wide basis for rate setting purposes. Further, the composition of the risk pool would be uncertain since there would be no employee participation requirements.

For HMO's, OPM has a regulatory framework that insures that it gets the same discounted rates as other large employers. However, for small employers, we would be negotiating for the basic community rate.

The coordinating office for the Service Benefit Plan is the Federal Employee Program office. It is the liaison among the Blue Cross and Blue Shield Association, the 67 participating local Blues plans, and OPM. OPM now negotiates with this national coordinating office for a single national rate. Under this approach, OPM would probably need to deal with each local plan separately in order to establish rates. This would make it difficult to maintain a single Service Benefit contract. Negotiating a rate for each State would represent a new venture for us. We would need some time set up a mechanism for doing this.

OPM would need to place a surcharge on the premiums to cover its administrative expenses. The FEHB rates currently include a 1 percent add-on for administrative expenses. We would anticipate a much lower surcharge.

STATE-BASED FEHB; OPM SETS UP AND ADMINISTERS

Description

OPM would, upon application by the State and approval by HHS, set up cooperatives and develop a program similar to FEHB for small employers in the State. These Programs would be very much like the FEHB Program, except where State law varies from Federal law; for example, benefits would have to parallel FEHB Program benefits except where modifications were necessary to meet minimum State requirements.

Comments

It is likely that not all HMO's in the FEHB Program would have the capacity to absorb a large influx of new enrollees and their families. In areas without FEHB HMO's, only the Service Benefit Plan would be available.

The coordinating office for the Service Benefit Plan is the Federal Employee Program office. It is the liaison among the Blue Cross and Blue Shield Association, the 67 participating local Blues plans, and OPM. OPM now negotiates with this national coordinating office for a single national rate. Under this approach, OPM would probably need to deal with each local plan separately in order to establish rates. This would make it difficult to maintain a single Service Benefit contract. Negotiating a rate for each State would represent a new venture for us. We would need some time set up a mechanism for doing this.

Rates would be set on a State-wide basis. Small employers would constitute a separate risk pool from the FEHB for rate setting purposes. Further, the composition of the risk pool would be uncertain since there would be no requirements regarding employee participation or employee contributions.

This approach would require OPM to work with as many as 39 different States to administer the program. OPM would develop expertise in the laws and regulations of each State. Differences in governing provisions from State to State would be difficult to administer.

OPM would require increased staff to administer the Program. Another source of funds would be needed, since using FEHB trust fund money would be precluded under current law. A separate trust fund would be needed for each participating State cooperative. State reserve requirements would apply. Money for initial development of the program would be needed since trust fund money would not be available until premium collections began.

In the case of HMO's, we would negotiate a rate for small employers at the same time we negotiate a rate for Federal

employees. In the case of the Service Benefit Plan, we would negotiate a rate for each participating State. Only one contract with each plan would be necessary, with the possible exception of the Service Benefit Plan.

APPENDIX

Characteristics of the FEHB Program

There are several characteristics of the FEHB Program that should be considered in determining how the FEHB Program can best be used to support the President's policy.

There are three types of plans within the FEHB Program:

1. The Government-wide Service Benefit Plan administered by Blue Cross and Blue Shield is open to all Federal employees. This plan pays claims for health care services and supplies. It also provides access to preferred provider organizations (PPO's).

2. Employee organization plans are sponsored by Federal employee organizations. They also pay claims for health care services and supplies and generally provide access to PPO's. The plans are limited to members of the employee organization. Some of the organizations are closed to anyone outside the scope of the organization itself. Others are open to other Federal employees on an associate membership basis. Many employee organizations contract with a major insurer to underwrite their plan.

3. Health maintenance organizations generally provide health care services and supplies rather than pay claims. Enrollees must live in the geographic area service by the plan and must utilize the plan's physicians and hospitals.

OPM's role is to:

- Review plan applications to determine whether they meet our standards.
- Negotiate benefits and rates.
- Conduct an annual open season.
- Coordinate with plans and agencies to make brochures, Program information, and open season information available to employees.
- Administer and oversee the contract with the plans, including monitoring plan performance to ensure that it meets our standards, auditing plans, and resolving audit disputes.
- Review disputed claims and defend our decisions if the claimant decides to take us to court.

- Receive withholdings and Government contributions from agencies and distribute them to administrative reserve, contingency reserve, and plans.
- Publish regulations to carry out the FEHB law and improve the Program.
- Provide guidance to agencies on the administration of enrollment.
- Maintain an FEHB administrative reserve for the Program and a contingency reserve for each plan.

The agencies' role is to:

- Distribute information to employees.
- Counsel employees about their rights and obligation under the FEHB Program.
- Determine who is eligible for coverage. (Generally, the FEHB law specifies who is eligible for coverage. The law allows OPM to regulate coverage rules for certain short-term and intermittent employees.)
- Determine who qualifies as a family member under the FEHB law and regulations.
- Process enrollments, changes in enrollment, and terminations of enrollment.
- Make the appropriate withholdings from the employees' pay.
- Remit employee withholdings and Government contributions to OPM.
- Work with carriers, as necessary, to reconcile enrollment records.

The carrier's role is to:

- Pay claims accurately and promptly or provide quality services.
- Implement cost containment measures and monitor utilization.
- Comply with Federal law and regulation (Federal Law generally preempts State law in health insurance matters when there is a conflict between the two).
- Reconcile enrollment records with employing agencies.

Prepared by the Office of Insurance Programs -- October 13, 1995

16 December 1994

TO: Jennifer Klein

FROM: Meredith Miller
Deputy Assistant Secretary for Pension and Welfare Benefits, U. S. Department of Labor

SUBJECT: Paper on Expanding the Federal Employee Health Benefits Program

Here is the research I spoke with you about with respect to expanding the Federal Employees Health Benefits Program (FEHBP).

DRAFT

SHOULD THE FEHBP BE EXPANDED?

It has been suggested that the Federal Employees Health Benefits Program (FEHBP), which has provided voluntary health insurance for Federal employees, retirees, and their dependents since 1960, be opened up to non-Federal enrollment.

Seldom mentioned in that context are the many problems of the FEHBP, which had become so pronounced that only a few years ago there were proposals to reform it. As Congressman William Clay, chair of the House Post Office and Civil Service Committee described the FEHBP in 1992, "[t]he program ... is ... bleeding. It is time to find a cure."

What are the main problems with the FEHBP? There is no competition among carriers to participate in the FEHBP -- there are no discounts or other favorable arrangements offered by carriers for the privilege of entering the FEHBP marketplace. The competition is solely at the consumer level, but this type of competition is to attract the better risks, not to provide the best product in the most cost effective manner. The result has been risk segmentation so severe that the premiums vary by 246 percent even though the expected value of the benefits varies only 46 percent. The premiums reflect enrollee characteristics, rather than the value of benefits. Moreover, there are too many plans (300 or so, with individuals choosing from about 3 dozen) with only subtle differences in benefits, confusing subscribers in making choices and multiplying the Government's cost as well as fragmenting its buying power. The studies of the FEHBP have described the FEHBP as inefficient, not cost effective, and have concluded that the program should be receiving more health care for the money it spends or spending less money on the health care protection it provides. It has been pointed out that the FEHBP's premiums would have increased more than they have in the past few years except that benefits were cut in 1982 and the growing reserves were drawn down.

Several bills were proposed during the 103rd Congress that would have affected the FEHBP, some of them changing the FEHBP and then opening it up and some opening it up without changing. There were a variety of ways the opening up was handled, some seeming to take into account the ramifications and some not.

There are a number of issues that need to be examined in whether to open up the FEHBP -- whether the FEHBP's problems should be corrected before it is opened up, and, if it is opened up, in what manner, to whom, and in what insurance environment (i.e., will there be insurance market reforms also?). Also, it is not clear how much interest there would be in the non-Federal marketplace in joining the FEHBP. At the present time 28 percent of Federal employees and retirees do not participate. It might be helpful to ascertain what percentage of those are eligible to participate and why they don't, even though the Government pays most of the cost. Also, there are those who are eligible to continue coverage under the FEHBP totally at their own expense for periods of time or life -- it might be useful to find out how many of those take advantage of the opportunity and, for those who do not, why not.

There are ways to expand the FEHBP or set up a separate FEHBP-like structure without causing problems to Federal enrollees or the FEHBP. Whether and how to open it and all the ramifications need to be considered as well as what the interest might be in enrolling in an expanded FEHBP before any decision is made.

THE FEHBP -- SHOULD IT BE EXPANDED? DRAFT

The purpose of this paper is to examine the Federal Employees Health Benefits Program (FEHBP) with a view to opening access to the FEHBP or an FEHBP-like structure to non-Federal enrollees.

This paper describes the FEHBP, its problems, examples of proposals to expand the FEHBP in the 103rd Congress, some issues to be considered in expanding FEHBP access, the states' activity in expanding state programs, the positives and negatives of FEHBP expansion, and recommendations.

OVERVIEW OF THE FEHBP

The FEHBP, established by the Federal Employees Health Benefits Act of 1959, P.L. 86-382 (FEHBPA), effective July 1, 1960, provides voluntary health insurance coverage for Federal employees, retirees, and their dependents.

In 1994, there were over 9 million individuals covered by the FEHBP, 2.3 million active employees, 1.7 million retirees, and 5 million dependents, making it the single largest employer-sponsored health benefit program in the U.S. Approximately 72 percent of Federal employees and retirees are enrolled in the FEHBP. The 28 percent not participating -- 500,000 retirees and 450,000 employees -- either declined FEHBP coverage or are ineligible. The estimated cost for FY 1995 is $17.7 billion.

FEHBP enrollees have a choice among many health plans with varying levels of benefits and premiums. Over 300 plans participate in the FEHBP. Enrollees can actually choose from among 18 to 35 options that are available to them in their occupation and their geographic area. The three major types of plans are as follows:

1) Government Wide-Plan:

Since 1990, this category includes only the Service Benefit Plan of Blue Cross and Blue Shield, open to all Federal employees and retirees, with a high and a standard option. (The number of government-wide plans is set at two by statute. The other one, Aetna, withdrew in 1989 because it was severely impacted by risk selection.)

DRAFT

2) Employee Organization Plans:

These are plans sponsored by unions or other employee organizations open only to "members." There were 14 in 1994. Some allow all FEHBP eligibles to join the organizations for a membership fee in addition to the health plan premium. These are, in effect, government-wide plans. Others are open only to employees in certain occupational groups or agencies -- there were 7 of these in 1994. Employee organization plans may participate in the FEHBP only with specific legislative authority.

3) Comprehensive Medical Plans or Health Maintenance Organizations (HMO's):

The plans arrange for health care from designated plan physicians, hospitals, and other providers in particular geographic locations. New plans cannot enter FEHBP without an act of Congress, except for HMO's. Virtually any bona fide HMO may enter the FEHBP.

The FEHBPA describes in general terms the types of benefits that are to be included in each plan. However, the statute does not prescribe any minimum level of benefits or any minimum floor that must be offered in specific areas of coverage. So, plans are relatively free to design their benefit packages.

When a retiree becomes eligible for Medicare at age 65, the FEHBP is secondary payor to Medicare and fully supplements Medicare.

Participants can enroll in or switch FEHBP plans once a year during "Open Season" or in certain circumstances, such as marriage, birth of a child, transfer abroad, or, if enrolled in a HMO, when the participant moves out of the HMO's service area.

Plans cannot exclude coverage for preexisting conditions or illnesses.

In the FEHBP, the Government-wide and employee organization plans are experience rated, as are some HMO's. The large majority of the FEHBP HMO's are community rated.

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The Federal Government and FEHBP participants jointly pay for the cost of the FEHBP plans according to a statutory formula. The Government's part of the premium (excluding the Postal Service) is the amount equal to 60 percent of the average of the high option premiums of what are known as the "Big Six" plans, but cannot exceed 75 percent of any plan's premium. In 1994, the Government's share was approximately 72 percent of the average premium. Premiums are paid on an individual and family basis.

The FEHBP is administered by the Office of Personnel Management, which, among other things, negotiates with plans on benefits and premiums, manages FEHBP premium payments, approves qualified plans for participation in the program, and determines the terms and conditions of and conducts the open season.

PROBLEMS WITH THE FEHBP

The FEHBP is being held up as a model for a national health care plan. The Heritage Foundation's Robert E. Moffit states, "This system based on consumer choice and competing providers works smoothly and is popular with lawmakers and civil servants alike. This is why few ordinary Americans ever hear their senator or congressman complain about his health benefits." Others have joined the chorus.

However, just a few years ago, the FEHBP was a target of criticism from many quarters for inefficiencies.

Jerome D. Julius, OPM's Deputy Associate Director for Retirement and Insurance, told the House Post Office and Civil Service's Subcommittee on Compensation and Employee Benefit, on May 24, 1989, "The Federal Employee Health Benefits Program is in dire need of comprehensive reform."

Congressman William Clay, Committee Chair, stated at hearings before the Subcommittee on May 20, 1992, "What we need -- an efficient health benefits program that will provide comprehensive coverage to Federal workers, retirees, and their families at a fair and reasonable price -- and what we have are two different things. The program ...is... bleeding. It is time to find a cure."

DRAFT

Senator Ted Stevens on August 2, 1989, in proposing reform of the FEHBP, stated, "...[F]or quite some time, I have been concerned about the health of the Federal Employees Health Benefits Program. It has become clear to many of us that that program is desperately ill. Once one of the most attractive selling points for a career in Federal service, it is no longer state of the art. A conglomeration of insurance carriers and a confusion of plans, the only choice that it offers today is chaos. Largely because of the adverse selection problems, one of the program's largest carriers, Aetna, recently abandoned it, causing much consternation on the part of those employees it covers and the Federal work force in general."

In a letter to the Congressional Research Service requesting an in-depth systematic analysis of the FEHBP, dated June 15, 1988, Congressman William D. Ford, then chair of the House Committee on Post Office and Civil Service, and Congressman Gary Ackerman, then chair of the Subcommittee on Compensation and Employee Benefits, stated that the FEHBP "...program in recent years has been plagued with substantial benefit reductions, skyrocketing premium increases, and wildly fluctuating reserve levels."

According to recent studies by the Congressional Research Service; Towers, Perrin, Forster and Crosby, Inc. (TPF&C) for OPM; the consultants to the House Committee on Post Office and Civil Service; and the General Accounting Office -- among others, there are problems and inefficiencies in FEHBP.

The problems fall in the following areas.

1. Participation of Plans in the FEHBP.

There is no competitive bidding process or renewal negotiations to control a plan's participation in the FEHBP. Plans qualify for participation by meeting certain statutory requirements and standards, but not cost, quality, or service standards. The Federal Government, as primary payer and sponsor of health benefits for nearly 10 million people, is not exercising its buying power in the marketplace. There is no competition by plans/carriers for entry into or for remaining in the FEHBP.

In the typical private sector and in most other governmental situations, the employer defines the benefits it elects to offer, solicits bids, evaluates the bids, and selects one or more from among those offering the best coverage at the best price.

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In the FEHBP, by contrast, there is no comparable solicitation, no bidding, no comparative evaluation, and no price concessions. The leverage that the nation's largest employer might have exercised in a competitive selection process is squandered.

Plans are admitted into the FEHBP without knowledge of the prices to be charged or benefits to be provided. There are no discounts or other favorable arrangements offered by carriers for the privilege of entering the FEHBP marketplace. Once in the FEHBP they remain essentially as long as they desire. The result is the Government does not necessarily get the best buy.

2. Risk Selection

A program offering a choice of competing health plans should have a system for managing the problem of adverse risk selection. (Risk selection occurs when individuals representing the same level of expected demands for medical services concentrate in a given plan or option.) The FEHBP does not. Consequently, as pointed out by TPF&C's *Study of the Federal Employee Benefits Program* for OPM in 1988, "[T]he history of FEHBP is a study in the erosion of the group insurance principle by risk selection."
Risk segmentation is so severe, according to a 1989 Congressional Research Service study, that premiums in the FEHBP vary by 246 percent even though the expected value of the benefits vary by only 46 percent. The premiums reflect enrollee characteristics rather than the value of the benefits.

In the case of Blue Cross/Blue Shield, both the high and standard options have approximately equivalent benefits from an actuarial standpoint, but there is more than a fivefold difference in employee premium rates, according to OPM.

In 1974, the high option of the two Government-wide plans accounted for 56 percent of total FEHBP enrollment. Today, only one of those plans currently exists and accounts for less than 15 percent of total FEHBP enrollment.

3. Consumer Driven Competition

As noted above, in State and local governmental and private sector situations, employers negotiate with competing plans before allowing them to offer their plan to employees. In this case, only after program administrators assure the value of the plans are they offered to employees. In the FEHBP, however, plans do not compete to enter the FEHBP. They compete for enrollees. The competition is solely at the consumer level, for which the FEHBP has often been praised. The theory behind

the choice in the FEHBP is that competition among plans at the consumer level leads to the most efficient provision of services to participants and lowers program costs. In fact, critics claim that this form of competition has done nothing to counteract inefficiency and lower costs and, in fact, may have exacerbated them. Competition at the consumer level winds up being primarily to attract the better risks. The result this has been risk segmentation, leading to prices based on enrollee characteristics rather than the value of benefits.

4. Choice of Plans and Range of Benefits

While each enrollee may choose from among two dozen to thirty-five of the 300 or so plans participating in the FEHBP, and thus there are many different plans from which to choose, it has been said that meaningful choice in the FEHBP is illusory. Because choice has led to risk segmentation, resulting in premiums based on enrollee characteristics rather than value, enrollees' ability to assess the value of competing plans is undermined, and, for lower income Federal retirees and employees, choice is limited by what enrollees can afford to pay, rather than by what benefits are suitable for their situation. According to a 1989 attitude survey by OPM of FEHBP membership, the majority of respondents said that comparing plans in the FEHBP is a problem and they would prefer a simpler program with fewer choices.

5. Consumer Information

According to Robert Moffit of the Heritage Foundation, "[m]embers of Congress and federal workers are not left alone in a bewildering and confusing health care market, but are given solid, 'user-friendly' information ... on the options available to them." This statement is contradicted by the 1989 OPM survey cited above and the various studies on the FEHBP. In fact, because of risk segmentation and its effect on premiums, it is extraordinarily difficult to make a rational choice among the FEHBP plans.

6. Portability

If Federal employees leave Federal service (other than by retiring), they have the same problem any other individuals have when they leave their jobs: they lose the health care they received on the job. Even if they can afford to pay the entire premium themselves (Government share and enrollee share), continuation of their FEHBP coverage lasts only for a certain period of time, just as continuation coverage in the private sector does. Federal employees have FEHBP insurance only if

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they are employed by the Federal government or retire from the Federal Government. Moreover, their benefits can change, just as private-sector employees' benefits can be changed. In 1982, benefits in the FEHBP were drastically cut. (In 1982, in order to stay within budget, OPM instructed fee-for-service plans to reduce benefit costs by 13 percent. Costs were reduced by introduction of various deductibles and co-payments.)

7. Financial Help

According to Robert Moffitt of the Heritage Foundation, one of the advantages of the FEHBP is that "[m]embers of Congress and all federal workers also get some financial help from the federal government in the purchase of their insurance. The government makes a contribution ... an average of a little more than 70 percent of the premium."

The "financial help" the Government provides to Federal employees through the FEHBP is its contribution to it <u>as the employer</u>. In fact, private-sector and state and local governmental employers often pay all the costs of health insurance for their employees and, at any rate, almost always contribute more than the Federal Government does for its employees.

Employer health benefit contributions are not taxable to employees. The premiums paid by employees for their health insurance is not deductible.

The Congressional Research Service studies and others have demonstrated that the typical FEHBP plan is less generous than the typical private-sector plan.

8. <u>Cost Control</u>

Mr. Moffet cites the FEHBP as a "program that works well in controlling costs" and states further that "this cost control is all the more remarkable, given that the Federal program, unlike many private or corporate health plans, is open to all retirees...[who are]...much more costly on average to insure than active workers...."

Mr. Moffet neglects to consider that, for Federal retirees eligible for Medicare, the FEHBP is secondary payor and, despite the fact that Medicare-eligible retirees thus typically receive lower benefits from the FEHBP, retirees pay the same premium as active employees (in addition to paying for Medicare). Therefore, Federal retirees eligible for Medicare subsidize active workers in the FEHBP.

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Moreover, according to the 1989 TPF&C study of the FEHBP for OPM, "...the FEHBP is inefficient and not very cost effective...[and]... the program should either be receiving more health care for the money it spends or spending less money on the health care protection it receives."

Furthermore, the FEHBP premiums would have increased more than they have except that FEHBP benefits were cut in 1982, and in 1986 concern about growing reserves caused plans to draw them down, thus reducing premiums.

9. Other Economic Inefficiencies

Specific economic inefficiencies were revealed in detail in the General Accounting Office, Congressional Research Service, TPF&C, and the House Committee Consultants studies. Too many plans with only subtle differences in benefits are available, confusing subscribers in making choices and multiplying the Government's cost as well as fragmenting its buying power.

There is a serious lack of accountability.

The FEHBP contracts are different from other government procurements -- they renew automatically and for experience-rated plans both gains and losses are rolled forward and are either drawn down or made up in the next contracting period, so there is, with certain exceptions, little real risk. Yet there are risk charges and profits.

Employee organization plans have evolved into additional "government-wide plans" and charge associate member dues for non-members for which no health care services are received but which enrich the employee organizations by millions of dollars.

The annual open season is expensive and exacerbates adverse risk selection.

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PROPOSALS IN 103RD CONGRESS
TO EXPAND COVERAGE OF THE FEHBP

Several bills were proposed during the 103rd Congress that would have affected the FEHBP.

The President's Health Security Act would have terminated the FEHBP, requiring Federal employees and annuitants to purchase health insurance through regional alliances serving the area where they reside. The Wellstone/McDermott single-payor proposal would likewise have eliminated the FEHBP.

Various other bills would have expanded the FEHBP by opening it in varying degrees to individuals and/or companies, and some would have modified the FEHBP as well.

For example, the Moynihan bill would have opened access only to the FEHBP community-rated plans, with the government-wide FEHBP plans closed to non-Federal enrollment.

The Kennedy bill would have modified the FEHBP package to be consistent with a standard package of benefits, required plans to be community-rated locally, and made FEHBP plans available to all Americans not receiving coverage through a large employer (with those individuals also able to purchase insurance directly from insurance companies or through voluntary state cooperatives). Employers, except those with fewer than five employees, would have been required to share the cost of the premium.

The Roth proposal would have expanded the current FEHBP to allow small employers with 100 or fewer employees (including businesses with one self-employed individual) to offer their employees access to FEHBP plans at the same premium paid for Federal enrollees, so long as a specified percentage of their employees enrolled. While employers would be required to forward premiums to insurance carriers, they would not have been required to pay for any part of the premium. Each plan participating in the FEHBP would have been required to insure an annual minimum number of small business workers. The Roth proposal retained the ability of current union plans to continue to provide coverage exclusively to its members.

The Dole plan would have opened the FEHBP to self-employed individuals and small employers (up to 50 employees) at the same premium paid for Federal enrollees plus an administrative fee.

The Mitchell bill would have modified the FEHBP, required a standard benefit package, and opened the FEHBP to workers in firms with fewer than 500, nonworkers, AFDC recipients, and the self-employed, but at an age-adjusted community rate until 2002 when both Federal and non-Federal individuals would have paid the same community-rated premium.

The Clay bill proposed to open the FEHBP to employees of businesses with 100 or fewer employees, the self-employed, and the uninsured. The Clay proposal would keep non-Federal enrollees in a separate risk pool, although over a period of years the two risk pools would merge. The Government would offer supplemental policies at no charge to Federal employees and retirees.

ISSUES TO BE CONSIDERED IN EXPANDING THE FEHBP

Is it feasible to expand the FEHBP, and should it be expanded? The answer to the questions depends on whether the problems of the FEHBP are corrected and the manner and degree of the expansion. As can be seen from the various proposals already made, there are many possibilities. There are also issues that must be addressed and ramifications that must be considered.

Would it be the FEHBP plans themselves that are offered to non-Federal enrollees? Or would an FEHBP-like structure be established to serve non-Federal enrollees?

What about those FEHBP plans that are not now open to the entire FEHBP population? For example, the plan of the Beneficial Association of Capitol Employees (BACE) serves members of Congress and congressional staff exclusively. Will such plans be allowed to continue in the FEHBP and to continue to restrict their coverage?

Would the FEHBP employee organization plans that now allow the entire non-member FEHBP population to enroll in their plans if non-members pay "associate member" fees be allowed to enroll non-Federal enrollees in their plans also?

Would the FEHBP plans be exempt from state premium taxes and mandated benefits, and other requirements, as they are now, when there are non-Federal enrollees?

Where would the plans/employers stand with respect to coverage under the Employee Retirement Income Security Act of 1974 (ERISA)? Would non-Federal employers who contributed to coverage of their employees under the FEHBP be deemed to have established an ERISA-covered plan? If so, what about employers who forwarded employees' premiums but did not contribute?

Would FEHBP coverage be opened only if mandates were involved, i.e., all individuals were required to have health insurance, or would it be opened on a purely voluntary basis? If the latter, would individuals be covered only if their employers contributed, or if a specified percentage of the firm's employees were covered? The answers to these questions are indicative of the adverse selection problems that could arise and the subsequent effect on premiums.

Would Federal enrollees and non-Federal enrollees be kept separate as risk groups, with separate accounting, record-keeping, premium-setting, etc.?

Would only certain FEHBP plans be opened and not others, e.g., only community-rated HMO's, but not the experience-rated government-wide plans?

Would it be a modified FEHBP that would be opened up or would the FEHBP as it is now essentially (although with some problems corrected) be opened up?

Should only options that would not harm current FEHBP enrollees be considered? Should there be a differentiation between the role of the Government as employer and the role of the Government as insurance facilitator for national health care?

Would there be any pre-existing condition exclusions for new non-Federal enrollees?

Would there be participation rules? Entry/exit rules? Additional costs assessed for additional administration burdens?

Would the FEHBP or an FEHBP-like structure be opened in the present insurance environment, e.g., where pre-existing condition rules exist? Or, would insurance market reforms be instituted nation-wide before the FEHBP is opened up? The interest in and the populations attracted to the FEHBP might be very different, depending on the answer.

Would administration of the FEHBP remain at OPM if expanded?

Does OPM or the FEHBP have the capacity to take on millions of more enrollees if it should come to that? Would the non-Federal enrollees be charged for the additional administrative costs that will be incurred by an expansion?

How likely is it that there would be much interest in an expanded FEHBP? Certain non-Federal enrollees have access to the FEHBP now -- Federal employees who quit their government jobs, children of Federal workers or retirees who do not have status as dependents, and ex-spouses have access to the FEHBP for varying periods to life. It might be useful to examine these populations to ascertain who takes advantage of this opportunity -- and for those who do not, why not. Moreover, 28 percent of Federal employees and retirees are not enrolled in FEHBP -- 500,000 retirees and 450,000 employees. It might be useful to ascertain how many are eligible to participate and why they are not covered, especially since the Government pays a large part of the costs. This might give us some idea of the populations interested in FEHBP coverage.

STATES' EXPERIENCE AVAILABLE

Do we have any models for opening up a large health benefit program to smaller groups or individuals? In recent years, some State health plans have brought additional local public sector and, in some cases, private sector employee groups into the State plan, giving the State enhanced group purchasing power and giving smaller groups access to more affordable health care. These States' experiences and the problems they encountered could be instructive if the FEHBP were to be opened up. For example, because of unstable membership and adverse risk selection concerns, some States impose entry and exit rules. Some states have separate risk pools because of adverse selection.

PROs AND CONs AND RECOMMENDATIONS

PROs to Expanding the FEHBP or FEHBP-like Structure

1. The FEHBP has a positive image in the eyes of the larger population.

2. This would be a method of providing health care to at least some of those who do not now have it.

3. There are ways to expand FEHBP to some extent or set up a separate FEHBP-like structure without causing problems to Federal enrollees or the FEHBP. There are a number of ways to accomplish this, e.g., the expansion could be limited to the FEHBP community-rated HMO's, or the Federal enrollees and expanded non-Federal groups could be kept in separate risk groups.

CONs

1. The problems of risk selection and other inefficiencies in the FEHBP should be corrected before it is expanded or duplicated. There are identifiable problems in the FEHBP which should not be expanded into the wider population.

2. It is unknown how many of the uninsured would be interested in paying the entire or even part of the FEHBP premium (except those who have conditions which preclude their obtaining insurance elsewhere). It would be wise to ascertain how widespread non-Federal enrollment might be.

3. If the FEHBP were opened up and were a failure, it could discredit further health reform efforts.

RECOMMENDATIONS

FEHBP can be opened to non-Federal enrollment, at least to some extent. Whether it should be opened, how, to whom, and to what extent it should be opened, and how to deal with existing problems in the FEHBP must be very carefully thought out and handled before the FEHBP is expanded or an FEHBP-like structure is established.

If the expansion or the establishment of an FEHBP-like structure is handled carefully with the existing problems and inefficiencies corrected, and all ramifications considered, it could be a success.

On the other hand, if it is not handled very carefully and cautiously, we could have, instead of the existing successful program with some problems covering Federal employees, a disaster.

STUDIES

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The FEHBP, the Metropolitan Life Insurance study, reported by John Creedon, "Statement of the Consultants of the Committee on Post Office and Civil Service before the Subcommittee on Compensation and Employee Benefits," in *Recommendations for Reform of the Federal Employees Health Benefits Program*. Hearings before the House Committee on Post Office and Civil Service, Serial No. 102-56, May 20, 1992.

Critical Issues in U.S. Health Reform, edited by Eli Ginzberg, Chapter 11, "Federal and State Public Employees Health Benefit Program," by Cathy Schoen and Lawrence Zachareas, Westview Press, 1994.

U.S. General Accounting Office, *Federal Health Benefits Program, Stronger Controls Needed to Reduce Administrative Costs*, GAO/GGD 92-37, (Washington, D.C., GAO, February 1992).

The Heritage Foundation Backgrounder, the Heritage Foundation, "Why Federal Unions Want To Escape the Clinton Health Plan," Robert E. Moffit, Washington, D.C., August 4, 1993.

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COMPARISON OF APPROACHES

Major Features	ACCESS TO FEHB PLANS TO FORM A PURCHASING COOPERATIVE FOR SMALL EMPLOYERS	FEHB ACCESS PLUS RATE NEGOTIATION BY OPM	STATE BASED FEHB APPROXIMATION; OPM SETS UP AND ADMINISTERS
Benefits	Negotiated between carrier and State cooperative or small employer with OPM assistance as requested.	The same as FEHB benefits, modified only by State requirements that exceed FEHB requirements.	
Rates		Based on the benefits offered and the characteristics of the group. Negotiated by OPM and carriers. There would be a surcharge for OPM's administrative costs.	Based on the benefits offered and the characteristics of the group. Negotiated by OPM and carriers. OPM's administrative surcharge would reflect the greater administrative effort involved
Informational requirements		FEHB literature modified for State enrollees.	
Enrollment and premium collection		Determined jointly by carrier and State cooperative.	Determined by carrier, State cooperative, and OPM.
Risk and reserves		OPM would incorporate State requirements into rate setting process.	OPM would incorporate State requirements into rate setting process. OPM could establish additional requirements if deemed necessary.
Disputed claims and court review		Carrier and State cooperative would determine review process. OPM would not be involved.	OPM could act as a consultant for the State or employer. Litigation would be against the carrier, not OPM.

Pros	• Minimizes Federal involvement and maximizes State and small business flexibility. • Access need not be restricted to FEHB plans. • Would not require extensive legislative and administrative changes.		
Cons	• Some States may want more assistance and less flexibility.	• More Federal intrusion. • More restrictive. • Problem of setting rates without experience. • Unknown risk pool. • Only FEHB plans would be available through this Program. Other plans could not participate, but could compete with this Program.	• More Federal intrusion. • More restrictive. • Problem of setting rates without experience. • Unknown risk pool. • Only FEHB plans would be available through this Program. Other plans could not participate, but could compete with this Program. • OPM would have to work with as many as 39 different States in setting up cooperatives. • OPM would need to develop expertise in the laws and regulations of each State.

ACCESS TO FEHB PLANS TO FORM A PURCHASING COOPERATIVE FOR SMALL EMPLOYERS

Description

States would request access to FEHB plans for purposes of establishing a purchasing cooperative. HHS would certify State-organized purchasing cooperatives. OPM would then provide a list of FEHB participating carriers, and small employers could contact them directly. If the State desired a larger role in the formation of the purchasing cooperative, it could do so at its option.

Comments

It is likely that not all HMO's in the FEHB Program would have the capacity to absorb a large influx of new enrollees and their families. In areas without FEHB HMO's, only the Service Benefit Plan would be available.

This approach would require few, if any, legislative and administrative changes. It might be possible to accomplish this through an Executive Order and regulatory changes. FEHB contracts would need to be amended to require FEHB carriers to accept the employees of small businesses for coverage. The State cooperative and the carrier could work out the terms of that coverage and the details for collecting premiums. The employees would not be covered under OPM's contract with the carrier. State roles could be active or passive, depending on State interests.

Benefits could duplicate those offered to Federal enrollees, except for modifications necessary to meet the requirements of State law, or greater variation of the FEHB package could be offered if desired by the State. Small employers who currently pay some portion of a premium for minimal (typically high deductible) catastrophic coverage would find FEHB-type coverage more costly. The advantages associated with establishment of a purchasing cooperative would largely result from the role played by the State, the size of the group, the percentage of each employer's workforce that participates, and the demographic characteristics of the covered population.

The participating carriers would be Blue Cross/Blue Shield and HMO's doing business in the State. All other FEHB carriers have selective memberships and do not provide coverage on an unrestricted basis.

FEHB ACCESS PLUS RATE NEGOTIATION BY OPM

Description

Same as before except that OPM would negotiate the rates for small employers for the FEHB benefits package modified if necessary to accommodate State requirements.

Comments

It is likely that not all HMO's in the FEHB Program would have the capacity to absorb a large influx of new enrollees and their families. In areas without FEHB HMO's, only the Service Benefit Plan would be available.

Rates would be set on a State-wide basis. Small employers would constitute a separate risk pool from the FEHB for rate setting purposes. Further, the composition of the risk pool would be uncertain since there would be no requirements regarding employee participation or employee contributions.

This approach would require OPM to work with as many as 39 different States to administer the program. OPM would develop expertise in the laws and regulations of each State. Differences in governing provisions from State to State would be difficult to administer.

In the case of HMO's, we would negotiate a rate for small employers at the same time we negotiate a rate for Federal employees. In the case of the Service Benefit Plan, we would negotiate a rate for each participating State. Only one contract with each plan would be necessary, with the possible exception of the Service Benefit Plan.Small employers would constitute a separate risk pool from the FEHB on a State-wide basis for rate setting purposes. Further, the composition of the risk pool would be uncertain since there would be no employee participation requirements.

For HMO's, OPM has a regulatory framework that insures that it gets the same discounted rates as other large employers. However, for small employers, we would be negotiating for the basic community rate.

The coordinating office for the Service Benefit Plan is the Federal Employee Program office. It is the liaison among the Blue Cross and Blue Shield Association, the 67 participating local Blues plans, and OPM. OPM now negotiates with this national coordinating office for a single national rate. Under this approach, OPM would probably need to deal with each local plan separately in order to establish rates. This would make it difficult to maintain a single Service Benefit contract. Negotiating a rate for each State would represent a new venture for us. We would need some time set up a mechanism for doing this.

OPM would need to place a surcharge on the premiums to cover its administrative expenses. The FEHB rates currently include a 1 percent add-on for administrative expenses. We would anticipate a much lower surcharge.

STATE-BASED FEHB; OPM SETS UP AND ADMINISTERS

Description

OPM would, upon application by the State and approval by HHS, set up cooperatives and develop a program similar to FEHB for small employers in the State. These Programs would be very much like the FEHB Program, except where State law varies from Federal law; for example, benefits would have to parallel FEHB Program benefits except where modifications were necessary to meet minimum State requirements.

Comments

It is likely that not all HMO's in the FEHB Program would have the capacity to absorb a large influx of new enrollees and their families. In areas without FEHB HMO's, only the Service Benefit Plan would be available.

The coordinating office for the Service Benefit Plan is the Federal Employee Program office. It is the liaison among the Blue Cross and Blue Shield Association, the 67 participating local Blues plans, and OPM. OPM now negotiates with this national coordinating office for a single national rate. Under this approach, OPM would probably need to deal with each local plan separately in order to establish rates. This would make it difficult to maintain a single Service Benefit contract. Negotiating a rate for each State would represent a new venture for us. We would need some time set up a mechanism for doing this.

Rates would be set on a State-wide basis. Small employers would constitute a separate risk pool from the FEHB for rate setting purposes. Further, the composition of the risk pool would be uncertain since there would be no requirements regarding employee participation or employee contributions.

This approach would require OPM to work with as many as 39 different States to administer the program. OPM would develop expertise in the laws and regulations of each State. Differences in governing provisions from State to State would be difficult to administer.

OPM would require increased staff to administer the Program. Another source of funds would be needed, since using FEHB trust fund money would be precluded under current law. A separate trust fund would be needed for each participating State cooperative. State reserve requirements would apply. Money for initial development of the program would be needed since trust fund money would not be available until premium collections began.

In the case of HMO's, we would negotiate a rate for small employers at the same time we negotiate a rate for Federal

employees. In the case of the Service Benefit Plan, we would negotiate a rate for each participating State. Only one contract with each plan would be necessary, with the possible exception of the Service Benefit Plan.

APPENDIX

Characteristics of the FEHB Program

There are several characteristics of the FEHB Program that should be considered in determining how the FEHB Program can best be used to support the President's policy.

There are three types of plans within the FEHB Program:

1. The Government-wide Service Benefit Plan administered by Blue Cross and Blue Shield is open to all Federal employees. This plan pays claims for health care services and supplies. It also provides access to preferred provider organizations (PPO's).

2. Employee organization plans are sponsored by Federal employee organizations. They also pay claims for health care services and supplies and generally provide access to PPO's. The plans are limited to members of the employee organization. Some of the organizations are closed to anyone outside the scope of the organization itself. Others are open to other Federal employees on an associate membership basis. Many employee organizations contract with a major insurer to underwrite their plan.

3. Health maintenance organizations generally provide health care services and supplies rather than pay claims. Enrollees must live in the geographic area service by the plan and must utilize the plan's physicians and hospitals.

OPM's role is to:

- Review plan applications to determine whether they meet our standards.
- Negotiate benefits and rates.
- Conduct an annual open season.
- Coordinate with plans and agencies to make brochures, Program information, and open season information available to employees.
- Administer and oversee the contract with the plans, including monitoring plan performance to ensure that it meets our standards, auditing plans, and resolving audit disputes.
- Review disputed claims and defend our decisions if the claimant decides to take us to court.

- Receive withholdings and Government contributions from agencies and distribute them to administrative reserve, contingency reserve, and plans.

- Publish regulations to carry out the FEHB law and improve the Program.

- Provide guidance to agencies on the administration of enrollment.

- Maintain an FEHB administrative reserve for the Program and a contingency reserve for each plan.

The agencies' role is to:

- Distribute information to employees.

- Counsel employees about their rights and obligation under the FEHB Program.

- Determine who is eligible for coverage. (Generally, the FEHB law specifies who is eligible for coverage. The law allows OPM to regulate coverage rules for certain short-term and intermittent employees.)

- Determine who qualifies as a family member under the FEHB law and regulations.

- Process enrollments, changes in enrollment, and terminations of enrollment.

- Make the appropriate withholdings from the employees' pay.

- Remit employee withholdings and Government contributions to OPM.

- Work with carriers, as necessary, to reconcile enrollment records.

The carrier's role is to:

- Pay claims accurately and promptly or provide quality services.
- Implement cost containment measures and monitor utilization.
- Comply with Federal law and regulation (Federal Law generally preempts State law in health insurance matters when there is a conflict between the two).
- Reconcile enrollment records with employing agencies.

Prepared by the Office of Insurance Programs -- October 13, 1995

16 December 1994

TO: Jennifer Klein

FROM: Meredith Miller
Deputy Assistant Secretary for Pension and Welfare Benefits, U. S. Department of Labor

SUBJECT: Paper on Expanding the Federal Employee Health Benefits Program

Here is the research I spoke with you about with respect to expanding the Federal Employees Health Benefits Program (FEHBP).

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SHOULD THE FEHBP BE EXPANDED?

It has been suggested that the Federal Employees Health Benefits Program (FEHBP), which has provided voluntary health insurance for Federal employees, retirees, and their dependents since 1960, be opened up to non-Federal enrollment.

Seldom mentioned in that context are the many problems of the FEHBP, which had become so pronounced that only a few years ago there were proposals to reform it. As Congressman William Clay, chair of the House Post Office and Civil Service Committee described the FEHBP in 1992, "[t]he program ... is ... bleeding. It is time to find a cure."

What are the main problems with the FEHBP? There is no competition among carriers to participate in the FEHBP -- there are no discounts or other favorable arrangements offered by carriers for the privilege of entering the FEHBP marketplace. The competition is solely at the consumer level, but this type of competition is to attract the better risks, not to provide the best product in the most cost effective manner. The result has been risk segmentation so severe that the premiums vary by 246 percent even though the expected value of the benefits varies only 46 percent. The premiums reflect enrollee characteristics, rather than the value of benefits. Moreover, there are too many plans (300 or so, with individuals choosing from about 3 dozen) with only subtle differences in benefits, confusing subscribers in making choices and multiplying the Government's cost as well as fragmenting its buying power. The studies of the FEHBP have described the FEHBP as inefficient, not cost effective, and have concluded that the program should be receiving more health care for the money it spends or spending less money on the health care protection it provides. It has been pointed out that the FEHBP's premiums would have increased more than they have in the past few years except that benefits were cut in 1982 and the growing reserves were drawn down.

Several bills were proposed during the 103rd Congress that would have affected the FEHBP, some of them changing the FEHBP and then opening it up and some opening it up without changing. There were a variety of ways the opening up was handled, some seeming to take into account the ramifications and some not.

There are a number of issues that need to be examined in whether to open up the FEHBP -- whether the FEHBP's problems should be corrected before it is opened up, and, if it is opened up, in what manner, to whom, and in what insurance environment (i.e., will there be insurance market reforms also?). Also, it is not clear how much interest there would be in the non-Federal marketplace in joining the FEHBP. At the present time 28 percent of Federal employees and retirees do not participate. It might be helpful to ascertain what percentage of those are eligible to participate and why they don't, even though the Government pays most of the cost. Also, there are those who are eligible to continue coverage under the FEHBP totally at their own expense for periods of time or life -- it might be useful to find out how many of those take advantage of the opportunity and, for those who do not, why not.

There are ways to expand the FEHBP or set up a separate FEHBP-like structure without causing problems to Federal enrollees or the FEHBP. Whether and how to open it and all the ramifications need to be considered as well as what the interest might be in enrolling in an expanded FEHBP before any decision is made.

THE FEHBP -- SHOULD IT BE EXPANDED? DRAFT

The purpose of this paper is to examine the Federal Employees Health Benefits Program (FEHBP) with a view to opening access to the FEHBP or an FEHBP-like structure to non-Federal enrollees.

This paper describes the FEHBP, its problems, examples of proposals to expand the FEHBP in the 103rd Congress, some issues to be considered in expanding FEHBP access, the states' activity in expanding state programs, the positives and negatives of FEHBP expansion, and recommendations.

OVERVIEW OF THE FEHBP

The FEHBP, established by the Federal Employees Health Benefits Act of 1959, P.L. 86-382 (FEHBPA), effective July 1, 1960, provides voluntary health insurance coverage for Federal employees, retirees, and their dependents.

In 1994, there were over 9 million individuals covered by the FEHBP, 2.3 million active employees, 1.7 million retirees, and 5 million dependents, making it the single largest employer-sponsored health benefit program in the U.S. Approximately 72 percent of Federal employees and retirees are enrolled in the FEHBP. The 28 percent not participating -- 500,000 retirees and 450,000 employees -- either declined FEHBP coverage or are ineligible. The estimated cost for FY 1995 is $17.7 billion.

FEHBP enrollees have a choice among many health plans with varying levels of benefits and premiums. Over 300 plans participate in the FEHBP. Enrollees can actually choose from among 18 to 35 options that are available to them in their occupation and their geographic area. The three major types of plans are as follows:

1) Government Wide-Plan:

Since 1990, this category includes only the Service Benefit Plan of Blue Cross and Blue Shield, open to all Federal employees and retirees, with a high and a standard option. (The number of government-wide plans is set at two by statute. The other one, Aetna, withdrew in 1989 because it was severely impacted by risk selection.)

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2) Employee Organization Plans:

These are plans sponsored by unions or other employee organizations open only to "members." There were 14 in 1994. Some allow all FEHBP eligibles to join the organizations for a membership fee in addition to the health plan premium. These are, in effect, government-wide plans. Others are open only to employees in certain occupational groups or agencies -- there were 7 of these in 1994. Employee organization plans may participate in the FEHBP only with specific legislative authority.

3) Comprehensive Medical Plans or Health Maintenance Organizations (HMO's):

The plans arrange for health care from designated plan physicians, hospitals, and other providers in particular geographic locations. New plans cannot enter FEHBP without an act of Congress, except for HMO's. Virtually any bona fide HMO may enter the FEHBP.

The FEHBPA describes in general terms the types of benefits that are to be included in each plan. However, the statute does not prescribe any minimum level of benefits or any minimum floor that must be offered in specific areas of coverage. So, plans are relatively free to design their benefit packages.

When a retiree becomes eligible for Medicare at age 65, the FEHBP is secondary payor to Medicare and fully supplements Medicare.

Participants can enroll in or switch FEHBP plans once a year during "Open Season" or in certain circumstances, such as marriage, birth of a child, transfer abroad, or, if enrolled in a HMO, when the participant moves out of the HMO's service area.

Plans cannot exclude coverage for preexisting conditions or illnesses.

In the FEHBP, the Government-wide and employee organization plans are experience rated, as are some HMO's. The large majority of the FEHBP HMO's are community rated.

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The Federal Government and FEHBP participants jointly pay for the cost of the FEHBP plans according to a statutory formula. The Government's part of the premium (excluding the Postal Service) is the amount equal to 60 percent of the average of the high option premiums of what are known as the "Big Six" plans, but cannot exceed 75 percent of any plan's premium. In 1994, the Government's share was approximately 72 percent of the average premium. Premiums are paid on an individual and family basis.

The FEHBP is administered by the Office of Personnel Management, which, among other things, negotiates with plans on benefits and premiums, manages FEHBP premium payments, approves qualified plans for participation in the program, and determines the terms and conditions of and conducts the open season.

PROBLEMS WITH THE FEHBP

The FEHBP is being held up as a model for a national health care plan. The Heritage Foundation's Robert E. Moffit states, "This system based on consumer choice and competing providers works smoothly and is popular with lawmakers and civil servants alike. This is why few ordinary Americans ever hear their senator or congressman complain about his health benefits." Others have joined the chorus.

However, just a few years ago, the FEHBP was a target of criticism from many quarters for inefficiencies.

Jerome D. Julius, OPM's Deputy Associate Director for Retirement and Insurance, told the House Post Office and Civil Service's Subcommittee on Compensation and Employee Benefit, on May 24, 1989, "The Federal Employee Health Benefits Program is in dire need of comprehensive reform."

Congressman William Clay, Committee Chair, stated at hearings before the Subcommittee on May 20, 1992, "What we need -- an efficient health benefits program that will provide comprehensive coverage to Federal workers, retirees, and their families at a fair and reasonable price -- and what we have are two different things. The program ...is... bleeding. It is time to find a cure."

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Senator Ted Stevens on August 2, 1989, in proposing reform of the FEHBP, stated, "...[F]or quite some time, I have been concerned about the health of the Federal Employees Health Benefits Program. It has become clear to many of us that that program is desperately ill. Once one of the most attractive selling points for a career in Federal service, it is no longer state of the art. A conglomeration of insurance carriers and a confusion of plans, the only choice that it offers today is chaos. Largely because of the adverse selection problems, one of the program's largest carriers, Aetna, recently abandoned it, causing much consternation on the part of those employees it covers and the Federal work force in general."

In a letter to the Congressional Research Service requesting an in-depth systematic analysis of the FEHBP, dated June 15, 1988, Congressman William D. Ford, then chair of the House Committee on Post Office and Civil Service, and Congressman Gary Ackerman, then chair of the Subcommittee on Compensation and Employee Benefits, stated that the FEHBP "...program in recent years has been plagued with substantial benefit reductions, skyrocketing premium increases, and wildly fluctuating reserve levels."

According to recent studies by the Congressional Research Service; Towers, Perrin, Forster and Crosby, Inc. (TPF&C) for OPM; the consultants to the House Committee on Post Office and Civil Service; and the General Accounting Office -- among others, there are problems and inefficiencies in FEHBP.

The problems fall in the following areas.

1. Participation of Plans in the FEHBP.

There is no competitive bidding process or renewal negotiations to control a plan's participation in the FEHBP. Plans qualify for participation by meeting certain statutory requirements and standards, but not cost, quality, or service standards. The Federal Government, as primary payer and sponsor of health benefits for nearly 10 million people, is not exercising its buying power in the marketplace. There is no competition by plans/carriers for entry into or for remaining in the FEHBP.

In the typical private sector and in most other governmental situations, the employer defines the benefits it elects to offer, solicits bids, evaluates the bids, and selects one or more from among those offering the best coverage at the best price.

In the FEHBP, by contrast, there is no comparable solicitation, no bidding, no comparative evaluation, and no price concessions. The leverage that the nation's largest employer might have exercised in a competitive selection process is squandered.

Plans are admitted into the FEHBP without knowledge of the prices to be charged or benefits to be provided. There are no discounts or other favorable arrangements offered by carriers for the privilege of entering the FEHBP marketplace. Once in the FEHBP they remain essentially as long as they desire. The result is the Government does not necessarily get the best buy.

2. Risk Selection

A program offering a choice of competing health plans should have a system for managing the problem of adverse risk selection. (Risk selection occurs when individuals representing the same level of expected demands for medical services concentrate in a given plan or option.) The FEHBP does not. Consequently, as pointed out by TPF&C's *Study of the Federal Employee Benefits Program* for OPM in 1988, "[T]he history of FEHBP is a study in the erosion of the group insurance principle by risk selection."
Risk segmentation is so severe, according to a 1989 Congressional Research Service study, that premiums in the FEHBP vary by 246 percent even though the expected value of the benefits vary by only 46 percent. The premiums reflect enrollee characteristics rather than the value of the benefits.

In the case of Blue Cross/Blue Shield, both the high and standard options have approximately equivalent benefits from an actuarial standpoint, but there is more than a fivefold difference in employee premium rates, according to OPM.

In 1974, the high option of the two Government-wide plans accounted for 56 percent of total FEHBP enrollment. Today, only one of those plans currently exists and accounts for less than 15 percent of total FEHBP enrollment.

3. Consumer Driven Competition

As noted above, in State and local governmental and private sector situations, employers negotiate with competing plans before allowing them to offer their plan to employees. In this case, only after program administrators assure the value of the plans are they offered to employees. In the FEHBP, however, plans do not compete to enter the FEHBP. They compete for enrollees. The competition is solely at the consumer level, for which the FEHBP has often been praised. The theory behind

the choice in the FEHBP is that competition among plans at the consumer level leads to the most efficient provision of services to participants and lowers program costs. In fact, critics claim that this form of competition has done nothing to counteract inefficiency and lower costs and, in fact, may have exacerbated them. Competition at the consumer level winds up being primarily to attract the better risks. The result this has been risk segmentation, leading to prices based on enrollee characteristics rather than the value of benefits.

4. Choice of Plans and Range of Benefits

While each enrollee may choose from among two dozen to thirty-five of the 300 or so plans participating in the FEHBP, and thus there are many different plans from which to choose, it has been said that meaningful choice in the FEHBP is illusory. Because choice has led to risk segmentation, resulting in premiums based on enrollee characteristics rather than value, enrollees' ability to assess the value of competing plans is undermined, and, for lower income Federal retirees and employees, choice is limited by what enrollees can afford to pay, rather than by what benefits are suitable for their situation. According to a 1989 attitude survey by OPM of FEHBP membership, the majority of respondents said that comparing plans in the FEHBP is a problem and they would prefer a simpler program with fewer choices.

5. Consumer Information

According to Robert Moffit of the Heritage Foundation, "[m]embers of Congress and federal workers are not left alone in a bewildering and confusing health care market, but are given solid, 'user-friendly' information ... on the options available to them." This statement is contradicted by the 1989 OPM survey cited above and the various studies on the FEHBP. In fact, because of risk segmentation and its effect on premiums, it is extraordinarily difficult to make a rational choice among the FEHBP plans.

6. Portability

If Federal employees leave Federal service (other than by retiring), they have the same problem any other individuals have when they leave their jobs: they lose the health care they received on the job. Even if they can afford to pay the entire premium themselves (Government share and enrollee share), continuation of their FEHBP coverage lasts only for a certain period of time, just as continuation coverage in the private sector does. Federal employees have FEHBP insurance only if

they are employed by the Federal government or retire from the Federal Government. Moreover, their benefits can change, just as private-sector employees' benefits can be changed. In 1982, benefits in the FEHBP were drastically cut. (In 1982, in order to stay within budget, OPM instructed fee-for-service plans to reduce benefit costs by 13 percent. Costs were reduced by introduction of various deductibles and co-payments.)

7. Financial Help

According to Robert Moffitt of the Heritage Foundation, one of the advantages of the FEHBP is that "[m]embers of Congress and all federal workers also get some financial help from the federal government in the purchase of their insurance. The government makes a contribution ... an average of a little more than 70 percent of the premium."

The "financial help" the Government provides to Federal employees through the FEHBP is its contribution to it as the employer. In fact, private-sector and state and local governmental employers often pay all the costs of health insurance for their employees and, at any rate, almost always contribute more than the Federal Government does for its employees.

Employer health benefit contributions are not taxable to employees. The premiums paid by employees for their health insurance is not deductible.

The Congressional Research Service studies and others have demonstrated that the typical FEHBP plan is less generous than the typical private-sector plan.

8. Cost Control

Mr. Moffet cites the FEHBP as a "program that works well in controlling costs" and states further that "this cost control is all the more remarkable, given that the Federal program, unlike many private or corporate health plans, is open to all retirees...[who are]...much more costly on average to insure than active workers...."

Mr. Moffet neglects to consider that, for Federal retirees eligible for Medicare, the FEHBP is secondary payor and, despite the fact that Medicare-eligible retirees thus typically receive lower benefits from the FEHBP, retirees pay the same premium as active employees (in addition to paying for Medicare). Therefore, Federal retirees eligible for Medicare subsidize active workers in the FEHBP.

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Moreover, according to the 1989 TPF&C study of the FEHBP for OPM, "...the FEHBP is inefficient and not very cost effective...[and]... the program should either be receiving more health care for the money it spends or spending less money on the health care protection it receives."

Furthermore, the FEHBP premiums would have increased more than they have except that FEHBP benefits were cut in 1982, and in 1986 concern about growing reserves caused plans to draw them down, thus reducing premiums.

9. Other Economic Inefficiencies

Specific economic inefficiencies were revealed in detail in the General Accounting Office, Congressional Research Service, TPF&C, and the House Committee Consultants studies. Too many plans with only subtle differences in benefits are available, confusing subscribers in making choices and multiplying the Government's cost as well as fragmenting its buying power.

There is a serious lack of accountability.

The FEHBP contracts are different from other government procurements -- they renew automatically and for experience-rated plans both gains and losses are rolled forward and are either drawn down or made up in the next contracting period, so there is, with certain exceptions, little real risk. Yet there are risk charges and profits.

Employee organization plans have evolved into additional "government-wide plans" and charge associate member dues for non-members for which no health care services are received but which enrich the employee organizations by millions of dollars.

The annual open season is expensive and exacerbates adverse risk selection.

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PROPOSALS IN 103RD CONGRESS
TO EXPAND COVERAGE OF THE FEHBP

Several bills were proposed during the 103rd Congress that would have affected the FEHBP.

The President's Health Security Act would have terminated the FEHBP, requiring Federal employees and annuitants to purchase health insurance through regional alliances serving the area where they reside. The Wellstone/McDermott single-payor proposal would likewise have eliminated the FEHBP.

Various other bills would have expanded the FEHBP by opening it in varying degrees to individuals and/or companies, and some would have modified the FEHBP as well.

For example, the Moynihan bill would have opened access only to the FEHBP community-rated plans, with the government-wide FEHBP plans closed to non-Federal enrollment.

The Kennedy bill would have modified the FEHBP package to be consistent with a standard package of benefits, required plans to be community-rated locally, and made FEHBP plans available to all Americans not receiving coverage through a large employer (with those individuals also able to purchase insurance directly from insurance companies or through voluntary state cooperatives). Employers, except those with fewer than five employees, would have been required to share the cost of the premium.

The Roth proposal would have expanded the current FEHBP to allow small employers with 100 or fewer employees (including businesses with one self-employed individual) to offer their employees access to FEHBP plans at the same premium paid for Federal enrollees, so long as a specified percentage of their employees enrolled. While employers would be required to forward premiums to insurance carriers, they would not have been required to pay for any part of the premium. Each plan participating in the FEHBP would have been required to insure an annual minimum number of small business workers. The Roth proposal retained the ability of current union plans to continue to provide coverage exclusively to its members.

The Dole plan would have opened the FEHBP to self-employed individuals and small employers (up to 50 employees) at the same premium paid for Federal enrollees plus an administrative fee.

The Mitchell bill would have modified the FEHBP, required a standard benefit package, and opened the FEHBP to workers in firms with fewer than 500, nonworkers, AFDC recipients, and the self-employed, but at an age-adjusted community rate until 2002 when both Federal and non-Federal individuals would have paid the same community-rated premium.

The Clay bill proposed to open the FEHBP to employees of businesses with 100 or fewer employees, the self-employed, and the uninsured. The Clay proposal would keep non-Federal enrollees in a separate risk pool, although over a period of years the two risk pools would merge. The Government would offer supplemental policies at no charge to Federal employees and retirees.

ISSUES TO BE CONSIDERED IN EXPANDING THE FEHBP

Is it feasible to expand the FEHBP, and should it be expanded? The answer to the questions depends on whether the problems of the FEHBP are corrected and the manner and degree of the expansion. As can be seen from the various proposals already made, there are many possibilities. There are also issues that must be addressed and ramifications that must be considered.

Would it be the FEHBP plans themselves that are offered to non-Federal enrollees? Or would an FEHBP-like structure be established to serve non-Federal enrollees?

What about those FEHBP plans that are not now open to the entire FEHBP population? For example, the plan of the Beneficial Association of Capitol Employees (BACE) serves members of Congress and congressional staff exclusively. Will such plans be allowed to continue in the FEHBP and to continue to restrict their coverage?

Would the FEHBP employee organization plans that now allow the entire non-member FEHBP population to enroll in their plans if non-members pay "associate member" fees be allowed to enroll non-Federal enrollees in their plans also?

Would the FEHBP plans be exempt from state premium taxes and mandated benefits, and other requirements, as they are now, when there are non-Federal enrollees?

Where would the plans/employers stand with respect to coverage under the Employee Retirement Income Security Act of 1974 (ERISA)? Would non-Federal employers who contributed to coverage of their employees under the FEHBP be deemed to have established an ERISA-covered plan? If so, what about employers who forwarded employees' premiums but did not contribute?

Would FEHBP coverage be opened only if mandates were involved, i.e., all individuals were required to have health insurance, or would it be opened on a purely voluntary basis? If the latter, would individuals be covered only if their employers contributed, or if a specified percentage of the firm's employees were covered? The answers to these questions are indicative of the adverse selection problems that could arise and the subsequent effect on premiums.

Would Federal enrollees and non-Federal enrollees be kept separate as risk groups, with separate accounting, record-keeping, premium-setting, etc.?

Would only certain FEHBP plans be opened and not others, e.g., only community-rated HMO's, but not the experience-rated government-wide plans?

Would it be a modified FEHBP that would be opened up or would the FEHBP as it is now essentially (although with some problems corrected) be opened up?

Should only options that would not harm current FEHBP enrollees be considered? Should there be a differentiation between the role of the Government as employer and the role of the Government as insurance facilitator for national health care?

Would there be any pre-existing condition exclusions for new non-Federal enrollees?

Would there be participation rules? Entry/exit rules? Additional costs assessed for additional administration burdens?

Would the FEHBP or an FEHBP-like structure be opened in the present insurance environment, e.g., where pre-existing condition rules exist? Or, would insurance market reforms be instituted nation-wide before the FEHBP is opened up? The interest in and the populations attracted to the FEHBP might be very different, depending on the answer.

Would administration of the FEHBP remain at OPM if expanded?

Does OPM or the FEHBP have the capacity to take on millions of more enrollees if it should come to that? Would the non-Federal enrollees be charged for the additional administrative costs that will be incurred by an expansion?

How likely is it that there would be much interest in an expanded FEHBP? Certain non-Federal enrollees have access to the FEHBP now -- Federal employees who quit their government jobs, children of Federal workers or retirees who do not have status as dependents, and ex-spouses have access to the FEHBP for varying periods to life. It might be useful to examine these populations to ascertain who takes advantage of this opportunity -- and for those who do not, why not. Moreover, 28 percent of Federal employees and retirees are not enrolled in FEHBP -- 500,000 retirees and 450,000 employees. It might be useful to ascertain how many are eligible to participate and why they are not covered, especially since the Government pays a large part of the costs. This might give us some idea of the populations interested in FEHBP coverage.

STATES' EXPERIENCE AVAILABLE

Do we have any models for opening up a large health benefit program to smaller groups or individuals? In recent years, some State health plans have brought additional local public sector and, in some cases, private sector employee groups into the State plan, giving the State enhanced group purchasing power and giving smaller groups access to more affordable health care. These States' experiences and the problems they encountered could be instructive if the FEHBP were to be opened up. For example, because of unstable membership and adverse risk selection concerns, some States impose entry and exit rules. Some states have separate risk pools because of adverse selection.

PROs AND CONs AND RECOMMENDATIONS

PROs to Expanding the FEHBP or FEHBP-like Structure

1. The FEHBP has a positive image in the eyes of the larger population.

2. This would be a method of providing health care to at least some of those who do not now have it.

3. There are ways to expand FEHBP to some extent or set up a separate FEHBP-like structure without causing problems to Federal enrollees or the FEHBP. There are a number of ways to accomplish this, e.g., the expansion could be limited to the FEHBP community-rated HMO's, or the Federal enrollees and expanded non-Federal groups could be kept in separate risk groups.

CONs

1. The problems of risk selection and other inefficiencies in the FEHBP should be corrected before it is expanded or duplicated. There are identifiable problems in the FEHBP which should not be expanded into the wider population.

2. It is unknown how many of the uninsured would be interested in paying the entire or even part of the FEHBP premium (except those who have conditions which preclude their obtaining insurance elsewhere). It would be wise to ascertain how widespread non-Federal enrollment might be.

3. If the FEHBP were opened up and were a failure, it could discredit further health reform efforts.

RECOMMENDATIONS

FEHBP can be opened to non-Federal enrollment, at least to some extent. Whether it should be opened, how, to whom, and to what extent it should be opened, and how to deal with existing problems in the FEHBP must be very carefully thought out and handled before the FEHBP is expanded or an FEHBP-like structure is established.

If the expansion or the establishment of an FEHBP-like structure is handled carefully with the existing problems and inefficiencies corrected, and all ramifications considered, it could be a success.

On the other hand, if it is not handled very carefully and cautiously, we could have, instead of the existing successful program with some problems covering Federal employees, a disaster.

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